Better Care Together Thurrock: The Case for Further Change

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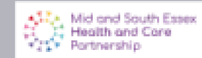
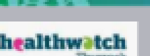
Corporate Director of Adults Housing and Health

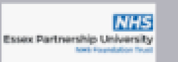
17 May 2022

Better Care Together Thurrock

The Case for Further Change
2022-20



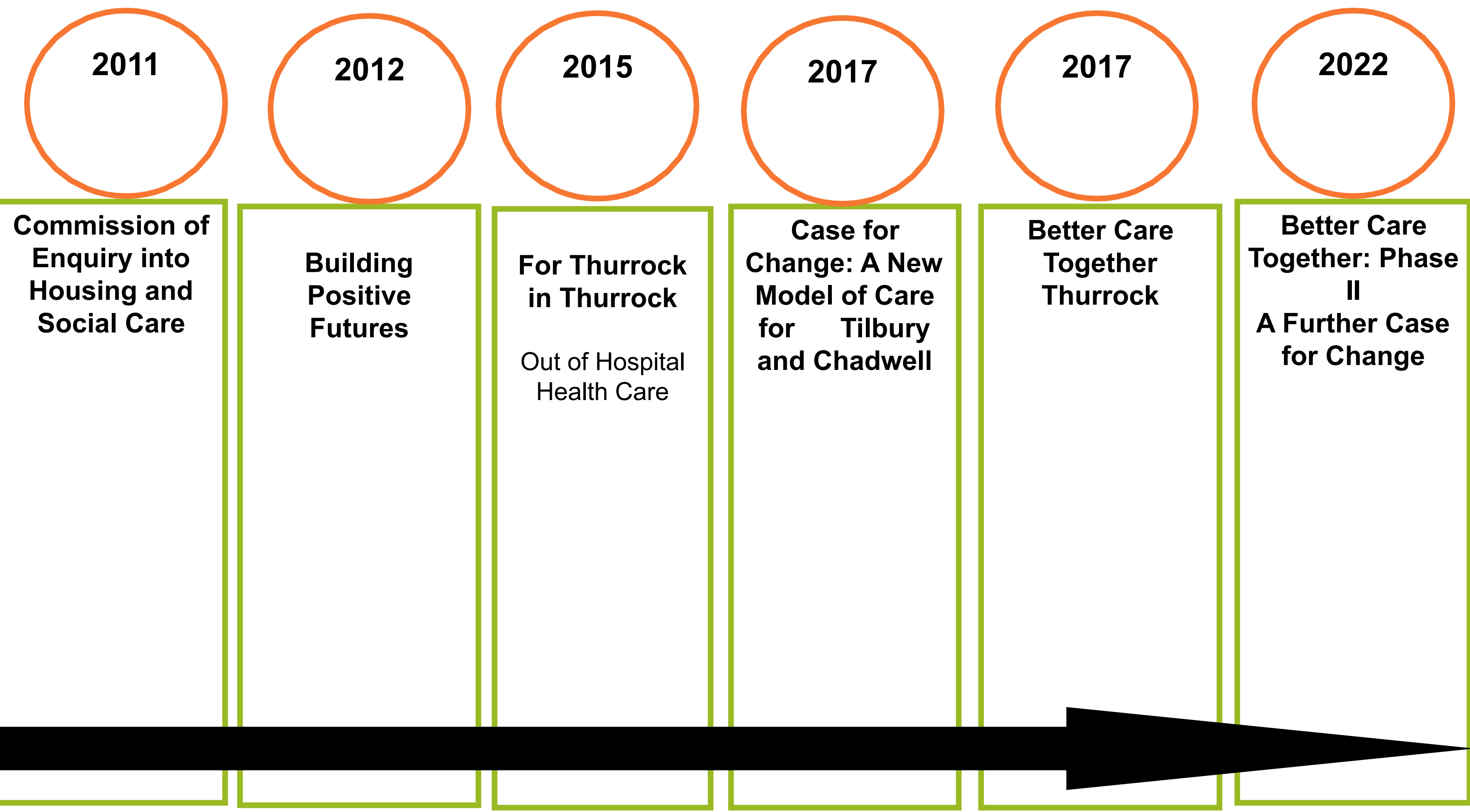




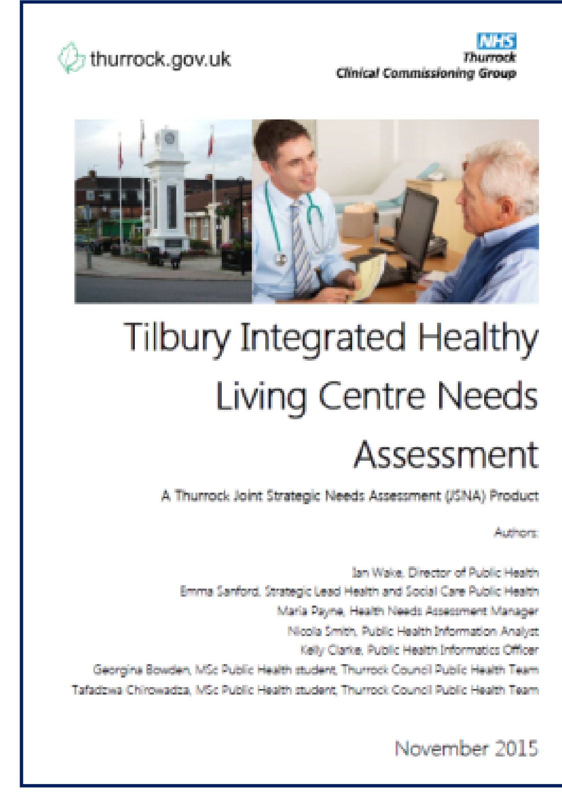
Overview

1. Purpose
2. Vision, Values and Principles
3. Overall care model
4. Individual elements
5. Next steps

THURROCK TRANSFORMATION – A JOURNEY THROUGH TIME….



A whole system's understanding, a whole system's approach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NHS Thurrock Clinical Commissioning Group

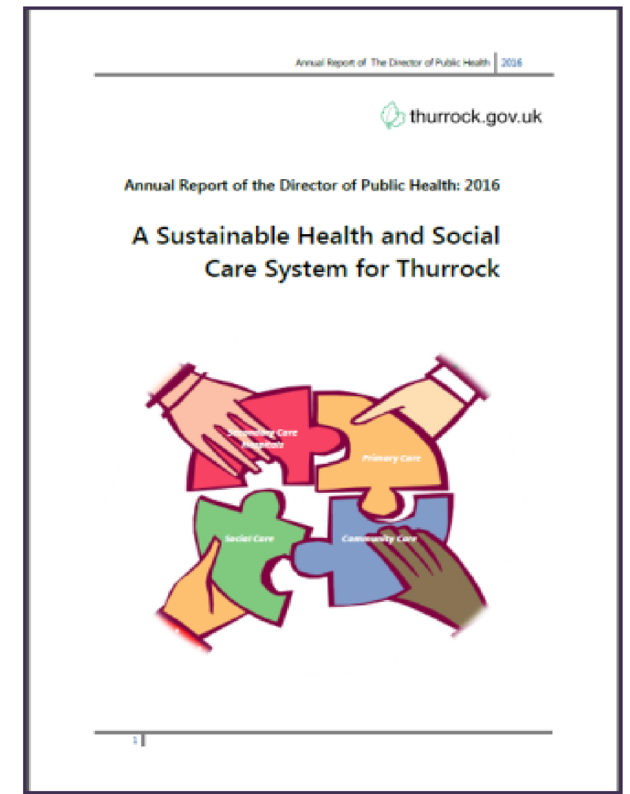
Tilbury Integrated Healthy Living Centre Needs Assessment

A Thurrock Joint Strategic Needs Assessment (JSNA) Product

Authors:

Ian Wake, Director of Public Health
Emma Sanford, Strategic Lead Health and Social Care Public Health
Maria Payne, Health Needs Assessment Manager
Nicola Smith, Public Health Information Analyst
Kelly Clarke, Public Health Informatics Officer
Georgina Bowden, MSc Public Health student, Thurrock Council Public Health Team
Tafadzwa Chirowadza, MSc Public Health student, Thurrock Council Public Health Team

November 2015


Annual Report of The Director of Public Health | 2016

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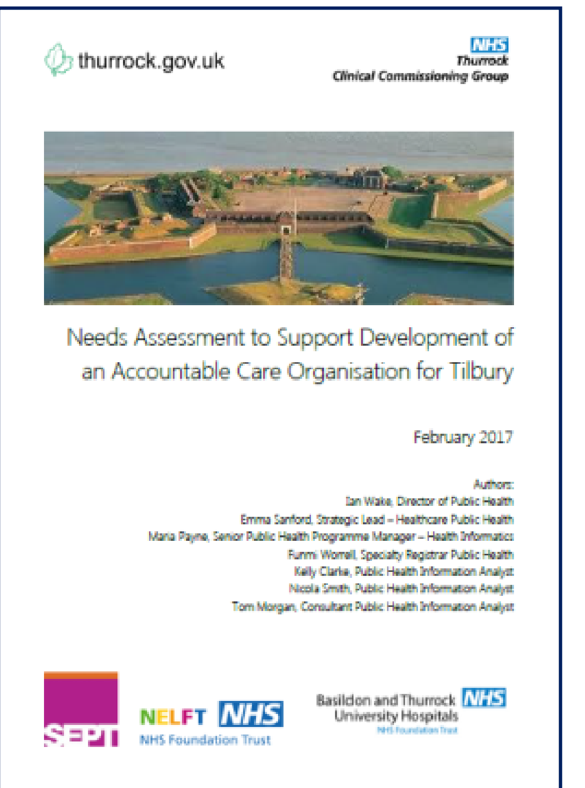
Annual Report of the Director of Public Health: 2016

A Sustainable Health and Social Care System for Thurrock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NHS Thurrock Clinical Commissioning Group

Needs Assessment to Support Development of an Accountable Care Organisation for Tilbury

February 2017

Authors:

Ian Wake, Director of Public Health
Emma Sanford, Strategic Lead – Healthcare Public Health
Maria Payne, Senior Public Health Programme Manager – Health Informatics
Funmi Worrell, Specialty Registrar Public Health
Kelly Clarke, Public Health Information Analyst
Nicola Smith, Public Health Information Analyst
Tom Morgan, Consultant Public Health Information Analyst

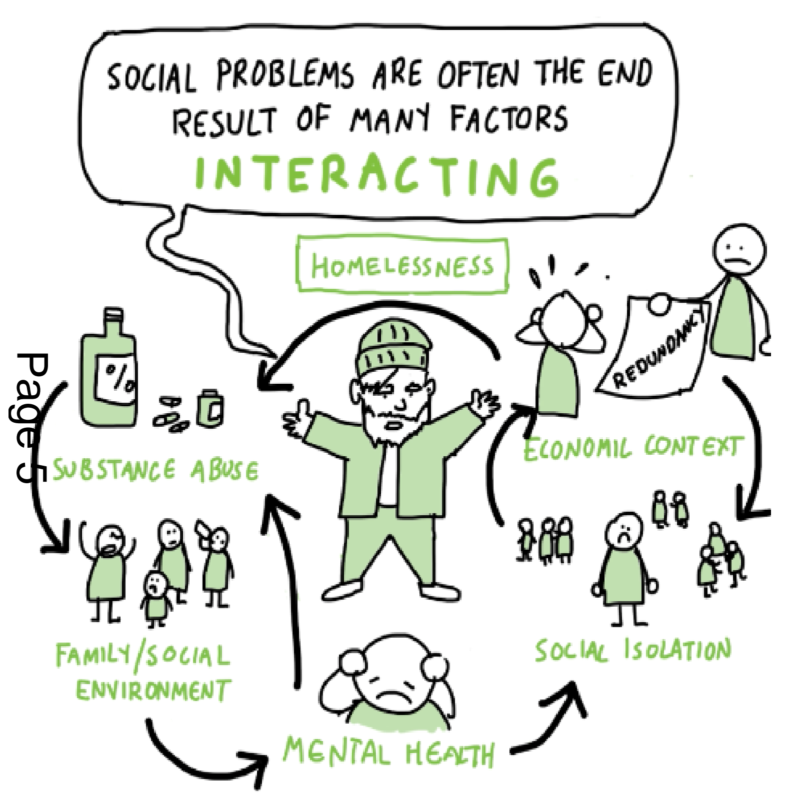
SEPT

NELFT NHS
NHS Foundation Trust

Basildon and Thurrock University Hospitals NHS

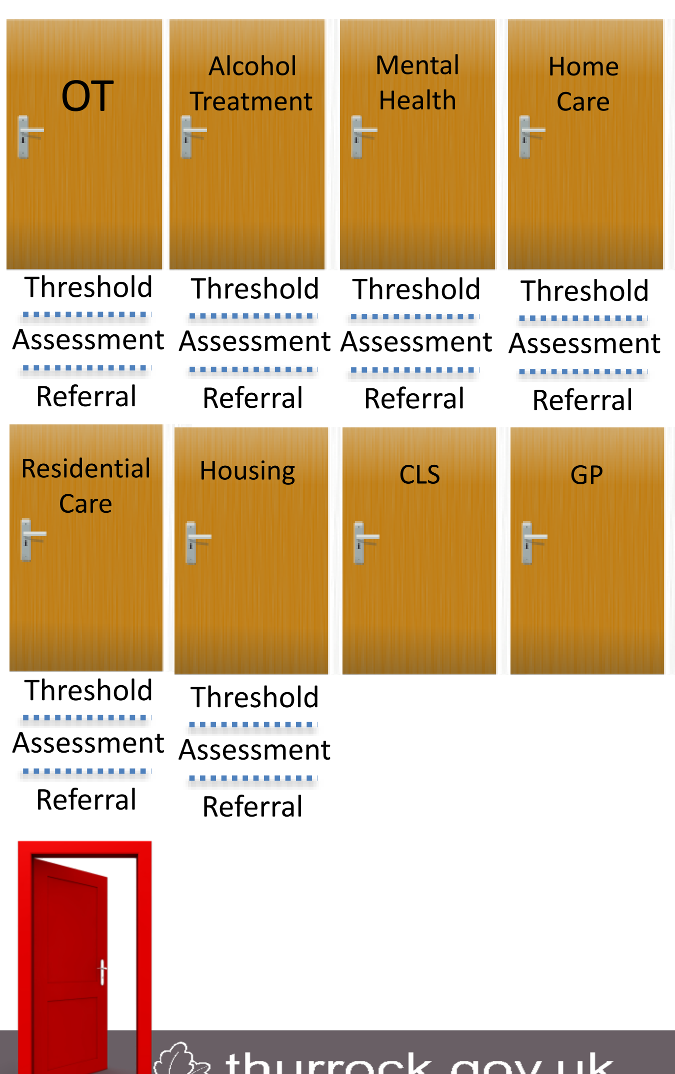
https://www.thurrock.gov.uk/healthy-living/health-statistics-and-information

The ‘WHY’: Owen, 60 year old widower, living alone in a one bedroomed council flat in Chadwell



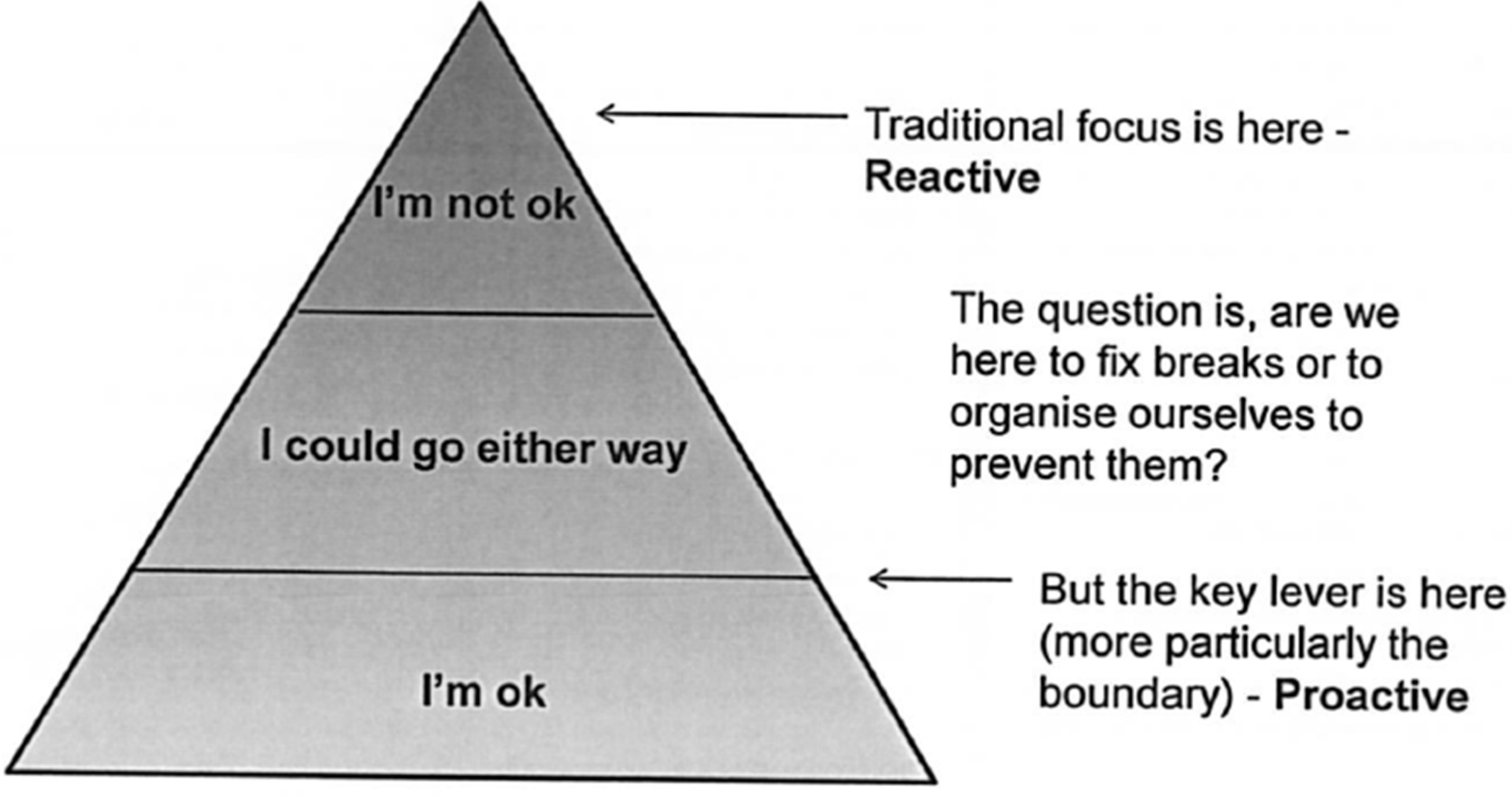
The ‘Need Paradox’

Total Cost ?£5000



Ambulance & A&E

The Vanguard Method – Beyond Command and Control



Current Service Landscape

Majority of Functions Delivered by Separate Teams with Different Thresholds and Referral Criteria

South West Essex or MSE Level

Speech and Language Team
Virtual Ward
Podiatry
Stroke Team
Community Respiratory Team
Dementia Support Team
Heart Failure Team
Parkinson's Team
Dietetics Team
Tissue Viability Team
Community Diabetes Team

Thurrock Borough Wide

Drug & Alcohol Treatment
Complex Care (ASC) Team
Occupational Therapy Team
Housing Operations (Tenancy & Estates Mgt)
Older Adults (NHS) Team
Homelessness Team
Integrated Care Team
ASC Reviews Team
ASC Mental Health Team
ASC OT Team
UCRT
Private Sector Housing Team

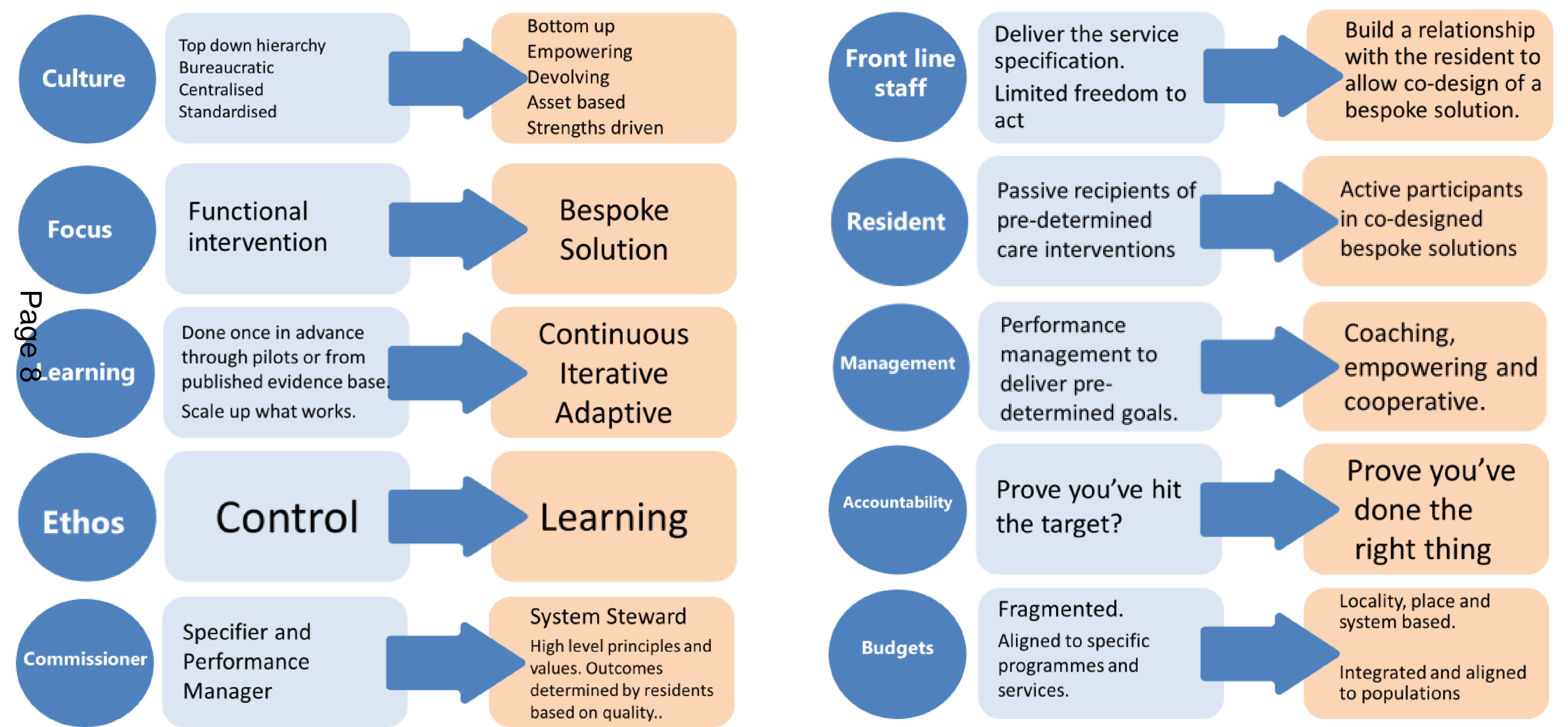
Wider Locality

IMC (Corringham)
Local Area Coordinators
Community Builders
Community Led Support Team
Community Hub
Micro-Enterprises
Wellbeing Teams (Tilbury and Chadwell)
Thurrock First
Integrated Primary and Community Care MH Team

PCN

GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
Mixed Skill Clinical Workforce
Social Prescribing

The Transformative Change we Need to Deliver



Our 12 Transformation Principles

1 AN EQUAL RELATIONSHIP WITH RESIDENTS
Responsibility for wellbeing is shared between individuals, neighbourhoods and our workforce. We do *"with"* not *"to"*. We constantly co-design and co-produce.

2 BESPOKE BY DESIGN
We work in partnership with residents to design the best bespoke integration solution for them in the context of their lives and the neighbourhood in which they live.

3 A STRENGTHS AND ASSETS APPROACH
Our solutions look to use the assets within neighbourhoods and don't just consist of the services we provide.

4 PREVENTION
Our starting point is to prevent, reduce and delay residents from requiring a health or care service; but where required we ensure it is appropriate, easy to access and high quality.

5 EMPOWER OUR WORKFORCE
We empower resident facing staff to make decisions in the context of each resident they serve rather than being constrained by thresholds and *one size fits all* service specifications.

6 INTEGRATED SOLUTIONS TO COMPLEX PROBLEMS
We deliver integrated solutions that minimise handoffs and referrals with fewer roles and services upskilled to deliver more tasks. Our mantra is *not wasting residents' time.*

7 LEARNING IS THE KEY STRATEGIC ACTION
We create learning environments as the primary mechanism to manage our constantly evolving system. We empower staff to innovate and share learning.

8 FLEXIBILITY
We are flexible enough to respond and adapt delivery to changes in individual, neighbourhood and place circumstances

9 BUREAUCRACY LIGHT
The amount of resource we spend on bureaucracy is kept to a minimum ensuring maximum resources are available to provide people with the solutions they require.

10 WHOLE SYSTEM APPROACH
We recognise that it is systems not services that deliver outcomes. We focus on creating healthy systems based on trusting relationships to where cooperation between actors is easy.

11 SUBSIDIARITY
We plan, transform and deliver at the lowest geographical level possible in the context of on-going engagement with residents.

12 ADDRESSING HEALTH INEQUALITIES
We will relentlessly focus on reducing health inequity. We will ensure that resources are distributed in a way that accounts for variation in need at neighbourhood level.

Wider Community

Locality and Neighbourhood based on going community engagement
- Community Reference and Investment Boards
- Community Development
- Co-design/Production
- Collaborative Communities Framework

Health & Wellbeing Team (x20)
- Domiciliary Care
- Community Nursing
- Holistic care and community connections
- Admissions avoidance
- Care brokerage and coordination
- Reablement
- Hospital Discharge Planning
- Community Nursing
- Community connections

Chapter 8
Integrated Support in the Home

Early care planning/D2A
Admission avoidance

Step up
Step Down

Integrated Locality Network (x4)

Community Hub /3rd sector
Micro Enterprises
Local Area Coordination
Community Led Solutions
Community Nursing
Older Adults / Frailty
Complex Care
Care coordination and planning
Housing & Homelessness
Addictions
Open Dialogue

Primary Care Network (x4)

GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
GP Practice
GP Practice

Chapter 5
Transformed Primary Care

Shared Back Office and Triage

Mixed Skill Clinical Workforce ARRS Roles

Integrated LTC Service

Mental Health IPCC Model

Chapter 7
Integrated Care and Support in the Community

Integrated Medical Centre
- Hub for all Integrated Locality Network Services
- Diagnostics
- Outpatients

Chapter 6
Population Health Management
- Healthy lifestyles
- Proactive early diagnosis
- Proactive clinical management
- PCN Intelligence Function

Chapter 9
Intermediate / Residential Care, and Supported Living

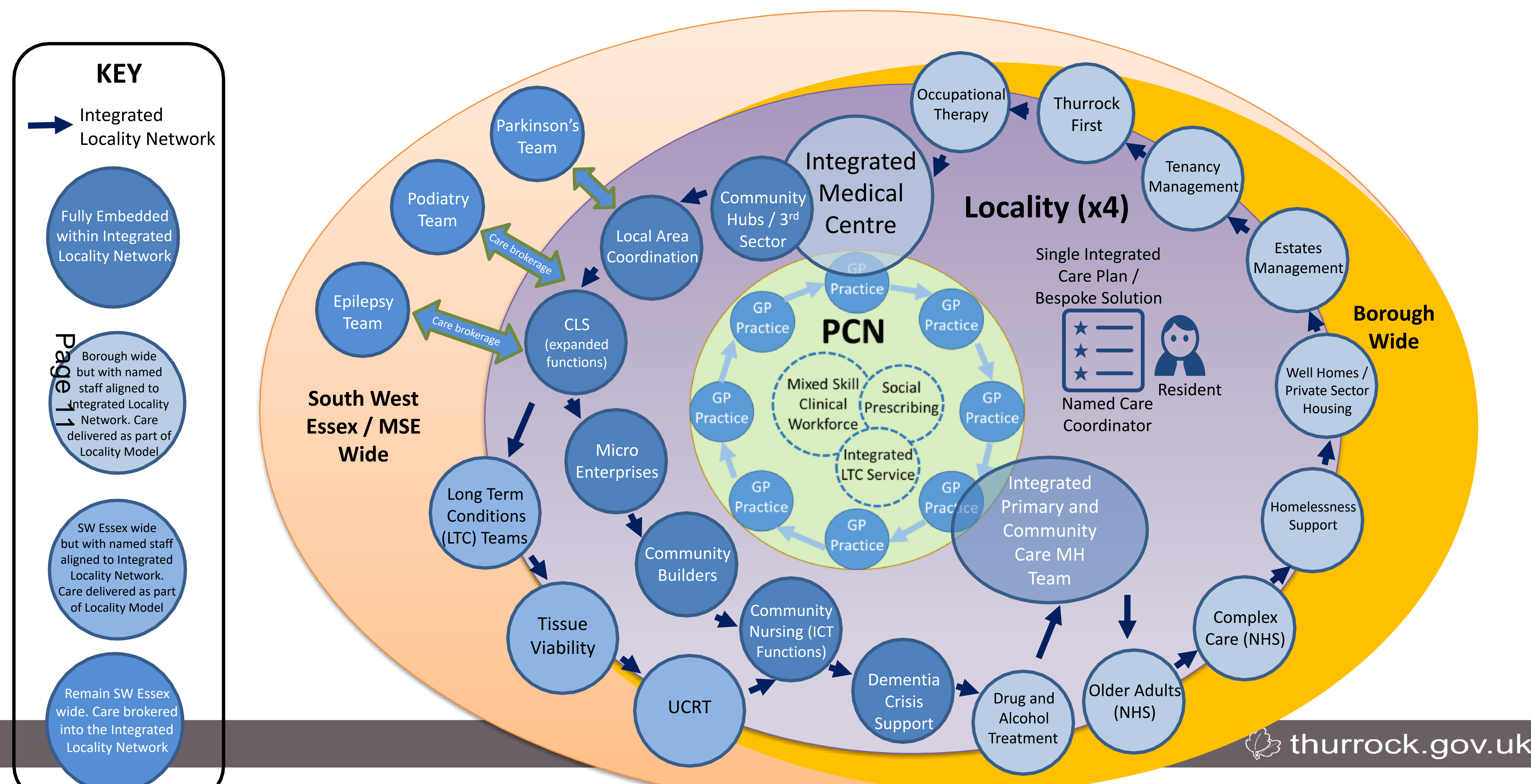
Whiteacres development:
- 45 self-contained flats with Extra Care Plus
- 30 Intermediate Care Studios with clinical in-reach
- Flexible in-borough supported living facilities with care in reach.
- Market development

Early care planning/D2A
Admission avoidance

Community Networks
Community Assets
Wider Public Services
Community Groups

Chapter 4
Community Engagement and Empowerment: Leveraging the Power of People

Integrated Locality Network: Integrated Support at Locality Level around the PCN



Integrated Locality Working

Pillar 1: Place as an Organising Principle

Pillar 2: Adopting a New Working Culture

Pillar 3: Coordinated, Bespoke Care

Place as an Organising Principle

PCN Locality as the Planning Footprint.

The Integrated Medical Centre acts as the locality 'hub'

A Single Integrated Locality Network.

- Relationships not referrals
- Alignment of named professionals within larger teams
- Support from small specialist teams brokered in + upskilling.

A New Working Culture

Empowered Staff

- Free to use judgement within broad framework of principles

Solutions not services.

A Learning Culture

Focus on what matters to residents.

- Build relationship and goal setting with residents

Coordinated, Bespoke Care

Bespoke Solutions to Complex Problems

Care Coordination.

- A single named person brokers all care required as part of the solution.

Single Integrated Care Plans

- For the most complex individuals l
- Linked to the goals that the resident has set for themselves.
- Across NHS, 3rd sector and LA.

Chapter 4: Community Engagement and Empowerment

Leveraging the Power of People

Community Led Support

Community Builders

Community Hubs

Local Area Coordination

Social Prescribing

Micro Enterprises

Asset Based Community Resilience focuses on moving the system from 'doing to' to 'doing with' and ultimately 'doing by'

To

For

With

By

nurture development

4.2 Develop User-Led and Direct Delivery Communities of Practice to foster innovation and determine what works

4.5 Micro Enterprise Development – Community Economic Unit (CEU) within each PCN/locality

4.3 Air Table / other architecture to capture community intelligence

v.uk

Chapter 5:
Transforming Primary Care

Improving Primary Care Access and Quality

5.1 Prioritise future investment to close the equity gap. All PCNs at least the same level of appointment to need as SLH

5.3 Investment in the ARRS programme including skills audit

5.7/8 Foster collaboration, sharing best practice and at scale delivery PCN level SystmOne unit

5.2/9 IMC and Integrated Locality Network Capacity within PCN

Chapter 6: Improved Health and Wellbeing Through Population Health Management

From reactive to proactive care

Figure 6.2

At risk of developing LTC

Undiagnosed, unmanaged

Diagnosed, but not on QOF registers. Inadequately managed

Diagnosed, on register, inadequate control of risk

Diagnosed, on register, Well-managed

Primary Prevention

Improve case finding

Systematically identify patients and add to QOF registers

Improve the clinical management of LTCs in Primary and Community Care

Improve the clinical management of LTCs in Primary and Community Care

Total Impact of QOF Indicators Analysed

£52,941

£52,036

£2,111,721

£837,319

£3,054,017

£0 £500,000 £1,000,000 £1,500,000 £2,000,000 £2,500,000 £3,000,000 £3,500,000

Avoided Ambulance Cost

Avoided A&E Cost

Avoided Elective and Emergency Admission Cost (includes 1 year post cost for stroke admission)

Avoided ASC Care cost (1 year only)

- **147** missed opportunities for stroke admission prevention
- Opportunity to prevent **384** hospital admissions across five high volume care pathways

Chapter 8: Integrated Support in the Home

Holistic care from fewer people

Wellbeing Teams Model

SPECIALIST SERVICES AND SUPPORT

HOSPITAL AND INTERMEDIATE CARE

Self-directed Health and Care Wellbeing Team

Single Integrated Care Plan

Personal Care
Hospital Discharge Planning
Community Connection
Reablement
Routine Clinical Interventions
Care Brokerage
Aligned Community Nurse
Care Coordination

FRIENDS AND FAMILY

COMMUNITY ASSETS/ 3rd SECTOR SUPPORT

COMMUNITY BASED PROFESSIONALS

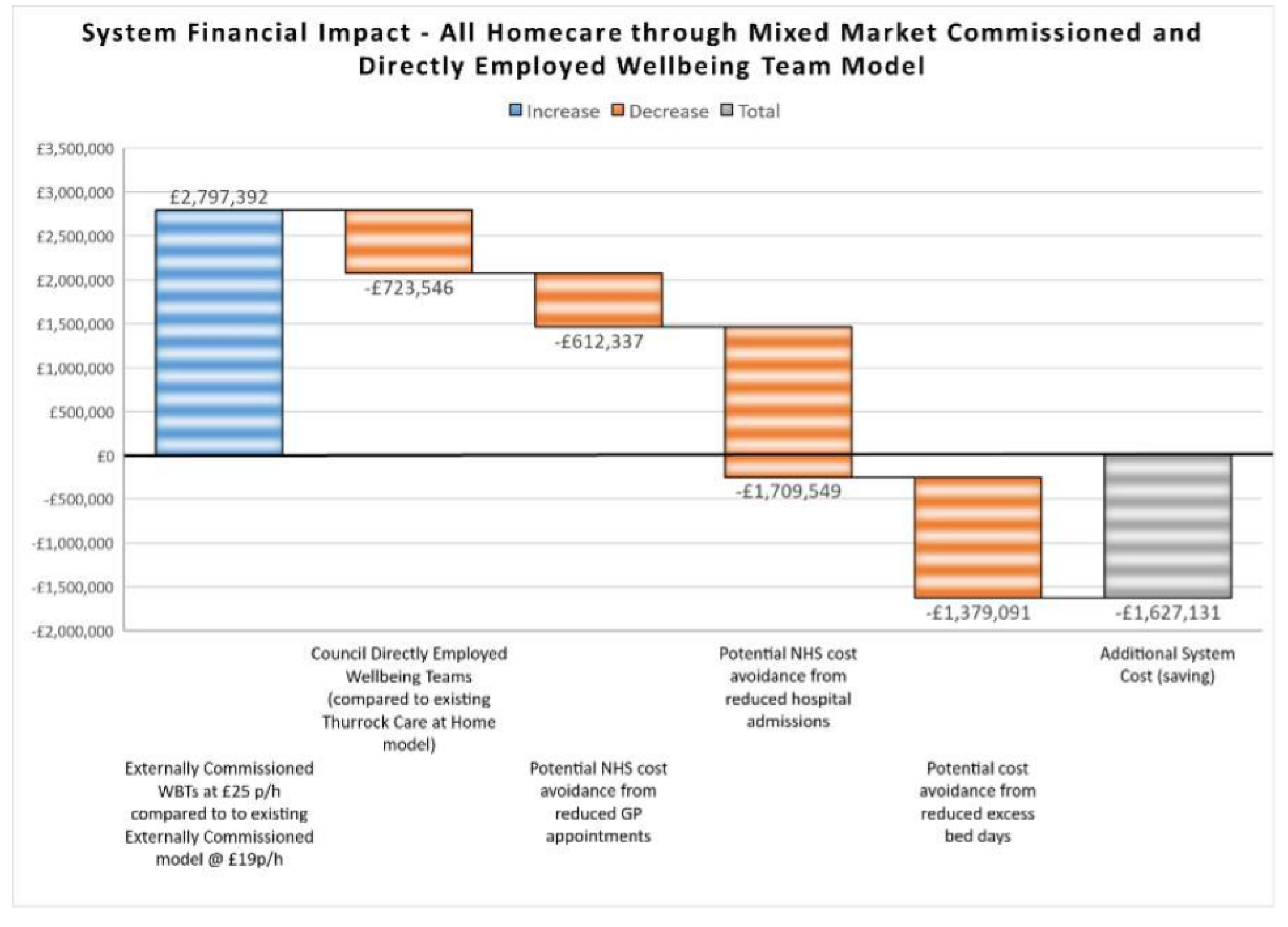
TECHNOLOGY

8.1 Provider Services Transformation across Tilbury and Chadwell

8.2 Collect more robust evaluation data

8.3 System business case

8.4 Market development



- Potentially affordable if mixed market model at £25 per hour externally commissioned

8.5 Upskill staff to create 'Health and Wellbeing Worker' blended role

8.6 Embed reablement and discharge planning

8.7 Align ICT with named community nurse for each team

Chapter 9:
Reimagining Supported Living, Residential and Intermediate Care

Dignity and independence with more intensive support

- **9.3** Exemplar model residential care facility – *Whiteacres site*
- **9.4** Include 30 studios for intermediate care
- **9.5** Business case to Cabinet in 2022/23
- **9.6** New model of MH Supported Living

Better Care Together Thurrock: Governance & Delivery Structure

System

MSE ICB

MSE Integrated Care Partnership

Devolution Agreement

Thurrock Health and Wellbeing Board

Thurrock Cabinet

Thurrock Integrated Care Alliance (TICA)

Thurrock Council Directors' Board

IMC Programme Board

Brighter Futures Board

Better Care Together Thurrock Executive

IMC Executive

Stronger Together (Chapter 4)

PCN Transformation (Chapter 5)

Population Health Management and Inequalities (Chapter 6)

Integrated Care & MH Transformation (Chapters 7 & 8)

Commissioning Resources & Performance (Chapter 10)

Residential / Intermediate Care (Chapter 9)

Clinical & Professional Forum

Locality

Individual IMC Project Boards

Community Reference and Investment Boards x 4

Communities of Practice

PCN & Locality Boards x 4

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Next Steps

- Communication and Engagement with wider staff groups
- ICS sign up
- Secondary Care Chapter
- One year delivery plan for 2022/23 – service plans
- Wider Support – Centre for Public Impact Proposal
- ICS devolution agreement
- Review commissioning to support