THURROCK'S BETTER CARE FUND PLAN 2016-2017 - draft

SUMMARY SHEET

Local Authority	Thurrock Council
Clinical Commissioning Group	Thurrock
Date agreed at Health and Wellbeing Board	21st April 2016
Date submitted	25th April 2016
Minimum required value of BCF pooled budget	£10,770,000
Total agreed value of pooled budget	In the range £19m to £27m

AUTHORISATION AND SIGN-OFF

Signed on behalf of the Clinical Commissioning Group	
By	Dr. Anand Deshpande
Position	Chair
Date	

Signed on behalf of the Clinical Commissioning Group	
By	Mandy Ansell
Position	(Acting) Interim Accountable Officer
Date	

Signed on behalf of the Council	
By	Roger Harris
Position	Corporate Director of Adults, Housing and Health
Date	

Signed on behalf of the Health and Wellbeing Board	
By	Councillor Barbara Rice
Position	Chair and Cabinet Member for Adult Social Care and Health
Date	

THURROCH'S VISION FOR HEALTH AND SOCIAL CARE SERVICES

1. Our vision for health and social care services

Thurrock's Better Care Fund Plan for 2015-16 set out the vision for Health and Social Care Services - linked to the Health and Wellbeing Strategy vision of 'resourceful and resilient people in resourceful and resilient communities'.

The focus of the 2015-16 Plan was to expand or accelerate a number of programmes that were already underway and that would work to prevent, reduce and delay the number of people aged 65 and over requiring health and social care services – including unplanned admissions to hospital. Consideration would also be given to the introduction of new initiatives linked to CCG and Adult Social Care Transformation Programmes. The programmes that would be expanded or accelerated would include Local Area Coordination (LAC) and the Rapid Response and Assessment service (RRAS).

Achieving the Vision would mean:

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

This year's Plan reflects what we will do during 2016-17 to move closer towards delivering these aims. We have already established an Integrated Director of Community Health Services (a joint Council and Community Provider post) which will accelerate the delivery of this vision. The planned changes are set out in more detail further in this plan.

Since the 2015-16 Plan was written, Thurrock's Health and Wellbeing Strategy has been refreshed. The Strategy provides a stronger focus on how the health and well-being of the local population will be improved through greater emphasis on prevention and early intervention – with a revised vision of 'adding years to life and life to years'. The Strategy is goal focused, and sees the Better Care Fund Plan as taking responsibility for the delivery of certain goals and objectives, and for contributing to the achievement of the vision for the health and well-being of Thurrock people.

The refreshed Health and Wellbeing Strategy 2016 – 2021 contains five clear goals, each defined by four outcome-focused objectives. These are:

GOALS	A. OPPORTUNITY FOR ALL	B. HEALTHIER ENVIRONMENTS	C. BETTER EMOTIONAL HEALTH AND WELLBEING	D. QUALITY CARE CENTRED AROUND THE PERSON	E. HEALTHIER FOR LONGER
OBJECTIVES	A1. All children in Thurrock making good educational progress	B1. Create outdoor places that make it easy to exercise and to be active	C1. Give parents the support they need	D1. Create four integrated healthy living centres	E1. Reduce obesity
	A2. More Thurrock residents in employment, education or training.	B2. Develop homes that keep people well and independent	C2. Improve children's emotional health and wellbeing	D2. When services are required, they are organised around the individual	E2. Reduce the proportion of people who smoke.
	A3. Fewer teenage pregnancies in Thurrock.	B3. Building strong, well-connected communities	C3. Reduce social isolation and loneliness	D3. Put people in control of their own care	E3. Significantly improve the identification and management of long term conditions
	A4. Fewer children and adults in poverty	B4. Improve air quality in Thurrock.	C4. Improve the identification and treatment of depression, particularly in high risk groups.	D4. Provide high quality GP and hospital care to Thurrock	E4. Prevent and treat cancer better

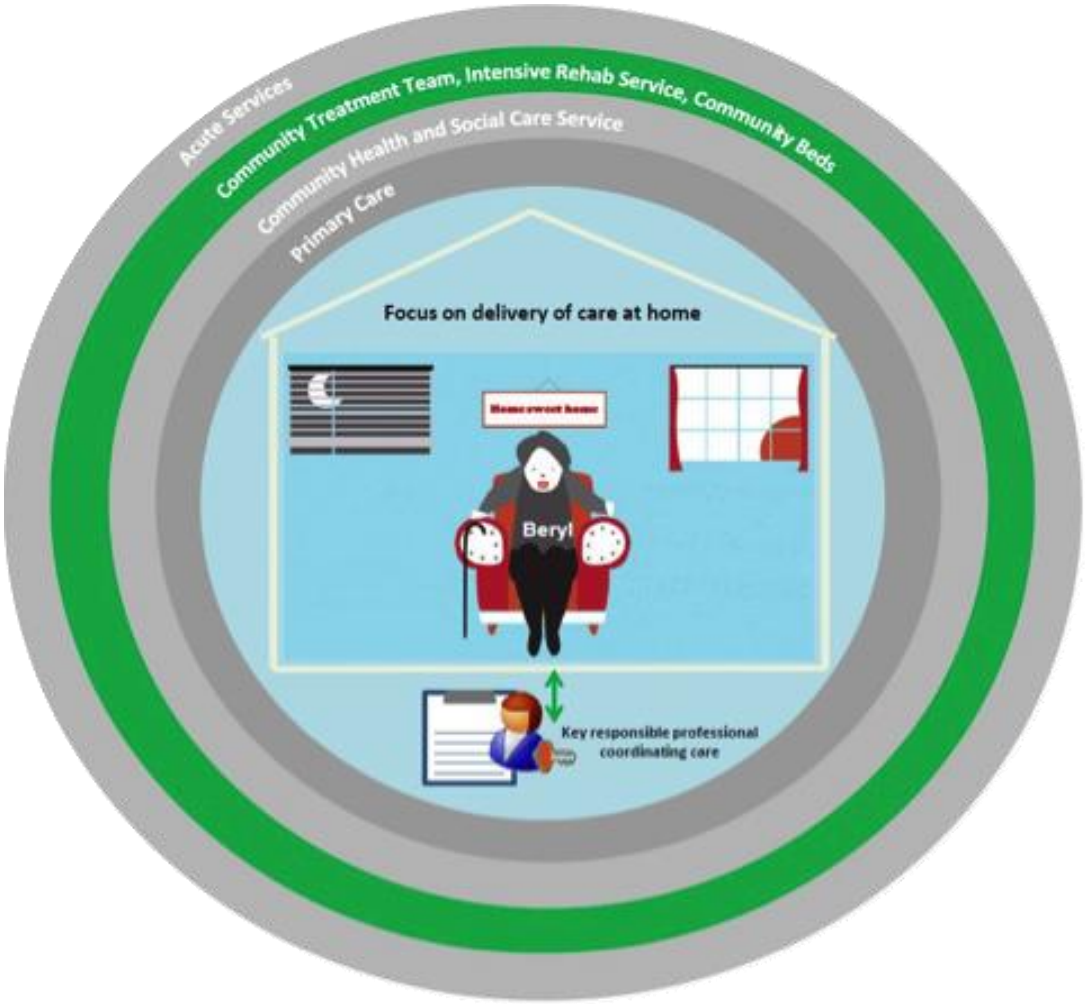
Whilst the achievement of all of the above goals and objectives will result in a healthier population and therefore reduced demand on health and social care resources, this Plan takes forward goal D 'Quality Care Centred Around the Person' in particular. It does however have strong links to other goals and objectives – for example, building strong and well-connected communities (under goal B) and 'significantly improve the identification and management of long-term conditions' (under goal E).

2. A description of how the BCF Plan contributes to the local implementation of the Five Year Forward View and the move towards fully integrated health and social care services by 2020

Thurrock's Better Care Fund Plan is aligned with the local implementation of the Five Year Forward View (the first year of which is the CCG's Operational Plan 2016-17) and the move towards fully integrated health and social care services by 2020. Local plans are set out within Thurrock Clinical Commissioning Group's Thurrock Transformation Plan and Operational Plan, and also contribute to the Sustainability and Transformation Plan which covers the same footprint as the Essex Success Regime. The objective of the transformation plans is for short term wins to support urgent system performance issues as well as moving to a longer term sustainable position. The year 2015-16 has seen significant steps being made towards the integration of health and social care through the BCF schemes and this will be developed further during the course of 2016-17.

For all organisations involved with the Essex Success Regime, there is no requirement to produce a separate Sustainability and Transformation Plan.

The CCG's Transformation Plan (and Operational Plan) outlines plans for providing health and care closer to or at home. The plans include a new model of care and a commitment to improve the quality and accessibility of service for the local population with a view to providing a more holistic model of locality based care closer to home.



When carrying out engagement on the development of Thurrock's refreshed Health and Wellbeing Strategy, many people raised concerns on aspects of the quality and accessibility of health services – community health services in particular. The CCG's Transformation Plan is part of the response to improving both quality and accessibility of community services – including an expansion of hospital services offered in the community.

Successful delivery of the CCG's Plan will require a range of out of hospital services which will be able to flex during changes in demand and that are based around the person. New models of care will be locality based and will be delivered through Multi-Disciplinary Teams spanning both health and social care.

Locality based teams will align with existing health hubs, taking a 'virtual ward' approach to providing care closer to or at home within each locality, and with new developments in the primary care estate – as outlined within the Primary Care Estate Strategy.

Individuals will be identified by risk stratification and will receive wider support to remain well – including through the Council's LAC service and local voluntary services based on a social prescription model.

The new model means that teams will work together to develop person-centred holistic care plans.

The changes set out within the CCG's Transformation Plan are integral to the Better Care Fund Plan. Delivery of the model will require joint and integrated working across a range of partners including health, housing, social care and the voluntary and community sector.

The schemes contained within this year's Better Care Fund Plan have been revised to reflect the development of the Transformation Plan (schemes 2 and 3 refer).

3. What will change as a result of the delivery of the BCF?

Building on the Better Care Fund Plan for 2015-16, and lessons learnt from the review of performance, the Plan for 2016-17 will mean:

- Many more opportunities for people to stay connected and supported within their own communities, so preventing or reducing the need for care and support services;
- Where services are needed, these will be coordinated around the individual – preferably at home and with the individual in control and able to exercise real choice;
- Following diagnosis (of any condition), pro-active support and coordination of care and support services linked to the person's home will reduce incidence of crisis; and
- Where acute services are needed, appropriate reablement support and intermediate care to prevent readmission and enable timely and effective discharge.

The direction of travel for the Better Care Fund was established in 2015-16 and, following a review of progress the Integrated Commissioning Executive has agreed to restructure the existing schemes and also to augment the specific components of each scheme. Overall the number of schemes has been reduced from 7 to 4. This is a consequence of:

- There is no payment for performance scheme in 2016-17 as a result of a change in the BCF policy guidance. In line with the guidance funding of £722,000 has been redirected for investment in out of hospital NHS commissioned services from 2016-17. Further, the achievement of our payment for performance target (3.2% reduction in unplanned admissions) in 2015-16 has released a non-recurring fund of circa £664,000 which will be used in 2016-17 to invest in a series of pilot initiatives which it is hoped will then prove self-financing in subsequent years;
- The Disabled Facilities Grant scheme now includes the funding formerly identified as Social Care (Capital) Grant;
- The successful implementation of the Care Act in 2015-16 means that the related activities of assessment and care management are now part of the mainstream social care programme for Thurrock and so do not require a separate specific scheme of work; and
- Following a review, the Integrated Commissioning Executive has agreed that the focus on addressing the needs of frail older people closer to home means it is appropriate to amalgamate two 2015-16 schemes (Locality Service Integration and Frailty Model) into a single scheme provisionally called Out of Hospital Community Integration.

In addition to the rationalisation of the schemes and the additional investment that has been secured for 2016-17 the following new initiatives will be taken forward in this Plan:

- The opening of two Integrated Health Living Centres is planned, with a total of four being planned by 2020 - providing local bases for 7 day working across the Borough for a range of services and solutions;

- Further investment in Local Area Co-ordination (Thurrock was Highly Commended for this service at the LGC awards in 2016) to provide Borough-wide coverage;
- As part of our Prevention and Early Intervention scheme a series of pilots will be undertaken to tackle:
    - Hypertension and Stoke
    - Falls prevention
    - Pre-diagnosis diabetes;
- Integrated commissioning of grants to voluntary and community organisations from the Better Care Fund from 2016-17 (where these were previously commissioned separately by the Council and CCG)
- Following the award of £768,000 of capital grant by the Homes and Communities Agency to our development partner Family Mosaic, Thurrock will make a contribution of £70,000 in 2016-17 and again in 2017-18 towards the costs of 6 homes specifically designed for young people with autism;
- As part of our Out of Hospital Community Integration scheme we will pilot the development of a new model of care for Care Home residents, including a premium for homes completing advanced training for staff providing complex care for eligible residents;
- Development of an integrated data set across health and social care to enable early identification of those at risk; and
- Further progress towards a Multi-speciality Community Provider (MCP) model.

The Planned investment in Better Care Fund Schemes in 2016-17

Scheme Ref	**Scheme Name**	**Amount** **£000s**
1	Prevention and Early Intervention	Circa £2,571,695
2	Out of Hospital Community Integration	Up to £16,773,337
3	Intermediate Care Review	Up to £6,587,158
4	Disabled Facilities Grant	£899,098
		In the range £19m to £27m

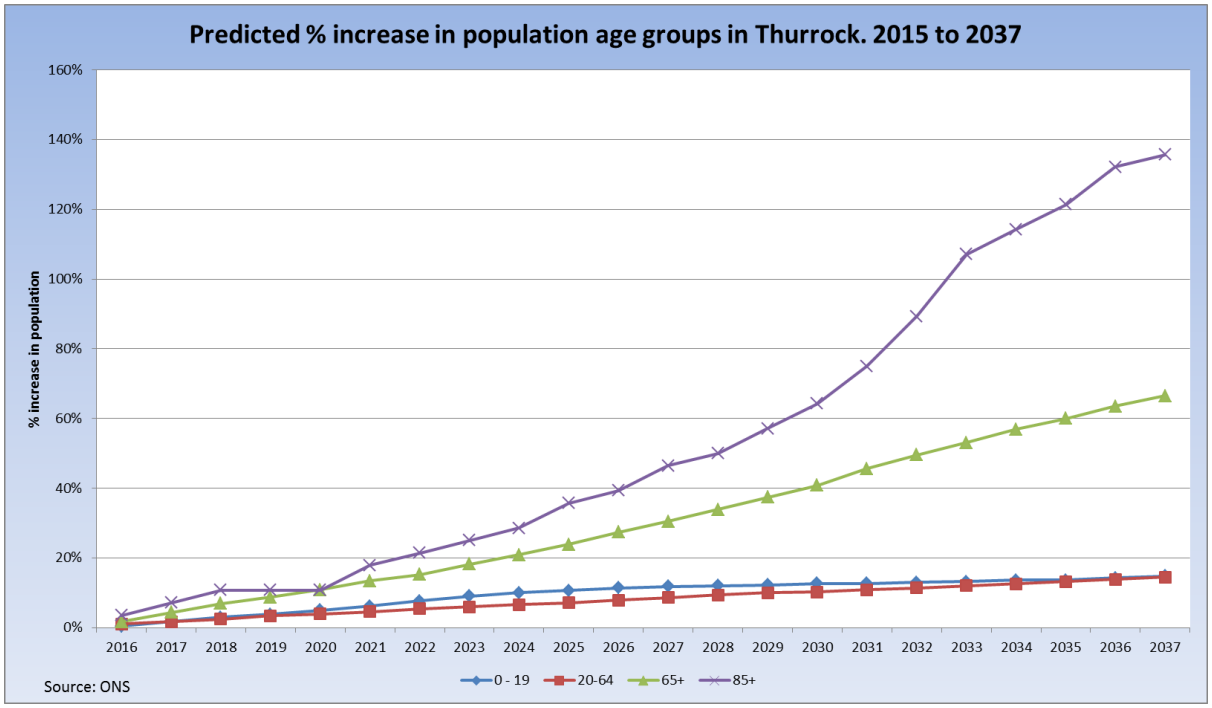
A range is given because it is an aspiration to increase the pooled budget so that we have a fully integrated pooled budget for older people across health and social care. However, at the time of drafting a number of funding elements are still to be confirmed.

Further details on the initiatives will be found in the relevant Better Care Fund Scheme.

THURROCK'S EVIDENCE BASE SUPPORTING THIS CASE FOR CHANGE

1 Needs Analysis

Our 2015-16 Plan set out Thurrock's Case for Change. This included setting out why we had decided to focus on people aged 65 and over. We identified that the two age ranges providing us with the greatest opportunities locally for improved health and well-being were in the 19-65 age group, and the 65 years and over age group. Based on activity costing, the age range of greatest opportunity was the 65 years and over cohort. The graph below is also evidence of the significant increase in population in the over 85s and over 65s age groups – whilst the numbers in the 0-19 and 20-64 age groups plateau.



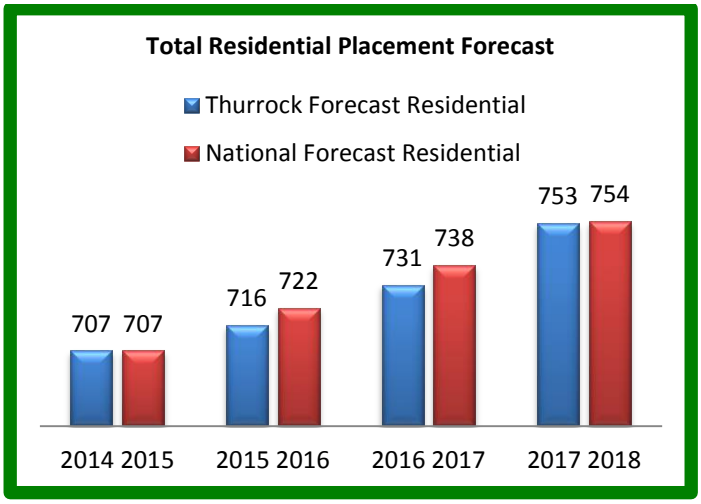
We have reviewed the information set out in our 2015-16 Plan. There is little significant change in terms of the causes of emergency admissions for those aged 65 and over. The one change of note is that one of the top-ten HRG codes for those aged 65 and over in Thurrock is septicaemia. Further work will need to be carried out to understand whether the change is significant in terms of our plan of action.

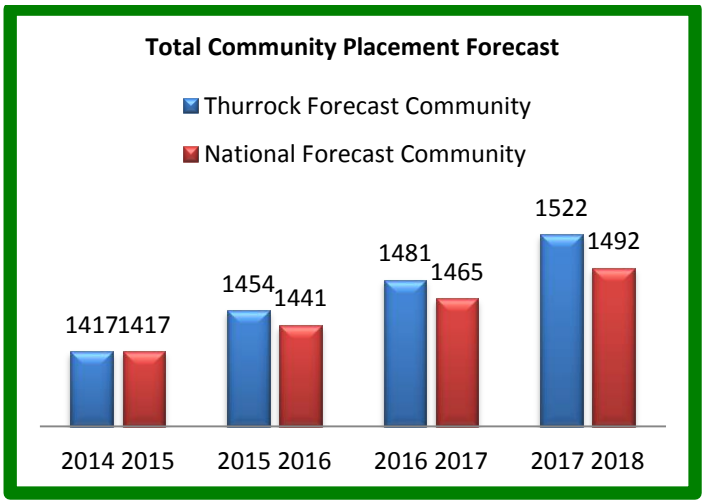
Top 10 HRG Codes for those aged 65+ in Thurrock

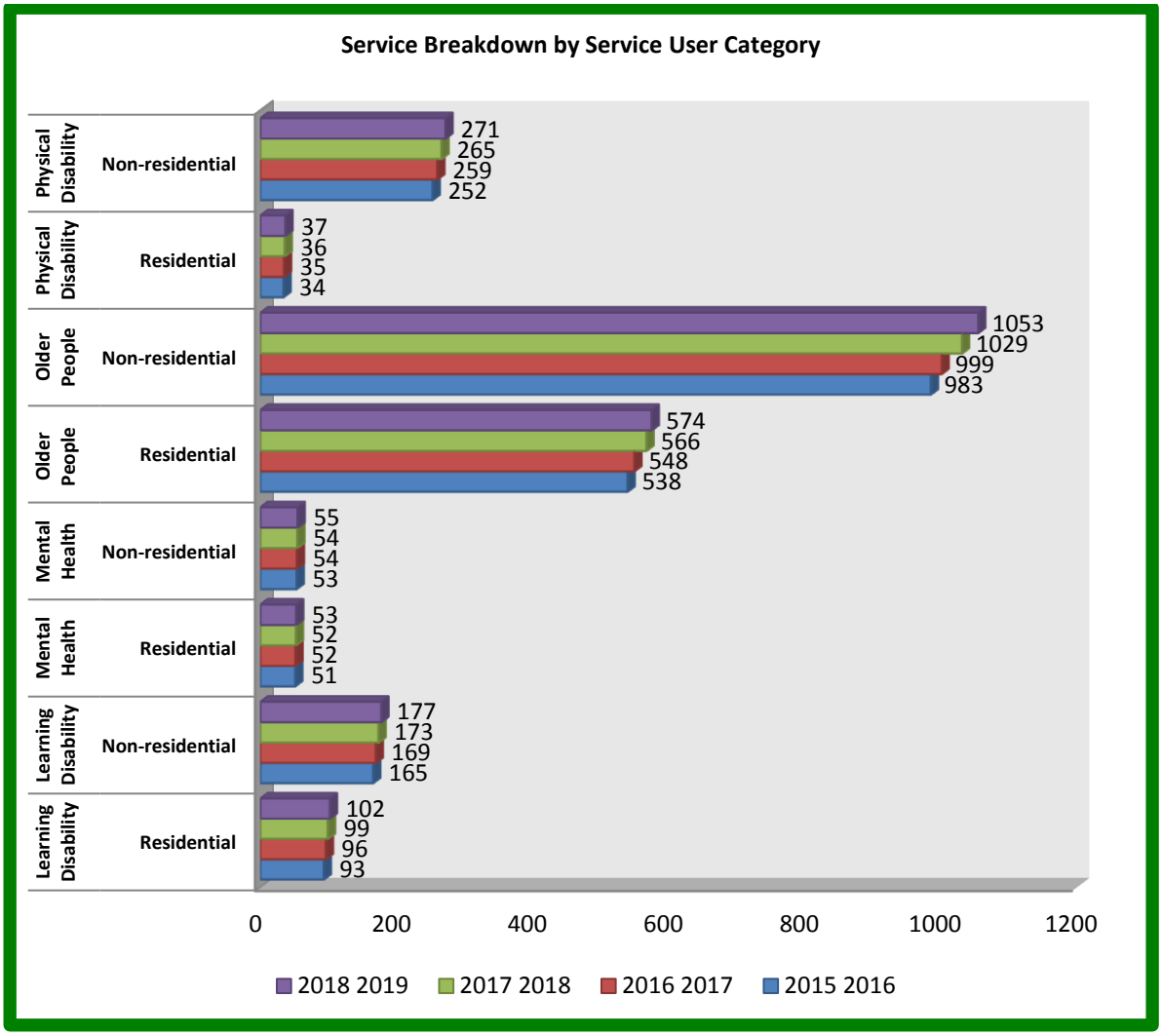
HRG Code	Total
Lobar, Atypical or Viral Pneumonia with Major CC	309
Septicaemia with Major CC	180
Kidney or Urinary Tract Infections with length of stay 2 days or more with Major CC	160
Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC	158
Non-Interventional Acquired Cardiac Conditions	148
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC	132
Heart Failure or Shock with CC	130
All patients 70 years and older with a Mental Health Primary Diagnosis, treated by a Non-Specialist Mental Health Service Provider	107
Muscular, Balance, Cranial or Peripheral Nerve Disorders; Epilepsy; Head Injury with CC	84
Arrhythmia or Conduction Disorders without CC	76

In terms of adult social care, demand continues to rise along with the complexity of cases seen. Despite this, we have been successful in reducing the demand for residential placements although this has increased the demand on our community places. This cost pressure is compounded by the implementation of the national living wage (NLW) and the pressure to maintain the cost per hour for domiciliary care. In response, we are developing innovative approaches to managing and growing the market, including supporting the development of micro-enterprises and initiatives such as Shared Lives, as set out within our Market Position Statement.

The Market Position Statement can be downloaded via the following link:
https://www.thurrock.gov.uk/our-vision-for-future/market-position-statement



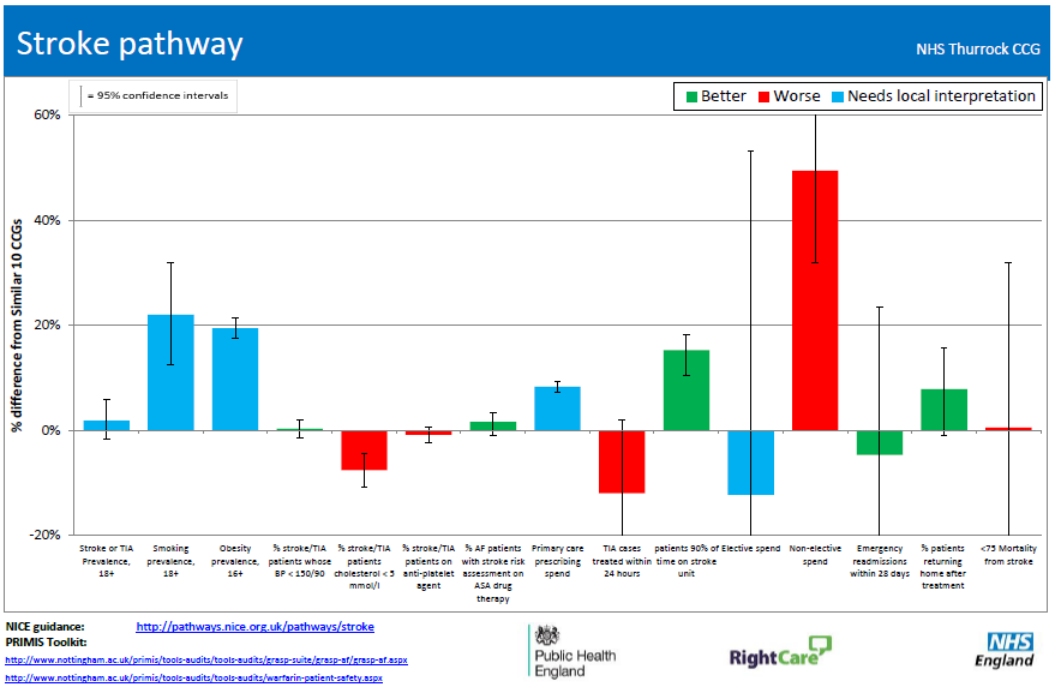




In addition to developing approaches to provide integrated care for individuals already known to both health and social care services, we are ensuring that we build on and introduce initiatives that identify individuals before they require services, or that prevent an individual's health from deteriorating further. We know that the key to managing demand and reducing pressure on the system has to be to prevent people from becoming ill in the first place, or ensuring that the system supports individuals to better manage their conditions – thus maintaining their health and well-being wherever possible.

This includes the expansion of the successful LAC project that was part of the 2015-16 Plan and continues in this Plan, and a further strengthening of prevention in Scheme 1 (Early Intervention and Prevention). Additional initiatives linked to our refreshed Health and Wellbeing Strategy include a focus on identifying individuals with hypertension and at risk of stroke, at risk of falling, and early on-set of diabetes/pre-diabetic conditions. Analysis carried out in one area of the Borough identified a significant amount of undiagnosed hypertension which if left undiagnosed and untreated was likely to result in stroke and therefore increased cost and pressure on the system.

The graph below shows that in terms of non-elective admissions for stroke, Thurrock is spending 50% more than comparable CCGs.



Further work to reduce pressure on the system is linked to Thurrock's involvement in the Essex Success Regime (ESR). The ESR identifies that the current NHS deficit in mid and south Essex could rise to over £216m by 2018-19 which would put the sustainability of health and care services at risk. The ESR aim is to get the system back into balance by 2018-19 and deliver the best joined up and personalised care for local people. This includes:

- More emphasis on helping people to stay well and tackling problems at an earlier stage to avoid crises;
- Joined up health and care services to provide more care for people at home and in the community, avoiding the need for a visit to hospital;
- New technologies and treatments to do more for people without the need to be in hospital, even in a crisis;
- When people do need the specialist care that only a hospital can provide, collaboration between hospitals and other services will ensure the best possible clinical staff and facilities; and
- By redesigning some hospital services, the improvements in staffing levels and capability will mean safer, more effective, and more compassionate care for patients.

This Plan links to the changes identified as required by the ESR – these are explored in more detail in the Plan's individual Scheme descriptions.

2. Segmented risk identification

We stated in our 2015-16 Plan that as part of the Unplanned Care Directly Enhanced Service, practices in Thurrock had carried out risk stratification of their registered population – identifying those at most risk of non-elective admission into hospital. This has seen 2% of the population receiving integrated care plans, with a proportion of those being reviewed within the Primary Care MDT reviews.

Risk Segmentation

The early work in 2015-16 saw the review and local development of a nationally published frailty risk stratification tool, the Electronic Frailty Index (eFI). The eFI, originally created by Professor John Young, National Clinical Director for Frailty and Prevention, has been further developed locally based on the Rockwood Frailty Scale in partnership with our local community provider.

The electronic frailty index (eFI) is available to help practices to identify the top 2% of vulnerable patients as part of the Avoiding Unplanned Admissions Enhanced Service (AUAES). The eFI has been developed by the University of Leeds, the Care of the Elderly team at Bradford Teaching Hospitals NHS Trust, the National Clinical Director for Frail Elderly at NHS England and TPP ResearchOne. The tool relies upon routinely-collected data from General Practice. It has been derived and validated on the ResearchOne database and is currently undergoing external validation on the THIN research database.

Building on the work from 2015-16 we have developed a Joint CQUIN for 2016-17 in partnership with our community provider to extend use of the eFI risk stratification tool to all of our practices over the coming year.

We know that patient pathways can be improved through better review and alignment of access criteria for initial assessment and ongoing care management and coordination to the best-placed health and care support for those living with frailty. The eFI is helping us do that by enabling us to identify within our population:

- those living with mild frailty that would benefit from education and supported self-management (provided with our local voluntary and community organisations);
- those living with moderate frailty that would benefit from proactive care and support planning;
- those living with severe frailty that need case management/End of Life care.

The problem we face is that people with frailty are currently either not reliably identified or, if identified, do not always receive a well-planned, coordinated package of care to support them to maintain an optimum level of wellbeing and independence. Thurrock providers agreed to roll out the use of the Electronic Frailty Index (eFI) in 2015/16 as part of a locally defined Commissioning for Quality and Innovation (CQUIN) scheme. This scheme will provide the opportunity to deliver well planned packages of care by identifying clients through the eFI tool, which provides a solution for a potential reconciliation of avoidable admission to hospital and to optimise patient experience and quality of life.

Better data sharing/Integrated data set

Further work on segmented risk identification is continuing as part of this plan. Work is being carried out between the CCG, Public Health and Adult Social Care on the development of an integrated data set to allow further risk identification. This has been built into and underpins our Scheme on prevention and early intervention.

We have an ambitious plan to merge SUS, Social Care, Community Health Care, and Primary Care data sets in this, although this is a long term view and we expect to do this in phases starting with SUS and Adult social Care.

At the time of writing we are undertaking soft market testing in advance of a procurement process. We expect to have entered an implementation stage by Autumn. Once this has commenced it will quickly feed into our Schemes on prevention and early intervention by identifying patients more appropriately

We expect the integrated data set to allow us to better identify people who are at risk of events such as falls, and hypertension to allow us to better target our early intervention and prevention Schemes.

(More details about this work are given in section 4. Better data sharing between health and social care, based on NHS number below).

THURROCK'S PLAN OF ACTION

1 Governance arrangements

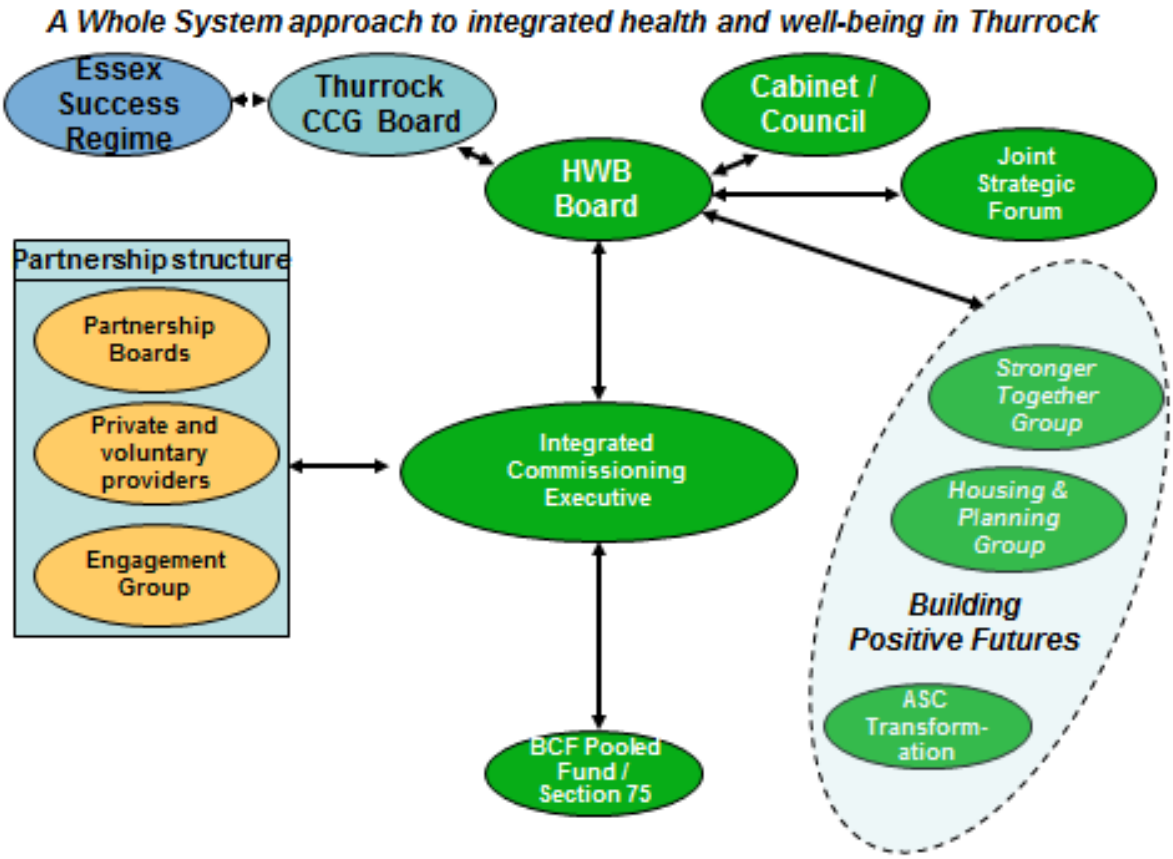
An Integrated Commissioning Executive has been established by Thurrock Council and Thurrock NHS Clinical Commissioning Group to oversee and sign off the development of all policy, commissioning and procurement, market engagement, efficiency, performance and processes related to the integration of adult social care and health in the Borough.

Where relevant the changes brought by the Essex Success Regime (which is the footprint for the local Sustainability and Transformation Plan) will also be considered by the Integrated Commissioning Executive.

There is also oversight by the Integrated Commissioning Executive of progress against relevant aspects of the QIPP challenge, the Primary Care and Estates Strategies, and the Council's efficiency programmes for adult social care.

The links to the Council's Building Positive Futures programme – which is focused on developing services, communities and the built environment to promote health and well-being – ensures that due regard is given to the impact of the wider determinants of health.

The Integrated Commissioning Executive reports to the Health and Wellbeing Board and its terms of reference are set out in the Section 75 Agreement for the Better Care Fund. The reporting lines are as follows:



2..Management and oversight of BCF

In relation to the Better Care Fund a joint Council and CCG Section 75 Agreement Project Group has established the arrangements for the Council to host the pooled fund. Responsibility and accountability for the Better Care Fund was assumed by the Integrated Commissioning Executive from April 2015.

The Integrated Commissioning Executive reports to the Health and Wellbeing Board (and the Cabinet of Thurrock Council, the CCG Board and relevant sub-committees) on its commissioning decisions, as set out in the Better Care Fund plan and associated Section 75 Agreement between the Council and the CCG. The Integrated Commissioning Executive also oversees the operation of the Better Care Fund, managing performance and risks within the Fund, and reporting these to the Health and Wellbeing Board. In order to avoid conflicts of interest, any discussions related to commissioning decisions, or payment, price or the performance of the pooled fund, or any other element of the whole system which may involve matters which are commercially sensitive, are also dealt with exclusively by the Integrated Commissioning Executive.

The arrangements are set out in detail in the governance section of the Section 75 Agreement and cover:

- 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

Membership of the Executive is:
- (Acting) Interim Accountable Officer, Thurrock CCG
- Corporate Director Adults, Housing and Health, Thurrock Council
- Director of Public Health, Thurrock Council
- Chief Finance Officer, Thurrock CCG
- Strategic Lead for Commissioning and Service Development, Thurrock Council
- Director of Commissioning, Thurrock CCG
- Director of Finance and Information Technology, Thurrock Council

The Integrated Commissioning Executive is serviced by a dedicated team led by the Pooled Fund Manager which reports financial and activity information at least quarterly. The Integrated Commissioning Executive meets on a bi-monthly basis (or more frequently if issues are escalated by the Pooled Fund Manager) to review performance against the Plan. The Integrated Commissioning Executive has delegated authority from the Health and Wellbeing Board to modify the plan, and the focus and funding for individual Schemes, where both the Council and the CCG agree this is appropriate. The Integrated Commissioning Executive reports progress against the plan to the Health and Wellbeing Board.

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

3 Performance Management

As noted above, the Pooled Fund Manager monitors financial and activity information on a monthly basis, escalating any issues/off-target performance to the Integrated Commissioning Executive as necessary. In addition, and at least quarterly, the Pooled Fund Manager provides a full report to the Integrated Commissioning Executive to enable it to:
- provide strategic direction to Schemes
- receive finance and activity information
- escalate any unresolved issues/off-target performance
- agree variations to the agreement and plan as required
- authorise the Pooled Fund Manager to approve expenditure

The key performance metrics monitored by the Pooled Fund Manager are detailed within the Better Care Fund Plan.

In the case of the introduction of new services or de-commissioning or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated, and risks fully assessed. Business plans will be agreed by the Health and Wellbeing Board on the recommendation of the Integrated Commissioning

Executive. These plans will include robust mobilisation plans for each service or initiative, including key milestones, impacts and risks.

4 Arrangements to support joint working

The Council and the CCG have a strong track record in the delivery of integrated health and social care services, including for example our well established Rapid Response and Assessment Service (RRAS), and Joint Reablement Team (JRT). These highly effective joint working arrangements with health and social care partners, which deliver strong performance levels against targets (including a close to target reduction in non-elective admissions in 2015-16), and very positive service user feedback, demonstrate a solid base on which to further extend integrated working through the Better Care Fund.

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

As part of the Better Care Fund Scheme in 2015-16 the Council and CCG implemented a range of recommendations from an independent evaluation which further strengthened its performance.

Actions and Milestones

Work Programme Initiative	**Start Date**	**End Date**
• Two Integrated Health Living Centres will be opened providing local bases for 7 day working across the Borough – Four to be completed by 2020	Sept 2016	On-going
• Further investment in Local Area Co-ordination (Thurrock was Highly Commended for this service at the LGC awards in 2016) to provide: Borough wide coverage	April 2016	On-going
• As part of our Prevention and Early Intervention Scheme a series of pilots will be undertaken to tackle		On-going
○ Hypertension and Stoke	July 2016	June 2017
○ Falls prevention	July 2016	June 2017
○ Pre-diagnosis diabetes	July 2016	June 2017
• Integrated commissioning of grants to voluntary and community organisations from the Better Care	Apr 2016	On-going

Fund from 2016-17 (where these were previously commissioned separately by the Council and CCG)		
• Following the award of £768,000 of capital grant by the Homes and Communities Agency to our development partner Family Mosaic, Thurrock will make a contribution of £70,000 in 2016-17 and again in 2017-18 towards the costs of 6 homes specifically design for young people with autism.	Apr 2016	Mar 2018
• As part of our Out of Hospital Community Integration Scheme we will pilot the development of a new model of care for Care Home residents including a premium for homes completing advanced training for staff and providing for eligible residents	July 2016	June 2017
• Further progress towards a Multi-speciality Community Provider (MCP) model	Apr 2016	On-going
• Integrated Data Set – a development across health and social care to enable early identification of those at risk.	July 2016	On-going

5 Risk log

The Risk Register for the Thurrock Better Care Fund provides an overview of the top 10 risks identified for 2016-17. It has been developed in conjunction with the Council's Corporate Risk Officer and the CCG's Head of Corporate Governance and agreed with key partners. The risks will be reviewed on a monthly basis by the Pooled Fund Manager, with oversight by the Integrated Commissioning Executive on a bi-monthly basis.

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

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

H&SC Transformation - Risk Register as at 13 April 2016

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
1	A reversal in the reduction of demand for acute services by 3.5% limits further investment in out of hospital NHS services.	1. The impact of each BCF Scheme has been assessed with regard to risks to the wider system. 2. Metrics for monitoring performance of each service are in development together with reporting arrangements.	4	3	12	1. Close liaison with acute providers on performance against QIPP Plans. 2. Co-ordinated action across the whole system to secure investment in out of hospital services and reduce demands on emergency admissions. 3. Arrangements for remedial action agreed if required.	9	April 2016	Director of Commissioning, Thurrock CCG
2	Workforce and capacity issues mean providers are unable to meet demand or provide good quality health and care services	Integrated Commissioning Executive established to monitor activity, performance and market conditions, and to develop alternative and more sustainable models of care closer to home.	4	3	12	1. Contingency plan to bring failing domiciliary services in-house in the short term. 2. Medium-term development of micro-enterprise service offers for less complex care, and more specialised care at home services. 3.The capacity and workforce requirements of each of the BCF Schemes has been reviewed.	4	April 2016	Strategic Lead (Commissioning and Procurement) & Director of Commissioning Thurrock CCG
3	Cost pressures in social care impact on	1. ASC Precept agreed by Thurrock Council.	3	3	9	1. Close monitoring of the effectiveness of the arrangements for	6	On-going	Strategic Lead

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
	the quality and availability of the services in Care Homes.	2.Enhanced care for care home residents including Complex Care Premium agreed as part of BCF				enhanced health care for care home residents.		2016-17	(Commissioning and Procurement)
4	Difficulties in sharing patient / service user level data may frustrate commissioning plans or performance and financial management.	1. Close liaison with CCG Head of Information Governance to agree strategy. 2. Close links with Southend Pioneer maintained	2	3	6	1. An Information Governance strategy for commissioning and providing integrated care, using the NHS number and with the required technical solutions is required. However, there is a clear dependence on legislation and regulatory changes before this can be achieved.	4	On-going	Strategic Lead (Performance, Quality & Business Support)
5	The changes required for the configuration of practices and estates strategy may make it difficult to engage GPs in integrated care programmes.	1. Strong early engagement of GP practices and timely implementation of the Primary Care strategy to involve GPs in change, and to ensure a common understanding of risks, opportunities and incentives.	2	2	4	1. Close Liaison with NHS England Essex Area Team regarding cluster arrangements	4	On-going 2016-17	(Acting) Interim Accountable Officer Thurrock
6	Uncertainty about the changing offer from ASC and Health may result in or late or low take up of community services, and a failure of the system to prevent crisis or	1. Initial scoping of communications plan completed. 2. Dependency on DH/NHS England communications noted	2	2	4	1. Strong campaigns to engage citizens and professionals across the system in the plans for integrated care, and reviews of the effectiveness of those campaigns.	4	June 2016	Manager Corporate Communications

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
	intervene in a timely way.	and detailed plans awaited				2. A joint formal CCG, Council and Provider promotion of integrated health and care service in Thurrock to initiate this campaign.			
7	Change may take longer or may be more difficult to achieve if a provider faced significant operational difference in neighbouring CCG areas.	1. Links made to Essex Success Regime regarding commissioning intentions and procurement plans	2	2	4	1. Liaison with B&B, CPR, Mid Essex, CCGs and ECC about the impact of our respective emerging commissioning plans to agree common principles, to identify variances and, where necessary, plan contingencies.		On-going	Directorate Strategy Officer, Adults Health and Commissioning
8	NHS provider may experience difficulties in delivering QIPP plan efficiencies or face unexpected costs in delivering integrated services.	1. Agreement for joint Council CCG monitoring of contract performance to be in place from April 2016. 2. Scorecard for monitoring performance against pooled fund targets being developed	2	2	4	Regular oversight of performance by Integrated Commissioning Executive	4	April 2016	Director of Commissioning Thurrock CCG/ Strategic Lead (Commissioning and Procurement)
9	Public engagement related to adopting healthier life styles, developing greater community resilience, and the importance of	1. Linkages with Stronger Together programme maintained. 2. Link to healthy lifestyles campaigns (linked to DH NHS	2	2	4	1. Campaign to promote community solutions to be planned	4	June 2017	Community Development and Equalities Manager

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
	accessing service in the community take longer to gain traction.	England campaigns) scoped.							
10	The impact, risks and benefits of commissioning integrated health and social care are not sufficiently understood.	1. Initial research and impact modelling of the benefits of integration undertaken. 2. BCF Plan Schemes amended to highlight benefits where these can be quantified	2	2	4	1. Further impact assessment of all commissioning plans to be undertaken using: • A common assessment tool • A joint sign off process • An agreed review period • A joint service restriction policy	2	April 2016	Director of Commissioning Thurrock CCG/ Strategic Lead (Commissioning and Procurement)

THURROCK'S AGREED APPROACH TO FINANCIAL RISK SHARING AND CONTINGENCY

The total value of the Better Care Fund in Thurrock is In the range £19m to £27m and for the year 2016-17 no amount of the Better Care Fund is described as 'at risk'.

The Council and CCG, working with its health care providers BTUH, NELFT and SEPT, agreed in 2015-16 to assume strategic responsibility for the whole health and social care system economy. They continue to accept collective responsibility for overspends, working together, and with other commissioners and providers, to pre-empt or minimise their occurrence.

The Health and Wellbeing Board has specifically considered performance against the total emergency admissions target set locally for 2015-16 and determined that in the light of the solid performance in the last year, together with the close working with the Essex Success Regime in the context of agreeing a new Block Contract with the Acute Provider BTUH, no "at risk" contingency is required in 201617.

Accordingly, the funding reserved as a contingency in 2015-16 (£722k) will in 2016-17 be invested in NHS out of hospital services.

The Health and Wellbeing Board remains closely involved in the arrangements for managing the pooled fund section 75 agreement which includes consideration of how financial underperformance will be managed. Section 75 performance reports for each BCF Scheme will continue to be provided to the Integrated Commissioning Executive and reported to the Health and Wellbeing Board from April 2016.

The issue of treatment of overspends in the BCF Schemes has also been agreed and the Health and Wellbeing Board have determined that the Better Care Fund for 2016-17 should again be fixed at the agreed value of the Pooled Fund. The effect of this is that any expenditure over and above the value of the fund will fall to the Council or the CGG depending on whether the expenditure is incurred on the social care functions or health care related functions.

The Section 75 Agreement stipulates that Financial Contributions in each Financial Year will be paid to the fund monthly in advance receivable on the first day of the month commencing 1st April 2016.

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

THURROCK'S 2016-17 BETTER CARE FUND SCHEMES

BCF Scheme 1 Prevention and Early Intervention

Scheme Overview

The objective of the Scheme is to provide an integrated response to a number of successful existing and developing initiatives that result in a cohesive prevention and early intervention offer spanning the community, public health, health and social care system. The Scheme was first introduced in 2015-16 (Scheme 4) and focused on demand management and crisis prevention.

Since the 2015-16 Plan was written, the Health and Wellbeing Board has refreshed its Health and Wellbeing Strategy 2016-2021. This has brought with it a stronger focus on preventing ill health and reducing and delaying the need for increased health and care interventions. The approach brings with it a range of service and non-service solutions which includes:

- The Borough-wide LAC service;
- Development of an integrated data set across health and social care to enable early identification of those at risk;
- Falls prevention – including building on our Well Homes initiatives;
- Stroke prevention – increased identification of those at risk of a stroke through increased and targeted health checks;
- Diabetes prevention – implementation of the national diabetes prevention programme; and
- Voluntary Sector Grants – introducing a joined-up approach across health and social care to how voluntary sector grants for the 65 and above cohort are awarded.

The aims and outcomes associated with this Scheme are focused on preventing illness and maintaining good health. There are a number of benefits including reducing pressure on the system – both in terms of demand and cost for health and social care services. The focus will help to shift the system towards maintaining good health and well-being rather than a system geared up to treat disease at a point where good health and well-being cannot be achieved. The Scheme reflects the whole population approach that underpins Thurrock's Health and Wellbeing Strategy.

Examples include our stroke prevention, falls prevention and Diabetes prevention schemes.

We plan to run several pilots to enable us to identify more of our currently un-diagnosed hypertensive patients. We currently only have around 50% of the expected prevalent population on GP disease registers. We have an ambition to get this up to 60% over the next 3 years resulting in a reduction in hospital and social care activity as a result of stroke.

A coherent falls prevention scheme, that fully implements the guidance provided by NICE, has been agreed for piloting in Thurrock. It has been evidenced that the impact of falls on the health and social care system in Thurrock is in excess of £4M

per year and that there are opportunities to prevent some of these falls from happening allowing our population to live more independently for longer and also make efficiencies in the system.

Thurrock has been accepted to be part of the National Diabetes prevention program. This will allow us to refer patients who are at risk of becoming Diabetic (as measured by their HbA1C or blood glucose measurements) for lifestyle intervention to prevent them from becoming Diabetic. We expect that the stroke prevention and falls prevention schemes will interlink with this programme helping us to identify patients who fall into this category.

The Scheme's focus is consistent with both the Health and Wellbeing Strategy and the Essex Success Regime.

Ultimately our vision is for prevention and early intervention to become embedded within our locality approach working within and alongside the communities they serve To be fully coordinated around the individual needing a solution bringing together all interventions designed to manage demand and prevent crisis; Thurrock's vision is to have the "right place, right time, right solution". Through utilising the opportunities created for pooling resources within the Better Care Fund, we are confident that this transformation can be accelerated.

Underpinning this Integrated care system is the work we are doing to link data sets across health and social care enabling us to see the whole patient pathway from start to finish. We plan to use this to better identify patients who are at risk but who may have been missed through other parts of the system.

The Scheme will work alongside our LAC offer. The LAC offer is open to everyone over the age of 18 who has the potential to place demand on a service. The LAC service has already had notable evidence of success across a range of areas of need including admission avoidance

The LAC offer is to be increased through 2016 with the appointment of two additional LACs made possible through a reconfiguration of generic floating support contracts across all service user groups.

The current support available through the LAC service is provided at 2 levels:

Level 1 support is the provision of information and/or limited support. There is no assessment or intake process. Anyone can contact the Local Area Coordinator for Level 1 support. Although information and advice is often given and no further support is needed at that time, a connection has been made that may be of benefit in the future.

Level 2 support is a longer term relationship supporting people (children and adults); who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty and require sustained assistance to build relationships, nurture control, choice and self-sufficiency, plan for the future, find practical solutions to problems etc.

We will be reviewing this through Scheme 1 to identify areas where we can further extend the LAC reach, and impact by exploring the more traditional "social prescription" approaches and seeing whether these offer additional opportunities and benefits to support this end.

One such approach is **The Social Prescription model**, which offers a service open to all patients, aged 18+ who present to their GP with issues that have a non-clinical underlying cause. These include housing, debt problems, loneliness and social isolation, similar issues to those currently supported by the LACs. These could however be expanded to include low-level mental health problems such as depression or anxiety, bereavement or support for victims of domestic violence gained through onward referral by local GPs into the extended LAC service in order to help:

- build self-resilience amongst patients in order to assist them to better manage their holistic health,
- reduce demand on primary care services, particularly from high intensity users,
- empower GPs with a practical mechanism to assist patients who present repeatedly with non-clinical issues.

The **voluntary sector grants** are crucial to a wide variety of community responses to support older age adults across Thurrock. The grants given by the Council and the CCG will be brought together to be managed by the Council for 2016-17. Supporting such organisation as Age UK, the Alzheimer's society and more locally our over 55's forum and Thurrock Asian association facilitate organisations to have a real presence in Thurrock representing people's views and supporting independence in the community.

BCF Scheme 2 Out of Hospital Community Integration

The problem of poor community coordination

People find the current system overwhelming complex and we aim to address this by developing locality (neighbourhood) based integrated community health and care teams which will be extended and enhanced to provide a wider skill mix to enable care closer to or at home whenever it is possible. The plan is to develop 'independent living centres' in each of the four localities to support extended primary care. We envisage that these centres will provide a range of enhanced health and social care services based on locality based needs assessments. Evidence from the King's Fund (2013 Making Integration Happen at Pace and Scale) makes it clear that integration is most effective where the target population is older people living with chronic conditions including mental ill health. The community investment will improve the support we offer to care homes by strengthening the skill mix and developing the capacity of the RRAS.

In Thurrock, we are developing a frailty model based on the principles of:

- care wrapped around the patient, whatever the setting of care and which is experienced by them as a single delivery system through multi-disciplinary, multi-organisational integrated care teams
- risk stratification to target the right services, at the right level, to the right people,

reducing inequalities by delivering the best possible outcome

- high quality pathways for people to maintain and maximise independence, to live in their own homes and where inappropriate admission to an acute hospital is seen as a system failure
- a sustainable and cost effective system across health and social care, supported by the right financial framework
- transformed services through a seamless and integrated approach to health and social care

The support provided out of hospital is vital to ensure that individuals are able to live at home for as long as possible. The model and planning assumptions regarding pathways of care and support are outlined in the Thurrock Market Position Statement which compliments and supports the For Thurrock in Thurrock Vision. Residential and nursing care is a key part of the system delivery and the quality of this support is to be encompassed with a model of enhancement for high quality delivery. A model is being developed to expand further the system already in place which provides for an increase in placement cost to providers who reach certain standards regarding quality and training for their staff teams in the provision of complex care.

The redesign of the delivery of domiciliary care is currently being developed creating a new Support to Live Well at home service which will be locality focused mirroring the Healthy Living Centre developments and will be inclusive of a range of options to support people at home including personal care, meal provision and assistive technology, together with links to voluntary organisation provision supporting prevention and early intervention and addressing isolation and loneliness.

CQUIN and joint working through the MDTs

To support this model our transformation plan For Thurrock in Thurrock includes significant investment in enhanced locality based Integrated Community Teams (ICTs) to build additional capacity and capability across our 4 localities.

This additional capacity and capability will help build the foundations of our integrated locality model albeit on a virtual basis until the new health living centre buildings are complete. We are working on the basis that the enhanced community solution will be in place by September 2016 and will be refined over time as the blueprint for each of the respective integrated Healthy Living Centres (Tilbury/Purfleet) are firmed up.

Community investment in 2016/17

To support people to remain independent, we will be redesigning the current continence service to reduce inequalities between patients in access to and outcomes from healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities. Many continence problems can be cured and certainly managed better. Improving continence care provision through integrated service improves quality of life and individualised care

The investment in the enhanced ICTs includes additional dementia nurses, community carers/support workers, additional Physiotherapy and Occupational

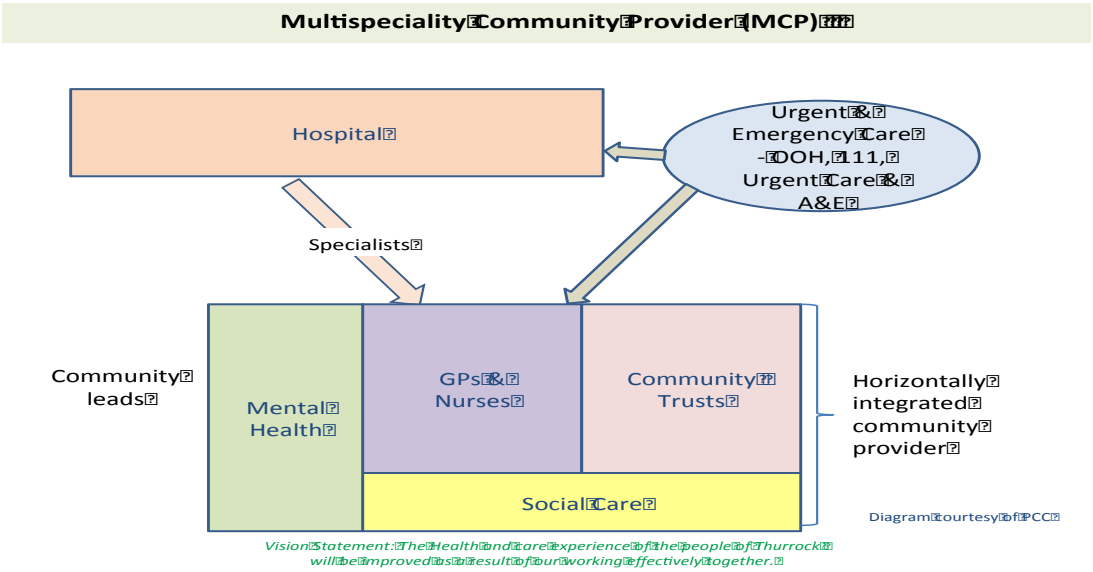
Therapy support to enhance MDTs, additional medical cover to facilitate 7 day admission and discharge, consultant psychiatrist/pharmacy input (and to care hones), and stronger links to Local Area Coordinators (LACs) and our community hubs through more defined 'social prescribing type' links between our practices and local voluntary and community organisations.

New models of Care

The NHS England's Five Year Forward View invites local systems to propose co-creating new models of care and organisation locally.
The document identifies (but does not limit us to) four possible models:

- Multispecialty community providers (MCPs), including a number of variants
- Integrated primary and acute care systems (PACS)
- Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms such as specialist franchises and management chains
- Models of enhanced health in care homes.

Our model of care, whilst not designed specifically as such, does predominantly match the makeup of a Multi-speciality Community Provider (MCP) and as such organically take us into the realms of the types of models currently being tested through the national vanguard sites.



Under this new care model outlined in the Five-Year Forward View, groups of practices would expand bringing in nurses and community health services, hospital specialists and others to provide integrated out of hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out of hospital settings.

Over time, these providers might take on delegated responsibility for managing capitated NHS budgets (or combined health and social care budgets) using a place based commissioning model to commission outcomes based services for their registered patients.

This model also offers the opportunity to reduce the number of contracts and thereby, the associated administration, monitoring and management costs incurred in keeping them on track.

Whilst we are still in the early stages of our journey to developing an MCP we recognise that an Accountable Care Partnership may offer the right vehicle to help us get there in a more collaborative way. Accountable Care Partnerships are new organisational forms, which integrate care around patients - and are accountable for the delivery and quality of that care. The partners include a range of providers working together to develop new ways of integrated working, governed by a form of partnership agreement. Within this model, each partner organisation retains their own identify, autonomy and governance, but agrees to work in partnership to achieve a desired outcome.

For us, the first step to progressing this approach would be to establish the basic legal framework for an ACP and to decide the detail of what sits within that framework. This would give time to build trust and to work through any problems, before developing into a full MCP.

Addressing workforce issues

Many providers in this locality are experiencing difficulties recruiting due to the close proximity with London where rates of pay are greater. The development of new models of care in primary care and the seven day working initiative is likely to exacerbate these recruitment concerns.

Whilst this is a national issue, in Thurrock we are aware that lack of adequate primary care workforce is more significant in Thurrock compared to the national picture.

Thurrock is also aware that there needs to be a system wide change in order to address the workforce need and that this shortfall cannot be met overnight. We have plans to address this both on a short term and a long term basis.

We expect having integrated healthy living centres with co-located services in a new and modern purpose built facility will attract newer work force (GPs and nurses). In addition the introduction of additional services from professionals such as acute hospital physicians, community nurses, physiotherapists and pharmacists will generate a wide resource of knowledge and experience from which to seek advice and enhance personal and practice development. It is believed that these opportunities will improve both recruitment and retention of newly qualified clinical staff who will wish to remain and develop their careers in Thurrock.

Whilst this remains a long term strategy (3-5 years), currently we are working with our local acute hospital on cross working of clinicians in the hospital and primary care setting to help recruit new breed of clinicians and retain our existing workforce locally.

As a system we are part of the EPIC work force development drive and working with

our stakeholders on the Essex wide foot print to future proof general practice in Essex and promote Essex as the first career location for GPs, Nurses and other health professionals. Thurrock actively promotes all the various Education and training courses organised by EPIC to ensure we develop and retain our existing pool of clinicians.

Working in collaboration with NHS England we intend to procure future primary care providers that are either a training practice or working towards achieving training status, helping qualified doctors complete the final stages of their GP training and providing on-going training and development for doctors, nurse practitioners and the wider clinical team.

Carers Grant

A range of services are offered to carers in Thurrock funded through the carers grant, and by the Council and CCG. This includes: a commissioned Advice Information and Support Service; short breaks delivered within residential care homes; day services to individuals to support carers in their caring role and carer's services to offer short breaks within the carers centre or through a sitting service at home. Carers also are entitled under the Care Act to an assessment of needs separate from the individual they support and these are delivered through social care.

BCF Scheme 3 Intermediate Care

Our vision is to improve the current intermediate care pathways in Thurrock. Thurrock adults who do not need to be in a hospital bed, but are not fit to be discharged home (intermediate care) can find themselves in any one of six locations across south west Essex. Thurrock residents can be discharged from hospital to intermediate care beds which can be a long way from home. We aim to simplify the inpatient options so that more people can be seen closer to home. Where a bed is not the best solution in helping to maintain independence and wellness, patients will be given support, by neighbourhood (locality based) integrated health and care community teams. These teams will aim to provide the right care, in the right place, at the right time, every time. This new care model will be facilitated by existing community health and care teams which will be developed and enhanced to increase and capability to provide a wider skill mix to enable the ethos and delivery of care closer to or at home whenever it is clinically possible.

The intermediate care working group have been meeting for the last 12 months or so to plan this Scheme. The working group includes clinicians from health and social care. The Scheme is built upon an audit of intermediate care which found that many people did not require being in an inpatient bed but there were gaps in community provision to provide a more appropriate alternative. We have engaged with the public on the transformation vision via our engagement plan led by Healthwatch.

The first phase of the implementation of the intermediate care review has already been completed. We have finalised the community investment required. This is known as our 'community solution'. The investments include:

- Crisis Dementia Nurses linked to RRAS - Extra resource in this team will ensure carers and people with Dementia get a timely response to enable them to remain in community.
  To give intensive support to these patients in the community and to support staff in care homes in managing challenging behaviour.
- Community carers/support workers - RRAS teams are able to assess but if care is required to support people through crisis this is commissioned. Having carers (who also understand dementia and challenging behaviour) will mean flexible care can be provided that will prevent admission/admission and timely discharge. To provide additional specialist mental health support to these patients in the community. To support carers to facilitate patients staying in their own homes for longer.
- Social worker to cover acute and community beds - In order for social care assessment to meet increased hours of operation, additional person will be required. Multi agency working in RRAS.
- JRT Additional carers - (Thurrock domiciliary based)". As more people will require care in the community and not in IC bed the demand on JRT will increase.
- Enhanced MDT (additional Physiotherapists and Occupational Therapists) - Currently there is one Physiotherapist and one Occupational Therapist in the team. In order for the team to provide 7 day cover and in reach at weekends to IC remaining beds this needs to be increased
- 7 day medical cover for Intermediate care ward - Medical session per day on AFC (Intermediate care wards) to facilitate 7 day discharge and admission.
- Consultant Psychiatrist /pharmacy input extra sessions In order for rapid access for Consultant appointments for medication review.
- Collins house - In order to provide increased care beds to replace IC beds it is estimated 5 additional beds are required (73 people average 21 nights)
- Care Home support - pharmacy geriatrician 2 support workers to support care/res homes - to sit under RRAS
- Falls prevention service

The second first phase of the transformation programme will be to recruit the new capacity. By the end of quarter 1 we expect to have the majority of the new posts in place. At the same time we will finalise our changes to the new pathways. This includes developing a ‘discharge to assess’ pathway so effective rehabilitation and reablement take place before CHC assessments, and that any long term support is put in place in a person centred way to make sure each individual has as much choice and control as possible.

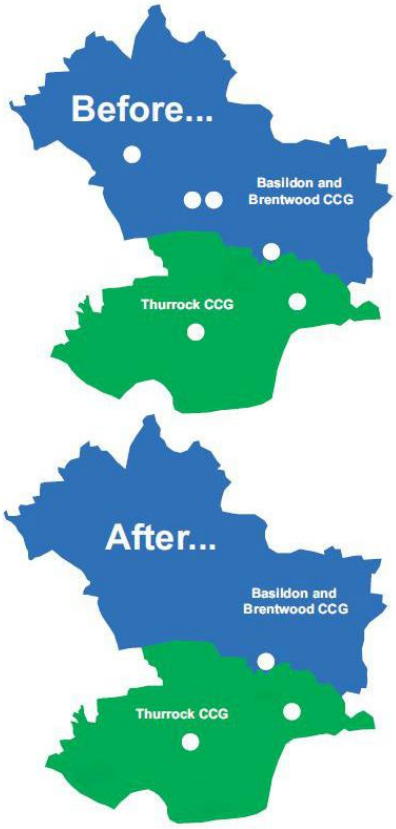
The third phase will be to begin to change the pathways. This will include testing the new community capacity and its ability to manage the new cohorts of patients without inpatient care. It will also mean changing the inpatient pathways so that more Thurrock people are seen within the Thurrock locality.

The final phase will be to assess the system impact of the changes to review the intermediate care capacity requirements and agree with partners the best system configuration.

Map of south west Essex

Before – top image
Thurrock adults who do not need to be in a hospital bed, but are not fit to be discharged home (intermediate care) can find themselves in any one of six locations across south west Essex.

After – lower image
The first phase of the transformation programme will involve moving Thurrock intermediate care provision, which is currently spread across six locations in south west Essex, to provide it on a Thurrock-only basis *For Thurrock in Thurrock*, making the best use of existing Thurrock resources.



This new care model will be facilitated by existing community health and care teams which will be developed and enhanced to increase capacity and capability to provide a wider skill mix to enable the ethos and delivery of care closer to or at home whenever clinically possible.

Our vision is based on shifting patient flows into appropriate beds where a bed is needed, and into the right environment to meet each patient's needs (a key factor of good quality care for people with dementia or challenging behaviour). Where a bed is not the best solution in helping to maintain independence and wellness, patients will be given support, by neighbourhood (locality based) integrated health and care community teams. These teams will provide the right care, in the right place, at the right time, every time.

BCF Scheme 4 Disabled Facilities Grant

Scheme Overview
The Disabled Facilities Grant (DFGs) helps to pay for major adaptations for owner occupiers, private tenants or housing association tenants.

Mandatory DFGs are available from local authorities, subject to a means test, for

essential adaptations to give disabled people better freedom of movement into and around their homes and to give access to essential facilities within the home.

The Council's Private Housing & Adaptation Service is working closely with Adult Social Care, Health and Public Health to improve independence at home. DFGs are delivered in partnership with our local home improvement agency the Papworth Trust.

In line with Department of Health guidance all funding pooled through the Better Care Fund – including DFG funding – will need to be allocated on the basis of plans that are jointly developed and agreed. Through this local planning process, some areas may agree to invest some of this funding in broader strategic capital projects. However, this is a local decision, to be considered as part of the BCF planning process.

The Disabled Facilities Grant for 2016-17 is £899,098.

THURROCK'S AGREED APPROACH TO FINANCIAL RISK SHARING AND CONTINGENCY

The risk of acute over-performance in Thurrock has been minimised as we are negotiating a block contract with our main provider under the remit of the Essex Success Regime. Therefore the need for a Risk Reserve to cover additional non-elective activity, should Schemes fail to deliver, is avoided.
We are using the proportion of the fund previously set aside for the payment for performance Scheme (£722k) to invest in initiatives that further streamline patient flows – including transfers of care. This will minimise and manage the risk of DTOCs.

NATIONAL CONDITIONS

1. Plans to be jointly agreed

The Plan is aligned with and supports the delivery of Thurrock's refreshed Health and Wellbeing Strategy. The Strategy has been developed through discussions with all key partners – including providers of health and care services, and has been agreed by the Health and Wellbeing Board. Thurrock's Health and Wellbeing Board includes NHS providers as full Board members.

The Plan builds on the one agreed in 2015-16 and has been updated to reflect progress made and next steps. This includes plans to develop a greater level of out-of-hospital community integration (Scheme 2) and also a revised intermediate care Scheme (Scheme 3). Providers have been involved in the development of the initiatives that form those refreshed Schemes.

This Plan also incorporates action being taken by Thurrock Adult Social Care to develop the care market – as set out within the Council's Market Position Statement. As the Council develops different initiatives designed to grow the care market and to provide alternatives to existing services, providers are being engaged – as they were with the development of the Market Position Statement. For example, market testing events are being held concerning the development of the Shared Lives initiative and the development of plans for how Domiciliary Care will be delivered across the Borough.

As stated earlier in the Plan, a number of risks are managed via the introduction of the Essex Success Regime (ESR). This includes the development of a block contract for the acute trust which means the risk of over-performance for 2016-17 is being managed.

Thurrock Council is a unitary authority and as such its responsibilities include Housing. The Director responsible for Adult Social Care is also responsible for Housing, and therefore appropriate engagement on DFGs has taken place in the development of this plan.

2. Maintain the provision of social care services

The 2015-16 Plan set out our approach to protecting social care services and how the BCF would assist. This included:

- Ability to reduce overall demand – e.g. responding to increased demographic pressures;
- Strengthening social care provision – reviewing existing services to ensure that they are value for money and person-centres – re-commissioning and re-modelling where required (ASC Transformation Plan);
- Reviewing the way we commission and procure services; and
- Shifting resource to ensure that it has the best possible impact.

We encompassed all of the above in an Adult Social Care Transformation Plan.

The Better Care Fund Plan for 2015-16 identified £2,529m for the purposes of protecting adult social care services – in addition to the £522k Care Act monies.

The Better Care Fund Plan further aided the protection of social care through its ambition to shift the health and care system towards prevention and early intervention – aiming to keep people well rather than focusing on treating them when they became unwell.

Our 2016-17 Plan continues to build on this approach.

For 2016-17, we have agreed that the BCF's contribution towards maintaining the provision of social care services will remain the same (amount to be confirmed by final submission). As already documented, the Plan will further contribute toward maintaining social care services by focusing on prevention and early identification.

Adult Social Care continues to face a number of challenges. This includes the introduction of the National Living Wage (NLW). We are anticipating that the NLW will add in excess of a £1m cost pressure to the Adult Social Care budget. This is in addition to year-on-year demographic pressures. 2015-16 has also seen a number of domiciliary care providers being unable to continue to provide a service mostly due to cost pressures. This has seen the Council take a significant amount of domiciliary care hours back in-house as a contingency measure. Work is being carried out to develop a different model for delivering domiciliary care in the future.

Whilst the Council has agreed to a 2% Council Tax precept for Adult Social Care in 2016-17, this will only help to offset some of the pressure faced by the service. The monies agreed as part of the Better Care Fund Plan have therefore been essential to protecting the service. Initiatives such as the review of and re-negotiation of high cost placements; market management and development; success at keeping more people at home; and development of early identification and prevention schemes have made an impact on reducing but not negating demographic pressures.

3. Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions and support timely discharge

Background 2015-16

We have worked with providers across the south west Essex health and social care economy to map the provision of services across 7 days. The work has been led by the System Resilience Group (SRG). In addition the CCG applied a local CQUIN to the main acute provider, Basildon and Thurrock University Hospital for 2015-16, focusing on 5 of the 10 clinical standards:

Standard 2 – All emergency admissions must be seen, and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of admission.

Services in scope: Acute Medical Unit; Surgical Referrals Unit; Paediatric Unit
Results: steady improvement over the year

Standard 5 – Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology.

Services in Scope: X-ray; Ultrasound; CT scanning; MRI – provided within 24 hours of request.

Results: Steady improvement in this standard has been seen across all modalities.

Standard 6- Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols

Service in Scope: Cardiology – improvement in time from PCI test request to provision of test, based on agreed trajectories.

Results: delivery against improvement trajectory

Standard 8 - All patients on the AMU, SRU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily*including all acutely ill patients directly transferred, or others who deteriorate. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Results: significant improvement over the year

Standard 9- Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Results:

- South West Essex 7-day service mapping agreed by SRG.
- Basildon Hospital has made available contact numbers for primary and community care colleagues to discuss patient care in advance of sending a patient to A&E.
- An evaluation of the above approach is planned for Q4.

Primary Care Seven Day Access

In 2015-16 we introduced 7 day access to primary care. Thurrock has 4 locality hubs where patients are able to see a GP or practice nurse seven days a week.

Action Plan 2016-17

Enhancing 7 day a week services is a key priority for the Thurrock system. The South West Essex System Resilience Group has overall oversight of 7-day service mapping. The Thurrock sub economy has identified a number of key priority developments to support seven day a week access.
Quarter 1

These include:

- Enhanced consultant cover to the intermediate care beds. This will enable 7 day a week discharges and improve patient flow.
- Enhanced therapist (occupational therapist and physiotherapist) cover to support the intermediate care beds. This will enable the rehabilitation to continue 7 day a week and reduce intermediate care length of stays. Again this will improve patient flows from BTUH.
- Enhancing mental health access by delivering IAPT services from the primary care hubs 7 days a week. We are focussed on parity of esteem and providing 7 day services in both mental and physical health care.
- Developing pathways from the 111 service to the primary care hubs to improve urgent care pathways. This will provide the 111 service with an alternative 7 day a week primary care based pathway for patients who may have ended up in A&E.
- Extended the operating hours of the RRAS, including more hours over the weekend

Quarter 2

Once we have implemented the above priority initiatives we will refresh the 7 day service mapping. This will enable us to develop a Thurrock focussed comprehensive plan for 7 day a week services. This will identify the next steps to further extend community, mental health, social care and primary care access. We expect to complete the action plan by Q2. This plan will link with the work being undertaken on the DTOC plan.

4. Better data sharing between health and social care, based on the NHS number

Our Joint Reablement Team is a multi-disciplinary Team and a prime example of the right behaviours and leadership being adopted and demonstrated. Staff are able to access relevant data in the social care database and regular weekly multi-disciplinary team meetings are held, whereby cases are openly discussed and decisions re next steps are jointly agreed.

Sharing of data is enabled and supported from a corporate perspective. In October 15 our Information Management Team updated the data protection statement, which in turn was included in our Sharing Information Form locally– this further clarifies our use of data (Fair Processing) and supports the lawful and appropriate sharing of data to support better care. We also have a data sharing policy which allows the electronic sending of confidential data outside of the Council's network via government connect (GC) e-mail or Leapfile should GC e-mail not be available. In relation to data security and governance we have recently successfully submitted the

Information Governance Tool Kit to cover the 2016-17 period; we achieved 92%. The tool kit also includes the Public Services Network (PSN) Certificate of Compliance.

We undertake regular data matching to identify the NHS numbers of individuals we support (where this has not already been captured through the front end process). Currently 96% of all those who received a service in year have an NHS number recorded in our database. This data matching exercise is undertaken on a regular basis with non-matches being followed up. This puts us in a strong position to progress the integrated data set utilising the NHS number as the consistent identifier.

Our data system supports the use of Application Programming Interfaces (APIs) and we already have one in place to support transfer of information from our on-line screening assessment tool to our social care database (LAS); the security requirement being met through the use of a 'Secure Sockets Layer (SSL)' connection; as and when other data systems are identified for integration we will be in a position to utilise APIs further.

At the moment our main focus is progressing the integrated data set; our information sharing and use of NHS number provides a strong foundation for this. Our aim, once we are able to access and analyse the data, is to identify key areas for further integration work, including, where appropriate, data systems to support this.

5. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

The problem we face is that people with frailty are currently either not reliably identified or, if identified, do not always receive a well-planned, coordinated package of care to support them to maintain an optimum level of wellbeing and independence.

In 2015/16 we piloted the use of the Electronic Frailty Index in 4 GP practices across South West Essex. The results from the pilot have been encouraging. The eFI has helped practices to identify patients who are already know to them as being frail but also patients who were less well known to them and potentially requiring additional support. The eFI has been developed by the University of Leeds, the Care of the Elderly team at Bradford Teaching Hospitals NHS Trust, the National Clinical Director for Frail Elderly at NHS England and TPP ResearchOne. The tool relies upon routinely-collected data from General Practice. It has been derived and validated on the ResearchOne database and is currently undergoing external validation on the THIN research database.

The focus for 2016/17 is to roll out the eFI tool to all practices in Thurrock. This will enable us to identify the top 2% of vulnerable patients. Thurrock providers have agreed to roll out the use of the Electronic Frailty Index (eFI) in 2015/16 as part of a locally defined commissioning for Quality and Innovation (CQUIN) scheme. This scheme will provide the opportunity to deliver well planned packages of care by identifying clients through the eFI tool, which provides a solution for a potential

reconciliation of avoidable admission to hospital and to optimise patient experience and quality of life.

The roll out of the eFI tool will support the mobilisation of the recent reconfiguration of NELFT community services. The new Integrated Care Director for Thurrock (NELFT and Thurrock Council) is ensuring that the plans are fully integrated between health and social care. This senior leadership is helping to ensure that health and social care are fully aligned. The NELFT reconfiguration has focussed on the development of the care coordinator role and enhanced integrated teams. Both health and social care are fully signed up to further extending the MDT approach around primary care. The Joint Reablement Team and Rapid Response and Assessment Service continue to show how integrated teams support joint working and joint packages of care. There is also good joint working within Continuing Health Care where joint funding applies.

We have agreed a number of key milestones in quarter 1. These are:

- To develop an operational policy for care co-ordination, multi-disciplinary working, named accountable officer and care planning.
- To roll out the eFI tool across Thurrock
- Work with NHS 111 to update and maintain an updated NHS 111 Directory of Service
- Redesign community geriatrician role and escalation/crisis plans

Improving dementia services are a key focus for 2016/17. We will improve the integration of health and social care dementia services by including the dementia nurses within the multi-disciplinary teams within the Rapid Response and Assessment Service. We are using an element of the Better Care Fund that would have been put aside for payment for performance in 2015-16, to strengthen this service. £110,000 of investment has been agreed for the development of extra resource within the RRAS to ensure that carers and people with Dementia get the timely response they need and are enabled to remain in the community. This will include supporting the reduction of 24 intermediate care beds which are outside the Borough and form part of Thurrock's intermediate care review. Individuals with dementia who would have previously been in an intermediate care bed, will instead be provided with intensive support in the community. Staff in care homes will also be provided with support to manage challenging behaviour.

In 2016/17 we will be working towards our short term goals of increasing integrated working (as described above) and also for our longer term ambitions to develop a MCP model. Our transformation plans are ambitious because they are working across all tiers of health and social care. Our ultimate ambition is that we will have a MCP model which will integrate out of hospital care for our 4 localities (neighbourhoods). These will integrate the service delivery between primary care, community services, mental health, social care and out of hospital provision.

6 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The Thurrock health and care system is embarking on an ambitious piece of work to align its vision for older people (BCF) with the primary care transformation programme already underway. The focus is on improving the quality and accessibility of service for the local population based on need (identified through health need, social need and deprivation analysis provided by Public Health), with a view to providing a more holistic model of locality based care closer to home for the local population.

The scope of this programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services *"For Thurrock in Thurrock"*. This will be refined as the programme gains pace in order to align with the context of the Essex Success Regime (ESR) to ensure a comprehensive plan for Essex sustainability going forward.

The current system is built on a "reablement" ethos across all health and care services where the emphasis of all providers is to support the service user to gain or maintain their optimal potential level of independence. However this is often not achieved.

Successful delivery of our vision will therefore require a range of out of hospital services which flex during changes in demand e.g. winter/summer, are based around local patient need as opposed to pre-determined service models, and prioritise domiciliary care packages over bed based care (but offer bed based care where required).

Our new model of care will be locality (neighbourhood) based and will be delivered through MDTs by fully integrated health and social care teams (drawing on the example of the Joint Reablement Team which is a joint Council and NELFT service), delivering coordinated care closer to or at home.

The locality (neighbourhood) based teams will align with the existing health hubs taking a virtual ward approach to providing care closer to or at home within each locality (neighbourhood), and with new developments in primary care estate as they emerge.

The transformation plan aligns with the local Health and Wellbeing Strategy and builds on the aims of the Better Care Fund (BCF) as a new model of care emerges from the vision and local ambitions through the course of the transformation programme in line with the NHS England document the "Five Year Forward View". Providers have been involved in the development of these plans – including via the Health and Wellbeing Board which key NHS providers sit on, and also specific meetings with providers.

We are committed to providing the best services we can for our population to meet their current and future needs, and recognise that we will only know if we are doing this if we ask.

We are fortunate in that our local Health and Social Care Engagement Group which meets monthly includes members of Thurrock Council, Thurrock Coalition, the CCG, Healthwatch and Thurrock CVS and we have been using this forum as a sounding

board during the developing phase of the vision to ensure we continue to get the message right, and communicate it in the best way possible.

We are also fortunate in having the support of a Patient Champion for the programme.

In addition, our Commissioning Reference Group (CRG) is providing supportive challenge as a critical friend to help guide us on our journey. The CRG is an advisory body to the CCG and helps us to fulfil our statutory duty to engage with and involve the public and patients in healthcare decisions. The chair of Thurrock CRG also serves on Thurrock CCG's Governing Body as a Lay Member (Patient and Public Involvement) and sits on the Thurrock Health and Wellbeing Board.

We have already been working closely with our system partners on a range of service developments and are committed to continue to work with them as we embark on our transformational journey.

The first phase of the transformation programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services ***"For Thurrock in Thurrock".*** To this end, steps are already being taken to further scope the development of the out of hospital adult care model by joint working between the CCG and Council and Health provider colleagues to identify workforce needs with a view to jointly commissioning fully integrated locality based health and care teams.

The locality based health and care teams will need to be mobilised before implementation of the vision can formally commence and we are working closely with our acute, community and mental health providers to map and gap what we currently have and what workforce capacity, skills and capability we will need for the future.

As outlined in the background above, the scope of this programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services *"For Thurrock in Thurrock"*. This will be refined as the programme gains pace in order to align with the context of the Essex Success Regime (ESR) to ensure a comprehensive plan for Essex sustainability going forward.

Thurrock's Better Care Fund aligns with the direction of travel set out within the recently refreshed Health and Wellbeing Strategy, and also the CCG's operating plan which is the first year of the new five year Sustainability and Transformation Plan (STP). As Thurrock is part of the Essex Success Regime, a separate STP has not been requires as work from the Essex Success Regime will also act as the area's STP. Both the Health and Wellbeing Strategy and Essex Success Regime have full provider involvement. Providers have already indicated that key actions from the Health and Wellbeing Strategy should be built in to provider contracts, and that the Strategy will be taken to provider Boards.

7 Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Thurrock has established a good track record in the reduction of non-elective admissions, having achieved a 3.2% reduction in 2015-16 (January – December 2015). Furthermore, risk of acute over-performance has been minimised because we are negotiating a block contract with our main provider under the remit of the Essex Success Regime. Therefore the need for a Risk Reserve to cover additional non-elective activity, should Schemes fail to deliver, is avoided.

We are therefore able to use the full share of the £1bn to invest in out of hospital services, and this has enabled us to expand the Schemes contained within the 2015-16 Plan.

This includes:

- Investment in dementia nurses linked to the successful Rapid Response and Assessment Service (RRAS);
- Investment in additional community carers and support workers to provide flexible care linked to the RRAS and with a focus on dementia;
- Investment in an enhanced Multi-Disciplinary Team – ensuring it can provide seven-day cover; and
- Investment in additional consultant psychiatrist and pharmacy sessions to ensure rapid access to medication review.

8 Agreement on local action plan to reduce delayed transfers of care (DTOC)

System resilience is key to our plan and the following initiatives will add capacity and capability to facilitate timely discharge. Dementia will be addressed through support to residential care homes to maintain people within the home, and support within the community for people to remain in their own homes. Primary care will screen patients that have mild cognitive impairment. This will be delivered through increasing the capacity of the dementia nursing service across Thurrock.

One of the work streams within the SRG is around care homes. We have completed a deep dive exercise, using the information that was gathered has enabled us to focus on the most problematic areas first. In Thurrock the CCG and the Council are working jointly and to facilitate earlier discharge with initiatives including:

- Jointly commissioning 5 additional beds in the Council's residential care home
- Agreeing a pathway for discharge to assess utilising beds within contracts already existing
- Supporting care homes out of hours to facilitate admission
- In July 2016 there will be 70 specialist dementia NHS care home beds available for South Essex
- HIDS with support patient flow
- The Voluntary sector will be engaged through a pilot for a living well at home service and to increase befriending and community responses that can support discharge.

To prevent admissions is a key part of the overall pathway. We will develop further the current RRAS single point of contact, and support care homes to prevent admission through falls prevention, Pharmacy support, Crisis Support, Geriatrician availability and Mental Health and Physical Health nurses who will deliver education to the workforce to include IV fluids and to use on going risk stratification.

NATIONAL METRICS

1 Non-elective admissions

Thurrock has established a good track record in the reduction of non-elective admissions – having achieved a 3.2% reduction in 2015-16 (January – December). Furthermore, risk of acute over-performance has been minimised because we are negotiating a block contract with our main provider under the remit of the Essex Success Regime.

In 2016-17 the Health and Wellbeing Board has set an ambitious target to maintain the reduction achieved in 2016-17 and to strive for a full 3.5% reduction in non elective hospital admissions in 2016-17 (against performance levels in 2014-15).

2 Admissions to residential and care homes

Our target for 2016-17 is 613.6 long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes/ per 100,000 population. It is important to note that the definition of this indicator has changed.

Thurrock performs well against this indicator and believes its target for 2016-17 to be ambitious.

The integrated offer as part of **BCF Scheme 2 - Out of Hospital Community Integration** will continue to use risk stratification to target people who are most at risk of admission to hospital or a care home, providing solutions which will promote health and well-being, and ensure unplanned interventions are avoided. The Scheme generates efficiencies by reducing duplication, by improving service user and patient experience and satisfaction, and by providing solutions closer to home.

3 Effectiveness of reablement

Our target for 2016-17 is to maintain our current performance – 90.9% of older people (65 and over) who are still at home 91 days after discharged from hospital into reablement/rehabilitation services.

Thurrock already performs well against this indicator – it is the best performing council in the Eastern Region. The target remains ambitious.

BCF Scheme 3 - Intermediate Care in particular will support the achievement of this indicator. The Scheme supports the additional investment in intermediate care and is designed to both ensure people are kept out of hospital once discharged, and to prevent unnecessary admissions. A proportion of the Fund previously used for the payment for performance Scheme, and now apportioned to out-of-hospital commissioned services will be used for this purpose.

4 Delayed transfers of care

Thurrock has low DTOC figures averaging 12 a week, which is comparable regionally to similar Council/CCG areas. The agreed target between the CCG and Council is to maintain this figure and work consistently to reduce it over 2016-17. The patient flow will be the key focus and initiatives are in place to prevent the admission but also when admission occurs to facilitate effective and timely discharge.

The practical close working relationship between the CCG and Council at frontline level gives daily and weekly monitoring to support timely discharge. The plan therefore is to add capacity to the community through the intermediate care review releasing resources that will deliver discharge to assess beds, and an increased JRT capability. Further, the retendering of Domiciliary Support with new contracts in place from the 1st April 2017 will provide an holistic living well at home service delivered in the heart of local communities