Thurrock Better Care Fund
Draft Submission – version 0.9

Local Authority
Thurrock Council

Clinical Commissioning Group
NHS Thurrock Clinical Commissioning Group

Boundary Differences
Co-terminus

Date to be agreed at Health and Wellbeing Board
10th February 2014

Date submitted
14th February 2014

Authorisation and Sign-off – 1st Submission

Signed on behalf of the CCG	**Thurrock CCG**
By	**CCG Board**
Position	**N/A**
Date	**CCG Board Meeting 29th January 2014**

Signed on behalf of the Council	**Thurrock Council**
By	**Roger Harris**
Position	**Director of Adults, Health and Commissioning**
Date	**13th February 2014**

Signed on behalf of the Health and Wellbeing Board	**Thurrock Health and Wellbeing Board**
By	**Thurrock Health and Wellbeing Board**
Position	**N/A**
Date	**10th February 2014**

In addition, Thurrock BCF Plan was considered by Thurrock Health and Wellbeing Overview and Scrutiny Committee on the 11th February 2014.

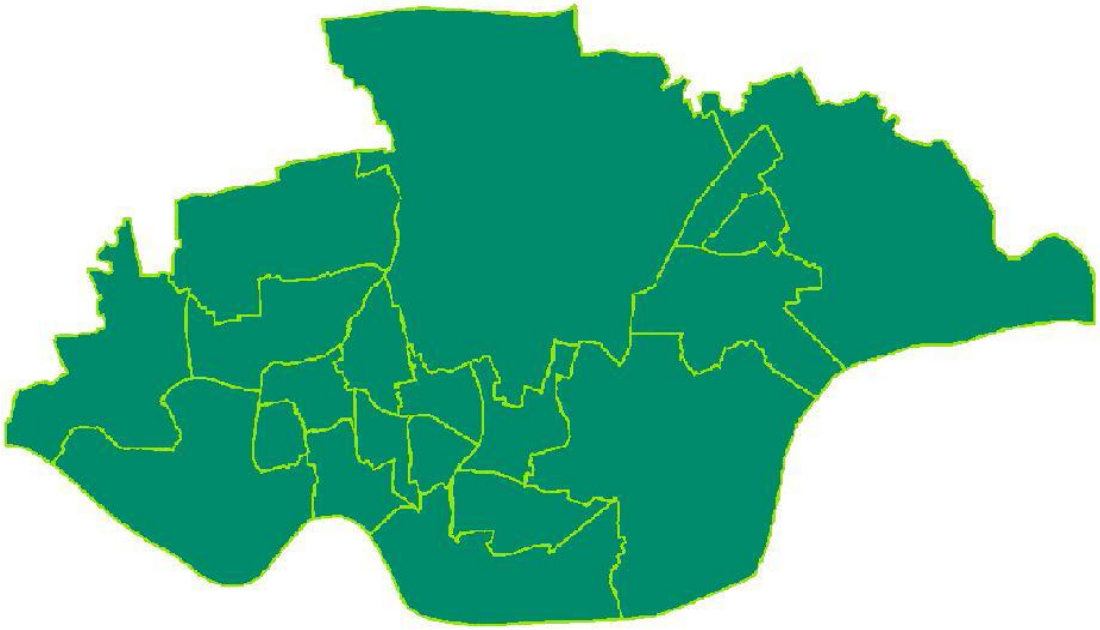
Final sign-off dates:

Thurrock Health and Wellbeing Board – 13th March 2014
Thurrock Council Cabinet – 19th March 2014
Thurrock Clinical Commissioning Group Board – 26th March 2014

Minimum required value of BCF pooled budget:	**2014/15**	£2,861,506
	2015/16	£10,565,000
Total proposed value of pooled budget:	**2014/15**	£3,723,506
	2015/16	£10,565,000* (minimum)

***The total proposed value of the pooled budget for 2015/16 will be decided during 2014/15. The ambition is for health and care funding, pooled or otherwise, to include the CCG unplanned care budget and the Adult Social Care older people budget. This will reflect this Plan's focus on older people and the frail elderly.**

Thurrock Profile



Introducing Thurrock

Thurrock's character and personality has formed and evolved over centuries as agriculture, industry and the river have shaped the landscape, the make-up of its people and the quality of life.

The enduring characteristics of those who live or have lived and worked in the Borough – enterprise, resilience, opportunism, adaptability – represent strength of spirit. It is this spirit that will drive a new tone and a fresh relationship between the public sector and everyone it does business with and is captured in the vision and priorities for Thurrock:

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

- Create a great place for learning and opportunity;
- Encourage and promote job creation and economic prosperity;
- Build pride, responsibility and respect to create safer communities;
- **Improve health and wellbeing**; and
- Protect and promote our clean and green environment.

Thurrock lies on the River Thames immediately to the east of London. Thurrock hosts two international ports which are at the heart of global trade and logistics and is strategically positioned on the M25 and A13 corridors, with excellent transport links west into London, north and east into Essex, and south into Kent.

With a population of 157,705 (Census 2011), Thurrock lies on the River Thames immediately to the east of London, and is home to some of the most exciting opportunities in the country. Thurrock hosts two international ports, London Gateway and Port of Tilbury, which are at the heart of global trade and logistics and is strategically positioned on the M25 and A13 corridors, with excellent transport links west into London, north and east into Essex and south into Kent.

There are many opportunities for growth and the current regeneration programme will once again change the landscape, with the expansion of the retail and leisure offer at Lakeside, the creation of the biggest container port in Europe at London Gateway, High House Production Park which hosts the Royal Opera House production facilities to name a few. All of these will bring new jobs and fresh opportunities for Thurrock's communities.

How people feel about where they live, how they feel about their public services, how they feel about themselves will be central to creating a collective sense of identify and direction. One in which people aspire for themselves and for their families to do well in their education, are equipped to take on a new and different type of jobs available, have the best possible quality of life and are proud of where they live.

The Council and its partners will be changing and adapting to help achieve this, enabling and facilitating change, preparing its residents for the new opportunities, engaging and involving, more in tune and in touch with the needs of local residents, partners, businesses and its employees, aligning expectations and aspirations.

The current economic downturn provides an opportunity and a catalyst for operating differently and valuing the perspectives of everyone who has a stake in the future of the Borough.

Context for Health and Care in Thurrock

Thurrock's current population (157,705) represents an increase of over 10% since 2001 and 22% since 1991. It is projected to be 207,300 by 2033. The population group aged 85 and over is projected to double. 12.4% of people live in the 20% most deprived areas of England, and the BME population in Thurrock has risen from 7.2% (2001) to 19.1% (2011).

We are committed to stimulating a diverse market for residents who require health and social care services, a market where innovation is encouraged and rewarded, and where poor practice is actively discouraged. This is a key part of shaping Thurrock and it directly relates to the priorities contained within Thurrock's Community Strategy.

Thurrock has four key health providers – North East London Foundation Trust (NELFT) who provide community services, South Essex Partnership Foundation Trust (SEPT) who provide mental health services, Basildon and Thurrock University Hospitals Foundation Trust (BTUH) who provide acute and secondary care services and East of England Ambulance Service NHS Trust provide urgent and emergency medical care to people who call 999.

The Primary Care provision in Thurrock consists of 42 GP practice locations (main and branch) and 167,946 registered patients as at 1st April 2013. There are 21 dental practices, 18 opticians' practices, and 32 pharmacies.

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 Thurrock's most deprived areas. The Essex Primary Care Strategy, currently being consulted on by NHS England Essex Area Team, contains proposals to address these issues.

With the expected ageing and growth of the population, we can expect a rise in age related disease prevalence and potentially increased demand on health and social care services. Dementia for example is predicted to increase steeply in Thurrock – by 2033 the population aged 85+ is projected to double. Long Term Conditions (LTCs) such as dementia and diabetes are more prevalent in older people with 58% of people over 60 having at least one long term condition compared with 14% of people aged below 40. LTCs account for 50% of all GP appointments and are estimated to account for £7 in every £10 spent on Health and Social Care (King's Fund).

Lifestyle factors are having a significant impact on the demand for health and social care services in Thurrock and will continue to do so unless we are able to at least halt current levels. 22% of Thurrock adults are smokers, with smoking prevalence and smoking-related deaths significantly higher than national averages. 25.1% of year 6 children and 28.1% of adults are classified as obese – this too is significantly higher than the England averages. These are factors we are addressing through our public health campaigns and through a range of initiatives that aim to develop more resilient communities – our Building Positive Futures programme.

As a unitary authority with responsibilities for social care, public health, housing, highways, planning, leisure and a range of other services, Thurrock Council, alongside Thurrock CCG, is in a strong position to mobilise on a wide range of fronts to address these challenges. In 2012 we launched our Building Positive Futures programme to:

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

The programme reports to a councillor and director-led sponsorship board with reporting lines into the Health and Well-Being Board, Cabinet and the Health and Wellbeing Overview and Scrutiny Committee. Crucial to the success of the programme is the involvement of Healthwatch, Thurrock CVS, and the Thurrock Coalition, which is Thurrock's user-led organisation.

In addition to preparing for integration with Health, the Council is preparing for reforms to the system of social care funding, including the introduction of a cap on care costs from April 2016, and a universal offer of deferred payment agreements from April 2015. The Council is in the process of establishing a Care Bill Implementation Board. The Board's programme of work will entail:

- Undertaking assessments and reviews for service users and carers against a new national eligibility criteria, and establishing care accounts;
- establishing the administrative arrangements for deferred payment and arranging loans; and
- a local information campaign to ensure the new arrangements are understood by local people.

Preparations in 2014/15 will involve the recruitment and training of staff and capital investment, including IT systems (which sits in the Better Care Fund).

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

We have established a Strategic Leadership Group that meets bi-monthly and is linked to the Health and Wellbeing Board. The Group includes all the main NHS Trusts working within Thurrock – North East London Foundation Trust; South Essex

Partnership Foundation Trust; and Basildon, Thurrock University Hospitals Foundation Trust, and East of England Ambulance Service NHS Trust.

The Strategic Leadership Group is responsible for the following:

- Contributing to the development of our strategy for integration;
- Reviewing national policy and overseeing its local application, as well as the implications for local commissioning of the NHS payment system, so that we can see a real shift in resources and activity from the acute sector into primary care and community services;
- Building a strong Thurrock identity for integrated care amongst all our providers;
- Working together to create and evaluate new models of care to secure improvements in quality and outcomes at an early stage; and
- Registering and managing risks and issues for residents, commissioning and providers, where these relate to the integration agenda.

Thurrock's Better Care Fund Plan has been developed and tested in conjunction with the Strategic Leadership Group. In addition, aspects of the Plan have already been rolled out with provider input. Providers will continue to be engaged as the Plan develops further and particularly as developments and improvements to service models are considered.

Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

We are working closely with community and voluntary sector partners (Thurrock HealthWatch, Thurrock Clinical Reference Group, Thurrock CVS, and Thurrock Coalition) to ensure that everyone is informed about these proposals, that everyone who wishes to is able to be involved in developing our plan, and that our vision reflects the views and wishes of our citizens.

Together **with community and voluntary sector partners**, we have developed an engagement plan which is attached to this document and describes our approach. Key to this and central to our local ethos is co-production. We are committed to ensuring that the development and delivery of this Plan involves on-going dialogue as opposed to one-off consultation events.

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.

Ref	Document	Synopsis
1	Community Strategy	A partnership document detailing the long-term vision and strategic priorities for Thurrock.
2	Thurrock Council Corporate Plan	The Council's organisational response to the Community Strategy.
3	Joint Health and Wellbeing Strategy	A partnership document detailing the vision and aims for improving health and wellbeing in Thurrock.

4	Thurrock Compact	A meaningful framework to support and inform joint working across sectors for the benefit of residents and communities in Thurrock.
5	CCG Operational Plan	Thurrock CCG's two year operational plan
6	CCG Strategic Plan	Thurrock CCG's five-year strategic plan
7	Joint Strategic Needs Assessment	Analysis of the health needs of Thurrock's residents to inform planning and commissioning.
8	Draft Primary Care Strategy	The Strategy outlines the vision for Primary Care in Essex and identifies how the vision will be delivered.
9	Delivering Seven Day Services	Describes how seven day services across health and social care will be delivered.
10	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.
11	Strategic Housing Market Assessment	This is a study of current and future housing requirements and housing need across south Essex, including the borough of Thurrock. It provides evidence to support development of local housing strategies and also the planning of other services such as health, education and transport.
12	Market Position Statement	The Market Position Statement for Thurrock provides details of the market for adult social care services and how demand is expected to change in coming years. The Market Position Statement will then set the direction for Commissioning Strategies for integrated adult social care and health care services to promote health and well-being in Thurrock.

Vision for Better Care

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

Thurrock's Vision for Health and Wellbeing

Thurrock's Vision for Health and Wellbeing contributes to the Community Strategy priority:

Improve health and wellbeing

Thurrock's Health and Wellbeing Strategy 2013 - 2016 establishes the overarching Vision for enabling all Thurrock residents to achieve good health and wellbeing:

Resourceful and resilient people in resourceful and resilient communities

Thurrock's Vision for Better Care

In late 2013 Thurrock Health and Wellbeing Board and Thurrock Clinical Commissioning Group Board worked together to develop a set of principles that frame Thurrock's Vision for integrated health and social care services. We believe these will support our vision of 'resourceful and resilient people in resourceful and resilient communities'.

Our vision is for all adults, children and young people to benefit from Better Care. The principles that frame our vision will enhance and improve the quality of solutions and outcomes for all our residents. In doing so we will ensure that we can achieve our aim of managing demand within available resources.

We have chosen to focus our Plan on the health and care of older adults. This is the area of highest spend and demand for both the CCG and Adult Social Care and an area in which we feel we can initially make the most impact. As our plans for Better Care develop we will broaden our approach to so that we address the needs of the whole community.

The principles that frame our jointly developed vision 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

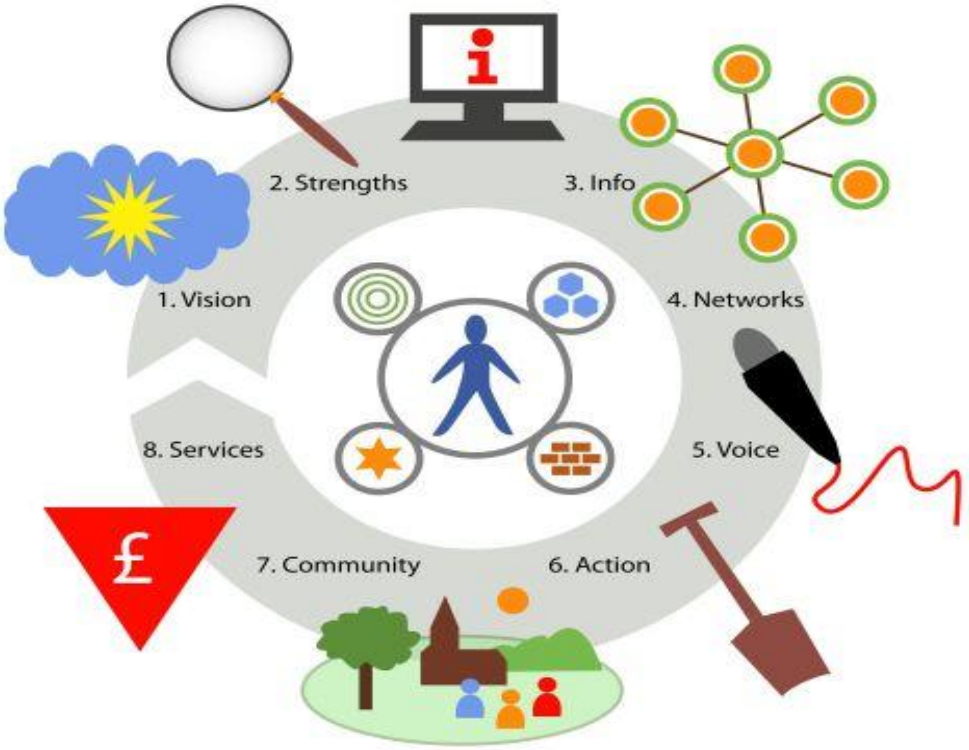
What each of these principles mean in terms of changes and benefits is detailed below. This will be further developed throughout 14/15 together with detailed plans to deliver the changes required.

Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing

Citizens and equal and active partners
We want local citizens to be equal and active partners with the CCG and the Council in improving health and well-being for the people of Thurrock. This means that individuals rather than health or social care services must be in charge of their health and wellbeing. Achieving this means that the health and care system is co-produced and that citizens are part of an on-going conversation about the support and solutions they require. Fundamental to this is co-production as an integral part of our planning and commissioning process.

Personal responsibility
Part of citizens being equal and active partners also means individuals taking responsibility for their own health and wellbeing. Achieving this will require us to have a new approach to assessment and management – and also to how we manage 'risk'. We will actively pursue this approach as part of our Plan.
Working with our voluntary and community sector, and patient and service user groups, we will develop an approach aimed at changing behaviour and encouraging greater personal responsibility. Success will depend upon ensuring that individuals can identify and access the information and support they need where they live. We want to ensure that resources are used appropriately, but that people are able to self-manage where possible – for example long-term conditions, and have the information required to improve or maintain good health and wellbeing.

The delivery of health and social care personal budgets will provide a further opportunity for people to take more personal responsibility and to achieve the outcomes they want in the way they want. The application of strength-based approaches to assessments will switch the conversation from 'what are your needs', which are then assessed against the services that we can offer, to a much broader question 'what would make a good life for you?' This facilitates a conversation that takes into account the whole person, and importantly enables an approach focused on what the person can do for themselves.



Broadening 'health and social care' – universal services
For many people, getting the support they need to be healthy, well and active life in their communities should not mean having recourse to community health or care services. Timely access to information and advice, or benefits or education, housing or leisure services, or sympathetic help in a shop or on a bus, will provide what they need. So part of our integration plan is to ensure that universal services, and not just those provided by the Council, but across the public, voluntary and private sectors are attuned to the needs of older adults.

Resilient communities, resilient citizens
Work is underway to create more hospitable, neighbourly, resourceful and resilient communities, recognising that such communities create health and well-being (Assed-Based Community Development - ABCD). For example, we have an ambition to become a dementia-friendly community - working in partnership with the local Alzeimer's Society. Our ABCD programme will involve the development of local health and well-being community plans that are owned by local communities themselves. As a start we are piloting a strength-based approach to a locally based Joint Strategic Needs and Strengths Assessment in one area of Thurrock. This will link strongly with the emerging Primary Care Strategy's direction of travel – e.g. a locality-based primary care model.

Choice and growing the market

We need to be able to offer greater choice for those who require services. To do this, we need to shape the market to offer better quality and greater choice of health and social care services – this is particularly important to the success of personal budgets. We will use our jointly developed Market Position Statement to ensure that we achieve plurality, and that our commissioning and procurement process for integrated health and social care services aids rather than prevents this objective. In particular we will commission community health care and social care services jointly, under the terms of a single contract whenever it is beneficial to do so. This will not only enable more co-ordinated care under a single service specification but also streamlined contractual arrangements and performance management and by so doing reduce wasteful duplication.

Public Health intervention

Public Health initiatives are also a fundamental part of enabling individuals and communities to take more responsibility for their own health and wellbeing. Thurrock's population has poor health outcomes resulting from higher than average obesity levels for both adults and children, and smoking prevalence. We will ensure that public health commissioning complements our work to strengthen communities as well as how we commission health and care to improve personal responsibility alongside prevention and timely intervention.

Health and care solutions that can be accessed close to home

We will ensure that people can access the help they need at home, or close to where they live. This will include health and care information and advice and support that is both web based and available within, and provided by, the community itself as part of our community hub development programme. This is consistent with the emerging Essex Primary Care Strategy, in particular GP practices forming a hub integrating with community services and social care and working collaboratively with acute services.

Advice and information
The Council in conjunction with the CCG and other health partners will provide advice and information about health and well being readily accessible via the web allowing people to serve themselves. Over time all our information and transaction services will be delivered online through My Account providing a consistent customer service no matter how or when or where people seek help with health or social care needs. This will enable residents to reduce multiple contacts - providing basic information only once, and receiving regular updates on progress.

Developing the 'place-based' offer
As part of our channel strategy, and following the success of the South Ockendon Centre, we will continue to roll out our place-based community hub programme which empowers communities so that they are resilient to any future reduction in public funding. This programme includes:

- Opportunities to integrate health and social care services at a neighbourhood level;
- A focus for Local Area Co-ordinators and citizens engaged with Asset Based Community Development to explore ideas and connect people so they are better supported in the community, by the community;
- The development of community plans to prioritise local improvements including, housing, health and the built environment;
- The place where people think of first if they cannot find what they are looking for via the web; and
- Where a community solution is the first consideration with traditional services sought only where specific needs are required.

Local Area Co-ordination
We also plan to increase the number of Local Area Co-ordinators (LACs) we have working in and with specific communities. Our LACs are already working successfully with GPs in our pilot areas and the prevention and timely intervention offer will be further enhanced by the introduction of health trainers to support service users in healthy lifestyle choices.

Alignment with Essex Primary Care Strategy
As part of the Primary Care Strategy we will see more primary care providers working at larger scale in primary care hubs. Some primary care-led sites will offer a full range of diagnostic and other hospital based services outside acute settings. The primary care workforce will change with a greater role for nurses, community pharmacists and health care assistants. There will be new and innovative opportunities for staff development within each hub linked to our community hub

programme that will fully integrate community health services adult social care. Patient voice will be strengthened within each primary care hub, building on the further development of patient participation groups.

Technological solutions
Telecare is now embedded in all joint assessments to support service users to remain independent. Over the past year Telecare usage has increased - with an average of 18 installations each month, and is included in 39.9% of all council funded social care packages. Over the next year, Telecare will be expanded with a wider range of equipment to support the changing needs of Thurrock's population, including projects such as the digital befriending service currently being piloted – for example Age UK is using Skype and TVHD webcams to combat social isolation by connecting families and friends by video conferencing.

Wider determinants of health and wellbeing
In furthering the principle of care closer to home we will continue to involve partners beyond health and social care. For example, we are working with housing colleagues to provide and develop across Thurrock suitable accommodation to support people as they grow older. This includes our 'HAPPI' standard specialised housing scheme at Derry Avenue where 28 flats for older people are closely linked to the community resource available at the South Ockendon Hub.

Services that when required are of high quality and tailored around the outcomes the individual wishes to achieve

Whilst our ambition is to reduce the number of people that need a 'service', we recognise that some people will always require a service and when they do, the service should be accessible, of high quality, and tailored to meet the outcomes the individual desires. We will involve citizens in conversations that help to define what 'good' quality means.

A focus on Primary Care
Thurrock's Health and Wellbeing Strategy has a clear priority to 'improve the quality of health and social care'. The focus of this priority is the quality and capacity of primary care services – although the priority covers the main areas of health and care provision (acute, residential, and community care). In particular, the focus is on the quality of GP provision as opposed to the other aspects of primary care. There are a number of reasons for this. Key issues for Thurrock include: patient access to services; under-doctoring, the number of GPs at or over retirement age, difficulty in recruiting and retaining new GPs in Thurrock; and the number of single-handed or small practices that exist. The Essex Primary Care Strategy is vital to the quality of primary care services in Thurrock being improved and ensuring consistency across the Borough. The Strategy seeks to address these issues through a number of work streams which include: developing a wider role for community pharmacists; creating community-based GP hubs – integrated with community care and adult social care; improving the primary care estate; creating more training practices to encourage new GPs in to the area; and a greater span of opening hours to encourage easier access for those requiring a GP service. The Primary Care Strategy's ambition is to see a shift of up to 5% in resources from hospital providers into primary care. The delivery

of the Primary Care Strategy is therefore intrinsically linked to the delivery of this Plan.

Health and social care workforce
We will work with providers to engage and empower the health and social care workforce to deliver better care. We acknowledge the findings of the Cavendish Review and whole heartedly agree that providing care to help people to recover after ill health, and to live independently, requires intelligent kindness, and a commitment to dignity. We see the need for health and social care staff to be developed to take on more challenging tasks, as well as the ability to work across organisational and professional boundaries, to provide better care. We will work with providers to test values, attitudes and aptitude for caring in the workforce, to move to commissioning based on outcomes, to support providers to pay a living wage, including time for travel, and to ensure zero hours contracts are used appropriately.

Quality Assurance System
We will also ensure that we have a good integrated Quality Assurance System in place. The Assurance System will help to ensure that provided services are high quality, maintain high quality, and identify any dips in performance.

A focus on prevention and timely intervention that supports people to be healthy and independent for as long as possible

Moving intervention 'up stream'
We know that if we want to continue to provide 'services' to those who need them and ensure that those 'services' are of high quality, we need to move- interventions 'up stream' whilst also seeking to reduce overall demand.

We have a number of initiatives in place already that focus on shifting and reducing demand for services. We will evaluate and build on these initiatives.

Strength-based approach
We have introduced a number of strength-based initiatives including Local Area Coordination (LAC) and Asset Based Community Development (ABCD). ABCD is based on the recognition that communities and the residents who live in them have many - often untapped - strengths, gifts and passions. We are encouraging communities and individuals to come together to identify and use those untapped resources. By recognising this, we encourage individuals, families and the wider community to think first in terms of local solutions to challenges rather than narrowly looking at "needs" that only the statutory sector can meet – assuming the individual meets the local authority eligibility criteria.

Developing Local Area Co-ordination
We already have three 'LACs' in place working within geographically based communities. The number is set to increase and is a key part of the BCF. LACs work with the community, and alongside professionals, to identify people at risk of crisis. Working with the resources available within the community and using a strength-based approach, the aims is to prevent those individuals from reaching crisis point and from requiring additional services. The focus is on 'solutions' and not 'services'. LACs work by 'connecting' people to networks available within their

community – including advice and support. This is particularly helpful to those people who are socially excluded – many of whom become frequent attenders of primary care services.

Timely intervention and prevention

As part of our Better Care Fund Plan we propose to initiate an approach to timely Intervention and prevention which:

- builds on the success of our two integrated health and care teams – the Rapid Response and Assessment Service (RRAS) and Joint Reablement Team (JRT) - a partnership with NHS South West Essex Community Services(NELFT) - which offer integrated services at the point of delivery (the approach is based on work undertaken by the Institute for Public Care with ADASS Eastern Region in 2011);
- will address high spend on adults aged 65+ when compared to its CIPFA statistical neighbours as well as those with Long Term Conditions;
- builds on a housing initiative which targets vulnerable people living in conditions that are detrimental to health & well-being as well as common causes of acute care including dementia, falls, COPD and loneliness; and
- also builds on our Primary Care Multi-Disciplinary Teams (MDTs) which are now in place and are highly successful at pro-active case management. Primary Care Multi-disciplinary Teams (MDTs) are effective because they ensure that the health and social care services provided to identified vulnerable older people are successfully co-ordinated so as to maximise individual independence and well-being, thus reducing the risk that the service user's condition will deteriorate to the point that they require admission to secondary care/residential care. Most primary care practices within Thurrock CCG have engaged in regular MDT meetings and has allowed the MDT to support robust patient / person centred clinical decision making and integration of care.

Systems and structures that enable and deliver a co-ordinated and seamless response

Wherever appropriate we will have one process, one assessment and care record, one pooled pot of money, one organisational response, and importantly, a single holistc response to the needs of our residents. The focus will be on achieving the right outcomes. The elements of the health and social care economy that we do not integrate will be managed as part of the 'whole system' so that care is co-ordinated at every point that touches a resident, service users or patient.

System transformation

Achieving this will require transformation of existing systems and structures. This will include developing the capability for sharing real-time information across all providers engaged in the care of older adults. It will also require complementary information management systems for commissioners and providers to enable effective management of performance, accountability and information governance. This will be a key part of the initial focus on managing care for older adults but will also provide the model for integrated services for adults who may be vulnerable because of learning disabilities or mental health problems, as well as children and young people.

Thurrock Council and CCG are carrying out a joint project to integrate health and social care data – bringing user and patient intervention and cost information together to enable intelligent and targeted evaluation of interventions on, reducing demand and pressures on acute support, measuring the impact and cost effectiveness of reablement. The system is also being used to help inform targeted multi-agency effort at GP Practice level through detailed risk profiling.

Integration Aims and Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the Better Care Fund will secure improved outcomes in health and care in your area.
Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

Our aims (principles) and objectives will drive the achievement of the following national conditions:

- Protecting social care services;
- 7-day service to support discharge;
- Better data sharing;
- Joint approach to assessments and care planning.

Our aims (principles) and objectives are described in the table below **[this section is to be completed and is work in progress]**.

Principles	**What will change over the next 5 years**	**What difference this will make**
Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing	*Individuals will be able to achieve the outcomes they want through personal health budgets and personal care budgets* *Citizens recognise the health and care system as being co-produced – and this is built within planning and commissioning processes* *Assessments are strength based and solution focused* *Fewer people require services and are able to access a range of support, advice and information from within their community* *For those who require a service, there is a good range of choice*	**To be completed**
Health and care solutions that can be accessed close to home	*When people require a service, this will be accessed through federations of practices with aligned community, mental health and social services.* *Some secondary care services will be available closer to home –*	**To be completed**

	alongside GP hubs. *The expansion of community hubs will mean that good advice, information and support is readily available and reduces the need for 'services'.* *Technology will be widely used to support people to be independent – particularly for people with Long Term Conditions. As a result, there will be fewer admissions due to poor management of these conditions.*	
High quality services tailored around the outcomes the individual wishes to achieve	*We will ensure that people are receiving the right care. No user will be placed in a long term care package until they have reached their optimal rehabilitation potential.* *Thurrock will have good quality primary care services – particularly GP services – this will include access to services.* *Citizens will have defined what 'good' quality means and services will reflect that definition.* *Health and care staff will be able to more freely work across organisational boundaries.* *Services will be outcome focused and work with individuals to reduce service need.*	**To be completed**
A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible	*There will be no unknown patients admitted to Basildon Hospital as emergencies* *Hospital non-elective admissions will have reduced by 15%.* *A prevention and timely intervention approach will be firmly embedded and be reducing service need – in particular the need for acute services. The cost of packages will have reduced as a result and more people will find the support they*	**To be completed**

	need in their own communities. *A greater number of people will be enabled to better manage their long-term conditions.* *Multi-disciplinary teams will be effectively identifying 'high risk' people at an early stage. Costs will reduce accordingly.*	
Systems and structures that enable and deliver a co-ordinated and seamless response	*All service users with dementia will have a joint health and social care plan.* *Joint health and care assessments will be common-place* *Systems will enable effective targeting – via risk stratification systems* *Health and care plans will be joint and holistic*	**To be completed**

As part of our transformation towards better care over the next two years we will:

- Undertaking a series of thematic reviews which will identify if and how care pathways and solutions need to change.

- Develop and define appropriate and co-produced integrated service models – based upon the results of thematic reviews.

- Develop locality plans to enable commissioning and service development and deployment on a community level and based around the strengths and needs of particular areas.

- Shift resource from secondary care to community and primary care and start to incentivise community care providers to keep residents independent at home and out of hospital and residential care.

- Through the delivery of the Primary Care Strategy, the development of geographically based primary care hubs will be underway. Multi-disciplinary teams made up of primary, community and social care will start to be established based on the hub 'footprint'. There will also be consideration of how certain secondary care services can be accessed closer to home as part of this work.

- Develop fully integrated governance and commissioning arrangements – sitting beneath and reporting to the Health and Wellbeing Board.

- Develop and start to deliver joined up care – including single assessment process, single point of contact.

- Continue to explore how prevention and timely intervention can be developed and delivered.

We have invested in Caretrak, a system designed to analyse health and social care data with the purpose of enabling us to effectively target care and support solutions. The system will enable us to deliver risk stratification by identifying those individuals who are most at risk against our chosen criteria.

Furthermore, the system will enable us to identify whether the initiatives and solutions we put in place are having the desired effect by an ability to track outcomes – e.g. reduced admissions, reduced cost etc.

We will continue to develop and identify how we can measure the impact the system is having as it changes.

The BCF Plan performance measures that we have identified are appended as part of this document.

Description of Planned Changes

Please provide an overview of the schemes and changes covered by your joint work programme, including: 1. The key success factors including an outline of processes, end points and time frames for delivery 2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care.

Achieving the Vision set out within this Plan will require significant transformational change. Whilst some of this is already in train – e.g. developing community resilience, other aspects of transformation are being developed and will continue to be developed. We have described the process through which the Plan, and therefore system redesign, will continue to evolve – governance. Our robust programme management arrangements alongside our Health and Wellbeing Board, Integration Leadership Group, and Strategic Leadership Group will provide the focus for both developing and delivering the required changes.

Schemes and Projects

The schemes and project below reflect spend for 2014/15. All schemes and projects will be reviewed as part of working supporting the Plan prior to 2015/16. Please also refer to the financial information on pages 44-45.

1. Empowered citizens who have the choice and independence and take personal responsibility for their health and wellbeing (community development, market development, personal health and social care budgets)

No	Scheme	Description	Investment Type	Min	Max
	Empowering citizens	Range of initiatives to support the empowerment of service users (assistive technology, direct payments, local area coordinators, mental health support, sensory worker)	Recurrent	£178k	£178k
	Voluntary Services	Review of services currently commissioned separately by the CCG and LA to look for development opportunities	Nil	Nil	Nil
	Telehealth	Continuation of current telehealth service. Evaluation and future service	N/R	£30k	£30k

		development			

2. Health and Care solutions that can be accessed close to home (system redesign)

No	Scheme	Description	Investment Type	Min	Max
	Stroke Services	Potential redesign of stroke services following consultation exercise (potential investment in Early Supported Discharge)	Recurrent	£50k	£50k
	Community Equipment	Redesign of equipment services currently delivered by Essex Equipment Service	Nil	Nil	Nil

3. High quality services tailored around the outcomes the individual wishes to achieve (service development)

No	Scheme	Description	Investment Type	Min	Max
	Community Bed Provision	Review and further development of Rehab/Nursing Home and Intermediate Care Capacity (Collins House, Mountnessing Court and Elizabeth Gardens)	Recurrent	£515k	£515k

4. A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible (admission avoidance, reablement, protection of social care)

No	Scheme	Description	Investment	Min	Max

			Type		
	Rapid Response Assessment Service and Reablement	Review of existing provision/refining model/sustainable commissioning	Recurrent	£1,025	£1,025k
	Protection of Social Care	Maintaining eligibility criteria	Recurrent	£1,666k	£1,666k
	Hospital Social Care Team	Additional support for acute social care team. Ensuring 7 day service provision	Recurrent	£80k	£80k

5. Systems and structures that enable and deliver a co-ordinated and seamless response (Whole system development, locality based MDTs, risk stratification)

No	Scheme	Description	Investment Type	Min	Max
	Caretrak	Implementation of Caretrak across Health/Social	Recurrent	£50k	£50k
	Primary Care MDT	Coordinator to support case identification and MDT process	Recurrent	£51k	£51k

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Implementing the Vision for Better Care in Thurrock will have an impact on all providers across the health and care system including care homes, community and mental health providers and third sector organisations. In addition, the Vision is reliant on working in close partnership with our acute providers (primarily Basildon and Thurrock University Hospitals Foundation Trust).

In conjunction with the lead commissioner (Basildon and Brentwood CCG), we are currently negotiating a block contract for non-elective care with Basildon Hospital to be introduced over two years. We will devise a system that incentivises primary care and community providers to see more people for longer and to keep people out of hospital. By making this agreement, we seek to offer stability to the acute system to allow for focus on service redesign to create a longer term sustainable health and social care system.

Incentivising primary and community care will assist with the delivery of the 15% reduction in non-elective care over the next five years.

We are keen for our providers to work with the CCG and Council to support the development and delivery of our vision for Better Care. To this extent, we have established the Strategic Leadership Group. This group has executive representatives from our local provider organisations in addition to the CCG and Council. Ensuring whole-system leadership is key to delivering the vision and goals contained within our Plan.

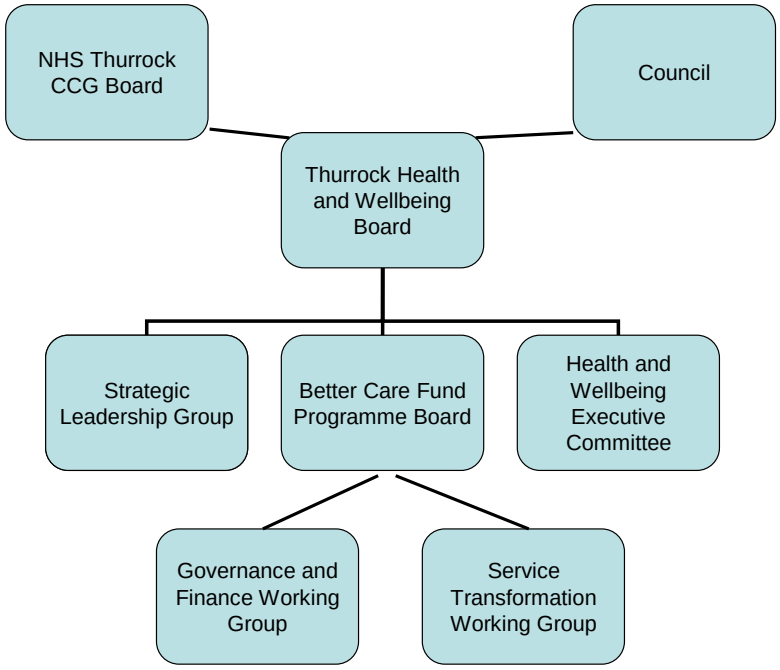
Governance

Please provide details of the arrangements that are in place for oversight and governance for progress and outcomes

Governance Arrangements

The governance arrangements for Thurrock's Better Care Fund are yet to be fully developed, and a task and finish group has been set up for this purpose.

The Governance arrangements that do exist will link to Thurrock Health and Wellbeing Board, with key decisions being made by the respective Executive body subject to delegations. The proposed structure is detailed below:



Next Steps

Through the work of Thurrock's BCF Project Board, a number of governance issues have been identified that require resolution prior to arrangements being clarified. This includes:

- CCG or local authority as 'host' organisation – pros and cons;
- Delegations – to Health and Wellbeing Board and the Section 75 Strategic Integration Group;
- Health and Wellbeing Board terms of reference;
- Financial governance – including risk sharing arrangements;
- S75 group membership and terms of reference;
- Procurement rules;
- V.A.T.;
- Workforce and human resources; and
- Information sharing.

We have established a Governance Task and Finish group to look at the aforementioned issues and to identify options and solutions. Section 75 arrangements will be established through the work of the Group. The Group will need to commission some specialist advice – e.g. in relation to procurement law and VAT.

Integrated Commissioning

The CCG and Local Authority have agreed to consider ways in which commissioning across health and social care can become more fully integrated. There are a number of options to be considered which include:

- Establish a single organisational integrated commissioning structure;
- Appoint a single Head of Integrated Commissioning across the Council and CCG who would manage all staff, but have dual accountability;
- Co-location with team members working on single projects for both organisations; and
- Limited changes amongst the staff but strengthen the governance arrangements through a more formal Joint Commissioning Board.

No final decision has been taken and will be explored and agreed during 2014-15. Depending upon the option chosen, there may be a stepped approach to achieving full integration of both organisations' commissioning arrangements.

Project Governance
Our Plan covers and outline of what we think 'Better Care' should look like (our vision). What we have not detailed is exactly how this will be achieved. We have established project management arrangements to define and deliver our vision for Better Care, and to ensure we incorporate a number of existing interdependent projects and programmes upon which the delivery of our vision rely – e.g. Building Positive Futures Programme.

As part of our Project Management Arrangements that sit beneath and report to the Health and Wellbeing Board, we have a Project Board and a number of work streams. This includes 'governance', as mentioned before, and service transformation. We also have an Engagement Group in place. The task and finish groups may expand and contract dependent upon the issues identified.

National Conditions

1. Protecting social care services

a) Please outline your agreed local definition of protecting social care services

b) Please explain how local social care services will be protected within your plans

Our approach to protecting social care services is two-fold:

1. Reducing overall demand:

Efficient, effective social care services are essential to reducing demand away from 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 spectrum, 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-oriented – re-focusing services and re-procuring services as necessary;
- Opportunities for out-sourcing to local community-based providers (CICs, micro business etc)

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

- Joint commissioning of integrated 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. We are embarking on a housing development programme to develop HAPPI housing for older and vulnerable people (partly funded by the HCA and our own HRA); we have successfully piloted Local Area Coordination and are extending 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.

2. 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 will be using a proportion of the £200 million available (£520k for Thurrock) from 14/15 to support demographic pressures and allow us to maintain our existing 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. 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 we resource should be shifted.

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

National Conditions

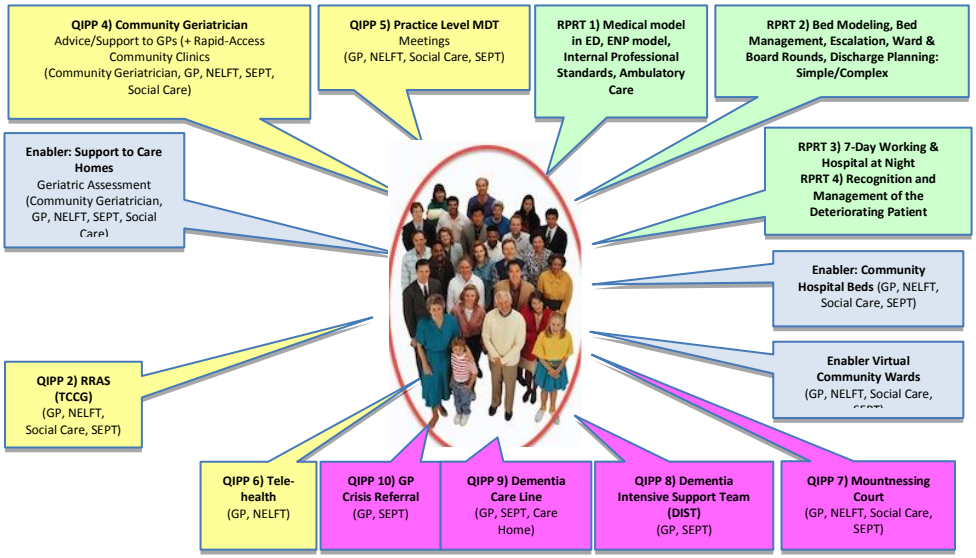
2. 7-day services to support discharge

a) Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)

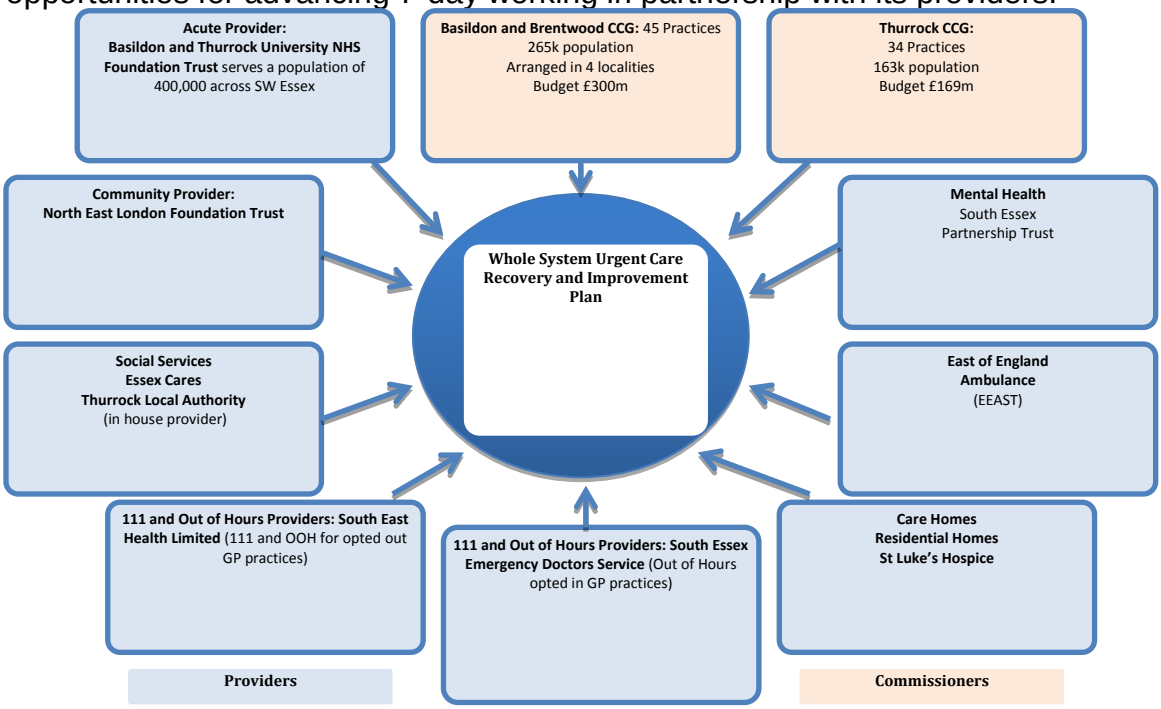
b) Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Under the governance of the South West Essex Urgent Care Programme Board, there has been a whole system focus on a few 7-day service initiatives, based on lessons from last winter. An executive level Task and Finish Group, has overseen the introduction of a new GP 'Streaming' role in the Emergency Department, and a Frailty Assessment Specialist Team in the Emergency Department comprising Consultant Geriatrician and Admissions Avoidance Team, both implemented from

September 2013. These join existing initiatives outlined below which already include elements of 7-day working:



Through the BCF and integrated working, we are committed to improving the quality of services provided for its population and continues to seek new ideas and opportunities for advancing 7-day working in partnership with its providers.



National Conditions

3. Data-sharing

a) Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS Number to be the primary identifier across Thurrock by April 2015

b) If you are not currently using the NHS Number as a primary identifier for correspondence please confirm your commitment that this will be in place and when by.

N/A

c) Please confirm that you are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

Social Care uses an IT system that allows health partners and staff to view information, contribute to information and to support the provision of support and services. 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.

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

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

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

d) Please confirm that you are committed to 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 Caldicott2.

Health and Social Care are committed to ensuring that the appropriate IG Controls will be in place that meet the requirements set out in Caldicott 2 and other areas as required.

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

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

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

Social Care has amended its service user information governance statement to incorporate sharing of information with health partners on an electronic basis

*The development of our data sharing arrangements will be in keeping with the Data Protection Act 1998, particularly principle 7 (security measures taken to protect data),

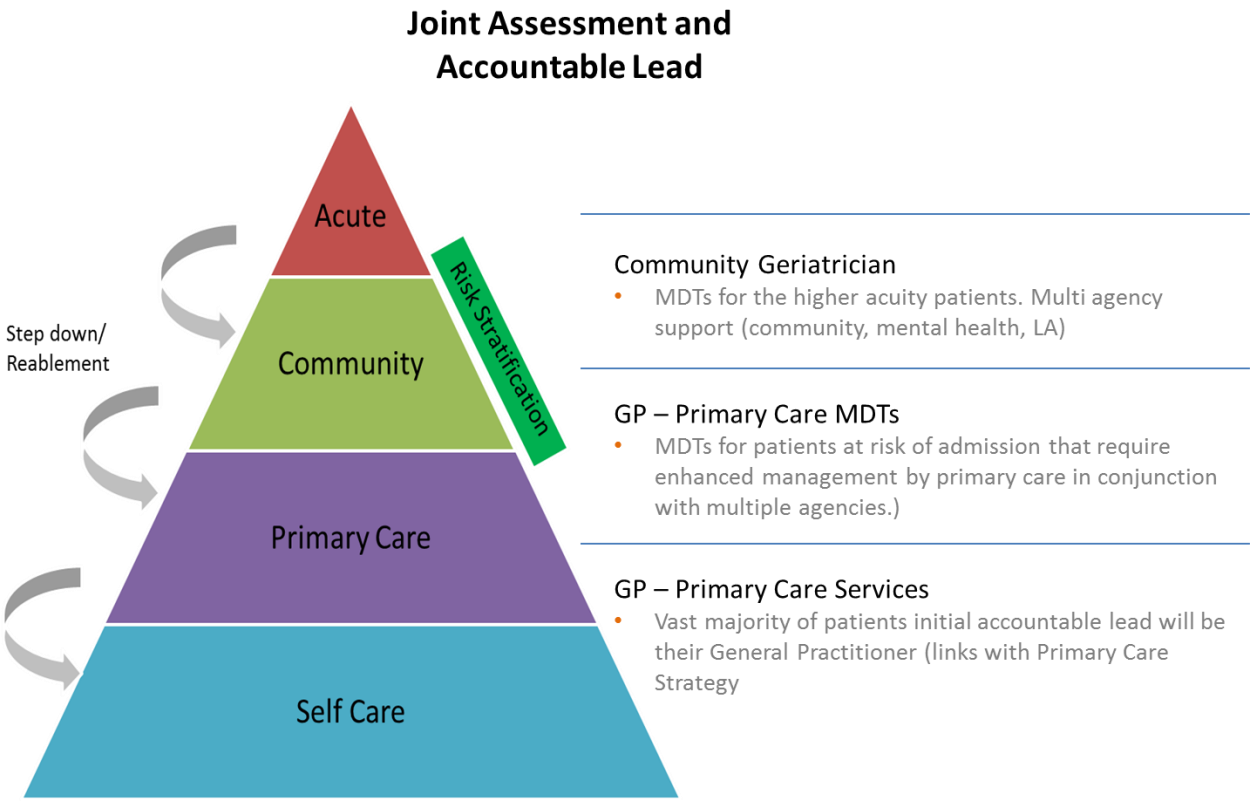
and Article 8 of the European Convention on Human Rights (the right to a private an family life).

National Conditions

4. Joint-assessments and accountable lead professional

a) Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

b) Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.



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

The risk stratification process is based on Caretrak. The CCG and LA have been working on implementing a Caretrak solution for two years. This has been delayed due to the Section 251 issues. However, a workable solution has now been identified that will allow for Caretrak to go fully functional in 2014/15.

Key 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. This is far too long and needs condensing in a few key risks

No.	Risk	Consequence	Probability	Impact	Controls
		STRATEGIC			
	In the absence of a single organisation of the implementation of Better Care decision making process are not clear	Decisions are not made, or are not made in a timely way or do not have the necessary authority to effect change	1	3	Clear governance arrangements including statutory accountability, schemes of delegation, dispute resolution processes and […] are required
	Co-ordinated care does not reduce demand or produce efficiencies, or benefits take longer to realise than planned	Implementation and operation costs may exceed budget plans	2	3	Financial contingency plan to alleviate cost pressures that may arise during implementation or benefits realisation
	Delays or difficulties with the implementation of initiatives to address under doctoring and the quality of Primary Care	The changes required to the configuration of practices my make it difficult to engage GPs in co-ordinated care programmes	2	2	Strong early engagement of GP practices and timely implementation of the Primary Care strategy to involve them in change, and to ensure a common understanding of risks, opportunities and incentives
	NHS providers face difficulty in delivering QIPP Plan efficiencies over 5 years	The failure to reduce demand for acute services places does not release funds for investment in community services and results in overspend	2	3	Close liaison with acute providers on performance against QIPP Plans and co-ordinated action across the whole system to reduce demands of acute services.
	NHS providers and a large number of ASC	Difficulty transforming care pathways and pace of	1	3	a) Strong early engagement to involve providers in

	providers are not operationally co-terminus with Thurrock may have difficulties implementing our local model of co-ordinate care if it varies significantly from others	change too slow to realise required financial benefits.			change, and analysis of their business risks and opportunities to ensure they can be incentivised to deliver co-ordinated care in Thurrock. b) Liaison with neighbouring CCG to avoid conflict in transformation plans.
	Difficulties implementing the Primary Care Strategy and to improve the quality and availability of primary care lead result in greater demand for acute care	The failure to reduce demand for acute services places does not release funds for investment in community services and results in overspend and poor care.	1	3	Strong early engagement to involve GPs in change, and analysis of their business risks and opportunities to ensure they are incentivised to deliver improved primary care.
OPERATIONAL / TECHNICAL					
	Mobilising the whole Council in implementing the care and support reforms in parallel with the implementing Better Care in partnership with the CCG overstretches capacity	Changes to funding 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	3	2	A change programme with appropriate governance, resources (both people and financial) to implement the reforms and to monitor impacts on service quality and user satisfaction, and all with multiple interfaces with Better Care
	The different organisational cultures in Health, and the LA, history and standing of the CCG and LA make it	Commissioning strategies and implementation plans for co-ordinated care may lack coherence or ambition	2	2	A single leadership structure, from the HWB Board down, will be needed to ensure goals, roles, processes, values, communications practices,

	difficult to provide effective leadership for the system				attitudes and assumptions are consistent across the better care programme.
	Difficulty in changing hospital contracts and or tariffs to enable greater investment in community based solutions	Access to the required health care services in community settings may be frustrated or delayed	2	2	Strong early engagement to involve the Hospital Trust in change, and analysis of their business risks and opportunities to ensure they can be incentivised to provide co-ordinated health care in the community in Thurrock
	The management of change (in relation to commissioning strategies, contracts and procurement, and operations and services) is not planned or executed effectively	Change is ineffectively or incompletely implemented with consequential impacts on individual service users/patients, budgets and organisational reputations	1	3	The development of an Benefits Realisation strategy together with communications and training programmes to ensure change is planned, implemented and managed effectively
	The incompatibility of Information systems (including for example those related to contracts and commissioning, service provision, personal data, performance and finance and charging).	If strategic, personal, operational or performance and financial information cannot be shared in a timely manner the necessary controls to deliver co-ordinated care will not be in place	2	3	An information strategy for commissioning and providing co-ordinated care, using the NHS number and with the required governance and technical solutions is required at an early stage
IMPLEMENTATION					
	Lack of capacity and/or capability requirements	A dedicated resource will be required to plan and	1	3	A resource plan for an integration team with roles and

	for an integrated programme.	implement better care while existing programmes for health and ASC are maintained and care and support reforms implemented			responsibilities specified, and clear interfaces with business as usual and care and support reform will need to be developed and agreed so that posts can be filled from early 2014/15
	The decommissioning and commissioning processes could introduce an element of double running and/or confusion about who had the lead responsibility for the provision of care at points of transition	Change is ineffectively or incompletely implemented with consequential impacts on individual service users/patients, budgets and organisational reputations	1	3	A plan for reviewing the portfolio of existing health and ASC services against Thurrock's Vision for Better Care and the care pathways to deliver co-ordinated care is required and in order to inform a managed change programme for those services

Key: 1 = Low / 3 = High

Outcomes and Finances

Outcomes and Metrics

1. Permanent admissions of older people (aged 65 and over) into residential and nursing care homes per 100,000 population

Outcomes

- Reduction in the number of older people placed into permanent residential or nursing care
- Increase in rates of older people supported to live independently in alternative settings such as supported living placements, extra care housing
- Evidence of local interventions and strategy delaying dependency, increasing effectiveness of short-term support and alternatives to more costly residential and nursing care to reduce admissions
- Evidence of social care budgets 'stretching further' through shift to greater use of preventative and community based support rather than higher cost longer-term support

Measurement

- Metric to be measured and tracked applying existing national definition as defined in the Adult Social Care Outcomes Framework (ASCOF)
- Progress to be monitored monthly at respective Council / CCG governance bodies
- Quarterly reporting to HWB Board to enable progress to be tracked

2. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcomes

- Increase in effectiveness of reablement / rehabilitation services in supporting more people to regain and retain independence
- Ensuring that the proportion of people that reablement / rehabilitation services are offered to does not decrease
- Evidence of the impact of preventative and shorter-term reablement / rehabilitation services delaying dependency, preventing avoidable admissions into residential or nursing care or hospital readmission and reducing costs associated with these

Measurement

- Metric to be measured and tracked applying existing national definition as defined in the Adult Social Care Outcomes Framework (ASCOF)
- Progress to be monitored quarterly at respective Council / CCG governance bodies
- Quarterly reporting (based on proxy measurement) to HWB Board to enable progress to be tracked
- Local customer satisfaction and experience survey to be used to assist measurement of effectiveness

3. Delayed transfers of care from hospital per 100,000 population

Outcomes

- Effective joint management of discharges across acute, mental health, non-acute and community services to facilitate timely and appropriate transfer from all hospitals for all adults
- Delayed transfers of care reduced and minimised
- Evidence of effective joint working and effective discharge planning across the sector supporting people to live independently at home
- Evidence of continuity of care that supports people before, during and after admission to hospital

Measurement

- Metric to be measured and tracked applying national definition for DTOCs as defined by NHS England
- Progress to be monitored quarterly at respective Council / CCG governance bodies
- Progress tracked through regular multi-agency MDTs
- Quarterly reporting (based on proxy measurement) to HWB Board to enable progress to be tracked

Assurance Process

- Performance metrics, targets and performance plans to be signed off by the Integration Leadership Group and Health and Wellbeing Board
- Performance metrics, targets and performance plans to be signed off by Council and CCG respective governance bodies – Cabinet and CCG Board
- The Plan has also been to the Health and Wellbeing Overview and Scrutiny Committee
- Performance metrics and plans to be incorporated into Council / CCG performance management and monitoring frameworks. To include regular reporting to the Integration Finance and Performance Group, reporting to the Integration Leadership Group
- Performance targets informed by comparative analysis against national and statistical comparators and historical trend patterns
- Performance metrics and agreement of local metric(s) assessed against local priorities and ambitions as set out in HWB Plan to ensure clear and demonstrable links

Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	899	N/A	597 **(1)**
	Numerator	180		135
	Denominator	21,090		22,600 **(2)**
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (%)	*Metric Value*	89.8	N/A	93 **(3)**
	Numerator	95		205
	Denominator	110		220 **(4)**
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)

		April 2012-March 2013		*April 2014 - March 2015*
Local Indicator: *% of Adult Social Care service users who are satisfied with their services and support.*	*Metric value*	59%	2014/15 survey	64% (based on 2014/15 survey)
	Numerator			
	Denominator			

* Patient / Service User Experience indicator – we have agreed that we will be adopting the national indicator that is currently being developed.

1. Target based on reduction in placements from March 2013 baseline of 180 to 135 by March 2015. Factors in improvement trend and accurate reporting of CHC and full-cost payers through 2013-14 and would bring Thurrock in below 2012/13 national average of 708.
2. Denominator estimated as 22,600 based on ONS Sub National Population Projections, September 2012.
3. Target based on a proposed ratio of 205 out of 220 people remaining settled and independent 91 days after discharge into reablement/rehab services.
4. Denominator based on a proposed increase of 100% on the number of people offered reablement/rehab services on discharge - 220 in 2014/15 from 110 in 2012/13. 220 would represent 7.7% of people discharged compared to 3.8% in 2012/13 and the national average of 3.3%
5. Target set based on % increase on assumed confidence interval of 3.5% required for statistical significant change and upward improvement trend on 2012/13 baseline. 2012/13 National Average = 63.7%, and 2012/13 SNN Average = 63.6%.

Finance

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority	TBC	£3,720k	£845k	*TBC*
CCG	TBC		£9,720k	*TBC*
BCF Total			£10,565k	

Contingency Plans

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Our contingency planning arrangements will be developed throughout 14/15 when we are clear exactly how the 15/16 BCF will be apportioned and the expected benefits. Our expectation is that we will retain a contingency fund. This may be money committed to schemes and initiatives, but that could be released should it be clear that expected improvements are not likely to be achieved. We will also look to pioneer authorities as they develop their Plans and work through their contingency arrangements.

Finance

Please summarise where your pooled budget will be spent. NB the total must be equal to or more than our total BCF allocation.

BCF Investment (£000s)	2014/15 Spend		2014/15 benefits		2015/16 Spend		2015/16 benefits	
	Min	Max	Min	Max	Min	Max	Min	Max

	£000	£000	£000	£000	£000	£000	£000	£000
Priority 1 – Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing								
BCF01 – Empowering Citizens	178	178						
BCF02 – Voluntary Services	0	0						
BCF03 – Telehealth	30	30						
Priority 2 – Health and care solutions that can be accessed close to home								
BCF04 – Stroke Services	50	50						
BCF05 – Community Equipment	0	0						
Priority 3 – High quality services tailored around the outcomes the individual wishes to achieve								
BCF06 – Community Bed Provision	515	515						
Priority 4 – A focus on prevention and timely intervention that support people to be healthy and live independently for as long as possible								
BCF07 –Rapid Response Assessment Service and Reablement	1,025	1,025						
BCF08 – Protection of Adult Social Care	1,666	1,666						
BCF09 – Hospital Social Care Team	80	80						
Priority 5 – Systems and structures that enable and deliver a co-ordinated and seamless response								
BCF10 – Caretrak	50	50						
BCF11 – Primary Care MDT	51	51						
Miscellaneous								
BCF12 – Programme Management Fund and Transformation Fund	TBC	TBC						
BCF13 – Care Bill Requirements	TBC	TBC						
Contingency Fund	79	79						
Total Spend	**3,724**	**3,724**						
BCF Funding Streams	**2014/15 'virtual' BCF**				**2015/16**			
Carers' Funding					178			
ASC Capital Grant					364			
Disabled Facilities Grant					481			
Mainstream NHS Funding					5,818			
Social Care Fund	2,342				2,342			
Additional £241 transfer from NHS to adult social care	520				520			
Reablement	862				862			
Total Available	**3,724**				**10,565**			