

Better Care Together Thurrock: The Case for Further Change

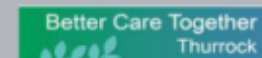
Ian Wake
Corporate Director of Adults Housing and Health

17 May 2022



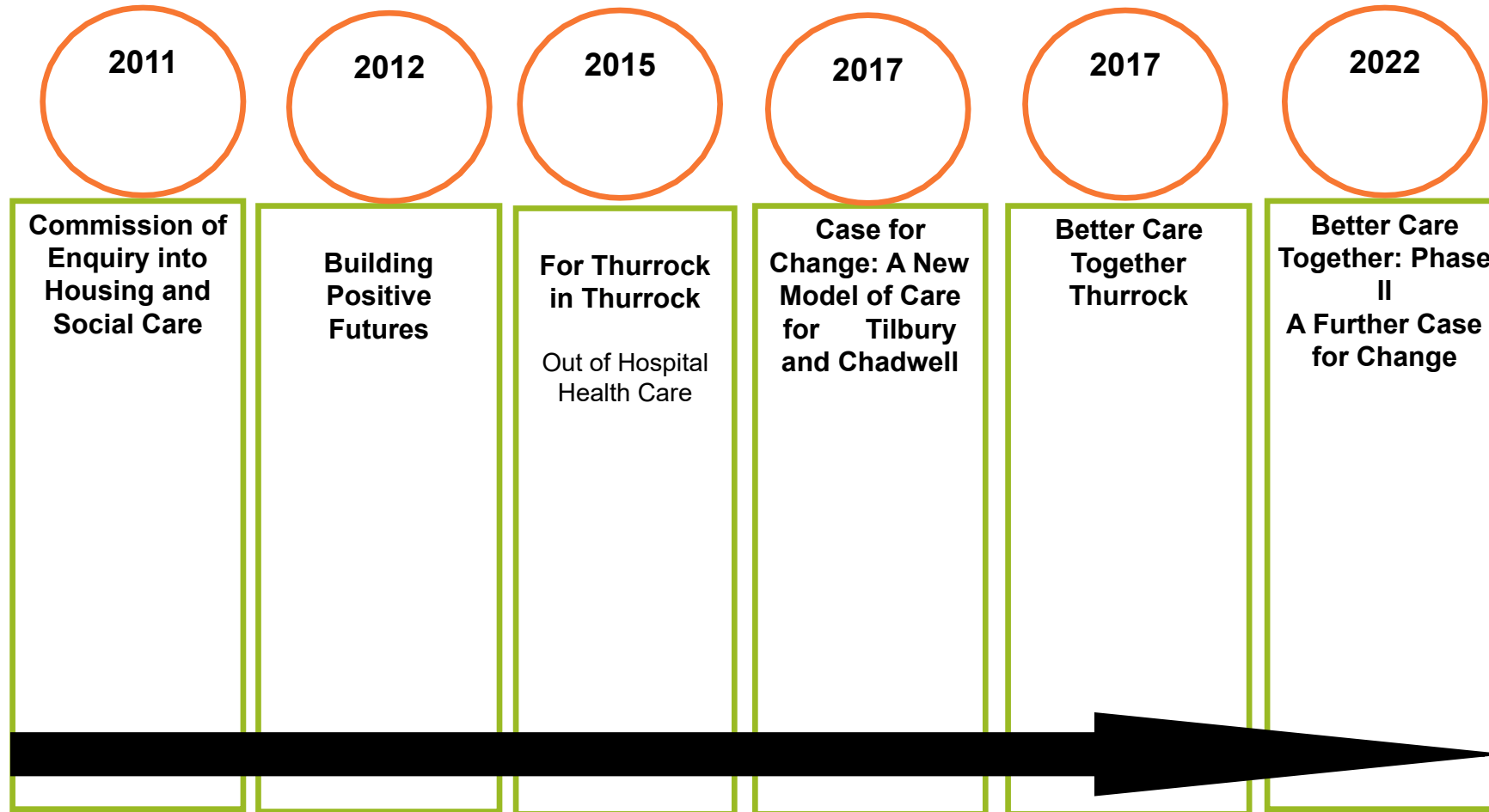
Better Care Together Thurrock

The Case for Further Change
2022-2026





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

thurrock.gov.uk 



Tilbury Integrated Healthy Living Centre Needs Assessment

A Thurrock Joint Strategic Needs Assessment (JSNA) Product

Authors:

Jan 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


thurrock.gov.uk


Annual Report of the Director of Public Health: 2016

A Sustainable Health and Social Care System for Thurrock



1

thurrock.gov.uk 






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

February 2017

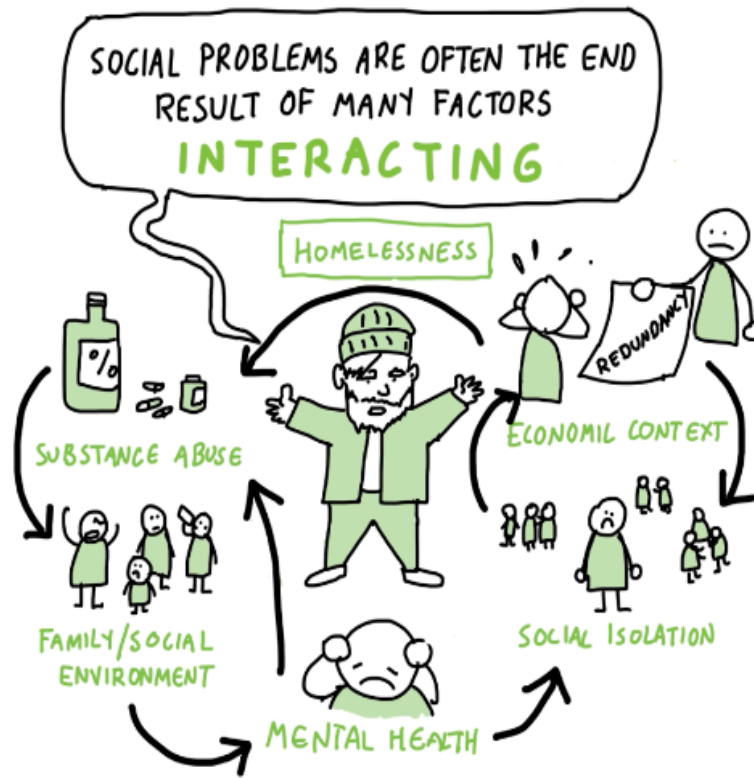
Authors:

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

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

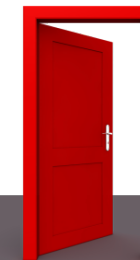
The 'WHY': Owen, 60 year old widower, living alone in a one bedroomed council flat in Chadwell



The 'Need Paradox'

Total Cost ?£5000

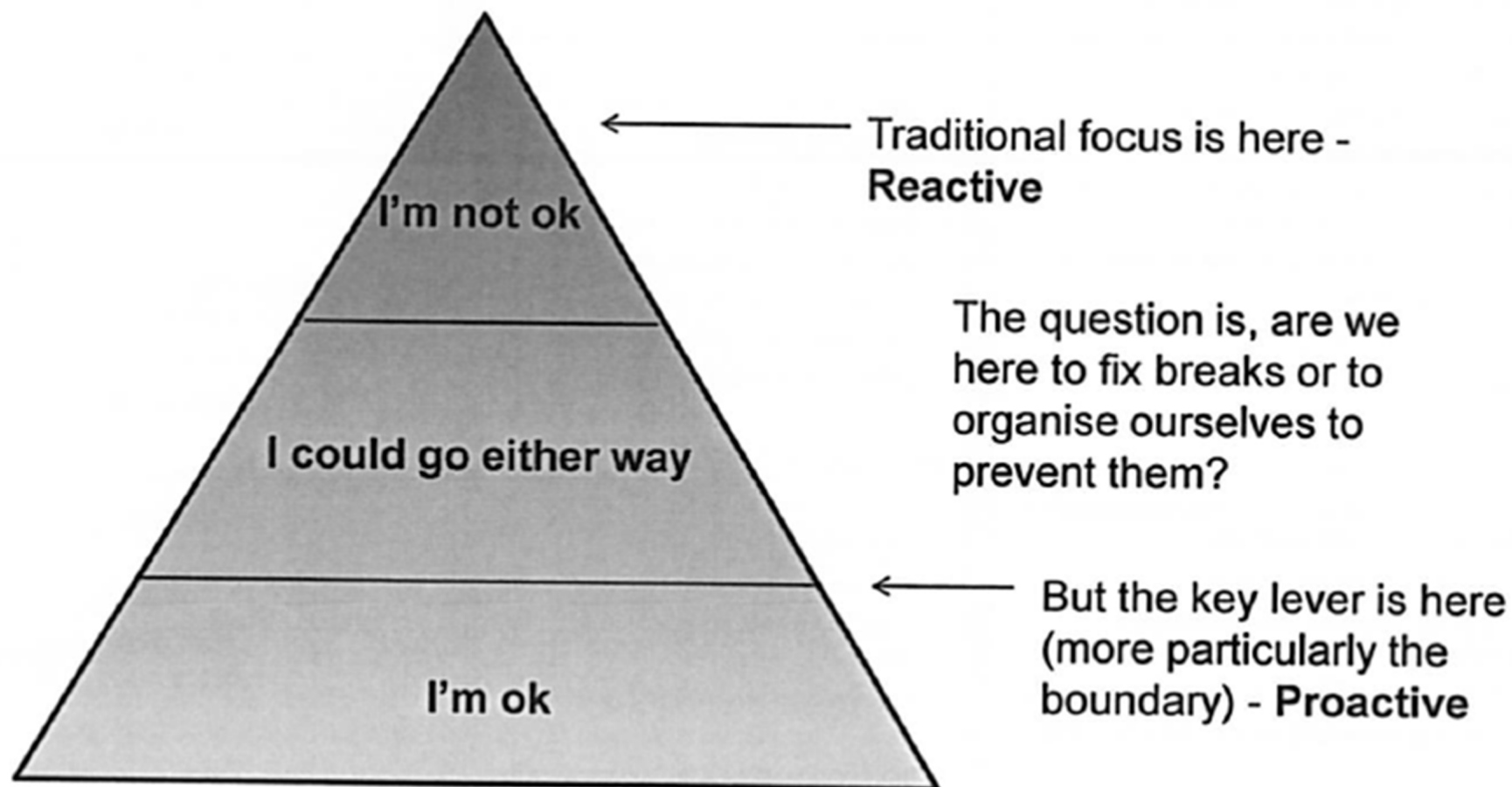
OT	Alcohol Treatment	Mental Health	Home Care
Threshold Assessment Referral	Threshold Assessment Referral	Threshold Assessment Referral	Threshold Assessment Referral
Residential Care	Housing	CLS	GP
Threshold Assessment Referral	Threshold Assessment Referral		

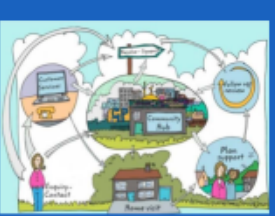


Ambulance & A&E

The Triangle of Needs

The Vanguard Method – Beyond
Command and Control

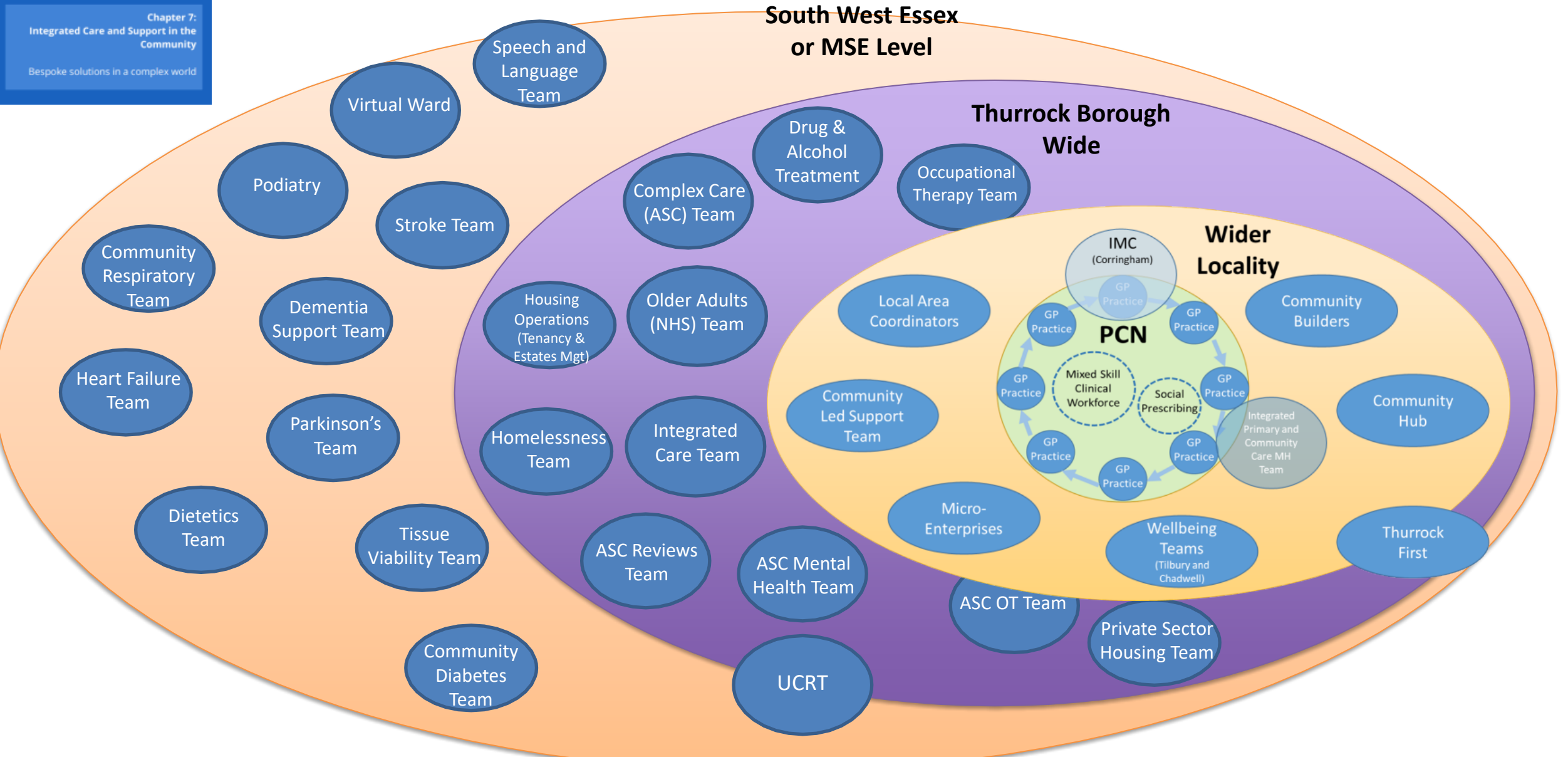




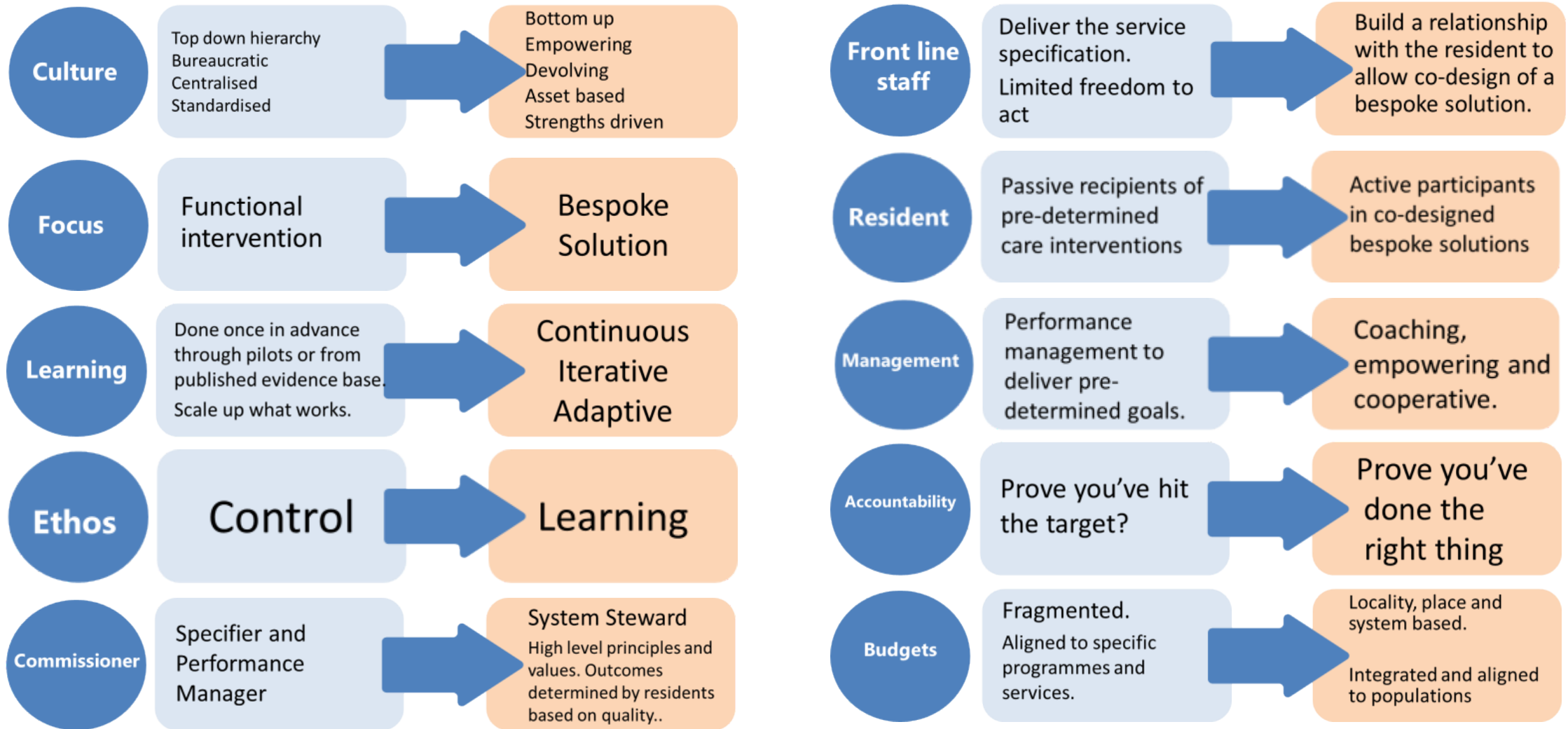
Chapter 7:
Integrated Care and Support in the
Community
Bespoke solutions in a complex world

Current Service Landscape

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



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

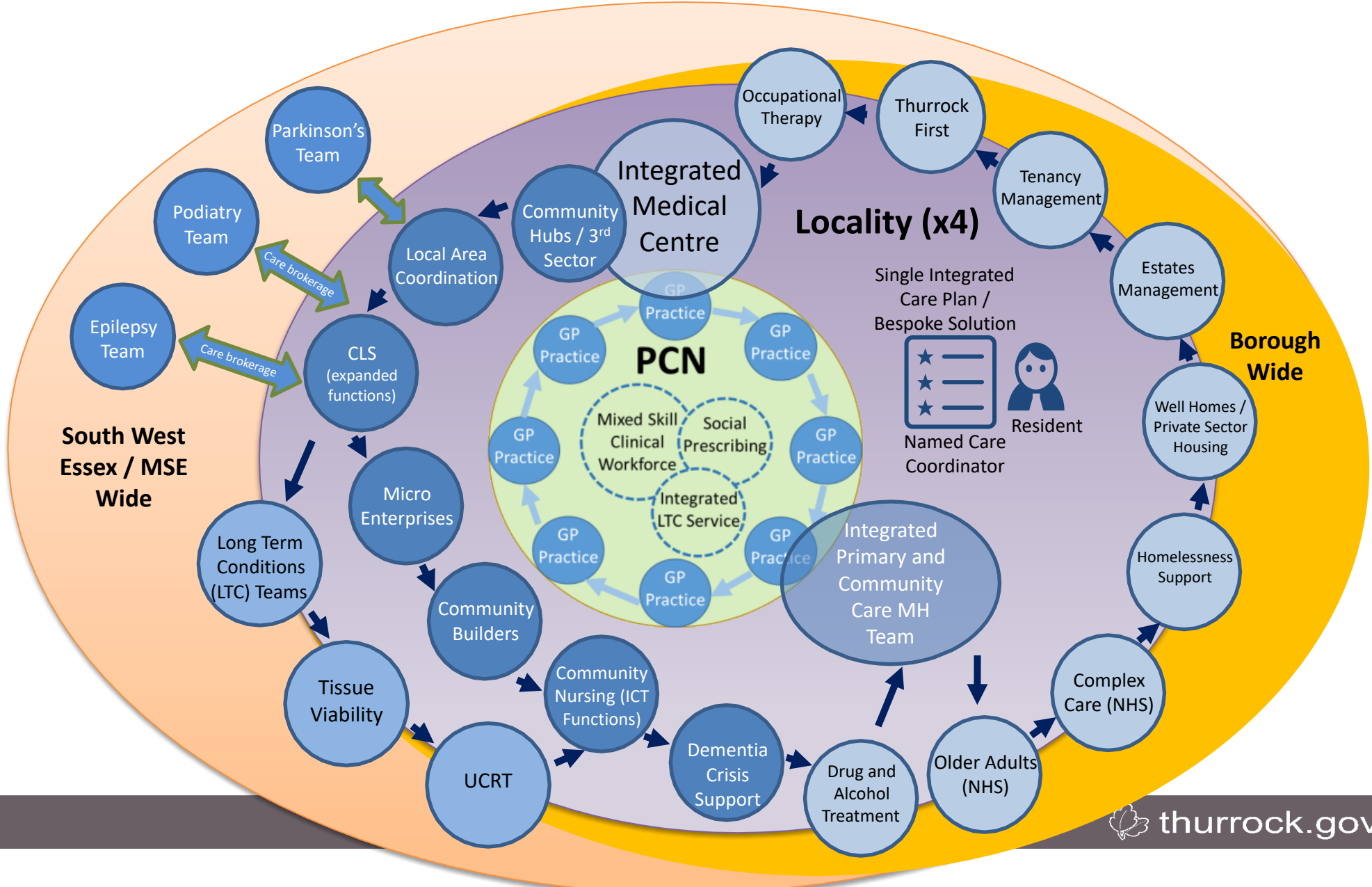
ADDRESSING HEALTH INEQUALITIES

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.

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

KEY

- Integrated Locality Network
- Fully Embedded within Integrated Locality Network
- Borough wide but with named staff aligned to Integrated Locality Network. Care delivered as part of Locality Model
- SW Essex wide but with named staff aligned to Integrated Locality Network. Care delivered as part of Locality Model
- Remain SW Essex wide. Care brokered into the Integrated Locality Network



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 I
- 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
Hubs

Social
Prescribing



Community
Builders

Local Area
Coordination

Micro
Enterprises

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

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 SystemOne unit

5.2/9

IMC and Integrated Locality Network Capacity within PCN

Chapter 5: Transforming Primary Care

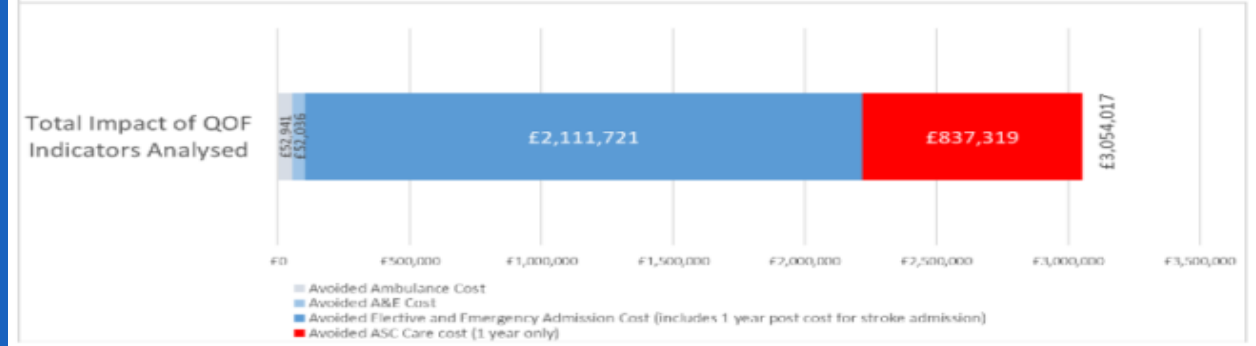
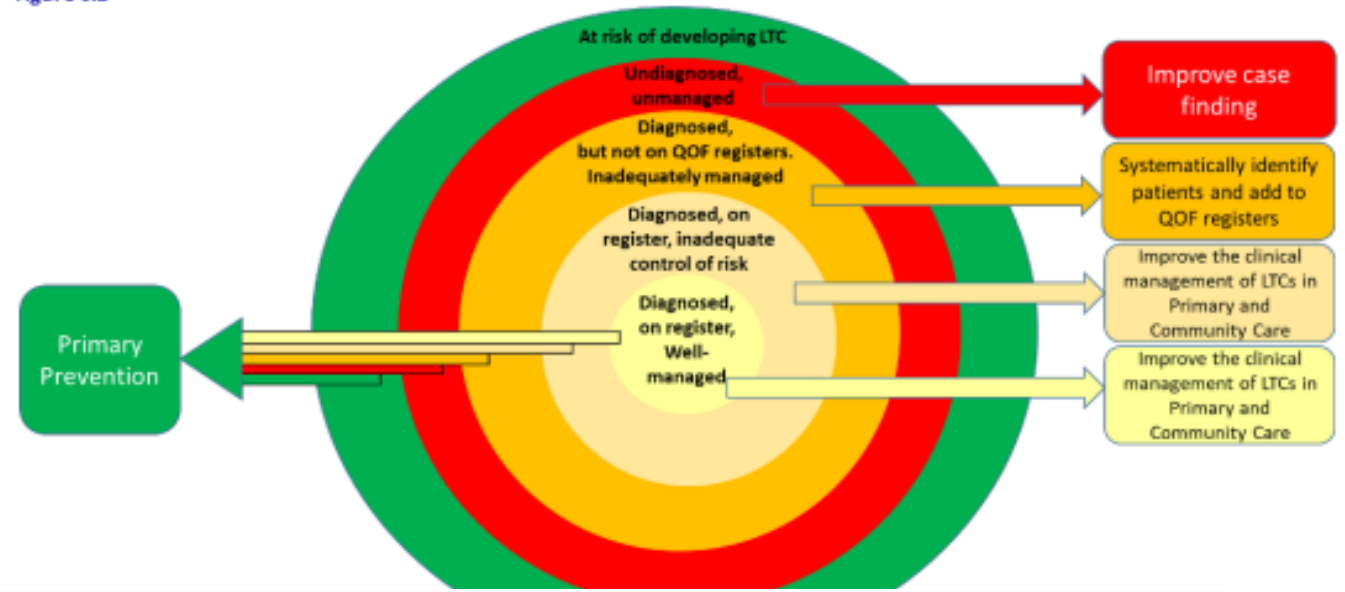




Chapter 6: Improved Health and Wellbeing Through Population Health Management

From reactive to proactive care

Figure 6.2



- **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



8.1

Provider Services
Transformation across
Tilbury and Chadwell

8.2

Collect more robust
evaluation data

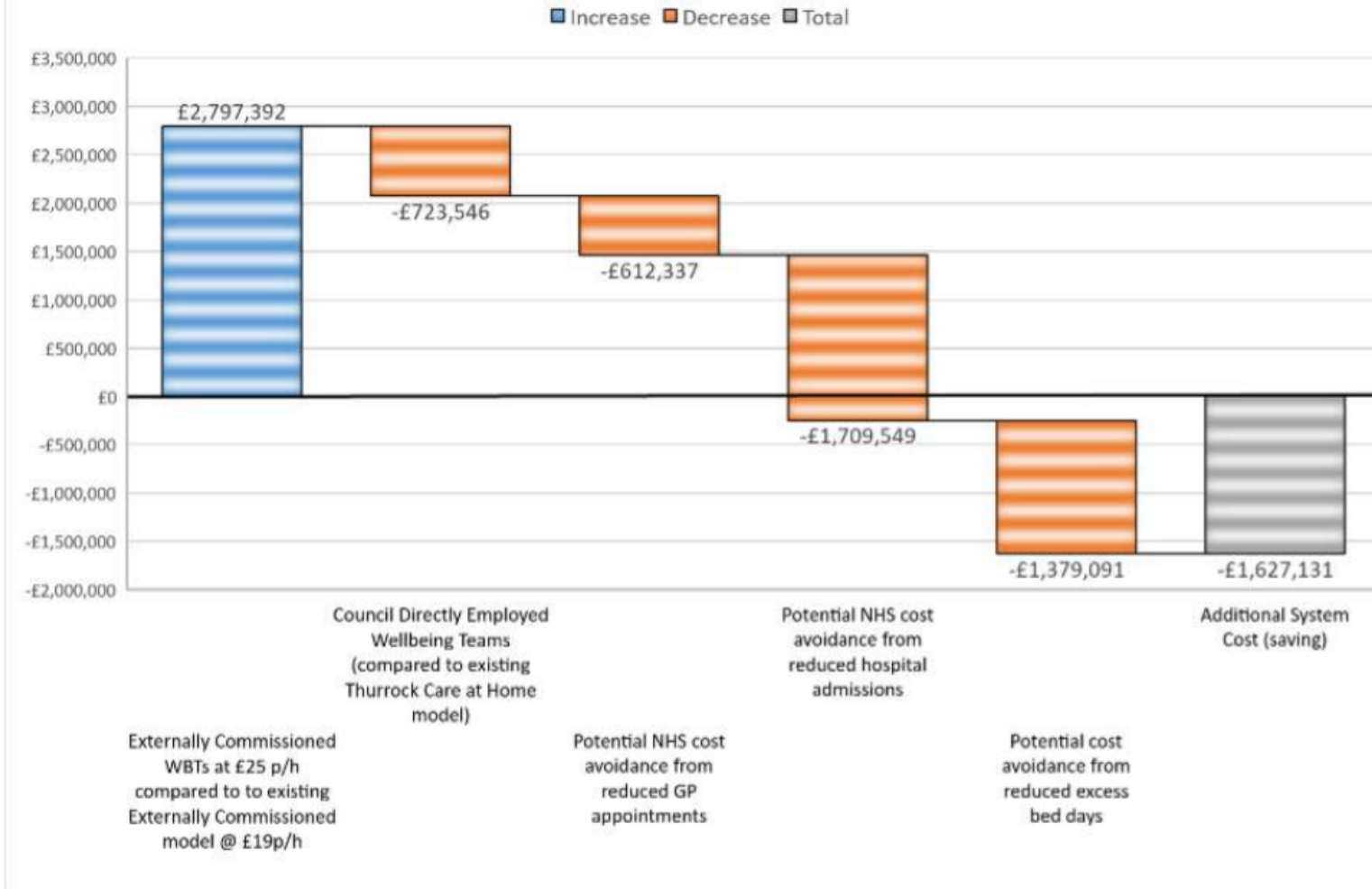
8.3

System business case

8.4

Market development

System Financial Impact - All Homecare through Mixed Market Commissioned and Directly Employed Wellbeing Team Model



- 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

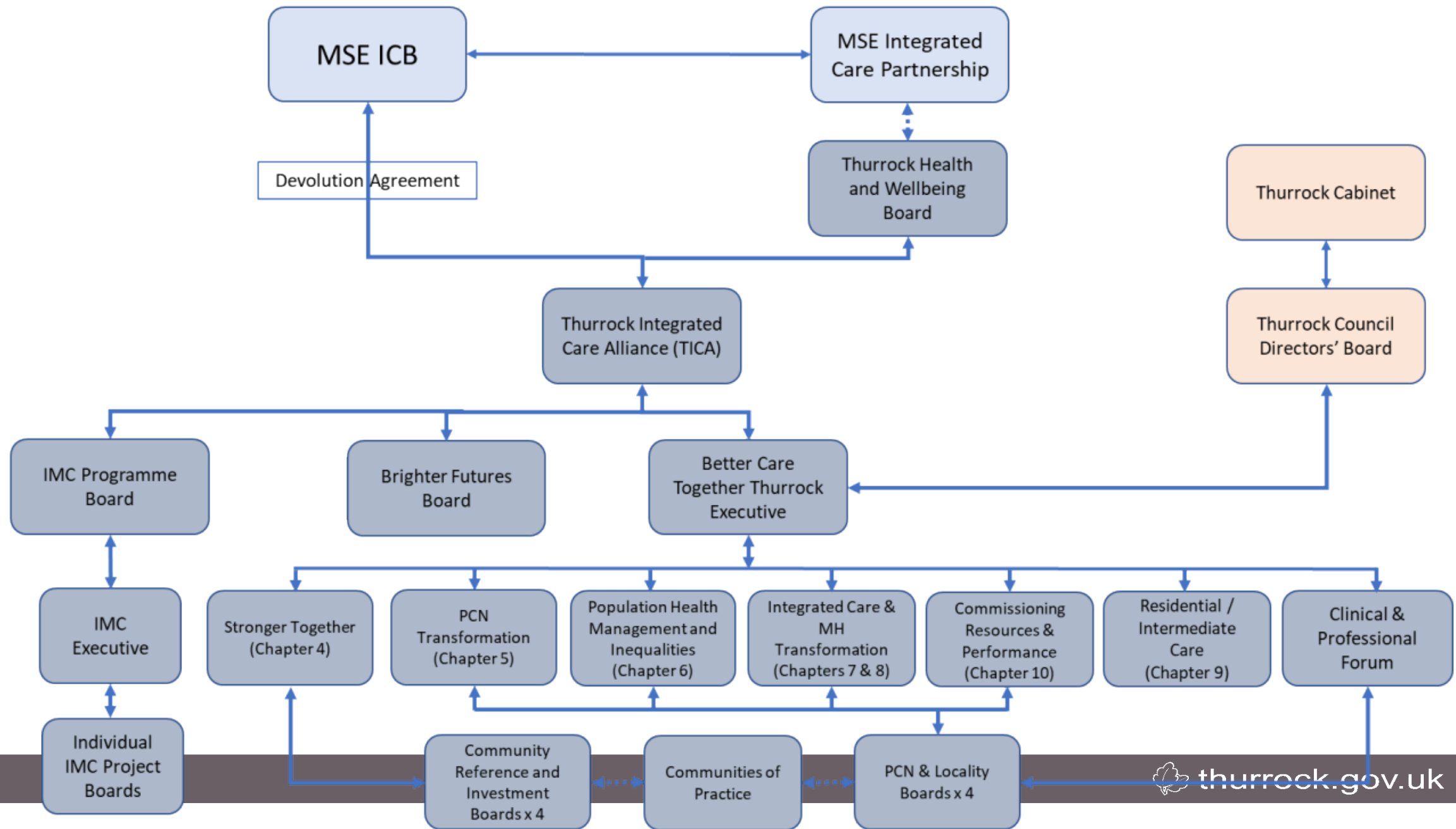
New model of MH Supported
Living

Better Care Together Thurrock: Governance & Delivery Structure

System

Place

Locality



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