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

Health and Wellbeing Board

The meeting will be held at **2.00 pm** on **11 September 2014**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL.

Membership:

Councillors Barbara Rice (Chair), John Kent, Tunde Ojetola and Joycelyn Redsell

Mandy Ansell, (Chief Operating Officer, Thurrock NHS Clinical Commissioning Group)
Dr Andrea Atherton, (Director of Public Health, Southend and Thurrock Councils)
Dr Anand Deshpande, (Chair, Thurrock NHS Clinical Commissioning Group)
Len Green, (Lay member, Clinical Commissioning Group)
Barbara Brownlee, (Director of Housing, Thurrock Council)
Roger Harris, (Director of Adults, Health and Commissioning, Thurrock Council)
Kim James, (Chief Operating Officer, Healthwatch Thurrock)
Carmel Littleton, (Director of Children's Services, Thurrock Council)
Lucy Magill, (Chair of Thurrock Community Safety Partnership)
Andrew Pike, (Director, Essex Area Team of NHS England)
Ian Stidston, (Director of Primary Care & Partnership Commissioning Essex Area Team of NHS England)

Agenda

Open to Public and Press

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1 Apologies for Absence

2 Minutes **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 17 July 2014

3 Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4	**Declaration of Interests**	
5	**Care Act Implementation Report**	**13 - 46**
6	**Update on the development of the Better Care Pooled Fund and Section 75 Agreement**	**47 - 58**
7	**Mental Health Crisis Care Concordat Report**	**59 - 94**
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9	**Thurrock Revised Better Care Fund Report**	**151 - 206**
10	**Forward Plan**	**207 - 208**

Queries regarding this Agenda or notification of apologies:

Please contact Ceri Armstrong, Strategy Officer by sending an email to
Direct.Democracy@thurrock.gov.uk

Agenda published on: **3 September 2014**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

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Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
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If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

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

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated "Good" or better
- Raise levels of aspirations and attainment so that local residents can take advantage of job opportunities in the local area
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Provide the infrastructure to promote and sustain growth and prosperity
- Support local businesses and develop the skilled workforce they will require
- Work with communities to regenerate Thurrock's physical environment

3. Build pride, responsibility and respect to create safer communities

- Create safer welcoming communities who value diversity and respect cultural heritage
- Involve communities in shaping where they live and their quality of life
- Reduce crime, anti-social behaviour and safeguard the vulnerable

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being
- Empower communities to take responsibility for their own health and wellbeing

5. Protect and promote our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Ensure Thurrock's streets and parks and open spaces are clean and well maintained

MINUTES of the meeting of Thurrock Health and Wellbeing Board held on 17th July 2014 at 11.00am

Present:

Board Member	Position	Organisation
Councillor Barbara Rice	Chair and Portfolio Holder for Adult Social Care and Health	Thurrock Council
Councillor Joy Redsell	Opposition Group Representative	
Roger Harris	Director of Adults, Health and Commissioning	
Carmel Littleton	Director of Children's Services	
Mandy Ansell	Chief Operating Officer	Thurrock Clinical Commissioning Group
Len Green	Lay Member Patient and Public Participation	
Kim James	Chief Operating Officer	Thurrock Healthwatch

Apologies:

Board Member	Position	Organisation
Barbara Brownlee	Director of Housing	Thurrock Council
Andrea Atherton	Director of Public Health	
Councillor Shane Hebb	Opposition Group Representative	
Councillor John Kent	Leader of the Council	
Lucy Magill	Chair	Thurrock Community Safety Partnership
Dr Anand Deshpande	Chair	Thurrock Clinical Commissioning Group
Ian Stidston	Director of Commissioning	NHS England Essex Area Team
Andrew Pike	Director	

In attendance:

Name	Position	Organisation
Allison Hall	Commissioning Officer	Thurrock Council
Debbie Maynard	Head of Public Health	
Michelle Cunningham	Thurrock Community Safety Partnership Manager	
Malcolm Taylor	Strategic Lead Learner Support	
Dermot Moloney	Business Improvement Manager -Housing	
Les Billingham (item 12)	Head of Adult Social Care	
Dawn Scrafield	Director of Finance	NHS England Essex Area Tam

Item	Key points and actions	Owner and deadline
1. Apologies for absence	Apologies as detailed.	
2. Minutes 13th	The minutes were agreed with the following	

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March 2014	amendments: • Cllr Kent was present on 13th March 2014	
3. Additional items to be considered as a matter of urgency	None	
4. Declaration of interests	No interests declared	
5. PREVENT: Thurrock's response to extremism	Michelle Cunningham presented PREVENT: Thurrock's response to extremism. Michelle stated that the greatest threat nationally was the Syrian crisis, and that locally, the threat was from right-wing extremism. All agencies are asked to incorporate the PREVENT agenda within their organisations. At a local level, there is good representation from local agencies. Issues are identified and managed, but there appear to be a lack of referrals which does not reflect what is known nationally. Leads have been asked to reinforce this message with staff, and there are a range of training tools available to train both professionals and the community. Carmel asked what information was used to judge whether there were not enough referrals. Michelle stated that concerns were raised informally, but then not followed through. Councillor Rice stated that she was not aware of the referral process, therefore could this be reinforced and publicised? Councillor Rice stated furthermore that she did not feel that the Board could agree recommendation 1.2 and that it should be amended as follows: *That Board members satisfy themselves that the Community Safety Partnership are cascading the Prevent agenda to commissioned services.* The amended recommendation 1.2 was agreed along with 1.1. Councillor Redsell stated that Councillors would like more information and training. Michelle and Roger would meet to agree how to ensure that commissioned services had a greater awareness.	Michelle/Roger
6. Engaging with Users and Carers of Services and the Public throughout the Commissioning process	Len Green presented Engaging with users and carers of services and the public throughout the commissioning process. Len stated that users and the public are involved as part of the Health and Social Care Transformation	

	Programme and the commissioning cycle in its entirety. The expectation is that all partners are involved and appropriately supported, and Len stated that there was an engagement group, chaired by Len, steering this work and ensuring involvement took place. Roger emphasised the Social Value Act and that a working party had been set up to map out good practice in the way the Council commissions and procures services. The working party will be reporting to Cabinet in November. Roger commented that 'proportionality' needed to be considered. Mandy commented that the CCG were undertaking an options appraisal on the Walk-In Centre, and asked when the CCG would need to present to the Group. Len said that he was happy to be involved as early as possible so he could identify the right people to input. Dawn asked whether a forward plan be shared, and Len agreed to prepare a paper for sharing. Councillor Redsell commented that the engagement flowchart looked busy and that Members were the conduit to the public and that also, there were a number of local and ward-level groups doing good work. Len responded that it was important to attempt to involve everyone, including small groups and wanted to emphasis involvement at the 'ideas' stage. Kim added that a targeted approach was required. Recommendations 1.1 and 1.2 were agreed – with a slight amendment to 1.1 to include NHS England.	Len
7. Healthy Weight and Tobacco Control Strategies	Debbie Maynard presented the Healthy Weight and Tobacco Control Strategies. **Healthy Weight Strategy** The ambition was to reduce the proportion of adults and children who are obese and ensure this continues on a downward trend. Debbie stated that the Public Health team would be refreshing the benchmarking previously undertaken against the 10 CIPFA comparator authorities. She also said that a healthy weight workshop had been held; surveys had been carried out with GPs, schools, and providers; and there had been consultation with different groups. The Healthy Weight workshop had refreshed the action plan. Carmel voiced here congratulations on the 'Beat the	

	Street' initiative. It was felt that the data underplayed the improvement that had been achieved and that East of England was not a comparator. The Board asked that a sentence was included within the Strategy to reflect this point. The statistics stated that there had been a 5% increase in year 6 obesity levels. Debbie was asked to explore this and provide a response. Debbie commented that the information was reliant on parents providing consent for their child to be weighed. Councillor Redsell stated that she had seen cars visiting the 'Beat the Street' points – and Debbie commented that the Facebook page 'named and shamed' those who cheated. Councillor Redsell queried whether the underweight and healthy weight statistic was correct. Debbie said that school nurses would have the role of improving weight. Michelle said she would link with Debbie on the community alcohol project. **Tobacco Control Strategy** Debbie commented that the Team were working with Trading Standards and schools around the impact and effects of E-cigarettes. The Strategy had been delayed to take in to consideration the results of this work. It was hoped that by the end of the year one brand of E-cigarettes would be regulated and could be monitored. Councillor Redsell commented that lots of people smoked that went to the College, and what could be done. Debbie replied that she was happy for the College to sign up to the pledge. Councillor Rice commented that she was please at the reduction in the number of 'red' rated actions. Recommendations 1.1 – 1.4 were agreed.	Debbie Debbie
8. Health and Wellbeing Strategy (Part 1 – Adults): 13/14 end of year review and 14/15 delivery plan	Roger presented the Health and Wellbeing Strategy Annual Report 2013-2014 and Delivery Plan 2014/15. Roger stated that the report and deliver plan related to Part 1 of the Strategy (Adults) and that Part 2 (Children and Young People) would be brought back to the Board in September. Roger recommended that a Board workshop was arranged to review and refresh the Strategy, and that this would take place during the Autumn.	Carmel Ceri

	Councillor Rice welcomed the proposal for an away day. She stated that with Public Health now being responsible for 0-19 years, there was an opportunity for the Strategy to be more combined rather than in two parts. Carmel commented that the Children's agenda sometimes got lost in joint strategies. Mandy said that the Mental Health and Children's Commissioning functions were being brought back to the CCG from the CSU. Roger felt that there needed to be distinct elements of Adults and Children's health and wellbeing in one overall strategy. Councillor Redsell stated that Elizabeth Gardens had been successful and was there the possibility of more schemes like this. Roger responded that the Council were looking at the possibility of more, including the reconfiguration of Piggs Corner and Kynoch Court, and that a fourth project was a possibility. The Health and Wellbeing Strategy's priorities would be refreshed as part of the review. Councillor Redsell felt that schemes such as Elizabeth Gardens helped people to downsize. Dermot stated that he felt more individual support needed to be provided in order to achieve this. Councillor Rice felt there was a need for more bungalows to meet the need, and that people did not necessarily want to move in to flats or high rises. Recommendations 1.1 – 1.3 were agreed.	
9. Special Educational Needs and Disabilities Reforms	Malcolm Taylor presented Special Education Needs and Disabilities reforms. Malcolm stated that key areas and actions to be taken were detailed within the report and that consultation and engagement had taken place concerning SEND requirements. The requirements spanned those aged 0-25 years old. A consultation officer based at The Beehive was engaging with Thurrock's specialist schools, and providers were also being engaged with. Progress had been made on Education, Health and Care Plans, with parents and children being placed at the centre.	

	There was a focus on reducing bureaucracy around SEND, and additional funding had been made available to assist with the changes being made. Debbie asked what work was being done with the 0-5 age group to prevent labelling. Malcolm stated that additional support was being provided to early years and there was a higher level of SEND than previously. Councillor Redsell asked about the challenge being presented by families moving in to the Borough in order to attend Treetops School. Malcolm stated that the Council were provided an increasing level of outreach support to manage the increase in demand. Landsdowne School was also supporting those children who were on the cusp of special school needs, and Beacon Hill was also able to provide capacity. Recommendation 1.1 was agreed.	
10. Thurrock Health and Social Care Transformation Programme	Roger presented the Health and Social Care Transformation Programme. The principles of health and social care transformation had been agreed and the minimum funding that would make up the pooled pot would be approximately £10.5 million. A governance structure had also been established. Roger stated that it was important that a real difference was made to the service user/patient. The BCF Governance Group had recommended that Thurrock Council hosted the pooled budget. Roger added that decisions would still need to be signed off by Cabinet and the CCG Board. New guidance on the BCF had meant a change to how the money could be used, and that there was now more emphasis on reducing unplanned care admissions. The Care Act consolidated all legislation related to Adult Social Care. It also introduced changes to funding and introduced a cap on how much an individual would be expected to pay. Changes in relation to funding would not go live until April 2016, whereas other legislative changes would come in to force as of April 2015. Roger stated that the funding cap would be a risk to the authority and the Council would have reduced levels of	

	income resulting from the changes. Dawn stated that the BCF focus locally was on increasing the amount of jointly provided community services and in doing so, reducing the amount of acute activity through unplanned emergency admissions. Dawn added that there needed to be a focus on understanding what the risks and challenges were and on the long-term benefits. Recommendations 1.1 – 1.5 were agreed.	
11. Thurrock CCG 5-Year Strategic Plan	Mandy Ansell presented the Thurrock Clinical Commissioning Group 5-Year Strategic Plan. Mandy stated that she and Roger had jointly presented the Plan to the NHS England Area Team and it was graded as 'amber' with no reds. The CCG had commissioned extra resource in order to move the Plan forward and to review the walk-in centre. Accident and Emergency target, 18 week challenge, cancer pathway, and IAPT remained challenging. The Plan would be reviewed again in September and had been consulted on thoroughly.	
12. Community Resilience	Les presented the report on Community Resilience. A key objective for Health and Wellbeing was building stronger communities. Highlights included Local Area Coordination, Community Hubs – which were showing an impact, and Asset Based Community Development. There were plans to expand both Local Area Coordination and Community Hubs across the Borough. In addition, European Funding had been received for a programme known as 'Animate'. Although not statutory, some of the services and approaches being developed were an essential part of achieving the savings required. Work was taking place with Birmingham University to develop research and monitoring to evidence the effectiveness of the preventative approach being taken. Work was taking place with Children's Services, but more needed to be done – particularly in relation to transition of young people from children's to adult services. Councillor Rice stated that she felt that the community was becoming involved in her ward, and that the	

	transition had been quicker than anticipated due to budget cuts. Councillor Rice also commented that the programme was over 5 years and that this was necessary to see the effects and embedding the changes. Councillor Redsell said that this was a good piece of work and asked whether 7 day working would be implemented. Les said that 7 day working had to be implemented and that work was already being undertaken to achieve this. Carmel stated that she would bring back a separate report on the work being developed in Children's services. Recommendation 1.1 was agreed.	Carmel
13. Forward Plan	The Forward Plan was noted.	

11th September 2014	ITEM: 5
Health and Wellbeing Board	
Care Act Implementation	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ceri Armstrong, Strategy Officer, Adults, Health and Commissioning	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

The Care Act received Royal Assent in May 2014. The Act is the first overhaul of social care legislation for more than 60 years, building on a 'patchwork' of Acts.

A report was presented to the Board's July meeting which outlined key elements of the Care Act.

This report updates the Board on progress being made to implement the Act's requirements against higher risk areas and allows the Board to receive the assurance it needs that those risk areas are being managed.

There are a number of the areas of the Act that impact on the health and social care system. These are not picked up within the main body of the report, but contained within the appended Department of Health presentation.

1. Recommendation(s)

1.1 For the Board to note progress being made to implement the requirements of the Care Act so that the Council is compliant with the relevant sections from April 2015.

2. Introduction and Background

2.1 In July, a report was brought to the Board on the Health and Social Care Transformation Programme. This included a summary of the arrangements that have been put in place to deliver health and social care transformation –

including the Care Act. The report also summarised the Care Act's key changes.

2.2 Since the July Board meeting, the Care Act Implementation Project Group has continued to meet. This report provides the Board with an update on progress to date.

3. Issues, Options and Analysis of Options

3.1 The Care Act Implementation Project Group (Project Group) has now completed a readiness assessment against each section of the Care Act's draft guidance and regulations. This has allowed the Project Group to assess where the Council is at most risk of non-compliance and to discuss what steps can be taken to reduce or avoid this risk.

3.2 Through the work of the Project Group, elements of the following areas have been highlighted as high risk:

- Promoting Wellbeing;
- Preventing, reducing or delaying needs;
- Information and advice;
- Assessment and eligibility;
- Personal budgets; and
- Sections of the draft Guidance relating to Carers.

Whilst the above areas are considered 'high risk', progress is being made as detailed below:

3.3 Promoting Wellbeing
The principle is aimed at dealing with specific circumstances of the individual to include their needs, goals and wishes. The concern with this section of the Act is that the concept is extremely broad. Practitioners will be expected to be able to apply this concept when undertaking assessments and ensure key questions are asked in order to elicit information that will address the criteria. A partnership approach to assessments is part of the wellbeing process and all agencies will be expected to focus on providing best care to the individual rather than concentrating on what services are to be provided by particular agencies.

Proposed actions to address the concerns raised with this section include practitioner training and also ensuring that the way assessments are carried out include the main headings from the guidance. The Public Health team are also reviewing this section and shadowing a social worker to identify whether any further work is required over and above that already identified.

3.4 Preventing, reducing or delaying needs
This section of the Act aims to prevent individuals from needing care and support, reducing or delaying the care and support they need, and also preventing individuals from reaching crisis point. Like the wellbeing principle,

the duty to prevent, reduce or delay needs is woven in to the fabric of the Act and its guidance.

To an extent, the requirement of this section of the Act will be met by the Whole System Redesign Group which is focusing on how best to reduce unplanned admissions. This includes early recognition and management of conditions to avoid individuals reaching crisis point. How we provide low level information, advice and support is also key to delivering the requirements contained within this section.

Actions being taken forward include the development of a business case for a Timely Intervention and Prevention service. Other actions include the review and development of our information and advice offer, the work of the Health and Social Care Whole System Redesign Group, and also existing strengthening communities work. Key risks to achieving the aims of this section will include: whether the initiatives implemented are able to reduce the number of people reaching crisis point and poor health; and the ability in times of financial constraint to free up the resource required to invest in preventative and low-level support initiatives.

3.5 Information and Advice

Like chapters on wellbeing and preventing, reducing and delaying needs, the role of information and advice is woven throughout the Act and central to the Council's ability to meet a number of the Act's requirements. For example, local authorities must establish and maintain a service for providing people in their areas with information and advice relating to care and support for both adults and carers. The information and advice available is also seen as a key part of the preventing, reducing and delaying needs requirements – the duty relates to the 'whole population' – not just those with eligible care and support needs.

As part of the Council's Corporate Transformation Programme, agreement has been given to purchase an information and advice system. The system will provide a repository for the Council's care and support information and advice requirements. The Council is also working with Thurrock Coalition to ensure existing information and advice is reviewed and to identify any gaps. A key part of the work will be ensuring accessibility to information and advice. An initial 'kick off' workshop has been arranged for the 4th September.

3.6 Assessment and eligibility

The Act establishes a national minimum eligibility standard. Whilst this is set at substantial and critical – which is where the Council currently sets its eligibility criteria – there is some concern that the definition of substantial may lead to the Council providing greater levels of support. The Government has stated that Council's will be recompensed for any additional costs, but possible increased costs and increased numbers of assessments linked to any change in criteria is a risk.

No further action can be taken until the final guidance and regulations have been published in October.

3.7 Personal budgets
Every individual eligible for care and support will have a personal budget. This is linked to the Dilnot changes, where no one will pay in excess of £72k towards the cost of their eligible care needs. The Council will need to develop a Resource Allocation System (RAS) to meet the Act's requirements. The RAS will enable an individual to complete a self-assessment attached to which will be an indicative budget linked to eligible care needs.

The Council, through its Corporate Transformation Programme, has purchased a system through which the RAS will be developed. Practitioners will need support to use the new system as there is an expectation that they will support an individual to complete the self-assessment. There are a number of risks related to this section of the Act. These include the ability to integrated the RAS system with other social care systems; the possibility that we may need to apply the new system to existing care packages – which will lead to capacity issues and possible increased costs; and the increased number of challenges the Council may see if the indicative budget is different from the final budget assessed by the practitioner. The use of a RAS will be a key shift in how the Council assesses care needs and charges, and thought will need to be given to how it should best be communicated.

3.8 Carers
It is extremely welcoming that carers, within the Care Act, receive a standing equal to that of the person they care for. The Council is already meets the majority of requirements contained within the Act and its guidance in relation to carers – having recently commissioned Cariads to provide an information and advice service. The key risk for the Council in relation to the Act's requirements is the potential for an increased demand for assessments and the capacity to be able to meet that demand. There is also some concern that an individual's expectations of what the Council will be mandated to deliver in response to completed assessments might need managing.

The Council has a carers' lead who is working closely with both carers and the provider to identify how the requirements of the Act can and should be met. As there is not one section within the Act relating to carers, the lead officer has assessed the Act in its entirety and has identified actions that need to take place in each section of the guidance as appropriate – e.g. information and advice, wellbeing, preventing, reducing, delaying needs etc. We are currently unaware as to whether carers will have a separate eligibility criteria.

3.9 The Project Group will continue to oversee the implementation of the Act's requirements and is utilising the £125 Care Act Implementation Grant to help to minimise any high risk areas.

3.10 The Association of Directors of Adult Social Services in conjunction with the Local Government Association has set up a number of regional programmes

to assist local authorities with their planning. The Council is well represented on the programme's many work streams which allows access to best practice and problem solving. The Council attended a regional event in July where the Department of Health delivered a presentation on its consultation of part one of the Care Act's draft regulations and guidance. This is attached at appendix 1 and provides a useful and concise summary of the non-Dilnot elements of the Act – i.e. those parts of the Act we will need to be compliant with from April 2015.

3.11 The Government has stated that local authorities will be recompensed for any additional costs arising from the implementation of the Care Act. This is a potential risk for the Council – particularly in terms of the cost pressures that will arise from the implementation of the Dilnot changes (from April 2016). The Government is currently consulting on how costs to Councils of the 2015 requirements will be assessed and met. The Government has already stated that implementation costs are expected to be met through the Better Care Fund – which is not new money and relies upon the CCG releasing funding currently attached to contracts. The Council itself, along with a number of other local authorities across the country, is carrying out detailed financial modelling to ensure that there is no gap between the Government's assessment and the local assessment.

4. Reasons for Recommendation

4.1 To assure the Board of steps being taken to implement the Care Act's requirements and to minimise risk areas.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The contents of this report have been informed by statutory guidance and by readiness assessments carried out by members of the Council's Care Act Implementation Project Group. The Project Group contains broad representation from the Council, health providers, Thurrock CCG, and Voluntary and Community Sector – via Thurrock Coalition.

5.2 The development and delivery of various statutory requirements will be carried out in consultation with a broader group of stakeholders – e.g. information and advice requirements are being developed in conjunction with Thurrock Coalition.

5.3 An Engagement Group is one of the Council and Thurrock Clinical Commissioning Group's Health and Social Care Transformation Programme arrangements. The Group has broad representation from the voluntary and community sector and is being kept fully informed and involved with regard to the Programme's various projects – including the Care Act.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The implementation of the Care Act compliments the Council's corporate priority 'improve health and wellbeing'. Implementation is a key priority for the Council and is a critical element of the Health and Social Care Implementation Programme.

7. Implications

7.1 **Financial**

Implications verified by: **Sean Clark**

Head of Corporate Finance

The Care Act brings significant financial implications, the extent to which are in the process of being assessed. The full cost of the Care Act is unlikely to be known until the statutory requirements become live. This is due to the complexity and assumptions behind understanding the true costs of the Act for the Council.

The Government is currently consulting on funding allocations for new adult social care duties for 2015/16. This exercise will be repeated for the funding cap responsibilities that will become statutory as of April 2016.

No additional cost pressures have been added to the MTFS based on the Government's assertion that additional cost burdens arising from the Care Act will be met via the New Burdens grant. This has been recognised in various budget reports as a risk.

7.2 **Legal**

Implications verified by: **Roger Harris**

Director of Adults, Health and Commissioning

The Care Act, Guidance and Regulations contain statutory requirements that the Council will need to comply with from April 2015 and from April 2016 (charging). Legal implications are considered within the body of the report and we will be working with legal to assess the full implications prior to April 2015.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

Community Development Officer

The Care Act 2014 seeks to provide a modern and up to date legal framework for all vulnerable adults. Its focus is to ensure that safeguarding, producing better outcomes and well-being are at the core of all adult social care activity. Some specific requirements e.g. the need to produce a register of people with visual impairments are targeted at specific groups.

The Council has established a Care Act Implementation Project Group to analyse and oversee the implementation of the Act's requirements. The Project Group contains broad representation from the Council, health providers, Thurrock CCG, and Voluntary and Community Sector – via Thurrock Coalition. An Engagement Group has also been established and is one of the Council and Thurrock Clinical Commissioning Group's Health and Social Care Transformation Programme arrangements. The Group has broad representation from the voluntary and community sector and is being kept fully informed and involved with regard to the Programme's various projects – including the Care Act.

The Council will develop its plans to meet the requirements of the Care Act over the next 6 months and will work closely with both the Project and Engagement Groups to identify equality and diversity implications arising from the implementation of the Act in Thurrock with a view to mitigating the potential for negative impact.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None identified.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Health and Social Care Transformation Programme Report to July 2014 Health and Wellbeing Board;
- Care Act Implementation Programme Section Assessments; and
- Care Act Draft Guidance (July 2014).

9. Appendices to the report

Appendix 1 – Department of Health presentation: 'a consultation on draft regulations and guidance for part one of the Care Act 2014'.

Report Author:

Ceri Armstrong

Strategy Officer

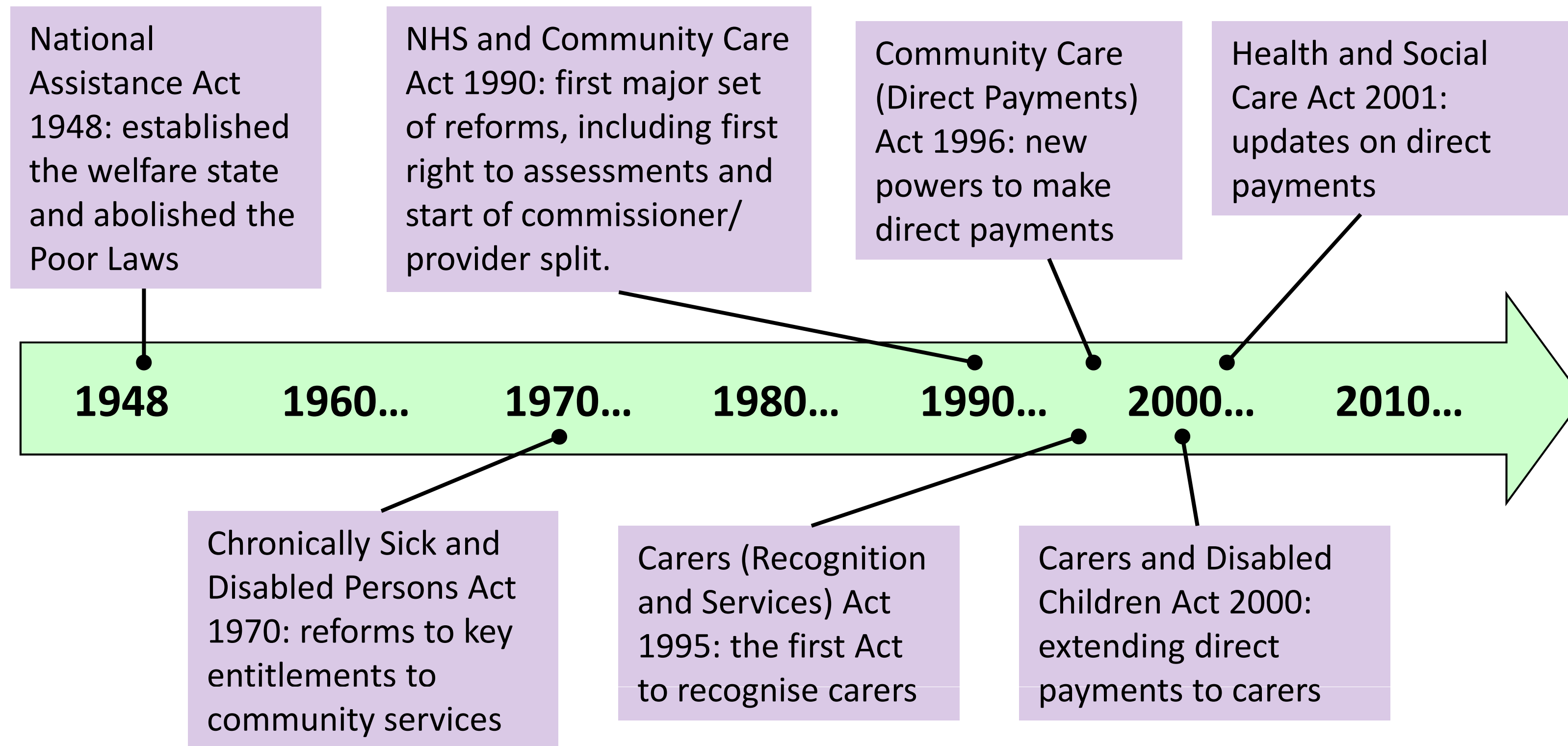
Adults, Health and Commissioning

Department
of Health

A consultation on draft regulations and guidance for part one of the Care Act 2014

A brief history of care and support

Social care law and policy has evolved over more than 65 years, incorporating around 30 Acts of Parliament, but reform has usually been piecemeal.



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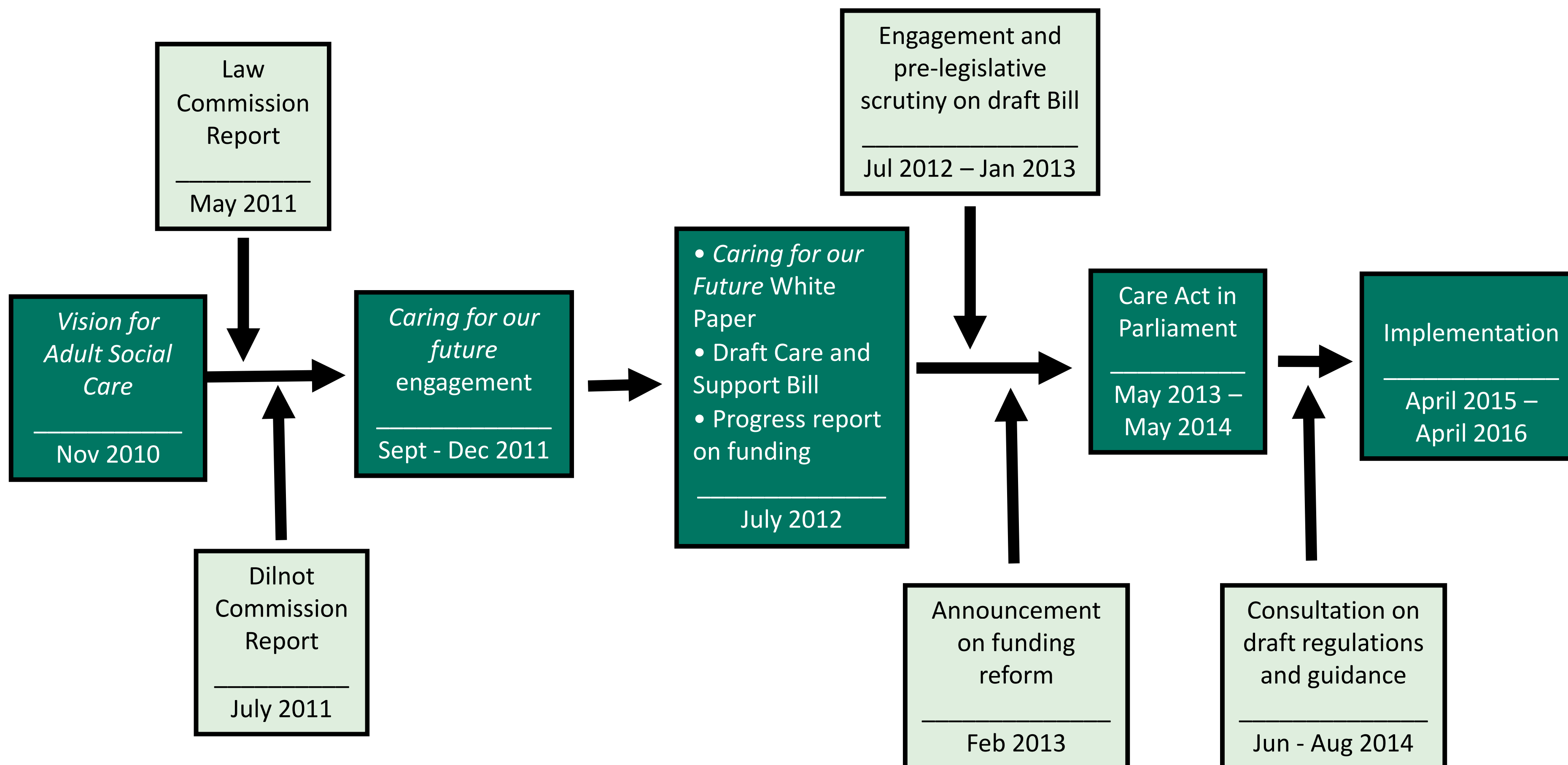
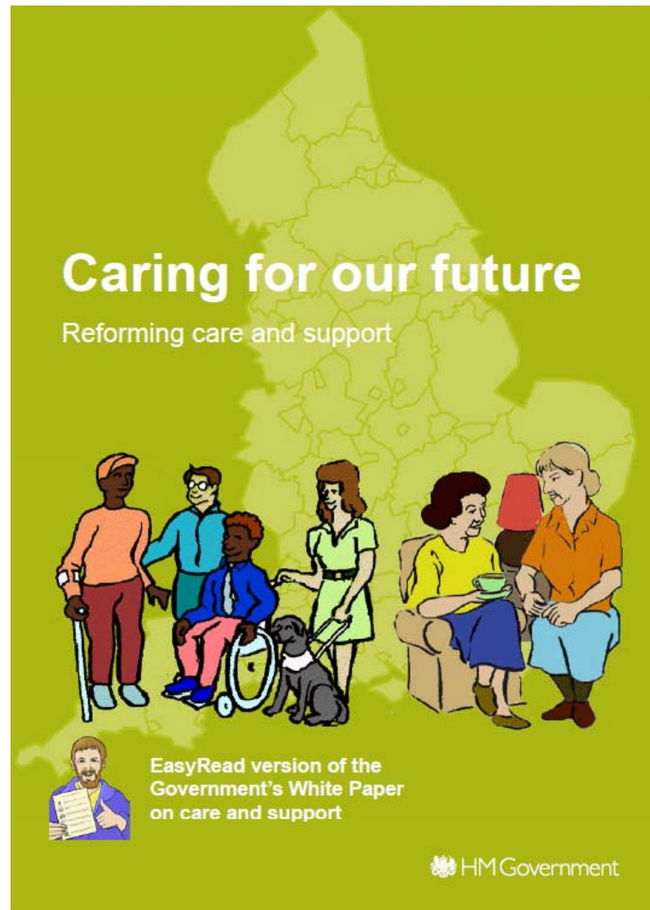
The reform timeline

The Care Act is the latest step in the timeline for reform, and builds the Government's *Vision for Adult Social Care* document and White Paper.



Caring for our Future



The care and support White Paper was published in July 2012 and set out the Government's vision for the future system.

If adult care and support in England is going to respond to challenges it must help people to stay well and independent:

- Promote people's **wellbeing**
- Enable people to **prevent and postpone** the need for care and support
- Put **people in control** of their lives so they can pursue opportunities to realise their potential

The Care Act 2014 underpins and implements this vision.

What does the Care Act do?

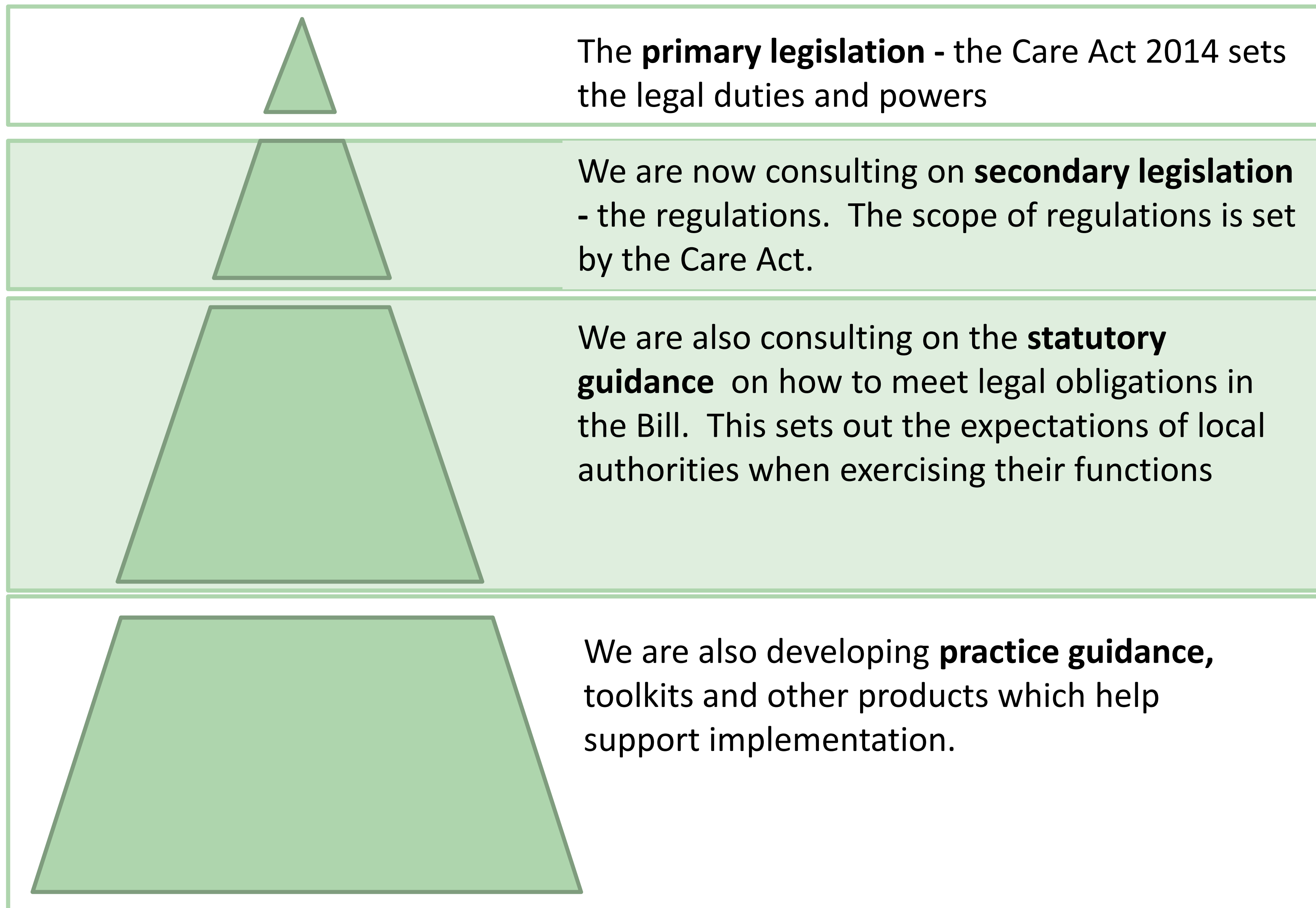
*The Act is **built around people**, it:*

- ensures that people's **well-being**, and the outcomes which matter to them, will be at the heart of every decision that is made;
- puts **carers** on the same footing as those they care for;
- creates a new focus on **preventing and delaying needs for care and support**, rather than only intervening at crisis point, and building on the strengths in the community;
- embeds rights to choice, through care plans and **personal budgets**, and ensuring a range of high quality services are available locally.

*The Act makes care and support **clearer and fairer**, it:*

- extends financial support to those who need it most, and protects everyone from catastrophic care costs though a **cap on the care costs** that people will incur.
- will ensure that people do not have to sell their homes in their lifetime to pay for residential care, by providing for a new **deferred payments** scheme;
- provides for a **single national threshold for eligibility** to care and support;
- supports people with **information, advice and advocacy** to understand their rights and responsibilities, access care when they need it, and plan for their future needs;
- gives new guarantees to ensure **continuity of care** when people move between areas, to remove the fear that people will be left without the care they need;
- includes new protections to ensure that **no one goes without care if their provider fails**, regardless of who pays for their care.

This consultation



This consultation

- Covers guidance and regulations for all elements of care and support reform that take effect in April 2015.
- It does not cover reforms for 2016/17 (including the cap on care costs) – there will be a separate consultation later this year.
- Runs from 6 June to 15 August 2014.

We want to hear what you think about the draft guidance and regulations

- We welcome views on anything included (or omitted) from the draft guidance and regulations.
- We are also asking specific questions in some areas.
- Do you have examples of best practice to help support delivery?

A quick note on our approach

- We haven't produced these drafts on our own! They were developed with a great deal of collaboration and stakeholder engagement – just like the Act itself.
- Within the guidance we've used examples and case studies to illustrate the guidance. Tell us if you think they're helpful or if you have better examples.
- We have tried to capture cross cutting issues throughout the guidance - have we succeeded?

The Care Act: Part One
draft guidance and regulations

The guidance: chapter by chapter

Ch	Topic
1	Promoting wellbeing
2	Preventing, reducing or delaying needs ☆
3	Information and advice
4	Market shaping and commissioning
5	Managing provider failure ☆
6	Assessment and eligibility ☆
7	Independent advocacy ☆
8	Charging and financial assessment ☆
9	Deferred payment agreements ☆
10	Care and support planning
11	Personal budgets ☆

Ch	Topic
12	Direct payments ☆
13	Review of care and support plans
14	Safeguarding
15	Integration, cooperation and partnerships ☆
16	Transition to adult care and support ☆
17	Prisons and approved premises
18	Delegation of local authority functions
19	Ordinary residence ☆
20	Continuity of care ☆
21	Cross-border placements ☆
22	Sight registers ☆
23	Transition to the new legal framework

☆ *Areas with related draft regulations*

General responsibilities and universal services

1. The wellbeing principle

- The wellbeing principle underpins the entire legal framework, and influences the way all functions are carried out in relation to individuals.
- How to define wellbeing – and how it relates to other areas in the Act.
- Duties and powers to "meet needs" replace previous entitlements to services.

2. Preventing, reducing and delaying needs

- Universal duty: applies equally to those not receiving services and their carers.
- Primary, Secondary and Tertiary prevention.
- Strategic approaches and working with partners and voluntary services.
- Regulations cover charging for prevention: limits and specific free provision.

General responsibilities and universal services

3. Information and advice

- Universal duty, but tailored information and advice for specific groups will be vital.
- Sets out how to provide information and advice, and to whom.
- Role of financial information and advice and how to help people benefit.

4. Market shaping and commissioning

- Commissioning focused on outcomes and promoting wellbeing.
- Promoting choice to drive quality and sustainability.
- Importance of workforce development and pay.

5. Managing provider failure

- Local authorities' responsibilities to meet needs in cases of provider failure. Emphasis on contingency planning and early warning. Regulations set out when there is a "business failure" to trigger local authority duty.
- New CQC oversight regime of financial health of "difficult to replace" providers. Regulations set out criteria for which providers are in regime.

First contact and identifying needs

6. Assessment and eligibility

- Duty to assess on appearance of need – for people who use care and carers.
- Must involve the person, and focus on their desired outcomes alongside needs.
- Must be proportionate to the person's needs, goals and circumstances.
- Consider how to prevent or delay needs, and whether other types of support available locally may also benefit, alongside the assessment.
- Regulations set out requirements around assessment, including training/expertise.
- New **national minimum eligibility threshold** ensures more consistency, designed to maintain existing levels of access. Local authorities can meet other needs.
- Regulations set out eligibility criteria, based on "significant impact on wellbeing".

7. Independent advocacy

- Duty to provide an independent advocate where someone has substantial difficulty being involved in the process and there is no one to act on their behalf.
- Regulations define "substantial difficulty" in involvement, requirements for an advocate, and what their role looks like.

Charging and financial assessment

8. Charging for care and support

- Charging framework clarified for 2015/16 but largely unchanged. Questions on small changes to 12-week disregard of property after entering a care home; and treatment of investment bonds/pre-paid funeral plans.
- Includes right to **choice of accommodation** and ability to make top-up payments. Question extension to other types of accommodation (e.g. extra care housing).
- Regulations set out process of financial assessment (including monies to be disregarded), limitations on power to charge and choice of accommodation.

9. Deferred payment agreements

- A person can 'defer' paying the costs of their care and support, so they do not have to sell their home at a point of crisis. New duty to offer to certain people.
- Amount that can be deferred usually based on loan-to-value ratio of home.
- Power to charge interest to offset risk and make cost-neutral.
- Questions on interest rate; extending scheme to extra care housing and supported living; and allowing people to keep some rental income.
- Regulations set out the criteria for DPAs, and other conditions.

Care and support planning

10. Care and support planning

- Duty to prepare a care and support plan for all those whose needs are being met, including carers. Must involve people in the planning process.
- Legal framework for combining or integrating plans for different people where appropriate.

11. Personal budgets

- Sets out what it will cost the local authority to meet the person's needs.
- Must be included with each plan.
- Process for calculating budget must be transparent.
- Can be combined with other public money, e.g. personal health budgets.
- Regulations specify that intermediate care and reablement are not included in a personal budget.

Care and support planning

12. Direct payments

- Right to request the amount identified in a personal budget as a cash payment, which people can use to purchase their own care and support.
- Direct payments must have proper oversight and be reviewed regularly, without being too burdensome.
- Questions on having first review after 6 months instead of 12; and easing restriction on paying family members to manage.
- Regulations set out situations where a local authority must not, or may not, offer a direct payment; and other conditions.

13. Reviews

- Review must be ongoing to ensure needs continue to be met over time.
- Planning and sharing timescales for regular reviews, and responding to a request for a review.
- Proportionality and timeliness of reviews.

Adult safeguarding

14. Safeguarding

- Definitions of “abuse” and “neglect”.
- The local authority role: new duty to carry out **enquiries** where risk of abuse or neglect. May require independent advocate.
- Requirement for all areas to establish a **Safeguarding Adults Board** (SAB): to coordinate activity of partners to protect adults from abuse and neglect.
- Multi-agency working: roles, responsibilities and information-sharing.
- LA, NHS and police as core members of SAB: local discretion for others?
- SABs to carry out **safeguarding adults reviews** into cases of concern, to ensure lessons are learned.
- New ability for SABs to require information sharing from other partners to support reviews or other functions,

Integration and partnership working

15. Integration, cooperation and partnerships

- Promoting **integration** with NHS and other services (including housing).
- Requirement to work collaboratively and cooperate with other public authorities, both generally and in specific cases.
- **Working with the NHS** and managing the legal boundary with local authority responsibilities. Regulations set out details and the process for dispute resolution.
- Managing delayed transfers of care out of hospitals. Largely replicates existing scheme, but discretionary not mandatory. Regulations set out processes to follow.
- **Working with housing** to integrate provision and ensure focus on suitability of living accommodation. Considers how housing supports core responsibilities in the other parts of the guidance.
- **Working with employment and welfare services** – also often highly relevant to care and support and JobCentre Plus is "relevant partner" for cooperation.

Integration and partnership working

16. Transition to adult care and support

- Duty to assess young people and their carers in advance of transition from children's to adult services, where likely to need care and support as an adult.
- How to determine where there is "significant benefit" for timing of assessment.
- Regulations set out process for providing services to adult carers of children.

17. Prisons and approved premises

- Each local authority responsible for prisoners in custodial settings in its area.
- Principle of equivalence with those in the community, however complicated in some areas, e.g. aids & adaptations. Some rights do not apply.

18. Delegation of local authority functions

- New power for authorities to delegate certain functions to another organisation.
- Local authorities retain ultimate responsibility for how functions are carried out, so people always have redress. Good contract management and avoiding conflicts of interest essential.

Moving between areas

19. Ordinary residence

- Local authority responsible for meeting the eligible needs of all those ordinarily resident in their area (who may be living elsewhere some or all of the time).
- Example scenarios to help decisions and aid dispute resolution between areas.
- Regulations set out the types of accommodation where ordinary residence applies in relation to "out of area" placements and the process for dispute resolution.

20. Continuity of care

- When someone moves area, current local authority must share the care and support plan and other information relating to the person and their carer.
- Information before the move, assessment and arranging to meet the needs on the day of arrival, based on the previous care and support plan.
- Regulations set out the requirements on the day of the move.

21. Cross-border placements

- New power ability to arrange care home placements across the UK.

Other areas

22. Sight registers

- Local authorities must keep a register of adults who are severely sight impaired and sight impaired in their area. Regulations define who should be treated as sight-impaired or severely sight-impaired.
- Local authorities may also maintain registers of other people with disabilities.

23. Transition to the new legal framework

- Transition in 2015/16: passporting people currently in the system under the new legal framework in the Care Act.
- No automatic need for re-assessment or new eligibility determination; will depend on previous local policies
- Preparing for 2016/17: steps to take in 15/16 to prepare for funding reform: understanding likely demand, awareness-raising, capacity-building, and early assessments

The consultation: more information

www.careandsupportregs.dh.gov.uk

- Consultation document
- Draft guidance and regulations
- Easy Read document
- Factsheets
- Impact assessment and equality analysis

Implementing the reforms: more information

www.local.gov.uk/care-support-reform

- Clause-by-clause summary of Care Act and implications for implementation
- Details of networks to plug into
- Shared tools and guidance used by local authorities
- Regular bulletins

What happens next?

• Finalise 2015/16 regulations and guidance	**October 2014**
• Ongoing work to develop practice guides, toolkits and implementation support	Over summer/ autumn 2014
• Separate consultation later this year on those elements of the Act that come into force in April 2016 (e.g. funding reform).	Late 2014
• New statute comes into force	April 2015
• Funding reforms come into effect	April 2016

Please respond to the consultation

Comment online	www.careandsupportregs.dh.gov.uk
E-mail us at	careactconsultation@dh.gsi.gov.uk
Share your thoughts	#careact2014
Write to	Care and Support Consultation, Room 313, Richmond House, 79 Whitehall, London, SW1A 2NS

Please make sure all consultation responses are received by **15 August 2014**

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11 September 2014		ITEM: 6
Thurrock Health and Well-Being Board		
Update on the development of the Better Care Pooled Fund and Section 75 Agreement		
Wards and communities affected: All	**Key Decision:** Non-key	
Report of: Mandy Ansell, (Acting) Interim Accountable Officer, NHS Thurrock CCG and Roger Harris, Director of Adults Health and Commissioning, Thurrock Council		
Accountable Head of Service: Not applicable		
Accountable Directors: As above		
This report is public		

Executive Summary

This report outlines the mandatory requirement to establish a Better Care Fund pooled fund to promote integrated care and support services. The pooled fund will be operated in line with the conditions set out in a Section 75 agreement as agreed by the Health and Well-Being Board, the Board of NHS Thurrock CCG and the Cabinet of Thurrock Council.

There are a number of administrative matters which must be addressed in establishing and operating a pooled fund, including the treatment of under and over spends and VAT. However, it is clear that the purpose of the exercise is to drive through significant changes to our health and social care systems so that care is more effective, efficient and economic, and so that service users, patients and carers experience better co-ordinated care and improved outcomes. This is consistent with our vision for integrated health and social care as contained within our BCF Plan.

1. Recommendation(s)

1.1 The Health and Well-Being Board are asked to agree the approach to setting up the Better Care Fund pooled fund, and the Section 75 Agreement between NHS Thurrock CCG and Thurrock Council.

1.2 The Health and Well-Being Board are also asked to note the milestones for entering into the agreement, establishing the pooled fund and setting up new contractual arrangements for the provision of integrated health and social care services from April 2015.

2. Introduction and Background

2.1 In the Spending Round announced in June 2013 the Government put £3.8 billion of existing health and social care funding into a single pooled budget, requiring health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities. In line with those requirements, as outlined in the report to the Board on 17 July 2014, the CCG and the Council are working to establish a pooled fund to drive closer integration and improve outcomes for patients, service users and carers. The fund must be established by April 2015 and administered in line with a Section 75 agreement between the CCG and the Council.

2.2 Further details on the requirements for the Section 75 agreement are set out in Appendix 1 of this report.

3. Issues, Options and Analysis of Options

<u>Sizing the Fund and identifying the Services</u>

3.1 The establishment of a BCF pooled fund is mandatory, as is the requirement to establish a fund of a minimum size. However, the actual size of the fund beyond that minimum mandated value, and the purposes to which the fund is applied are matters to be determined locally. Although the Spending Round announcement only covered 2014/15 and 2015/16 it is understood the intention is to see pooled funds grow in subsequent years and ever greater integration achieved.

3.2 The initial focus for Thurrock's Better Care Fund is on individuals aged 65 and over who are most at risk of hospital admission or residential home admission. In line with the Care Act guidance on 'preventing, reducing or delaying needs', our aim is to develop integrated approaches that target 'individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing'. Accordingly it is proposed that the services to be included in the pooled fund in Thurrock, and so the value of the Better Care Fund itself in 2015/16, will be arrived at by identifying those services which are most relevant to preventing or reducing admissions of those aged 65 and over.

3.3 Work to refine the scope of the pooled fund for 2015/16, and to identify the services which will be funded under the terms of the Section 75 agreement, is currently being undertaken. This work will need to be completed in time for the submission of the revised BCF Plan on 19 September 2014.

<u>The range of calls on the Better Care Fund</u>

3.4 As noted in the report on 17 July, the Better Care Fund is to be established, and a reduction in total emergency admissions achieved within existing Council and NHS funding – there is no new money. In addition to the challenge of driving through significant change in our health and social care system there are a set of national "must dos", including 7 day working, better data sharing, an accountable professional for people over 75 and protection for adult social care services. Further, it was announced as part of the

Spending Round that the Better Care Fund would include £135m of revenue funding for costs to councils resulting from Care Act implementation in 2015/16. This revenue funding will be identified from the £1.9bn of NHS funding, and will cover a range of new duties on councils relating to the Care Act. For Thurrock this has been estimated to be £521,000. In addition, the NHS England Directions 2014 specify at least £200m nationally "must be used for purposes related to service integration." For Thurrock the allocation is £545,000. Work to identify the funding for Care Act implementation, and for purposes related to service integration, is currently being undertaken and the source of the funds will need to be specified in the Section 75 agreement.

<u>The payment for performance element of the fund.</u>

3.5 While the initial focus of the Better Care Fund when it was launched in August 2013 was on integration, (its original title was the Transformation Integration Fund) the revised guidance issued on 25 July 2014 places a specific requirement for a minimum target reduction in total emergency admissions. The guidance makes it clear this should be 3.5% for all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower. Supplementary guidance published on 18 August states that the local target should be "ambitious and stretching" while taking into account a range of factors including "whether the local population is projected to increase by more than the national average." This is clearly a factor for Thurrock and so it is proposed a local target lower than 3.5% should be set.

3.6 However, whatever local target is set it is clear that a range of factors related to services which are not be included in the pooled fund could affect total emergency admissions. As the initial focus locally is limited to those aged 65 and over and most at risk of admission, a focus on those services outside the pooled fund will continue to be needed. Moreover, the definition of total emergency admissions includes the admission of children and young people even though the Better Care Fund is targeted at older adults. Further, some elements of acute services as well as all primary care services are specifically excluded from the Better Care Fund but these too will have an impact on total emergency admissions.

3.7 A further factor which must be considered in relation to the target reduction in total emergency admissions is that Thurrock shares the foot print of BTUH with Brentwood and Basildon CCG. This means that there is a potential for Essex and Thurrock to take different approaches to the reduction in admissions and so there is a potential risk that conflicting approaches may present a barrier to achieving the target. For this reason discussions have commenced with Brentwood and Basildon CCG, Essex CC and NHS Essex Area Team with a view to agreeing a set of principles which would help ensure a consistent approach to the target reduction, and a mechanism for resolving issues which might represent a barrier to achieving the target.

3.8 For these reasons it is proposed that a local target which is "ambitious and stretching" is set which takes into account:

- The starting point locally in relation to reductions in emergency admissions;
- The trend in performance locally;
- Performance compared to peers; and
- Local population growth.

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

Risk of overspends

3.10 Another area of risk concerns overspends on services included in the pooled fund. While community health services are block contracts and so represent a fixed cost, the cost of acute services may be influenced by demand and any performance over planned activity levels may result in an overspend. Similarly, the cost of a number of social care services, including care home places and home care is influenced by demand. There is also a risk that changes resulting from the Care Act, including eligibility criteria and the funding reforms, may lead to increases in demand while also reducing income from charges.

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

Administrative arrangements and milestones

3.12 In addition to the submission of the revised Better Care Fund Plan on 19 September, and any further work required in the subsequent assurance process, the CCG and Council must agree the local arrangements for establishing the pooled fund and the approval of the Section 75 agreement to allow the pooled fund to operate from April 2015. It is proposed that a report recommending approval of the Section 75 agreement should be presented to the Board of NHS Thurrock CCG on 26 November 2014 and the Cabinet of Thurrock Council on 3 December 2014.

3.13 For the Council to host the pooled fund, and to make payments to third party providers from the fund from April 2015, it will need to agree contract novations with the CCG and the provider where it is not currently a party to the contract for the service. In view of the timescales, involved waiver requests and contract award requests for these contracts will need to be approved no later than February 2015. Activities ranging from the placement of purchase orders to performance management will also need to be undertaken in good time.

Risks related to timescales, complexity and capacity

3.14 Councils and CCGs were given a little over 15 months to establish their Better Care Fund, which for Thurrock involves establishing a joint venture amounting to at least £10.5m in 2015/16, while embarking on major changes to the whole health and social care system. Major revisions to guidance on the operation of the fund were received on 25 July 2014 – little more than 8 months before it is to be operational. The conditions attached to the fund have also become more complex, and the risks associated with the national conditions are judged to have increased. Councils and CCGs are expected to manage this change programme within their existing resource envelope.

3.15 A Risk Register for the Better Care Fund has been established and a Project Group comprising senior officers from the CCG and the Council is meeting monthly to oversee the development work and to actively manage the risks identified. The Project Group reports to the Health and Social Care Transformation Board so that linkages with the implementation of the Care Act, and corporate efficiency initiatives are also actively managed.

Milestones

3.16

Health and Well-Being Board agreement to Section 75 agreement	13 November 2014
NHS Thurrock CCG Board approval of Section 75 agreement	26 November 2014
Cabinet of Thurrock Council approval of Section 75 agreement	3 December 2014
Waiver requests and contract awards	From January 2015
Purchase to pay arrangement	From January 2015
Contract and Performance management	From January 2015
Payments of providers from the BCF pooled fund	From April 2015

4. Reasons for Recommendation

4.1 The proposals for managing the risks and issues identified in Section 3 are considered to be prudent, while acknowledging that further analysis, and indeed further guidance from Government in some cases, is required.

4.2 As there are a number of detailed issues which are still to be resolved in relation to the establishment and operation of the pooled fund, and the Section 75 agreement between Thurrock Council and NHS Thurrock CCG, a further report and full draft of the Section 75 agreement will be brought to the Health and Well-Being Board on 13 November.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The process of community engagement in the redesign of health and social care services in Thurrock is being planned in conjunction with Thurrock Healthwatch, Thurrock Coalition, Thurrock CVS and the Thurrock Commissioning Reference Group.

5.2 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services will be required under the terms of the Health and Social Care Act 2012. This will be undertaken through the Thurrock consultation portal and will invite residents to comment on the vision for Better Care in Thurrock.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The planned reduction in emergency admissions, which brings with it the potential to invest in services closer to home, will help prevent, reduce or delay the need for health and social care services. This will help deliver the Community Strategy priority to improve health and well-being.

6.2 Achieving closer integration and improved outcomes for patients, service users and carers is also seen to be the main way to manage demand for health and social care services, and so manage financial pressures on both the CCG and the Council.

7. Implications

7.1 **Financial**

Implications verified by: **Sean Clark**

Head of Corporate Finance

The above report contains the current know position of the Better Care Fund, guidance on which is still being received. While reasonable progress has been made in understanding the detail of how the pooled fund will operate and the timescales for the project, the complexity of the health and social care system itself presents a major challenge. These challenges must be identified, and arrangements for managing risks must be agreed, before the Section 75 Agreement can be finalised.

7.2 **Legal**

Implications verified by: **Daniel Toohey**

Principal Solicitor - Contracts & Procurement

The above report contains the current know position of the Better Care Fund, guidance on which is still being received. Further, the Council is seeking clarification from Government on a number of legal points. As noted previously the governance arrangements for the Better Care Fund will need to

be agreed by the Health and Well-Being Board, and approval from the Cabinet of Thurrock Council and the Board of NHS Thurrock CCG will be required before the pooled fund can be established.

7.3 **Diversity and Equality**

Implications verified by: **Teresa Evans**

Equalities and Cohesion officer

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and social care services. The commissioning plans developed to realise this vision will need to be developed with due regard to equality and diversity considerations. This will include adherence to the relevant 'Equality' Codes of Practice on Procurement. These require consideration of the equality arrangements of all such providers, such as relevant policies on equal opportunities and the ability to demonstrate a commitment to equality and diversity. These arrangements will also be subject to a full review as part of the contract management of the services to be provided.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None identified at this time.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- HM Treasury Spending Round 2013 Cm 8639
- NHS England Statement on the health and social care Integration Transformation Fund, 8 August 2013
- Annex to the NHS England Planning Guidance Developing Plans for the Better Care Fund (formerly the Integration Transformation Fund), 2013
- NHS England Better Care Fund – Revised Planning Guidance, 25 July 2014

9. Appendices to the report

- Appendix 1 – the BCF Pooled Fund Model

Report Author:

Christopher Smith
Programme Manager, Adults, Health and Commissioning

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APPENDIX 1

1. The Better Care Fund Pooled Fund Model

1.1. The establishment of a national £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Spending Review states that the BCF at a local level is to be a single pooled fund, not simply aligned budgets or joint commissioning, and a S75 agreement is the means by which pooled funds are to be put in place.

1.2. Under these arrangements each of the partners make contributions to a common fund (including any contributions through the provision of key premises, goods and services in kind). The fund is ring fenced to be spent on specifically agreed services and functions that parties to the agreement have specified in the S75 agreement. Among other matters the ownership and disclosure of any capital items purchased by the pool, and reporting any requirements, are subject to the usual audit and accounts procedures.

1.3. A pooled fund is held by a host organisation who will take responsibility for administering the fund (effectively acting as a ‘banker’).

1.4. The minimum contribution to the BCF pooled fund in 2015/16 has been specified by NHS England in the allocations published in December 2013, and for Thurrock this minimum amounts to £10,565,000. The S75 agreement will also need to address the period of the agreement and how future years’ contributions are to be determined, along with reporting and risk management arrangements.

2. Implications of the BCF Pooled Fund Model

2.1. The Health and Well-Being Board on 17 July 2014 agreed the recommendation that the Council should manage the pooled fund as a host partner. Determining the host partner is a matter for local decision, and approval by the relevant parties’ governance structures (in the case of Thurrock, NHS Thurrock CCG Board and Cabinet of Thurrock Council). Summarised in the following paragraphs is CIPFA and other guidance on the key financial arrangements for managing a pooled fund.

2.2. The operation of the pooled fund will be managed by the host partner. This will include receiving all of the cash relating to the S75 agreement and facilitating the expenditure against the pool. The host partner will also be expected to regularly report performance against the budget for the S75 activity, as agreed by the partners. The respective S75 partners responsibilities for the collection and provision to the host partner of this information therefore also needs to be included in the agreement.

2.3. Pooled fund income and expenditure will be recorded in the accounts of the host partner, in accordance with the regulations relating to the host partner organisation, using their accounting principles and policies, scheme of delegation, standing orders and standing financial instructions. On the basis that the host partner will collect the cash into the pool and administer payments from the pool, there should be no reason why recharges among the partners will be necessary, however in accordance with the risk management agreement; recharges may be required among partners in accordance with an agreed formula.

2.4. There will be costs incurred in administering the pooled fund which will need to be met out of the pooled fund; this will be calculated and agreed as part of the S75 agreement.

2.5. The partners must also include in the agreement how to report and manage surpluses and deficits, and the agreement should specify the level of permitted variation, both in year and between years, acceptable to the partners.. As noted above, the accounting treatment, within the pooled fund, must adhere to the host partner's legal responsibilities and each party must account for its own share of the assets, liabilities and cash flows which arise from the pooled funds as a note within their respective accounts. Therefore, where the local authority is the fund host, carry forward of fund balances is permissible, reducing both year-end reconciliations and transactions.

2.6. Pooled fund assets and liabilities are shared at the end of the life of the partnership according to arrangements set out in the S75 agreement.

2.7. The Chief Finance Officer (CFO) of the host partner will have financial responsibilities and accountabilities in the administration of the agreement. The duty of CFOs is to ensure effective management of public money is being addressed by the host partner's arrangements for the financial management which must be informed by the specific responsibilities of all the S75 partner(s) CFOs.

2.8. Internal Audit – Partners can retain the right of access to the financial records and arrangements of the pooled fund by their own internal audit service.

2.9. External Audit – Notwithstanding the partners' rights to retain access by their internal audit service, the host partner's external auditors will audit the entirety of the activity, allowing reliance to be placed on the financial records by partners.

2.10. Local authorities and NHS bodies are subject to different VAT regimes. Therefore the agreement needs to be clear on how income, expenditure and VAT will be accounted for before joint arrangements are entered into.

2.11. There are two alternative arrangements for the host partner with regards to VAT:

i) The host partner's VAT regime applies – i.e. funds are paid to the host partner and payments are made directly by the host to provider(s).

ii) The host partner acts as 'agent' for the other partner(s) – i.e. funds are paid to the host partner and payments are made by the host to reimburse partners for payments they make to provider(s).

If the local authority hosts the pool under option (i) any VAT payable is directly recoverable, maximising pooled resources and reducing the associated payments administration.
If the NHS is the host body, it would be preferable for the NHS to operate on an 'agency' basis, under option (ii) as this would then enable the NHS body to invoice the local authority for expenditure incurred by the pool in meeting the local authority's objectives thereby allowing the local authority to recover VAT on this expenditure. This would however both increase the fund administration and not enable any VAT incurred by the health partners to be reclaimed.

2.12. These VAT considerations have informed the recommendation that Thurrock Council is the appropriate fund host partner and, if agreed by HWB, this will be reflected in the final BCF submission.

2.13. The details of these matters do not need to be determined for the final BCF submission but will need to be addressed in the S75 Agreement(s) which must be in place for 1st April 2015. In order to ensure all the administrative arrangements are in place to achieve this deadline it is proposed that the completed S75 will be presented to the Health and Well being Board for agreement on 13 November, and then to the Board of NHS Thurrock CCG on 26 November and to Cabinet on 3 December for approval.

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11th September 2014	ITEM: 7
Health & Wellbeing Board	
Mental Health Crisis Care Concordat	
Wards and communities affected: All	**Key Decision:** Not Applicable
Report of: Mark Tebbs (Head of Mental Health & LD Commissioning)	
Accountable Head of Service: Mark Tebbs (Head of Mental Health & LD Commissioning)	
Accountable Director: Mandy Ansell (Interim Accountable Officer Thurrock CCG)	
This report is Public	

Executive Summary

Improving Outcomes for People experiencing Mental Health Crisis

This briefing sets out the key considerations regarding the mental health crisis concordat. The paper considers:

- Overview and background information
- The key expectations and principals of the Concordat*:* (DH Dec 2014)
- Summary of challenges
- Next steps

1. Recommendation(s)

1.1 It is recommended that the board notes the contents of this report for information with consideration given into signing the principals of the Concordat approach.

2. Introduction and Background

2.1 The mental health crisis concordat is a national agreement between services and agencies involved in the care and support of people in crisis. The concordat sets out a new agreement between police, the NHS, the Local Government Association, Association of Directors of Adult Social Services and other emergency partners in a

bid to improve mental health crisis care. The agreement has been signed by more than 20 national organisations in a bid to drive up standards of care for people experiencing crises. The concordat is seen as a key tool to ensure that individuals experiencing crises will consistently receive a robust and responsive service from all agencies.

2.2 **Key Expectations & Principles:**

The concordat expects that local partnerships of health, criminal justice and local authorities will agree to commit to a local **Mental Health Crisis Declaration** by December 2014. These will consist of commitments and actions at local level that will deliver services that meet the principles of the national concordat.

The primary aim of the concordat serves as a joint statement of intent and common purpose. The concordat aims to ensure there is clear agreement and understanding of roles and responsibilities for each service. This will help to make sure people who need immediate mental health crisis support will get the right services when they need them.

The focus and vision of the concordat is arranged around four key objectives:

- Access to support before crisis point
- Urgent and emergency access in crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crisis

3. Issues, Options and Analysis of Options

3.1 **Summary of Challenges**

The key challenges are to:

- ➢ Ensure health based places of safety and beds are available 24/7 in case someone experiences a mental health crisis
- ➢ Police cells not being used because mental health services are not available. The use of police vehicles as a form of patient transfer is discontinued, with a

commitment to halve use of cells as a place of safety for people experiencing mental health issues compared to 2011/2012

- Timescales put in place so police responding to mental health crisis know how long they will have to wait for a response from health and social care workers, thus making sure patients get suitable care as soon as possible.
- People in crisis should expect that services will share essential "need to know" information about them so they can receive the best care possible.

4. Reasons for Recommendation

4.1 The East of England held a conference on the 4/07/14 to support local areas to develop the declaration. The board is requested to note the following:

- The PCC's (Police & Crime Commissioners) office, in collaboration with the safeguarding hub, have had an initial meeting to identify key stakeholders for an Essex wide footprint including Thurrock & Southend for a declaration in line with the vision of the concordat
- A letter to Thurrock CCG COO, executives of the acute trusts and ambulance trust and local executives of national bodies that are signatories to the concordat will be sent out by Morris Mason (Assistant Chief Constable Essex Police) setting out the basis and principals of concordant. The letter will ask for commitment from an executive level to agree ownership of declaration and nominate individuals to be part of planning group on behalf of relevant organisations.
- Development of Action plan and agreed footprint for localisation

5. Consultation (including Overview and Scrutiny, if applicable)

At the concordat working group meeting on the 30th July 2014, hosted by the Chief Constables office it was agreed by group members that there should be two events undertaken in relation to the concordat one that highlighted the signing up to the declaration of the required organisations and a further event aimed at operational staff. These would form part of consultation for the declaration and agreed action plan.

6. Impact on corporate policies, priorities, performance and community impact

Not applicable

7. Implications

7.1 **Financial Mike Jones Management Accountant**
Mxjones@thurrock.gov.uk

Achieving a robust local action plan might well include some financial commitment taking into consideration current commissioned services with a possibility of redesign dependent on any potential gaps.

7.2 **Legal Dawn Pelle**
dawn.pelle@ BDTLegal.org.uk

No implications.

The concordat is a joint statement of commitment by signatories with one shared vision to work together to improve the system of care and support so people in crisis because of mental health condition are kept safe and helped to find the support they need whatever the circumstances in which they first need help and from whichever service they turn to first.

7.3 **Diversity and Equality: Teresa Evans Equalities and Cohesion Officer**
Tevans@thurrock.gov.uk

No Implications

The ethos of the concordat is broadly based on equal access for everyone during crisis. It focuses on an awareness of commissioners and providers being aware of the Equality Act 2010 and applying it to mental health services. The Health and Social Care Act 2012 also introduced new legal duties regarding health inequalities for NHS England, stating that inequality of access to services and inequality of outcomes from them must be reduced.

Equality and diversity is a key policy objective within England’s cross government strategy for mental health, No health without mental health.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

No Implications

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

http://www.crisiscareconcordat.org.uk/

9. Appendix to the report

Appendix 1 Mental Health Crisis Care Concordat

Signatories of Mental Health Crisis Care Concordat

Association of Ambulance Chief Executives
Association of Chief Police Officers
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Police and Crime Commissioners
British Transport Police
Care Quality Commission
College of Emergency Medicine
College of Policing
The College of Social Work
Department of Health
Health Education England
Home Office
Local Government Association
Mind
Mental Health Network, NHS Confederation
NHS England
Public Health England
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics' and Child Health
Royal College of Psychiatrists

Report Author:

Alfred Bandakpara-Taylor

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Concordat – Improving outcomes for people experiencing mental health crisis

We, the undersigned, commit to work together to improve the system of care and support so that people in crisis as a result of a mental health condition can be kept safe and helped by us to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.

We will work together, and with local organisations, to stop crises arising whenever possible through prevention and early intervention. We will seek to ensure vulnerable peoples' needs are met when urgent situations arise. We will strive to ensure that all relevant public services support any person who appears to have a mental health problem to move towards Recovery.

Jointly, we hold ourselves to be accountable for enabling this commitment to be delivered across England."

Draft – v4.0; 16th September

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The case for change

3. Key Commissioning Responsibilities

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Access to support before crisis point

Urgent and emergency access to crisis care

Treatment and care when in crisis

Recovery and staying well / preventing future crises

5. Characteristics of effective mental health crises services

- Appendices
- Reference material/sources of evidence quoted

1. Concordat statement: The Vision

We recognise that people experiencing mental health crisis are among the most vulnerable in our society. They should be able to expect a timely and appropriate response from the services we represent which is effective in meeting their needs.

We acknowledge that this is not always the experience of people with these needs and so together we are committed to ensuring action is taken to make this the norm across England.

We are committed to work together to achieve Parity of Esteem for people experiencing mental health crisis, ensuring they get the same level of service at all times as people needing urgent and emergency care for physical health conditions.

We can achieve this by working together to anticipate and prevent mental health crises; to improve crisis care for people who need it; and to make sure that there is an effective emergency response system established, in which each agency involved will support the others, in the best interests of the people that need us..

Our intention is that people in mental health crisis will be treated with respect, compassion and dignity, they will be kept safe and their needs will be addressed appropriately and in a timely way to achieve the best outcome and experience possible for the individual.

We are committed to ensuring that people in mental health crisis can expect the following outcomes at different points in their experience:

- **Access to support before crisis point**

When I need urgent help to avert a crisis I, and/or people close to me, know who to contact 24/7. People take me seriously and trust my judgement, and I get speedy access to a service that helps me get better.

- **Urgent and emergency access to crisis care**

If I am in mental health crisis this is treated as an emergency, with as much urgency as if it were a physical health problem. If I have to be taken somewhere, it is done safely and supportively in suitable transport.

I am seen by a mental health professional quickly and do not have to wait in conditions that make my mental health worse. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me, to check any relevant information that services have about me, and to follow my wishes and any previously agreed plan.

I am safe and treated kindly, with respect, and in accordance with my legal rights. If I have to be held, this is done safely, supportively and lawfully, by people who know what they are doing.

Anyone at home, school or work who needs to know where I am has been informed and I am confident that arrangements are made to look after anyone who depends on me.

- **Treatment and care when in crisis**

I get support and treatment from people who have the right skills and who focus on my recovery, in a setting that is suited to my needs.

I have support to speak for myself and make decisions about my treatment and care. If I do not have capacity to make decisions about my treatment and care, any statements of wishes, or decisions, that I made in advance are checked and respected, and I am able to have an advocate.

- **Recovery and staying well / preventing future crises**

I, and/or people close to me, have an opportunity to reflect on the crisis, and to find ways to manage my mental health in the future, with support if needed. We have an agreed strategy for how I will be supported if my mental health gets worse in the future.

This Concordat will have succeeded when local health, social care, criminal justice systems and service users across England have embraced and committed to the principles and outcomes it sets out, and are working together to review, monitor and continuously improve the experience of people in mental health crisis in each locality. For that reason we have included within the Concordat a pledge that will allow local partnerships and individual organisations to commit to ensure higher standards of care in their areas [to be drafted].

At a national level, the following organisations are **signatories [indicative list, not yet complete or definitive**] to this Concordat, committing to work together to support local systems to achieve systematic and continuous improvements for crisis care for people with mental health issues across England:

Department of Health

Home Office

Children and Young People's Outcomes Forum

Association of Ambulance Chief Executives

[Association of Chief Police Officers - check correct term for National Policing Lead]

Association of Directors of Adult Social Services

Association of Police and Crime Commissioners

Care Quality Commission

Clinical Commissioning Groups Mental Health Network

College of Emergency Medicine

College of Policing

College of Social Work
Health Education England
HM Inspectorate of Constabulary
Criminal Justice Joint Inspectorate
Local Government Association
NHS England
Public Health England
NHS Confederation
Royal College of Psychiatrists
Royal College of General Practitioners
Royal College of Nursing

2. Introduction

Aim and purpose

This Concordat sets out the agreement between the signatories of the:

- Vision for the outcomes that people in mental health crisis should expect
- Actions which each party has committed to in enabling the delivery of this vision across England
- Shared and collaborative accountability framework through which each signatory will continue to work with its Concordat partners to monitor progress in delivering these commitments [DN: Do we need to say more about this and if so, does it go in the main body or as annex?]

The main body of the document sets out the vision and outcomes that people in mental health crisis should expect. These guiding principles are described from the service user's perspective framed by a proxy mental health crisis pathway as follows:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Treatment and care when in crisis
- Recovery and staying well / preventing future crises

The document provides further details, for each of these elements, of the outcomes which people experiencing mental health crises should expect, illustrated by case studies from across the country illustrating examples of positive practice in each area. The annexes contain the actions committed to by each party, which are also structured in the above format, and also include a dissemination and communications plan.

An annual Concordat Summit will be held by signatories to review progress, refresh the direction of travel and put results in the public domain in order to build public confidence in mental health crises services.

Scope

The scope of the Concordat spans the health, social care and criminal justice systems. It defines the outcomes expected for people of all ages and mental health crises in the broadest sense, including physical health related needs, including:

- Suicidal behaviours
- Clinical depression
- Dementia
- Personality disorder
- Alcohol and drug dependence
- Adults with self-harm events
- Psychosis relapse
- Children's crisis conditions

- Social crisis such as homelessness or bereavement resulting in mental health trauma
- The physical health emergencies which have arisen as a result of a mental health condition e.g. overdose

The case for change

Individuals suffering from mental ill health may come into contact with a range of emergency and urgent services. This can lead to:

- Inappropriate emergency responses;
- Lack of clarity about which service should do what and when;
- Disruption to providing continuity of care for those with long-term mental health conditions;
- Tensions between agencies on the ground based on a lack of clarity about the most appropriate response

A series of recent publications [add references - Mind report, Adebowale report, NHS England Urgent & Emergency Care Review, CQC Crisis Review, Crisis Resolution Fidelity Report] have highlighted the fact that despite many examples of good practice, mental health crises services often fall short in providing effective care and treatment for people who are among the most vulnerable in our society. Moreover, the outcomes and experience for people in mental health crises are disproportionately poorer than the general population.

Detentions under the Mental Health Act are on the rise, which is placing more pressure on statutory services to ensure that they are working together as efficiently as possible to provide an effective response within available resources.

3. Key Commissioning Responsibilities

The legal and policy framework is summarised at annex 4.

The NHS Mandate

'By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence based services.' [HMG, NHS Mandate]

The NHS Mandate sets out the Government's priorities for the spending of NHS resources from 2013 to 2015. It will establish the improvements that will be made to mental health services and show where improvements to mental health services can improve the performance of the NHS as a whole. Specifically, this includes '*supporting people with multiple long-term physical and mental health long-term conditions…delivering a service that values mental and physical health equally'*. [HMG, NHS Mandate]

Delivery of these commitments related to parity of esteem is central to the NHS's work to improve mental health services and will provide the impetus for driving improvements to mental health crisis care linked to the NHS Urgent and Emergency Care Review.

Commissioner responsibilities

Health and social care commissioners should ensure that sufficient resources to meet their statutory duties are made available within the acute care pathway to ensure patient safety, enable service user and patient choice and for individuals to be treated at or close to home.

Commissioners will want to have a strategic focus on prevention, wellbeing and community services alongside suicide and self-harm prevention programmes which respond to local needs. They will ensure a range of service provision which is timely, accessible, offers choice and appropriate care, including NICE approved interventions. The acute pathway should be effective in response to local needs:

"An effective pathway is one where all those involved in providing the service share aims, priorities and values as well as operational policies. The relationships between the component parts are as important as the properties of the parts themselves. There need to be clear arrangements in place for the cohesive overall management of a locality's acute care services and its workforce" [Mental Health Joint Commissioning Panel].

An effective response to mental health crises requires a range of services which meet local need. The characteristics of effective crisis services are described in Section 5.

Clinical Commissioning Groups, as commissioners of health services, will undertake statutory assessments of need and commission services with partner local commissioners in social care and others. Services should be commissioned at a level that ensures that people should never be turned away from mental health

services because S 136 rooms or wards are full, or because staff are unavailable, or because they are not currently resident in a particular area.

Police and Crime Commissioners [Home Office to draft]

Provider responsibilities

NHS commissioned providers are responsible for ensuring that people have positive experiences of the care they receive. This will include effective levels of access to, and waiting times for, mental health services. NHS England are mandated to consider new access standards, including the financial implications of any improvement in quality standards [HMG, NHS Mandate, 2013, pages 18-19].

In an emergency, immediate access to an effective crisis response is critical – particularly where this involves a Mental Health Act assessment. Providers have a duty to report on quality standards, including service user experience feedback.

The focus on patient safety in the NHS sets an expectation that people with mental health problems will be cared for in a safe environment and protected from avoidable harm: *'(NHS England) will need to work with Clinical Commissioning Groups to ensure providers of mental health services take all reasonable steps to reduce the number of suicides and incident of self-harm or harm to others, including effective crisis response.'* [HMG, NHS Mandate,].

The role of regulators

[CQC to add]

The role of police forces

[National Policing Lead to add]

4. Core principles and outcomes

This section sets-out the principles and the outcomes which mental health crisis services should provide from a service user perspective. It also forms the approach to the structure of the Action Plan at annex 1. The structure is summarised in the boxes below:

Access to support before crisis point

When I am beginning to experience the early signs of crisis, I will get the help I need from health and social care professionals in the community when I need it to address my needs and prevent my from experiencing a crisis episode

Urgent and emergency access to crisis care

When I recognise that I am beginning to experience a crisis, I will be able to contact Crisis Services on a 24/7 basis and get the right help and support I need to deal with the problem and to prevent it getting worse.

When I am experiencing a crisis, emergency services will respond quickly and ensure that I am kept safe. Rapid decisions will be taken about the service that is most appropriate to my needs. If I cannot be supported at home, I will be transported to an appropriate service in a safe and supportive way. All the professionals involved in this process will work together in my best interests to manage my care safely and effectively.

Treatment and care when in crisis

When I am in crisis and need to attend health service facilities, my physical and mental health needs will be assessed and treated promptly and effectively in the most appropriate care settings to meet my needs. Services will ensure my safety and begin to work towards helping me to move to Recovery.

Recovery and staying well / preventing future crises

People should expect a whole system approach

People needing urgent help with their mental illness, or friends and family close to them, may seek help from a number of different sources – including their GP, helplines or voluntary sector groups, emergency departments, social services, mental health trusts, or the police.

For there to be an effective emergency mental health response system, there should be detailed local planning, commissioning and coordination arrangements in place between all the agencies that are regularly contacted by people in mental distress

People needing help should be treated with respect, compassion and dignity by the professionals that they turn to.

1. Access to support before crisis point

1.1 People vulnerable to mental health crises should expect early intervention by services to address their needs focusing on prevention

First and foremost, people in mental distress should be kept safe. Mental health services, whether NHS, local authority or voluntary sector need to intervene early to prevent distress from escalating into crisis.

Early interventions include help at home services, specifically Early Intervention or Crisis Resolution/Home Treatment services, and peer support including access to crisis houses or other safe places where people can receive attention and help.

Early intervention and crisis services should be appropriate and acceptable for the range of protected characteristics, so that people from BME communities, people with learning difficulties, physical health conditions, people with dementia and children and young people can find and stay engaged with services which keep them safe, improve their mental health and prevent further crises.

Action for groups of people who are experiencing discrimination or inequality.

2. Urgent and emergency access to crisis care

2.1 People in crisis are amongst the most vulnerable in our society and must be kept safe, have their needs met appropriately and be helped to achieve recovery

People experiencing mental distress should be able to find the support they need - whatever the circumstances in which they first need help, and from whomever they turned to first.

All agencies supporting this Concordat believe that responses to people in crisis should be the most community-based, least restrictive options most appropriate to

the needs of the individual. Community based alternatives should be used in accordance with locally agreed access standards and protocols.

For BME communities in particular there is evidence of poor experience of services and lack of access contributing to a vicious circle where support is only sought and offered once crisis is reached, often as a result of contact with the police or child protection services.

2.2 People in crisis should expect all staff to have the right skills and training to respond to their needs appropriately

Local shared training policies and approaches should be in place which describe and identify ‘who needs to do what and how does it all fit together’ to ensure the safety of and continuity of treatment and support for a person with mental health problems. Each statutory agency should review its mandatory training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations.

Staff (for example, Emergency Departments and hospital security staff) whose role requires increased mental health awareness should expect to be prepared for this through training and clear line management advice.

2.3 People in crisis should expect parity of esteem and an appropriate response and support when they need it

People in mental health crisis who need help need to receive it promptly. This means that:

• Standards of access for emergency mental health care should be in line with equivalent service standards in Emergency Departments

• Mental health services should be capable of providing high quality and safe care at the time it is needed - seven days a week and overnight

• Hospital, step-down and community services should be commissioned at a level that allows for beds or alternatives to hospital admission to be immediately available in response to a person in urgent need

• If people are already known to mental health services, their crisis plan and any advance statements should be available and respected.

2.4 People in crisis who need to be supported in an NHS Place of Safety will not be excluded

NHS places of safety should operate at a level that ensures that staff and facilities are available to manage and support the vulnerable individuals that need them. Intoxication alone should not be used as a basis for exclusion, although in very exceptional circumstances, and in accordance with agreed risk protocols, there may

be too high a risk that the NHS would be unable to keep either the individual and staff safe.

A previous history of violence should not in itself lead to exclusion and only in exceptional circumstances, in accordance with agreed risk management protocols, should a police custody suite be used to manage disturbed behaviour.

The overall aim should be to reduce substantially the inappropriate use of police custody suites which is likely to result in a poorer experience and outcomes for vulnerable people.

2.5 People in crisis should expect that statutory services share essential 'need to know' information about their needs

All agencies (including police or ambulance staff) have a duty to share essential 'need to know' information for the good of the patient, so that the professionals or service dealing with a crisis know what is needed for managing a crisis and any associated risks to the distressed person or to others.

Information on patients should, in practice and through appropriate sharing protocols, follow them through the system and ensure that people known to services get the treatment they need quickly and where applicable the services are aware of their crisis plan and any advanced statements – no matter at what point they re-enter the mental health system.

Within the requirements of the data protection legislation, a common sense and joint working approach should guide individual professional judgements. If the same person presents to police, ambulance or emergency departments repeatedly, all agencies should have an interest in seeking to understand why and how to deal with that person appropriately to secure the best outcome. This may include identifying whether the individual is already in treatment and/or is known to services, their GP or other community-based mental health services.

2.6 People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help and to be supported by mental health services in taking the appropriate steps to meet the needs of the individual and to maintain community safety

Police officers responding to people in mental health crisis should expect response from health and social care colleagues within locally agreed timescales, so that the individuals receive the care they need at the earliest opportunity.

Police officers should recognise, through appropriate awareness training, that people with vulnerabilities related to their poor mental health will be a key aspect of their work, and that partnership working and good communication with health colleagues will therefore be essential to meet the mental health needs of vulnerable people in

crisis, and the small number of mentally disordered offenders, whose behaviour poses a risk of danger to themselves or to others.

Police officers should have the training, capacity, and support to decide how best to help vulnerable people, whether they should be assessed under Section 136 of the Mental Health Act 1983, or whether they can be helped in some other way.

Street Triage pilots: these mental health nurses, as part of the crisis home treatment response services, will be able to provide on the spot advice on mental health and substance misuse, and also check on people's health history, to help police officers make good decisions based on a clear understanding of situations. We will be testing whether this means that people reach the services they need more quickly and with a better outcome.

Local protocols should be developed to ensure that when a police officer makes contact with health services because he or she has identified a person in need of emergency mental health support, an NHS coordinator should take responsibility for arranging that support. When the police officer and the vulnerable person arrive at the hospital (Emergency department, mental health unit or hospital based place of safety) NHS staff should take responsibility for the person, thereby allowing the officer to leave, so long as the situation is agreed to be safe. As a guide, hospital staff should not be expecting police officers to stay for longer than one hour after bringing a mentally ill person to a hospital. Locally agreed protocols will cover circumstances where they may need to stay longer, for example when based on an assessment of risk and with the support of a police supervisor. Local protocols should provide for include escalation to more senior staff in case of disagreement.

• NHS England regions are obliged by the Mental Health Act 1983 to commission health based places of safety. These should be staffed at a level that allows for 24/7 availability, with agreed arrangements in place to handle multiple referrals.

• Local agreements should guide professional judgements on when it is appropriate for police custody to be used as a place of safety due to seriously disturbed or aggressive behaviour. Local Mental Health Partnership Boards should also review each individual case circumstance when this has occurred to ensure it was appropriate and whether there are any lessons to be learnt for the future.

• In cases where police custody is used as a place of safety, the aim should be to transfer the patient as soon as possible to appropriate health services. If this cannot be arranged then they should be transferred to a health based place of safety at the earliest opportunity.

• Police vehicles should not be used to transfer patients between units within a hospital.

• All police staff should have training in de-escalation/safer restraint as part of mental health awareness training

2.7 When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect.

When deciding upon any course of action, all professional staff should have regard to the Mental Health Act principle of least restriction and ensure that the services impose the least restriction on the person's liberty.

• Clinical Commissioning Groups, local authorities and mental health service providers should ensure that approved section 12 doctors and Approved Mental Health Professionals (AMHPs) are available to carry out assessments of people in mental health distress, within locally agreed timescales of their arrival at a designated place of safety, or other appropriate setting.

• There should not be circumstances under which mental health professionals will not carry out assessments because no beds are available

2.8 People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support

People with mental distress often seek help from Emergency Departments – sometimes directly, or because they have harmed themselves, or are experiencing a physical or mental health crisis. They may also be brought in by others because they have attempted suicide or taken a substance which has altered their mental state. They may be brought in by the police, either voluntarily or on a section 136.

Clear responsibilities and protocols should be in place between emergency departments and other agencies and parts of the acute and mental health and substance misuse service.

There should be a local forum (such as a Local Mental Health Partnership Board) for agreement of protocols and escalation of issues, ensuring that :

• People experiencing mental health crises, self-harming or suicidal behaviour are treated safely, appropriately and with respect by Emergency Department staff

• Clinical staff identify mental health problems in people presenting with a physical health problem and refer them to a GP or specialist help where necessary

• Clinical Commissioning Groups give priority to establishing effective liaison psychiatry services in place for people of all ages of a similar standard to the RAID model [see Box X]

• Clinical staff are equipped to identify and intervene with people who are at risk of suicide through training such as ASIST, through induction and on-going training in the application of the relevant NICE guidelines, statutory and legal requirements under the Mental Health legislation and communicate with other services so that people who are at risk are actively followed up.

• Emergency department staff treat people who have self-harmed in line with the NICE guidance and quality standard. All people who have self-harmed should be offered a preliminary psychosocial screening at triage. Screening should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

• Emergency departments are able to cope with and keep safe mentally ill people who present in states of intoxication or who display violent behaviour. There should be explicit protocols agreed between the police and mental health trusts on the handling of people who are intoxicated or violent, including escalation procedures for managing disagreements between professionals.

• Clinical Commissioning Groups should ensure that Emergency departments, Police and Ambulance services agree protocols and arrangements regarding the security responsibilities of the hospital. They should also agree with police a protocol regarding the safe operation of restraint procedures on NHS premises. Emergency departments should have facilities to allow for rapid tranquilisation of people in mental health crisis who need it.

2.9 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

The experience of mental health patients accessing the NHS via the 999 system could be further improved by Commissioning Ambulance services to:

- provide 24/7 mental health professionals within the clinical support infrastructure in each 999 control room. This would assist with the initial assessment of mental health patients and help ensure a timely and appropriate response.
- to enhance the levels of training for ambulance staff on the management of mental health patients. This could include the ability to provide more multi-agency training with other professionals to ensure a truly joined up approach
- to be able to work flexibly, including across borders by exercising judgments in individual cases which they can be confident their commissioners will support; or, outside the usual contract scope, to ensure that an individual’s safety [and treatment] is not compromised. There may be occasions in large geographical areas where an ambulance from “across the border” is better placed to respond than one from within the local area.

2.10 People in crisis who need routine transport between NHS facilities or from the community to an NHS facility will be conveyed in a safe, timely and appropriate way

In the case of routine transfers of mental health patients it should be noted that there are multiple providers of routine patient transport services and such contracts are no longer always operated by NHS ambulance services.

Commissioners will need to ensure that the transfer arrangements put in place by Mental Health Trusts and Acute Trusts provide appropriate timely transport for these patients.

2.11 People in crisis who are detained under S136 powers can expect that they will be conveyed by emergency transport from the community to an NHS facility/Place of Safety in a safe, timely and appropriate way

Where a police officer or an AMHP requests NHS transport for a person in mental health crisis under their Section 136 powers for conveyance to an Emergency Department or NHS Place of Safety (or in exceptional circumstances, to police custody suite), the patient should be conveyed in a safe and timely way.

3. Treatment and care when in crisis

3.1 People in crisis should expect local mental health services to meet their needs appropriately at all times

Response to mental health crisis should be on a similar basis to physical health {"parity of esteem between mental and physical health"). This means that health and social care services should be equipped to deal safely and responsively with emergencies that occur at all times of day and night, seven days a week, 365 days a year., .

4. Recovery and staying well / preventing future crises

4.1 People in crisis should be able to expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

The Care Quality Commission will inspect the whole system pathway, regulating acute health trusts and mental health and primary care and social care providers, talking account of this Concordat when looking at the support mentally ill receive in response to their physical health, mental health, substance misuse and other relevant crisis situations. They will also ensure that, across the care pathway, there is evidence that the least restrictive care has been provided and that mental health legislation (and codes of Practice) is complied with.

5. Characteristics of effective mental health crisis services

The signatories to the Concordat have identified and agreed that effective local mental health crises services include the following characteristics:

- Evidence based early interventions commissioned from agencies to prevent escalation from mental health need to crisis
- All partners including Health, Social Care, Criminal Justice and Voluntary Sector, independent sector and local community leaders should be involved in assessing local needs within the Joint Strategic Needs Assessment (JSNA), sharing relevant data in order to understand the pattern of need and inform commissioning and planning of the primary care, social care, specialist mental health, substance misuse and other relevant services to meet local needs
- Telephone help lines or on-line services, including computer-based self-help
- Crisis houses and recovery house provision for people who cannot be treated at home but who do not need to be admitted to hospital
- Other domiciliary or non-residential alternatives to hospital admission (including respite for those with a long term mental health conditions
- Supported housing
- Direct payment schemes
- Early intervention mental health services
- Psychiatric liaison mental health services to Emergency Departments,
- Access to telemedicine or telepsychiatry
- Community mental health teams
- Psychology and specialist mental health services
- NHS Place (s) of safety
- Peer support
- Day hospital places/ inpatient beds in a safe and therapeutic settings [2].
- Plans for extending access to Improving Access to Psychological Therapies (IAPT) and other services which provide clinical and economic evidence based interventions for people with mental ill health, thus reducing mental ill health and escalation to crisis
- A 24/7 single point of access to specialist mental health response, giving rapid access to appropriate integrated assessment of physical, mental health and substance misuse presentations and provision of care and support, wherever it is needed 24/7
- Services with access thresholds that respond effectively to early signs of mental distress, including when combined with other needs, providing a response which prevents escalation to crisis point
- Good communication between voluntary sector services (for example The Samaritans) and health services, including consideration of when self-referral to services may be helpful
- Emergency Departments that provide the right help to people in mental distress and ensure they get appropriate care for both their physical and mental health and substance misuse conditions
- Mental health professionals who respond promptly and effectively to GP and police referrals
- Good quality health based places of safety which are available 24/7 and effectively coordinated with local police, emergency departments, ambulance

services and mental health services, particularly Approved Mental Health Professionals (AMHPs) and Section 12 doctors

- The use of police cells as a place of safety only in exceptional circumstances
- A range of community based alternative services which can respond to mental health crises in the community, for example help at home services, crisis houses, and other safe places where people can receive attention, support, care and/or therapy
- Ambulance services are appropriately trained to recognise mental health crises and substance misuse crises as emergencies and respond appropriately
- Appropriate and clear protocols on the minimal use of restraint in crisis situations – to protect the distressed person, staff and the public. Effectively monitored protocols for police and health service staff that use restraint will provide clear explanations of the circumstances and situations that warrant the use of restraint, and will set out where the responsibility lies in each case [this is linked to wider guidance on the use of restraint in health and social care settings]

We also recognise that the exact way in which services are delivered will depend in part on demography and geography.

Annex 1. Concordat Action Plan

1. Access to support before crisis point

No	Action	Timescale	Led By	Outcomes
1.1	Consider the types of services provided and how the range of options can be expanded in line with local leads and preferences including crisis houses, non-residential crisis services, host families, retreats, hotels, and peer-survivor services	Annually through the Joint Strategic Needs Assessment (JSNA) process	NHS England/ Clinical Commissioning Groups	Service users have their needs met appropriately with increased choice and control
1.2	Set standards for the use of Crisis Care plans, in line with Care Programme approach guidance (DH publication 2010)	April 2014	Clinical Commissioning Groups	Service users jointly produce contingency plans in case of relapse or crisis

2. Urgent and emergency access to crisis care

No	Action	Timescale	Led By	Outcomes
2.1	Local social services should review their arrangements for out of hours AMHP provision and consider the implementation of a scheme that employs sessional AMHPs in addition to existing resources to ensure they are able to respond in a timely manner	By April 2014	ADASS and LGA (with College of Social Work)	Reduction in delays experienced by service users awaiting an AMHP assessment
2.2	As part of AMHP service reviews, authorities who have combined the services with children's safeguarding should satisfy themselves, in consultation with the police and mental health providers, that AMHPs can be available within locally agreed response times	By April 2014	ADASS and LGA (with College of Social Work)	Reduction in delays experienced by service users awaiting an AMHP assessment
2.3	The Department of Health will review with the Care Quality Commission whether additional powers are required for them to monitor AMHP services	By April 2014	DH and CQC	Service users experience an improved quality of service
2.4	Make available a map of the location of all health based Places of Safety in England	October 2013	Department of Health	Service users experience more appropriate NHS provision and the use of police custody suites is avoided
2.5	Themed inspections of the quality of all Health Based Places of Safety in England. This should include information about the number of beds, opening hours and staffing	April 2014	Care Quality Commission	Service users experiences improved access and quality of NHS services

	levels. Include the national stakeholders in the scoping of this work.			
2.6	Information sharing and communications: All agencies have a duty to share information for the good of the patient, so that the professional or service dealing with a crisis (including police or ambulance staff) knows key information. (see note)	Current	All agencies through Caldicott and data protection officers (DN How to account for actions led by all)	Improved management experienced by the person in crisis
2.7	The NHS ambulance services in England will introduce a single national protocol for the transportation of S136 patients, which provide agreed response times and a standard specification for use by Clinical Commissioning Groups. (see note)			
	Placeholder: Police training – College of Policing leading work on the syllabus.			
	Is there an action on looking at provision of appropriate adults for people with MH problems (in the exceptional event they end up in custody)?			
	Identify and monitor indicator of improved emergency responses for people with MH problems arising from the duty to collaborate between the police and ambulance services arising from the Policing Bill?			

3. Treatment and care when in crisis

No	Action	Timescale	Led By	Outcomes

4. Recovery and staying well / preventing future crises

No	Action	Timescale	Led By	Outcomes
4.1	Good practice booklet produced and disseminated nationally drawing from local areas	November 2013	Home Office	Service users experience more appropriate and consistent responses

Notes

Note 2.6:
Information sharing and communications: All agencies have a duty to share information for the good of the patient, so that the professional or service dealing with a crisis (including police or ambulance staff) knows the following key information.

- The name, address/contact details of the person (or a description if mute)
- Details of any relative(s)/friend(s) or carer who can be contacted
- Gender/Age
- Language spoken (if not English) and any communication needs e.g. sign language
- Description of current behaviour/presentation
- Are likely to be effected by drink or drugs
- Physical illnesses and any prescribed medicines or dietary requirements
- Whether the person is already engaged with his/ her GP and / or mental health services and the name of the team and any involved professional
- Whether they have a crisis plan or other advance statements
- Any clinical information e.g. prescribed medication, psychological therapy
- Any presenting risk factors (for example, self-harm, suicide, physical aggression, confusion, impaired judgement, self-neglect, missing from home)
- Children, dependents, pets or other factors to take into account in planning the most appropriate response

Note 2.7:
The **NHS ambulance services** in England will introduce a single national protocol for the transportation of S136 patients, which provides the following:

- An 8 minute response time to any such patient that presents with a life threatening illness or injury or who is being actively restrained.
- A 30 minute response time with a clinician who can make a face to face assessment of any S136 patient who does not have a life threatening illness or injury and who is not being actively retrained. This initial clinical assessment may be provided by a clinician in a rapid response vehicle and where this is the case a supporting transporting resource will also need to be provided in an appropriate timescale.
- Clinical commissioning groups will commission services that ensure ambulance trusts are able to meet the terms of this protocol

APPENDICES TO BE WORKED ON

NHS England Urgent and Emergency Care Review - System design objectives

1. Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice.
2. Increase my or my family/carer's awareness of early detection and options for self-care and support me to manage my acute or long term physical or mental condition.
3. Increase my or my family/carer's awareness of and publicise the benefits of 'phone before you go'.
4. If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.
5. Improve my care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway.
6. Wherever appropriate, manage me where I present (including at home and over the telephone).
7. If it's not appropriate to manage me where I present (including at home and over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre if needed.
8. Ensure all urgent and emergency care facilities are capable of transferring me urgently and that the mode of transport is capable, appropriate and authorised.
9. Information, critical for my care, is available to all those treating me.
10. Where I need wider support for my mental, physical and social needs ensure it is available.
11. Each of my clinical experiences should be part of a programme to develop and train the clinical staff and ensure their competence and the future quality of the service is constantly developed.
12. The quality of my care should be measured in a way that reflects the urgency and complexity of my illness.

Appendix: NICE standards of care

NICE clinical standards of care

CG 16: short term management of people who have self-harmed

CG 133: Longer-term management of people who have self harmed

CG Depression (replaced by CG90) and CG Anxiety

CG 82: Schizophrenia 2009,

CG 44: BPAD, 2006, & BAP 2009

CG Treatment of Psychosis in Substance Misuse (March 2011

CG 100: Alcohol dependence & harmful alcohol use,

2010 CG 51: Drug Misuse: psychosocial guidelines

CG 76: Medication Adherence – involving patients in decisions about prescribed medicines and supporting adherence, 2009

CG Borderline PD (BPD)

CG Antisocial personality disorder

CG Violence

CG ADHD

CG Autism spectrum disorders in children & young people

SCIE standards of care

Homeless

Home care and personalised budgets

Annex 4: The legal framework, existing standards and policy overview

The legal framework which governs the experience of a person experiencing a mental health crisis is set by the ***European Convention on Human rights (ECHR)****,* in particular:

- Article 3 (the prohibition of torture or degrading treatment);
- Article 5 (the right to liberty);
- Article 8 (the right to respect for a person's private and family life, which includes the right to moral and physical integrity); and
- Article 14 (the prohibition of discrimination)

Additionally, the *Equalities Act 2010* may be applied to the impacts of differing levels or variations in service provision. A range of international law and conventions adopted by the UK guide interpretations of rights and responsibilities in the management of mental health crises (see Annex DN: ref: UN convention on the rights of the disabled person) – notably UNCRDP Article 25 'the right to parity of physical and mental healthcare', which is further promoted as a key policy objective within England's cross government strategy for mental health 'No health without mental health' (HMG 2011).

The *NHS Constitution* (REF) sets out further statements of rights and pledges – in particular the right of every patient to be treated with dignity and respect, a right to drugs and treatment recommended by the National Institute for Clinical excellence (NICE) when these are recommended by a doctor – though at present few (DN: no) NICE guidelines are applicable in the case of mental health crises presentations.

The first points of access to NHS services, unrestricted by nationality or immigration status are GP services. GPs are prohibited from refusing to register a patient on grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. The National Health Service (General Medical services Contracts) Regulations 2004 require GPs to provide medical services for the management of registered patients and temporary patients who are, or who believe themselves to be, ill. The regulations also require GPs to provide services for "immediately necessary treatment" for up to 14 days for anyone who needs it, including those who are not registered with a GP in the area. Medical services should be delivered "in the manner determined by the practice in discussion with the patient", providing for a degree of choice and control by service users. Health service providers are subject to part 3 of the Equalities Act 2010 which means that, when planning service provision, they have a duty to consider in advance what reasonable adjustment they should make to ensure that a person with any disability should not be at a substantial disadvantaged in their access to services and treatments. This includes commissioners planning services that can identify and respond to the needs of people in distress as a result of a mental health crisis. NHS Trusts should publish the arrangements they have in place to ensure that a level of healthcare is in place and available when it is needed.

If a person seeks help as a result of mental health distress, their first point of contact should be their primary healthcare team or GP. Article 25 of the UNCRPD (which guides the interpretation of the law) states the need for early identification and intervention by services designed to minimise and prevent further disability. Thus

Standard 2 of England's National Service Framework for Mental Health (DH 2001) states that any person who contacts a primary healthcare team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments including referral to specialist services for further treatment or care if necessary.

Very many people present to services in a mental health crisis related to some aspect of social care. Their needs can be met through Local Authority powers and duties e.g. care packages, accommodation, social work support and the provision of Approved Mental Health Profession services under the Mental Health Act 1983. The National Health Services and Community Care Act 1990 S47 (1) imposes a duty on the Local Authority to assess a person who appears to them to be in need of community care services, although considerable discretion is allowed for in the exercise of this duty. Further duties to assess health or housing need and provide services, which include people with a mental disorder, are set out within the Chronically Sick and Disabled Person's Act 1970.

In 2011, 104,000 people using specialist mental health services were admitted to an inpatient hospital bed. Of these 16,647 people were detained in hospital under the provisions of the Mental Health Act 1983. Hospitals are one part of the crisis care system, but effective responses require alternatives including crisis resolution teams, home treatments (including detoxification) and a range of evidence based alternatives to admission.

People with long term mental health conditions are more likely to have poor physical health than the general population and may present in urgent situations to their GP or to Emergency Departments. The Equalities Act 2010 and Disability Discrimination Acts of 1995 and 2004 require, firstly, that people with mental health disabilities are given access to health services on an equal basis to other patients and, secondly, that where necessary reasonable adjustments should be made to take account of the impacts of their disability. Specific responsibilities that providers should take into account are set out in NICE Guidance (for Schizophrenia, Bi-polar Disorder, Depression in children and young people).

Mental health is the only area of NHS care to be governed by additional legislation providing for compulsory medical treatment. The civil and criminal provisions of the Mental Health Act 1983 are wide ranging. Within the context of this Concordat is the principle that the "least restrictive alternatives" should be applied. Police powers of arrest under Section 136, and Ambulance Service duties to convey patients are further interpreted within the Code of Practice and subsequent standards and Guidance documents (DN : to cite/Ref), alongside the responsibilities of Local Social Services Authorities to provide an Approved Mental Health Professionals service and the powers and duties which relate to the NHS. Where mentally disordered people are help in Police custody for any reason, the Police and Criminal Justice Act 1984 (including the need for 'Appropriate Adults') will apply alongside the provisions of the Criminal Justice Act comes into effect. Where a criminal offence may have been committed, the Police may consider charging a mentally disordered person with an offence in order that a prosecution can be taken forward by the Crown Prosecution Service. Extensive Guidance on the prosecution of Mentally Disordered Offenders is available.

Local Authorities commission:

- tobacco control and smoking cessation services
- alcohol and substance misuse
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- Interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

Reference material/sources of evidence quoted

Health and Well Being Board

Part Two

1 Year Children's Partnership Delivery Plan

2013/2014

DRAFT

Priority 1
Raise attainment at the end of all key stages with a particular focus on Early Years Foundation Stage, Key Stage One and Key Stage Two

Objective		**Where do we want to be by 2016**	**Action 2013/14**	Lead	**Deadline**
1.1	Continue to focus on Foundation Stage, Key Stage 1, Key Stage 2 and Key Stage 4 outcomes with the aim of no schools below the floor standard and all children achieving their potential	All children and young people at each key stage to make at least expected levels of progress contributing to above national average performance by 2016 and no schools below the floor standard	Set up an education commission to identify areas of good practice and areas for development which will accelerate progress in raising attainment and ensuring all schools are good or outstanding	Carmel Littleton/Vivien Cutler	March 2013
			Publish the education commission findings and draw up an action plan to address recommendations	Carmel Littleton/Vivien Cutler	December 2013
			Work with schools and other partners to ensure a high quality package of school improvement services are on offer and taken up by schools and settings in Thurrock, including commissioned support	Vivien Cutler	September 2013
			Second and commission outstanding practitioners to vulnerable Thurrock schools for the year 2013-2014 identified by need	Vivien Cutler	April 2013
			Ensure all activities	Sue Green	Completed by June 2013

			delivered through Children's Centres are linked to the early years curriculum. Monitor and evaluate delivery of contracts that are linked to EYFS in Children's Centres Increase registration levels in all Children's Centres to at least 85% Increase take up of three and four year old early education to 95% Implement the extended early education offer for 2 year olds ensuring that by September 2013 at least 400 children are accessing this.	 Sue Green Sue Green Sue Green Sue Green	and monitored quarterly. December 2013 September 2013 September 2013 March 13
1.2	Embedded strategies to narrow the gap between boys and girls at all key stages and target resources to ensure all children make expected progress during their primary school years	Gaps in performance of vulnerable and underperforming groups against the rest decreasing as per milestones Thurrock will perform well compared to statistical neighbours and national comparators	Complete an analysis of take up of early years education across all ages and groups to identify those not accessing early education. Implement Thurrock's school improvement plan to narrow the gaps in attainment	Sue Green Vivien Cutler	July 2013 September 2013

1.3	Increase our capacity to provide early-education to two-year olds in line with national targets	Clear targeted eligibility criteria in place focused on those most in need of support Sufficient numbers of high quality places available through a range of early education providers 400 places by September 2013 Integrated family support available to those most in need of it.	Childcare Sufficiency plan in place and increasing places month on month from April. Communication plan in place and circulated to partners Ongoing analysis of take up undertaken to identify any inequalities and address these Project plan for phase two (September 2014 implementation) in places and being delivered Additional support needs aligned with Early Offer of Help implementation	Sue Green	April 2013 April 2013 Commencing April 2013 October 2013 September 2013
1.4	Increase the percentage of good or better outcomes in Ofsted inspections of primary schools	In 2016 all schools will have been judged good or better, most for some considerable time	Conduct targeted, termly reviews on a rolling programme to identify key issues for OFSTED and commission support through the SI team Commission effective support for schools requiring improvement and schools in a category of concern to accelerate improvement	Vivien Cutler/Ruth Brock Vivien Cutler/Ruth Brock	April 2013 ongoing April 2013

			Action	Lead	Deadline
			Provide detailed reports for vulnerable schools to ensure that leadership teams and governing bodes are well prepared for OFSTED inspections	Vivien Cutler/Ruth Brock	Ongoing from April 2013
			Work with the diverse school estate in Thurrock to ensure that opportunities for rapid school improvement are maximised, evidenced through improved outcomes e.g. through clustering, federations, academies	Vivien Cutler/Ruth Brock	Ongoing from April 2013
			Commission a high quality programme for Heads and Deputies based on raising standards linked to effective school improvement and the OFSTED framework	Vivien Cutler/Ruth Brock	Ongoing from April 2013

Priority 2 Promote and improve the health and well-being of children and young people					
Objective		**Where do we want to be by 2016**	**Action 2013/14**	**Lead**	**Deadline**
2.1	Through the Healthy Child Programme, offer every family a programme of screening tests, immunisations, developmental reviews, and	Robust systems in place that ensure: • Improved vaccination uptake • Improved screening uptake • Improved breastfeeding prevalence – particular in under 25s	Service design implementation for Early Offer of Help is completed with a shared delivery plan Partnership Locality	Debbie Maynard	May 2013 September 2013

	information and guidance to support parenting and healthy choices	Performance for women stopping smoking at the time of delivery is maintained and if possible, bettered. Increased number of breast feeding friendly places in the Community.	planning and delivery is in place with integrated management arrangements and strong links with local CCGs Children's Centre priorities focus on increasing vaccination, screening and breast feeding (particularly in under 25's) and progress is measured. All Children's Centres have breast feeding friendly provision.		May 2013 May 2013
2	Promote and enable children, parents and families to make positive lifestyle choices, to enable children and young people to be physically active and achieve and maintain a healthy weight	Families, children and young people choose and are supported and enabled to lead healthier lifestyles: • Children and young people are more physically active • Children and young people are able to achieve and maintain a healthy weight	Develop a Thurrock sports and physical activity action plan Develop a healthy weight action plan Delivery of first year of 3 year healthy weight action plan All children's centres and LA Youth provision offer access to information support and guidance on physical activity and activities to support healthy weight management.	Grant Greatrex Debbie Maynard Debbie Maynard Sue Green	June 2013 March 2014 March 2014 May 2013

2.3	Reduce and prevent the avoidable harm on children and young people engaging in risk taking behaviour	Parents children and young people make positive decisions about risk taking and avoiding damaging behaviours: • Children and young people do not start smoking • Children and young people do not misuse alcohol or drugs • Young people make purposeful decisions about their sexual health and delaying sexual activity. • Local Authorities should be working towards achieving a Chlamydia diagnosis rate (15-24 year olds) of at least 2400 per 100,000 population (provisional); increasing the diagnosis rate will reduce the prevalence of infection. Young people have easy access to health services they trust, for example credited "your welcome" young people-friendly services The continued and sustained reduction in the under 18 conception rate (female population aged 15-17) is maintained for Thurrock	Delivery plan in place for all youth activities to reduce risk taking behaviour	Sue Green	May 2013
			Joint planning between Children's Centres and the Teenage Pregnancy Reduction Programme ensures take up of services by teenage parents in centres increases		May 2013
			Team to support review of young people undertaking risky behaviours.		September 2013
			Undertake a full review of children and young people undertaking risky behaviours:- Sexual Health Drugs and Alcohol Smoking	Debbie Maynard	September 2013
			Development of the action plan following the review	Debbie Maynard	March 2014
			Implementation of action plan	Debbie Maynard	From March 2014
			Develop a proposal for health improvement provision to reduce risk taking behaviours in our	Debbie Maynard	March 2014

			Schools.		
2.4	Appropriate support in place to meet the mental and emotional health needs of children and young people in Thurrock	Children and young people are achieving good mental and emotional health Child and young people showing signs of a mental or emotional health disorder are identified at the earliest opportunity Child and young people with a mental health disorder have access to appropriate child and adolescent emotional well-being and mental health services	Meeting the mental and emotional health needs included in local delivery plan for early offer of help Develop and implement a CAHMS strategy Develop care pathway for CAHMS including for vulnerable groups To have in place comprehensive Tier Two and Tier Three CAHMS service contracts	Sue Green Catherine Wilson/ Roland Minto Catherine Wilson/ Roland Minto Catherine Wilson/ Roland Minto	May 2013 September 2013-03-12 March 2014 March 2014

Priority 3 Ensure progression routes to higher level qualifications and employment					
Objective		**Where do we want to be by 2016**	**Action 2013/14**	**Lead**	**Deadline**
3.1	Ensure high quality opportunities for learning, skills development and training linked to the regeneration opportunities in the Borough	90% of 16-18 year olds in learning Increase in level 2 and 3 qualifications Employment opportunities created by regeneration opportunities are accessed by local people	To deliver key first year objectives of the Raising Participation Age plan with particular regard to Informing choice/IAG Data mapping KS4 alternative provision options NEET prevention Analysis of key groups completed and	Vivien Cutler Michele Lucas	March 2014

			identification of the best methods to engage targeted groups completed. Analysis of sector based skills shortages completed and used to inform programme planning. Annual programme of NEET reduction including resource needs in place.	Michele Lucas	Measured quarterly June 2013 July 2013
3.2	Increase the delivery of level 2 and level 3 apprenticeship opportunities	More apprenticeships with access to on-going employment opportunities are offered targeted to those most in need of support	Implement plan to increase volume of apprenticeships in the priority sectors Q1: Public sector/logistics Q2: H&S care/retail Q3: Engineering/construction Q4 Evaluation report Increase volume of L2 and L3 apprenticeships by targeting individuals and employers	Michele Lucas Michele Lucas	June 2013 September 2013 December 2013 March 2014 May 2013 Measured quarterly
			Increase of level 2 and 3 apprenticeships by at least 20% year on year	Sue Green	March 2014 and yearly

3.3	Reduce the number of young people aged 16-18 who are NEET by 0.5% per annum until we are above the National Average	Decrease in those from targeted groups who are NEET A targeted programme for those on the edge of care is in place Targeted programmes linked to key employment sectors and regeneration opportunities are in place Performance is better than National levels on NEET By March 2014 5.7% or fewer 16-18 year olds NEET	Reduce NEET by securing a range of bespoke programmes to meet learner needs including LAC Teenage parents Young offenders Delivery of Care to Work Programme Programme of intervention for those on the edge of care – including young mothers	Paul Coke Natalie White James Waud Alison McCleave Paul Coke James Waud	September 2014

Priority 4 Early offer of Help					
Objective		**Where do we want to be by 2016**	**Action 2013/14**	**Lead**	**Deadline**
4. 1	Implement our Troubled Families Initiative	All families identified under the Troubled Families programme are accessing appropriate support services resulting in behaviour and lifestyle changes	Deliver and Evaluate Troubled Families program me Clear referral pathways between teams in place. All families open to the Troubles Families team have an EWO allocated	Teresa Goulding Sue Green Sue Green	Evaluation April 2014 June 2013 June 2013

			where attendance is below 85% All families are considered for referral to the REED ESF Families programme and if not appropriate the reasons recorded.	Sue Green	June 2013
4.2	Implement our strategy to support challenge and change parenting in Thurrock	Integrated multi-agency offer in three locality hubs with a targeted outreach programme Targeted support offer linked to commissioned services in place Clear processes for the transition of support as needs deescalate or escalate Support for universal services and community provided support to enable them to meet the needs of parents in their area Co-ordinated delivery through a range of partnerships in place ensuring that support is available based on community delivery with a clear pathway to specialist services where needed Children's centres are delivered through a mix of Local Authority and Commissioned Services The locality offer is integrated with the development of community hubs and it	Commencement and transition to commissioned services in place. Staffing restructure completed and staffing changes implemented with integrated management in place. Service delivery objectives agreed by partners and delivery commenced. Transition managed through existing arrangements to ensure service delivery continues in line with the CYPP. Clear referral mechanisms in place and communicated to partners Monitoring and evaluation processes in place and routinely used and reported on.	Sue Green	May 2013 September 2013 September 2013 April 2013 May 2013 September 2013

		based on ABCD and Local Area Coordination	Commissioned offer in place for early help Referral and support system in place to access early help service Locality governance structures developed for early help	Catherine Wilson Sue Green Sue Green/Rubina Mazher	April 2013 April 2013 April 2013 onwards

Priority 5
Mitigate the impact of child poverty

Objective		Where do we want to be by 2016	Action 2013/14	Lead	Deadline
5.1	Increase parental employment and skills by providing access to adult training and skills development	Increase in adults with level 2 and 3 qualifications particularly in areas where there are high levels of poverty. Level 2 increase by 5% per annum (in line with changes over recent years) to reach above England average. Level 3 increase by 2% per annum to reach estimated levels required by Thames Gateway Skills Audit	Development of peer support programme to support increased take up – pilot in Community Hub Integration of referral into Early Offer of Help and Troubled Families Support Improved links with REED ESF Project and identification of additional funding opportunities.	Sue Green	June 2013 June 2013 August 2013
5.2	Increase benefit take up by providing high quality advice and guidance targeted to areas where there is a high prevalence of poverty and	Access to childcare element of working tax credits at least in line with national average particularly in areas with high levels of child poverty	Develop links with the Welfare Benefit Reforms Lead to support joint delivery of support.	Sue Green/Ian Badman-Dunphy	April 2013

	workless households		Explore partnership opportunities to develop a Child Poverty Partnership with community support at its heart. Increase the take up of Working Tax Credits to 15.5% particularly targeting areas of the highest child poverty. Restructure the provision of information, advice and guidance to ensure that it targets those areas most in need / least likely to access services Implement Child Poverty Checklist across range of teams		May 2013 January 2014 May 2013 April 2013
5.3	Improve housing for families and for vulnerable young people and prevent homelessness	A good standard of private accommodation Ability to identify and record information relating to families at risk Increased stock New housing of good design Sustain low eviction rate upon implementation of changes linked to Welfare Reform	Develop links with housing teams and ensure that information is included on Ask Thurrock and in locality information outreach offer Implement a programme to Increase the number of accredited landlords	Sue Green Barbara Brownlee	June 2013 Increased number of accredited landlords – double current numbers of accredited landlords by March 2014 (target)

Priority 6
Strengthened Communities

Objective		Where do we want to be by 2016	Action 2013/14	Lead	Deadline
6.1	Co-produce community hubs designed to build community resilience	Hubs in place and fully operational across the borough High levels of volunteering to support self help Principles of ABCD and LAC fully integrated in Thurrock	Implement pathfinder Strong links in place between teams. Wishes Peer Support programme delivered in partnership with South Ockendon Centre. Locality integrated management arrangements in place and opportunities for joint planning and delivery identified and committed	Sue Green	April 2013 June 2013 June 2013 September 2013
6.2	Ensure high quality educational outcomes across Thurrock	Thurrock is recognised as a place where children are able to attend high performing schools at primary and secondary level in any locality.	Implement initial findings of Education commission	Vivien Cutler	Education commission initial action plan implemented by April 2014

Priority 7
Promote the attainment and achievement of under-achieving children

Objective		Where do we want to be by 2016	Action 2013/14	Lead	Deadline
7.1	Improve the attainment of pupils for all underperforming pupils with a particular focus on narrowing the gap between those and other	Most LAC students at Key Stage 1 (KS1) who are not statemented for SEN should attain a secure level 2 Most LAC students at Primary School	To achieve consistently 85% or more high quality PEPs compliant with the statutory time frames through	Sue Green	July 2013

pupils	(KS2) who are not statemented for SEN to progress by approximately one level every two years Most LAC students at GCSE to achieve their predicted grades or higher	Development of a monthly virtual school newsletter for schools, carers and LAC		April 2013
		Virtual head to ensure all yr 11 are receiving tuition fro English/Maths and any other subject where they are not achieving their potential	Natalie White	September 2013
		Review the impact of pupil premium and PEA for 2012/2013 and implement learning in allocations for 2013/2014	Natalie White	August 2013
		Implement action plan to improve achievement for Yr 6 LAC	Natalie White	Milestones in service plan including April and October data collection, review of yr 6 predicted grades and impact of tuition in April 2013 and evaluation of Go girl programme in April 2013
To source and secure alternative provision for 14-16 year old vulnerable learners including those within the Pupil Support Service	Engagement of 14-16 year olds who are disengaging from the curriculum is eliminated	Identify, signpost and commission a range of bespoke programmes to engage hard to reach and disengaged learners through an ESF application	Michele Lucas	Tbc re funding application

	To offer quality provision to a broad spectrum of post 16 LDD learners as identified in the RPA plan	A good quality pathway is available for all post 16 learners with a learning disability	Provide a pilot for employability skills and work experience for 6 learners with a job coach Evaluate programme to identify sustainable models for 14/15	Alison McCleave with Lifestyle Solutions	Summer term 2013 recruit 6 learners

Priority 8
Promote and support inclusion

Objective		Where do we want to be by 2016	Action 2013/14	Lead	Deadline
8.1	Meet the needs of children and young people with SEN and Learning Difficulties through the development of enhanced, targeted support, focusing resources on the most vulnerable pupils	Access to all statutory targeted support services for pupils with SEN/ LDD will be through clearly identified referral channels with threshold criteria to ensure that there is effective delivery to the most vulnerable pupils thus enabling these pupils improved access to these services and support leading to enhanced outcomes.	Service offer to vulnerable pupils	Clare Moore Malcolm Taylor	September 2014
			New Service Level agreements for all targeted services to children and young people with SEND (SEN &Disabilities)	Malcolm Taylor	September 2014
			Children's centres to ensure activities on offer are appropriate for children with a range of needs.	Sue Green	May 2013
			Children's Centres to ensure baseline data on access is in place.		April 2013

			Children's Centres to ensure that the number of registrations by families with children with SEN and Learning Difficulties increases and is in line with local population data. Planning of positive activity and youth provision for young people includes activities that are appropriate for young people with a range of needs. Youth Cabinet membership continues to reflect a wide range of needs.		July 2013 April 2013 September 2013
8.2	Develop the offer to all pupils accessing pupil support services to significantly improve the outcomes and life chances of pupils in short-stay provision	Access to Pupil Referral Units and Alternative Provision will be through the Inclusion Panel ensuring a reduction in the use of exclusions and improved service offers for all Vulnerable pupils accessing these services. An effective range of Alternative Provision and Pupil Referral Units will be delivered through enhanced models of service delivery consulted on with all stakeholders.	Inclusion Panel to provide effective access to managed moves and fair access school places New models of alternative provision and Pupil Referral Units Dedicated budgets for Pru .	Malcolm Taylor M Vickers T Bartlett M Vickers T Bartlett	September 2013 By April 2014 By April 2014
8.3	Fully implement a new Special Educational Needs and Disability strategy	A fully implemented integrated SEN / Disability Strategy including improved access to Disabled Children's services, with strengthened engagement of	Implementation of strategy including Transition strand and parental engagement process	Clare Moore Malcolm Taylor	July 2013

		young people and their parents/carers.	Funding process to be agreed Integrated working processes to be developed and piloted To ensure strategy fully implemented to meet statutory requirements	Malcolm Taylor Malcolm Taylor Malcolm Taylor	July 2013 July 2013 By April 2014
8.4	Implement improved processes for children with complex needs, disability and continuing health care needs	A co-ordinated system of Education, Health and Care assessments and Plans based on the new SEN legislation building on the Early Support model.	New system of Education Health and Care Assessment and Plans to be in place to support children and young people aged 0-25 years incorporating changes to post 16 assessments.	Malcolm Taylor	By April 2014

Priority 9 Narrow health inequalities for children and young people					
Objective		**Where do we want to be by 2016**	**Action 2013/14**	**Lead**	**Deadline**
9.1	Target key areas of need in Thurrock for improving the wider determinants of health	Inequalities narrowed and key indicators of inequality reduced – e.g. low breastfeeding rates, infant mortality and low birth weight babies. Health outcomes improved.	Review services to target provision to areas identified as suffering from significant child health inequality Develop and implement action plan in response to review	Debbie Maynard Clare Moore Debbie Maynard	September 2013 By April 2014

9.2	Through the HCP, offer a progressive universal service to all families, with additional services for those with specific needs and risks	A model unit at Basildon and Thurrock University Hospital Foundation Trust to support the reduction in the numbers of acute and unplanned admissions through robust triage and case management Increased utilisation of community services through the development of initiatives responding to fever, respiratory disease, gastro enteritis and asthma through the development of a single point of entry as part of the Early Offer of Help Strategy Vulnerable pregnant women are targeted to ensure they are supported and access rolling programme of ante-natal and post-natal care	Set up a Paediatric Hospital Review Task and Finish Group to develop an action plan Implement and review action plan Alternative community pathways developed to reduce Hospital activity To develop a maternity capacity plan Develop capacity planning programme Service design implementation for Early Offer of Help is completed with a shared delivery plan Partnership Locality planning and delivery is in place with integrated management arrangements and strong links with local CCGs Children's Centre priorities focus on increasing vaccination, screening and breast feeding (particularly in under 25's) and progress is measured.	Debbie Maynard Sue Green	By April 2013 March 2014 March 2014 April 2013 Deliver first year plan by March 2014 May 2013 September 2013 May 2013

9.3	Focus on the most vulnerable children and families by identifying children with high risk and low protective factors, and to ensure that these families receive a personalised service	Vulnerable and high-risk pregnant women are identified during early ante-natal assessment with the midwife and health visitor Emotional wellbeing of looked after children improved Children in care access immunisations routinely and uptake is increased.	Improve immunisation rates year on year for children in care for each specific type of immunisation (varied target) Have in place a Sickle cell and Thalassemia screening plan Improve screening services	Debbie Maynard Rubina Mazher Roland Minto Debbie Maynard Debbie Maynard	March 2014 April 2013 March 2014
9.4	Reduce the health inequalities faced by some families by developing a targeted, integrated approach to local delivery of services	Integrated multi-agency local offer in place with evidence of improved health outcomes Close links with GPs and clinical commissioning groups in place	Multi agency integrated locality delivery teams in place Locality governance structures in place including links with local universal services	Debbie Maynard	April 2013 From April 2013

Priority 10 **Provide outstanding services for children who have been or may be abused**					
Objective		**Where do we want to be by 2016**	**Action 2013/14**	**Lead**	**Deadline**
10.1	A child-centred system that protects children from abuse and neglect (Munro Review of Child Protection)	Local MASH in place and appropriate assessments organised at every level – CAF, Social Care and Community Bases Assessments for the Courts Families receive the help they need when they need it and feedback on services is good and shows improvement Thurrock is seen and known to deliver a child centred service through a coordinated and collaborative learning environment Shift towards a community-based approach where volunteers carry out appropriate support tasks and changes in the community are understood and met	Complete a gap analysis against Munro review recommendations Development of an action plan Quality assurance of delivery through audit and performance monitoring	Barbara Foster Neale Laurie Neale Laurie Neale Laurie Rhodri Roland	May 2013 June 2013 September 2013 then quarterly audit
10.2	All agencies deliver high quality child protection services	All inspection results graded as 'good' or above Inspections of the Youth Offending Service, unannounced Child Protection, and overall Looked After Children are graded as 'outstanding' Children and families are receiving help at the appropriate point from agencies other than social care There is a co-ordinated multi-agency	Undertake a peer review Implement peer review action plan Review of Troubled Families delivering outcomes in line with the financial framework Implement a MASH pathfinder	Neale Laurie Teresa Goulding Rubina Mazher Clare Moore James Waud	September 2013 By April 2014 July 2013 September 2013

		approach to child protection which is supported by excellent multi-agency training. The extended health visiting workforce is fully involved in the safe guarding role with children and families Local MASH in place and appropriate assessments organised at every level – CAF Social Care and community based assessments for the Courts	Implement community based assessment pathfinder All staff to be trained in child protection. Parent Outreach Worker role to be evaluated to ensure that it supports families most in need of support. Residential visits process is reviewed to ensure it is best practice	Rubina Mazher Paul Coke Clare Moore Sue Green	September 2013 September 2013 September 2013 May 2013
10.3	Combat violence against women and girls	Strengthen all community responses and attitudes to violence against women and girls and the prevention of violence against women and girls. Better understanding of the triggers and influences that lead to child exploitation Reduction in instances of Child Sexual Exploitation There are clear pathways and sign-posting in place for professionals across all agencies when there is a concern about a child or young person at risk of exploitation	Develop VAWG implementation plan Deliver first year of VAWG plan (focusing on the themes of Education, Housing, and Health) Develop Child Sexual Exploitation multi agency strategy All children's centres support parents who are victims of violence. Clear signposting and referral processes are in place for pre statutory	Barbara Foster Alan Cotgrove Barbara Foster Neale Laurie Sue Green	June 2013 By April 2014 By April 2014 April 2013 September 2013

			intervention services to ensure appropriate support is provided. The EOH Commissioned offer is integrated with other service delivery to provide an offer of support locally and this is monitored and evaluated .		June 2013

Priority 11
Providing outstanding services to the most vulnerable children and young people

Objective		Where do we want to be by 2016	Action 2013/14	Lead	Deadline
11.1	Children and young people diverted from committing offences	Best national Youth Offending Service outcomes achieved Youth offending rates in Thurrock remain low Those most at risk of offending are provided with early help A range of alternative options (sanctions) are in place	Undertake a peer review Expand the capacity of ISS (intensive Supervision and Surveillance) The provision of the youth offer includes targeted activities and support young people at risk of committing offences.	James Waud James Waud Teresa Goulding Sue Green	March 2014 September 2013 May 2013-03-12

		Intervention processes in place that tackle more serious offenders Joined-up approach with Early Offer of Help and Troubled Families to delivery of diversionary initiatives and consequently minimal custody rates Full application of Troubled Families innovations and learning	Grangewaters to offer a programme of targeted activities and support through positive activities throughout the year.		May 2013
10.2	Re-offending prevented	Re-offending rates remain low Wide range of alternatives to custody Range of opportunities to improve the quality of life of those who have already offended	Partnership working with the Troubled Families team to provide access to diversionary activities and support. Improve the range of participation in employment, education and training for young people who have re-offended YOS audit and scrutinise all cases of re-offending YOS lead a programme to create realistic and cost conscious	Sue Green James Waud	May 2013 March 2014 January 2014 September 2013

			alternatives to custody for young offenders		
11.3	Disabled children and their families have a multi-agency service	A fully integrated Education, Health and Social Care Team, where families have access to a single assessment and single plan Information, advice and guidance via a one-stop-shop Parent groups will fully integrate to gain strength and fully participate in decision-making and strategic planning Disabled Children and their families have the choice to access a wide variety of short break opportunities Seamless transition to adulthood	Implement monitoring and review of SEN and Disability strategy by the LSCB Stay Safe Group	Clare Moore Malcolm Taylor	March 2014
			Launch the integrated parents group (PEG)	Clare Moore Sue Green	May 2013
			Children and families have access to a wide range of services through the locality teams as a part of their package of support.	Sue Green	September 2013
			Re-commission short break services	Clare Moore Catherine Wilson	October 2013

Priority 12
Provide outstanding services for children in care and leaving care

Objective		Where do we want to be by 2016	Action 2013/14	Lead	Deadline
12.1	Ensure that public care is reserved for those children for whom there is no safe and appropriate alternative and that those young people leaving care reach their full potential	The right children are in care and there are suitable services for children on the edge of care Interventions work effectively to ensure teenage entrants in to care are the exception Disabled Children have a range of local services to prevent them from being in care Progress on the National Adoption Scorecard Achieving 'outstanding' in LAC inspection – including the new challenging standards for care leavers	Peer review in preparation for Ofsted to take place Implementation of action plan	Neale Laurie Alan Cotgrove Neale Laurie	By September 2013 By April 2014
12.2	Achieve the highest possible standards of Corporate Parenting	Evidence of improved life chances of Looked After Children and those leaving care Top quartile performance on NEET All children in care are fulfilling their potential	Review of best practice participation standards (LILAC)	Paul Coke Roland Minto	September 2013

		Effective Corporate Parenting Committee ensuring that children looked after gets the best possible service that can be offered.			
12.3	The best possible placement for every child and young person	Decline year on year of children placed outside Thurrock Increase capacity of in-borough fostering service for Thurrock children Effective interagency commissioning arrangements for placements	Implementation of fostering service development plan Review of existing placements Increase use of adoption placements for Looked After Children Refresh fostering service development plan Implementation of development plan Refresh of sufficiency strategy Review and agree panel arrangements	Roland Minto Roland Minto Catherine Wilson Roland Minto Roland Minto Clare Moore Malcolm Taylor Roland Minto Catherine Wilson Catherine Wilson	September 2013 March 2014 March 2014 April 2013 By March 2014 June 2013 September 2013

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Thurrock Children & Young People Partnership

Thurrock CYPP

Business Plan

2014- 2015

Introduction by Carmel Littleton – Chair Children & Young People Partnership Board

I am pleased to present the Thurrock CYPP Business Plan for the next year covering the period 2014 to 2015.

In this, the second year of our 3 year strategy, we continue to strive to achieve the very best we can, for our children and young people. In a fast moving landscape of changing legislation, higher public expectations, increasing demand and ever-tighter resources, our partnership have stepped up to the challenge.

We are ambitious for our children and young people, and proud of their positive contributions and achievements. As a vibrant and dynamic place, Thurrock is changing socially and culturally and the regeneration of Thurrock offers unparalleled opportunities for our children and young people. This plan of the Children's Partnership and the Local Safeguarding Children's Board shows what we agree are our priorities and how we can achieve these so that children's lives are improved. Our Health and Well Being Board play a key role in ensuring we make the best decisions together for our Children, Young People and their Families.

With significant changes nationally and locally it can feel particularly challenging at this time, but we are committed to our relentless focus on early intervention and safeguarding. This year sees the exciting introduction of our Multi Agency Safeguarding Hub (MASH) This new operating model will deliver improved co-ordination of services, earlier identification of problems and swift and effective early help. Young people and families will supported earlier to prevent escalation of problems to statutory services. It is based on evidence of what works well, to secure the best possible positive outcomes for all children and young people, as well as providing the most efficient use of resources including better value for money. Bringing partners together in a single location, at the Civic Offices, will make a substantial difference. We are especially proud to be the ambassadors for Essex developing our innovative way of working with a single front door for Children's Services for all initial queries and concerns.

Relationships with our schools and academies continue to grow positively and together there has been a step change in what can be achieved for our children and young people.. Together we remain innovative and forward-looking. This ensures a continued focus on high quality education for all Thurrock children and young people and to be relentless in our ambitions for them.

Looking forward, Thurrock Children's Services will continue work in partnership on the development of more integrated local services and will use this as the basis to drive further improvements for children, young people and families.

Carmel Littleton
Chair

We have set four Aims in our 3 year strategic plan 2013 – 2106 to achieve our ambitions for Children and Young People in Thurrock

1. **Outstanding universal services and outcomes**

2. **Parental, Family and Community Resilience**

3. **Everyone Succeeding**

4. **Protection When Needed**

Our Delivery Plan 2014/2015

We have set out our second year delivery plan within our three year strategic plan. Our vision and strategic aims will remain unchanged but our objectives and actions are influenced through service improvement requirements to meet the changing workforce of children's services and how it meets the needs of the children and young people in the Thurrock, both now and in the future. Our new approach to strategic oversight and scrutiny will enable a greater focus on new ways or working.

The Partnership come together to agree common priorities and deliver outcomes that improve the quality of life and opportunities for local children and young people. The Partnership holds each other accountable for their joint and single agency contribution to improving Thurrock's children services.

Strategic Aim 1		**Outstanding universal services and outcomes – Priorities for 2014/2015**				
Objective 1		**Action**		**Measure**	**Time scale**	**Lead Group: Education Alliance and Excellence Network**
1.1	Raise attainment at the end of all key stages with a particular focus on Early Years Foundation Stage, Key Stage One and Key Stage Two	1.11	Prepare a report on progress made on the action plan of the Education Commission	Progress report	Twice annually Sept & March	Education Alliance Mike Peters/Ruth Brock
		1.12	Prepare report on activities of Children Centres and links with early years curriculum	Progress report	Twice annually Aug & Feb	Early Offer of Help (EOH) Sue Green/Chris Wade
		1.13	Report on the progress and activity to raise registration levels in Children Centres to 85%	Progress report and recommendations	September 2014	EOH Sue Green/Ruth Brock
		1.14	Report on progress to increase take up of early education of 3 and 4 year old children to 95%	Progress report and recommendations	December 2014	EOH Sue Green/Ruth Brock
		1.15	Embed strategies to narrow the gap between boys and girls at all key stages and target resources to ensure all children make expected progress during their primary school years	KS2 above national average gap narrowed between all vulnerable and underperforming groups	November 2014	Education group Mike Peters/Ruth Brock
		1.16	Increase our capacity to provide early-education to two year olds in line with national targets	800 places	September 2014	EOH Sue Green/Ruth Brock
		1.17	Ongoing analysis of take up of early-education to two year olds undertaken to identify any inequalities and address these	Analysis report	October 2014	EOH Sue Green/Ruth Brock

		1.18	Project Plan (1.17) for Phase Two in place and being delivered	Plan	November 2014	EOH Sue Green/Ruth Brock
		1.19	Commission a high quality programme for Heads and Deputies based on raising standards linked to effective school improvement and the Ofsted framework	Programme	October 2014	Thurrock Learning & Skills Board/Thurrock Excellence Network Ruth Brock/Michele Lucas

Strategic Aim 1		**Outstanding universal services and outcomes – Priorities for 2014/2015**				
Objective 2		**Action**		**Measure**	**Time scale**	**Lead Group: Chair PEHWB**
2.1	Promote and improve the health & well-being of Children and Young people	2.11	Update report on healthy weight strategy (2014-2017) and strategic delivery plan. (HWBB report)	Progress Report	Biannual July & December 2014	Public Health Strategy Board (PHSB) Debbie Maynard
		2.12	Prepare report on progress of the revised CAMHS service provision	Report	September 2014	Physical Emotional Health & Wellbeing Group (PEHWB) Catherine Wilson
		2.13	Children's 5-19 service (school nursing) New service model scoping paper incorporating service review exercise with CIPFA comparators and commissioning update.	Progress report	March 2015	Public Health Strategy Board (PHSB) Debbie Maynard
		2.14	Receive report on Risky behaviours to incorporate updates on DAAT, Tobacco control, sexual health services. Report to include latest data and details of commissioned services, service reviews and strategic actions.	Progress report	Feb 2015	Public Health Strategy Board (PHSB) Debbie Maynard

		2.15	Children's 0-5 services (including health visiting) update paper to be provided detailing allocation and transition arrangements.	Progress report Progress report	Jan 2015 Jan 2015 Final report Nov 2015	Public Health Strategy Board (PHSB) Debbie Maynard
		2.16	Preventative MH services scoping paper provided.	Progress report	Oct 2014	Public Health Strategy Board (PHSB) Debbie Maynard
		2.17	Receive Communications Plan from Public Health and identify Partnership outcomes to support improving the health of children and young people	Communication plan	Oct 2014	Public Health Strategy Board (PHSB) Debbie Maynard
		2.18	Receive Annual Public Health report	Report	Annually May 2014	Public Health Strategy Board (PHSB) Debbie Maynard
		2.19	Partnership Locality planning and delivery is in place with integrated management arrangements and strong links with local CCGs.	Progress report	Feb 2015	EOH Sue Green

Strategic Aim 1		Outstanding universal services and outcomes – Priorities for 2014/2015				
Objective 3		**Action**		**Measure**	**Time scale**	**Lead**
3.1	Ensure progression routes to higher level qualifications and employment	3.11	Receive report on progress to increase level 2 & 3 qualifications	% change to be analysed in report	Oct 2014	Education alliance Mike Peters
		3.12	Prepare report on the delivery of year 2 of the Raising Participation Age Plan	% NEET and in education, employment or training	Oct 2014	Education alliance Mike Peters
		3.13	Reduce the number of young people aged 16-18 who are NEET	0.5% reduction until performance is above national levels - Data/progress report	November 2014	Education alliance Mike Peters
		3.14	Ensure high quality opportunities for learning, skills development and training linked to the regeneration opportunities in the Borough	Implement plan to increase volume of apprenticeships in the priority sectors Q1: Public sector/logistics Q2: H&S care/retail Q3: Engineering/construction Q4: Evaluation report	March 2015	Thurrock Learning & Skills Board Michelle Lucas
		3.15	Increase volume of L2 and L3 apprenticeships by targeting individuals and employers	Progress report	March 2015	Thurrock Learning & Skills Board Michelle Lucas
		3.16	Increase of level 2 and 3 apprenticeships by at least 20% year on year	Progress report	March 2015	Thurrock Learning & Skills Board Michelle Lucas

Strategic Aim 2		Parental, Family and Community resilience - Priorities for 2014/2015				
Objective 1		**Action**		**Measure**	**Time scale**	**Lead**
4.1	Early Offer of Help	4.11	Receive report on progress of Early Help services improved outcomes	Progress report	Twice annual (October/March)	EOH Sue Green/Chris Wade
		4.12	Receive a report on progress and outcome benefits of the Troubled Families Programme	Annual report Additional 60 families	Annually July	Stay Safe group Teresa Goulding
		4.13	Develop a revised EOH Strategy	Strategy	Sept 2014	EOH Sue Green/Chris Wade
		4.14	Develop a MASH Strategy	Strategy	Sept 2014	EOH Chris Wade/Marisa De Jaeger
		4.15	Conduct a post implementation review of MASH and revised EOH provision	Review document	December 2014	EOH Chris Wade/Nicky Pace
		4.16	Work with the Police Commissioner's Office to review existing service provider to victims and multi-agency early offer provision.	Report	March 2015	CYPP Alan Cotgrove

Strategic Aim 2		Parental, Family and Community resilience - Priorities for 2014/2015				
Objective 2		**Action**		**Measure**	**Time scale**	**Lead**
5.1	Mitigate the impact of child poverty	5.11	Working with partners develop an advice strategy that lessons the impact of welfare reform for those families and young people who are at a higher	Multi agency strategy	Feb 2015	Public Health Strategy Board (PHSB) Debbie Maynard

			risk from the effects of poverty			
		5.12	Receive reports on activities to support families accessing and understanding child care provision, promoting moving into work and sustainable employment	Multi agency reports	Twice annually October / Feb	Executive group/full board
		5.13	Increase parental employment and skills by providing access to adult training and skills development	Report on increasing adults with level 2 & 3 qualifications Target L2 74.1% L3 42.2% by October 2014	December 2014	EOH Michele Lucas
		5.14	Increase the take up of Working Tax Credits to 15.5% particularly targeting areas of the highest child poverty.	Progress report	Jan 2015	EOH Sue Green/Michele Lucas
		5.15	ESF Families programme commenced and meeting targets	Report on achieving 200 families by September 2014	November 2014	EOH Sue Green
5.2	Strengthen communities	5.21	Improve housing for families and for vulnerable young people and prevent homelessness - 200 new homes by 2014/15	Progress report	February 2015	Barbara Brownlee
		5.22	Introduce social lettings agency by 2014/15	Progress report	February 2015	Barbara Brownlee
		5.23	Develop links with housing teams and ensure that information is included on Ask Thurrock and in locality information outreach offer.	Progress report	October 2014	EOH Sue Green
		5.24	Implement a programme to increase the number of accredited landlords	Progress report	December 2014	Stay Safe Barbara Brownlee
		5.25	Community hubs designed to build community resilience - Evaluation of the Ockendon pathfinder and future roll out of additional community hubs	Evaluation /progress report	December 2014	EOH Sue Green

		5.26	Implement a strategy to support, challenge and improve parenting in Thurrock	EOH Strategy	Sept 2014	EOH Sue Green
		5.27	Service delivery objectives agreed by partners and delivery commenced (5.26)	EOH Strategy	Sept 2014	EOH Sue Green
		5.28	Locality integrated management arrangements in place and opportunities for joint planning and delivery identified and committed	EOH Strategy	Sept 2014	EOH Sue Green

Strategic Aim 3		**Everyone Succeeding - Priorities for 2014/2015**				
Objective 1		**Action**		**Measure**	**Time scale**	**Lead**
7.1	Promote the attainment and achievement of underachieving children	7.11	Report on the development and access of services for pupils with SEN / LDD to support the best possible academic achievement and wellbeing	Report & outcomes	November 2014	SEND Malcolm Taylor
		7.12	Develop and improve Personal Education plan forms & systems during 2014	Report and outcomes	February 2015	SEND Malcolm Taylor

Strategic Aim 3		**Everyone Succeeding - Priorities for 2014/2015**				
Objective 2		**Action**		**Measure**	**Time scale**	**Lead**
8.1	Promote and support inclusion	8.11	Provide update on embedding of the disability charter	Progress report	July 2014	SEND group Malcolm Taylor

		8.12	Children's Centres to ensure that the number of registrations by families with children with SEN and learning difficulties increases and is in line with local population data.	Progress report	January 2015	EOH Sue Green
		8.13	Develop the offer to all pupils accessing pupil support services to significantly improve the outcomes and life chances of pupils in short-stay provision	New models of alternative provisions and Pupil Referral Units	Sept 2014	SEND group Malcolm Taylor
		8.14	Implement improved processes for children with complex needs, disability and continuing health care needs	New system of Education Health and Care Assessment and Plans to be in place to support children and young people aged 0-25 incorporating changes to post 16 assessments	Sept 2014	SEND group Malcolm Taylor
8.2	Narrow health inequalities for children and young people	8.21	Vulnerable pregnant women are targeted to ensure they are supported and access rolling programme of ante-natal and post natal care	Progress report on the capacity planning programme	March 2015	Public Health Strategy Board (PHSB) Debbie Maynard
		8.22	Children in care access immunisation routinely and uptake is increased	Report on improved screening services	March 2015	Public Health Strategy Board (PHSB) Debbie Maynard Roland Minto

Strategic Aim 4		Protection when needed - Priorities for 2014/2015				
Objective 1		**Action**		**Measure**	**Time scale**	**Lead: Chair Stay Safe group**
9.1	Provide outstanding services for children who have been or may be abused	9.11	Implementation of Multi Agency Safeguarding Hub (MASH)	Process in place	June 2014	EOH project group Sue Green
		9.12	Revised Threshold document produced by the LSCB	Revised document	May 2014	CYPP Business team Alan Cotgrove
		9.13	Report from the Munro Principal Social Worker on progress of improving services for children	Report	October 2014	Stay Safe group Head of CATO
		9.14	Undertake a gap analysis against Munro review recommendations & develop any relevant action plan	Report	October 2014	Stay Safe group Head of CATO
		9.15	Quality Assurance of delivery through audit and performance monitoring	Report	Quarterly Oct & Jan	Head of CATO
		9.16	Receive report on progress of action plan for continuous improvement of services to children with focus on Ofsted inspection process (CSC)	Report	July 2014	Executive group
		9.17	Receive report on quality assurance audits of safeguarding to improve service provision to children including peer audits	Report and recommendations	Quarterly Oct & Jan	Stay Safe group Head of CATO
		9.18	Receive report and recommendation from Essex Police CAIT on police response to safeguarding	Report	Annually September	Stay Safe group Head of CATO
		9.19	Receive report and outcomes of change process following quality assurance of childrens services	Report	Feb 2015	Stay Safe group Head of CATO

		9.20	Parent Outreach Worker role to be evaluated to ensure that it supports families most in need of support	Report	December 2014	EOH Sue Green
		9.21	Residential visits process is reviewed to ensure it is best practice	Progress report	Feb 2015	EOH Sue Green
		9.22	The EOH commissioned offer is integrated with other service delivery to provide an offer of support locally and this is monitored and evaluated	Progress report	March 2015	EOH Sue Green

Strategic Aim 4		**Protection when needed - Priorities for 2014/2015**				
Objective 2		**Action**		**Measure**	**Time scale**	**Lead: Chair Stay Safe group**
10.1	Provide outstanding services to the most vulnerable children and young people	10.11	Receive progress report on activity to reduce Violence against women and girls	Annual report	Jan 2015	Stay Safe group Cherrylyn Senior
		10.12	Receive a report from Disabled Children Team on activity and services provided to prevent children from being in care	Annual report	Feb 2015	SEND group Malcolm Taylor
		10.13	Receive a report from BTUH on the progress made on paediatric services following 2013 review	Progress report	November 2014	Stay Safe group BTUH Head Safeguarding
		10.14	Receive a report on the development on integrating parent groups in decision making and outcomes for disabled children	Progress report	December 2014	SEND group Malcolm Taylor
		10.15	Report from Youth Offending Services showing progress since last year's inspection and outcome of the action plan	Report	November 2014	Youth crime governance group James Ward

		10.16	Review and implement relevant recommendations from the children's commissioner report on CSE	Progress report	March 2015	Child Sexual exploitation Group (CSE) Jason Reed
		10.17	Deliver the Walk on line roadshows (E-safety) to year 5	Programme	March 2015	E- SAFETY GROUP Neale Laurie
		10.18	Expand the capacity of ISS (Intensive Supervision and Surveillance)	Progress report	Feb 2015	Youth Crime Governance Group James Ward
		10.19	Implement monitoring and review of SEN and Disability Strategy by the LSCB and Stay Safe Group	Report	March 2015	SEND group Malcolm Taylor
		10.20	Launch the integrated parents group (PEG)	Report	Sept 2014	SEND group Malcolm Taylor
		10.21	Children and families have access to a wide range of services through the locality teams as a part of their package of support	Report	Nov 2014	EOH Sue Green
		10.22	Re-commission short break services	Update report	Nov 2014	SEND group Malcolm Taylor

Strategic Aim 4		**Protection when needed - Priorities for 2014/2015**				
Objective 3		**Action**		**Measure**	**Time scale**	**Lead: Chair Stay Safe group**
11.1	Provide outstanding services for children in care and leaving care	11.11	Receive a performance report on indicators of outcomes progress to ensure care numbers are consistent with national comparators	Performance report	Bi Annual Aug/Feb	Executive Group Head of CATO
		11.12	Report from LAC Manager setting out progress of service provision to aspire to grading of outstanding	Report	September	Executive Group Roland Minto
		11.13	Receive report and recommendations on quality assurance audits on service provision to children in care or leaving	Report and recommendation	Quarterly Aug & Nov & Feb	Stay Safe group Head of Cato

			care			
		11.14	Produce a revised Adoption Development Plan	Progress report	Annually Jan 2015	Executive Head of CATO
		11.15	Receive a report on the voice of child in improving and development care services	Report	December	Stay Safe group Head of CATO
		11.16	Receive report on activity to ensure that LAC are achieving their academic potential to the level of their peers	Report	Sept 2014	Education group Mike Peters
		11.17	Report on the review and recommendations of the current placement strategy to ensure best value and good outcomes for children.	Report	Jan 2015	Executive group Head of CATO

Thurrock Children & Young Person Partnership Board

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Business Plan coordination and publication by:

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Toni Archer CYPP Project Manager

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Date of Meeting 11 September 2014	ITEM 8
Health & Well-Being Board	
Title of Report: Children and Young People Partnership Plan: Progress report 2013-2014 and Delivery Plan 2014-2015	
Report of: Alan Cotgrove, Business Manager, Children and Young Person Partnership Board	
Wards and communities affected: ALL	**Key Decision:** N/A
Accountable Director: Carmel Littleton Director of Childrens Services	
This report is Public	
Purpose of Report: • To provide an end of year report on the 2013/14 CYPP plan • To provide details of the 2014/15 CYPP delivery plan	

Executive Summary

The Health and Wellbeing Board strategy sets out those services for children that will be managed through the Children and Young People Partnership (CYPP). The CYPP has developed and agreed its three year plan 2013-2016 which is being implemented through one year delivery plans in support of the Health and Wellbeing vision that "every child has the best possible start in life"

The four overarching priorities agreed to achieve our ambitions for Children and Young People in Thurrock 2013-2016 are:-

- Outstanding universal services and outcomes
- Parental, Family and Community Resilience
- Everyone Succeeding
- Protection When Needed

This report provides details of the progress achieved against those priorities for the first year delivery plan 2013/14 and highlights some of the early work of our longer term aims undertaken as part of that programme.

Each of the four priorities has below it three objectives, which set out where we are now and where we want to be in 2016. This report provides details of the initial progress achieved in year one against those objectives.

The report also includes the details of the delivery plan for year two of the Children's Partnership Plan which covers the period April 2014- March 2015 and some early indicators of progress that has been made to date.

1. RECOMMENDATIONS:

1.1 The Board note progress made and outcomes achieved through the Children and Young People's Plan for 2013/14.

1.2 That the Board note the Delivery Plan for 2014/15

2. INTRODUCTION AND BACKGROUND

2.1 The Children and Young People Partnership Delivery Plan spans the three year strategy of the Health and Wellbeing Board for 2013-2016.

2.2 The Children's Plan includes a number of objectives scheduled for completion within the first year, some which are part of continuing service improvement plans and other more complex objectives that span the full period of the current three year strategy.

2.3 This report covers the first year Delivery Plan and the objectives and delivery plan for the second year 2014/15.

2.4 Governance and monitoring of the plans is achieved through the CYPP Partnership Delivery Groups and those groups affiliated with the Health and Wellbeing Board infrastructure which report to the CYPP Executive and Full Board on progress.

3. 2013-2014 Delivery Plan

3.1 Over the last year there have been a number of significant influences that have impacted the Children's Partnership world.

3.2 National and local guidance as well as some high profile cases of child sexual exploitation have raised the awareness and expectations on the safeguarding elements in the public domain around agencies that support safeguarding children.

3.3 Ofsted's approach to future inspections of children's services has shifted direction with further change expected again in September 2014 for schools following changes in the national curriculum. The aim to attain higher achievement in education will pose its own challenges within the changing landscape of education establishments.

3.4 The new service provision and structure of the health service changes during 2013/14 are still being embedded as agencies adjust to the new working environment.

3.5 Alongside these challenges is the need for greater efficiency and making sure that all agencies make best use of all their resources in the multi-agency partnership environment. The pace of change affecting children's services in delivering better outcomes for children and young people in Thurrock requires constant review and reflection.

3.6 There have been a number of new strategies, policies and procedures implemented during this reporting period across children's services.

3.7 New meeting forums have emerged - for example the Child Sexual Exploitation group and some of the existing meetings needed to adjust or shift in direction to meet new demands, to make sure that the Children's Partnership is fit for purpose to meet the needs of Thurrock children.

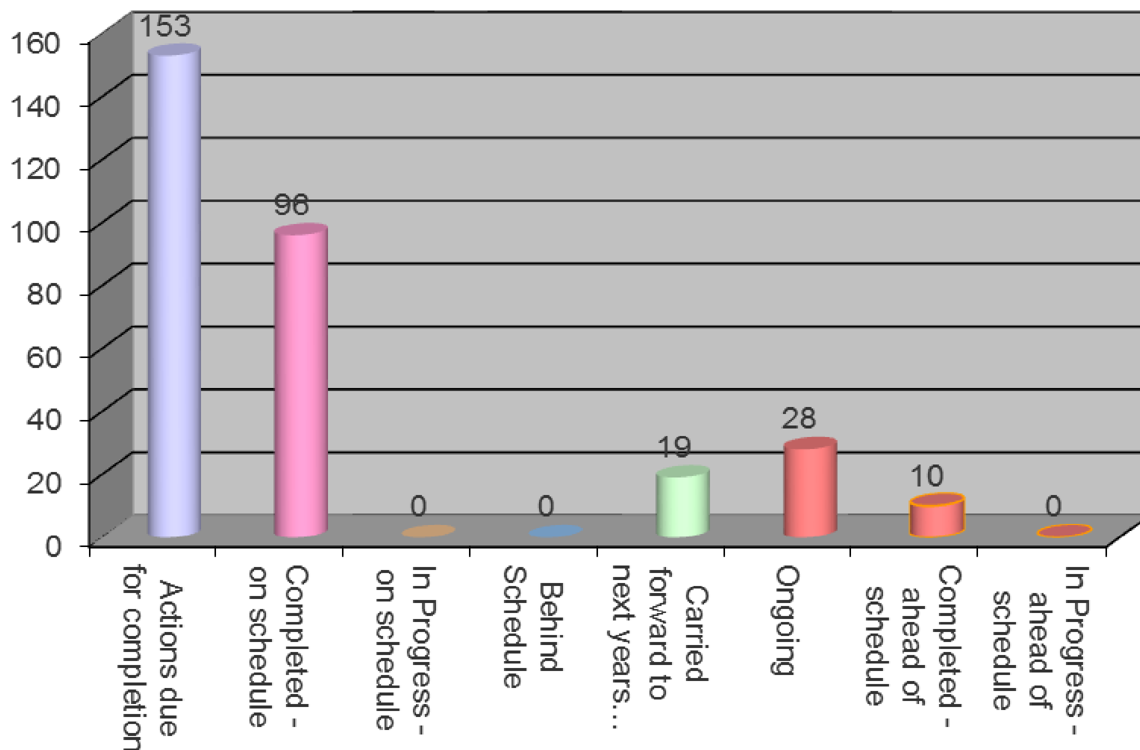
3.8 The way the CYPP Partnership Plan has been implemented allows the flexibility for these changes, resulting in some of the tasks being reviewed and refreshed, with new realistic timeframes identified to reflect the changing dynamics of children's needs and the services provided.

4 PERFORMANCE SUMMARY 2013 – 2014 Plan

4.1 The 2013/14 plan incorporated 12 priorities with 153 objectives.

4.2 The administration of the programme has been conducted by the Children's Partnership Business Team. A detailed breakdown of each objective has been maintained to enable a clear audit process linking them with the impact and outcomes achieved for children and young people.

4.3 The chart below shows the overall position of progress of the plan at the end of March 2014. 124 of the 153 actions have been completed, 19 carried forward into the 2014/5 plan with 10 having been completed ahead of schedule.



5. Impact and outcomes

5.1 Priority 1: Outstanding universal services and outcomes

"Raise attainment at the end of all key stages with a particular focus on Early years Foundation stage, key stage One and key stage Two"

Foundation Stage

This reporting period covers the academic year 2012/2013 and results reported in summer 2013. Thurrock is performing above the national and comparator average on the good level of development (GLD) measure (Thurrock 53, National 52) and percentage achievement of at least the expected standard in all early learning goals (ELG) measure (Thurrock 51, National 49).

On the measure of average points score, Thurrock is consistent with both national and comparator averages (Thurrock 32.5, national 32.8).

Key Stage 1

Thurrock's outcomes for reading at level 2B+ are in line with national (79% in Thurrock and nationally) and on a three year upward trajectory. In writing at

level 2B+, they are 1% below national (66% compared to 67%) but also on a three year upward trajectory. In maths at level 2B+, they exceed the national figure for the second year running (80% compared to 78%).

Key Stage 2

Performance on the key measure of reading, writing and maths at level 4+ is 72% compared to 76% nationally. There is significant variation among boys and girls achievement across Key Stage 2, although this is in line with the national trend.

Key Stage 4

Performance on the key measure of 5+ GCSEs A*-C including English and Maths improved to 59.5% ranking Thurrock 95th out of 151 authorities. However, Thurrock dropped just below national (60.8%) and Statistical Neighbour (60.5%) averages in 2012/13.

97.4% of pupils achieved 5+ GCSEs graded A*-G which is the highest ever for Thurrock with the gap to the national average increasing to 1.4%. This places Thurrock in the top quartile nationally (ranked 16/151 authorities) and above all statistical neighbours.

Looking forward:
Our plans for 2014/15 are to build upon our success and focus on developing further the take up of early year's education provision, raising attainment and implementing the findings of the Education Commission Report.

5.2 Priority 1: Outstanding universal services and outcomes

"Promote and improve the health & wellbeing of children and young people"

Overall, the health and well-being of children in Thurrock remains mixed compared with the England average across key indicators.

Obesity and Excess Weight

Children in Thurrock have average levels of obesity. The most recent National Childhood Measurement Programme data 2012/13 shows Thurrock to have an obesity prevalence in Reception-aged children of 9.6%, which is significantly higher than the East of England average (8.1%), and is above the England average of 9.3%. In Year 6 children the prevalence is 19.8%, which is more than double the prevalence in Reception.

For excess weight in 4-5 year olds (measured through the National Child Measurement Programme (NCMP)), Thurrock has dropped by 1.4% in 2012/13 compared to 2011/12. This is broadly in line with the England average (Thurrock, 22.1%, England average, 22.2%).

For excess weight in 10-11 year olds (measured through the National Child Measurement Programme (NCMP)), Thurrock has dropped by 0.8% in 2012/13 compared to 2011/12. This is 3.2% higher than the England average (Thurrock, 36.5%, England average, 33.3%).

Breastfeeding

A lower percentage of mothers initiate breastfeeding in Thurrock compared to the England average for 2012/13, with 69.5% breastfeeding (73.9% national). By six to eight weeks after birth, the percentage of mothers who breastfeed their babies is lower than the England average, with 36.1% of mothers continuing to breastfeed (47.2% national). This shows slight improvement on the 2011-12 position of 35.7%.

Immunisations

A lower percentage of children in Thurrock receive their first immunisation for MMR by the age of two than nationally – 91.9% compared to 92.3% in 2012/13. Thurrock has improved from 90.1% in 2011-12

Smoking

Performance for women stopping smoking at time of the time of delivery is better than average – 11.4% remaining smoking compared to 12.7% nationally for 2012/13. The provisional outturn for 2013/14 shows further improvement to 10.7%.

Under 18 conceptions

Data released by the Office for National Statistics shows that the under 18 conception rate decreased by 10.3%, from 34.0 per 1000 women aged 15-17 in 2011 to 30.5 per 1000 women aged 15-17 in 2012.

Looking forward:
Our plans for 2014/15 continue to build on improving health outcomes and include a healthy weight strategy and delivery plan for the period 2014-2017. Further work is planned on what is commonly termed “Risky behaviours“ looking at tobacco control, drugs and alcohol support and revised sexual health services. Also greater cross authority commissioning is beginning to take place with a refreshed CAMHS (Child and Adolescent Mental Health Service) provision.

5.3 Priority 1: Outstanding universal services and outcomes

“ensure progression routes to higher level qualification and employment

Qualifications at level 2 and 3 at age 19

Data released in early April by the DfE indicates that Thurrock has improved the rate of young people achieving at least a level 2 qualification by age 19 in 2012/13 by 5% to 87.2% exceeding the national average of 84.9% for the first time.

Thurrock has also seen an improvement in the rate of young people achieving at least a level 3 qualification by age 19 to 52.8% - an increase of 3.6% reducing the gap to the national average of 56.2% to 3.4%

Looking forward:
Our 2014/15 plans aim to build on the processes in place that have supported the improvement in attainment.

5.4 Priority 2: Parental, family and community resilience

“Early offer of help”

The main focus in the plan for 2013/4 was the recommissioning process of early help services, realignment of service structure and the development of the Multi Agency Safeguarding Hub (MASH).

The r-commissioning of services has taken place, taking account of the benefits and efficiency benefits and potential of working across authorities to streamline services.

The Multi Agency Safeguarding Hub (MASH) was scheduled to go live in April 2014. The significant shift in multi-agency ways of working and the infrastructure required to achieve this change brought a number of challenges to this process which resulted in the launch date being deferred until September 2014.

The MASH is now in place and early findings have shown many benefits in risk analysis and sharing of information.

The larger family of early help provision and locality teams are still embedding across the borough and will be a focus during the next year.

Looking forward:

Work is planned during 2014/15 with the Police Commissioner’s Office which takes on responsibility from October 2014 for a number of victim support and multi-agency early help services across Essex. A refreshed early offer of help strategy replacing the 2012 version and a new MASH strategy will be implemented with a post implementation review of MASH and performance processes embedding localities services will take place later in the year.

5.5 Priority 2: Parental, family and community resilience

"Mitigate the impact of child poverty"

The level of child poverty (as measured by the % of children under 16 living in families in receipt of out of work benefits or tax credits) in Thurrock is higher than the national average with 22% of children under 16 living in poverty (some 7,510 children) compared to 20.6% nationally.

Clear links with the Welfare Benefit Reforms Group have been put in place with joint provision of the Emergency Living Fund vouchers through Children's Centres and joint promotion of Money Advice Service sessions.

REED referrals for improving employability have increased and there are currently 41 cases with a further 90 referrals being considered. Co-location with the team is being implemented alongside co location with Job Centre Plus staff at the Central locality office.

Peer support is underway through the Community Hub and events to further develop support for adult skills and training development are in place.

Looking forward

Further development of Community Hubs is planned across the borough and the impact of welfare benefit reform is to be further reviewed.

5.6 Priority 3: Everyone succeeding
Promote the attainment and achievement of under-achieving children

NEET (Young People Not in Employment, Education or Training)

NEET levels for 16-18 year olds (based on age at the start of the academic year) again shows strong performance in 2013/14, decreasing to 5.5% at the end of March 2014 from 6.2 % at the end of March in 2013.

Tuition has been provided for all Year 11s that required it. All schools and the council's Care and Targeted Outcomes Team have been made aware in June and July 2013 of responsibilities around the funding of additional tuition and other needs.

A review was undertaken of the impact of the Pupil Premium funding across all Thurrock schools in July 2013. There was a correlation with the summer results for Sep 2013. A meeting with Fleet Tutors in July 2013 was held to move commissioning of additional tuition directly to schools that have the Pupil Premium funding for Looked After Children.

Looking forward

Our 2014/15 plans aim to build on the processes in place that have supported the improvement in attainment.

5.7 Priority 3: Everyone succeeding
Promote and support inclusion

New arrangements have been developed with the organisation Special Needs and Parents (SNAP) to develop the directory of services to cover part of the Local Offer. This work has been commissioned with a completion date of March 2014. The outline directory of Special Educational Provision has been completed as part of the Local Offer.

A new Service Level Agreement has been agreed with Gable Hall Academy and Corringham Primary School which has ensured the ongoing service from the mainstream resource base for pupils with speech and language needs. A new Service Level Agreement has been agreed with Stanford Le Hope School and the St Clere's Co-operative Trust for the resource base for pupils with visual impairment.

5.8 Priority 3: Everyone succeeding
Narrow health inequalities for children and young people

Linking with Clinical Commissioning Groups – Public health now working with CCGs on service redesign.

Two of the High Impact pathways have been launched across South West Essex . High Impact Pathways (HIP) have been endorsed by clinical lead for Paediatrics for CCG. Next phase of HIP to include Asthma and Febrile illness. Briefing papers were sent out to schools

The Annual Public Health report is now used as a yearly benchmark of Children and Young People's health. The maternity capacity plan has been currently being updated to reflect the current demands on units in Essex. Public health are now working with Public Health England to improve immunisation uptakes

5.9 Priority 4: Protection when needed "Provide outstanding services for children who have been or maybe abused"

Child protection

The rate of children subject to child protection plans continues to rise. The provisional rate per 10,000 children in 2013/14 is 75 (288 children). This compares to a rate of 53 in 2012/13 – an increase of 41%. The rate also places Thurrock well above both 2012/13 national (38) and SNN (34) averages. Internal and independent audits and have shown that decision making appears to be sound.

Looking forward

Peer audits have been implemented and although at an early stage it is anticipated that the MASH process will impact positively on future safeguarding performance.

5.10 Priority 4: Protection when needed "Provide outstanding services for children in care and leaving care"

The rate of children looked after continues to rise. The provisional rate for 2013/14 is 75 per 10,000 children (291 children). This reflects a rise of some 6.6% from 2012/13. The rate is higher than both national (60) and SNN (67) average rates.

Placement stability is a critical factor, anchoring most other outcomes for children looked after. The 2013/14 data shows that 8% of looked after children had 3+ moves during the year. This shows improvement on the 2012/13 position of 11% and is better than both national (11%) and SNN (11%) in 2012/13.

Educational outcomes for children looked after by Thurrock Council remain mixed which is common for education datasets containing low numbers of pupils. Thurrock is in the top quartile on two indicators and the bottom quartile for four indicators. At Key Stage 2, 57.1% achieved the benchmark measure of level 4+ for reading, writing and maths combined in 2012/13 which is a big improvement from 201/12 of 30%. Outcomes continue to be scrutinised at both officer level and at the corporate parenting committee.

Outcomes for care leavers

81.8% of Looked After Children are provisionally recorded as in suitable accommodation in 2013/14. This shows an indicative improvement of 9.4% from 2012/13 position of 72.4%. Thurrock remains below both national (88%) and SN (83%) from 2012/13.

31.8% of Looked After Children are provisionally recorded as in suitable employment (employment, education, training) in 2013/14. This is significantly below both national (58%) and SNN (53%) averages from 2012/13.

Looking forward:

Our plans for 2014/15 include additional “gatekeeping” procedures that ensure that we do all that we can to exhaust the possibility of children staying in the family environment. Children’s Social Care have implemented a new process of reviewing placements and closer scrutiny on enhancing fostering arrangements to reduce movement in placements Additional work is planned to support looked after children to get into suitable employment, education and training and suitable accommodation.

6. ISSUES AND/OR OPTIONS: N/A

7. CONSULTATION (including Overview and Scrutiny, if applicable)

7.1 The Children’s Partnership Board and its subgroups scrutinise the detailed work of the partner agencies in implementing the Children and Young People’s Plan.

8. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

8.1 The progress made within the plan supports of the Health and Wellbeing vision that “every child has the best possible start in life”

8.2 This report highlights some of the key activities and outcomes achieved within the first year of the plan.

9. IMPLICATIONS

9.1 FINANCIAL

Verified by Michael Jones
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Mxjones@thurrock.gov.uk

Funding of the work of the Children’s Partnership and its activities is conducted through partner’s contributions.

9.2 LEGAL

Implications verified by Lyndsey Marks
Lyndseymarks@bdtlegal.org.uk

There are no direct Legal implications.

9.3 DIVERSITY AND EQUALITY

Implications verified by Rebecca Price
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There are no direct diversity or equality implications. The Children's Partnership plan aims to improve services for all children and young people in Thurrock.

BACKGROUND PAPERS USE IN PREPARING THIS REPORT

2013/16 Children and Young People Partnership Plan

APPENDICES TO THIS REPORT

- Appendix 1 – CYPP Plan 2013-2014
- Appendix 2 – CYPP Plan for 2014-15

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11th September 2014	ITEM: 9
Health and Wellbeing Board	
Thurrock Revised Better Care Fund Plan	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Roger Harris, Director of Adults, Health and Commissioning, and Mandy Ansell, Acting Interim Accountable Officer, Thurrock CCG	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning, and Mandy Ansell, Acting Interim Accountable Officer, Thurrock CCG	
This report is Public	

Executive Summary

This report outlines the rationale for the revised Better Care Fund Plan and also the issues requiring resolution prior to the final plan being ready for sign off.

The first Better Care Fund Plan was submitted in April 2014. In July, the Government announced that Plans were to be revised and issued new guidance. Revisions are focused around achieving reductions in total unplanned admissions – with performance linked to reductions.

Revised plans are due for submission on the 19th September 2014.

1. Recommendation(s)

1.1 That the Board agree the outline Better Care Fund Plan; and

1.2 That the Board agree to delegate final sign-off to the Chair.

2. Introduction and Background

2.1 Thurrock's Better Care Fund Plan was submitted in April 2014 having been agreed by the Health and Wellbeing Board at a special meeting held in February 2014. The Plan set out Thurrock's ambition for health and social care and identified the steps that would be taken to deliver that ambition.

2.2 The Better Care Fund was announced as part of the June 2013 Spending Round (originally known as the Integration Care Fund). The purpose of the Fund as set out within the Spending Round was:

'To improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs. The Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.'

2.3 Areas were asked to develop plans by April 2014 which would set out the area's ambition for health and social care, how the £3.8 bn would be used to deliver that ambition, and also how a number of national conditions would be achieved.

2.4 Subsequent to submitting Thurrock's Plan, it was assured and signed off and arrangements were put in place to oversee its development and delivery.

2.5 In July 2014, the Department of Health and Department for Communities and Local Government sent a letter to Health and Wellbeing Board Chairs to announce changes that they were making to the Better Care Fund. The changes related to the letter's following statement:

'we know that unplanned admissions are by far the biggest driver of cost in the health service that the Better Care Fund can affect. We need the plans to demonstrate clearly how they will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community'.

2.6 The fundamental change relates to the pay for performance element of the Fund (£1 billion of the total £3.8 billion). In the first tranche of guidance related to the April 2014 submission, pay for performance was spread across 5 key indicators – both adult social care indicators and health indicators. At least 70% performance against target was required for the performance element of the BCF to be paid – with improvement plans required if this target was not achieved. All of the performance money would remain within the pooled fund.

2.7 The July 2014 guidance changes the pay for performance element of the Fund which is linked solely to achieving a reduction in 'total emergency admissions' – the expected minimum target being 3.5% for 'all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower' (Revised planning guidance 25/07/14). Furthermore, if Plans do not deliver the agreed reduction in total emergency admissions, the performance element that would have been part of the pooled fund will remain within CCG budgets to pay for the unplanned acute activity. Guidance also states that the remaining money from the £1 billion performance pot 'will be

spent by CCGs on NHS commissioned out-of-hospital services as part of the BCF plan'. There is concern that a number of the elements that have an impact on 'total unplanned admissions' will not be within the BCF's control – e.g. paediatric admissions.

2.8 As a result of the newly released guidance, all areas were required to revise their BCF plans – which are to cover the year 15/16 only. Due to the changes required, this has meant a rewrite of the original plan and a greater degree of detail.

2.9 Attached to this report is the outline Better Care Fund Plan for Thurrock. The guidance was issued during the height of the summer period, and taking into consideration committee report deadlines and the availability of key individuals, it has not been possible to present a final report to the Board. As with the first iteration in April, the Board are asked to agree the outline plan and delegate final sign-off to its Chair prior to the submission deadline of 19th September.

3. Issues, Options and Analysis of Options

3.1 At the time of writing this report there are a number of issues to resolve before Thurrock's Plan can be finalised. A verbal update will be given to the Board at its meeting on areas where progress has been made. Key issues are detailed below:

Pay for performance
Thurrock's pay for performance amount (e.g. as part of the £1 bn) is £2.8 million. As a proportion of this, a 3.5% reduction in emergency admissions equates to approximately £800k. Work is currently taking place to identify what a stretching but achievable reduction would be in Thurrock. Thurrock CCG's 2-year plan has set a target for 0% in 2015/16 (although the 2014/15 plan represents a 6% reduction on the previous year). The section 75 group are working on identifying how the financial risk of not receiving the £800k will be managed – it is certain that none of the £800k can be committed to redesign. The remaining amount of Thurrock's performance pot - £2 million – will need to be spent on CCG commissioned out-of-hospital services.

Schemes
There is an expectation that the BCF Plan will be accompanied by a detailed scheme descriptions for each scheme attached to the Fund. At the time of writing – and possibly even at the time of submission – the Council and CCG continue to identify a) the size of the Better Care Fund; and b) what funding streams will transfer from CCG and Council budgets to the pooled fund. Our Plan focuses on the over 65 age group most at risk of admission to hospital or a residential home, so the CCG and Council are looking at existing funding streams linked to these areas. An added complication is that funding is mostly linked to contracts, and therefore freeing up resource to be able to redesign or reprocure services is complex. Due to the time taken to instigate redesign, it is unlikely that we will see much change during the 15/16 year and

therefore it is likely that schemes will reflect this fact.

Provider Engagement
Health providers will need to complete a template to say that they agree with the Plan and that it is achievable – in terms of reducing non-elective admissions. At the time of writing, we are intending to approach providers through the South West Essex Resilience Group. This will take place in conjunction with Basildon and Brentwood CCG – in recognition that both Basildon and Thurrock CCGs will be requiring a reduction in unplanned admissions from the same hospital. We continue to work with providers through our Strategic Leadership Group.

Risk and Contingency Arrangements
At the point of writing this report, we are still developing our contingency plan and risk sharing arrangements. This will also be considered as part of the developing section 75 agreement between the Council and Health. We are clear that the £800k linked to a 3.5% reduction in total emergency admissions cannot be contributed to any other redesign initiatives due to the high risk that very little reduction will be achieved.

Plan of Action
Plan guidance expects areas to detail key milestones associated with the delivery of the BCF Plan and any key dependencies. As already stated within this report, due to the time associated with system redesign, it is unlikely that we will see significant change much before 2016. As a result, our 'plan of action' will detail how we are using our Whole System Redesign Project Group to undertake this work, and the key milestone we will have to achieve in order to review and revise how the money within our pooled fund is currently spent. This includes changes to commissioning intentions, contract variations, and reprocurement.

3.2 **Next Steps**
Next steps are as follows:

- Health and Wellbeing Board to sign off outline plan and agree to delegate sign off for final plan to its Chair – 11th September
- Final national checkpoint (3 of 3) – 12th September
- Final sign off by Thurrock Health and Wellbeing Board Chair and Thurrock CCG Chair – by 18th September
- Final submission – by midday 19th September
- Assurance on submitted plans – between 19th September and 10th October

3.3 Whilst the focus of this report is on delivering the requirement for a revised Better Care Fund centred on reducing total unplanned admissions, the focus of our work locally remains the same. Our ambition is to deliver whole system transformation, and transformation that not only enables health and social care to be sustainable, but ensures a seamless experience for the individual

regardless of the organisation they interact with.

4. Reasons for Recommendation

4.1 All areas (based on Health and Wellbeing Boards) are required to submit revised Better Care Fund Plans by the 19th September. The Plans must have been signed off by the relevant Health and Wellbeing Board.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Consultation on the Plan and subsequent redesign is taking place through the Health and Social Care Transformation Programme's Engagement Group. Health providers have been engaged via the Strategic Leadership Group – and possibly at the time of writing – via the South West Essex Resilience Group.

6. Impact on corporate policies, priorities, performance and community impact

The Plan contributes to the 'Improve Health and Wellbeing' priority.

7. Implications

7.1 **Financial**

Implications verified by: Mike Jones
01375652772
mxjones@thurrock.gov.uk

Financial implications are detailed within the report. Key implications are linked to the risk sharing arrangements that will be contained within the related section 75 agreement.

7.2 **Legal**

Implications verified by: Dawn Pelle 02082272657
dawn.pelle@BDTLegal.org.uk

The Department of Health and Department for Communities and Local Government wrote to the Chairs of Health and Wellbeing Boards on the 11th July to ask all areas to submit revised plans. NHS England and LGA guidance (Better Care Fund – Revised Planning Guidance) sets out additional requirements and supersedes previous planning guidance released in December 2013 (Better Care Fund Annex of Planning Guidance).

7.3 **Diversity and Equality**

Implications verified by: Natalie Warren
01375 652186

nwarren@thurrock.gov.uk

Thurrock's Better Care Fund focuses in the first instance on those over the age of 65 who are at greatest risk of hospital admission or admission to residential home. According to research carried out by Thurrock's Public Health team, individuals aged 75 admitted to A&E are over two times higher than the under 75 population; 60% have a limiting long-term illness; 32% are predicted to have a fall; and 28% are unable to manage at least one mobility activity on their own. It is hoped that focusing on the over 65 age group will have the greatest impact on reducing unplanned hospital admissions or admissions to residential homes.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None identified.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

Department of Health and Department for Communities and Local Government letter to Health and Wellbeing Board Chairs 11th July 2014

Better Care Fund – Revised Planning Guidance 25/07/14

Health Needs Assessment for the over 75 year old Thurrock Population

9. Appendices to the report

Thurrock Better Care Fund September 2014

Report Author:

Ceri Armstrong

Strategy Officer

Adults, Health and Commissioning

Local Government Association

NHS England

Updated July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and signoff

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

By	Dr Anand Deshpande
Position	Chair
Date	TBC

By	Mandy Ansell
Position	Acting Interim Accountable Officer
Date	TBC

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

<Insert extra rows for additional Councils as required>

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

c) Related documentation

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

Document or information title	Synopsis and links

2) VISION FOR HEALTH AND CARE SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Healthy, active ageing and supporting independence

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

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

Living well with simple or stable long-term conditions

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

Living well with complex co-morbidities, dementia and frailty

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

Good rehabilitation and re-ablement after acute illness or injury

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

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

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

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

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

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

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

social services will ensure whole person approaches;

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

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

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

In summary, this will mean:

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

3) CASE FOR CHANGE

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

Rhodri/Phillip

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

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

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

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

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

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

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

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

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

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

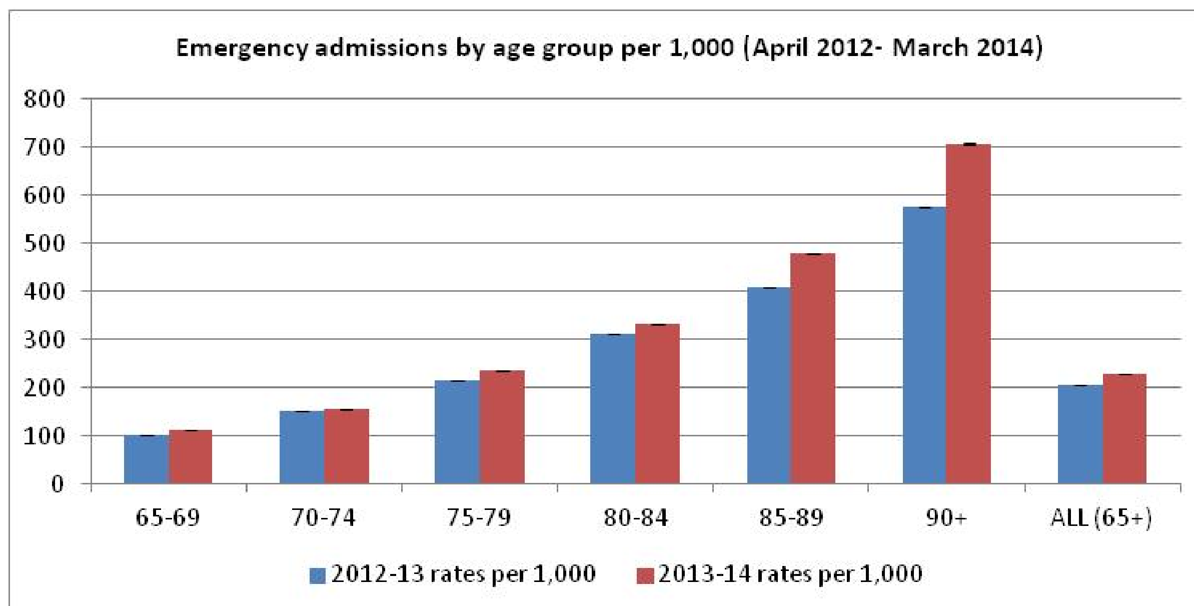


Table 1 - Top 10 HRG codes for those aged 65 years or more in Thurrock CCG (April 2012-March 2014)

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

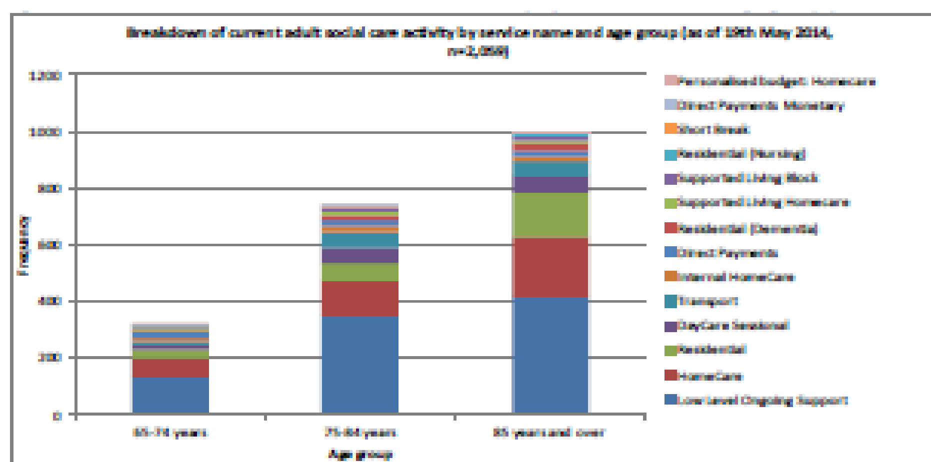
Table 2 - Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

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

Social Care Demand & Spend

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

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



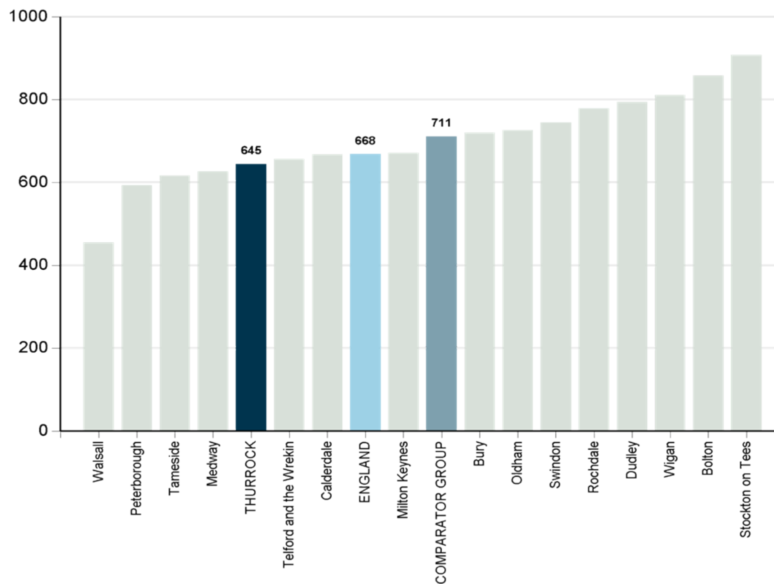
Source: Thurrock council adult social care.

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

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

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

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



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

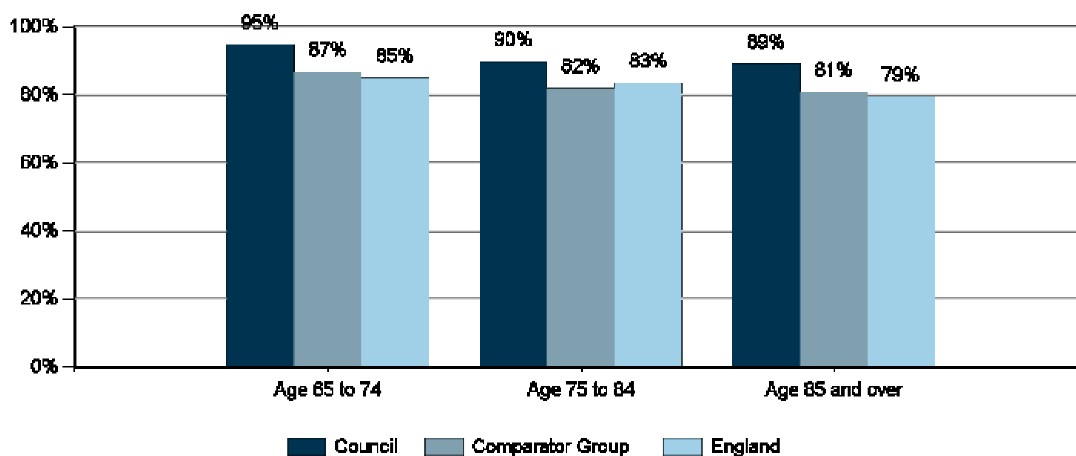
	Actual	Projected				
	Sep-13	Apr-14	Apr-15	Apr-16	Apr-17	Apr-18
Standard Placements	286	299	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	381	402	414	425	434	443

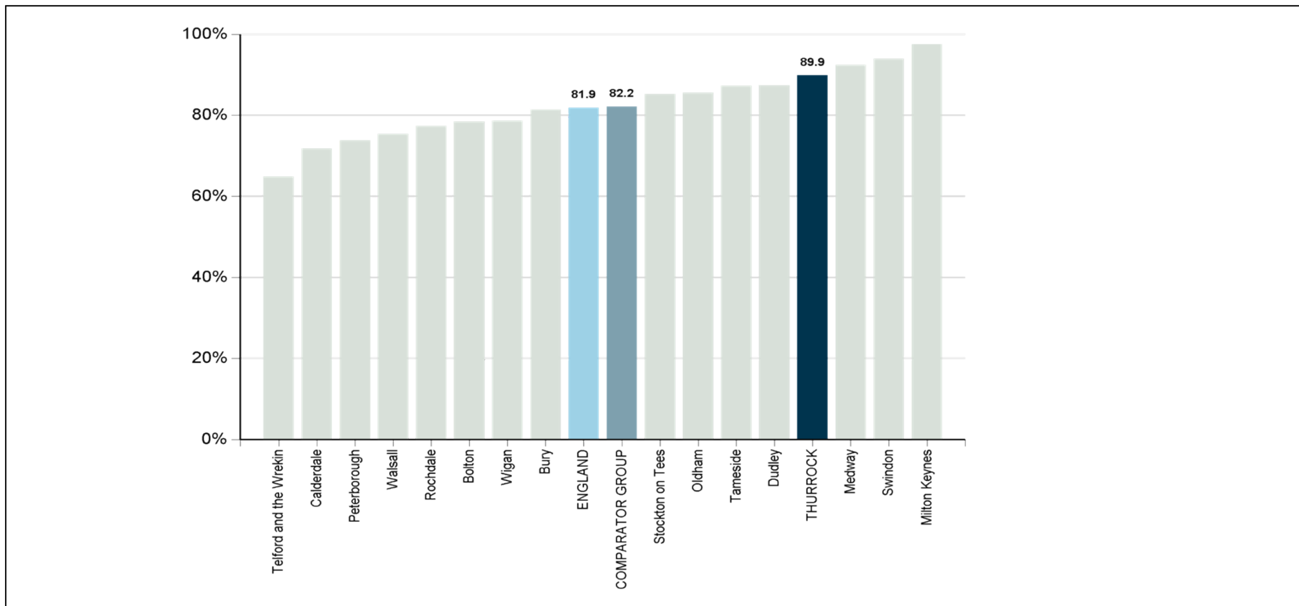
Supporting people to achieve and maintain independence at home through effective discharge from hospital into reablement / rehabilitation services is a priority for Thurrock. Overall, Thurrock performs comparatively well on this key measure. 89% of people discharged into these services were still at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

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

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

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





4) PLAN OF ACTION

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

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

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

In addition the Transformation Programme Board will work closely together:

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

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

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

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

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

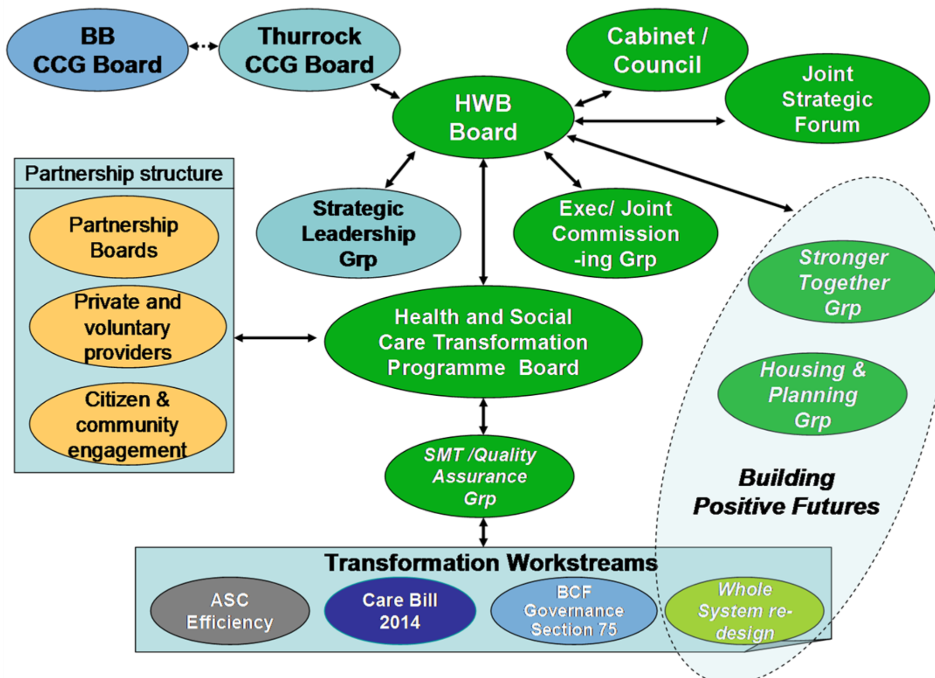
6 month Review of performance of 2014/15 BCF schemes completed and commissioning plans developed for 2015/16	End October 2014
Clinical Analysis of patient records to determine the likely causes of emergency admissions of patients aged 65 and over in a sample area	October/November 2014
Semi structured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

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

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

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

The reporting lines are as follows:



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

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

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

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

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

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

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

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

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

d) **List of planned BCF schemes**

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

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

5) RISKS AND CONTINGENCY

a) Risk log

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

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

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

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

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

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

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

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

b) Contingency plan and risk sharing

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

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

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

6) ALIGNMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hubs
GP practices will organise themselves into hubs, collectively serving perhaps 20,000 people. This does not mean that your GP will be in a different building, but that they will be part of a team offering more services and more access.

Your local 'chemist' will play a key part in 7-day face-to-face access, with an increasing role in repeat prescriptions, monitoring, and managing long-term conditions.

Nurse Practitioners, Community Services and Social Care will work closely with the hubs to support people with long-term conditions. They will have strong collaborations with acute hospitals.

GP practices
GPs will be in hubs, sharing specialists and improving access.

Optometrists
Opticians will work more closely with GPs and other primary care providers, extending the role they can play in your health.

Single-handed GP practices will benefit from being part of hubs, enabling them to offer 7 day a week access, and access to specialist teams

Dentists
Alongside optometrists and pharmacists, dentists will work in networks that either mirror the hubs or are a part of them.

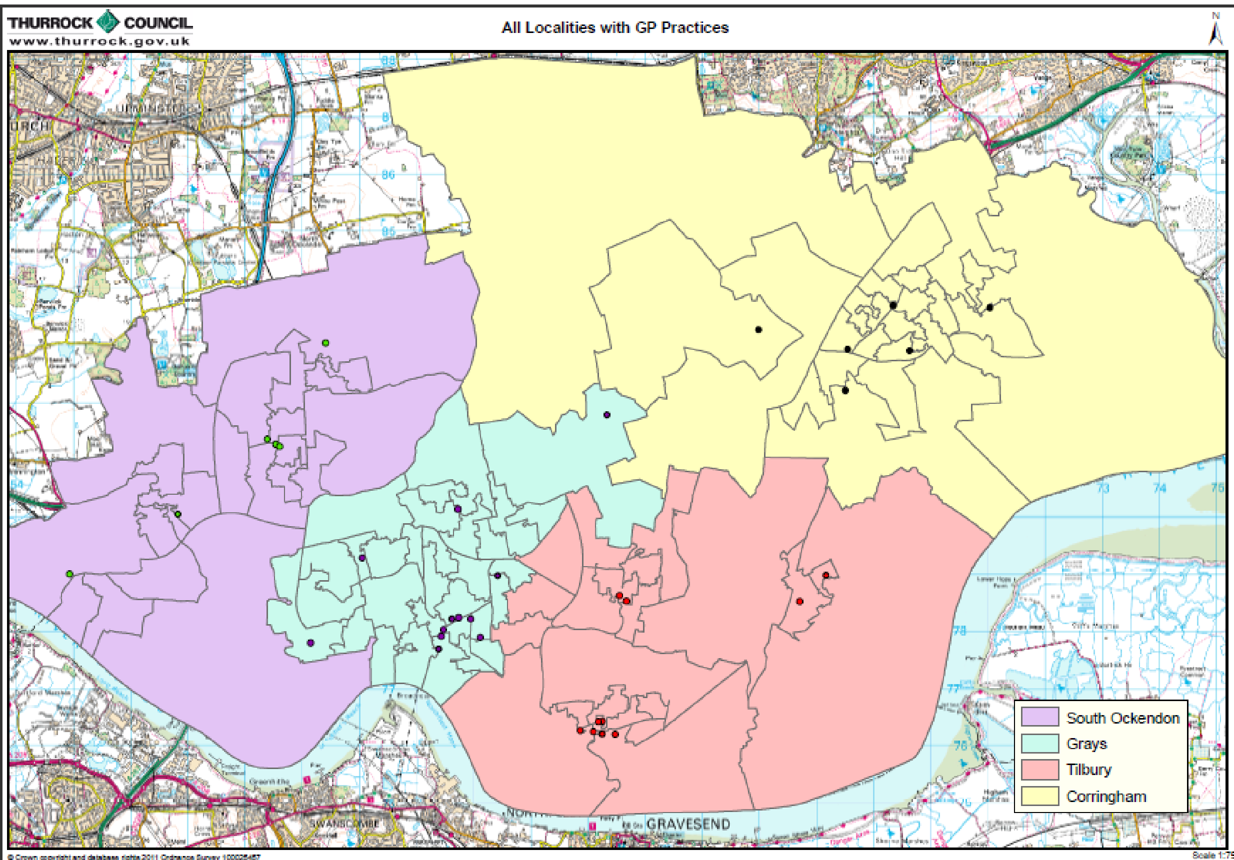
Health visitors, district nurses and school nurses will be aligned with or directly employed by the Hubs, and in close contact with specialist paediatricians

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

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

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

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



Seamless Single Contact Service Solutions

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

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

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

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

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

William

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

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

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

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

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

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

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

Fig 1

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

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

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

We will also use the BCF to review commissioning and procurement to develop:
- Joint commissioning of integrated health, public health, social care and housing services;
- A mixed economy of locally run care services; and

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

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

Shifting Resource

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

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

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

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

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

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

£521k - Ade

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

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

Key elements are as follows:

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

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

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

Ade/William?

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

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

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

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

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

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

c) Data sharing

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

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

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

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

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

- **Active Work Programmes**

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

    All health and social care providers identify patients

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

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

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

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

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

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

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

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

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

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

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

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

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

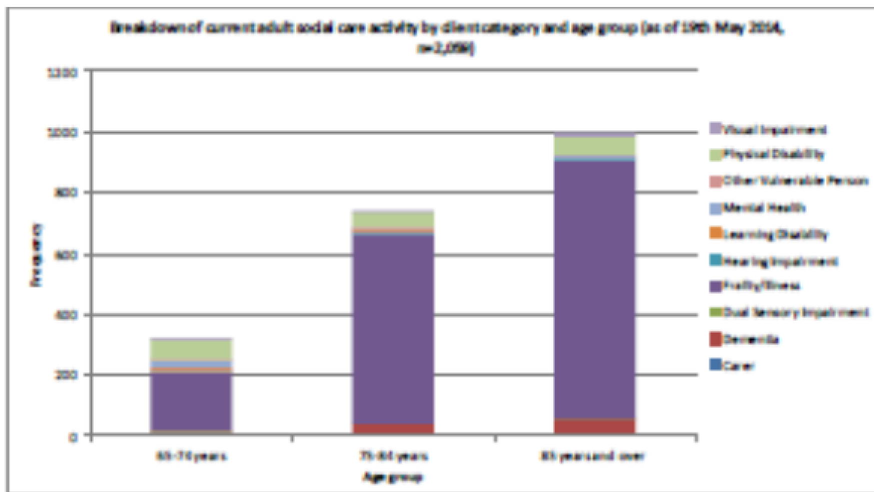
i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

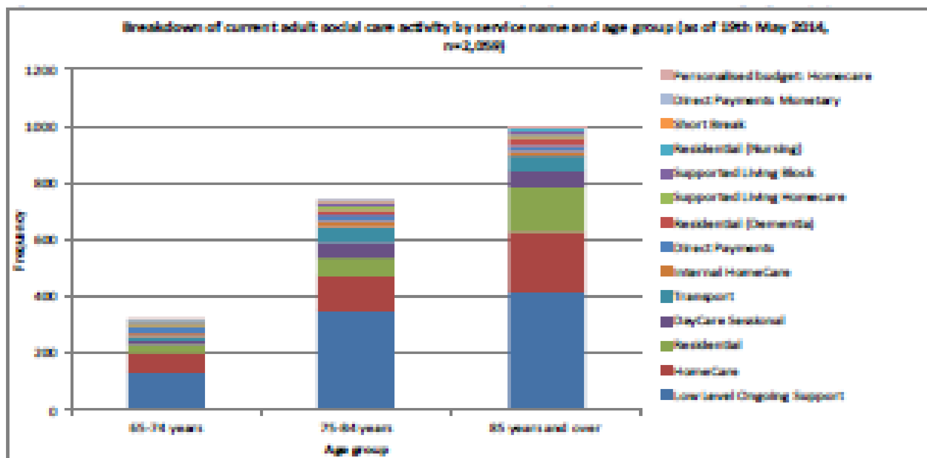
Phillip/William/Rhodri?

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

1% Benchmark – EOL Register

Adult Social Care Analysis *(p32 HNA)*

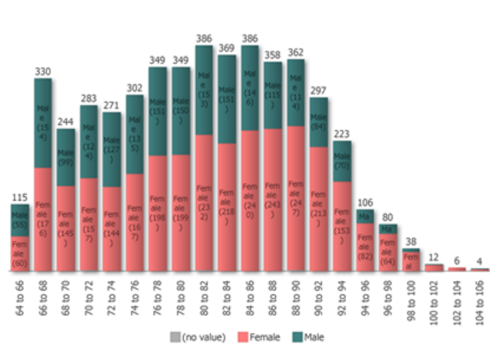


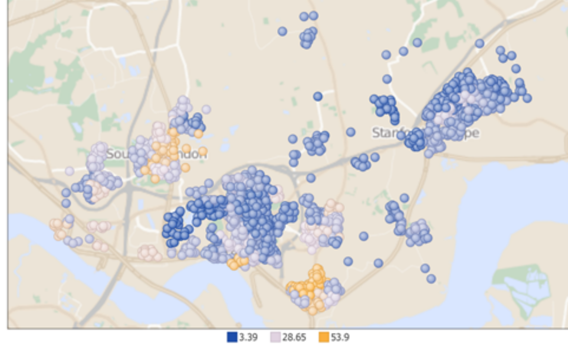


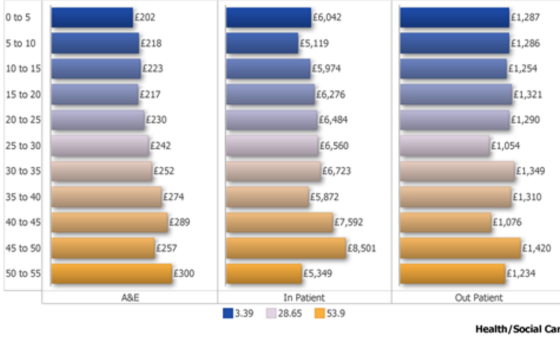
Source: Thurrock council adult social care.

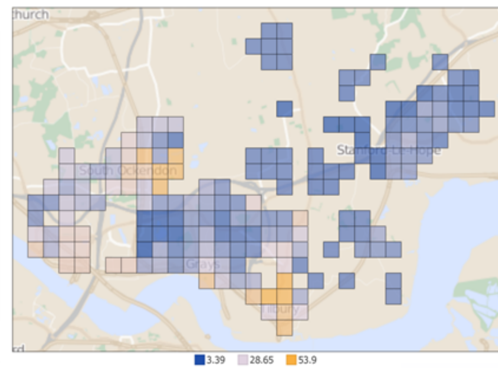
Safeguarding Adults >65 Number

Preparatory slides from Healthtrak









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

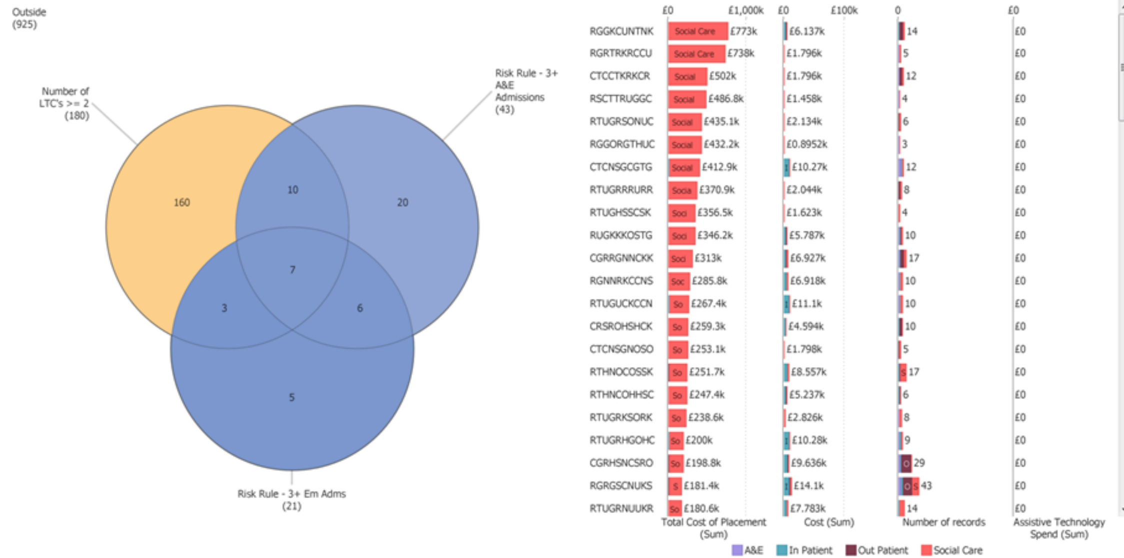
Text

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

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

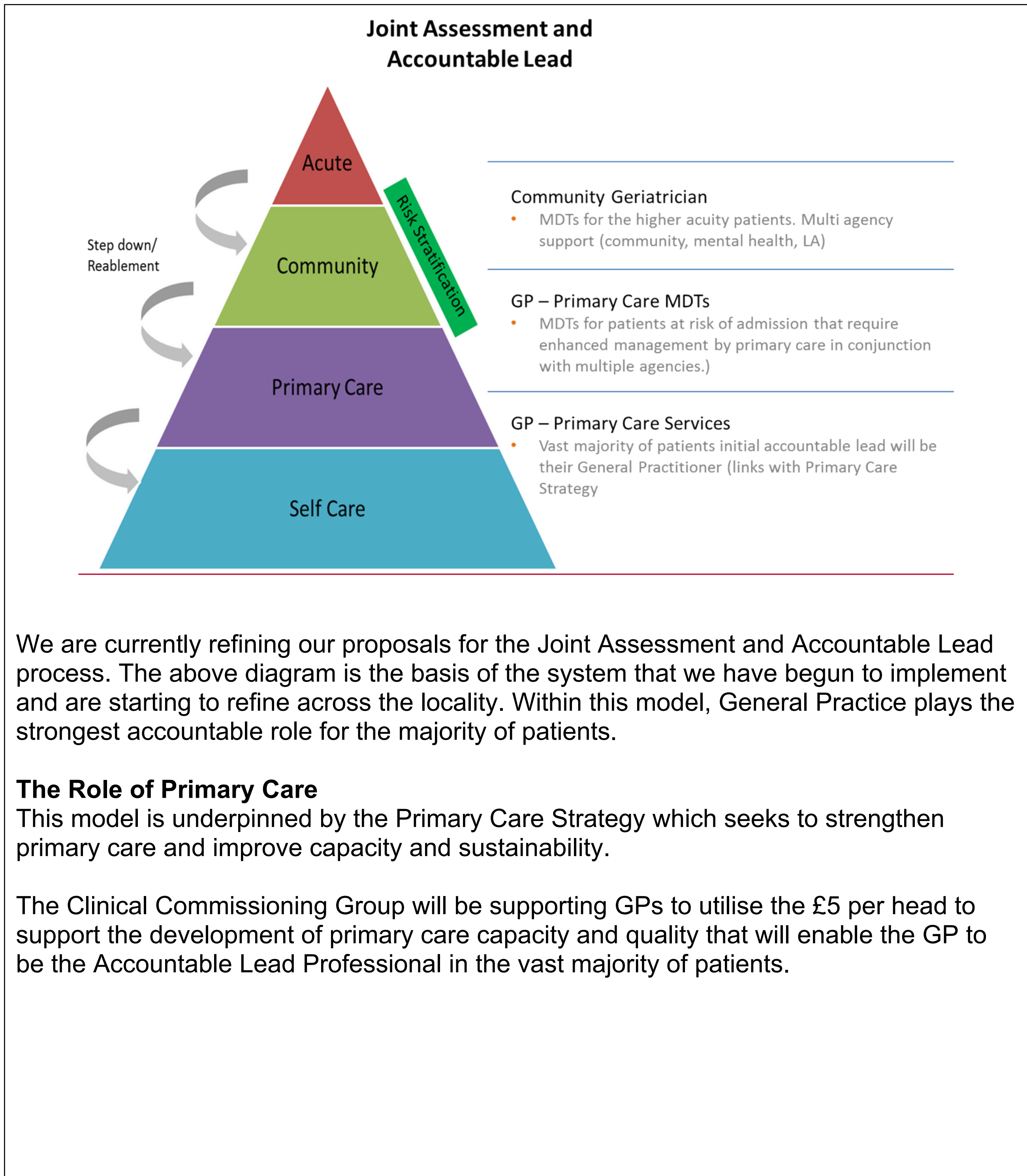
Venn showing number of individuals with multiple LTC's and multiple Emergency and A&E admissions

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



Cost and activity breakdown by Risk Strat groups

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



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

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

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

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

8) ENGAGEMENT

a) Patient, service user and public engagement

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

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

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

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

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

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

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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

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

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

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

ii) primary care providers

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

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

TBC

c) Implications for acute providers

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

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

Ade/William

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

ANNEX 1 – Detailed Scheme Description

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

William/Catherine

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

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

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

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

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

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

ANNEX 2 – Provider commentary

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

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

For HWB to populate:

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

For Provider to populate:

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

Health and Wellbeing Board Forward Plan

Date	Agenda	Lead
11/09/14	• Development of Section 75 Agreement • MH Crisis Care Concordat • Update on the SEN Reforms • HWBS – 13/14 review and 14/15 delivery plan – Children and Young People • Care Act Implementation • Better Care Fund Plan – agree revised plan	Christopher Mark Tebbs Malcolm Taylor Alan Cotgrove Ceri Ceri
13/11/14	• Pharmaceutical Needs Assessment – Final Document • Autism Strategy Action Plan – Refresh and Update • Housing and Planning Development Advisory Group • Public Health Services Commissioning Update • Market Position Statement • Healthwatch Annual Report • CAMHS • Well Homes • Board Development Session Proposal	Debbie Catherine Les Debbie Catherine Kim Paula Louisa Sharon
15/01/15	• Health and Wellbeing Strategy Refresh	Sharon / Ceri
12/03/15		

Health and Wellbeing Board Forward Plan

- Primary Care Strategy – November?
- JSNA Refresh
- Children and Young People – key items to be identified
- Use part of meeting as workshop or for a 'key note' speaker to be invited?