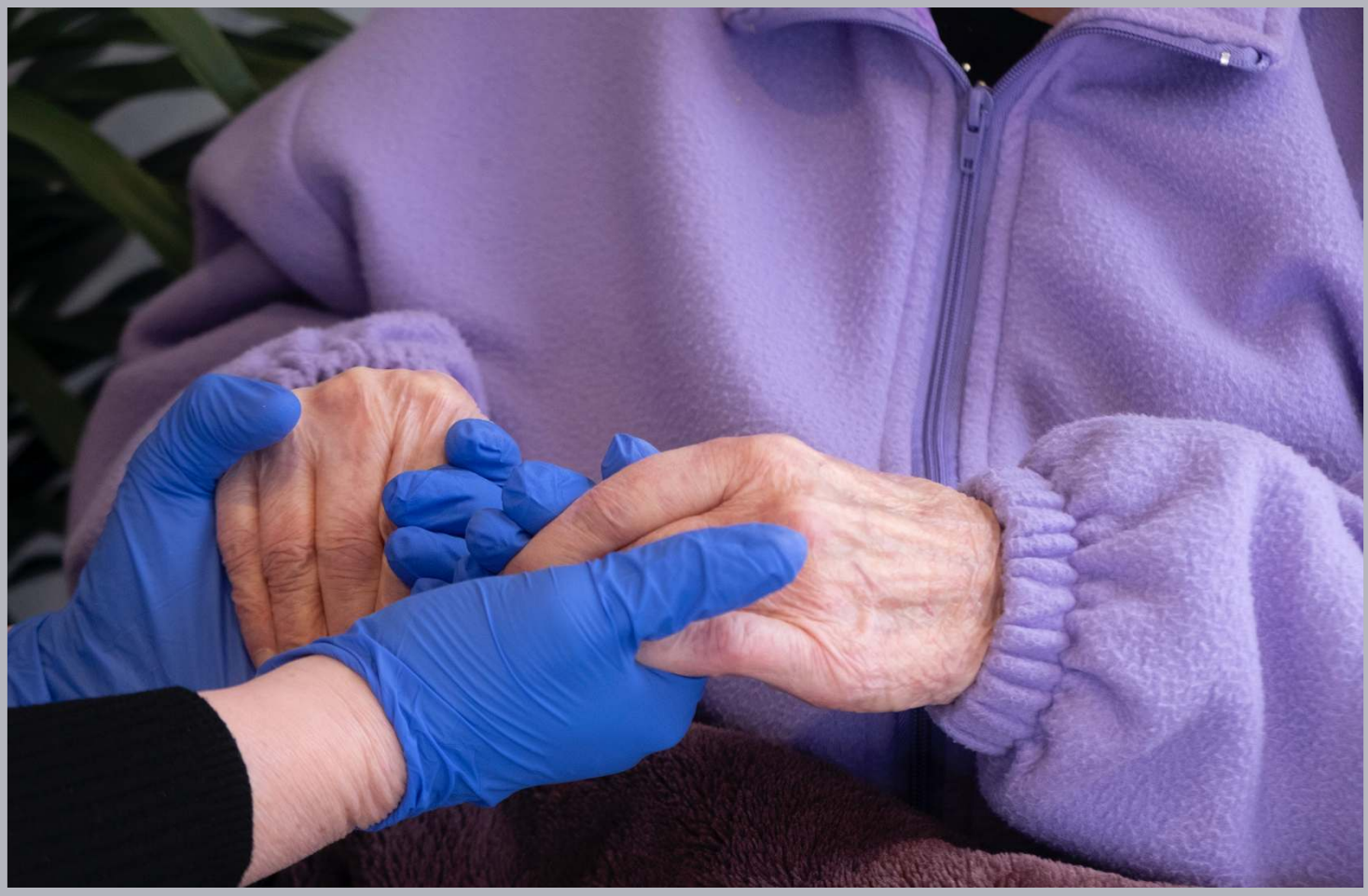

Better Care Together Thurrock

The Case for Further Change 2022-2026

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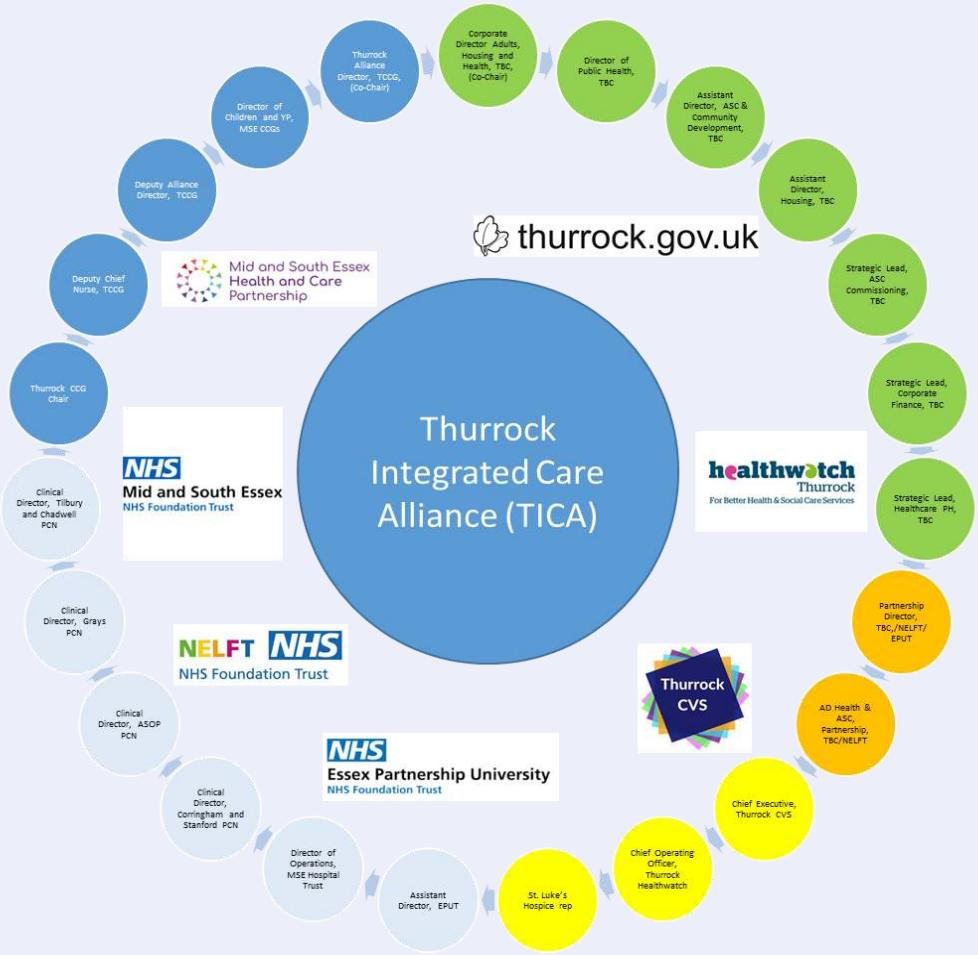
Introduction

This *Case for Further Change* strategy sets out a collective plan to transform, improve and integrate health, care and third sector services aimed at the borough's adults and older people to improve their wellbeing.

This strategy has been developed and agreed by the Thurrock Integrated Care Alliance (TICA) and its partner organisations. Partners across Thurrock have a long history of working together to agree and deliver shared outcomes. The approach taken has been inclusive, bringing together commissioners, providers and colleagues from Thurrock Council, the NHS, third/voluntary sector and Healthwatch. It also reflects on-going comprehensive engagement with residents including co-design and co-production approaches.

In late 2019, following a review of local arrangements, partners agreed to strengthen, further embed and accelerate collaborative arrangements by establishing the Thurrock Integrated Care Alliance. TICA is the highest strategic level officer only partnership responsible for health, care, housing and third sector service strategic transformation across the borough including developing and overseeing the deployment of the Better Care Fund.

The current membership of TICA is shown below.

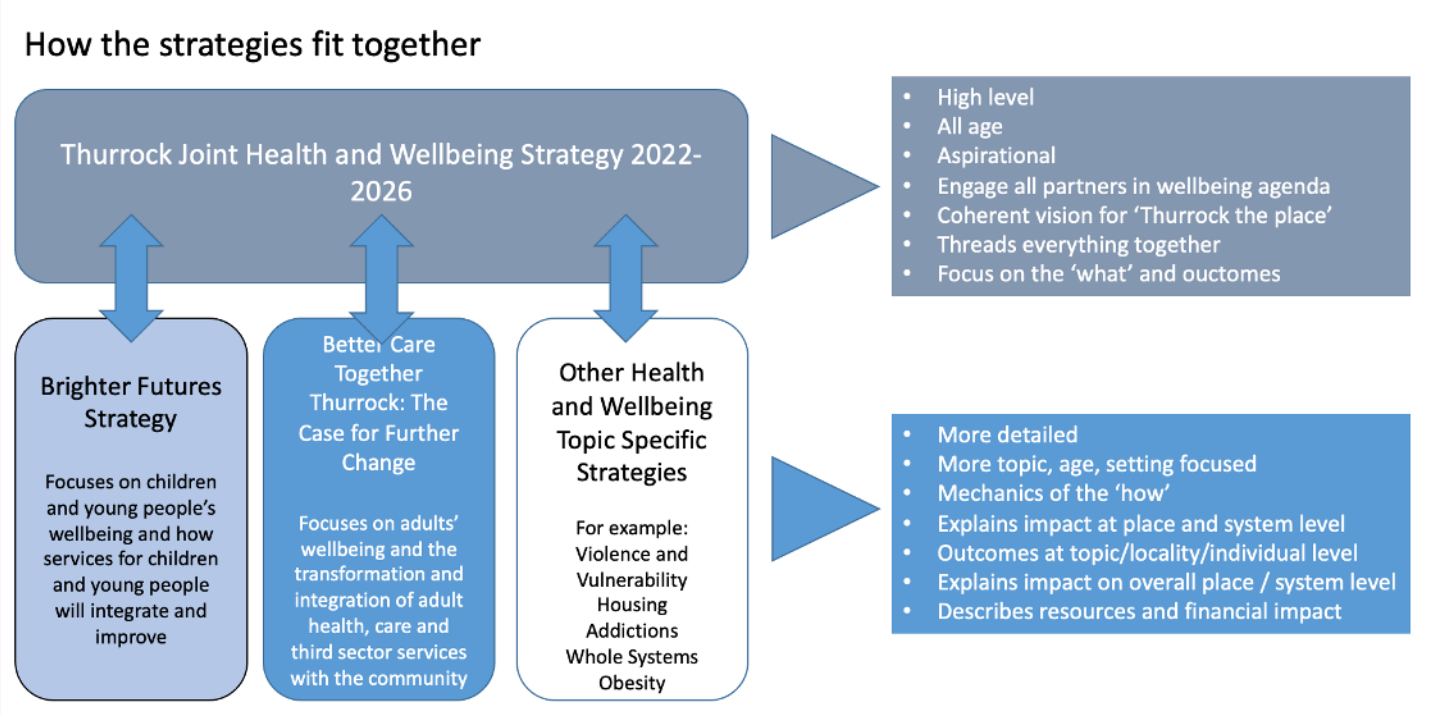


Strategic Context

From April 2022, Thurrock will be one of four *Alliance Places* that sit under the Mid and South Essex Integrated Care System (MSE ICS). The Kings Fund has recognised that 70% of health care integration and transformation operates at a geographical level below ICS boundaries, and the new MSE ICS has recognised the key principle of *subsidiarity*, that decision making on the planning and delivery of health and care services should be made at the lowest possible geographical level.

As such, the MSE ICS has proposed making the four *Alliances* sub committees of the Mid and South Essex Integrated Commissioning Board with the opportunity to negotiate significant delegated decision making authority and resources based on agreement of strategic plans at *Alliance/Place* level.

This strategy forms part of a suite of three documents that describe Thurrock's *Place Based Strategy* as shown below



The Thurrock Joint Health and Wellbeing Strategy 2022-2026 is the highest level strategic document that describes our collective ambition to improve the health and wellbeing of our residents. The theme of the strategy is *Levelling the Playing Field* and the strategy sets out high level actions to address health inequalities across the six domains of:

- Healthier for Longer including mental health
- Building Strong and Cohesive Communities
- Person Led Health and Care
- Opportunity for All
- Housing and the Environment
- Community Safety

The Joint Health and Wellbeing Strategy therefore addresses the wider determinants of health including education, employment, crime and community safety, and housing, as well as healthy lifestyles and health and care. It concentrates on the 'what' and the 'why' and points to additional more detailed and topic specific strategies that deal with delivery of individual objectives (the '*how*').

Two key additional documents sit underthe Joint Health and Wellbeing Strategy, of which, this is one.

The second is the *Thurrock Brighter Futures Strategy,* which sets out our collective plans to improve the health and wellbeing of children and young people in the borough.

How this strategy is structured

Chapter 1 provides an introduction to Thurrock and sets out the high level health needs of our residents, our ambitious place based regeneration plans and our collective transformation journey over the past decade.

Chapter 2 describes the collective vision, aims, principles and values that all partners have signed up to, and that underpin our work. It also describes the *Human, Learning, Systems* approach on which the next phase of our transformation journey is based.

Chapter 3 describes our overall new model of care on which this strategy is based and how the respective elements fit together.

Chapters 4 to 9 unpack the detail behind our six strategic actions to transform, integrate and improve care:

Chapter 4 builds on our vision and values to explain how we will make them real, and critically, how we will engage the third sector and communities as equal partners in our strengths and asset based approach moving forward.

Chapter 5 details our plans to improve access and quality of General Practice in the context of the new Primary Care Networks

Chapter 6 sets out our approach to transforming care from reactive to proactive and preventative using Population Health Management Techniques to deliver improved primary prevention and the diagnosis and management of long term conditions

Chapter 7 describes how we will build an integrated health and care community workforce around each PCN to deliver proactive holistic, strengths based care to our residents, maximising the opportunities of the new Integrated Medical Centres.

Chapter 8 details our plans to transform care at home including the next phase of our Wellbeing Teams model.

Chapter 9 describes our plans to re-imagine how we deliver residential and intermediate care through our proposals for an "Extra Care Plus" facility at the Whiteacres site in Thurrock.

Chapter 10 discusses the practical delivery enablers we require to make this strategy an reality including governance, integrated budgets, integrated commissioning, management and development of the market and how we will monitor performance and quality.

Chapter 1: Introducing Thurrock

Chapter 1. Introducing Thurrock

1.1 Welcome to Thurrock

Based at the heart of the Thames Gateway in close proximity to the east of London, Thurrock is a busy borough with picturesque towns, reams of beautiful countryside and 18 miles of river frontage. We are a borough of contrasts with urban areas of Grays, Tilbury and Purfleet to the south and rural villages and open countryside to the north. Our borough boasts more than 18 miles of beautiful river front and his proud of its rich heritage and growing cultural scene. 70% of Thurrock is greenbelt, with several rural villages and many areas of wildlife and natural beauty.

Historic Thurrock

The borough is home to two historic forts that were built to protect the Thames estuary. Tilbury Fort is where Queen Elizabeth I delivered her stirring speech to troops gathered to battle the Spanish Amadea, whilst Coalhouse Fort was built in the latter half of the 19th century as part of a new front line defence. The Thurrock Museum in Grays showcases 250,000 years of the borough's eventful past.

Opportunity and Growth

Thurrock is a unique place and its geography, economy and demographic profile distinguish it from neighbouring authorities. We are home to some of the most exciting opportunities in the county. Our growth programme is perhaps the largest and most ambitious in England. £6Bn has already been invested by the private sector in Thurrock up until 2017, with 7,000 new jobs created and 1,170 new businesses choosing Thurrock including leading ports and logistics centres, retail and creative industries.

Purfleet on Thames

Purfleet Centre Regeneration Limited is a joint venture between Urban Catalyst and Swan Housing in partnership with Thurrock Council to regenerate over 140 acres to create Purfleet-on-Thames. Developed on healthy town principles, Purfleet-on-Thames will create a new waterfront destination on the River Thames; an international create hub and high quality new residential with place making at its core. The vision for Purfleet-on-Thames includes:

- A state of the art film and TV studio facility and related creative industry hub
- Attractive new waterfront commercial and retail space
- Up to 2,850 new homes, including significant health and education facilities
- Community facilities
- Leisure uses
- Upgraded and additional public transport facilities

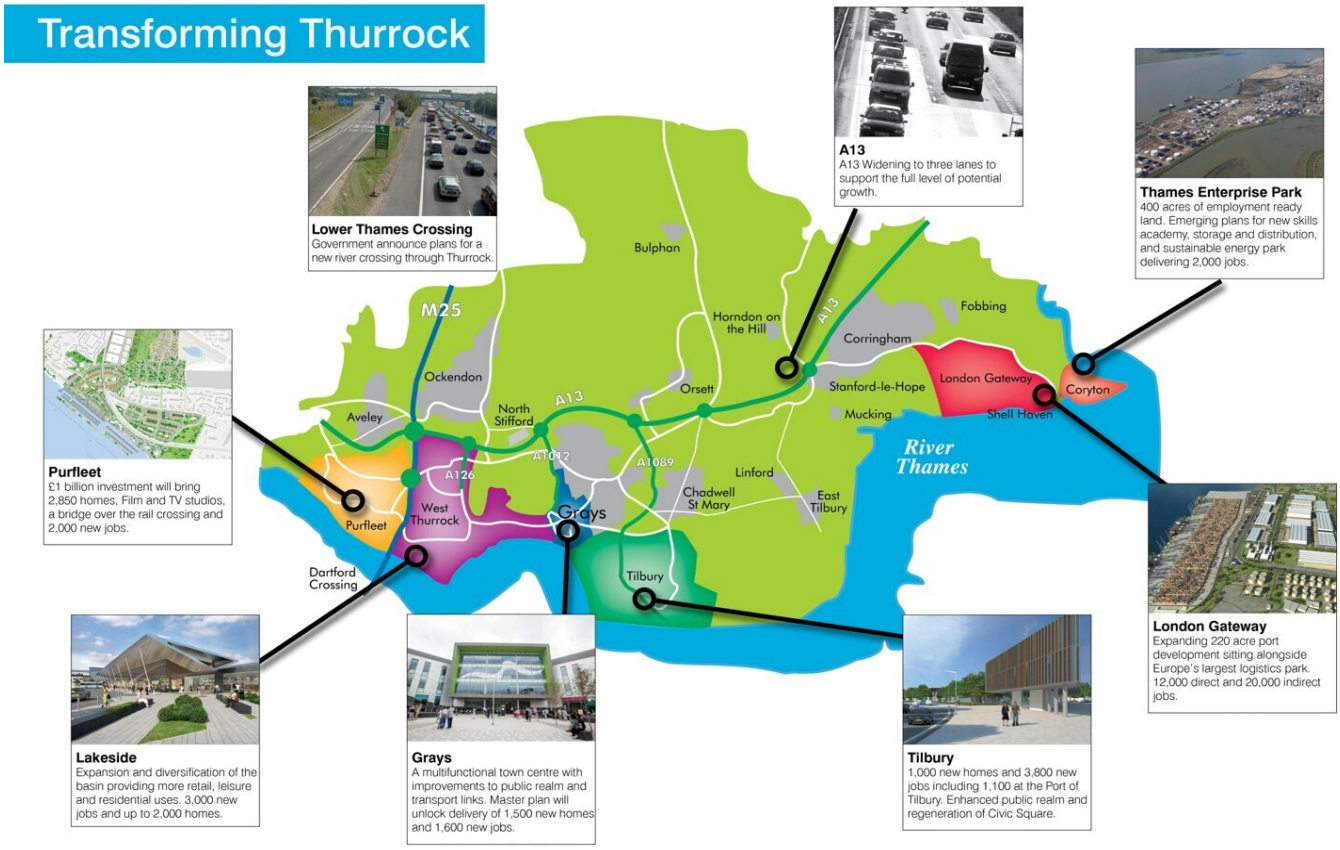
Thames Freeport

A successful bid backed by Thurrock Council to create a Thames Freeport will deliver transformational change across the entire borough, create 25,000 direct new jobs and up to another 20,000 indirect job opportunities, and will see unprecedented inward investment. Thames Freeport is an economic zone connecting Ford's word-class Dagenham engine plant to the global ports at London Gateway and Tilbury. Businesses looking to expalnd or reshore their operations will be able to take advantage of the tax benefits of establishing within the Freeport and being part of a customs zone, which makes it easier and cheaper to move goods into and out of the country.

More broadly, over 1,000 acres of land are ready for commercial development with 30,000 new homes likely to be built. Thurrock is at the heart of global trade and logistics, with no fewer than three international ports. We are well positioned on the M25 and A13 corridors with excellent transport links west into London, north and east into Essex, and south into Kent.

Figure 1.1 below shows the extent of our regeneration plans.

Figure 1.1



1.2 The Health of Our Residents

Thurrock is home to a diverse population of residents that is increasing by over 10% every decade. Our current population is estimated to be 178,300. Structurally, our population is younger than England's with 22% being aged 14 and under.

The 2011 census found that 81% of our residents were White British and 19% from a non White British background with Black African, Caribbean and black British being the second most common ethnicity at 7.82%

Mortality

The main causes of death amongst Thurrock residents in 2020 were cancer, cardio-vascular disease, COVID-19, dementia and respiratory disease. For premature (under 75) mortality, they were cancer, cardio-vascular disease and COVID-19. (Figures 1.2 and 1.3)

Figure 1.2

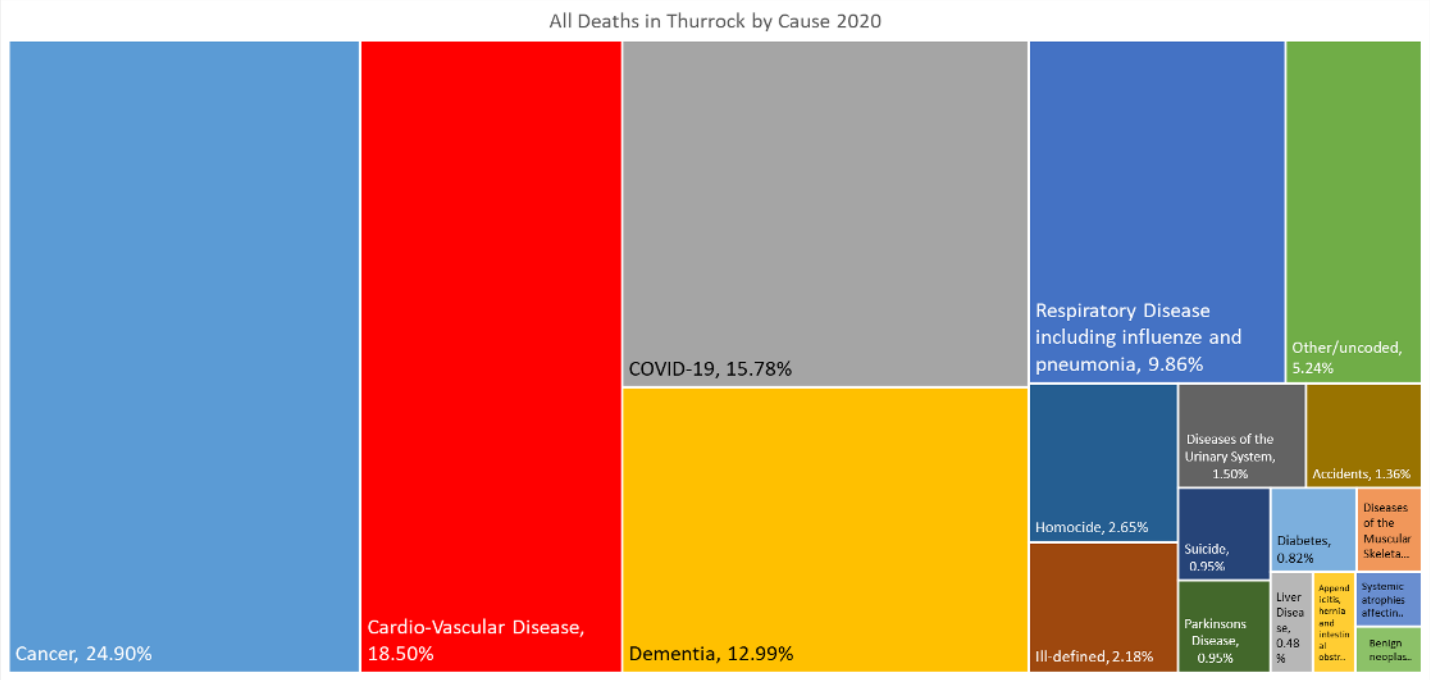
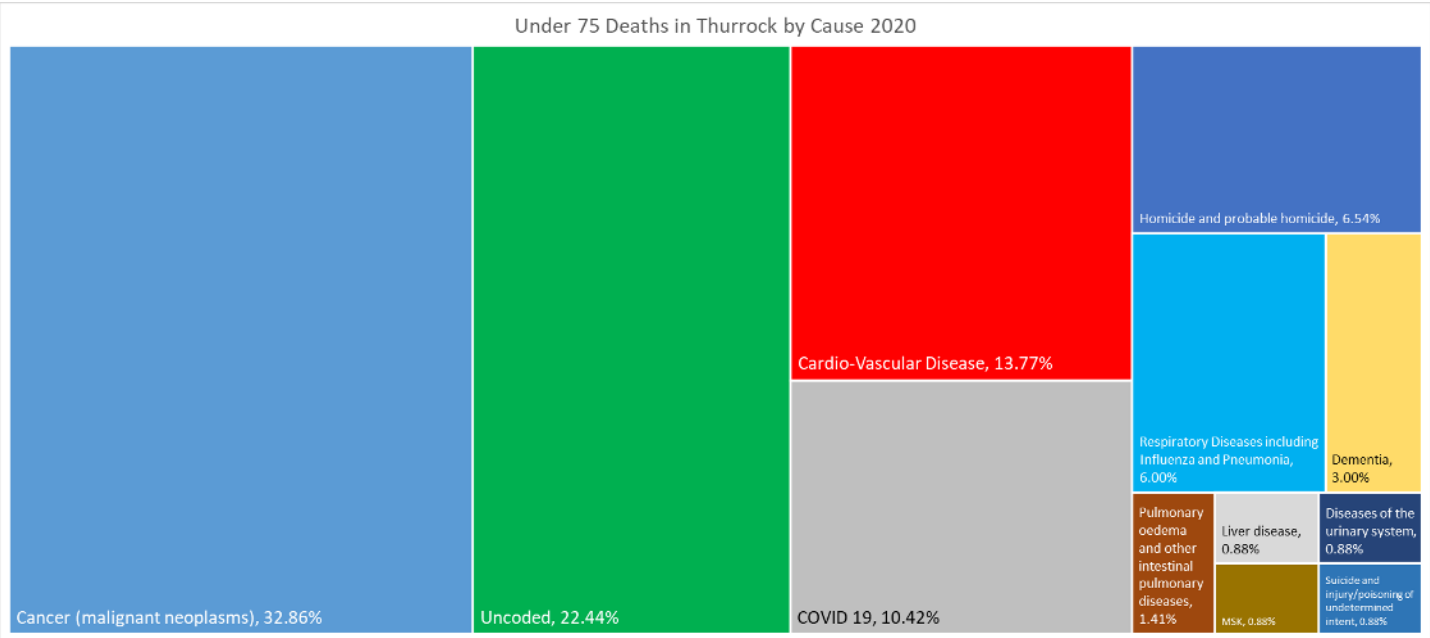


Figure 1.3



Health Inequalities

Health inequalities remain a significant issue in Thurrock with our more deprived populations suffering lower levels of both total life expectancy and the numbers of years of their life that they can expect to live without disability.

Figures 1.4 and 1.5 show life expectancy and disability free life expectancy for males and females in Thurrock by IMD 2019 deprivation decile. They demonstrate the clear health inequity between both total life expectancy and disability free life expectancy linked to deprivation, with both measures increasing as deprivation decreases. Only the least deprived 35% of our population are likely to reach retirement age before reaching the end of disability free life.

Figure 1.4

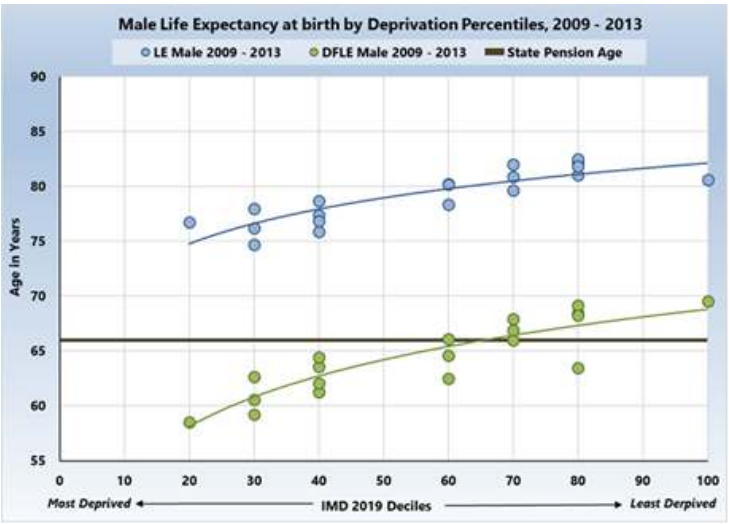
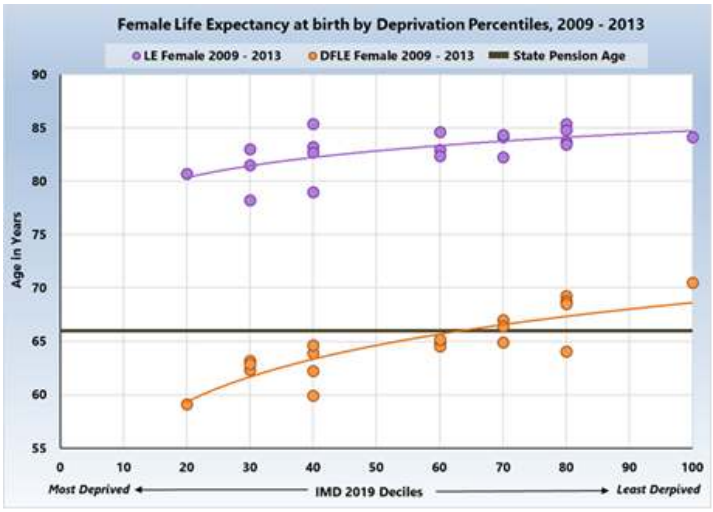


Figure 1.5



The Mortality Attributable to Socioeconomic Inequality (MASI) index shows the total number of deaths and mortality rate per 100,000 population attributable to socio-economic deprivation. Thurrock has the third worse MASI in Mid and South Essex with 2,522 deaths being attributable to socio-economic causes between 2003 and 2018 (Figure 1.6).

Figure 1.6

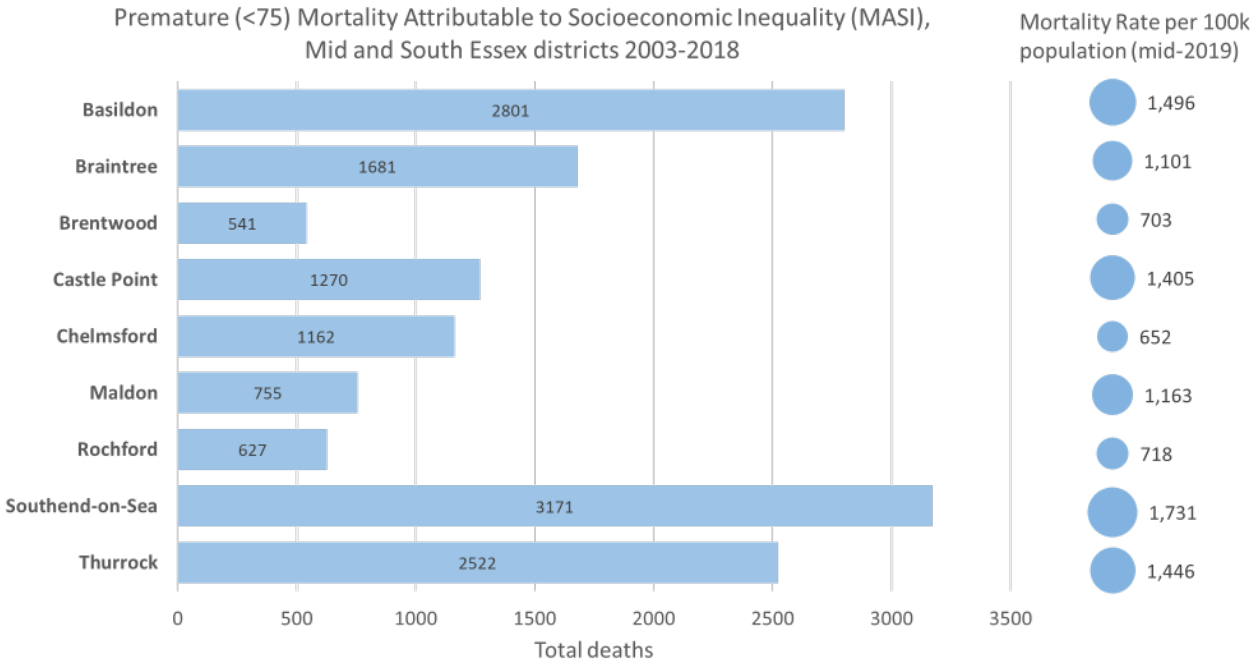
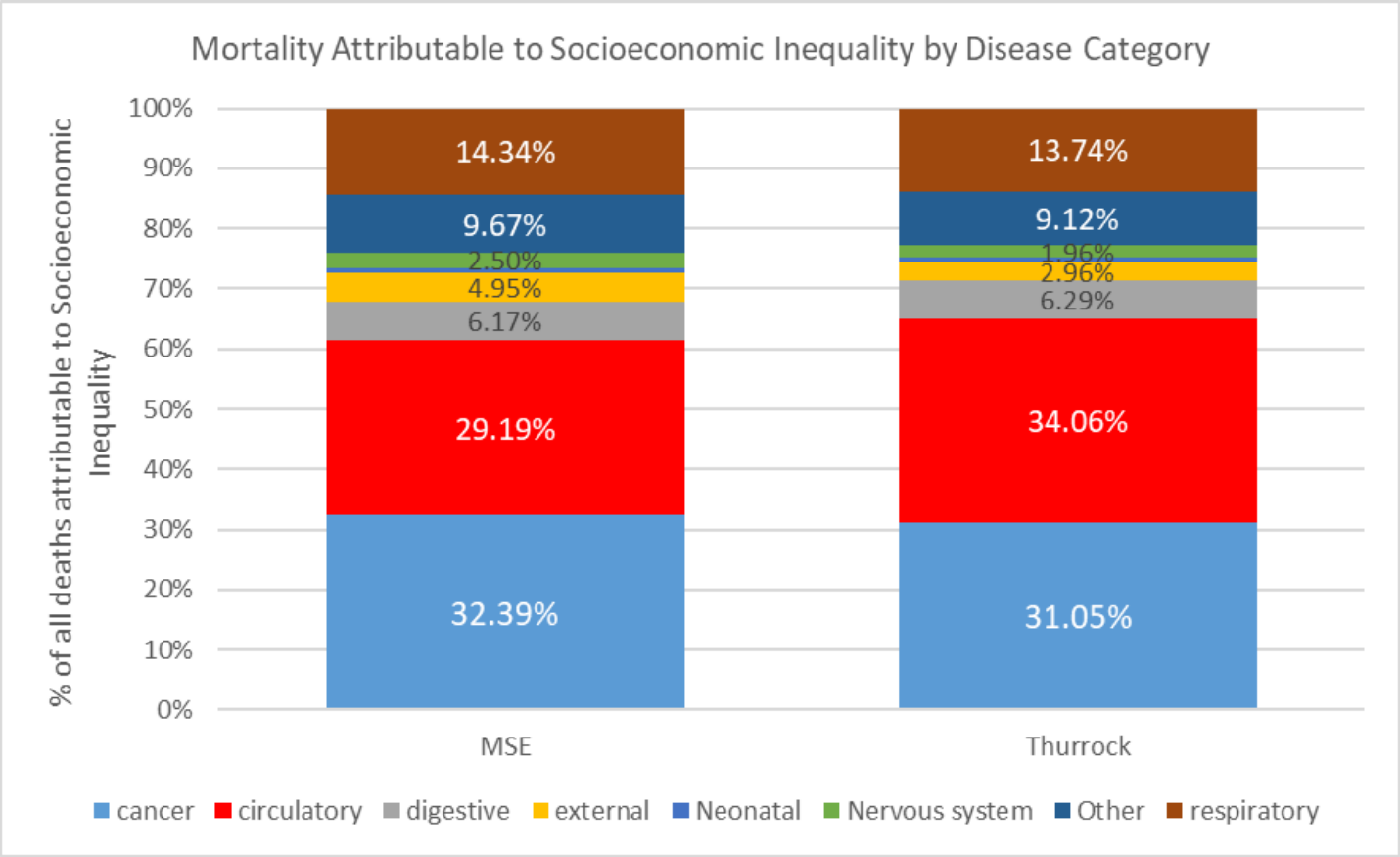


Figure 1.7 shows the underlying causes of deaths due to socio-economic inequality for Mid and South Essex and Thurrock. Thurrock's main cause of death due to socio-economic inequality in cardio-vascular disease. This differs from Mid and South Essex where cancer is the most common cause of death driven by socio-economic inequality.

Figure 1.7



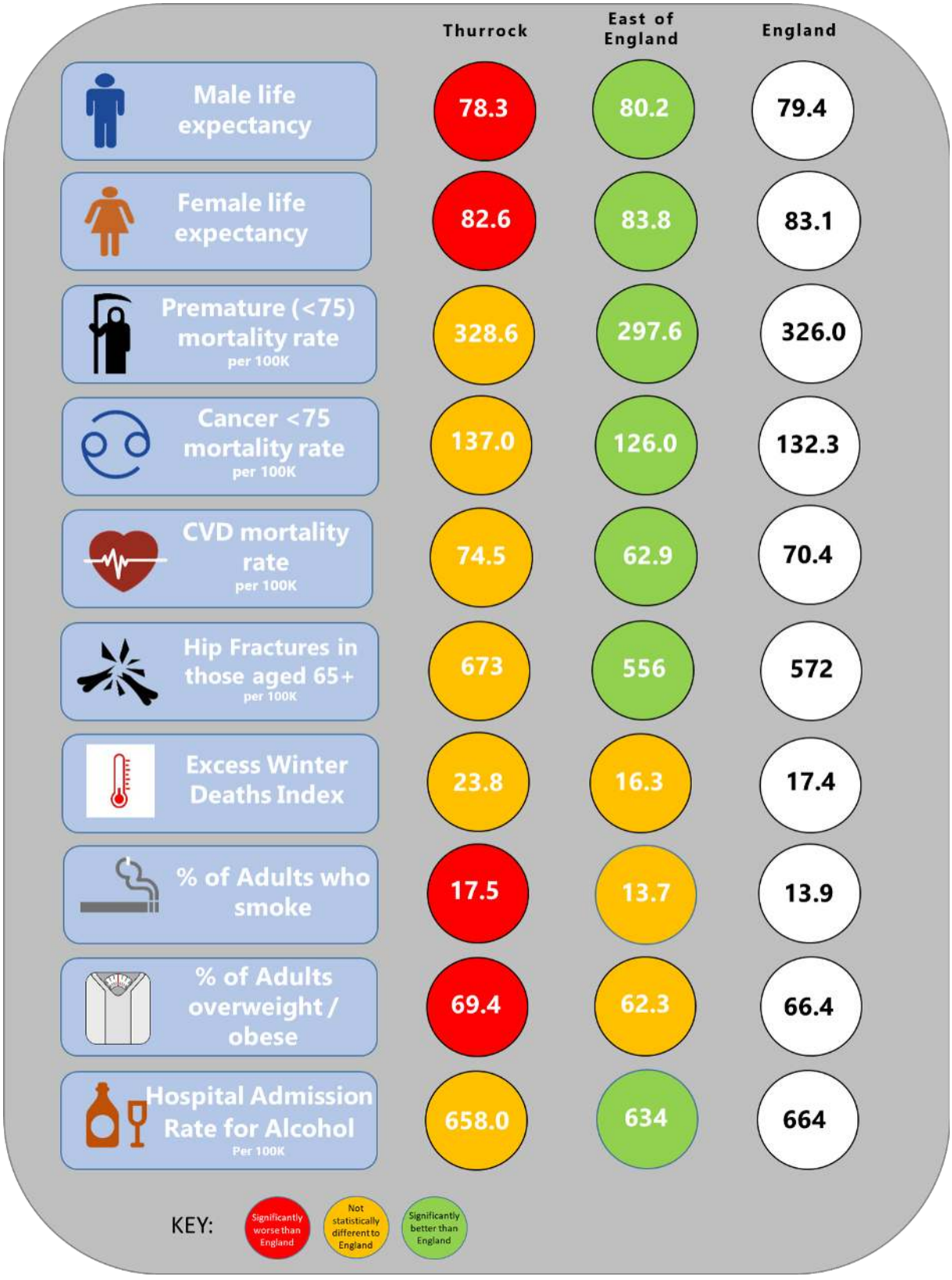
Comparative Health Need

Figure 1.8 overleaf summarises some of the key health outcome metrics and compares Thurrock to regional and national averages.

Thurrock's population is generally less healthy than that of the East of England and England. This reflects the higher levels of deprivation and health inequalities faced by many of our residents within the borough.

The more flexible way in which Integrated Care Systems can allocate resources presents an opportunity to distribute funding in a fairer and more equitable way to address the higher health needs of Thurrock residents compared to more affluent communities within our local system..

Figure 1.8 Comparative Health Need of Thurrock Residents to East of England and England



1.3 Thurrock's Transformation Journey

Thurrock has been developing and refining its vision for the local health and care system since 2011 when the Commission of Enquiry into Cooperation between Housing, Health and Social Care across local authorities in South Essex produced its report. Responding to the Ageing Well agenda, the Commission of Enquiry identified the need to shift the health and care system to a position where it focused on improving wellbeing rather than being designed to respond to need. This introduced a focus on what the community itself had to offer and started the move away from the 'service knows best' approach that had tended to dominate public service. The Commission of Enquiry announced the arrival of the first health and care transformation programme – **Building Positive Futures** (BPF), and the first step towards changing the construct of the local health and care model.

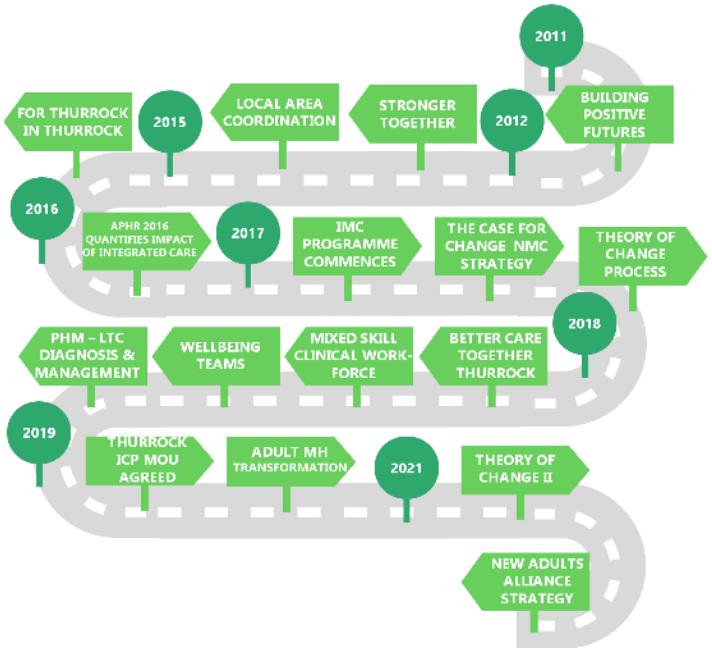
Stronger Together: developing an holistic and asset-based offer

Such was our belief in the power of communities to enhance people's lives, that the **Stronger Together Partnership** was established. The partnership was very much a collaboration of people who wanted to do things differently and saw the value of the community and its assets. Led by Thurrock's Community and Voluntary Service (CVS), and working in partnership with council, local NHS and local community and voluntary sector groups, Stronger Together Thurrock introduced a programme of initiatives based on developing and embedding a strengths and assets based approach. A range of innovative programmes were developed including Micro-Enterprises, Time Banking, Social Prescribing and Community Hubs.

Local Area Coordination - achieving a 'good life'

The introduction by the Partnership of Local Area Coordination (LAC) helped show that there was a different way of supporting people often on the cusp of entering services, at the point of crisis, or deemed 'complex' by the existing system. It also showed that there was a different way of delivering public service.

Thurrock's Transformation Journey



LAC proved that people with the most complex circumstances could build their own vision 'for a good life' and be empowered to find pragmatic and innovative solutions – drawing on family and community resources, before considering commissioned or statutory services. Local Area Coordinators were released from the bureaucracy associated with public service to have the time needed to help people realise their version of a 'good life', help people build connections and capacity so that they became more resilient, and build new community connections and capacity where it did not already exist.

Local Area Coordinators were able to build trusting relationships with the people they supported and others within the community as well as finding ways to work across organisations and services. The lessons from LAC and Stronger Communities were the catalyst for rethinking how public service operated and its relationship with the people it was there to support. Ultimately, it was about moving public service from 'doing to' and 'doing for' to 'doing with' – or ultimately people 'doing by themselves'.

For Thurrock in Thurrock

For Thurrock in Thurrock proposed a new model of health care that would place greater emphasis on care based within distinct areas (localities). Health and social care teams would work closely together to deliver care closer to home, moving away from the current more complex system.

The proposals aimed to see less fragmentation between services and less reliance on services. There was a focus on the delivery of local care with greater integration between providers to ensure best use of available funds.

Achievements under For Thurrock in Thurrock included:

- Commissioning the delivery of ***Social Prescribing*** (via Stronger Together Thurrock and Thurrock CVS)
- The implementation of ***Thurrock First*** - an integrated single point of contact across community health, mental health and adult social care
- The implementation of the ***Rapid Response and Assessment Service (RRAS)*** - a joint team by Thurrock Council and NELFT comprising of advanced nurse practitioners, social workers and healthcare assistants that provides rapid health and social care assessment for residents and their carers approaching crisis. The team aims to provide immediate care and support with a view to preventing avoidable hospital and residential care admissions.
- Other local initiatives such as ***Shared Lives***, which enabled people with care needs to live with a carer or family in their home, and ***Time Bank Thurrock***, which encouraged volunteering and the sharing of assets within communities.

The Integrated Medical Centre Programme

In 2015 the Care Quality Commission highlighted a major crisis in Primary Care, rating the majority of our GP surgeries as 'Requiring Improvement' or 'Inadequate'. Thurrock was highlighted as the fourth most under-doctored area in England with ratios of Full Time Equivalent GPs:Patients reaching 1:13,000 in some surgeries.

After undertaking locality needs assessments, our Public Health Team recommended the creation of four Integrated Healthy Living Centres (since renamed Integrated Medical Centres) as one solution to both improve primary care capacity and create attractive working environments that would attract new GPs to the Borough.

The recommended blue print saw the inception of a programme agreed with system partners to create four Integrated Medical Centres as a new focus from which to deliver integrated health and wellbeing services including a new and expanded Primary Care offer, diagnostics, secondary care outpatient clinics, health improvement and lifestyle modification programmes, community and mental health treatment, and services to address the wider determinants of health including community and voluntary grups, libraries and community hubs, housing advice and local area coordination.

The Case for Change: A New Model of Care

Chronic under-doctoring in Thurrock helped to accelerate system change in Thurrock and helped to further the new architecture for health and care. The production of a new strategy - ***The Case for Change - A New Model of Care*** was designed to enhance capacity in Primary Care, but also improve the identification and management of Long Term Conditions, and enable the health and care system to shift to focus on enabling people to 'achieve a good life'. This piece of work developed by the then Director of Public Health introduced a 'New Model of Care' for the local health and care system.

The findings and recommendations encompassed whole system change and led to the initial phase of the Better Care Together Thurrock transformation programme. It concluded that:

- Funding and patients were in the wrong part of the system (Acute) with the system set up to react to crisis and a need to shift demand from the 'acute' end 'upstream' to the community;
- Inadequate capacity in Primary Care was contributing to inadequate quality (and increased pressure on the rest of the system) meaning that people with Long Term Conditions were potentially not being identified and managed and that a priority for system redesign should include increasing capacity in Primary Care, Community Healthy and Adult Social Care;
- Solving the capacity and quality issues would mean that money would be freed up; and
- Solving the quality issues would mean integrating the system – and the money.

Better Care Together Thurrock

The Case for Change - A New Model of Care led to a ***Theory of Change*** process where system partners came together to agree new transformation system priorities. This led to the creation of ***Better Care Together Thurrock*** - our agreed programme of adult health and care transformation to implement the *Case for Change* strategy. It included a number of initiatives being introduced and tested in one particular area of the Borough (Tilbury and Chadwell). These included:

- The development of a Primary Care Network (prior to the introduction of PCNs as part of the NHS Long-Term Plan) – bringing GP practices in Tilbury and Chadwell together with the opportunity to share resources and capacity;
- Enhancing the capacity of Primary Care through the introduction of a mixed skilled clinical team – moving away from people always seeing a GP when they did not need to or where it was more appropriate for them to see a different clinician;
- A Population Health Management Programme focussing on improving the diagnosis and management of Long Term Conditions.
- The creation of Wellbeing Teams as a radically different way to deliver integrated, person centred health and care to residents with high levels of care acuity (see below)

Through this work, a strong focus on redefining the current system around 'place' and 'neighbourhood' was emerging and would become the organising principle for the future health and care system. The *Case for Change* also marked the time that all system players would sign up to an agreed 'direction of travel' and therefore the basis for redesign.

The emergence of a 'blue print' for the future system

At the same time, work was developing to provide additional capacity for Primary Care through the introduction and testing of new models of enhanced skills workforce. Adult Social Care introduced two key 'test and learn' initiatives utilising the same PCN geographical 'footprint'. Whilst the initiatives were introduced to help shape and redesign social care, they also provided the opportunity to test a collaborative and place-based approach to working with health and the community – plus other organisations and services key to delivering improved outcomes for people. A future health and care 'blue print' was starting to emerge.

The key initiatives that were introduced would test a completely new way of delivering social care and provide the basis from which an integrated health and care system could be developed further:

Community Led Support – located within the community, CLS social work teams focused on reducing unnecessary bureaucracy and challenging anything that stopped the team from doing what was right for the individual.

They created easier ways for people to access advice and support and co-created solutions with individuals that were based on 'what mattered' rather than needs and conditions. Much of the approach mirrored the principles that had made Local Area Coordination so successful. In addition, CLS principles were consistent with recommendations and learning that had emerged from Building Positive Futures and with the Case for Change:

- Co-production brings people and organisations together around a shared vision;
- There is a focus on communities and each will be different;
- People can get support and advice when they need it so that crises are prevented;
- The culture becomes based on trust and empowerment (with and across organisations);
- People are treated as equals, their strengths and gifts built on;
- Bureaucracy is the absolute minimum it has to be; and
- The system is responsive, proportionate and delivers good outcomes.

Wellbeing Teams – were designed to respond to the fragility of the current domiciliary care market, but more importantly test the delivery of a very different approach to providing support in the home. Consisting of small self-managed teams, Wellbeing Teams moved away from a traditional 'time and task' approach to domiciliary care and instead co-produced the support required with the individual focusing again on what mattered most. Team members were recruited against values rather and were recruited on a salary.

Like CLS, Wellbeing Team principles were consistent with what had been learnt through the development of Building Positive Futures, Stronger Together Thurrock, and A Case for Change. Both Wellbeing Teams and CLS showed what could be achieved when working at a locality level and provided a sound base from which to construct the health and care system people required rather than the system provided.

A Memorandum of Understanding across the Integrated Care System – defining the role of place in delivering population health

With the NHS White Paper establishing Integrated Care Systems (ICS) that would cover a geography far greater than the boundaries of Thurrock, it was key that the overriding vision for a place-based agenda was agreed not only by local system partners, but also by partners across the broader ICS.

An ICS partnership Memorandum of Understanding (MoU) was developed based on the principle of subsidiarity and a population health system. The nature of the agreement contained a commitment to:

- Prevention;
- Partnership;
- Whole Systems Thinking;
- Strengths and Asset Based Approach;
- Subsidiarity;
- Empowering Staff to 'do the right thing';
- Pragmatic Pluralism;
- Leverage Health Intelligence and the Evidence Base; and
- Innovation.

The MoU recognised *'the critical and increasing importance of localities and PCNs'* and supported *'the principle of subsidiarity; that the starting point for planning, transforming and delivering services should be at the most local level practicable'.*

Furthermore, the MoU cemented the *'aspiration to deliver Community-Led Commissioning/Resource prioritisation'* and recognised the need *'to shift power from organisations to communities, allowing them to drive what is commissioned, what it looks like, and to be part of the decision-making process'.*

The MoU acknowledged Thurrock as a defined 'place' – one of four across the Mid and South Essex Integrated Care Partnership.

Adult Mental Health Service Transformation

Following issues highlighted by Thurrock Healthwatch and a Local Government Peer Review Team, Thurrock embarked on a major programme of mental health service transformation including a new crisis care pathway and new Integrated Primary and Community Care model of care based around each PCN and co-designed with primary and secondary care clinicians and the community. This is explored further in Chapter 7.

Chapter 2: Our Vision, Aim, Principles and Values

Chapter 2: Our Vision, Aim, Principles and Values

2.1 Introduction

Chapter 1 set out our transformation journey to date. This chapter builds on that journey, and sets out our vision and aim for transformed and integrated health, wellbeing and care in Thurrock moving forward.

We share a collective passion to move from a 'one size fits all' top down, centralised and deficit driven approach to one that recognises the uniqueness of each resident and the need to co-design human solutions based on strengths and assets in the context of a whole system managed through learning. Section 2.2 of this chapter describes the failure of the paradigm of *New Public Management* through which we have historically delivered much public service over the last 30 years, and proposes a new *Human Learning Systems* approach and values that we will adopt to deliver transformational change.

Section 2.3 translates this theory to practice in Thurrock. It sets out our shared vision, goal and principles through which we will deliver transformation in Thurrock based on the *Theory of Change* workshops that all senior Thurrock leaders have participated in, and from wider stakeholder engagement at our recent *Better Care Together* three day conference.

2.2 Human Learning Systems

The space in which the MSE ICS and Thurrock Integrated Care Alliance operate in is multi-factorial and messy. Every one of our residents is unique and complex.

People have different strengths and skills and face different challenges that they respond to in a myriad of different ways. The issues we are trying to solve are complicated and difficult. Challenges such as obesity, diabetes, mental ill health or homelessness are caused by a tangled web of different interdependent causes. The systems designed to respond to these challenges are complicated and are not necessarily designed to deliver the outcomes people want – they often deliver 'interventions' in silo and have traditionally applied a 'one size fits all' approach to a 'problem'. The range of people and organisations involved in creating outcomes for residents is usually beyond the management control of a single person or organisation. For example, what arrives at the 'front door' of adult social care is often a result of actions that occurred at the hospital, by the community health provider, by the GP practice and/or within the family or community itself.

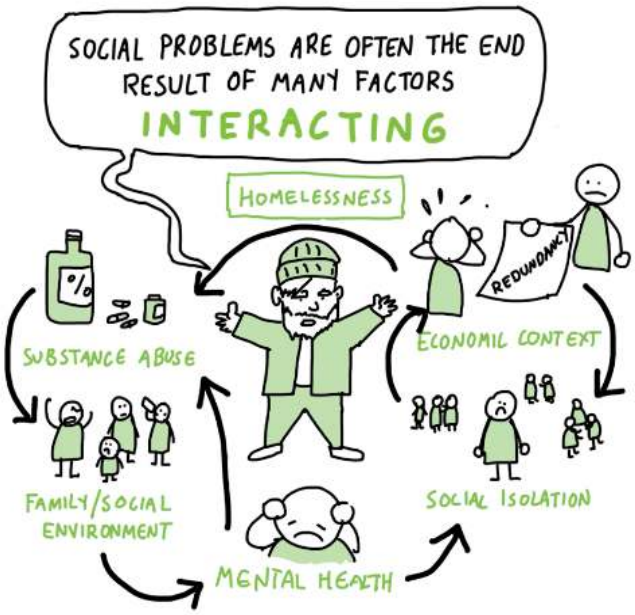
Such systems can be conceptualised as complex. It is the system and the interaction between all of the variables and system actors within the system that delivers the outcome. The variables within the system are not connected in neat linear ways, the system is constantly changing and the system does not necessarily respond in a predictable or repeatable way to defined inputs. We know we are in the territory of complex systems when:

- The system is built on human relationships;
- There are a wide variety of strengths and needs and these look different from different perspectives;
- The outcome is produced by the system itself, namely by the many factors within the system interacting together in an ever-changing way; and
- Individuals are working in systems that are beyond the control of any one of the system actors.

As public servants, we have aimed to respond to this level of complexity by trying to simplify the situation by developing services or programmes that respond to a particular 'need' or 'condition'. We have applied a 'New Public Management Approach' of *metrics, managerialism and markets*. We believed that the best way to manage the complexity was to specify SMART targets in advance for each element of the system, employ commissioning managers to turn these targets into specifications and provider managers to manage each system element against these specs. We believed in performance managing providers using performance data from pre-defined KPIs. We believed that we could improve cost efficiency through requiring providers to compete for contracts against these pre-defined KPIs.

However, this is entirely the wrong paradigm through which to understand how outcomes are made for residents in complex systems, as it is not individual programmes or services that deliver outcomes, but the interaction of a dynamic and messy system.

Most of the intractable problems that complex systems are trying to solve, whether that be the mental health crisis, homelessness crisis, obesity epidemic, or health and care financial sustainability are getting worse. Most of the demand on the most expensive parts of our system, i.e secondary and tertiary care relate to failures further upstream. Our historical approach has failed and that we need a new approach.



Paradoxically, in seeking to make complex systems easier to manage by applying a *New Public Management (NPM)* approach we actually make outcomes more difficult to achieve because when we pre-define services, processes, programmes and targets in advance and measure performance against these, a series of terrible things happen:

- We constrain front line professionals' ability to respond to the lived reality of individual residents; the individual needs and strengths of the people whom they seek to support and the underlying drivers behind these needs and strengths. We do '*to*' not '*with*'; we deliver *one size fits all* approaches, and; we fail to harness the power and strength of the individual and their immediate environment

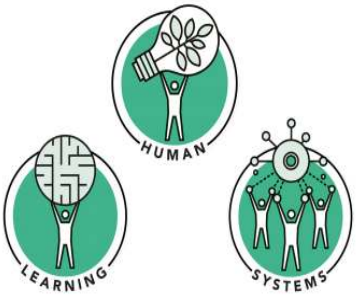
- We fragment the system into thousands of different services or programmes that operate independently of each other, commissioned from hundreds of different discrete budget lines held across multiple organisations. In doing so, we inhibit our ability to coordinate action across the system to respond to the complexity and variety of underlying needs of different residents in the equally varied context in which they live their lives. The system elements treat symptoms not causes. The system is bewildering to residents, impossible to coordinate and extremely expensive to administer.

- In fragmenting the system, we fragment the system's resources. Siloed, discrete budgets aligned to multiple teams incentivise individual managers to act in a way that protects their own service budget, not the system budget as a whole. Individual organisations are disincentivised from making investments that would improve the overall financial health of the system if another organisation reaps the financial benefit from the investment.

- Prevention is marginalised and separated from treatment. It happens in a different element of the system, often in a different organisation. Savings that flow from prevention are not re-invested in more prevention as another organisation usually reaps the benefit. NPM prescribes that the way to manage system demand is to establish eligibility thresholds for each service in order to keep people with low level needs away from the front door. The majority of services are set up to wait until a resident deteriorates to a point where they meet the threshold for intervention; the system is largely reactive rather than proactive. However, at a system level, this approach exacerbates rather than reduces demand; the system waits until people reach 'crisis point' before it responds, or sends them (via a complicated referral route) to someone else's front door – often A&E. People end up going round and round a system of our making without any real or lasting resolution.

- As no single programme can deliver high level outcomes, performance management focuses on multiple process or output KPIs as a proxy for outcomes. There is a focus on measuring quantitative data and very little focus on measuring the impact of the commissioned service on the outcomes someone wishes to achieve. We also fail to measure the overall outcome of the system because it is beyond the sphere of influence of any one system element. In short, in focusing on thousands of proxy process and output KPIs of each element of the system, we become guilty of what the philosopher Fredrich Nietzsche deemed *'the greatest form of human stupidity'; we* forget what we were trying to achieve.

- We limit our overall operating capacity. Resources are confined to those awarded to individual organisations largely through taxation. Opportunities arising from use of resources within the private sector and grant funding available to third sector organisations are marginalised. We fail to harness community assets and resources and the human resource of the residents we are engaging with and their family and friends; they become passive recipients of our services as opposed to equal partners in their care journey.
- Because we have specified each element of the system in advance based on needs assessments that consider deficits, we tend to end up with a very biomedical and deficit driven approach. Individual services are set up to 'fix' a problem that we have pre-defined. Humans are defined in the narrow term of a biological machine, and the purpose of the commissioned service is to *fix the machine*. Variation in wider determinants of health that account for between 75-80% of variation in health outcomes between residents are largely ignored.



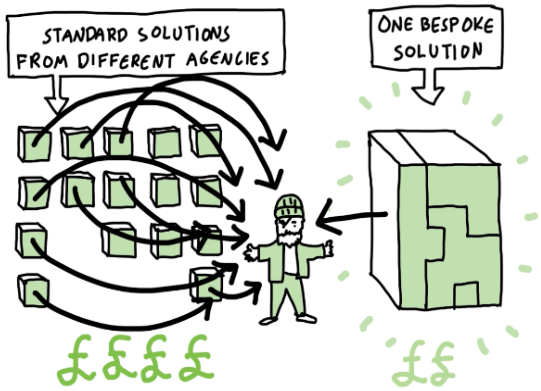
This strategy offers an alternative paradigm for public management. We call this paradigm Human Learning Systems (HLS). HLS is based on a different set of fundamental beliefs, and therefore has a different set of mutually supportive management practices. The HLS approach to public management continuously explores the messy reality of how the outcomes that matter to each person might be achieved in their unique life context. The job of public management – of organising this work – is to create the conditions whereby public service makes this possible in the most efficient and effective way. It is public service for the real world.

HUMAN

Human public service is informed by the beliefs that every resident that access one of our services is a complete, complex and unique individual with a unique set of strengths and needs. **The aim of human public service is to build a relationship with each resident we seek to serve to understand their unique context and co-design a bespoke solution with them** to empower them to address their needs. Building a trusting relationship is the starting point for human public service as the fundamental basis to allow solutions to be co-designed. Solutions need to be bespoke to the individual resident and may contain elements of service provision historically provided in multiple different services across different organisations.

To respond in a human way, we need to stop seeing people in the historical way we have set up our services, for example in terms of someone with a housing problem, a mental health problem or an obesity problem and start from their own perspective. We need to ditch our individual service thresholds that determine who can and cannot be considered eligible for a specific intervention. We need to empower front line workers to make the right decisions and do the right thing for resident sat in front of them in the context of that resident's life. As a result, commissioners need to give up the illusion of control and the belief that they can pre-determine or pre-specify one size fits all operating models for individual services. We need fewer service specific roles and a workforce upskilled to deliver a wider range of interventions. We need to ditch assessments based on our own predefined deficits and limit handoffs and onward referrals.

People who work in a way that is informed by complexity use the language of *'being human'* to describe what they do. This means recognising the variety of human need and experience, building empathy between people so that they can form effective relationships, understanding the strengths that each person brings, and deliberately working to create trust between people. Managers talk about 'liberating' workers from attempts to proceduralise what happens in good human relationships, and instead focus on the capabilities and contexts which help enable these relationships. They talk about providing support that is bespoke. For funders and commissioners, being human means creating trust with and between the organisations they fund. Trust is what enables funders and commissioners to let go of the idea that they must be in control of the support that is provided using their resource.



LEARNING

Everyone agrees that learning is important, so how is learning different in an HLS approach? Old world NPM theory proscribes that we start with a problem, test potential solutions, find something that works and then scale it up. "What works" is published in evidence based for others to replicate.

However, in a complex system, this strategy is limited, as it assumes that the system is static and linear when in fact it is dynamic and every changing. As such 'what works' is also changing and evolving. What might work to solve one resident's depression may not work for another resident. What might work in one community may be ineffective in another. There are cultural differences, community differences and policy differences and these are ever changing. COVID-19 has radically changed how our society operates, yet most of the published evidence base is based on experiments undertaken before COVID.

An HLS approach to Learning recognises both the dynamic nature of the system we operate in that delivers outcomes for residents, and the differences between different systems. In order to learn in an HLS approach, we need to learn continuously to keep pace with these changing differences. ***Continuous learning*** **becomes the key strategic outcome and mechanism through which we manage the system and leaders need to signal this.** We need to commission a learning environment to constantly test, embed and refine *what works.* Our workforce needs to be empowered and given permission to test new approaches and report what works and critically where things don't work or stop working. We need to capture and use data and intelligence in a different way to support learning including qualitative data and resident stories. We need to bring different professionals together to reflect regularly and share learning.

Commissioning for Learning

- Co-design / co-produce
- Continuously test what is working and what is not during the contract and flex and adapt the contract

Commissioning a Learning Culture

- Trust and collaboration rather than competition providers and provider-commissioner
- Reflective practice
- Positive error culture
- Separating performance and funding conversations
- Empower staff to try new approaches and share results
- Focus performance data on collection of learning results

Accountability:

- Wider use of data and intelligence including qualitative data and resident stories
- Against a broader set of principles and values
- Require front line professionals to account of their actions and whether they solved the resident's problem in the *context* they found themselves in to:
    - Peers
    - Service Users
    - Managers

SYSTEM

If we accept that it is the interaction of all of the many variables in the system that create positive outcomes for residents, rather than individual services or programmes, then we need to ask ourselves a new question: '*How do we create healthier systems?*,' because healthier systems create better outcomes.

The role of system leaders and commissioners shifts from one of specification and performance management to one of *system stewards*; their function is to look after the health of the system. System Stewards start by building trusting relationships between all of the system actors. They ask questions like:

- Who are all of the system actors who have a role in delivering the system outcome?
- How can a build relationships between the system's actors based on trust?
- How can we collectively develop a sense of shared purpose?
- How can we ensure that we can learn together?
- How easy is it for us to collaborate together and share information?

There then needs to be processes of co-design, experimentation, finding out what works and embedding that practice within the system. This will inevitable change the system and so the cycle repeats as the new system needs to be re-revealed. This is shown in figure 2.2 overleaf

Systems operate at different scales. A system could be a resident's life, an individual service, an organisation, a neighbourhood, a borough, or a specific outcome. A system that delivers the outcome of obesity will look different to a system that delivers the outcome of good mental health.

Figure 2.1 Systems at Different Scales

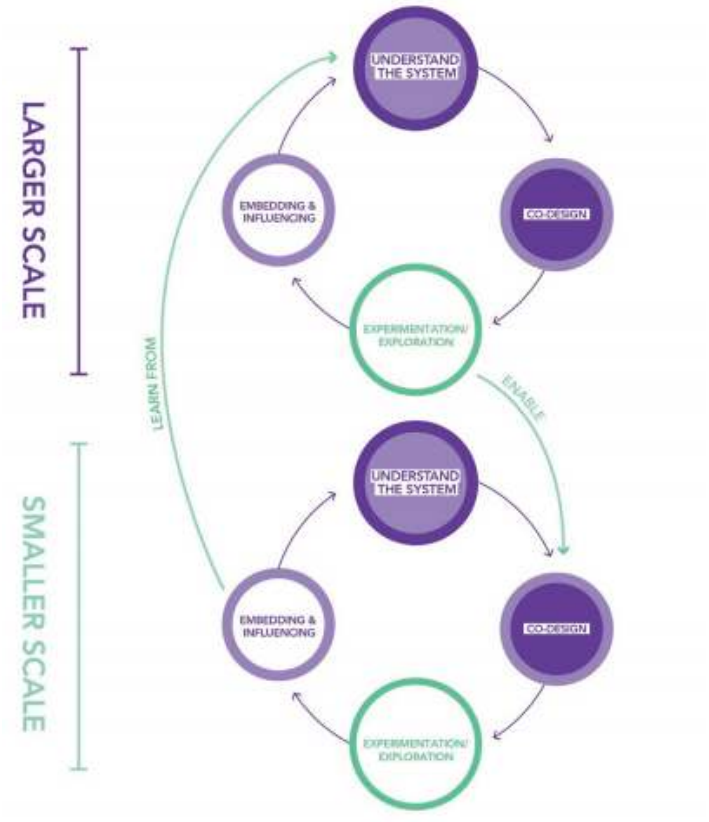
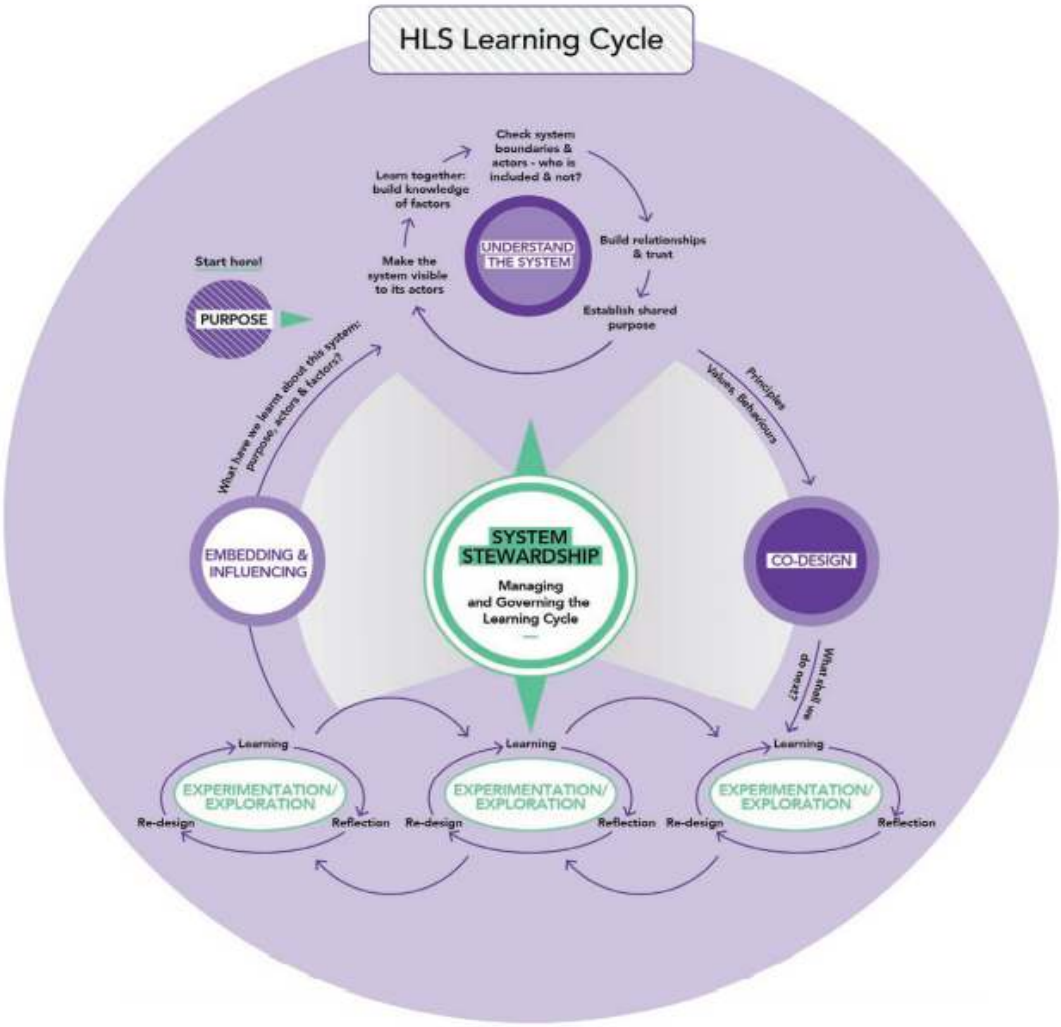


Figure 2.2. The HLS Learning Cycle



Implementing an HLS Approach in Thurrock

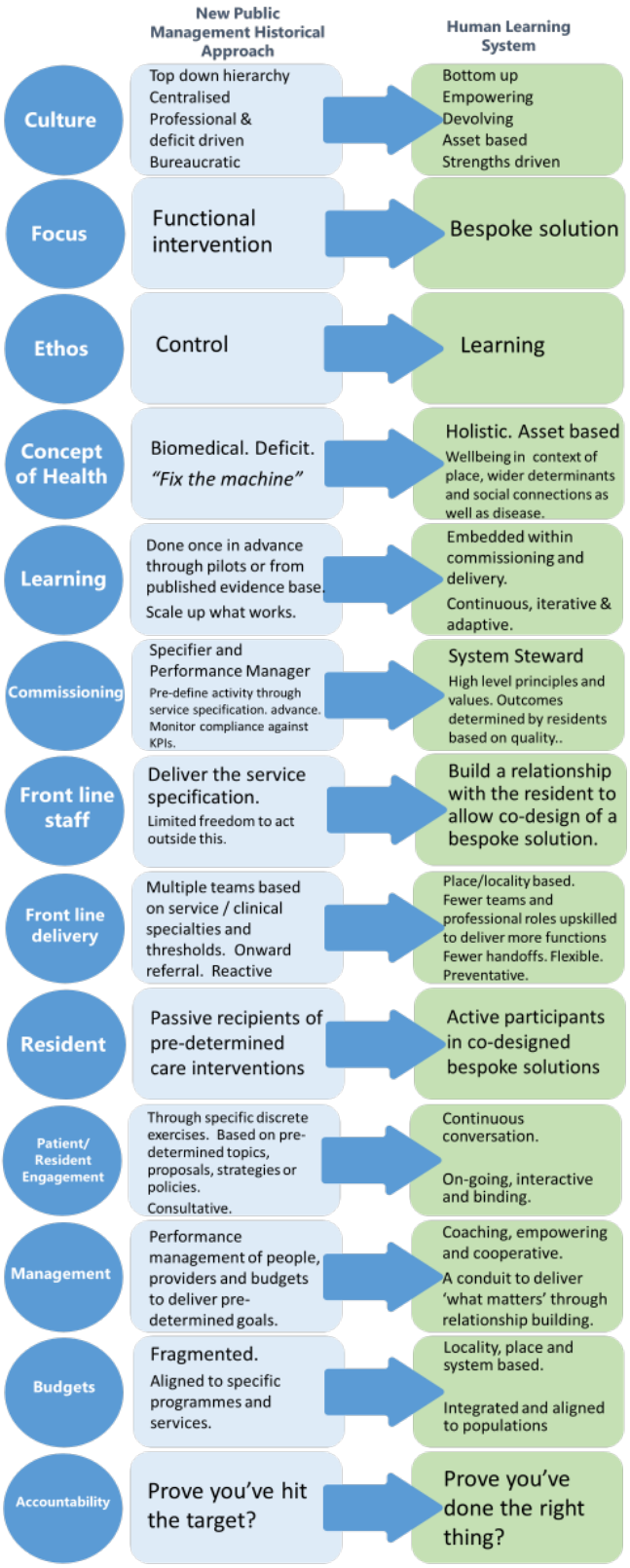
Many of the most succesful areas of transformation in Thurrock are already operating on HLS principles. These include our Local Area Coordinators, Community Led Solutions, Community Builders, Wellbeing Teams, and Integrated Primary and Community Mental Health Care. They are delivering better outcomes for residents by freeing front line staff from pre-defined service specifications, KPIs and bureaucracy and empowering them to co-design bespoke solutions with residents that respond to individual context.

Similarly, our *Theory of Change* process has formed the basis of a shared vision between Thurrock leaders based on long-term trusting relationships and a sense of shared purpose.

However, our successes still operate in a wider context of *New Public Management* with too many discrete services and thresholds, onward referral and pre-defined operating models.

Moving forward, we will transform our entire Alliance on HLS principles, delivering bespoke solutions co-designed with residents. This requires a systemic shift in the way we conceptualise and deliver public service in health, wellbeing and care across our borough. The transformative change we will deliver is set out in Figure 2.3 overleaf.

Figure 2.3: The Change We Will Create



2.3 Our Shared Goal, Desired Impact, Outcomes and Principles

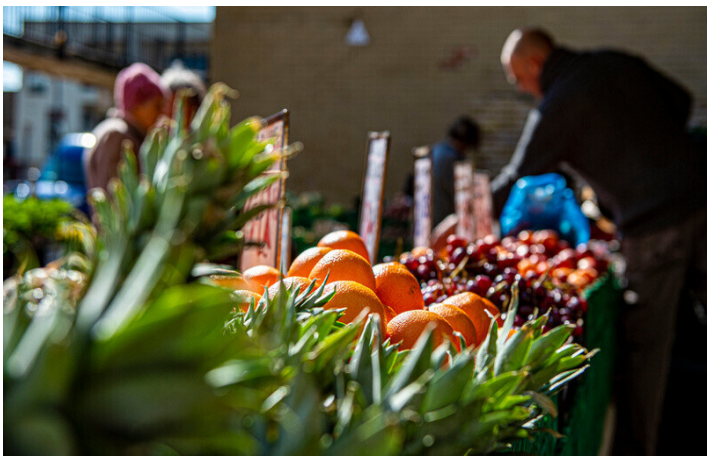
A HLS approach is based on the concept that we need to create healthy systems to deliver healthy outcomes. A healthy system is underpinned by strong relationships between all system actors based on respect and trust and a shared vision and understanding of the system.

In 2020, Thurrock CVS facilitated a second *Theory of Change* process consisting of a series of workshops that brought Thurrock's health, care, well-being and third sector system leaders together to debate and agree our vision, goals and principles that under pin our local transformation. This built on the original *Theory of Change* workshops that were undertaken in 2017. We believe that much of our transformational success to date in Thurrock is due to the strength of our local long term partnership relationships and shared values.

From the second *Theory of Change* process, we agreed the following:

Our Overarching Goal

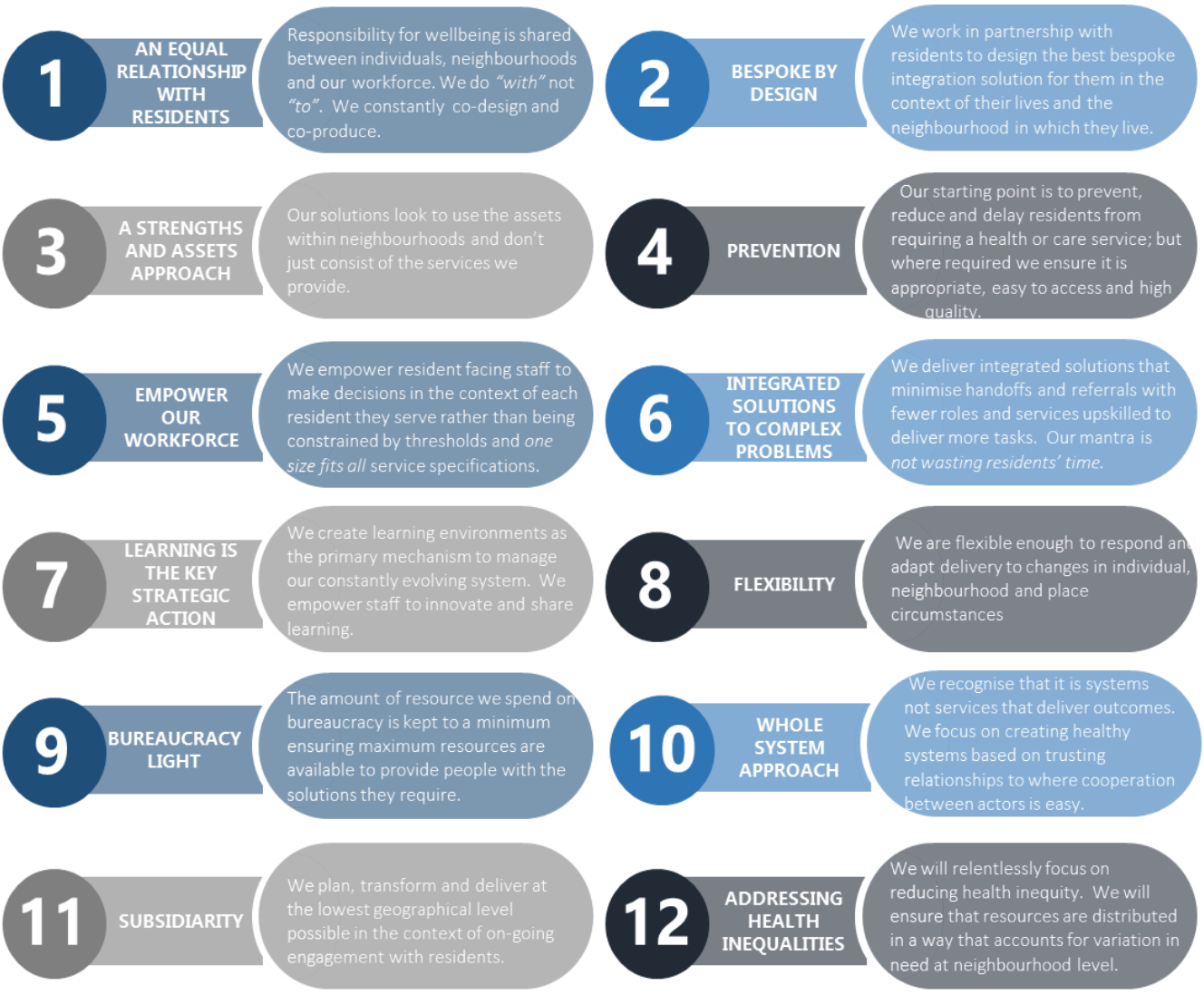
Better outcomes for individuals, that take place close to home and make the best use of health and care resources.



Our Desired Outcomes

- Residents are able to achieve more of what matters to them
- Support is provided in collaboration with the community and focuses first and foremost on what the community can offer
- Residents maximise opportunity to stay as healthy as possible and require fewer interventions from services.
- Residents are able to find the right solution for them first time and in the right place.
- Residents are empowered to achieve their version of a good life
- Our alliance and system resources achieve better outcomes through earlier intervention and preventative integrated solutions that reduce 'failure demand'.

Our 12 Transformation Principles



Chapter 3: Our Integrated Wellbeing Model

Chapter 3: Our Integrated Wellbeing Model

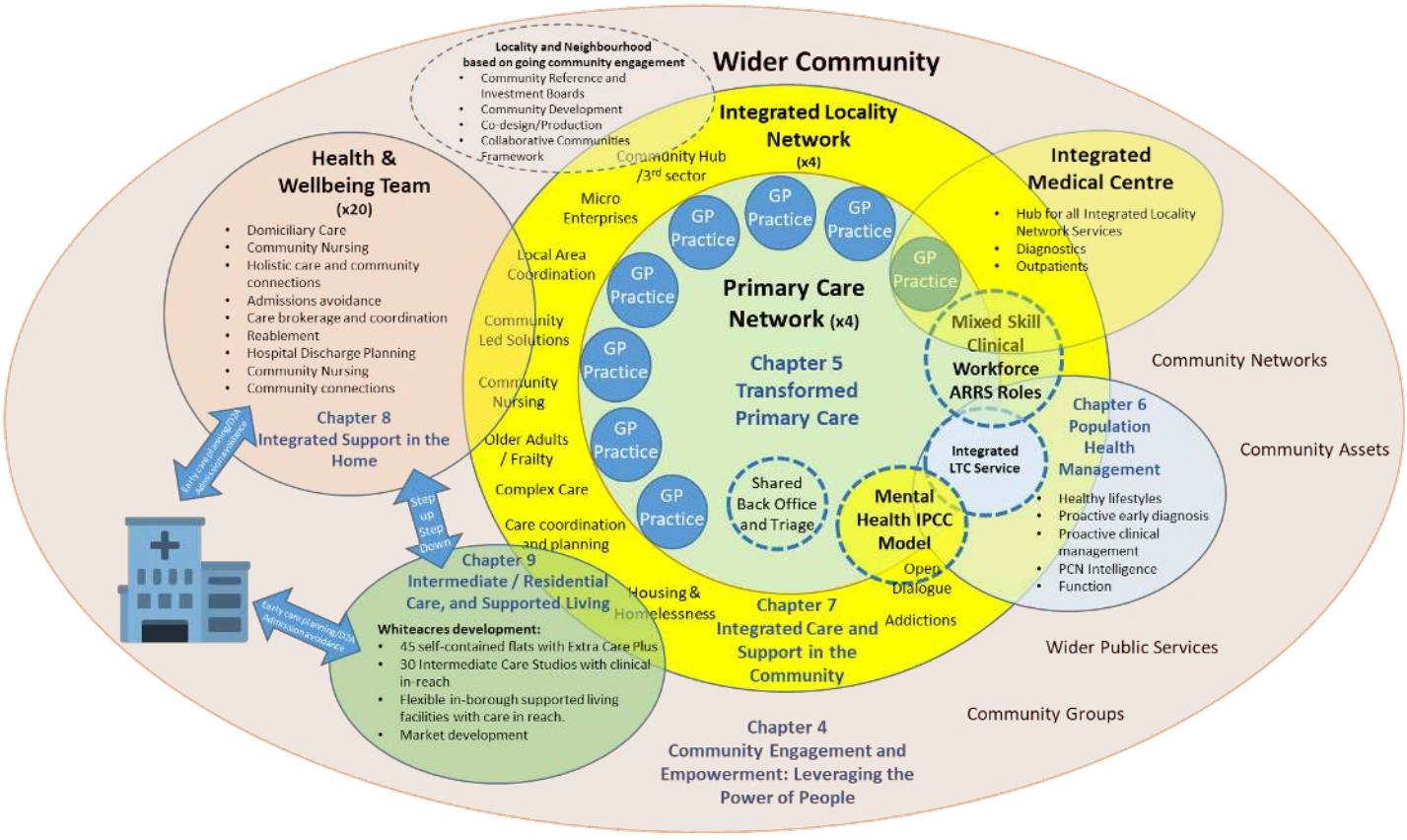
This chapter provides an overview of our wellbeing model and how the different elements interact. Chapters 4 to 9 unpack each element individually and act as individual strategies in and of themselves that can be read independently and provide a blue print for transformation of specific system elements.

However, as we noted in Chapter 2, in a complex system, it is the interaction of variables, elements and ultimately people that deliver outcomes rather than individual teams or programmes. It is therefore important to understand the interdependencies between the chapters and their respective transformation plans.

In developing a whole system approach to health and care transformation, we have tried to make it as easy as possible for front line staff to collaborate with each other and residents to co-design single integrated solutions, keeping bureaucracy, assessment and onward referral to an absolute minimum, freeing up staff to spend more time delivering care.

Figure 3.1 shows our re-imagined and transformed system, our Integrated Wellbeing Model and the remaining chapters within this strategy to provide more detail on each element:

Figure 3.1



Leveraging the Power of Residents and Communities (Chapter 4)

At the heart of our plans are residents and communities. Historically, we have too often seen the world through teams, services and problems that we have defined in advance rather than through the eyes of residents. Residents don't live their lives through our services and the 'deficits' we define need fixing but through their own communities and neighbourhoods.

Thurrock already has a long tradition of working in a strengths and assets based way; starting with 'what's strong' rather than 'what's wrong'. Programmes like Stronger Together, our Collaborative Communities Framework, Micro Enterprises and Local Area Coordination recognise the power of harnessing the skills, abilities and ingenuity of those with whom we work, their families, friends, neighbourhoods and communities. We are proud and extremely fortunate to have exceptionally strong partnerships with a vibrant and diverse community and voluntary sector, and our Community Hubs already provide places from which residents come together to help each other. However, too often our engagement with residents remains in silos, centred around services or strategies that we think are important, and is consultative rather than binding. We recognise that we need to go further; building Community Reference and Investment Boards as single mechanisms to have an ongoing conversation with residents and genuinely co-design and co-commission in a way that addresses their neighbourhood and locality priorities. We will build on our successes to date and extend the strengths and assets based ethos across our entire health, care and wellbeing system. Chapter 3 sets out our plans to do this.

Transformed Primary Care (Chapter 5)

In the centre of our transformed system is primary care. Ensuring high quality and easily accessible primary care is critical to our residents, and whilst the quality of primary care locally has improved significantly over the past six years, we know that satisfaction locally lags behind national benchmarks. The ratio of general practitioners and practice nurse to patients in Thurrock has historically been significantly worse the England and in a competitive workforce market, we need to create a system attractive to future clinicians to attract the brightest and best to the borough.

The inception of Primary Care Networks (PCNs) provides a huge opportunity to "level up" primary care services locally, providing the ability to deliver more services once at scale, share best clinical practice and share and expand the existing workforce; improving access and reducing variation in outcomes between individual practice populations. Our plans to do this are set out in detail in Chapter 5.

Preventative and Proactive Approaches through Population Health Management (Chapter 6)

Too often, our health and care service waits until people become seriously unwell before providing a service. We need to shift focus from this 'reactive' care model to one that is genuinely proactive and preventative; empowering residents to address unhealthy behaviours, diagnosing chronic disease conditions earlier and providing high quality clinical management to ensure people can stay as healthy as possible for as long as possible. Population Health Management (PHM) – using integrated data and intelligence to identify risks earlier and intervene provides new opportunities to tailor proactive care at different cohorts of residents to improve their health and manage their long term conditions. Thurrock has been an early adopter of population health management approaches and our PHM approach has already significantly improved cardio-vascular disease outcomes in our population and prevented hundreds of strokes and heart attacks. But to date, this work has largely been delivered in clinical silos, considering different conditions in isolation, and in organisational silos, focusing action and individual GP surgery level. Chapter 6 sets out the next phase of our transformation on proactive and preventative care including embedding healthy lifestyle services within each Primary Care Network, creating Integrated Long Term Conditions clinics where multiple chronic diseases can be managed in a one-stop-shop, and leveraging the power of integrated data to support clinicians and other front line staff to deliver proactive, tailored interventions to residents.

Integrated Care within the Community around the Primary Care Network (Chapter 7)

Beyond the Primary Care Network, there currently exists a dizzying array of individual teams and services, provided by different organisations, each with their own referral criteria, threshold and standard operating procedure, each designed to 'fix' a single issue clinical or social problem. However, we know many of our residents do not live their lives like this; they face complex challenges with multiple causes needing support from many different places. The way we have designed our system in this fragmented way is no-longer fit for purpose. It hinders collaboration between professionals, it delivers 'one size fits all' simple solutions and it is hugely inefficient to administer. Worst of all, too often it fails meet the complex needs of many of our residents, leading to 'failure demand' where residents end up accessing the most expensive elements of our system like Accident and Emergency because either their health has deteriorated from lack of earlier support, or simply because it is the 'front door of last resort'. Paradoxically, the greater the resident's need and the more complex a resident's problem is, the more difficult we make it for them to access the support they require, because the more teams and services they need to navigate.

Radical change is required to address this fragmentation. We will bring a wide range of professionals from multiple teams together in a single Integrated Locality Network at locality level around each PCN. Our Integrated Locality Network model will make it easy for different professionals to build relationships with the PCN and each other, to co-design single integrated bespoke solutions with residents and negating the need to make individual referrals or assessments. For the most complex problems, this will include a single integrated care plan and care coordination. We also want move all provision to adopt a strengths and assets based coordinated approach. Ultimately, through further test and learn pilots, we will create new 'blended roles' within the Integrated Locality Network; staff trained to undertake common tasks traditionally undertaken by different teams and organisations, for example a new Community Case Worker role that is able to deliver mental health, housing, debt advice and addictions support. Chapter 7 of this strategy details our plans for Integrated Locality Networks.

Integrated Support within the Home (Chapter 8)

As our population ages, care is increasingly delivered within the home. Historically, this has been fragmented into a failed, fixed 'time and task' model of domiciliary care, supplemented by multiple health professionals from different teams coming into the home to deliver different tasks. This model is inefficient, in personal, inflexible and reactive. Our Wellbeing Team model has already demonstrated a better way of delivering home care; small self-directed teams of Wellbeing Workers forming long-term relationships with those whom they care for and with their families and friends, to deliver a more flexible, holistic and preventative approach. We want to build on our learning from the Wellbeing Team pilot and roll out the model across the borough. But we also want to go further, upskilling Wellbeing Workers to undertake more routine clinical tasks, aligning Community Nursing functions, and embedding early hospital discharge planning and reablement within the teams. This will facilitate early supported discharge and discharge to assess approaches, improve care continuity, rationalise the number of different professionals needing to visit residents at home and creating truly Health and Care Wellbeing Teams. Teams would also be responsible for brokering in more specialist support from the Integrated Locality Network where necessary and for care coordination around a single integrated plan. Our evaluation shows that residents cared for by Wellbeing Teams have significantly lower rates of hospital admissions and GP appointments. Through our new approach, we believe that we can deliver higher quality outcomes for residents, a more personal and preventative service at a reduced overall system cost. Our plans for the next phase of Wellbeing Teams are set out in Chapter 8.

Intermediate and Residential Care, and Supported Living (Chapter 9)

Finally, we know that there are some residents whose health and care needs are such that they are unable to remain in general needs housing, or are unable to be discharged home directly from hospital and so are placed in either residential/nursing care or intermediate care beds. Our residential care providers have performed magnificently throughout the COVID-19 epidemic by continuing to provide high quality care to some of our most vulnerable residents. However, entry into residential care is almost inevitably due to necessity rather than choice, with residents having to trade the privacy and independence of living in their own home for the additional intensity of care available on site in residential and nursing facilities. In Chapter 9, we aim to address this by reimagining and setting out plans to build new type of "Extra Care Plus" facility where residents are able to live independently within their own apartment but with the same level of 24/7 care on-site that is delivered in traditional residential care settings. Our proposed development at the Whiteacres site in South Ockendon will also encompass 30 intermediate care studios, again with access to 24/7 specialist care on site and additional clinical in-reach from the Integrated Locality Network as an alternative to Community Hospital Intermediate Care beds.

The chapter also sets out exciting new plans to purchase dedicated housing stock in which to provide additional supported living facilities within the borough with flexible 'care in-reach' from the Integrated Locality Network as an alternative to traditional models of supported living for people with mental health problems, where care packages are commissioned in advance and fixed. We believe this new model will support independence and 'move on' back into the community for those struggling with their mental health in a way that traditional models of supported living are failing to do.

Chapter 4: Community Engagement and Empowerment

Leveraging the Power of People

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

4.1 Introduction

Our partnership with the strong, diverse and vibrant communities that we serve is at the heart of everything that we do in Thurrock. We are incredibly fortunate to have a vibrant and committed community and voluntary sector within the borough, and we are rightly proud of our deep and long-term relationship with them. As we described in Chapter 1, they have been front and centre of our transformation journey to date.

Chapter 2 set out our shared values and principles including a commitment to strengths and asset-based working and Human, Learning Systems principles. In January 2021, Thurrock Council's Cabinet approved our *Collaborative Communities Framework* that encapsulates this shared commitment to work in partnership with residents and the third sector. In this chapter, we dive deeper into this area and discuss in more detail our partnership with the third sector and residents and their critical role in the next phase of our transformation journey as we devolve more power down to community level and build on our existing success in Asset Based Community Development and strengths/asset-based community approaches to delivering services in partnership.

Case Study One: John

John is 70 years old and lives alone in Grays. He fell down the stairs at home and was discovered on the floor by a delivery driver who called an ambulance. John was admitted to hospital where he was found to have unmanaged health conditions and an addiction to alcohol.

On discharge planning, Thurrock's Adult Social Care Hospital Team referred John to *By Your Side*, the borough's voluntary sector community support service. Buy Your Side worked alongside John's social worker and Local Area Coordinator to enable a smooth discharge from the acute hospital by sorting out practical problems that would otherwise have delayed his discharge home. John's property and possessions were found unsuitable for him to return straight home to, and so the service organised a cleaning team to get the property ready.

Over a six week period, *By Your Side* supported John with volunteers and through community connections by:
- Collecting equipment from Thurrock Hospital prior to John's discharge.
- Sourcing donated bedding and clothing from local projects, to replace items after the clear up of his home.
- Shopping for new clothing on John's behalf.
- Making welfare calls to John every other day, to check in on him and ensure he felt safe and was not anxious.
- Undertaking John's food shopping.

By facilitating a smooth discharge, and providing six weeks' support to John, *By Your Side* used knowledge of community assets and networks to help John regain his independence and confidence whilst he settled back into his home. They encouraged him to look for ways to support himself going forward by signposting to the *Thurrock Micro Enterprises Scheme*. They also connected John to other residents in the community with shared interests to improve his mental and social wellbeing and provide an alternative to drinking alone in the house.

As the above case study demonstrates, involving the community and its assets can have a very positive impact upon the delivery of solutions that support improved health and well-being in our citizens. It is therefore no surprise that most emerging strategies in health and social care put the importance of engagement, both at a community and individual level, as a central principle in their plans to transform the way that services are delivered. Alongside this, various power and influence sharing techniques, such as co-production and co-design, have a significant role within such plans. However, there is also evidence that involving communities and individuals in their health and care can prove counterproductive if the techniques used do not take account of how people and communities organise their lives, or if the involvement seems to be no more than lip service:

Whilst the evidence suggests that for some individuals there are a range of clear and identifiable benefits from community engagement, across the review studies the range of methods and approaches used varies and are not consistently replicated across all settings and initiatives to allow the evidence to demonstrate which is the most successful. It is difficult, therefore to attribute specific benefits to any one approach or method. Evidence from a number of studies [1] [2] does suggest however, that individuals are less likely to find community engagement a positive experience where *consultation* is the main method employed by professionals and no real power to effect change is ceded to community members.

Therefore, if the approach used in Thurrock is to continue to have the impact required to significantly improve the overall well-being of our individuals and communities it must guard against such pitfalls. These include:

- A failure to effectively engage because the ways in which engagement is delivered do not reflect the ways in which individuals and communities organise themselves
- Top down approaches, such as surveys and formal consultations, where the subject matter is predetermined by professionals and limited in scope and where the method is difficult to access
- Feedback is poorly relayed (or worse not provided at all), which further emphasise the common belief that consultation and engagement is pointless and changes nothing where there is no evidence of the essential power shift away from professionals and organisations and towards citizens and communities; this shift being crucial to feelings of authentic influence emerging from active community involvement
- Where engagement activity is badly co-ordinated and organised, leading to a large number of such activities, often asking very similar questions, landing in communities all at once; this creates "engagement fatigue" so often a characteristic within communities
- Where engagement becomes the property of a few very active and vocal citizens, who do a valuable job in representing themselves, but who cannot claim to be truly representative of the diverse and complex communities that exist
- Failure to ensure real investment is made in the infrastructure within communities (along with our crucial local third sector) meaning that growing expectations on them amount to *"asset stripping"* rather than a greater reliance upon community assets.

There is therefore a need to design a representative, bottom up, flexible and multi-faceted local methodology for community engagement and co-design if the Thurrock Place Based Strategy is to deliver transformation; a transformation that provides clear evidence that these agreed priorities are at the heart of the local transformation in health, care and well-being.

4.2 Our solution: Asset Based Community Development

Asset Based Community Development's (ABCD) premise is that communities themselves can drive real improvement in wellbeing by mobilizing existing, but often unrecognised assets. As a challenge to established forms of delivery, particularly commissioning, it asks that we consider:

- What can communities can do for themselves if professional services get out of the way?
- What can communities do with some support from organisations?
- What is left that is appropriate for organisations to deliver?

This radical challenge to the statutory and third sector creates a useful analytical tool for understanding the extent to which the "professions", in the broadest sense, have encroached on and usurped areas within which individuals and communities are best placed to identify and manage their own solutions; it therefore resonates with emerging themes such as self-care and prevention.

By adopting an asset based approach, Thurrock, through the Stronger Together Partnership, has successfully introduced a number of innovations (Local Area Coordination, Time banking, Social Prescribing, Community Builders, etc.) since 2013, however more can be done.

ABCD is a powerful method for facilitating the shift in power essential for successful transformation in the Thurrock model; shifting people away from being passive recipients of service to active citizens fully engaged in their health and well-being. Our approach empowers residents to contribute to how, when, where, and the way they receive the support necessary to them realising their vision for a good life (Figure 4.1).

Figure 4.1 – Citizen Power Progression

Commissioning for Change

As we learnt in Chapter 2, the historical *New Public Management* model of how the public sector has commissions services has led to a fragmented and confusing service landscape that fails to solve residents' problems and disempowers them from engaging as equal partners in action to improve their wellbeing. Commissioners set the model that they require, often with little involvement of those to be supported, select through a restrictive procurement process that vastly favours big organisations above SMEs and the Third Sector, and then set a series of performance indicators that have little to do with achieving the outcomes people would choose for themselves.

Conversely, Thurrock's Human Learning Systems approach, which has already underpinned some of our most successful transformation, seeks to deliver bespoke, integrated human solutions in partnership with residents. In many ways, this is antithetical to the traditional model of commissioning now used. Transforming commissioning to support HLS will require a change in culture, with all involved: commissioners, providers, practitioners and the public having to work for or with support systems in a more relational, collaborative and open way. It will also generate significant challenges to accepted models of governance and regulation. However, it is a challenge worth meeting.

This approach also provides the opportunity to embed our commitment to the realisation of social value through commissioning, reflecting community priorities at PCN/neighbourhood level in a refreshed version of our Social Value Framework. We will continue to explore the approach to support a sustainable third sector with community investment that keeps bureaucracy to a minimum.

Model of Good Practice:
Liverpool City Region Combine

Rather than develop a service specification that stated *'for the next three years you need to deliver these outcomes'*, the specification allowed the provider/commissioner always to evaluate and develop delivery models/services to ensure that they continued to respond to the variety of needs demonstrated by the client group, reflect best practice and have a clear learning impact on future delivery and commissioning.

4.3 Thurrock's Transformation Proposals for Our Next Phase of Asset Based Community Development

Improving engagement/co-design

As has already been stated, the traditional forms on engagement (such as consultation and surveys) are not effective and can even have an adverse impact upon well-being with people feeling pressurised to take part or communities suffering from "consultation fatigue".

Instead, we need to build an infrastructure to allow engagement and influence to become part of the DNA within a given locality, and to improve drastically our ability to collect the background noise found in every interaction that takes place between staff employed in their given localities and citizens.

Building the infrastructure

Thurrock already has a number of key operations and personnel that operate within their communities and are accessible to citizens in a range of ways:

Community Led Adult Social Care Support Teams (CLS).

Our CLS teams operate across the four quadrants within Thurrock that match the four Primary Care Networks (PCN) already established.

They operate a series of Talking Shops, utilising a range of accessible community assets such as supermarkets and libraries, within which members of the public drop in to address any social care needs, or often other types of support requirements, can be discussed and solutions identified or information and advice is provided.

Social Prescribers

Working out of GP surgeries the social prescribers provide a wide range of information, support or signposting to assist people to identify the solutions they require across a very wide range of well-being issues.

Alongside these two examples we have a range of other community based support services that provide direct support utilising community assets, such as Local Area Co-ordinators, Housing officers and the Micro Enterprise Scheme, or who provide localised statutory support such as Community Health providers and Well-Being teams.

However, in order to co-ordinate these schemes better and to fully involve citizens and professionals in the design and delivery of localised support we will further enhance the PCN based infrastructure through the development of Communities of Practice in each location.

Community Builders

Our Community builders operate across the four localities within Thurrock, helping communities to have a voice and connect in their local area and to take part in local decisions. They met with local groups and residents helping them to access opportunities.

Community Hubs

Community Hubs act as a physical anchor to bring people together where they live to enjoy time together, reflect on and discuss local issues and potential solutions, and access information about activities and support available locally. Being able to meet different people where you live is essential to building cohesive communities in a borough that is facing growth and demographic change. By sharing concerns and aspirations, citizens are more likely to create resilient and strong communities. Most hubs are co-located in Thurrock libraries and are organised on PCN footprints.

A Nitter-Natter Group at one of the Thurrock Community Hubs

Communities of Practice (CoP)

A Community of Practice can been defined as *"a process of social learning that occurs when people who have a common interest in a subject or area collaborate over an extended period of time, sharing ideas and strategies, determine solutions, and build innovations".*

In Thurrock we will use this mechanism to establish two Communities of Practice on each of the four PCN footprints to bring together people with vested interests in those locales to ensure delivery and design are coordinated and based upon community concerns and choices.

Community of Practice (User Led)

The first CoP will be formed from a wide variety of interested groups and individuals across the locality in question and be charged with agreeing priorities, designing strategies and solutions to meet those priorities and ensuring local intelligence feeds into all decision making processes from a neighbourhood to a system wide scale. As such, it will be the major forum to ensure community interests are represented at every level of decision making.

Community of Practice (Direct Delivery)

The second CoP will be formed from paid staff and others who are directly involved in the delivery of transformed support services across the PCN footprint. Having this CoP will ensure that the support being provided stays within the design principles as set out within this strategy, and vision and local priorities that emanate from the user led CoP. It will be a forum for learning and discussion, using HLS methodology, where those with a key responsibility for improving local outcomes will have an open and transparent opportunity for exploring emergent themes and issues and collaborating to ensure learning informs the evolution of solutions to meet changing circumstances identified from local intelligence and the wider system.

The Communities of Practice infrastructure will be started in one PCN area, to allow a test and learn approach to be used before scaling up across Thurrock.

Improving local intelligence

We need to improve the collection of local intelligence without adding to the burden that local communities feel when constantly being asked to respond to consultations. One obvious way would be to capture intelligence from interactions between professionals and members of the public.

To do so successfully organisations need a way of capturing this constant flow of information in a centralised and coordinated way; thereby having the ability to analyse the data, use it constructively and, where possible, ensure a constant feedback loop is in place so that citizens see evidence of their opinion being used constructively.

This would quickly be seen as an authentic use of people's perspective, not just a service led, top down exercise in gathering information having already decided what is to be done. This approach would contribute towards a growing sense of community empowerment, with individuals becoming far more active citizens as they experienced a genuine sense of involvement and influence.

There are a number of platforms that can support the collection of real time intelligence, enabling information to flow, be analysed, and used to inform the evolution of the system in a very timely and direct way. It would also enable feedback to be delivered more consistently and quickly than is currently possible. We will provide such a platform through the *Air Table* system as part of our improved community engagement and co-design strategy, building on the HLS priorities of collaboration and learning as crucial components of the transformed system.

Resourcing the Community

In order to break down siloed budgeting, we need to create four genuine pooled funds at locality level. These funds can then be used from which to commission integrated services that respond to the needs and deliver the solutions identified within the four localities. Figure 4.2 sets out our approach.

Figure 4.2

These four Community Investment Funds will provide a mechanism by which to deliver solutions at locality geography that addresses multiple needs that historically would be the responsibility of different organisations or teams within organisations, hence delivering a more integrated system and holistic response. A shared fund provides opportunities to access additional funding streams open to public and voluntary sector including bidding for third sector grant funding against matched funding already held within the Community Investment Fund. It also provides a mechanism to capture additional resource from the private sector.

We will create Community Reference and Investment Boards comprising of a range of community leaders to oversee the process.

By placing responsibility on the Community Reference and Investment Board for distribution of funds, we devolve power from public sector organisations to communities. The process will follow HLS principles by commissioning for learning and on high level principles and values rather than predetermined actions, empowering providers to offer bespoke solutions to residents and separating decisions about funding from decisions about performance. In short, it will foster collaboration rather than competition.

Again, the proposal is to develop a single board, on the same PCN geography as that in which the Communities of Practice test and learn site is being deployed, to ensure there is time to fine tune any issues prior to scaling up Thurrock wide.

Micro Enterprise Development

Thurrock council, in partnership with Community Catalysts, has driven the development of a Micro Enterprise scheme locally for the past four year. Micro enterprises are small, local businesses, very often sole traders, who provide a vast range of needed services to their community. Typically, micro enterprises (Micros) are started by people who are marginalised, either through underlying factors such as ill health or loss of a long term career, consequently they are individuals who struggle to enter, or return, to employment.

Developing Micros has a number of key benefits:

- They create supply that is needed in the local economy.
- This supply is often "bespoke". For example, in the care field, the partnership between the cared for and the carer creates a service based on the unique situation of the person supported, not on the restrictions that inevitably exist with large provider organisation.
- The money flow stays within the local economy.
- The impact upon the well-being of the person running the micro is very significant. This results from a growth in sense of purpose that was not previously present, or, which returns, as a result of making a positive contribution.

Since the inception of the programme in 2015, we have supported the development of well over a hundred micros enterprises. They provide a variety of services, the majority in the care and well-being sector. These enterprises have added a hugely positive dynamic to the communities they serve, and their success has generated much interest, hence the continued expansion of Micros.

Thurrock currently has one full time officer supporting this programme who is becoming increasingly stretched as more services require support. There has also been a shift in the type of contact received, at times moving away from the usual individual who wishes to start a micro, towards people who have very innovative ideas, but whose start-ups would be best suited to establishing a Social Enterprise or charity and not a sole trader type of provision. There are a number of local schemes that can provide support: CVS, the School for Social Entrepreneurs, Business Link, DWP etc., but none of these provide the longer term practical support required to give these start-ups a good chance of success. There is a danger that we are missing out on the establishment of a range of local entrepreneurs, with excellent ideas, who could provide exciting and much needed local economic activity, whilst also creating a very positive impact upon their own, and others, well-being and sense of purpose.

We will therefore expand the programme to deliver a "Community Economic Unit" (CEU), in each of the Primary Care Network areas that could support both the ongoing development of Micro Enterprises and provide the kind of practical advice and guidance needed to support other forms of community economic development.

The CEU would work closely with the coterminous Community Reference and Investment boards and the Communities of Practice to provide a comprehensive local economic infrastructure capable of supporting micro and macro support to all aspects of commercial activity in their area.

It seems abundantly clear that one of the most significant long term consequences of the pandemic will be a down turn in overall economic activity, with the already disadvantaged hit particularly hard in terms of employment opportunities. This programme has the potential to link with skills investment opportunities though the *Levelling Up* agenda to help ensure disadvantaged groups can access real opportunities for this cohort of our society to find meaningful employment, utilising their own initiative and creativity, thereby having a significant impact upon their sense of self-worth.

Case Study 2: The Power of Micro Enterprises

A is a young man in his 30s who was introduced to Thurrock's Micro Enterprises Scheme by the DWP. He had formerly held a senior position in local industry, however the pressurised environment in which he worked had led to an episode of mental ill-health that had also led to his involvement in substance misuse and subsequent job loss.

Whilst in rehabilitation, A's Community Led Solutions Team supported him to take up a hobby, and he found that angling supported his wellbeing and recovery. He became passionate about the sport and was interested in setting up his own angling business. His aim was not only to earn a living but also to support others who found themselves in a similar position to himself.

Working in partnership with the DWP, Thurrock Council, and other organisations, the Micro Enterprises Scheme supported A to set up his business, find funding to purchase equipment and apply for his coaching badge. A is now set to launch his business in the Spring of 2022 and is already receiving enquiries about his new venture.

A said:
"Spending time outside in nature by the water dramatically improved my well-being. It was like I had found a whole new world that I wanted to live in again. My anxiety and depression became manageable without the use of substances. I have been clean ever since. I owe my life to fishing, and I intend to share this new world with as many new people as possible. I honestly believe that fishing can help change many lives for the better, and possibly even replace anti-depressants".

This statement shows the power of the Scheme in transforming residents' lives. Not only does it provide different, low or no-cost alternatives to people, it also gives the person behind the micro-enterprise that all important sense of purpose and control, fundamental to improving their wellbeing.

4.4 The Impact of Thurrock's Approach and System 'Ask'

Impact

The impact of such a wide scale cultural and delivery transformation will be system wide and extensive. They will achieve the following significant but far from exhaustive outcomes:

- Making co-design a reality
- Achieve massive culture change from 'doing to' to 'doing with' (Strengths based)
- Transform the commissioning landscape – moving to collaboration and stewardship
- Radically challenge the current performance culture that encourages organisational performance 'gaming' and is largely meaningless to the people we support
- Encourage culture change in providers – moving from competition to cooperation in the pursuit of best outcomes
- Improve preventative services – reduce demand
- Improve models of self-care – reduce demand
- Reduce duplication-improve efficiency
- Create more resilience in communities and individuals

It is clear that the health and care system is failing and in need of radical transformation if it is to be fit for purpose for the 21st Century. Moving to more localised organisation and delivery of services, based upon what people can do rather that what they cannot, involving citizens more directly in their care and producing a dynamic system that can constantly learn and develop seems to offer an evidence based and cogent alternative. This strategy and our collective approach will deliver this paradigm; the real question is, if not this, then what?

Our ask of Mid and South Essex ICS

Whole System Support

A recent report by the Kings Fund[3], reviewing the opportunities created by the establishment of Integrated Care Systems made the following observation *"Social care and local government have a strong history of mobilising assets around the needs of the individual and tackling inequalities. They have wide experience of engaging with communities and have proven expertise in working within constrained budgets. They bring this strength to ICS partnerships".*

To take full advantage of these strengths, and therefore to deliver on a number of key system priorities, it will be vital to empower local authorities and the third sector, to do more of what they do best; deliver preventative, personalised services at place.

To enable this empowerment to fully be achieved, the whole system will need to value and support the leadership that local authorities and the third sector can make by devolving significant authority and resource down to enable significant local decision making. The proposals set out in this chapter for power sharing, co-design and co-production with residents and the third sector start with the need for an effective infrastructure at neighbourhood level to enable an on-going conversation with residents. This infrastructure requires resourcing.

Subsidiarity

The principle of subsidiarity, which is the idea that a central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level, is central to our transformation programme. Wherever practicable, decision making has been cascaded down to the front line, empowering people to take decisions without having to face the encumbrance of a lengthy and costly bureaucratic process, and enabling staff to use their experience and creativity to innovate and find solutions. Local evidence to date shows that this improves outcomes for people, improves staff morale and therefore retention and generates efficiency; alongside this there is no evidence to date that this approach increase risk, either to the individual or to organisations, often cited by centralising, hierarchical organisations as a rationale for not distributing power and decision making. This principle would need to be replicated between the whole system and Thurrock to enable authentic place based working to be fully realised.

Sovereignty of Thurrock Integrated Care Partnership

In addition to the above conditions for success, organisational and system sovereignty would need to be ceded to the local care alliance. This would enable integration between roles without the need for cumbersome formal agreements to be in place and for the devolution of budgets, necessary if radical reform can take place such as delivering financial control in some areas to communities via the proposal to create Community Reference and Investment Boards.

Furthermore, it will become increasingly important to redirect resources within the system, to invest in those things that are having the most impact in improving outcomes whilst creating system efficiencies. Traditionally this has proven extremely difficult, resulting in a system that has resources often tied up in the wrong place. To invest in the things where the evidence proves their impact on outcomes and savings it will be necessary to create processes that enable the money to be moved easily where the case to do so is overwhelming.

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2. The experience of community engagement for individuals: a rapid review of evidence. Pamela Attree PhD,Beverley French PhD,Beth Milton PhD,Susan Povall PhDEt Al (2010) ↑

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Chapter 5:

Transforming Primary Care

Chapter 5: Transforming Primary Care

5.1 Introduction

This chapter focuses on how primary care provision in Thurrock can be further transformed whereby it plays a pivotal role in improving outcomes through developing communities of practice and integration with wider wellbeing services on a Primary Care Network (PCN) footprint. This chapter will also discuss some of the historic and current challenges facing primary care, and how our new primary care vision of integrated care will respond to these challenges.

Ensuring high quality Primary Care that is easy to access and responds both proactively and reactively to resident need is fundamental for improved population health and system sustainability. Primary care is the healthcare setting most accessed by our residents. It acts as the gatekeeper for a wider range of more specialist services and is the setting in which most secondary preventative activity is delivered that keeps residents with long-term conditions as well and independent as possible. Poor quality, inadequately resourced and difficult to access primary care will inevitably lead to both preventable and avoidable serious adverse health events and drive residents to more expensive elements of the health and care system, most typically hospital through A&E.

Although since the introduction of PCNs, General Practice in Thurrock has been providing some services on a PCN footprint, core service delivery continues to be delivered in silos with practices running varied operating models. This has meant variation in quality of care provision to different practice populations and has limited individual practices' resilience to respond to adverse circumstances, highlighted during the COVID-19 pandemic. To drive improvement in access and quality, there is a need to 'level up' the provision of care within all of our surgeries around best practice and to capitalise on the 'at scale' opportunities that PCNs bring by integrating both back-office functions and clinical services on a PCN footprint. In order to drive improved quality, we want to work with our practices to ensure no Thurrock surgery is CQC challenged. We also want to foster greater integration of practices and PCNs with the wider community services through the development of blended roles that work beyond organisational walls to deliver coordinated and joined up care. This will ensure key principles around delivering right care at the right time within the limited resources with reduced duplication can be achieved.

5.2 Background and Overview

Thurrock CCG, established on 1st April 2013, has been responsible for commissioning (buying) healthcare services to meet the needs of residents in Thurrock (a GP registered population of circa 183k), which includes acute care, community services, mental health and some specialist services.

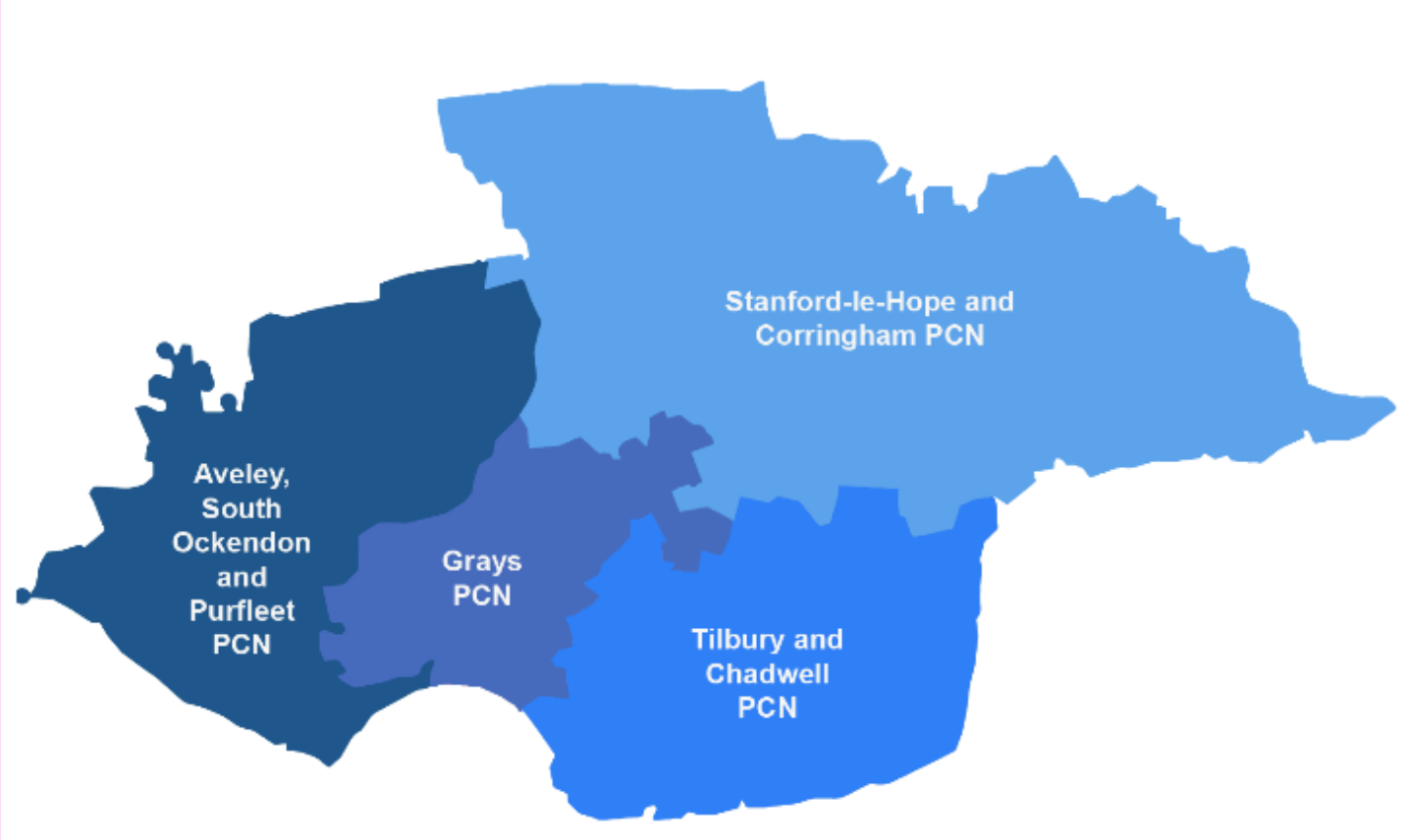
In 2017, as part of the original *Case for Change* strategy, Thurrock CCG worked closely with Thurrock Public Health Team to implement a new model of care via Tilbury and Chadwell due to the fragile state of primary care in Tilbury and Chadwell following the CQC (Care Quality Commission) closure of three GP practices in the area. This locality working model pre-empted national strategy and MSE (Mid and South Essex) Primary Care Strategy. This included recruitment of additional clinical roles to support GPs including nurse prescribers, practice based pharmacists, physicians associates and paramedics, and action to improve quality including practice based profile cards, quality visits and action planning and programmes to improve the diagnosis and management of long term conditions set out in the next chapter.

From April 2021, Thurrock CCG has taken on primary care delegation. This has helped plan and shape future primary care service in Thurrock in a way that will benefit the patients. NHS England (NHSE) continue to commission services such as dentists, pharmacists and ophthalmology. These responsibilities will shift to the Mid and South Essex ICS Integrated Commissioning Board from July 2022.

The primary care GP practice landscape in Thurrock consists of 27 practices delivering services from 38 premises with seven being single handed. There are a variety of GMS, PMS and five APMS contracted practices who are grouped into four Primary Care Networks (PCNs) ranging from the largest with 10 practices and the smallest being 6 practices within a PCN (figure 5.1 overleaf). PCNs consist of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations

The PCNs each has a designated Clinical Director, who are General Practitioners from local member practices, to drive their development.

Figure 5.1 - The four Thurrock Primary Care Networks



In 2021, the Mid and South Essex Health and Care Partnership agreed that a refresh of the 2018 Primary Care Strategy was required.

The strategy refresh built on the existing 2018 strategy focusing heavily on the element of collaborative working and taking account of changes in national and local policy including the *NHS Long Term Plan* (2019), *Investment and Evolution: A five year-framework for GP contract reform* (2019), the *MSE Health and Care Partnership Five Year Delivery Plan* (2019) and, the recent publication of the DH&SC White Paper.

In summary the MSE Primary Care strategy refresh highlights the ambition for Primary Care Networks:

- Locality based community of practice which will be the vehicle for collaborative working at the local level, and
- Improving population health and driving local integration

The refreshed Mid and South Essex Primary Care Strategy has already resulted in further transformation of the primary care landscape in Thurrock, supporting:

- Integrated working between surgeries and PCNs to deliver the COVID-19 vaccine programme in the borough under a single collaborative agreement
- Formation of the Thurrock Clinical Professional Forum and the Networking meetings to consider clinical pathway redesign to improve patient access to services.
- Implementation of Population Health Management in three of the four PCNs through the Obesity pilot PCN Accelerator Programme and an NHS England/Improvement PHM programme.

However, we wish to go much further, and the next sections of this chapter set out our plans to improve primary care access, improve quality and address inequity, improve primary care estates, and address workforce issues.

5.3 Improving Primary Care Access

5.3.1 Current Issues with Access

Primary care access across the country has been impacted by COVID-19 over the last 23 months. From March 2020, primary care was expected to deliver services in a new way and in response to the pandemic, evolving from *'in person'* services to total virtual triage with increased reliance on IT and digital technology. This has meant most appointments are undertaken remotely, either through video, online and telephone consultations and face to face appointments reserved for urgent and where clinically indicated, to ensure compliance with the national Infection & Protection Control (IPC) guidelines.

Since the publication of the new Standard Operating Procedure and IPC guidelines in April 2021, primary care services have been in recovery and reset, working towards business as usual whilst ensuring continued safety measures. Incrementally the Standard Operating Procedures have been relaxed by NHS England in July 2021 to ensure primary care returns to pre-pandemic activity levels.

Figure 5.2 shows the monthly number and type of GP practice appointments delivered in the borough between April 2019 and November 2021; pre, during and post pandemic.

Figure 5.2

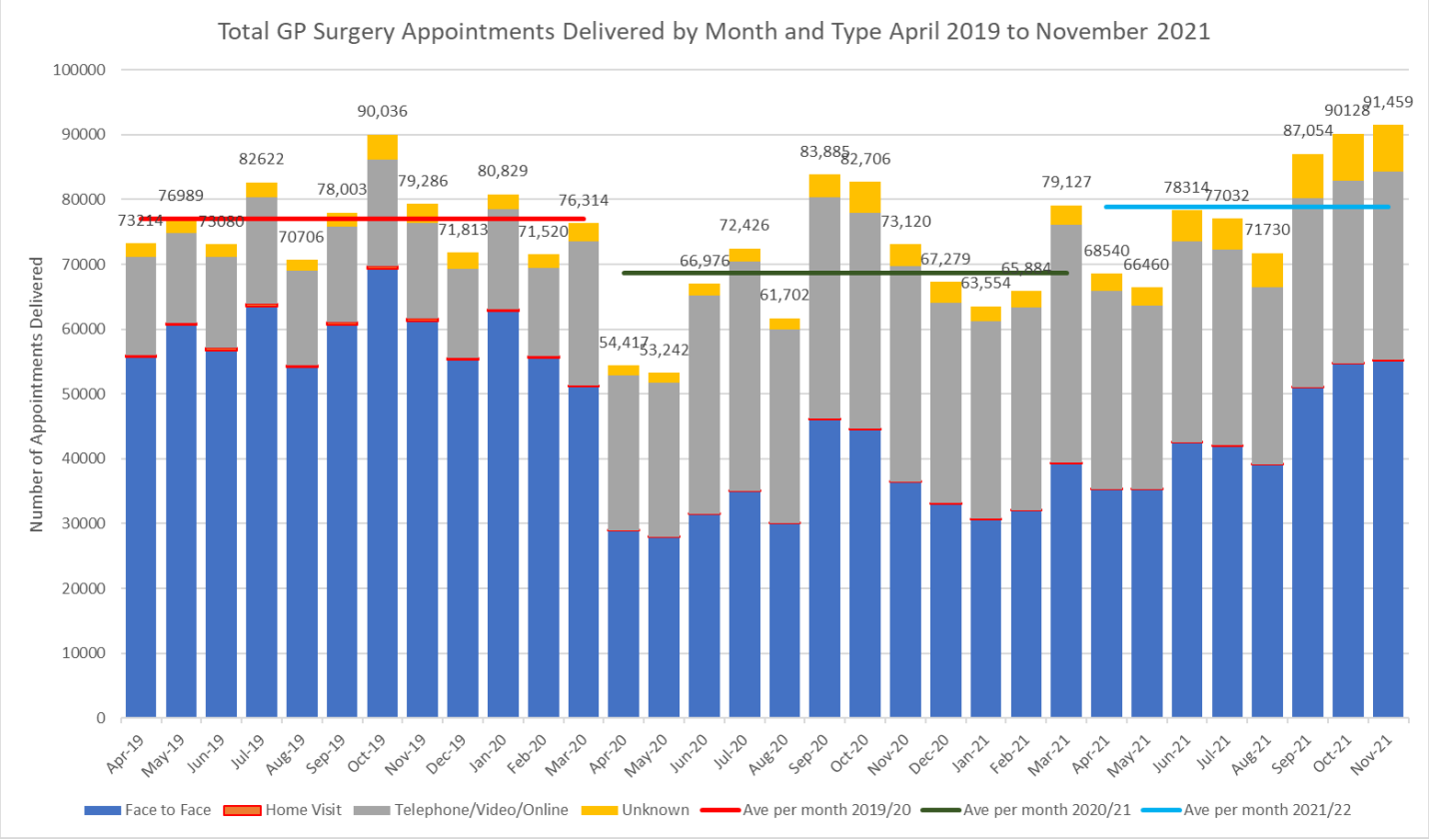
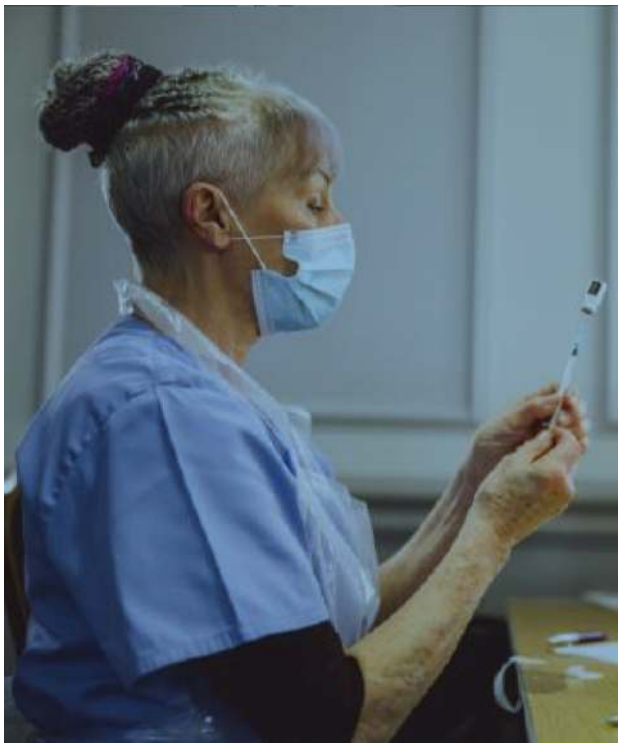


Figure 5.2 shows that average number of appointments per month dropped in 2020/21 compared to 2019/20 as the COVID-19 pandemic hit. This was likely a function of both reduced demand as residents were reluctant to access health services in general during the early stages of the pandemic, and the need to divert existing primary care capacity to support the pandemic response. There is also much greater proportion of appointments delivered by telephone/video/online compared to face-to-face in 2020/21 compared to 2019/20 in line with the revised infection prevention and control guidance and standard operating procedures mandated by NHSE for the safe operation of primary care.

Despite ongoing additional demands on primary care in 2021/22 due to COVID-19, particularly the roll out of the vaccination programme, overall appointments delivered have recovered steadily from a low in April 2021 and are now at levels well exceeding the 2019/20 mean. The proportion of face to face appointments has also increased but are below 2019/20 levels. This reflects are more permanent move to a hybrid model.

> Appointments delivered in GP surgeries in the last three months to December 2021 now significantly exceed pre-pandemic levels, despite the significant additional demands placed on surgeries due to COVID-19 and the impact of lockdown and scaling back of some non-COVID19 services during 2020/21. This is an extraordinary testament to the hard work and dedication of all GP practice staff in Thurrock



Like much of the NHS, primary care has experienced unprecedented demand in 2021/22 caused by the temporary scaling back of some services during 2020/21 in order to free up capacity to respond to the COVID-19 pandemic. Although the number of appointments offered is now higher compared to pre-pandemic levels, demand continues to outstrip supply. Where routine monitoring of long- term conditions were paused, patients are now presenting with more complexity with multiple pathologies requiring more frequent and regular appointments. Backlog in the other parts of the health and care system has also had an adverse impact on primary care, stretching capacity further.

Frequent COVID-19 outbreaks in practice premises, general practice having to resource the vaccinations sites and operate on a seven-day model have resulted in staff shortages that have limited practices' ability to increase capacity for their core work.

Increased reliance on virtual and telephone triage / consultations has required almost all practices to operate on old telephone systems that are unable to cope with the increased demands placed upon them. This has further added to the frustrations of residents who are either unable to get through on the limited telephone lines available or have to wait for a long time before they can speak to a receptionist or clinician.

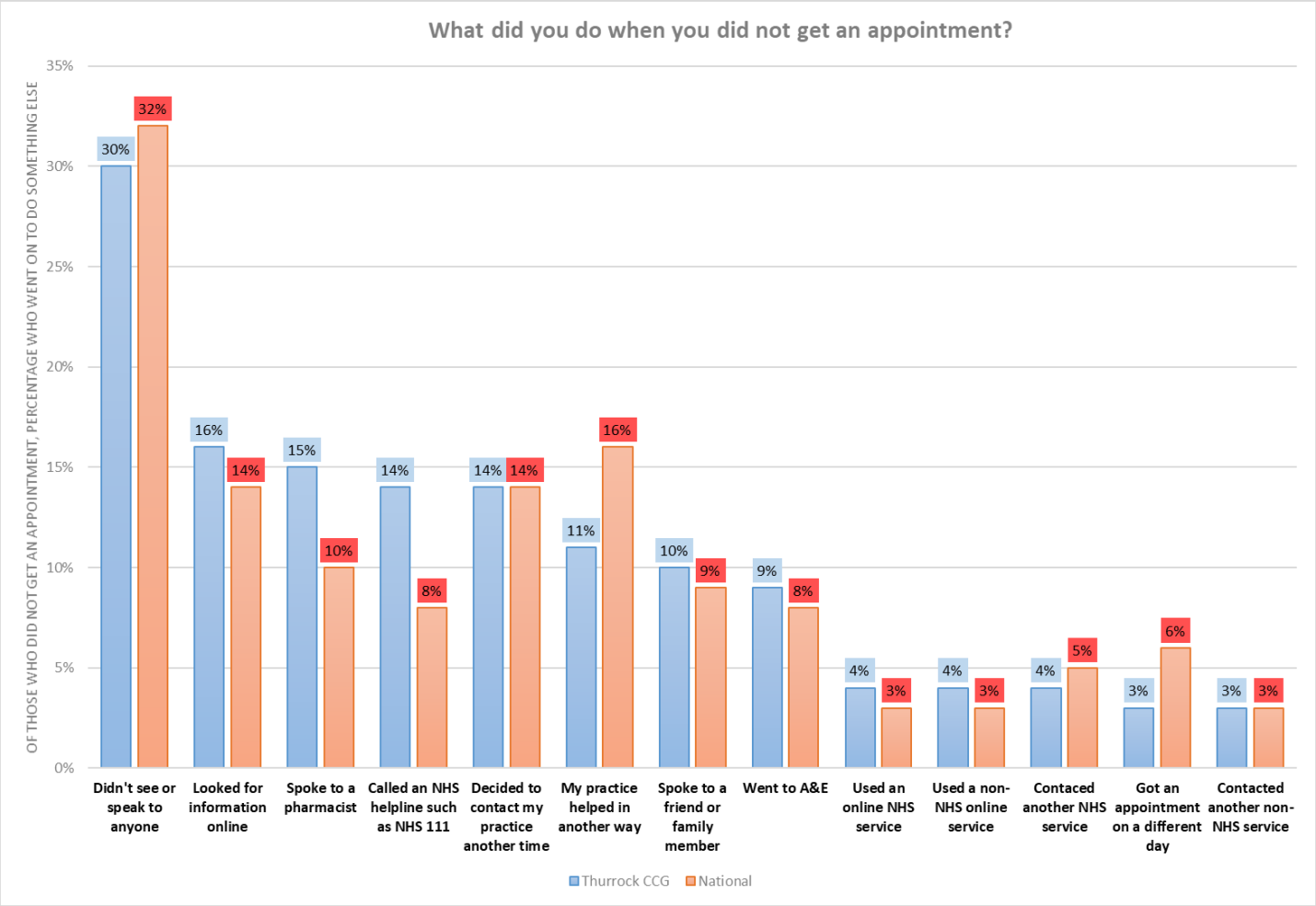
A recent survey undertaken by the CCG has highlighted a stark difference in the operating model of the practices:

1. Variations in the way practices triage patients.
2. Variations in the way practices offer same day, urgent and routine appointments.
3. Variations in the way patient can access their practices for appointments.
4. Variation in the way face to face and virtual appointments are split.
5. Physical opening times of the premises.

This variation in the practice operating model appears to be contributing to poor access to primary care and to health inequalities. Evidence shows that when patients do not get an appoint in Primary Care, the following happens as shown in Figure 5.3 overleaf.

- 14% will re-contact practice later
- 15% will use the pharmacist
- 14% will use another service, for example, NHS 111
- 16% will go online for advice
- 11% felt their practice helped in another way
- 10% got help from friends and family
- 9% will go to A&E

Figure 5.3



GP Patient survey

Some of the challenges facing primary discussed above is reflected in the most recent GP patient survey shown in figure 5.4 overleaf. The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The results show how people feel about their GP practice through a range of questions.

Overall, Thurrock patients:

- Have been less satisfied with General Practice services compared to 2019 and are less satisfied with General Practice services compared to patients, on average, in England
- Reported a greater reduction in satisfaction during the pandemic compared to the England average.
- Where patient satisfaction scores have increased between 2020 and 2021, they have generally done so more slowly in Thurrock than in England (figure 5.3)

The trend shows in the last two years, patients were least satisfied in the top four areas detailed below:

1. Access via the phone
2. Appointment times available
3. Overall experience making an appointment
4. Choices of appointments (at last booking)

Figure 5.4

		POSITIVE SATISFACTION		CHANGE SINCE 2020	
No.	Question	CCG result (%)	National result (%)	CCG result (%)	National result (%)
30	Overall experience of GP practice (likely IAF indicator)	72 →	83 ↑	0	+1
1	Ease of access to practice via phone	55 →	68 ↑	0	+3
2	Helpfulness of practice receptionist	84 ↑	89 →	+1	0
4	Ease of use of online services	66 ↓	75 ↓	-2	-1
6	Satisfaction with appointment times available	60 ↑	67 ↑	+5	+4
14	Choice of appointment when last booked	61 ↑	69 ↑	+8	+9
15	Satisfaction with type of appointment offered	75 ↑	82 ↑	+11	+9
20	Overall experience of making an appointment	60 ↑	71 ↑	+4	+6
26	Mental health needs recognised and understood	80 ↓	86 ↑	-1	+1

Figure 5.5 below show aggregated results for Thurrock PCNs and how the results compare to national and CCG averages.

Figure 5.5

Of the four key indicators shown in figure 5.5, only Stanford-le-Hope PCN has patient satisfaction levels above the England mean for 2020/21.

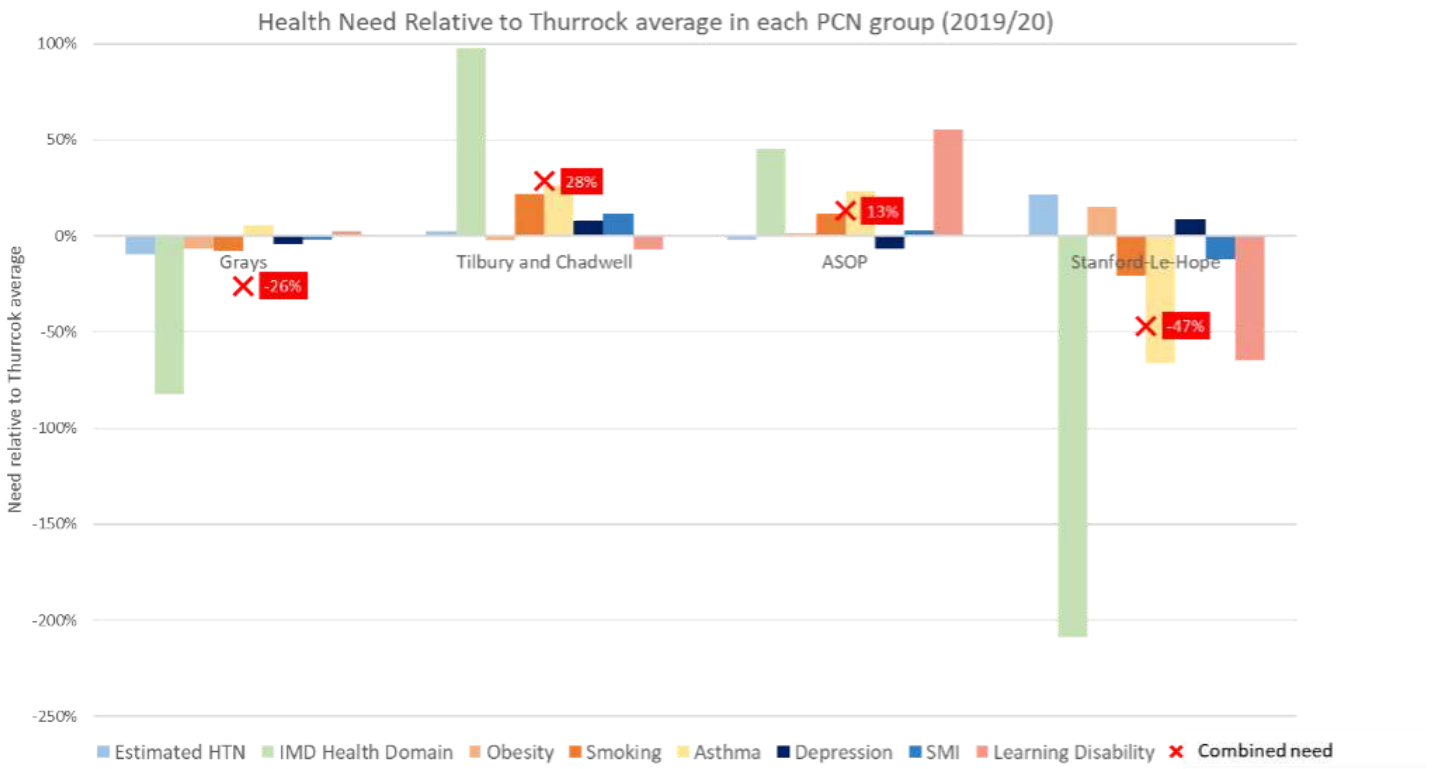
5.3.2 Inequalities and Unwarranted Variation in Current Capacity

Chapter 2 set out evidence on the significant health inequalities within our population. Many of the drivers of these are socio-economic and beyond the control of health services alone, however there is also an inequitable distribution of resources between different practice populations, with the most deprived practice populations generally experiencing the poorest ratio of clinicians to patients.

Inequalities in health outcomes occur when differing health needs between populations, cohorts or groups of individuals are not sufficiently met. To address health inequalities, we need to ensure that primary care services are resourced in a way that is equitable. This is not the same as resourcing all practices equally on the basis only of their list size; we also need to take into account the increased health need and hence demand from practice populations experiencing greater levels of poorer health caused by greater levels of deprivation. Left unaddressed, the practice populations with the greatest need for appointments will experience the greatest difficulty in accessing appointments, perpetuating existing inequalities. This phenomenon was first identified nationally in 1971 by Tudor-Hart who named it *the Inverse Care Law.*[1]

Comprehensive analyses undertaken by the Thurrock Public Health Team demonstrates this point as shown in figure 5.6

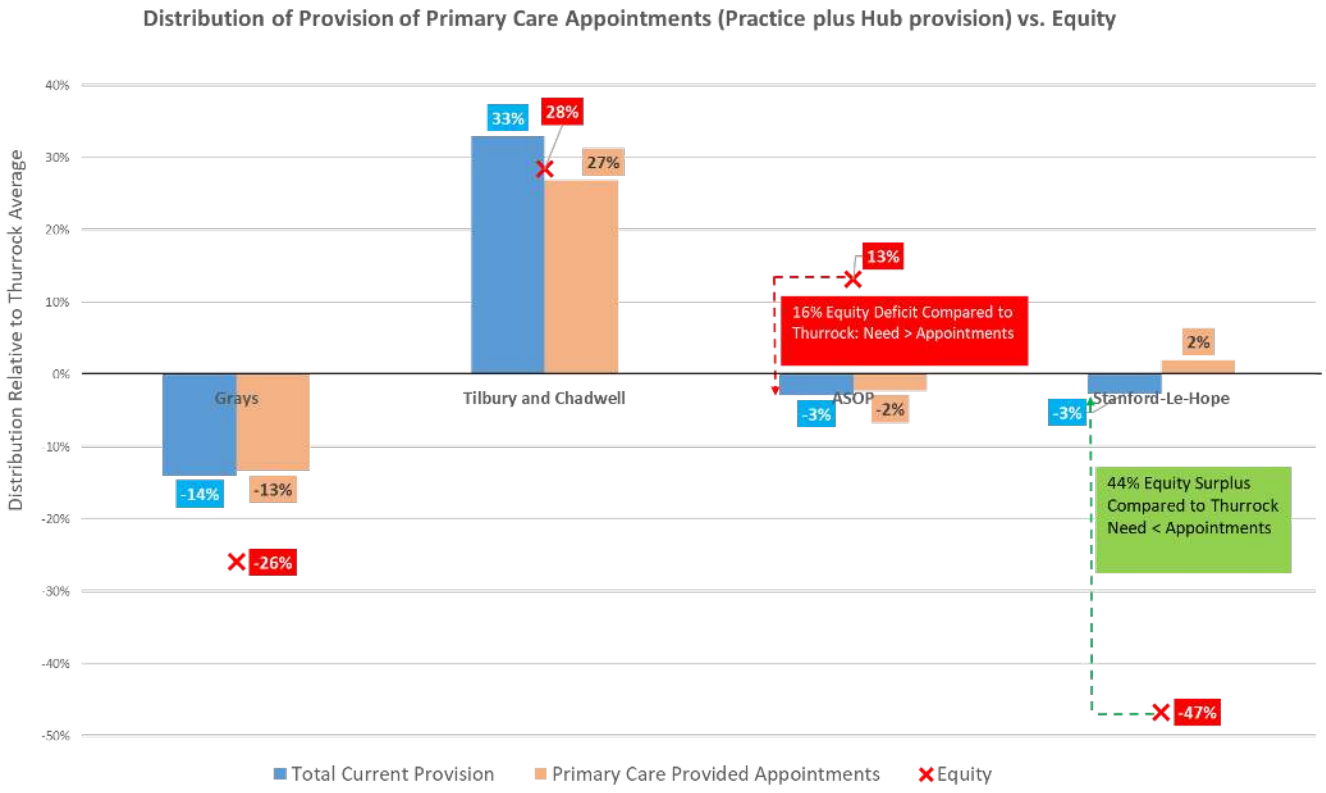
Figure 5.6



We considered a basket of eight indicators covering estimated hypertension (high blood pressure) prevalence, the Index of Multiple Deprivation health domain, and prevalence of smoking, obesity, asthma, depression, serious mental ill-health and learning disability at PCN level. Bars in figure 5.5 show how much greater (bars above the zero) or less (bars below the zero) need and hence demand is on each indicator compared to Thurrock as a whole. **Negative bars do not necessarily suggest a low overall need; only that that need is lower, relative to the borough as a whole.** We have also created a 'combined need' score shown by the red cross for each PCN. For example, overall need in Tilbury and Chadwell across all indicators is 28% greater than Thurrock as a whole, whilst in Stanford-le-Hope it is 47% less than across the entire borough.

Figure 5.7 triangulates this variation in PCN level population need against primary care appointment availability to show differences in equity between population level need in each PCN and appointment availability relative to Thurrock as a whole. The pink bars show appointment availability provided within the PCN's GP surgeries, the blue bars show all appointment availability including addition provision provided by the GP hubs, and the red "X" shows variation in need.

Figure 5.7



By comparing overall PCN population need relative to appointment availability, we are able to determine equity surpluses or deficits between need and appointments in different PCNs in Thurrock, relative to the borough as a whole.

ASOP has the greatest equity deficit gap between need and appointment availability. It has overall PCN population level need that is 13% above Thurrock's but an overall level of appointment availability that is 3% below Thurrock's giving a 16% deficit.

Conversely, Stanford-le-Hope PCN has the greatest equity surplus. It has overall practice population need that is 47% lower than Thurrock's but appointment availability only 3% lower, giving a 44% equity surplus compared to Thurrock overall. This does not mean that the population of Stanford-le-Hope has low overall health needs; only that they are lower than those in the population of Thurrock as a whole.

Tilbury and Chadwell has near equity between need and appointment availability compared to Thurrock as a whole. It has significantly greater need, but a significantly greater level of appointment availability compared to Thurrock as whole. This perhaps reflects the additional resources and investment provided to Tilbury and Chadwell through the original *Case for Change* strategy of primary care transformation

It is striking how these findings correlate strongly with resident satisfaction of GP services data presented earlier. ASOP has the lowest level of satisfaction, whilst Stanford-le-Hope has satisfaction levels above the England mean.

5.3.3 How We Will Improve Access

Levelling Up Through Investment to Close the Equity Gap

The analyses presented in figure 5.7 clearly demonstrates that appointment availability is not currently distributed in an equitable way between PCNs that sufficiently takes account in differences in need and demand, and suggests a link between this inequity and patient satisfaction with access to GP surgeries.

However, the analyses only compares resources ***between*** Thurrock PCNs yet we also know that the borough as a whole is under-doctored and under-nursed, with overall patient satisfaction scores around access significantly worse than England's, and worse in all three PCNs other than Stanford-le-Hope. **It would therefore be wrong simply to redistribute existing resources between PCNs, as whilst this may create a more equitable situation within Thurrock, it would still result in poorer access to primary care appointments for our residents compared to England's and likely bring satisfaction for Stanford-le-Hope residents back down below the England's mean, essentially "levelling down".**

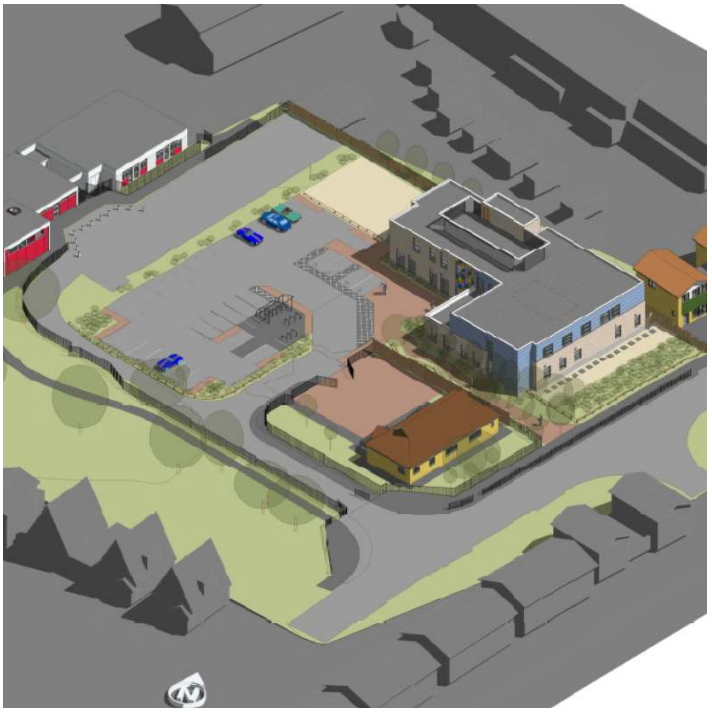
Instead, we need to use Stanford-le-Hope as a baseline for equity, and seek to bring appointment availability in the three other PCNs up to their level of equity, essentially "levelling up".

The creation of Integrated Care Systems and system budgets affords the potential opportunity to redistribute system resources in a more equitable way and as a Thurrock Integrated Care Partnership we will continue to make the case to the Mid and South Essex ICS for re-distribution of resources to address the equity gap in ASOP, Grays and Tilbury and Chadwell compared to Stanford-le-Hope.

As future growth funding is made available, we will prioritise investment in a way that first closes the equity deficit between ASOP and Thurrock and then levels up the three other PCNs to Stanford-le-Hope levels of appointment availability.

Integrated Medical Centres

Increasing practice resources to address the health equity gap alone will not be sufficient. Thurrock operates in a competitive market for GPs and other clinical specialities that operate within Primary Care. To attract the brightest and the best to the borough, we need to create a working environment that is highly attractive to clinicians. We see our new IMCs and wider locality model as the solution to this:



Mid and South Essex Health ICS, local NHS providers and Thurrock Council have a shared commitment to build four new Integrated Medical Centres (IMCs) in the borough, one per locality and provide a wide range of integrated health, care and third sector provision.

This will include services that address wider determinants of ill health, a place for community assets and voluntary groups to offer a wide range of local support including, Local Area Coordination, Community Led Solutions, Health and Wellbeing Teams, Employment, Education and Training advice, Housing and benefit advice, and where possible cafes and community hub and library facilities. In addition, the IMCs will offer an opportunity for a new and expanded Primary Care Offer, diagnostic facilities, secondary care outpatient clinics for the most common conditions, health and wellbeing improvement and healthy lifestyle programmes, community and mental health treatment, Social Care and third sector services.

IMCs will include at least one GP practice within them, and act as the locality 'hub' from which a wide range of additional services will be provided, that will integrate with all GP practice provision within the PCN and wider locality provision in a single locality model. Details of our new Integrated Locality Model are set out in Chapter 7.

We envisage this new way of working will provide an attractive environment in which to deliver clinical services for GP practice staff, allowing easier access to a wide range of integrated provision including services that address wider social and environmental causes of ill-health. This in turn should free up the time of GPs to concentrate on more complex patients with easier access to Consultants, and allow other practice clinical staff to work in a more coordinated and integrated way within a wider network, making a most efficient use of existing resources that will ultimately impact positively of access. It will also allow Thurrock to attract new GPs to the borough.

A Mixed Skill Clinical Workforce

Our 2017 *Case for Change* strategy highlighted research suggesting that for 27% of GP appointments, the resident would have been better served by having direct access to a different type of health professional, avoiding the need for on-ward referral. For example, Practice Based Pharmacists can undertake medication reviews far more quickly than General Practitioners. Similarly, one in six GP appointments are for musculoskeletal problems; we can deliver better outcomes for this patient cohort if they can book an appointment directly physiotherapist for assessment and treatment within the surgery, rather than seeing a GP first and then waiting for a referral.

The strategy demonstrated that in the context of a national shortage of General Practitioners, diversifying the clinical workforce within surgeries to include Nurse Practitioner, Practice Based Pharmacists, Physiotherapists, and Paramedics could allow surgeries to offer a better service to patients and free up GP time to concentrate on more complex patients.

Since 2017, we have made considerable investment into these additional clinical roles, initially in Tilbury and Chadwell, and more recently within other PCNs.

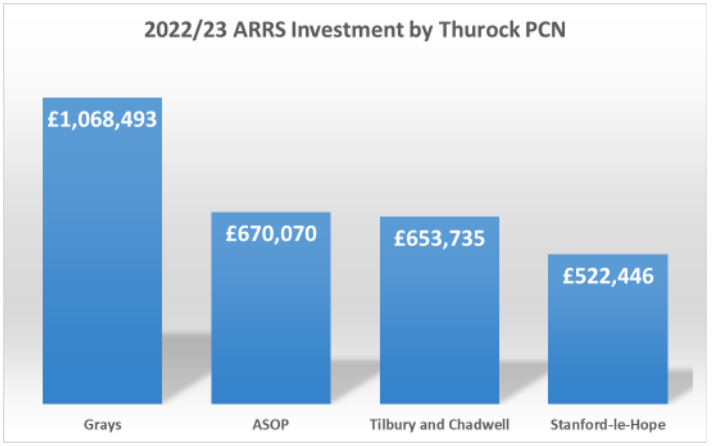
In February 2020, NHS England and Improvement (NHSEI) and the British Medical Association (BMA) published the 2020/21 GP Contract Deal. This new deal included major investment through the Additional Roles Reimbursement Scheme (ARRS), with the aim of securing an additional 26,000 staff across primary care. The ARRS is the most significant financial investment element within the Network Contract Direct Enhanced Service (DES) and is designed to provide reimbursement to Primary Care Networks to build workforce capacity, create bespoke multi-disciplinary teams that work at scale to deliver population health interventions and make support available to patients where it is most needed.

The ARRS enables PCNs to recruit a selection of roles and claim 100% reimbursement for all positions recruited. 15 roles are available to recruit via the scheme in 2021/22, which includes the following:

- Clinical Pharmacist
- Physiotherapist
- Paramedic
- Physicians Associate
- Podiatrist
- Occupational Therapist
- Dietitian
- Pharmacy Tech
- Mental Health Practitioner
- Social Prescribing Link Worker
- Health and Wellbeing Coach
- Nursing Associate
- Trainee Nursing Associate
- Care Coordinator
- Advanced Practitioner

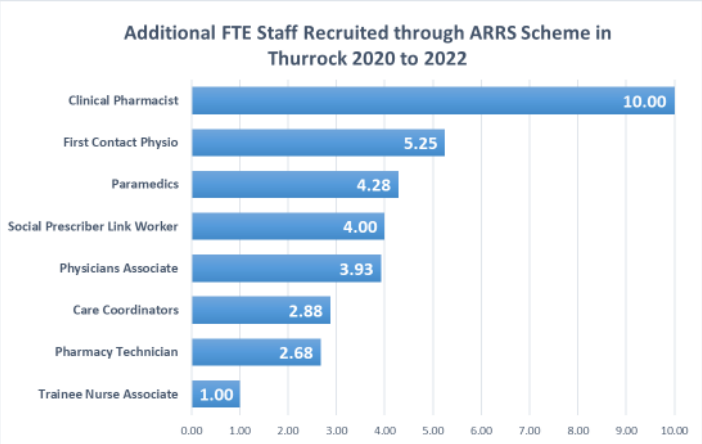
Figure 5.8 below shows the additional investment provided by NHS England to support in scheme in 2022/23.

Figure 5.8



To date, Thurrock PCNs have recruited a total of 34.02 full time equivalent additional primary care front line clinical staff through the ARRS scheme. The skill mix is shown in figure 5.9

Figure 5.9



The introduction of the nationally funded ARRS roles and recruitment to date is building additional capacity within PCNs, plugging some of the workforce gap. However, recruitment remains challenging at least one PCN, and there is a need to carry out a skills gap analysis, triangulating the skills mix in the existing workforce with demographic needs.

Sharing capacity at PCN level through integrated clinical models, rather than assigning roles simply to work within individual practices, provides further opportunity for more efficient use of the new capacity.

We will continue to expand the skill mix of the PCN workforce in 2022/23 through the ARRS scheme and undertake a workforce skills gap analysis to inform future recruitment and ensure that the most appropriate roles are recruited.

Cloud Telephony System and Standardisation of Patient Triage

It is imperative that the existing GP telephony systems are upgraded to improve access and general practices' ability to embed new models of care. Whilst this has been recognised and work is underway nationally, it is important we accelerate the implementation locally.

Two Thurrock PCNs are piloting an innovative project incorporating cloud-based telephony run by staff specialising in care navigation. Centralised cloud technology operated on a PCN footprint will not only improve access to patients but will also free up individual practice phone lines for virtual consultations.

It is envisaged additional functionality such as direct booking for same day face to face appointments in community pharmacies could be added to this service during the pilot phase.

Successful implementation would represent progress towards merging and providing standardised centralised patient triage and wider back-office function at scale. This is the only pilot project of its type across MSE, so learning and best practice will be shared across the system once the pilot is complete.

New ways of working – Virtual triage, Online and Video Consultation

Although there has been concern raised both nationally and locally about difficulties that some patients experience in being able to see a GP in person, many residents find telephone or technology appointments more convenient, particularly for routine issues as it saves an unnecessary trip to the surgery. Moving forward, we need to implement a hybrid model that both provides choice and delivers the maximum number of appropriate appointments from the workforce capacity that we have available.

Implementation of virtual triage, increased use of digital platform and video consultation work was being undertaken prior to the COVID-19 pandemic. However, due to the nature of the changes required to ensure continued access to Primary Care during the pandemic, this work was accelerated to meet demand.

Our *Virtual Triage Model* was introduced in March 2020 when COVID-19 changed the way GP practices delivered care to their registered population. National guidance and standard operating procedure were produced for all GP practices to ensure patients receive safe and standardised care despite being registered with different practices.

Over the last two years, Online Consultation (OC) and Video Consultations (VC) have been widely used by practices with face-to-face consultation reserved for clinically appropriate patients and urgent appointments. Given the national direction of travel, these newer consultation modes are expected to become part of the 'new normal', alongside the need to offer face to face appointments as part of a hybrid model.

A single online consultation platform was procured centrally by the five Mid and South Essex CCGs to replace existing platforms procured by practices. However, this 'one size fits all' solution has been unpopular with many practices and there has been a wide variation and inconsistent use. In order to encourage greater adoption of on-line and video consultations, we will therefore learn lessons from this previous procurement, and ensure that in future, practices are offered a choice of online consultation platform providers to suit their needs.

Thurrock First

Thurrock First is our single point of access across community health, mental health and adult social care. The service consists of a team manager who is a qualified social worker, two senior co-ordinators, 17 Thurrock First Advisors who take telephone calls, a Community Psychiatric Nurse, a Mental Health Act Assessment Coordinator plus casual bank staff.

It aims to reduce, prevent and delay the need for more significant care by intervening early and works closely with the Urgent Care Response Team (URCT) who can be mobilised to attend residents' houses where they are in crisis.

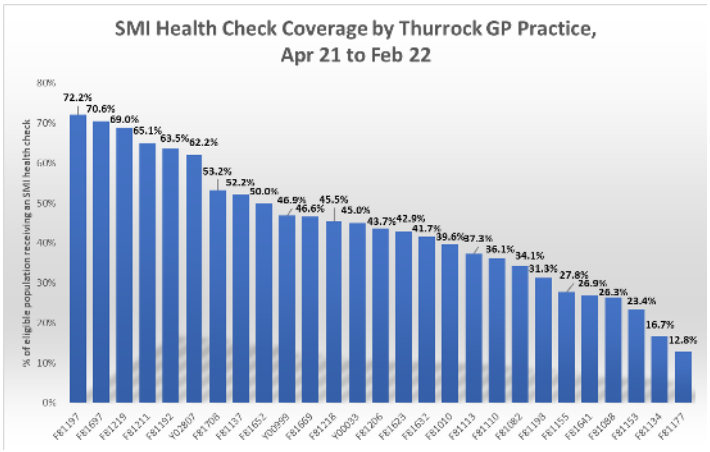
Evaluation evidence suggests that the service has a significant positive impact on reducing 'failure demand' and preventing residents from otherwise needing to access Primary Care. However, we believe that it has potential to be used by a greater number of residents and awareness of the service and its capabilities amongst residents could be improved.

In 2022/23 we will invest in a comprehensive communications campaign to promote Thurrock First to residents as a mechanism for reducing demand on overstretched Primary Care services.

5.4 Improving Quality and Addressing Variation in Outcomes

There is currently significant and unacceptable levels of variation in health outcomes for residents between different practice populations both within Thurrock and nationally. Figure 5.9, which shows the coverage of Serious Mental Ill-Health (SMI) Health Checks between different practice populations demonstrates this. In two practice populations, over 70% of the eligible cohort had received an SMI health check by February 2022, whist in one practice population, this figure falls to only 12.8% of the patient cohort.

Figure 5.10



5.4.1 What is causing these inequalities in health outcomes?

Inequalities in health outcomes are complicated and multifactorial, caused by a mixture of socio-economic and demographic differences, geographical differences, ethnicity and cultural differences, and differences in health behaviour between different practice populations. The way we have designed our health and care system historically has constrained clinical staff in addressing the root causes of ill-health and limited them largely to reacting to demand that has resulted from them by prescribing medication or onward referral. We have already discussed our plans to address these issues through four new Integrated Medical Centres and a new Integrated Locality Model. Chapter 7 sets on in more detail.

However, the way we have historically commissioned and delivered primary care has also contributed to inequity and variation in outcome. Section 5.3.2 has already highlight inequity in provision of appointments between PCNs when the health needs of the residents they serve is taken into account.

Current variation in outcomes have a number of possible causes including:

1. Variation in provision of General Practice services
2. Variation in clinical skill mix between different surgeries. For example, one surgery may have a practice nurse specialising in respiratory conditions, another with a specialism in diabetes.
3. Variation in quality of care between practices (measured by QOF)
4. Variation in resources made available to primary care vs demand
5. Variation in clinical operating models and clinical practice
6. General Practice working in silo, so pathways are not co-ordinated for patients
7. Variation in estates between different practices, that may limit for facilitate better clinical practice.

CQC Inspections and Ratings

CQC inspections and rating of individual GP practices are considered as the barometer of quality of care provided by general practices. Table 5.1 shows the current CQC inspection overall ratings for each GP practice in Thurrock.

Table 5.1

SURGERY NAME	OVERALL CQC RATING	COMMENTS
Aveley Medical Centre	REQUIRES IMPROVEMENT	Last inspection 26/08/2021
Balfour Medical Centre, Grays	GOOD	Last inspection 21/02/17
Chafford Hundred Medical Centre	GOOD	Last inspection 26/10/17
Commonwealth Health Centre, Tilbury	GOOD	Last inspection 05/02/19
Dell Medical Centre, Grays	GOOD	Last inspection 02/11/17
Derry Court Medical Centre,	GOOD	Last inspection 13/07/17
East Thurrock Medical Centre	GOOD	Last inspection 16/05/17
East Tilbury Medical Centre (College Health)	NOT YET INSPECTED	Not inspected whilst under new provider
Hassengate Medical Centre, SLH	GOOD	Last inspection 29/02/16
Horndon Surgery	GOOD	Last inspection 28/04/16
Kadim Primecare Medical Centre, Grays	GOOD	Last inspection 28/09/16
Milton Road, Grays	GOOD	28/08/18
Neera Medical Centre	GOOD	Last inspection 16/01/17
Oddfellows Hall Health Centre	GOOD	Last inspection 01/05/19
Pear Tree Surgery, South Ockendon	GOOD	Last inspection 31/07/17
VH Doctors Ltd, Purfleet Care Centre	GOOD	Last inspection 30/07/16
Rigg Milner Medical Centre, East Tilbury	INADEQUATE	Last inspection 28/05/2021
Sai Medical Centre, Tilbury	GOOD	Last inspection 11/10/16
Sancta Maria Centre, South Ockendon	GOOD	Last Inspection 10/07/18
South Ockendon Health Centre	GOOD	Last inspection 06/08/19
Southend Road Surgery, Stanford-le-Hope	GOOD	Last inspection 28/11/18
Stifford Clays Health Centre	GOOD	Last inspection 06/10/16
The Grays Surgery	GOOD	Last inspection 29/08/18
The Sorrells, Stanford-le-Hope	GOOD	Last inspection 04/10/16
The Surgery, Orsett	GOOD	Last inspection 5/2/16
Thurrock Health Centre (College Health)	GOOD	Last inspection 5/6/19
Tilbury & Chadwell Group (College Health)	GOOD	Last inspection 9/4/19

As table 5.1 shows, the vast majority of GP practices in Thurrock are rated 'Good', with only two practices receiving a *Requires* Improvement or *Inadequate* rating. The Primary Care Team at Thurrock CCG has worked incredibly hard in conjunction with individual surgeries over the last six years to improve quality and this has undoubtedly delivered substantial improvement.

In 2015, when this work began, the majority of surgeries had received CQC ratings of either *Requires Improvement* or *Inadequate*

As a result of routine primary care activity, health checks and QOF (primary prevention and long-term conditions diagnoses and management) work was paused during March 2020, patients are now presenting with complex conditions, multiple pathologies, and poorly controlled long-term conditions. Significant back logs for specialist services, investigations and monitoring have adversely affected the quality of care provided to the service users.

Improving care and quality to service users remains a challenging but imperative as the health and care system resets and recovers.

Primary Care Estates

The poor quality of Primary Care estates in some parts of Thurrock is making service delivery in certain practices more challenging, impacted by the lack of adequate space, an increasing workforce and growing population. In addition, aging estates are impacting on Infection Protection and Control (IPC) guidelines. This has impacted on the patient perception of their practice's ability to deliver services.

Thurrock Council's new Local Plan will set out proposals to build in excess of 30,000 new homes over the next 30 years and so it is imperative that we ensure current and future estates are fit for the future to accommodate the additional demand on primary care services.

Primary Care Workforce

Thurrock has one of the highest levels of under-doctoring and under-nursing in primary care in England, with the highest GP to patient ratio across Mid and South Essex. Workforce data shows a decrease in GP Partners alongside an increase in salaried GPs with an overall small decrease in GP workforce from March 2019 to March 2021. Thurrock has also experienced a decrease in nursing capacity in Primary Care. However, direct patient care roles and admin/non-clinical staff numbers have increased slightly from March 2019 to March 2021.

Evidence shows that the clinical workforce in Thurrock has a significantly higher proportion of older (over 55) staff compared to the England and MSE average. This has had an impact during the pandemic as there have been staff who have taken early retirement and moved onto pastures new due to burnout. A proportion of practice clinical staff have also been categorised as *"shielding"* and Clinically Extremely Vulnerable (CEV). This has negatively impacted on the resilience of our primary care workforce.

5.4.2 How we will Reduce Variation in Outcome and Improve Quality

In order to reduce health inequity, we also need to shift the balance from reactive to proactive care, preventing, diagnosing and intervening at the earliest possible opportunity to prevent conditions from worsening.

Surgeries also need to work in collaboration other elements of the NHS, council and third sector to deliver integrated solutions with residents that address health needs including socio-economic factors. We have already started this transformation by embedding social prescribers within our four PCNs and we believe the plans set out in both Chapter 6 and 7 will shift the balance from reactive to proactive and preventative care.

Integration and the Sharing and Standardisation of Best Practice at PCN and Locality Level to "Level Up" Quality.

Practices have historically been commissioned to operate as individual and separate small businesses, largely in silos, and to some extent, in competition with each other. It is therefore unsurprising that there is significant variation in clinical practice, operating models and workforce skill mix. This is well evidenced in the Thurrock Local GP Access Questionnaire. Historically, Thurrock has had too many small surgeries with insufficient resilience and skill mis to deliver a primary care model fit for the 21st century.

The recent formation of Primary Care Networks provides a huge opportunity to reimagine how we deliver primary care to our residents over a wider footprint, sharing clinical capacity, best clinical practice, back office function and intelligence to "level up" the quality of care delivered to every resident.

PCNs are on a journey to work collaboratively with system partners like local authority, community services providers, secondary care providers and voluntary services to ensure the population receives a seamless service from all providers involved. Siloed working has been the historic method of working in primary care and transforming this is the way forward in providing an integrated model of health and social care and will help in improving the patient journey at all touch points. The Integrated Medical Centres (IMCs) presents us with a unique opportunity to provide services that are delivered in a truly integrated way. We will empower staff to redesign services and develop integrated care solutions in conjunction with residents, supported with an interoperable IT system

To facilitate a more consistent way of working and best clinical practice we will encourage and facilitate collaboration between practices, building on the work we have already begun through our Clinical Professional Forum and Network Meetings.

We will also encourage PCNs and practices to provide certain back-office functions and clinical services collaboratively from a merged central location. This will not only help rationalise and make best use of existing estates and address variation but will also reduce duplication and drive efficiencies. A couple of Thurrock PCNs are being supported to centralise certain functions as part of their accelerator project.

To facilitate a more consistent way of working for the ARRS staff, every PCN will be offered a PCN wide clinical SystmOne unit which both PCN practices and ARRS staff have access to. This improves patient safety and allows merging of central functions to deliver a better service to patients as well as improve staff retention figures.

ARRS staff, although PCN aligned, currently need to deliver clinical services at individual surgery because they are only able to access clinical information from the records of patients at the surgery that the patient is registered. This necessitates extensive travel between surgeries to deliver their clinical interventions something that is inefficient and is having a negative impact on staff retention. To address this, we will offer every PCN a single PCN wide SystmOne unit (the database that stores patient medical records). Having a PCN based S1 unit for ARRS roles will allow ARRS clinical staff to work out of fewer sites, for example that PCN's IMC, reducing travel time and increasing capacity for front line care. It will also promote integration of ARRS clinical functions with other diagnostic and outpatient capacity and wider clinical and wellbeing services, and empower staff to redesign and transform the local offer.

We will also encourage PCNs to use existing staff with special interest and ARRS staff to provide care for patients with LTC on behalf of all the practices from a central clinical space, and through Integrated Long-Term Conditions Management Services that provide a 'one stop shop' for management of all cardiovascular conditions and diabetes. This will present opportunities to cohort patients on levels of complexity with best and most appropriate use of clinical skill mix, ensuring a consistent and standardised care across PCN.

The implementation of PCN-led clinics for speciality areas of LTC will enable residents from neighbouring practices to be seen at a dedicated location, by the team specialising in their condition. Establishing direct links with consultants will reduce referrals to secondary care and unplanned attendances. Further implementation of the improvement measure below is expected to reduce variation and improve health outcomes for residents of Thurrock. Our plans on Long Term Condition Quality Improvement are set out in detail in Chapter 6.

More broadly, the development of a high quality Primary Care offer in Thurrock is reliant upon the ability to collaborate effectively with local people and local communities. Our Strategy introduces a new framework for engagement and collaboration based on the development of communities of practice as set out in Chapter 3. These allow people who have a common interest in a subject or area to collaborate over an extended period of time – sharing ideas and strategies, determining solutions and building innovations. The impact of this form of engagement will be to ensure that services and solutions (and decisions about services and solutions) are built to reflect what people want and need and how they wish those services and solutions to be delivered.

We also see the ARRS and wider primary care workforce being part of a single Integrated Locality Network of front line professionals who will come together to co-design single integrated solutions with residents, minimising bureaucracy and on-ward referral between different teams, and addressing the holistic health and wellbeing needs of residents within a single solution. Chapter 7 discusses these plans in more detail.

Improving Quality through Continuity of Care

Evidence suggests that providing continuity of care in primary care, i.e. being able to see the same clinician on many different occasions is important for many residents, particularly those with more complex needs and multi-morbidity. Care provided primarily through the same clinician negates the need for the resident to tell their story multiple times, and allows the clinician time to develop a more detailed understanding of the needs of residents and spot changes or patterns in health and wellbeing over time. One systematic review which considered the impact of continuity of care on patient satisfaction concluded significantly higher patient satisfaction levels when they received interpersonal continuity of care.[2] A second, which considered impact on health outcomes and costs, concluded that interpersonal continuity of care is associated with improved outcomes, lower hospitalisation rates, improved preventative care and lower costs.[3]

As we seek to spread best practice between different GP practices through a PCN based model, and deliver broader integration of primary care with other services and professionals through our Integrated Locality Network and Integrated Medical Centres, we will support surgeries to develop clinical operating models that prioritise continuity of care where possible.

Supporting Integration through Commissioning

We will support integration at PCN level by ensuring that future enhanced non-core services are commissioned on PCN footprint. This will encourage greater integration of PCN member practices and will drive standardisation of care and reduce health inequality.

This commissioning will be based on population health management/ population cohort model. We will seek to commission services on a PCN footprint with payments on achievement on outcomes as opposed to transactions. This will help drive up standards with challenge and support provided from member practices to low uptake practices. We will start by revising our Stretched QOF commissioning arrangements to reflect these new arrangements

Workforce Collaboration and Resilience

Sharing the existing practice clinical workforce more broadly between practices across the PCN including the new ARRS roles will increase workforce resilience at individual surgery level and improve clinical skill mix.

There is an opportunity to upskill practice and ARRS staff to reduce variation of working practices. We will work to support PCNs to ensure that future ARRS role recruitment is aligned with PCN need and skills gap analysis. This helps to address the disproportionate variation in service provision and gives everyone an equity of offer based on population needs. All future resources should be maintained at that distribution of need level.

Evidence suggests training practices tend not to suffer from staff shortages. For all future procurements of core primary care services, prospective providers will be required to achieve or work towards achieving training practice status.

Quality & Patient Safety

This has been a success story for Thurrock where the CQC rating of vast majority of practices have improved to GOOD through dedicated and bespoke support to practices by the CCG's primary care, quality and patient safety and medicines management team. The support needs to continue to ensure improvements achieved over the years are sustainable with an ambition to have no CQC challenged practices in Thurrock.

As the last section demonstrated, quality, as defined by CQC ratings has already improved substantially since 2015. Regular quality visits comprising where our GP profile cards containing benchmarked quality metrics, together with joint action planning with surgeries has improved standards.

Over the last two years, COVID-19 has temporarily altered the way in which we have been able to engage with practices, with a move to a completely virtual model. Moving forward, we will engage with practices to reinstate the pre-covid face-to-face proactive practice visits with joint CCG and Public Health teams so that a holistic overview of the practice can be taken to share best practice and provide support in required areas of concern. We will also seek to build on previous good practice, looking not only at quality at practice, but at PCN level and replacing annual profile cards with real time data through building informatics capacity within each PCN. This approach is discussed in more detail in the next chapter.

There is a concerted effort to support primary care to increase the number of annual Learning Disability Health Checks and Serious Mental Illness Health Checks too. This will support in the reducing variation in quality of care as well as standardising care for specific cohorts. We are now actively engaging practices on performance of SMI and LD health checks, sharing their current data and providing support to improve. This includes linking practices with the ELDP and Thurrock Lifestyles Solutions for additional support on LD health checks, and ensuring that EPUT Mental Health Practitioners are embedded in every PCN in Thurrock through our new Mental Health Integrated Primary and Community Care model. More details are set out in Chapter 7.

We are also extending support on quality improvement to adult social care. A Lead Nurse for care homes and home care works in partnership with Thurrock Council's safeguarding team and contract team to monitor and support the adults in residential placements in Thurrock. All care home residents now also have a named GP and clinical in-reach support from an extended Primary Care team. The aspiration for this is that all residential providers in Thurrock achieve a rating of good alongside ensuring that the providers are quality employers that attracts people to work in Thurrock.

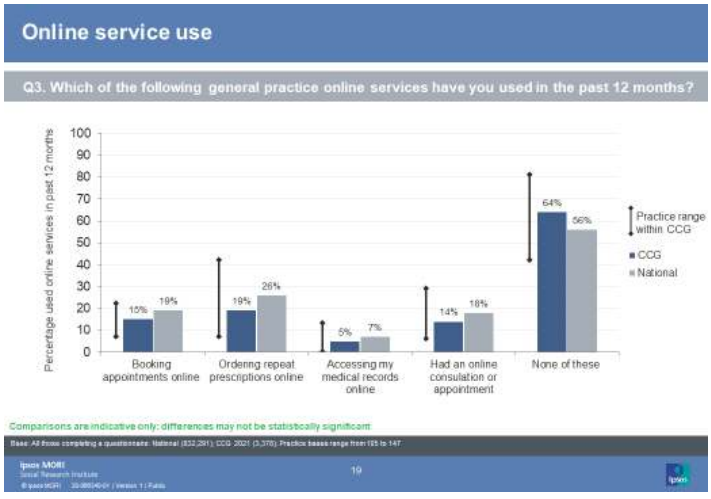
Alongside national and MSE wide communications strategies, further work is required to communicate new models of care locally to residents by various methods of patient education.

Patient Education and Access to information

The following graph shows the online level of activity undertaken by Thurrock residents and this also shows that further work with patients is required in this area too.

In addition, schemes are required to assist with digital poverty, enabling residents to access the new models of care. Working with third and voluntary sector partners, to provide digital access and education.

Figure 5.11



Residents need to be at the heart of further transformation of primary care and the re-design of services. We will ensure primary care representation on the new resident engagement and participation mechanisms set out within Chapter 3 of this strategy including Community Reference and Engagement [illegible]s and Communities of Practice.

Primary Care Estates

The MSE Estates Strategy is looking at primary care estates per PCN and assessing how primary care estates need to be made future proof especially with the increasing PCN workforce. The MSE wide strategic estates committee is working towards ensuring that primary care estates are used and fit for purpose. The Integrated Medical Centres are clearly part of our solution, but there is a need to bring all GP practice estate up to a standard fit for the future.

Workstreams are in place to support individual practice improvement requests, for example, extensions to existing premises, improving current premises, using the estate in a different way by centralising some of the back-office functions which frees up overall PCN space.

Virtual integration models are being implemented across MSE, including PCN Clinical Units to enable integrated working across PCN roles.

Local integration is being driven by locality-based community in practice models where locality-based solutions are being mapped out so a holistic delivery of services can be achieved.

5.5 Conclusion and the Desired Outcomes We Will Achieve From Our Plans

Primary care is at a critical point where some of the transformation initiatives that were implemented since 2015 had started to show some gains and improvements in quality and care provided by primary care. The practices' CQC rating across the primary care landscape in Thurrock is a testimonial of the improvements made pre pandemic. These gains to some extent have built resilience that helped practices to weather the pandemic.

The two-years of the pandemic presents primary care with a series of complex challenges of its own in terms of built-up backlog but also presents us with some opportunities where there was greater collaboration between practices, and wider health and care providers, roll out of the digital model of care and provision of some services at scale on PCN footprint.

It is therefore important to build up on some of these opportunities and initiative discussed in the chapter.

We believe that implementing the plans set out in this chapter will deliver the following desired outcomes and ultimately improve population health and reduce health inequalities.

Desired Outcomes

- A levelling up of the Primary Care offer across Thurrock with appointment levels against population need at least in all PCNs as good as the level of equity currently available within the Stanford-Le-Hope PCN currently, addressing the "inverse care law" and reducing health inequalities.
- At scale provision of certain elements of Primary Care services at PCN rather than practice level, with improved sharing and clinical skill mix and adoption of best clinical practice within all surgeries
- Development of blended staff roles able to deliver a broader range of functions, and integration between Primary Care staff and wider health and care services at PCN/locality level.
- Improvement in patient satisfaction across the borough to at least the level currently experienced only in Stanford-le-Hope PCN
- Residents actively engaged in co-design of on-going Primary Care transformation
- A shift from reactive to preventative care
- Improved continuity of care.
- Fit for purpose estates to provide integrated services, e.g. Integrated Medical Centres, supporting practices with their Estate Improvement Plans.

5.7 Our Ask To the System

1. Recognise the importance of high-quality primary care in preventing demand on more expensive elements of the system including hospital front door and that there is inequity in Primary Care in Thurrock, both between the borough as a whole and England, and within the borough. Distribute and prioritise future system resources and growth funding to allow us to address these issues.
2. Devolve power and decision making to Thurrock level to allow us to transform Primary Care locally, in conjunction with our local clinicians and residents
3. Support integrated care and the provision of real time linked data to PCNs through development of a single shared care record.

Chapter References

1. Tudor-Hart, J. The inverse care law. *The Lancet*. 1971; 297(7696): 405-412. THE INVERSE CARE LAW - The Lancet ↑

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Chapter 6: Improved Health and Wellbeing Through Population Health Management

From reactive to proactive care

Chapter 6: Improved Health and Wellbeing through Population Health Management

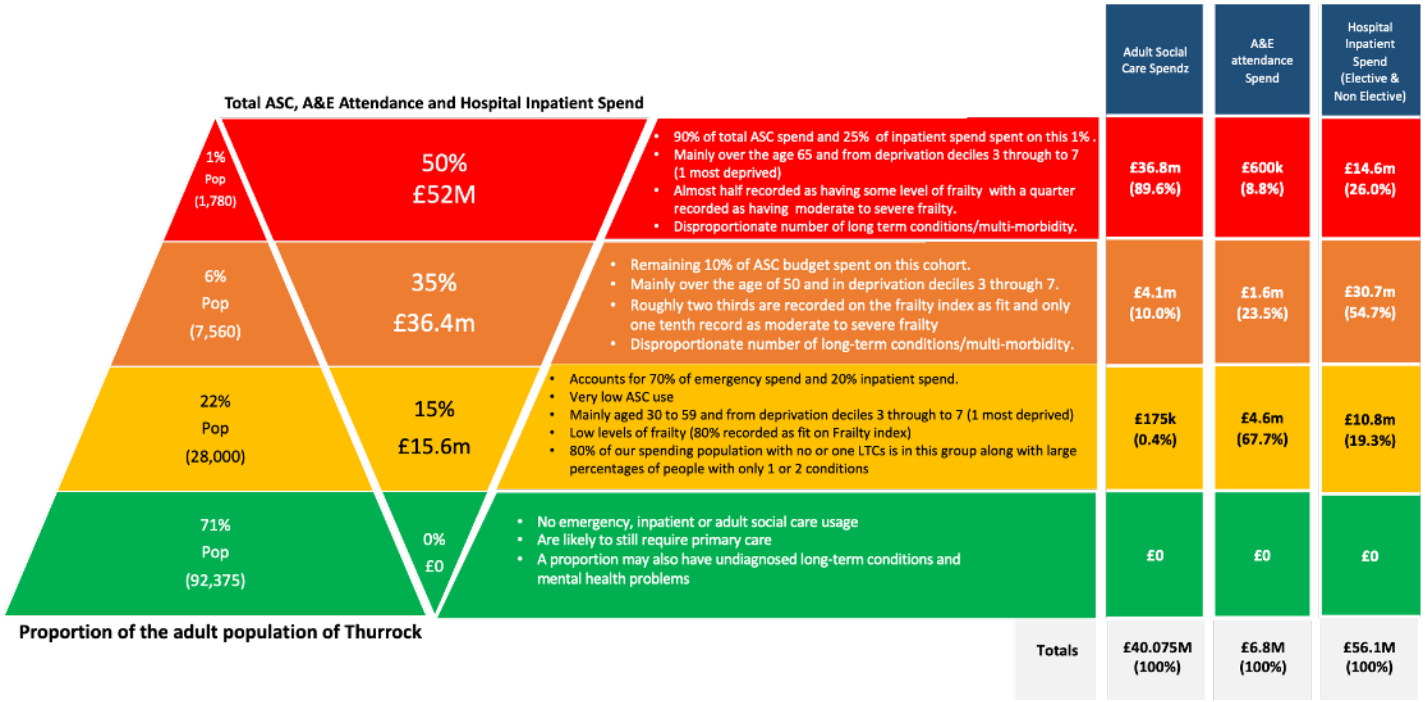
6.1 Introduction

This chapter sets out collective action that we will take in Thurrock to deliver proactive care to our residents using insights through Population Health Management. Population Health Management (PHM) is an approach that uses data and intelligence to understand the differing needs of different cohorts of residents and then provide proactive tailored interventions to the each cohort to respond to those needs and to keep them as well and independent as possible for as long as possible.

6.2 Segmenting the Thurrock Population

Figure 6.1 shows a high level segmentation of Thurrock residents aged 18+, considering the total spend on Adult Social Care and hospital A&E attendance and inpatient services (both elective and emergency).

Figure 6.1



50% of the entire spend on ASC and hospital A&E/inpatients can be attributed to only 1% of the population (1,780) residents (shown as the red segment). A further 35% of the entire spend is attributable to only 6% of residents (shown as the orange segment). 22% of the population consume the remaining 15% of ASC and hospital A&E/inpatient spend (the yellow segment) and that remaining 71% of residents consume no ASC and hospital A&E/inpatient spend.

The most resource consuming 1% are most likely to be over the age of 65, have a high level of frailty and a disproportionate number of long term conditions/multimorbidity. Almost 90% of the total ASC budget and over a quarter of hospital inpatient spend is spent on this segment and as such are highly likely to include residents with learning disabilities and/or mental health care needs. They are most likely to need integrated health and care services to help them maintain wellbeing and independence for as long as possible. These are discussed in Chapters 7, 8 and 9.

The second most resource consuming 6% are mainly over 50 and use almost all of the remaining ASC budget. They have lower levels of frailty but are also diagnosed with a disproportionate number of long-term conditions. Over half of the total hospital inpatient budget is spent on this cohort. They are likely to require high quality integrated health and care services within the community to diagnose and manage their long term conditions and keep them as independent as possible for as long as possible. Action to prevent future high cost demand on adult social care needs to focus on this cohort.

The third (yellow) cohort that consumes the remaining 15% of the budget are adults mainly aged 30 to 59 with low levels of recorded frailty. They are most likely to be diagnosed with one or two long term conditions. They consume almost no ASC spend but almost a fifth of the hospital inpatient budget and two thirds of spend in A&E. They are likely to need high quality management of their existing long term conditions in the community to prevent them needing to access A&E and to prevent their conditions worsening such they consume more health services. This is the most important segment to focus coordinated secondary prevention on, in order to prevent future hospital inpatient spend.

The 71% majority of the population who are not consuming hospital inpatient, A&E or ASC budgets are the most likely to be healthy. They may still have lifestyle risk factors that if not addressed will cause them to require hospital or ASC services in the future. They are also likely to be accessing primary care services episodically and may also have undiagnosed or diagnosed long term conditions being managed in primary care. Providing effective diagnosis of undiagnosed long term health conditions, good access to primary care and services that assist in their general wellbeing and address unhealthy lifestyles are likely to be most important to this cohort in order to prevent them from progressing into a higher cost segment.

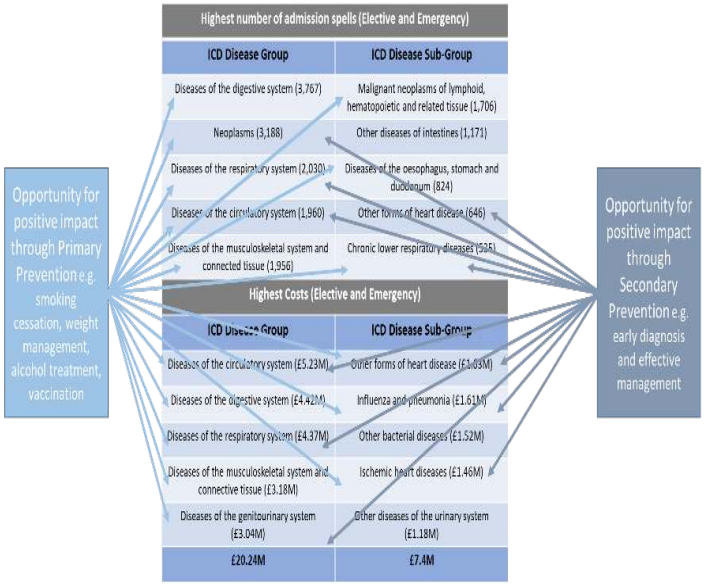
6.3 A proactive and preventative care approach

An inadequate or too reactive approach to the health and care of segments two, three and four (orange, yellow and green) is likely to result in conditions worsening, risks increasing, outcomes deteriorating and residents moving upwards into a higher cost segment. Conversely, intervening early through systematic primary and secondary prevention activity is the most effective way of keeping residents well and preventing them progressing to higher cost segments.

- **Primary Prevention** relates to programmes or activity to intervene to prevent adverse health events or disease occurring by modifying risk. Examples would include smoking cessation, weight management or treatment of alcohol addiction.
- **Secondary Prevention** describes programmes or activity that aim to diagnose and treat conditions as quickly and effectively as possible to prevent them progressing or deteriorating. Examples include the effective diagnosis and management of blood sugar levels in those with diabetes, or the management of Atrial Fibrillation through anti-coagulation therapy to prevent an AF related stroke.

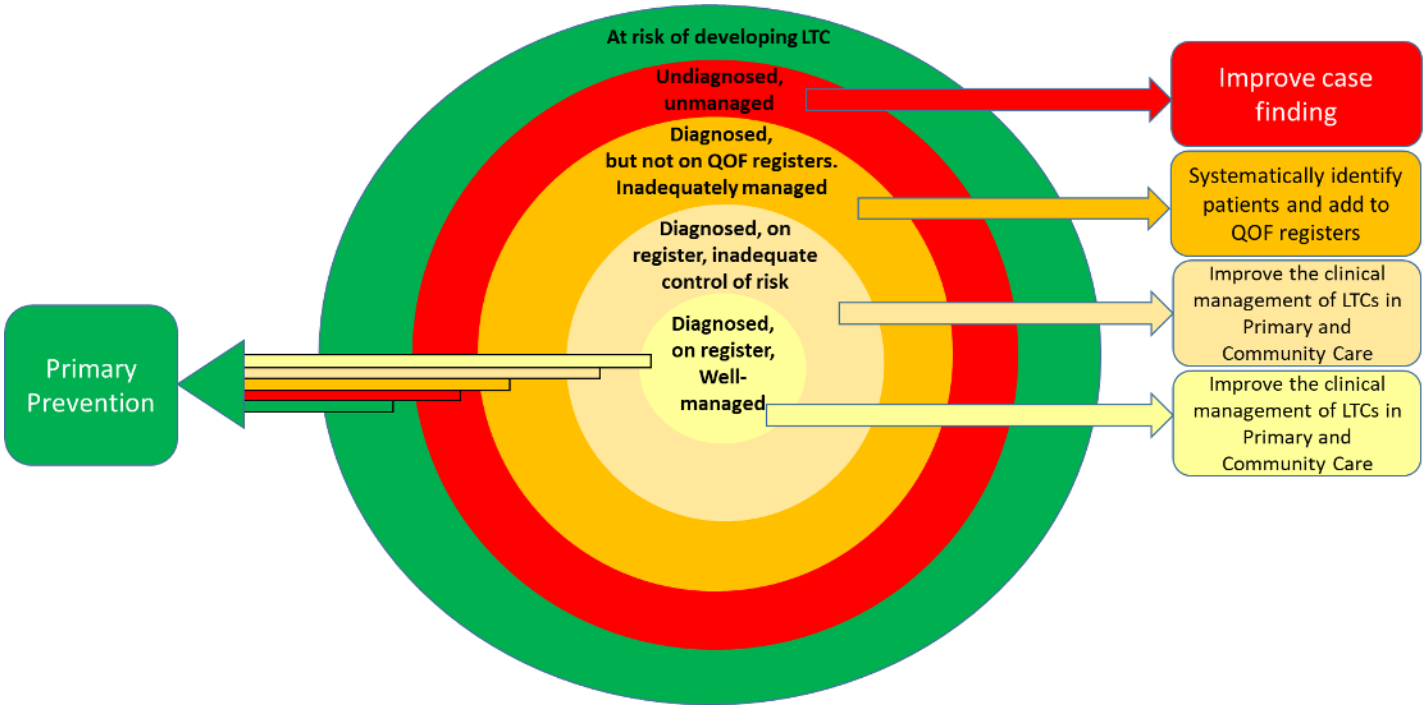
Figure 6.2 shows the ICD Disease Groups and Disease Sub-Groups that are responsible for the most frequent hospital admissions in Thurrock, and for the most costly. It demonstrates the significant opportunity for both primary and secondary prevention activity on reducing both hospital admission demand and cost.

Figure 6.2



The population of Thurrock residents can be further segmented by their long-term conditions and how effective local health and care services are at responding to them. However, some residents may fall into different segments for different conditions. This is shown in figure 6.3 overleaf.

Figure 6.3



Many residents may be at risk of developing long-term conditions as a result of their lifestyle or wider determinants of health but are yet to do so. These are shown in the green segment. Primary prevention for example, empowering residents to live healthier lives, addressing wider determinants of health and vaccination is the most effective way of preventing long term conditions from developing in the future. Primary prevention is the single set of interventions that will benefit the outermost green segment, but will also potentially benefit all other segments where there are existing individual lifestyle risk factors that could also be mitigated.

The red segment represents the cohort of residents who have already developed long-term conditions but these are yet to be diagnosed. As a result, these long-term conditions will not be being effectively managed and over time, the health of residents in this cohort is likely to deteriorate, placing them at high risk of more serious health events and admission to hospital. The most pressing need of this cohort is quick diagnosis and effective management.

The orange segment represents the cohort of residents who have received a diagnosis and may even be receiving some form of treatment for a long-term condition, but who have not been added to the appropriate QOF disease register.

As a result, their long-term conditions will not be being managed in a systematic way and they may not be receiving all of the appropriate monitoring and clinical management to keep them as well as possible.

The two most inner segments represent the total population of residents already diagnosed and on QOF registers. The beige segment represents those who whilst diagnosed, do not have their clinical biomarkers adequately controlled. This may be as a result of poor patient engagement; other individual risk factors such as deprivation, lifestyle, age or genetics; inadequate clinical management, or; general complexity. As a result, they are at high risk their condition deteriorating, more serious adverse health events occurring and hospital admission. Their primary need to improved management of their existing long-term conditions to bring clinical biomarkers back in range and their risk reduced. In complex cases, this may require specialist clinical input. Conversely, the yellow segment represents the cohort of residents who are well-managed, in receipt of all recommended clinical interventions and with their clinical biomarkers in range with a low risk of serious adverse health events or hospital admission. They require on-going monitoring and management to maintain their lower risk profile.

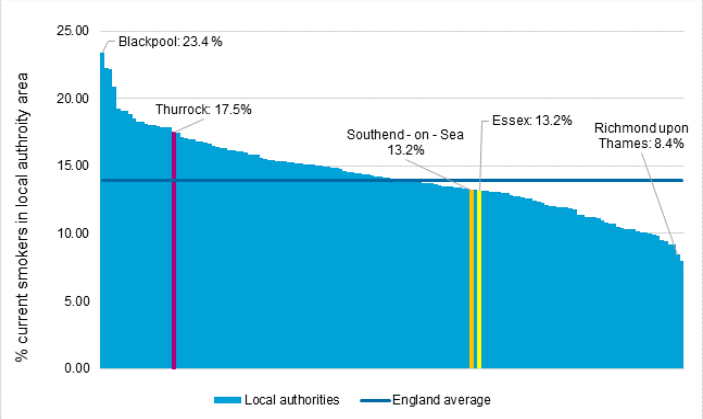
Sections 6.4 to 6.8 of this chapter deal with our plans to deliver the five different categories of intervention that will most benefit each cohort.

6.4 Primary Prevention

Tobacco Control

Although declining, Thurrock has a significantly high prevalence of smoking in adults compared to both the East of England and England (Figure 6.4). Smoking prevalence is highly correlated with deprivation and differences in smoking prevalence between deprived and affluent communities are the single biggest factor explaining differences in health inequity.

Figure 6.4

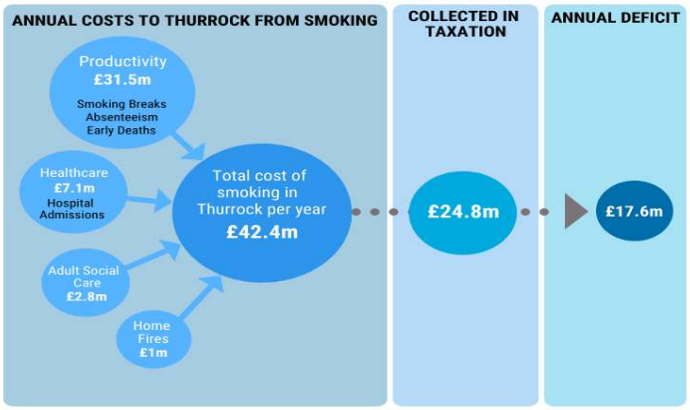


BOX 6.1: THE IMPACT OF SMOKING IN THURROCK

Thurrock has:

- **25% high smoking attributable mortality than England's**
- **27% higher smoking attributable hospital admissions than England's**
- **Higher smoking attributable hospital admissions for asthma**
- **Half of all smokers living in the eight most deprived wards**

Figure 6.5



We calculate the total cost of smoking in Thurrock to be £42.4M with an annual local financial deficit of £17.6M (Figure 6.5).

Action to Reduce Smoking Prevalence

At present, part of the Public Health Grant is used to commission a range of programmes and services to assist Thurrock smokers to quit and reduce smoking prevalence. These include:

- Stop smoking services in GP practices and pharmacies
- A stop smoking service through Vape Shops
- The Allen Carr Easy Way stop smoking service
- An 'in house' specialist stop smoking service provided by Thurrock Healthy Lifestyle Solutions.
- Targeted enforcement action to reduce the supply of illegal and counterfeit cigarettes.

In 2020/21, the Thurrock Public Health Team completed a detailed Joint Strategic Needs Assessment Product on Tobacco Control with 14 specific recommendations that can be found on the council's website.

Reducing smoking prevalence within our population is a complex and multifactorial problem that requires a whole system approach, and is worthy of a separate strategy in and of itself. The JSNA provides a detailed analyses of the current issues and this now needs to be converted into a whole system response.

The JSNA demonstrated that smokers are not uniformly distributed throughout our population, and there are disproportionate rates of smoking in deprived wards and amongst those with serious mental ill health.

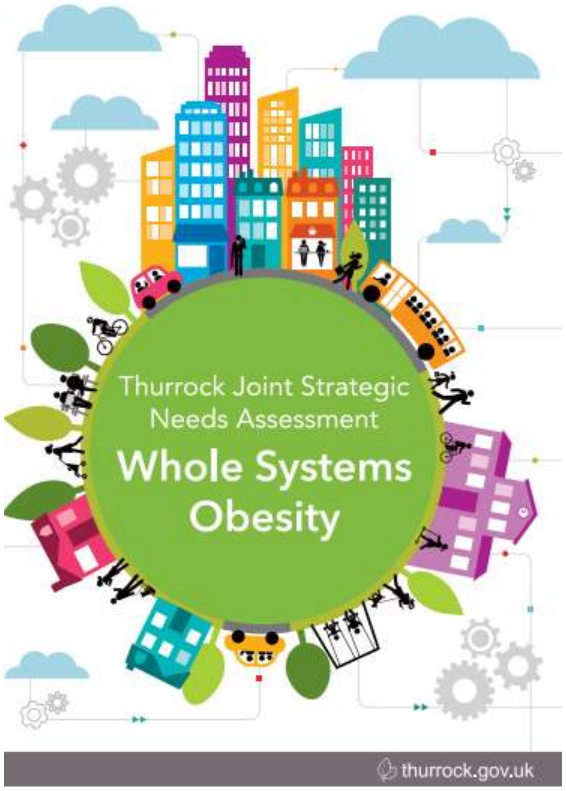
At present smoking cessation services sit separately to other health and care services and remain largely the responsibility of the Public Health Team. There is an opportunity to deliver a more integrated model, aligning and embedding the existing Thurrock Healthy Lifestyles Service within the integrated care models we will create around the PCNs. (See Chapter 7). There is a need to make it a priority for all health and care partners in Thurrock and to embed a stop smoking offer within community and secondary care pathways, particularly respiratory, cardio-vascular and mental health.

We will take the following strategic action as TICP to reduce smoking prevalence in Thurrock:

Obesity

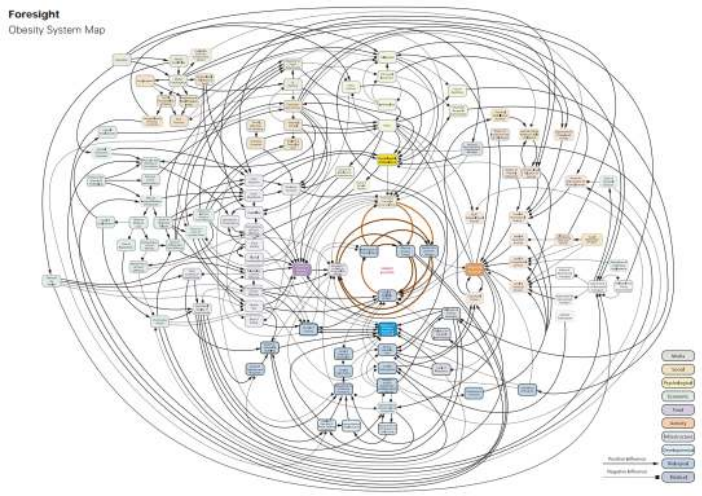
It is well-evidenced that obesity is both a risk factor for development of certain long term conditions, and a contributing factor itself to disease complications and higher service use/cost. For example, an obese woman is 13 times more likely to develop type 2 diabetes than a healthy weight woman. Co-morbid obesity also significantly increases treatment costs of other long term conditions with obese patients estimated to have approximately 30% higher medical costs than non-obese patients. Similarly, research by Public Health England 2015 also found that severely obese people are over 3 times more likely to require social care than those of a normal weight, with examples of requirements including housing adaptations, carers or provision of appropriate transport and facilities. The same research also cited that obesity reduces life expectancy by an average of 3 years, and severe obesity could reduce life expectancy by an average of 8-10 years.

As shown in Section 1.2, Thurrock has a significantly greater proportion of it adult population who are overweight or obese compared to England and the East of England, and also higher levels of adult physical inactivity.



Like tobacco control, obesity is a highly complex and multifactorial problem requiring a whole systems approach. The 2007 Foresight map (Figure 6.6) identified 148 variables that interact as a system at community level to determine levels of obesity in a given population. As such, our response to obesity needs to be a Human Learning Systems one; we cannot commission our way out of obesity through individual lifestyle modification programmes.

Figure 6.6 – The Foresight Map (2007) – factors that influence obesity



Thurrock developed a detailed Joint Strategic Needs Assessment product on Obesity in 2018 followed by a Whole Systems Obesity Strategy based on the JSNA. The JSNA and Whole Systems Obesity Strategy can be found on the www.thurrock.gov.uk website.

Our Whole Systems Obesity Strategy centres action around the six goals:

- **GOAL A: Enabling settings, schools and services to contribute to children and young people achieving a healthy weight**
- **GOAL B: Increasing the opportunity for positive community influences on obesity** including coordinated action of a wide range of partners to deliver improvements o nutritional health and physical activity
- **GOAL C: Improving the food environment and food choices** with action to create a healthier food environment in Thurrock and improved opportunities for access to healthy good
- **GOAL D: Improving the physical activity environment and getting the inactive active** including action around improving the borough's built environment to increase physical activity and wellbeing, the prioritisation of active travel in transport and planning policies, and commissioning programmes to support physical activity.
- **GOAL E: Improving the identification and management of obesity** including improved obesity case finding and support within primary care, improving education in the prevention of obesity and ensuring equitable and high quality weight management services.

A review and refresh of the current action plans under each goal is in progress following the COVID-19 pandemic. This will include refreshing the plan in the context of wider strategic work to ensure that environments in Thurrock are designed to enhance and maintain both physical and mental health and well-being to tackle the obesogenic environment including:

- Thurrock Active Place Strategy
- Engagement in Thurrock's Local Plan and Design Strategy via the Design Charrettes process and production of a dedicated Local Plan JSNA.
- Thurrock's Active Travel Needs Assessment and new Transport Visioning Strategy work.
- Health Impact Assessment – through the Health and Planning Advisory Group (HPAG) to feed in health impacts of planning applications or respond to health impact assessments which are submitted as part of planning applications.

We are also using Population Health Management techniques to identify and respond to the needs of specific population cohorts at high risk of complications from obesity. The Population Health Management Team is working with clinicians in the Stanford and Corringham and ASOP PCNs to pilot an innovative new personalised approach to Obesity set out in Box 6.2 that addresses inequalities and social deprivation factors associated with obesity as well as traditional physical activity and nutritional approaches (Box 6.2)

Box 6.2 Combatting Obesity through PHM

The Combating Obesity in ASOP and Stanford-le-Hope project has been supported by the PHM Team to develop a personalised care service that targets both obesity and associated health inequalities due to social deprivation.

Population Health Management analyses reveals that Thurrock is in the worst quartile for obesity rates across all ages, inactivity and diet. Furthermore, there is a high correlation between obesity and deprivation requiring for the approach to supporting patients to be holistic.

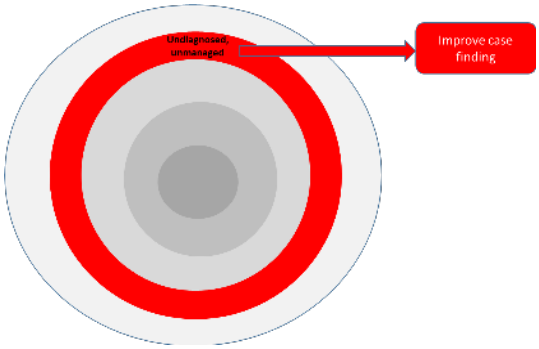
A project group was established with strong clinical leadership. The PHM Team supported by identifying the highest risk cohort of 550 people based on a risk model informed by evidence. The criteria used includes high clinical risk and other Long Term Conditions diagnoses, poor Hb1Ac levels and whether residents are of a high risk ethnicity.

Further to identifying the cohort, the Thurrock team were supported with completing a logic model and identifying and engaging with stakeholder activities, which sit at the core of developing the right interventions for the cohort.

A high level operating model has been established and the next steps for the group are to recruit the required staff, develop the right tools in the GP systems, and to finalise the estates and equipment for the model.

We will take the following actions as the Thurrock Integrated Care Partnership to address obesity within our population:

6.5 *Find the missing thousands.* Improving diagnosis of undiagnosed long term conditions.

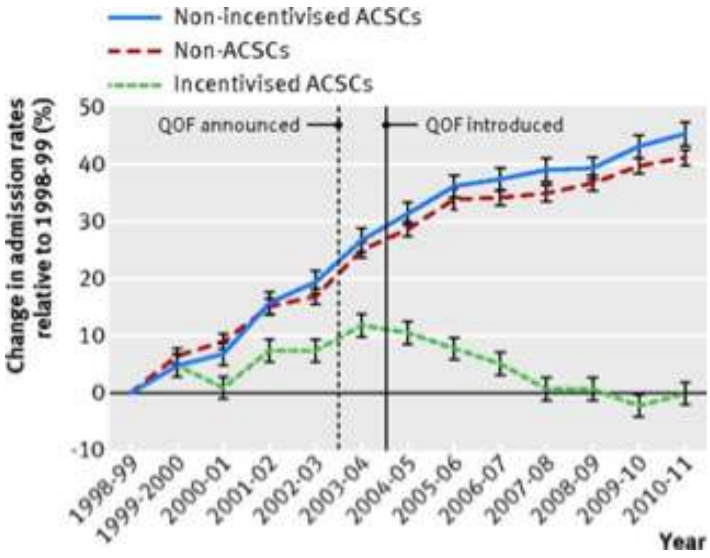


6.5.1. Incompleteness of Thurrock Long Term Condition (QOF) Registers

The Quality Outcomes Framework (QOF) is the mechanism through which GP practices provide evidence-based secondary preventative clinical care to manage long-term conditions and keep residents as well and independent as possible for as long as possible. After a diagnosis for a long-term condition, residents should be added to the specific QOF disease register for that long-term condition and ten receive appropriate monitoring and clinical interventions to prevent their long-term condition deteriorating or more serious adverse health events such a strokes, heart attacks and hospital admissions from occurring.

There is clear evidence of the effectiveness of QOF as a secondary prevention programme. Figure 6.7 shows the impact that QOF had on ambulatory sensitive care conditions that were incentivised under the scheme, compared to those that were not included.

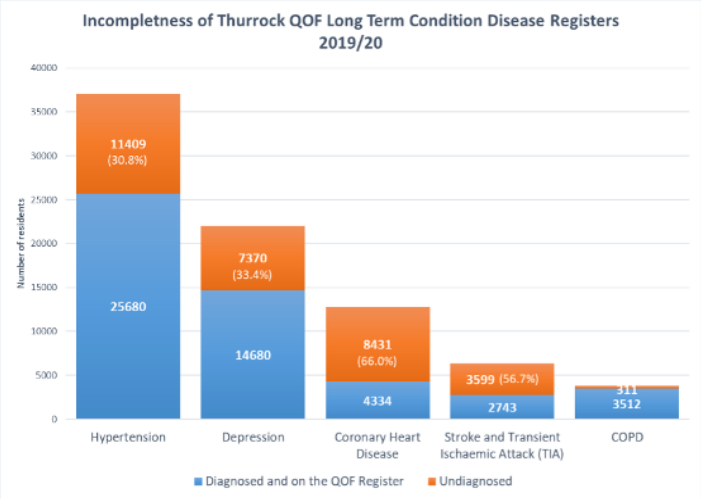
Figure 6.7



Many QOF disease registers in Thurrock remain incomplete and don't reflect the total number of residents living with each long-term condition. We know this from modelled estimates from Public Health England produced for some disease registers that estimate the expected prevalence of specific long-term conditions within Thurrock based on the demographic characteristics and health status of our residents. We have used these models and updated them to account for demographic population growth since they were first produced. By comparing the updated figures to numbers of our residents on different disease registers we can estimate the numbers of residents with undiagnosed long term conditions.

Figure 6.8 (overleaf) shows numbers of diagnosed and undiagnosed residents with hypertension (high blood pressure), depression, coronary heart disease, COPD and stroke/TIA.

Figure 6.8

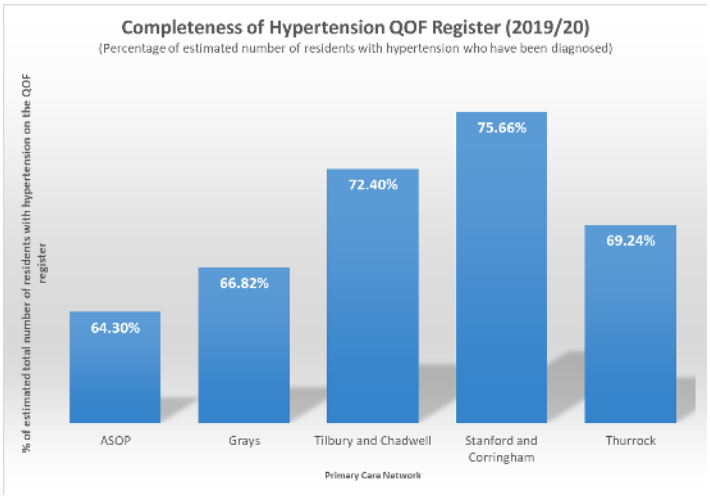


The most incomplete disease register in percentage terms is the Coronary Heart Disease register with an estimated 66% of residents with CHD undiagnosed. The disease register with the largest absolute number of undiagnosed residents is Hypertension, with an estimated 11,409 residents in Thurrock who are unaware that they have high blood pressure.

Population level case-finding of both undiagnosed CHD and stroke/TIA remains difficult because of the need to undertake complex diagnostic processes. However, population screening for high blood pressure and depression can be undertaken using simple diagnostic tests and offers further scope for improvement.

There is also significant variation at GP practice an PCN level in the completeness of QOF registers. For example Figure 6.9 shows the completeness of hypertension QOF registers between the four Thurrock PCNs.

Figure 6.9



Identifying patients with long term health conditions who are unaware that they have them ("find the missing thousands"), is a key priority if we are going to intervene early with excellent clinical management to prevent chronic diseases progressing and residents' deteriorating towards more serious adverse health events requiring hospital admission and adult social care intervention. It delivers a return both in population health and system operational and financial sustainability terms.

6.5.2 The Impact of Incomplete QOF Registers

Using Thurrock's Medeanalytics linked data-lake, we are now able to understand the impact that case-finding of long-term conditions has on emergency hospital admissions. Figure 6.10 shows the number and proportions of residents admitted to hospital as an emergency for different conditions, who were previously diagnosed and on the appropriate QOF register or were not previously diagnosed and on the appropriate QOF register.

Figure 6.10

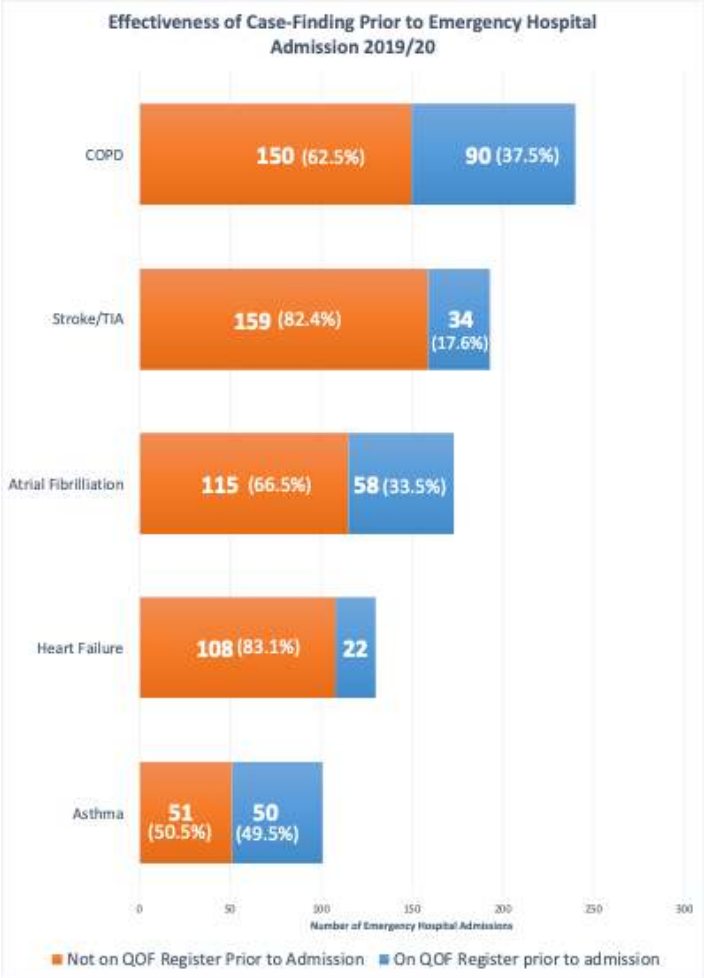
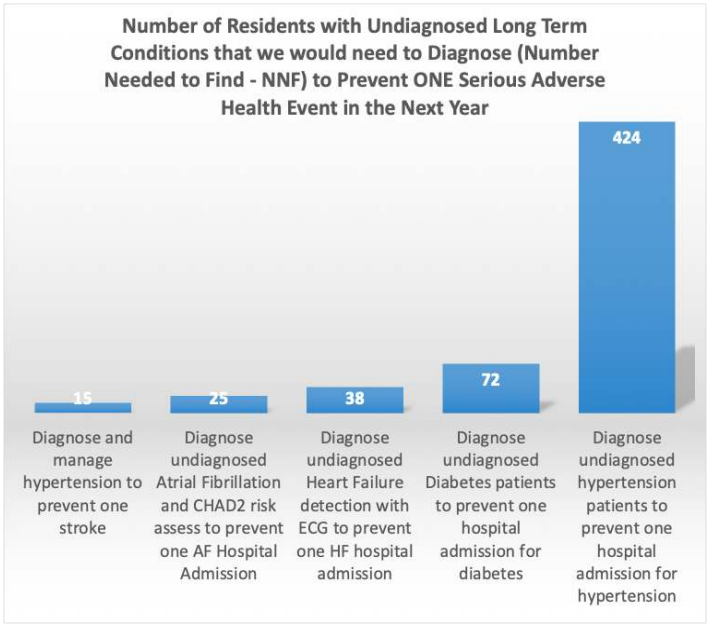


Figure 6.10 demonstrates just how reactive the local NHS system remains. Across all emergency admissions for long term conditions, the majority of residents were not previously diagnosed and on the correct QOF register. For stroke/TIA and heart failure, the proportion was more than four in five.

By failing to identify, diagnose and provide proactive preventative care to residents with long-term conditions, we wait for serious adverse health events to occur before intervening. This produces poorer population health outcomes and wastes system resources. However, it demonstrates the significant positive impact we can have in both health and financial terms by systematic action to improve case-finding.

Figure 6.11 shows the number of residents with different undiagnosed long term conditions that we would need to diagnose and add to the appropriate QOF register to prevent **one** serious adverse health event in the next 12 months. (The Number Needed to Find - NNF). The smaller the NNF, the fewer residents we need to diagnose to prevent the adverse health event. The case finding activity with the smallest NNF is diagnosing undiagnosed hypertension in order to prevent strokes. For every 15 undiagnosed residents with hypertension placed that we diagnose and treat, we prevent one stroke. Similarly we only need to diagnose 25 residents with undiagnosed Atrial Fibrilliation (AF) to prevent one hospital admission for AF and 38 undiagnosed heart failure patients to prevent one heart failure admission.

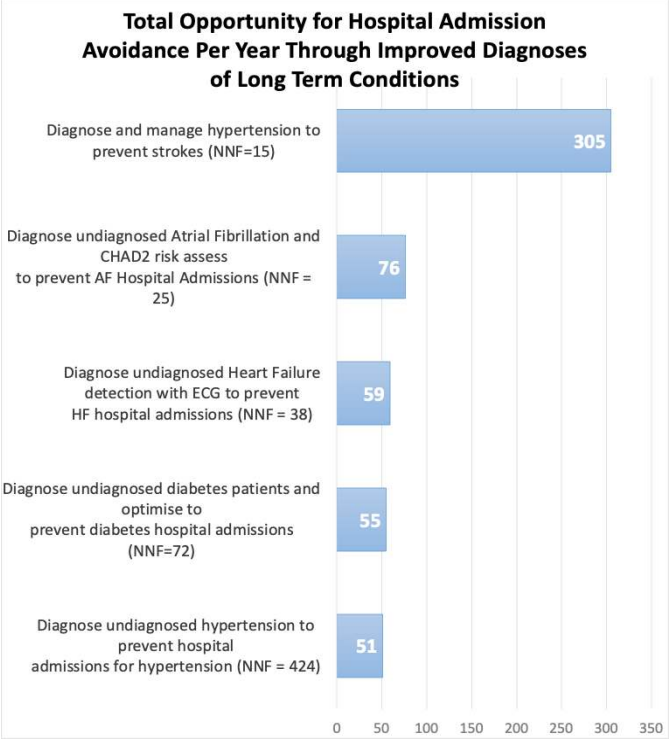
Figure 6.11



For every 15 residents with undiagnosed hypertension that we diagnose and treat, we prevent one hospital admission that year for stroke.

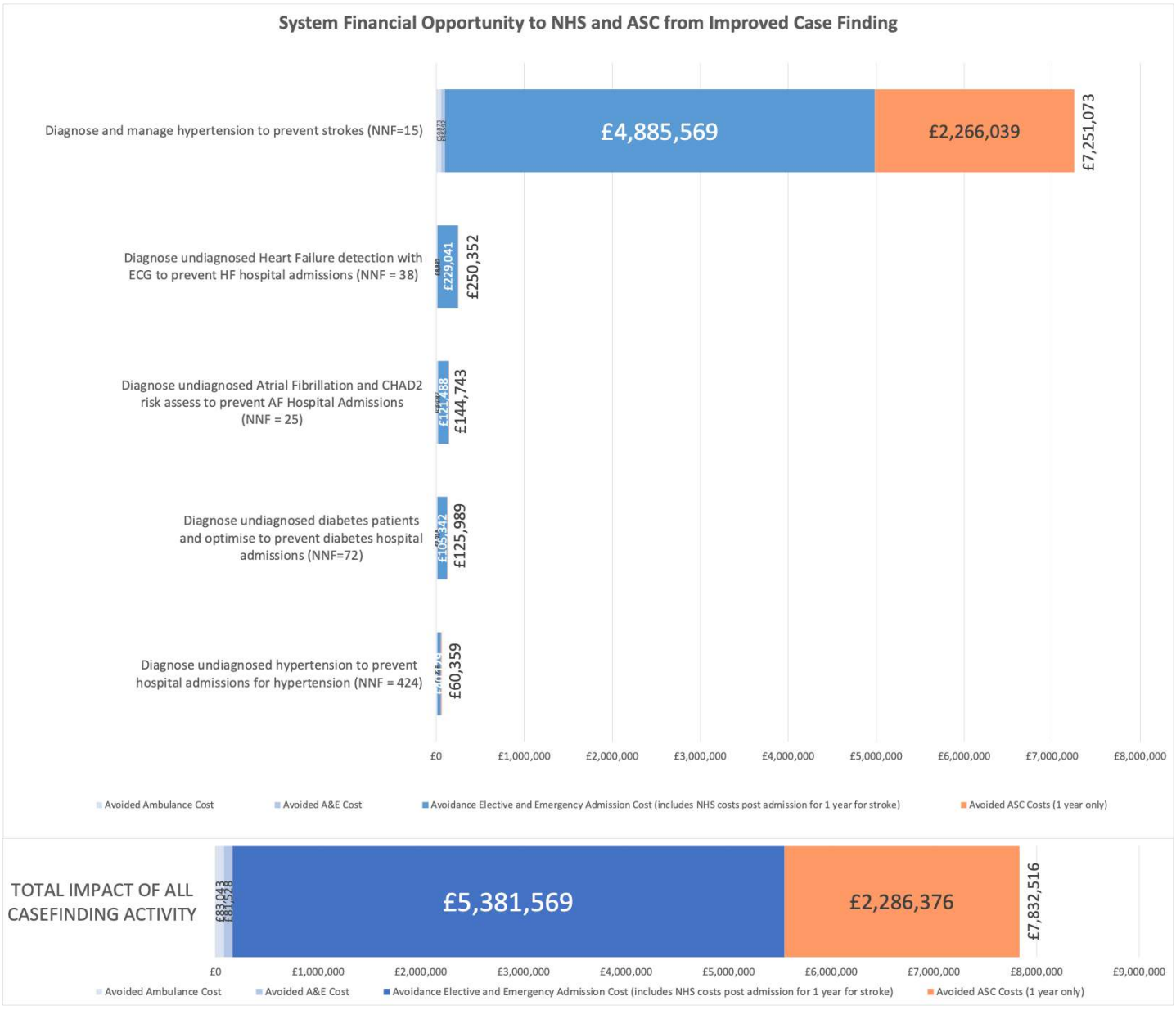
Figure 6.12 shows the total hospital admission avoidance opportunity per year through case finding (i.e. effective diagnosis of all patients with undiagnosed long term conditions and addition to QOF registers so that they could receive treatment). We calculate that there is potential to prevent 546 hospital admissions in Thurrock per year from improved case finding, demonstrating significant positive impact that case finding activity can have of the health of our residents and on the operational sustainability of our health and care system.

Figure 6.12



There is significant potential financial opportunity that can be gained by maximising diagnoses of un-diagnosed long-term conditions. Figure 6.13 shows a potential to deliver almost £8M in cost avoidance (almost £5.4M of avoided cost to the NHS and almost £2.29M to Adult Social Care) in Thurrock if case finding operated at 100%. The biggest opportunity lies in diagnosing and management of hypertension to prevent strokes.

Figure 6.13



6.5.3 Improving Case-Finding of Specific Long Term Conditions

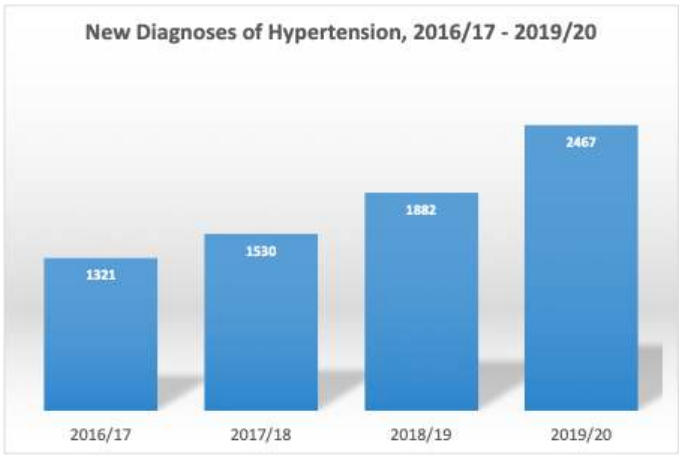
Hypertension Case finding

The 2017 *Case for Change* strategy set out ambitious plans to improve the diagnoses of hypertension including:

- Blood pressure monitoring machines in GP practices and other health care settings.
- Additional funding to GP practices to systemically record blood pressure through the *Stretched QOF* contract
- Use of the third sector and community assets to measure blood pressure including Community Hubs

Figure 6.14 shows the success of this programme to date. Since 2017/18, 5879 new diagnoses of hypertension have been made, with significant year on year increases against the 1321 2016/17 baseline.

Figure 6.14



Atrial Fibrillation Case Finding

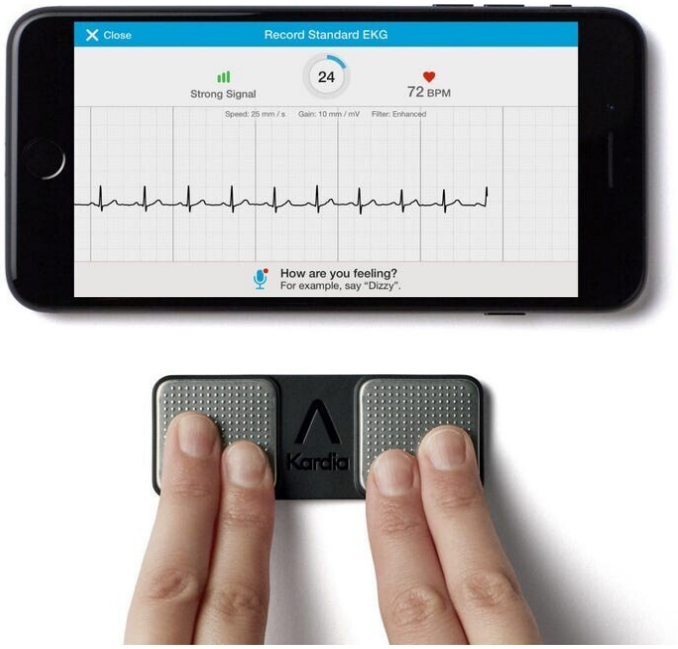
Individuals with untreated atrial fibrillation (AF) face a fivefold increased risk of ischaemic stroke compared with those without the condition. Evidence suggests that one-third of all patients with ischaemic stroke had previously known or recently diagnosed AF.[1]

AF-related stroke is, on average, more severe than non-AF-related stroke and associated with worse outcomes but risk can be significantly reduced by appropriate use of anticoagulation therapy in patients characterised as medium or high risk using the CHAD2VASc scoring[3]. As such, early and accurate diagnosis of AF is an essential step in gaining protective coverage from anticoagulation therapy in order to prevent stroke.

A major diagnostic challenge relates to those with paroxysmal or asymptomatic (silent) AF. Studies indicate that even short episodes of 'silent' AF are associated with increased stroke risk.[4] However, residents with asymptomatic AF will be much less likely to have their condition diagnosed until an ischaemic stroke event has occurred.

AF risk increases with age and other cardio-vascular disease risk markers including hypertension, underlying heart disease and obesity. Many studies have reported the benefits of singe time-point screening of older patients >=65 years. Handheld devices such as the AliveCor provide heart rhythm readings to a mobile phone that can then be read by a clinician. A systematic review of 30 studies covering over 122,000 patients, increased AF prevalence by 2.1% (one new case detected for every 48 people screened) using single-time point screening. 67% of screen detected new AF cases were subsequently indicated for oral anticoagulation.[5]

AliveCor Testing Device for AF Screening



Targeting single time-point AF screening in specific healthcare settings can yield even better results. For example, one study that systematised AF screening in community podiatry clinics resulted in an AF detection prevalence of 4.6% or 1 in every 22 people screened.[6]

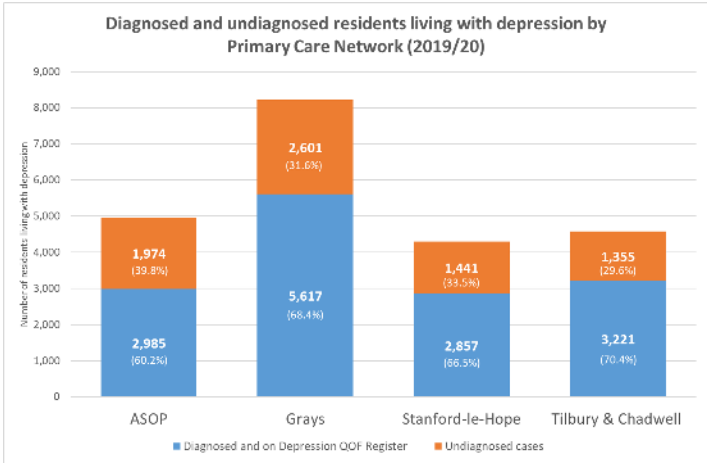
A potential issue with single time-point screening is the possibility of 'missing' an AF signal in patients with paroxysmal (silent) AF who may not be experiencing an AF episode at the time of screening. Longer term screening of higher risk groups addresses this flaw. The Swedish STROKESTOP study used twice-daily screens over a two week period and increased AF prevalence in the screening cohort by 3% (detecting one additional case for every 33 people screened). The ASSERT-II study used implantable subcutaneous ECG monitoring devices over a 16-month period in patients with higher CHA2DS2VASc score of 4.1 and found 34.4% of participants had at least one episode of AF lasting five minutes or more; one in every 2.9 people screened.[7]

Patients with AF are not only at an increased risk of overt stroke, but are also more likely to suffer a clinically silent vascular brain lesion and can occur whether or not AF is silent or persistent.[8] Research indicates a link between AF and cognitive decline including both vascular and Alzheimer's dementia even in patients with no history of stroke. Anticoagulation was associated with a 39% reduction in incidence of dementia.[9]

Depression Case Finding

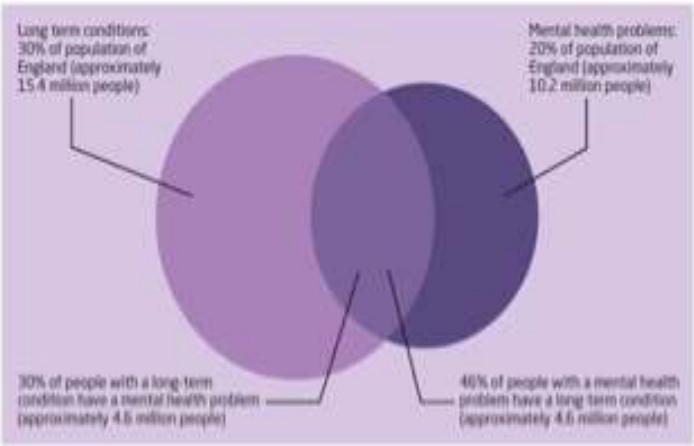
Under-diagnosis of depression remains a significant issue in Thurrock, as shown in figure 6.15. We estimate that there are 22,050 residents living with depression in Thurrock, of whom 7,370 remain undiagnosed. The depression QOF registers are most incomplete in ASOP with only 60% of depression cases diagnosed.

Figure 6.15



There is a bi-directional relationship between depression and other long term health conditions and significant overlap between both cohorts as shown in figure 6.16. People with depression may be more at risk of developing other long term conditions, and those with other long term conditions may be more at risk of becoming depressed.

Figure 6.16



Evidence also shows that those with physical long-term health conditions and co-morbid depression have poorer outcomes and cost the health and care system more money. [10]

A patient with a physical long term condition (LTC) without depression is estimated to cost the NHS £1,760 a year less than a patient with both a long term condition and co-morbid depression (£3,910 vs £5,670). Early identification and subsequent management of depression would delay and reduce higher level interventions later on.

If 46% of the cohort of residents of Thurrock with undiagnosed depression have other co-morbidities, diagnosing and treating their depression presents an opportunity for delivering better outcomes and delivering savings to the local health and care economy of almost £6M per annum.

We have already implemented a range of measure through *Better Care Together Thurrock* to improve depression diagnosis in primary care including embedding PHQ2/9 screening tools in SystmOne together with electronic IAPT referral and encompassing depression screening as part of the NHS Health Check.

6.5.4 Future Proposed Action to Improve Case Finding of Undiagnosed Hypertension, Atrial Fibrillation and Depression.

Implementation of the approach taken on hypertension case finding in the original *Case for Change Strategy* has yielded significant positive results and we will continue action to systematise hypertension case finding within primary care and other health and community settings and through stretched QOF, enhancing current success by use the Primary Care Networks to spread best practice between surgeries. Building on this success, we will seek to use these mechanisms to incentivise and fund primary care to improve diagnoses of AF and depression. We will work with each GP practice and PCN to identify a case finding lead to coordinate further work within each surgery and PCN area, and develop a network of best clinical practice.

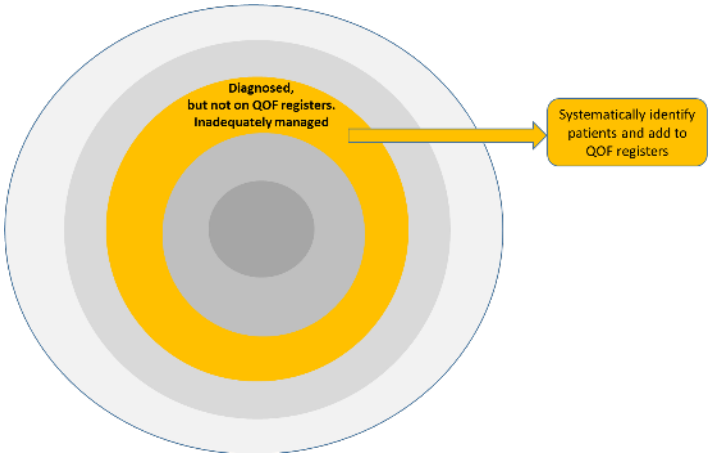
The Better Care Together Thurrock PHM work stream has already implemented digital solutions to remind clinicians of case finding opportunities. For example, a SystmOne template now prompts clinicians to undertake a PHQ9 depression screen when undertaking reviews of other physical long term conditions with patients. We will seek to expand this approach and create additional screening prompts on SystmOne for clinical staff reviewing other high risk groups.

However we wish to go further, embedding hypertension, AF and depression case finding in the roles of front line clinical and adult social care staff across Thurrock including Wellbeing Teams and the Integrated Care Teams that we will build across the four PCNs (see Chapter 7).

In order to improve AF case finding, we will expand the number of AliveCorr devices available to resident facing staff caring for older residents. We will seek to embed route single-time point AF screening in settings accessed by target populations, where evidence has suggested they have yielded positive results elsewhere including community podiatry and flu vaccination clinics. Using Human, Learning, Systems methodology, we will encourage staff to test and learn screening in other settings.

The Public Health Team will co-develop a more detailed Case Finding strategy covering hypertension, AF and depression in 2022/23 in conjunction with clinical leaders within the PCNs, NELFT and EPUT. The strategy will set out in more detail, revised screening protocols including target groups, staff training requirement, targets and resources.

6.6 Ensure prompt inclusion into QOF following a Long Term Condition Diagnosis



6.6.1 Case Finding through Digital Clinical Audit

Following diagnosis of a specific long-term condition, it is vital that the resident concerned is added to the appropriate QOF register promptly to ensure that they receive systematic monitoring and clinical intervention to prevent their long-term condition deteriorating.

The 2017 Case for Change Strategy recommended a digital solution to interrogate GP clinical systems to identify those residents who may have received a long-term condition diagnosis but had not been added to the appropriate QOF register and so may not be receiving systematic clinical management. A company called Interface Clinical Services was commissioned through the Better Care Together Thurrock Population Health Management work stream to construct and run the queries on SystemOne.

Their system undertook remote digital clinical audit of Thurrock GP surgery records, searching for patients who had indicators in their medical records that would suggest that they had been diagnosed with a long-term condition, but who were not on the correct QOF register, for example patients prescribed anti-hypertensive medication who weren't on the Hypertension QOF register. The work identified 8,459 potential patients who required review by individual surgeries, and a considerable potential to increase both QOF prevalence across most domains. As individual surgeries receive part of their income through levels of QOF prevalence, the work was also able to identify significant additional potential income into Thurrock GP surgeries.

However, the solution whilst identifying significant potential numbers of additional residents that may need to be added to QOF registers, still required individual surgeries to review these patients before adding them to QOF registers. Due to capacity limitations in some surgeries, actual numbers of patients added to QOF varied considerably.

Interface Clinical Services

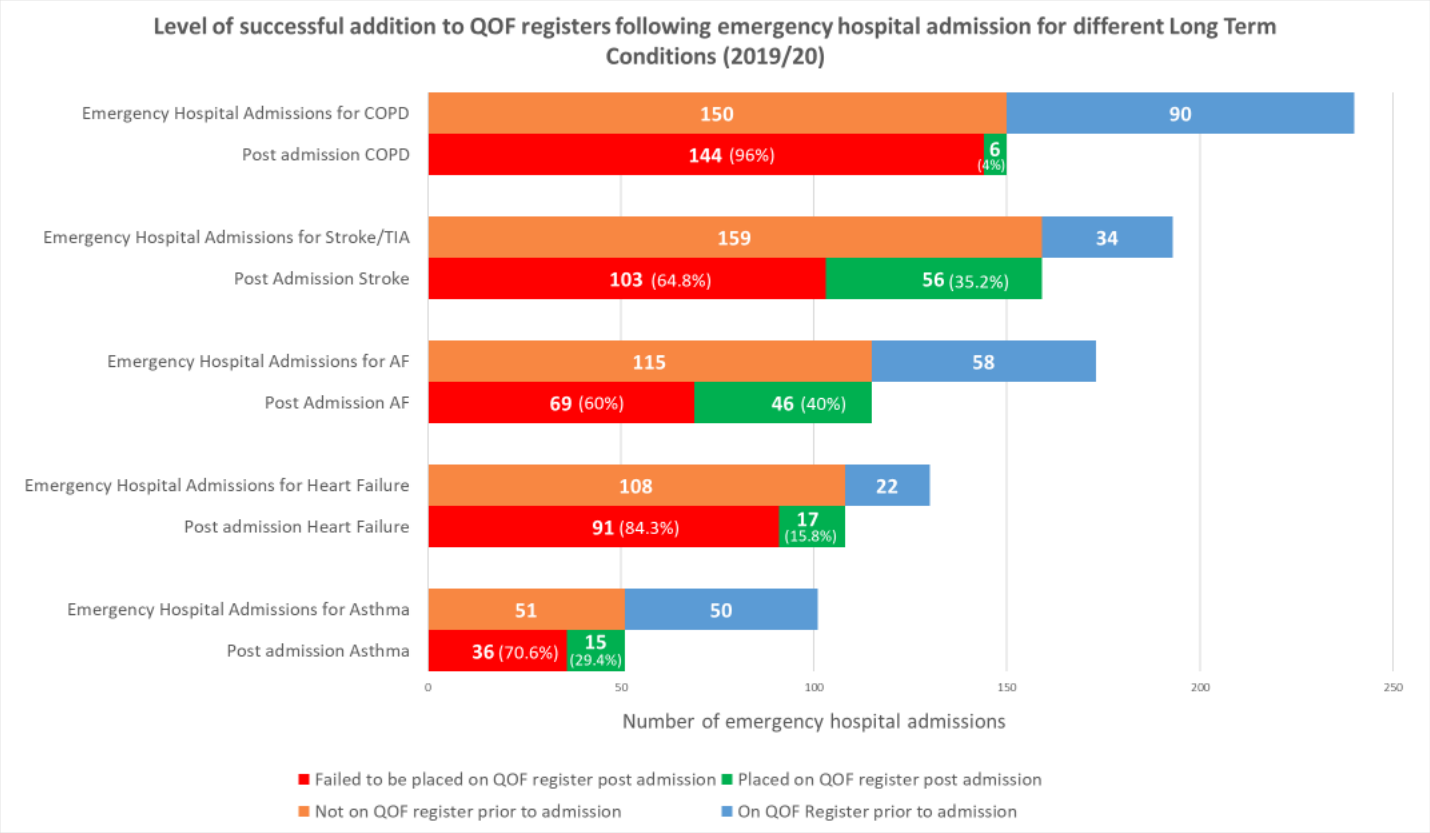
6.6.2 Adding Residents to QOF Registers Following Diagnosis after an Emergency Hospital Admission

In 6.5.2 we demonstrated that the majority of hospital admissions for the most common long-term conditions were from residents that were not previously on the appropriate QOF register and therefore not being appropriately/systematically managed clinically.

Further analyses of the Thurrock Mede-Analytics data-lake demonstrates that even after a long-term condition related emergency hospital admission, far too few residents are successfully added to the appropriate QOF register. In the cohort of residents admitted to hospital and not previously on a QOF register, for every long-term condition analysed, as a system, we fail to add them to the QOF register in the majority of cases post admission following hospital diagnosis. As such, for significant numbers of residents, systematic secondary preventative activity, monitoring and clinical management fails to occur post hospital diagnosis, needlessly elevating the risk of further deterioration and re-admission.

The scale of this failure is set out in figure 6.17. For example of the cohort of residents not on the COPD QOF register prior to a hospital admission for COPD, 96% failed to be added to the COPD QOF register post admission and so potentially missed out on onward systematic management of their COPD on discharge. For Stroke/TIA patients, as a system, we failed to add almost 65% to the QOF register, and for Heart Failure patients, we failed to add over 84%.

Figure 6.17



Ensuring all residents admitted to hospital as an emergency because of a long-term condition receive on-going appropriate preventative clinical management by addeding to the appropriate QOF register is a 'quick win' in terms of population health gain and system financial and operational sustainability

6.6.3 Action to Improve QOF Register Completeness Following Diagnosis

The work of Interface Clinical Services in 2018 demonstrated that there was a significant cohort of residents who had likely received diagnoses for long-term conditions but were not being managed systematically through QOF. This is both bad for residents and causes a loss of potential national funding into our local primary care system. The suspension of QOF during 2020/21 and again in the final quarter of 2021/22 due to COVID-19 pressures, the completeness of QOF disease registers is likely to have degraded further. The analyses in the last section, also clearly demonstrates a systemic failure in the interface between Primary and Secondary Care following long-term condition hospital admissions, with the majority of patients admitted who were not previously on QOF registers, failing to be added post admission. Addressing both of these issues presents a 'quick win' opportunity in terms case-finding and a 'win-win' opportunity in terms of resident health outcomes and avoidable demand and cost through a reduction risk of future emergency hospital admission.

As the Mid and South Essex Population Health Management Programme and creation of a MSE linked dataset through the Arden Gem DESCRO progresses at pace, it will soon be possible to create a more sophisticated in-house Intelligence Function at PCN/Alliance level to support with remote digital clinical audit in real time. Such a function, with access to linked patient level hospital admission data, prescribing data and clinical biomarker datasets could then regularly interrogate patient records on behalf of practices to identify patients who have received a long-term condition diagnosis but are not on QOF registers.

One of the barriers to success of the 2018 Interface Clinical Services case-finding work was a lack of capacity within surgeries to manually review patient records identified as potentially needing to be added to QOF, and make the addition. The subsequent formation of Primary Care Networks provides an opportunity to undertake this work once per PCN at scale through a single function. In order to overcome previous capacity barriers, we go further than the 2018 programme with two new strategic actions:

Firstly, the Thurrock Public Health Team will work with local clinical leaders to develop and agree clinical protocols that allow the highest risk and most obvious patients to automatically be added to the correct QOF register. For example, patients with an existing diagnosis for a long-term condition made in secondary care following an emergency hospital admission and correct diagnostic procedure.

Secondly, in 2022/23, we will bring forward a business case for investment into a dedicated clinical resource to review patients identified through the dedicated PCN/Alliance Intelligence Function and Digital Clinical Audit Programme in order for appropriate patients to be added to disease registers at pace. We envisage such a function to quickly become financially self-sustaining through improved clinical management of patients at high risk of hospital admissions, and the resulting admission avoidance.

SUMMARY OF STRATEGIC ACTIONS

6.12 We will create single back office PCN/Alliance level Primary Care Intelligence Function, capitalising on the 'at scale' opportunity provided by PCNs to provide near real time intelligence to practices on patients long-term condition and to improve the intelligence interface between Primary and Secondary Care following admission/discharge

6.13 We will use the new Intelligence Function to regularly systematically interrogate linked hospital-prescribing-clinical biomarker datasets against QOF in order to identify patients who are yet to be added to QOF registers, but whose clinical records suggests there is a high probability that they should be

6.14 We will develop and agree clinical protools with local PCN clinical leaders that allow the highest risk and most obvious patients to be automatically added to QOF, for example those with an existing hospital admission related to a long-term condition with supporting diagnostics

6.15 In 2022/23, we will bring forward a business case for dedicated Clinical Review resource, shared at PCN level to support in the review and where appropriate, addition to QOF of patients identified through systematic remote digital clinical audit.

6.7 Improve the Clinical Management of Residents Diagnosed with Long Term Conditions. *Treat the Missing Hundreds.*

6.7.1 Diagnosed Long-Term Conditions within the Thurrock population

Almost 4 in every 10 residents in Thurrock are living with one or more long term conditions that have been successfully diagnosed, and have been added to GP Practice QOF disease registers.

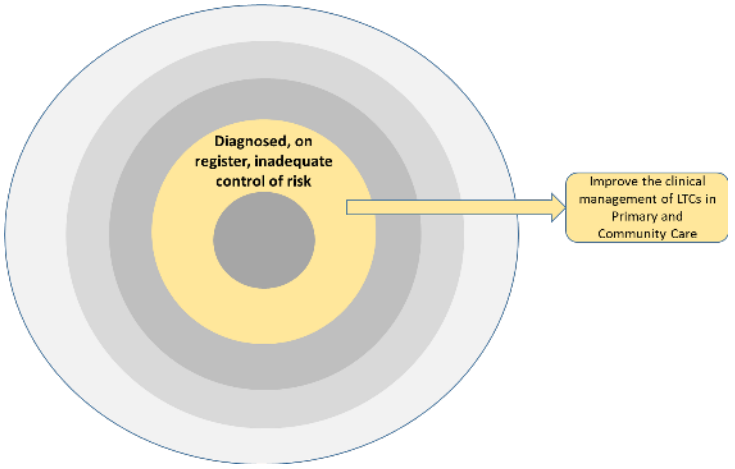
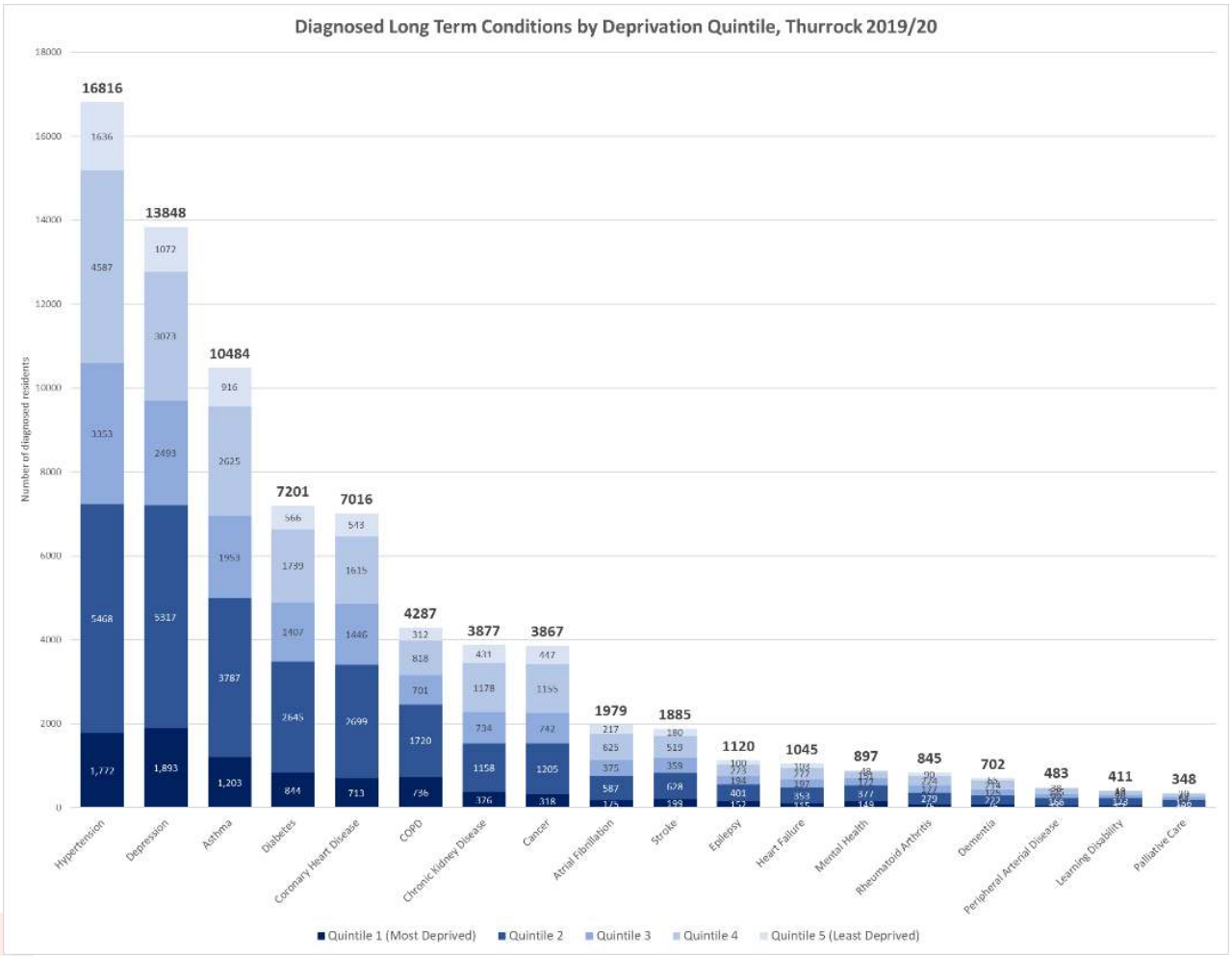


Figure 6.18 shows numbers of residents in Thurrock diagnosed with different long-term conditions and on different QOF registers in 2019/20 by deprivation quintile. The most common diagnoses relate to cardio-vascular (hypertension, CHD, AF and Stroke), respiratory conditions (asthma and COPD), and diabetes. Figure 6.18 demonstrates the impact that social determinants of health play in long-term condition diagnoses, with residents from the more deprived quintiles 1 and 2 being over-represented on the individual QOF registers, and those in the least deprived quintiles 4 and 5 being under-represented.

Figure 6.18



6.7.2 Current Management of Long Term Conditions in Thurrock

Clinical management of resident's long-term conditions is provided primarily through their GP practice via QOF, with additional clinical support provided through specialist NELFT teams for respiratory, heart failure, stroke rehabilitation and diabetes. The new Integrated Primary and Community Care PCN Mental Health services and IAPT will also provide clinical support to some residents with common mental health disorders such as depression and anxiety.

About 70% of the NHS budget is spent on the treatment of residents with long-term conditions. The majority of residents in Thurrock with long-term conditions are well-managed but a minority show clinical biomarkers that place them at higher risk of their condition deteriorating and more serious adverse health, emergency hospital admissions and entry into the Adult Social Care system. Optimising the clinical management of long-term conditions in Thurrock is one the most effective interventions that we can make to improve population health and prevent demand on the most expensive elements of the system.

Table 6.1 shows the percentages by PCN, of residents on some of the long-term conditions QOF registers, who have either not received the specified key clinical intervention for that indicator or whose clinical biomarkers are outside the optimum range specified by the indicator. It demonstrates the further scope for improvement in long-term conditions management of our residents and also variation in performance across indicators between different Primary Care Networks.

Table 6.1

QOF indicators	ASOP	Grays	Stanford-Le-Hope	Tilbury & Chadwell
	Numbers show % patients on registers not receiving treatment (%)			
AF006 – AF, stroke risk assessed (CHADS2 VASc), last 12 months	1.5	0.57	6.3	0.8
AF007 – AD CHADS2-VASc >= 2, not treated anti-coagulation	6.9	2.7	8.1	2
AST003 – Asthma, no asthma review 12 months	17.5	20	22.6	14.5
CHD005 – CHD, not taking aspirin/anti-platelet therapy/anti-coagulant	9.2	2.5	7	4
COPD003 – COPD, no review – MRC scale	7.2	5.7	11.2	7.9
COPD008 – COPD review, dyspnoea scale >= 3, no offer referral to pulmonary rehab	8	5.5	26	16
DM006 – DM, nephropathy or micro-albuminuria, no ACE-I or ARBs	16.5	14	12.8	22
DM012 – DM, no foot examination, 12 months	13	10.7	12.7	9.8
DM023 – DM and CVD, not treated with statin	5.4	6	5.3	4.9
HYP003 - <80, hypertension, BP > 140/90	23.1	23	24	21.1
HYP007 - >79, hypertension, BP > 150/90	15.8	6.5	11.5	9.1
MH002 – SMI, no comprehensive care plan in place	21.3	6.4	33.1	26.7
STIA007 – Stroke, no anti-platelet agent/anti-coagulant	3.6	1	3.1	2.7
HF002 – HF confirmed by echocardiogram 3-12 months from registered	5.8	2.9	5.6	5.9
DEP003 – New diagnosis depression reviewed 10-56 days following diagnosis	15.6	13.3	31.5	16.2

>20%	>15-20%	>10-15%	>5-10%	>2-5%	<=2%

6.7.3 Missed Opportunities for Secondary Prevention through Long-Term Conditions Management

Failure to optimise the management of long-term conditions in every Thurrock resident leads to the health status of a minority of residents deteriorating unnecessarily, causing preventable serious adverse health events requiring emergency hospitalisation. Through interrogation of the Thurrock Mede-Analytic Linked Patient Data Lake, we are now, for the first time, able to quantify this 'failure demand', namely the missed opportunities for prevention on cohorts of Thurrock residents admitted to hospital as an emergency because of deterioration in their long-term health condition.

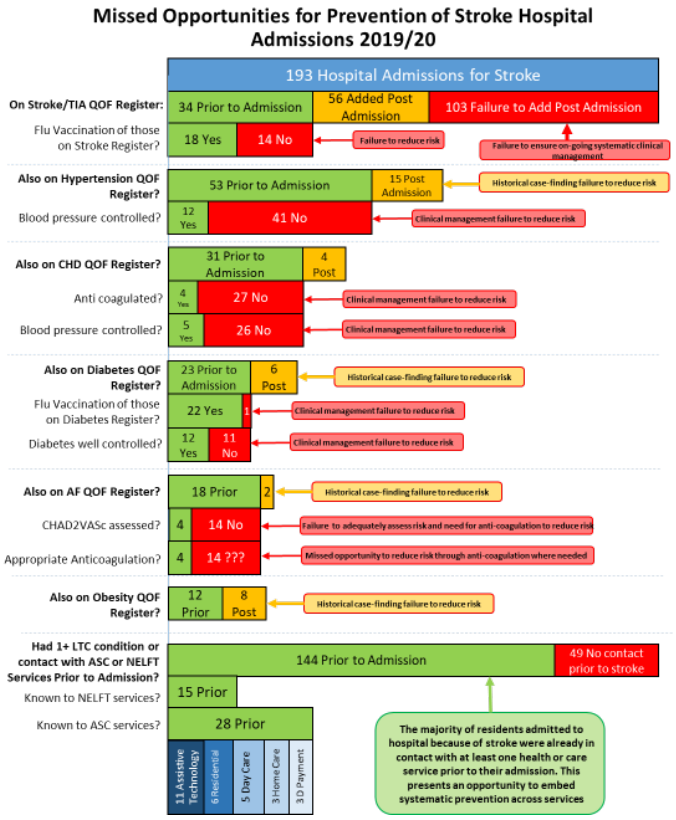
The reasons behind this failure demand are likely to complex and multi-factorial and are likely to include insufficient sufficient capacity and capability within primary and community care to undertake proactive clinical management, fragmentation of the service landscape, inadequate systems to identify and proactively manage all patients and resident behaviour (for example a failure to access care in a timely way or a failure to comply with the advice of clinicians).

In highlighting failure demand, we do not seek to make simplistic judgements or blame on any one group of clinicians or residents; simply to highlight that a collective systemic failure in proactive care underlies and drives serious adverse health events and hospital admissions that could be prevented.

Missed Opportunities for Stroke Prevention

Figure 6.19 shows the missed opportunities for prevention in cohort of 193 Thurrock residents admitted to hospital because of a stroke in 2019/20.

Figure 6.19



There were a total of 91 case finding failures pre admission and a further 103 stroke patients failed to be added to the Stroke/TIA QOF even after their admission for stroke, substantially increasing the risk of on-going failure of secondary preventative activity, systematic clinical management and further strokes.

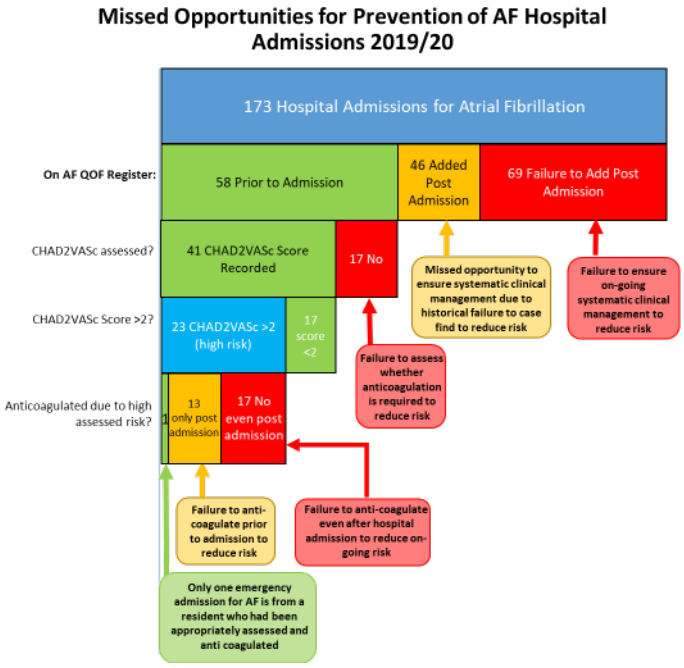
In addition, there were at least 147 missed opportunities relating to optimal clinical management prior to stroke admission that increased residents' risk of a stroke. Of those stroke patients on the hypertension and CHD QOF registers, 77% and 83% respectively had uncontrolled blood pressure. Of those on the Atrial Fibrillation register, 77% had not received a CHAD2VASc assessment to ascertain the need for anti-coagulation and so had not received appropriate anti-coagulation if needed; the single most effective intervention at reducing stroke risk in patients with AF. Of those on the diabetes QOF register, almost half had diabetes that was poorly controlled.

Of the 193 hospital admissions, it is striking that almost three quarters (144 residents) were already receiving care for a long-term condition from their GP and/or NELFT, and/or services from Adult Social Care. This demonstrates the opportunity for embedding systematic action to improve long-term conditions care across the wider local health and care workforce.

Missed Opportunities for Prevention of Atrial Fibrillation Emergency Hospital Admissions

Figure 6.20 shows the missed opportunities for prevention in cohort of 173 Thurrock residents admitted to hospital because of atrial fibrillation in 2019/20.

Figure 6.20



There were 115 missed opportunities for case-finding AF prior to hospital admission that could have resulted in systematic preventative care being provided to residents to prevent the admission. There was a failure to add 69 (40%) of the 173 residents admitted to the AF QOF register even after the admission making proactive and preventative on-going management of their AF unlikely and significantly increasing the risk of further hospital admissions.

Of those already on the AF register prior to hospital admission, there was a failure to CHAD2VASc risk assess 29.3% of residents to ascertain the need for anti-coagulation to reduce their risk of AF and stroke admissions. Of those 23 residents that were assessed as needing anti-coagulation (CHAD2VASc score >2) only one resident (4.3%) was receiving appropriate anti-coagulation therapy prior to admission , and a further 17 failed to receive anti-coagulation even after hospital admission.

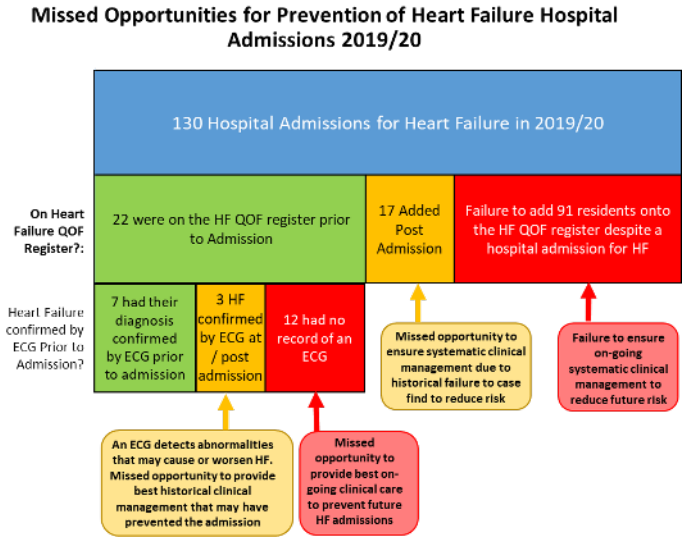
The failures in case-finding, CHAD2VASc score assessment and anti-coagulation therapy meant that only one of the 173 residents admitted to hospital for AF was anti-coagulated prior to admission. Addressing this failure represents a 'quick win' that would yield significant population health and system demand reduction benefits in a very short time period

The failures in case finding, CHAD2VASc score assessment and anti-coagulation therapy meant that only one of the 173 residents (0.58%) admitted to hospital for AF was receiving anti-coagulation therapy prior to admission. Addressing this failure represents a 'quick win' that would yield significant population health and system demand reduction benefits in a very short time period.

Missed Opportunities for Prevention of Heart Failure Emergency Hospital Admissions

Figure 6.21 shows the missed opportunities for prevention amongst the 130 residents admitted to hospital as an emergency because of heart failure in 2019/20.

Figure 6.21



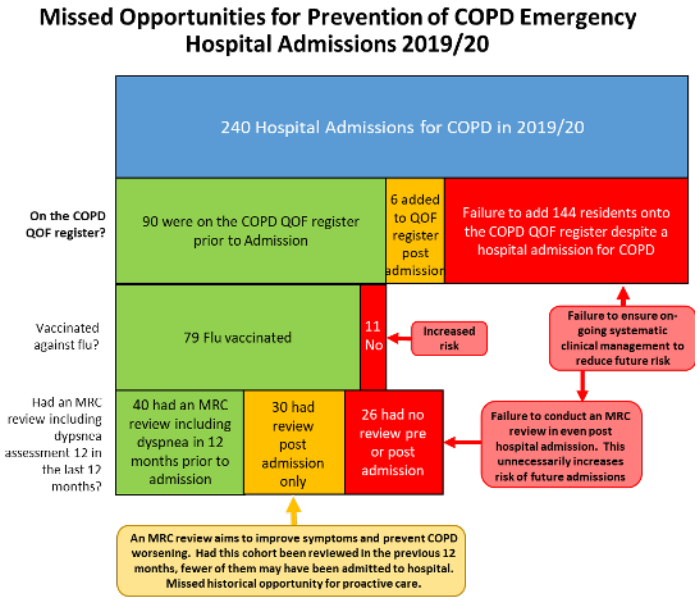
In total there were 108 case-finding missed opportunities, with the majority (83%) of emergency hospital admissions for heart failure being from residents who were not previously on the Heart Failure QOF register. There was a failure to add 91 residents (84%) of this cohort to the register even after their hospital admission, making systematic and proactive on-going heart failure care unlikely and increasing the risk of further hospital admissions and a deterioration in their condition.

Of the 22 residents admitted to hospital who were already on the Heart Failure QOF register, only seven had had their heart failure confirmed by an ECG prior to admission. An ECG allows clinicians to detect abnormalities that may cause or worsen heart failure and provide appropriate clinical management. Three residents received an ECG either on or after admission, but 12 (55%) had no record of an ECG even after hospital admission. Through analyses our analyses of the Thurrock Medeanalytics data lake comparing outcomes of HF residents receiving an ECG and appropriate clinical management with those who do not, we calculate that had an ECG been obtained prior to admission, two of these heart failure admissions could have been prevented.

Missed Opportunities for Prevention of COPD Emergency Hospital Admissions

Figure 6.22 shows the missed opportunities for prevention amongst the 240 Thurrock residents admitted to hospital as an emergency because of COPD in 2019/20.

Figure 6.22



In total there were 150 case-finding missed opportunities, with almost two-thirds of emergency hospital admissions for COPD being from residents who were not previously on the COPD QOF register. There was a failure to add 144 residents (96%) of this cohort to the register even after their hospital admission, making systematic and proactive on-going COPD care unlikely and increasing the risk of further hospital admissions and a deterioration in their condition. A further 30 residents received an MRC review after their hospital but 26 residents had no MRC review either pre or post admission making it more difficult for them to receive appropriate clinical management and potentially increasing the risk of further exacerbations and hospital admissions.

Of the 90 residents admitted to hospital who were already on the COPD QOF register, flu vaccination coverage was good (88%) with only 11 having not received a flu vaccination in the previous 12 months. However less than half (44.4%) had received an MRC review including dyspnoea in the 12 months prior to admission. An MRC review assesses the degree of breathlessness in patients with COPD in order to assist clinicians provide appropriate management of a patient's condition to prevent it from deteriorating. 30 residents received an MRC review post hospital admission but there was a failure to conduct a review in 26 residents even after hospital admission for COPD making systematic management and preventative care of their condition less likely or effective.

Missed Opportunities for Prevention of Asthma Emergency Hospital Admissions

Figure 6.23

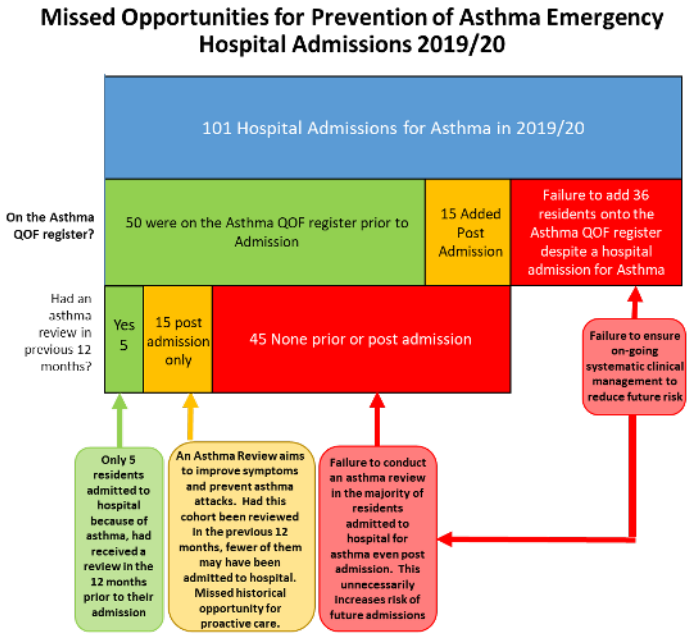


Figure 6.23 shows the missed opportunities for prevention amongst the 101 Thurrock residents admitted to hospital as an emergency because of asthma in 2019/20.

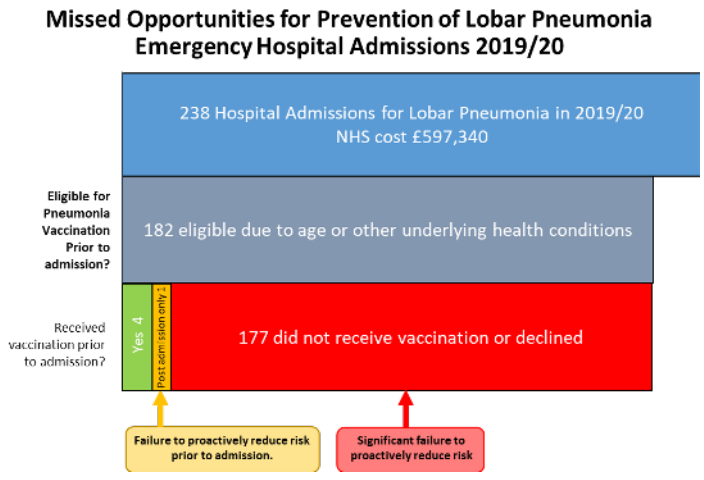
In total there were 51 case-finding missed opportunities, with over half of emergency hospital admissions for asthma being from residents who were not previously on the asthma QOF register. There was a failure to add over two-thirds (71%) of this cohort to the register even after their hospital admission, making systematic and proactive on-going asthma care unlikely and increasing the risk of further hospital admissions and a deterioration in their condition.

Of those residents on the QOF register prior to admission, only five had received an asthma review in the previous 12 months (5% of all admitted patients). Only a further 15 received an asthma review post admission. An asthma review aims to improve symptoms and prevent future asthma attacks. Failure to conduct reviews in the majority of residents both pre and post hospital admission significantly increases the risk of further deterioration in their condition and future hospital admissions.

Missed Opportunities for Prevention of Emergency Hospital Admissions due to Lobar Pneumonia

Figure 6.24 shows missed opportunities for prevention of the hospital admission of the 238 Thurrock residents because of Lobar Pneumonia in 2019/20.

Figure 6.24



Lobar pneumonia is a lung infection causing a build-up of fluid in the lungs to reduce the effectiveness of the alveoli to oxygenate blood.

Pneumococcal vaccination is recommended for adults aged 65+ and younger adults with other underlying health conditions that elevate their risk of pneumonia including those with chronic lung, liver and renal disease and those who are immune supressed. Whilst vaccination doesn't eliminate risk of pneumonia completely, it significantly reduces risk it.

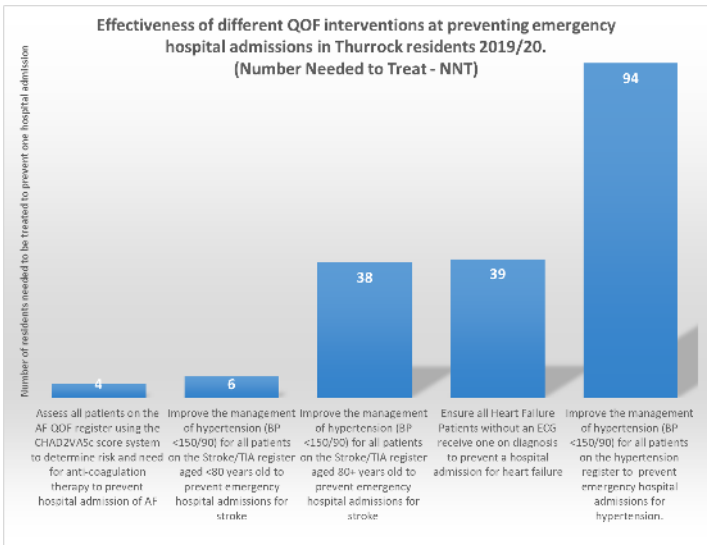
Of the 238 residents admitted to hospital for lobar pneumonia, 182 (76%) were eligible for pneumococcal vaccination. Almost all of the eligible cohort admitted to hospital (98%) were unvaccinated and only one resident received vaccination post admission.

Increasing pneumococcal vaccination coverage in eligible cohorts is a 'quick win' to prevent significant numbers of hospital admissions for pneumonia.

6.7.4 The Potential Opportunities of Optimising Long Term Conditions Management on Preventing Hospital Admissions

Through analyses using the Thurrock Medeanalytics Linked Data Lake, we are able to calculate the impact that different clinical interventions specified under QOF have on hospital admissions. Figure 6.24 shows the number of residents that we would need to treat using different QOF interventions to prevent one hospital admission (the 'Number Needed to Treat' or NNT). The smaller the NNT, the fewer number of residents need to receive the intervention to prevent one hospital admission and so the comparatively, the more effective the intervention is at preventing a hospital admission.

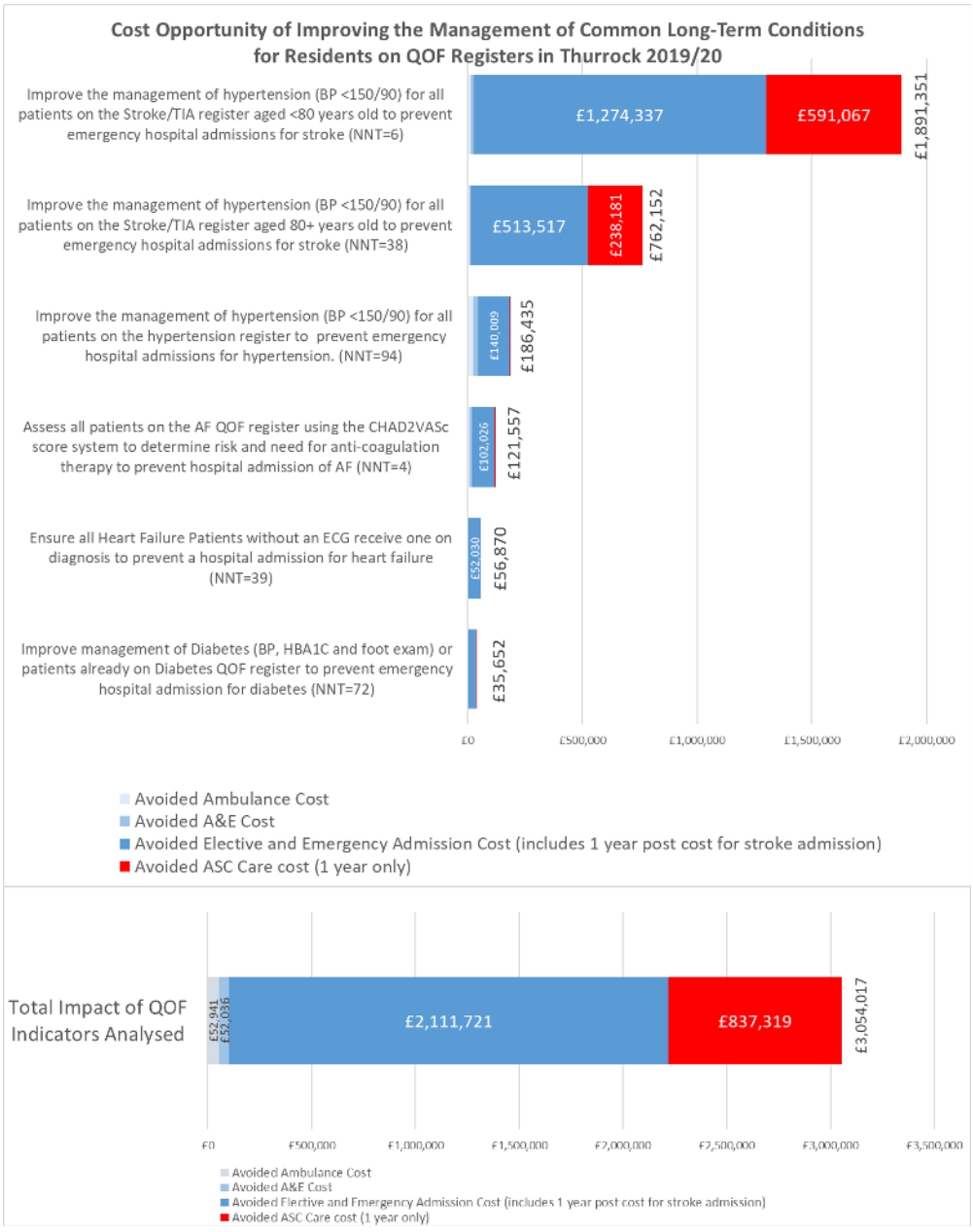
Figure 6.25



The most effective interventions (with the smallest NNTs) are risk assessing residents on the AF CHAD2VASc score and prescribing anti-coagulant therapy to those at high risk, and managing blood pressure on those with existing stroke/TIA history who are aged under 80. Delivering these interventions to only 4 and 6 residents respectively will prevent one of them experiencing a hospital admission in the next 12 months.

By comparing health and care service use between cohorts of Thurrock residents with long-term conditions who do and do not receive successful QOF interventions using the Thurrock data lake, we can now accurately calculate the opportunity to reduce demand and cost on different services within our local system through improving long-term condition management. This is shown in figure 6.26 for the most cost effective clinical interventions.

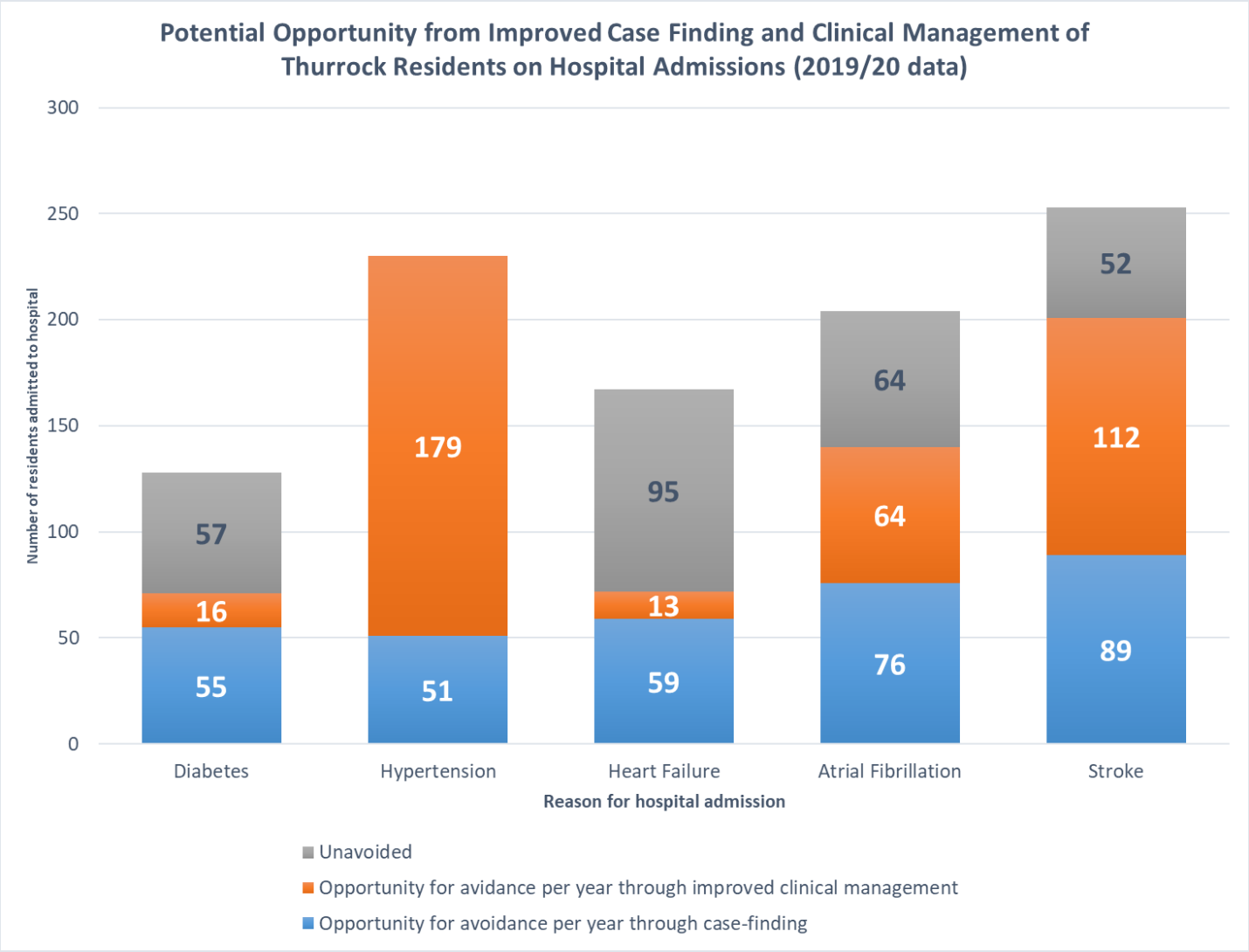
Figure 6.26



In total, at full optimisation of all residents against the six QOF indicators analysed (only a very small proportion of all QOF indicators), there is an opportunity to deliver a total of £2.112M savings through avoided NHS ambulance and hospital demand and a further £837,319 to Adult Social Care. This demonstrates significant opportunity to improve the financial and operational sustainability of the local health and care system through further improvements in long-term condition management within Primary and Community Care. From the analyses undertaken, the biggest opportunity rests in improving the optimisation of residents with a history of stroke/TIA.

We are also able to calculate the potential impact that improved case-finding and optimising clinical management (of the QOF indicators analysed above) could have on prevention of hospital admissions for different long-term conditions amongst Thurrock residents. This is shown in figure 6.27.

Figure 6.27



Our analyses demonstrates that a significant proportion of hospital admissions are preventable and avoidable through improved case-finding and clinical management, delivering a win-win of both improved population health outcomes for residents and operational and financial sustainability to health services.

6.7.5 The Thurrock Population Health Management Programme to date

Thurrock's 2017 *Case for Change* strategy set out a series a strategic recommendations for improving the management of diagnosed long-term conditions that have been successfully implemented through the Population Health Management Programme within *Better Care Together Thurrock:*

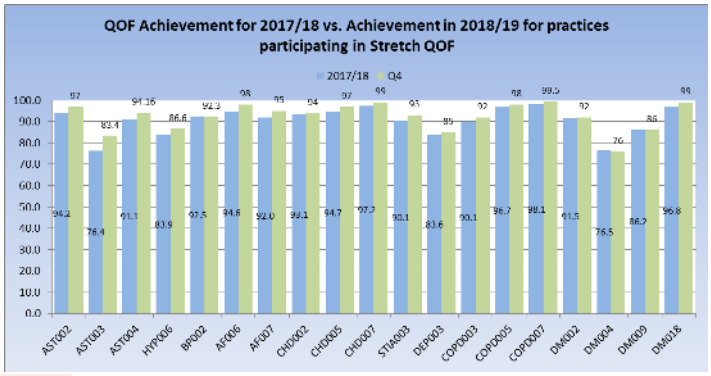
Stretched QOF

The national QOF framework financially incentivises individual GP practices to deliver clinical interventions and/or ensure clinical biomarker optimisation to a certain proportion of residents on individual QOF disease registers (typically between 80-95% depending on the clinical indicator). However this still leaves between 5-15% of patients on the register where resources are not provided to practices to deliver the intervention, and these remaining patients are likely to be those hardest to reach and least likely to engage with the surgery. As such, it can be argued that QOF national commissioning perpetuates existing health inequalities.

The Thurrock Stretched QOF contract, first introduced in 2018 addresses this inequity by providing additional financial incentive to practices to deliver clinical management to the remaining cohort of residents on the QOF indicators identified as having the biggest positive impact on population health. Our evaluation of the contract suggests has delivered a saving in avoided adult social care and NHS demand of £3.28 for every £1 invested by preventing serious adverse health events. For example, we estimate the contract has prevented 40 strokes, delivering £873,000 in avoided Adult Social Care and NHS treatment costs.

Figure 6.28 shows the impact that the Stretched QOF contract had in improved performance on the indicators incentivised compared to the previous year's baseline before the contract was introduced.

Figure 6.28



Cardiovascular Disease Upskilling Programme

We commissioned a CVD Upskilling Programme for Primary Care clinicians between July 2018 and February 2019. The Programme, accredited by the Royal College of General Practitioners consisted of six modules covering:

- Heart Failure
- ECG Interpretation
- Echo report Interpretation and Valve Disease
- Stable Angina/CAD CV Risk Assessment, Prevention and Diabetes
- Atrial Fibrillation
- Palpitations and Arrythmia

The modules aimed to increase primary care clinicians' knowledge and confidence in the diagnosis and management of cardio-vascular disease and was attended by 29 clinicians from 23 surgeries.

The evaluation from the programme was incredibly positive. Some of the comments from clinicians attending the course are below

"*My knowledge was sorely out of date, worse still, having rated myself at 4, I had no insight!*",
GP attending Diabetes Module

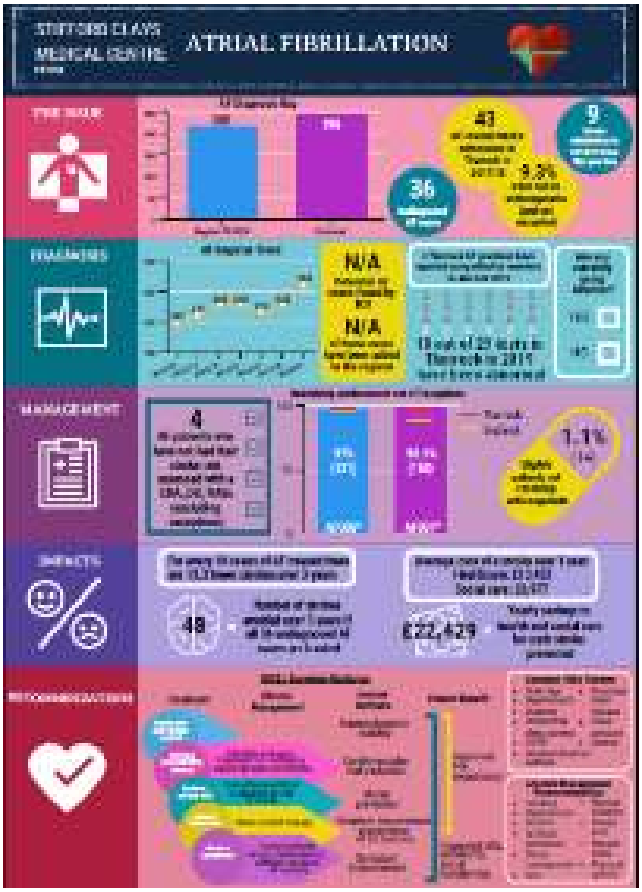
"*This programme should be mandatory for all GPs*",
GP after attending Heart Failure module

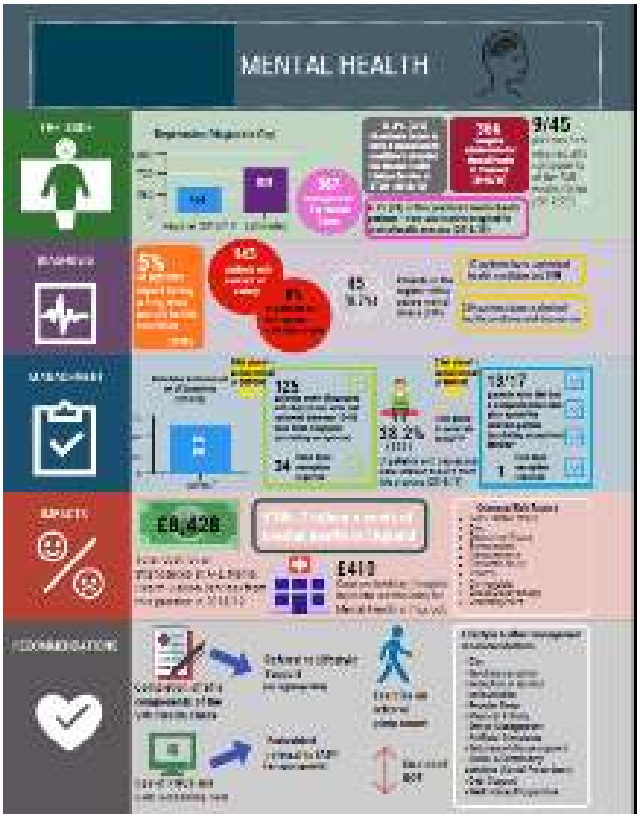
"I will completely change my clinical practice following this module".
GP attending AF Module

Long Term Condition Practice Based Profile Cards

The Public Health Team has produced dedicated Long Term Conditions Profile cards for every surgery since 2018, benchmarking long term condition management performance of the surgery against a range of indicators relating to long term condition management together with their referral behaviour and practice population's hospital admission rates for Ambulatory Sensitive Care Conditions. The cards form the basis of bi-annual Quality Improvement visits where a public health specialist meets with practice clinicians to discuss their data and agree a quality improvement action plan to improve clinical practice and performance.

More recently, additional topic specific profile cards for each practice on Mental Health and Atrial Fibrillation have also been developed.





Impact of Thurrock's Population Health Management Programme to date

Early evaluation of the PHM programme appears to show a positive overall impact on population health outcomes. The upward trend in cardio-vascular emergency hospital admissions is reversed in the year after the programme was introduced was reversed and begins to fall for both heart failure and stroke. (Figures 6.29 and 6.30 below).

Figure 6.29

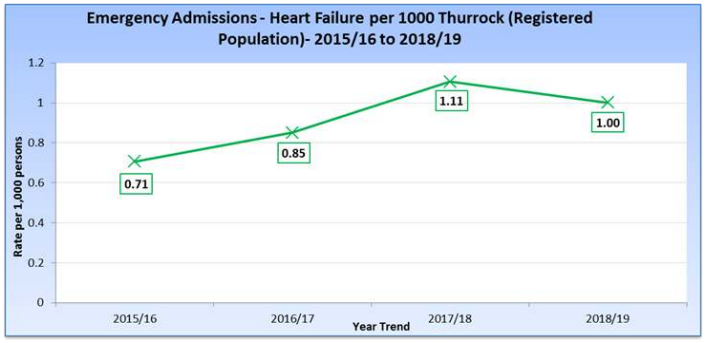
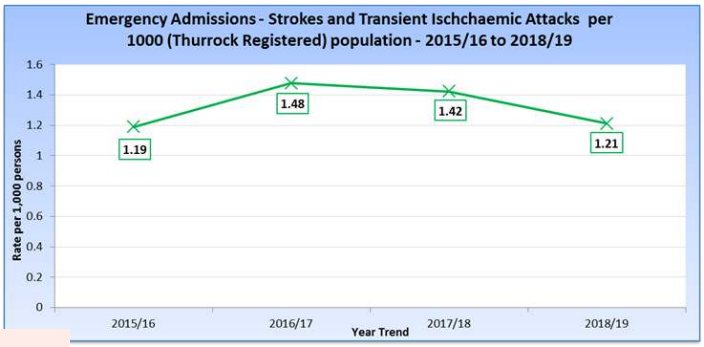


Figure 6.30



6.7.5 Future Strategic Action to Improve Long-Term Conditions Management

Whilst the evaluation data in the previous section on the impact of our Population Health Management Programme to date is encouraging, it is worth noting that it pre-dates the COVID-19 pandemic.

During the last 20 months, QOF has been suspended for two years running as Primary and Community Care capacity and capability was diverted into mitigating the negative effects of the pandemic. Whilst understandable and necessary, this has almost certainly had a negative impact on the previously hard-won improvements in long-term condition management. We are now seeing in impact of pausing secondary prevention activity within the community in the form of significant increases in the clinical complexity and numbers of residents, very unwell with non-COVID conditions arriving at the hospital and adult social care front doors.

Demand on Primary Care is at record levels and GPs report huge difficulty in continuing to be able to deliver proactive care in a context of reactive demand that significantly outstrips supply. Chapter 5 sets out our plans to address this capacity-supply gap and doing so successfully is fundamental to re-starting effective proactive long-term conditions management. Chapter 7 sets out additional action that we will take to build integrated community teams around PCNs and surgeries to provide additional capability to deliver proactive care.

Addressing Multi-Morbidity and Leveraging the Opportunities of PCNs

Increasing primary and community care capacity is only part of the solution. It is vital that we also use the capacity that we have in the most efficient and effective way deliver the greatest impact at population level. When the original PHM programme was introduced in early 2018, Primary Care Networks did not exist and QOF was organised at GP practice level. Every surgery was responsible for delivering every indicator on every disease domain independently. This is undoubtedly not the most efficient way of delivering QOF. Different surgeries have different clinical skill mixes with different specialities. One may have a practice nurse specialising in diabetes, another with a GPwSI specialising in heart failure. These differences can cause variation in outcome for residents.

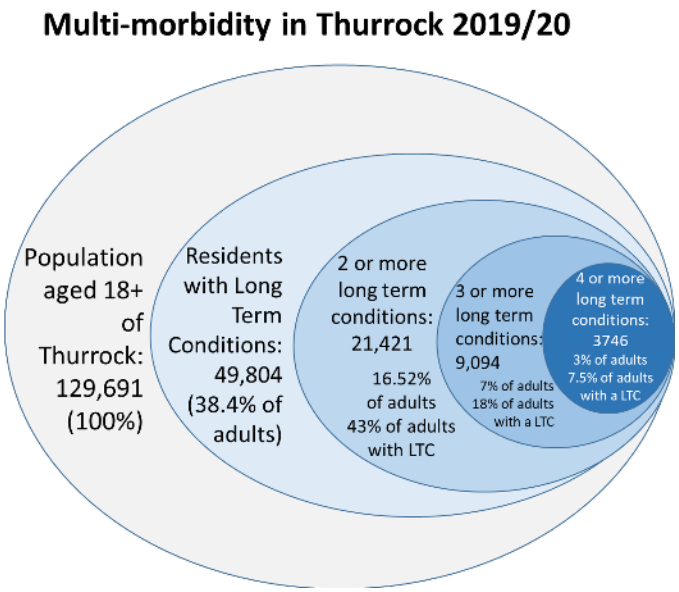
Similarly, residents with the same long-term condition have differing needs. The majority are likely to be well controlled and need only annual monitoring. Some may have some clinical bio-markers moving out of control and need more intensive support. A minority are likely to be complex and may need intensive specialist clinical input. The skills and qualifications of the clinicians to manage these three different cohorts also varies. The most complex are best managed by specialist GPs with Consultant input, the first can be well managed by practice nurses.

Engagement with Thurrock GPs suggests that they often report difficulty accessing Consultant input or advice without making a hospital outpatient referral that may have a waiting list of many months. As a result, where a more timely and urgent response is required they are forced to send patients to A&E. This is an inefficient use of system resources and inconvenient for patients.

Thurrock has already pioneered a new Integrated Primary and Community Care model for mental health, co-designed through bringing GPs together with Consultant Psychiatrists to devise a more effective way of working together. The model, based around each PCN, marries Primary Care staff with specialist psychiatric nursing and psychology staff with dedicated Consultant Psychiatry Session input, blurring the lines between primary and secondary care and addressing the historic fragmentation between and within care pathways. We intend to use it as a blue print for other long-term conditions management, working with PCNs and their constituent practices to co-design integrated long-term conditions management functions at PCN with shared capacity and a better staff skill mix including consultant input into specialist clinics. The new Integrated Medical Centres with their access to secondary care diagnostics and outpatients plus third sector support provide a unique opportunity for better patient cohorting based on risk and new integrated and holistic models of long-term condition care.

The second issue with our historic approach to QOF and stretched QOF is that it fails to recognise and address the fact that many residents with long-term conditions are living with more than one long term condition (multi-morbidity). In 2019/20, of the cohort of residents diagnosed with Long Term conditions, 43% have at least two, 18% have at least three and 7.5% have at least four or more long-term conditions respectively, as shown in figure 6.31 (overleaf)

Figure 6.31



QOF and Stretched QOF requires surgeries to treat long-term conditions entirely independently. This is both inefficient for staff and wastes the time of residents who may need to attend many different appointments from different services for each long term condition. The Thurrock Mede-Analytics Linked Data Lake now allows us easily to understand the overlap between different QOF registers. For example, figure S shows the overlap between the cohort of residents on:

- CVD (Heart Failure, CHD and Stroke/TIA) QOF registers – orange circle
- The Diabetes QOF register – yellow circle
- The Hypertension QOF register – grey circle

Almost 30% of this cohort are on more than one of the three categories of register. Conversely, only 11% of those on the diabetes register are not on any of the other registers, and only 6.6% of the CVD cohort are not on either of the other two registers.

Our analyses using the Thurrock data lake also demonstrates rapidly elevating risk of an emergency hospital admission within one year as the number of long-term conditions a resident is diagnosed with increases, particularly for some combinations of long-term condition.

Figure 6.32

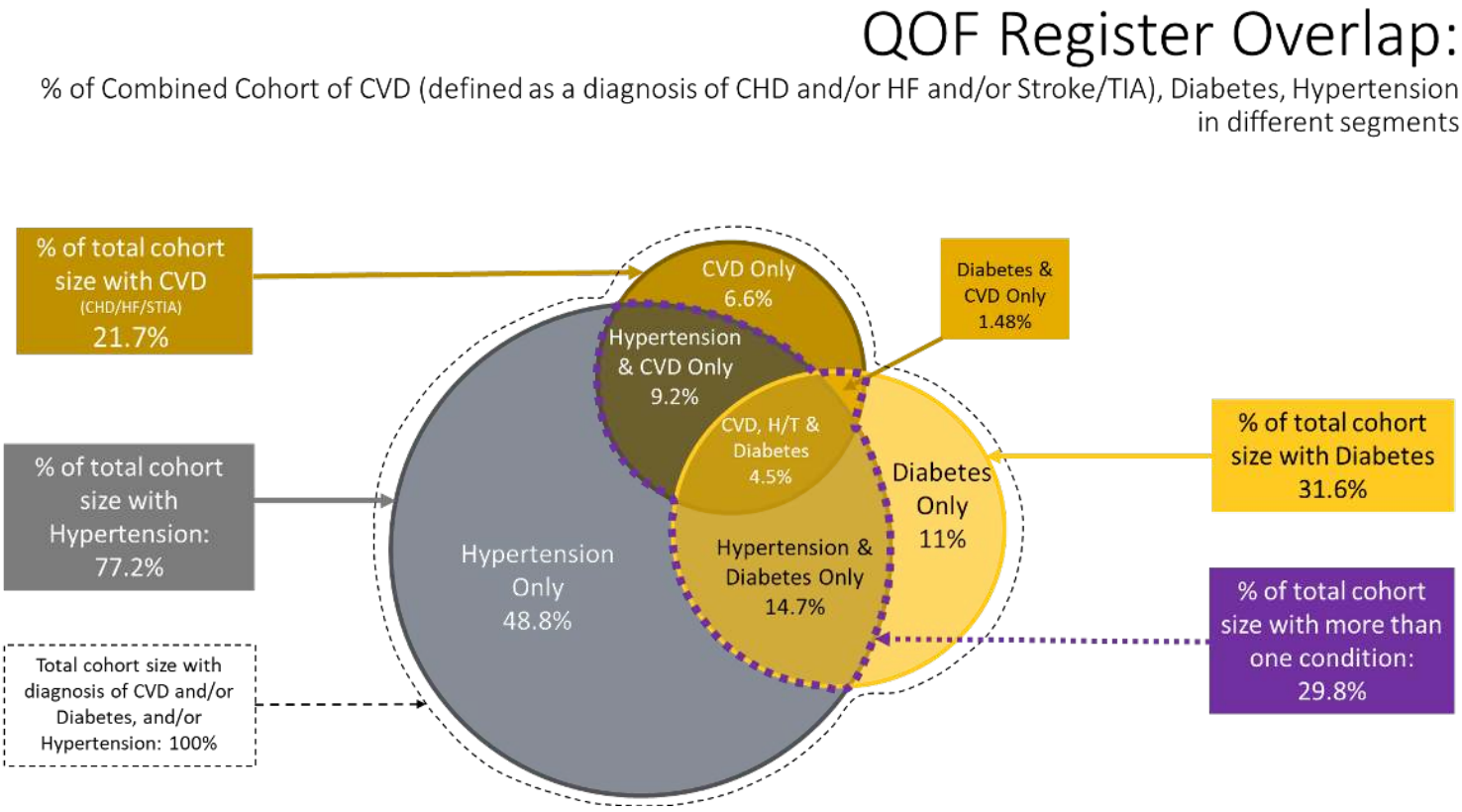
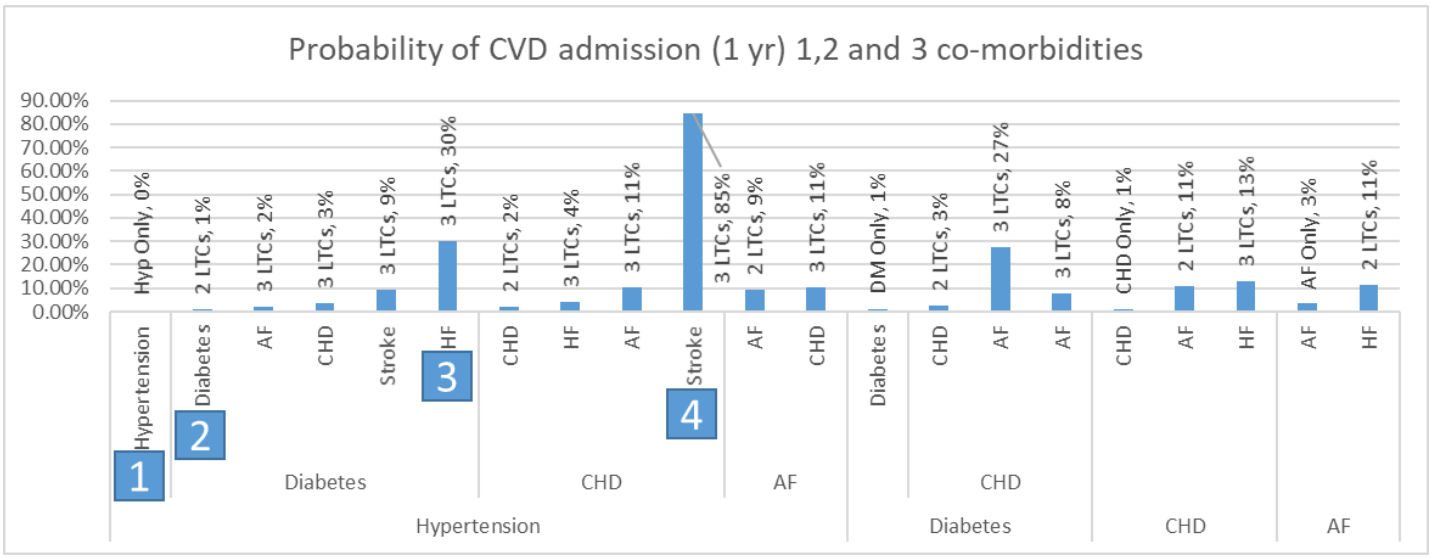


Figure 6.33 shows the probably of an emergency hospital admission for residents with either hypertension, diabetes, CHD or AF only and then each of these four base conditions combined with additional long-term conditions. For example the probably of a hospital admission within a year for a resident only with hypertension is virtually 0% (Point 1). This rises to 1% when the resident also has diabetes (Point 2) but 30% where the resident has hypertension, diabetes and heart failure. Similarly where a resident has hypertension, CHD and a history of stroke/TIA, the probability rises to a massive 85% (Point 4)

Figure 6.33



We will therefore work within PCN, community NHS and secondary care clinical leaders to create multi-morbidity clinics at PCN level starting with a single service to manage more complex patients with multiple cardio-vascular disease conditions and/or diabetes. The services will have secondary care consultant and specialist nursing input. They will be based within the new Integrated Medical Centres when built giving further integration with diagnostics and outpatient services.

We will co-design the new services with residents using Human Learning Systems principles to ensure that they are truly holistic and respond to resident needs. We will embed existing fragmented lifestyle modification services commissioned from the Public Health Grant within the services and create new 'blended health coach' role that can address wider determinants of health, lifestyle issues such as addiction, social health needs, social prescribing, self-care and in-depth motivational interviewing.

In order to further support this new way of working, we will re-design the Stretched QOF contract to provide financial incentives to practices to collaborate to support this new model of care, with payments made on performance at PCN level and where bundles of clinical care interventions are successfully delivered. We will continue to make use of PHM integrated data to identify and incentivise the clinical management activity that will have the greatest positive impact on population health and avoidable hospital and adult social care demand and resources, creating a virtuous positive reinforcement circle where savings from avoided high cost activity can be re-invested in further primary and secondary prevention at PCN level.

We will further support PCNs to achieve maximum levels of long-term condition optimisation through the dedicated Intelligence Functions that we will create at PCN level (as set out in Strategic Action 6.12. These will access Population Health Management Data in near real time using the new linked dataset being constructed through the Arden Gem DESCRO, allowing practices, PCNs and the new multi-morbidity services to be able to quickly identify residents requiring review and clinical management.

We will create a series of real-time data dashboards using this new informatics capacity that will replace the bi-annual profile cards, allowing earlier and more systematic management of all residents with long term conditions.

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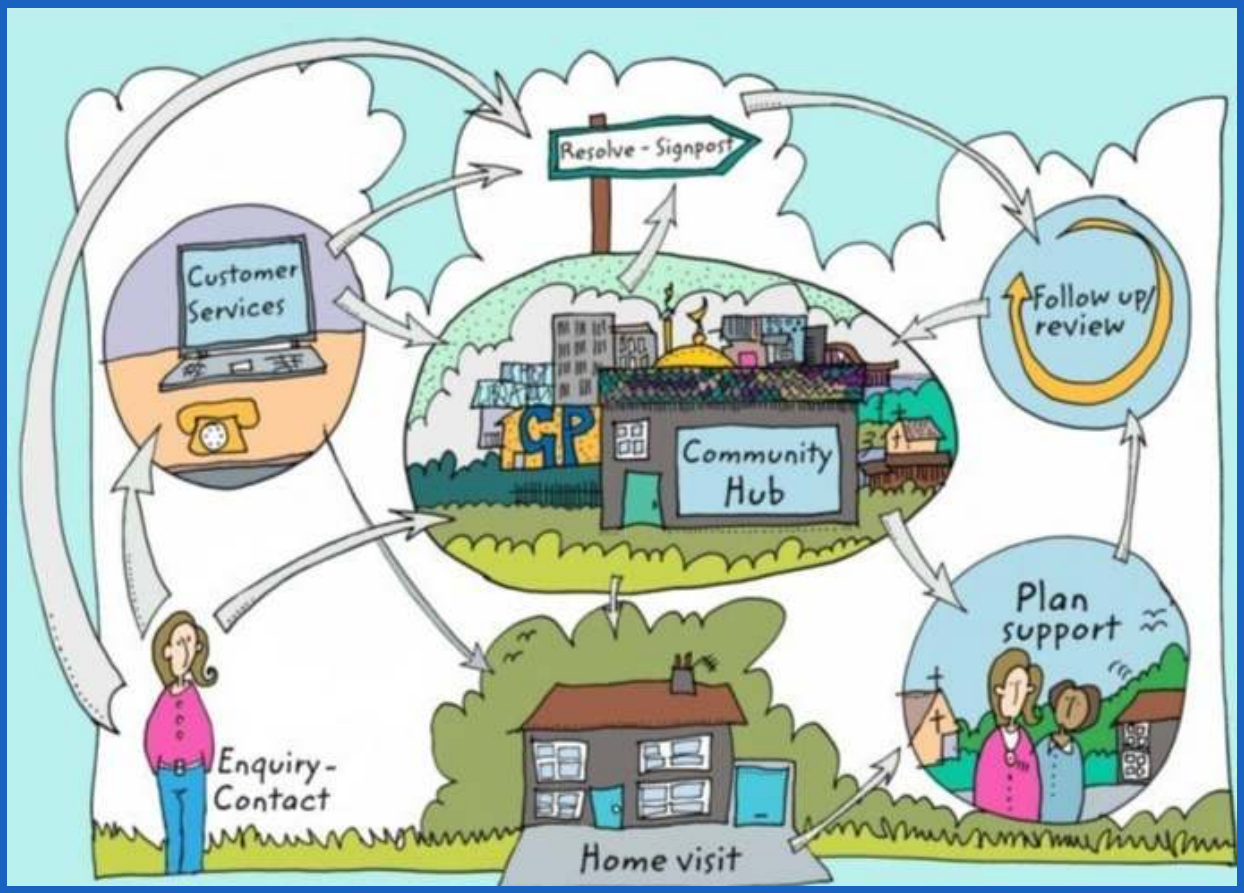


Chapter 7: Integrated Care and Support in the Community

Bespoke solutions in a complex world

Chapter 7: Integrated Care and Support in the Community

7.1 Introduction

In this chapter we discuss the next phase of our wider adult health, care and wellbeing service transformation to create truly integrated and responsive teams at Primary Care Network (PCN) Locality level based on Human Learning Systems principles. Through our transformation journey to date, we have already built many of the 'ingredients' for change; teams such as Local Area Coordination, Community Led Solutions and our new Mental Health Integrated Primary and Community Care models are already working within in the community in partnership with residents on strengths and asset based principles to deliver holistic and bespoke care.

However at present, this good practice is still operating in a wider *New Public Management* based fragmented landscape, and too often still within silos. We want to go further and faster, creating new *blended roles* that can deliver a wider range of functions traditionally split between different teams within health and care, and to create single PCN/locality based integrated networks that will respond in a coordinated and integrated way to deliver care in partnership with residents. This will ensure key principles around getting things right first time and continuity of care with reduced duplication can be achieved.

7.2 The Historical Approach to Delivering Community Care

In Chapter 2 we discussed the complex environment in which residents live. A wide variety of different social, environmental, economic, behavioural and biomedical factors interact together to determine wellbeing. However we have fragmented public services to deal with single 'problems' defined in advance by us, driven by processes that reinforce that focus. What people actually want is a system that treats them as individuals and supports them to achieve or maintain a fulfilled life whatever the circumstances.

Currently, people needing support will have to meet set criteria and thresholds. The support that they then receive, if deemed eligible, will be standardised and focused on a single need, and rarely sufficiently tailored or personalised. Residents' lives are rarely like this. They often have multiple interconnected needs requiring support from different teams and organisations. They need an integrated solution, but are required to navigate a bewildering public sector landscape and try and access multiple different services, each likely to be provided in isolation, and each having its own referral route and eligibility criteria.

The net impact of this is to distance people from their care and support, creating a professional "firewall" around the intervention. Evidence suggests that when people see themselves as invested in their own health and wellbeing their outcomes improve.

> *People do not live their lives in silos; they experience care and support across many different services. We know that for many people, the issues they face are about the lack of co-ordination of services around their needs.*[1] *Moreover, gaps in care co-ordination disproportionately affect those with the greatest needs and the poorest outcomes*[2] **From: Understanding Integration: How to listen to and learn from people and communities**[3]**.**

All of this can take a significant amount of time; time in which the resident's health and wellbeing can decline. The more 'needs' the resident has, the greater the difficulty they will experience in interacting with the system, and the more fragmented the response will be.

This way of working increases rather than manages demand. It ignores the importance of building trust between the individual and those providing care and support, exacerbating bureaucracy and cost, increasing delay and building significant amounts of waste in to the system. Ultimately, it is costly for both the system and for residents requiring support.

The current system design disempowers both the resident seeking support and the staff attempting to provide it. Power and control sits almost exclusively with those who have centrally planned and commissioned the system. Over the years, 'choice' and 'personalisation' have dominated the health and care agenda, but what has emerged is neither. An individual may be able to choose where they receive treatment or be in receipt of a direct payment so that they can arrange their own care, but what they actually receive is rarely any different than would have been offered by the 'system'. This is especially true for older people.

In short, how the system is constructed and how it operates makes no sense to the people who need it and little sense to the people working within it. Both parties know this but feel powerless to do anything about it.

The actual case studies (names have been changed) below of Thurrock residents demonstrate the impact this has on people and their lives and the resource wasted in 'failure demand' caused by a failure to design an integrated solution.

Case Study: Owen

Owen is a 60 year old man who lives alone. Owen lost his wife a few years ago and has become isolated and depressed. He always drank heavily, but since his wife died, his drinking has spiralled downwards into alcoholism and he is drinking five bottles of wine a day. Owen's health has declined, and with it his mobility. He current receives an externally commissioned care package to help him with personal care.

Owen's GP referred to him to the Occupational Therapy Team to try and improve his physical functionality. When the OT attends Owen's home, they find Owen slumped in a chair, unable to move, and uncommunicative. Owen's carers have just left. Owen's mobility has declined so much due to his alcoholism that they are unable to lift him out of his chair. The OT can't help because Owen is so inebriated.

Owen's Adult Social Care Support Planner attend's Owen's home. Owen needs a short term residential care placement because he is unsafe to be left at home as he cannot cook, use the lavatory or dress unaided, but his Support Planner is unable to find a residential care placement to accept Owen because they are all concerned that they will be unable to manage his withdrawal from alcohol.

Alcohol Treatment Services are not providing any home visiting at the time, and have been commissioned to only offer an assessment for alcohol treatment in the community within two weeks of a referral. To receive a community detox, Owen would need to first go through a separate assessment process. Fast tracking of alcohol treatment requires another referral for a further assessment by a panel. Owen has no transport to support him to access their services.

The Support Planner is left with no other option than to call an ambulance to convey Owen to hospital. The hospital will hopefully provide an alcohol detox as an inpatient and then discharge Owen back into the community where he will start drinking again. He knows this, because he has already been around the same loop five times in the past year.

For Owen to access community alcohol rehabilitation support, another separate referral is required.

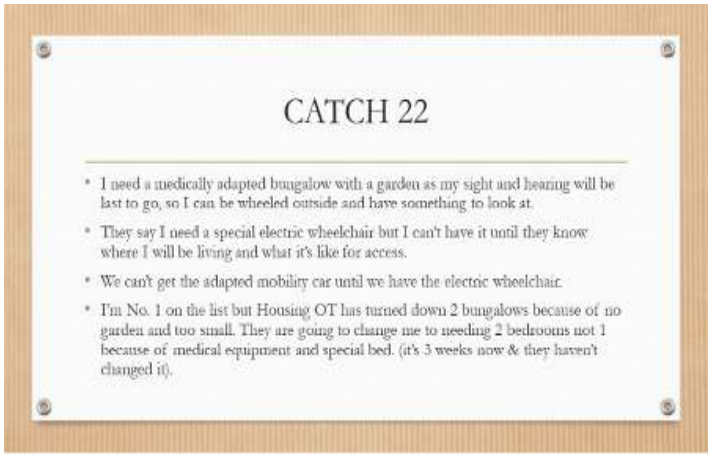
Case Study: George

George has mobility difficulties and needs the support of two home carers with transfers. He lived in a private rented room until he was made homeless. He has since been placed in a temporary rented room in a House of Multiple Occupation (HMO), however the room is inadequate for George as it is a first floor room with no lift.

If he is to improve his mobility, George needs to have physiotherapy and the space to practice exercises. However, George's physiotherapist has assessed his home environment as unsafe to the the exercises.
George is currently supported with a home care package that has provided 21 hours a week of double-handed home care for the last nine months. The cost of the care package is £700 per week.

George is unlikely to improve until he has the right living environment. He is stuck upstairs and he has become very depressed. As a result, he has had to access Mental Health services and is waiting for a further assessment from the Housing team.

Figure 7.1 – The Catch



7.3 Learning from the Transformation We Have Undertaken to Date

In Chapter 2 (section 2.2), we set out the fundamental change principles that we want to introduce across our Thurrock Alliance based on Human Learning System theory and in Chapter 3 we set out our approach to community engagement and strengths based working.

We need a system that people can access at any point, mostly from within their local community, to get the support they require. This support must be coordinated and focused on achieving what matters most to them – which may mean accepting an element of risk. Those providing a service must work together in the community and with the community to deploy resources effectively, overcome organisational boundaries and unhelpful process and bureaucracy, and to deliver an integrated bespoke solution. Resource must be used collectively and in its widest sense – with solutions provided incorporating community assets, technology and provision that is creative and diverse.

From the learning we have already gained from our transformation journey, we know that we need to transform our current services in the following ways:

From Fragmented to Coordinated and Integrated.

Our learning has already helped us to identify ways of working that reflect a coordinated and integrated approach based around localities that cover the same geography as Primary Care Networks. By bringing different teams together at locality level, different front line staff are forming relationships and networks that allow them to design integrated solutions in conjunction with residents.

From Specific Need or Condition-Led to Strengths-Based

Chapter 3 has already discussed our strengths and asset based approach.

The learning from strengths-based working has enabled us to start to shift the way that the workforce operates including changing existing process and practice so to focus more on the strengths that the individual has or are available to the individual as part of any solution. Adopting a strength-based culture is essential for shifting power to individuals and communities (Figure 7.2).

Figure 7.2

From One-Size-Fits All to Personalised and Bespoke

The learning from our transformation programme has meant that we have started to shift the way we work to be able to offer a response that is personalised and tailored to the individual. Whilst bespoke may sound more expensive we have found that by providing the right response first time we limit failures and the revolving door, therefore also providing the most cost effective intervention in the long run.

From Top Down to Bottom Up, Centralised to Localised

In Thurrock, we fundamentally reject the maxim that efficiency is always gained by centralising services over a bigger geographical footprint. Our learning demonstrates the reverse; by bringing teams together at locality level allows resident facing staff to work more effectively and creatively with residents to solve problems, preventing 'failure demand'.

Our transformation approach reflects a strong place-based focus with 'subsidiarity' being a key principle. Different areas of the Borough have different requirements, and developing a system that can identify and respond to these different requirements remains vital.

From Reactive to Preventative

Our original 2017 *Case for Change; New Model of Care* strategy made an incontrovertible case that demonstrated the resources within our system were too often in the wrong place, with a shift from acute to community being the aim, and a shift of focus from reactive treatment to proactive prevention being the solution. Since then, we have already transformed key elements of our local operating model to focus on preventing, reducing and delaying the need for health and care.

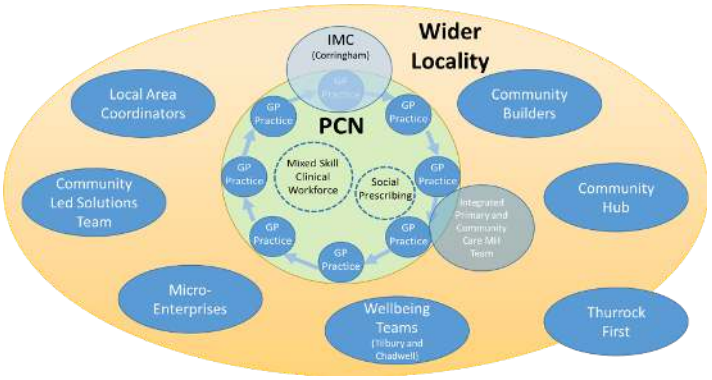
Traditionally, public sector services have attempted to control cost by setting eligibility thresholds to determine who can and cannot access the service. Our learning has taught us that paradoxically, by failing to act early, we increase cost, often by driving residents to the most expensive parts of the system. Instead of waiting until people are 'ill enough' or in sufficient 'need' to meet criteria for support, we have transformed many system elements to intervene earlier and proactively keep people well.

Learning from approaches such as *Local Area Coordination*, *Community Led Support* and our new Mental Health IPCC model all described in the next section helped to start to shift the system to focus on prevention by default. Eligibility thresholds have been shelved; all of these initiatives work on the two 'first principles' of: *Early intervention* and on *focussing on reducing the need for or reliance on future services*. They also aim to provide a coordinated approach that deals not with one issue at a time, but all of the key requirements that the person has to achieve the outcomes that are important to them. For example, this might need to incorporate a plan of action that spans housing requirements, health requirements and care requirements – as well as social requirements.

7.4 Examples of Locality Based Services We Have Already Transformed In Line With Our Principles and Values.

Our transformation journey to date has helped us to identify how to achieve the change we require and we have already reimagined and rebuilt many services in Thurrock based on our transformational change principles and strength and assets based approach as set out in figure 7.3.

Figure 7.3



Thurrock First

Thurrock First is our single point of access across community health, mental health and adult social care. The service consists of a team manager who is a qualified social worker, two senior co-ordinators, 17 Thurrock First Advisors who take telephone calls, a Community Psychiatric Nurse, a Mental Health Act Assessment Coordinator plus casual bank staff.

Thurrock First operates between 7am to 7pm, 365 days a year, taking calls via a single telephone number directly from residents and their families, and from health and care professionals. It aims to reduce, prevent and delay the need for more significant care by intervening early and works closely with the Urgent Care Response Team (URCT) who can be mobilised to attend residents' houses where they are in crisis.

Advisors are trained to undertake proactive ASC assessments on the phone including carer assessments and can work proactively with residents to find a bespoke solution. They also have a direct link into EPUT services, with the CPN within the team acting as a backup resource for AMP Mental Health Assessments where required. They also work closely with the Adult Social Care Hospital Team to facilitate timely hospital discharge by making sure community health, care and social needs are in place.

We are currently aligning advisors to our *Community Led Support* locality teams to allow them to develop even more knowledge of community assets within specific localities, allowing them to build more create solutions with residents.

Local Area Coordination

Thurrock now has 14 Local Area Coordinators (LACs), each aligned to specific neighbourhoods within the Borough. The LAC's primary role is to develop a detailed understanding of all of the community assets, networks, services, organisations and groups within their neighbourhood and more broadly across the borough, and then work with residents to find pragmatic solutions to problems, drawing on these resources before considering commissioned or statutory services.

The service always starts with the question *'What does a good life mean to you?'*, making it holistic and bespoke. This means that instead of simply assessing or referring residents into services they:

- Invest enough time in understanding what a good life looks like to the individual or family, and how they could get there.
- Help people to build their own capacity and connections, so that they can stay strong and independent.
- Build new community connections or capacity where they do not exist.

Local Area Coordinators also work in a truly integrated way. They are able to navigate across services and organisations to find solutions and overcome barriers that prevent people reaching crisis point.

In keeping with our model of distributive leadership we have moved the LAC team in to a self-managing model with a single coach overseeing the team.

This has proved a highly effective and an efficient model since its inception a couple of years ago; streamlining the structure from having one manager and two deputies, thereby losing two management posts with no reduction in performance.

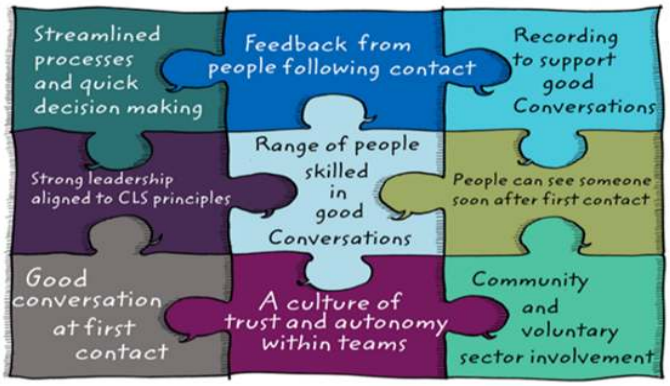
Community Led Support

Community Led Support (CLS) is an approach to social work that means that social work teams provide a coordinated response building networks with other professionals within a specific locality so that they can be mobilised to provide a joined-up response and not a response that purely considers adult social care needs. Teams are based in the community and aligned with the four Primary Care Network (PCN) areas and work solely within their locality out of a number of different community settings.

The approach representatives a radical departure from traditional social work models based on assessing deficits and prescribing pre-commissioned services.

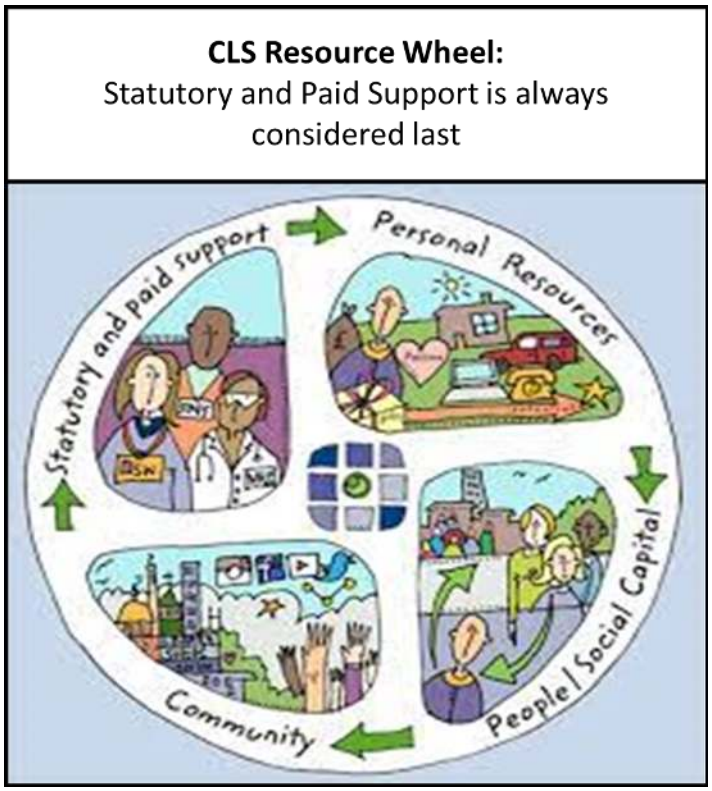
We challenged social work teams to reimagine how they worked and the processes required to support them, based on CLS principles shown in figure 7.4. This helped professionals to start to make the shift from providing automatically prescribing a pre-commissioned service, to providing wide ranging solutions that are tailored to the individual.

Figure 7.4



The use of a resource wheel helped professionals to consider a multitude of options before considering statutory and paid support.

Figure 7.5



CLS has been extremely successful with numerous case studies showing how people have been effectively supported in a different way. Early successes have included reduced waiting times, improved access – with regular 'drop in' sessions being organised close to where people live, and working with other professionals and organisations in the area, including community-based groups and the Voluntary Sector, to develop innovative and streamlined ways of delivering what people required and how they required it.

The success of the pilot has led to teams being implemented in each of the four Primary Care Network (PCN) area, providing Borough-wide coverage. The learning from LAC and CLS has provided a blueprint for redesigned local integrated care and support.

Approaches such as CLS do not rely on thresholds and eligibility before they help someone. They identify what the person requires to live a good life, and in doing so, they help to put in place a plan that focuses on preventing that person's health and wellbeing from declining.

Both CLS and LAC initiatives have shown the power of place based working and of taking time to have conversations with people that focus on what matters to them. This has led to very different solutions being developed, many of which have prevented and reduced the need for services or helped to reduce the reliance on a service response. In addition, the impact on staff morale has been significant, with staff enjoying the trust invested in them to make the right decisions and the freedom to develop innovative and impactful solutions. Thurrock has an excellent record of retaining staff and of recruiting new staff members who have joined the Authority as a result of what they have heard about the approach Thurrock has implemented.

Technology Enabled Care

We have introduced a model for the use of technology within our communities that builds on the principles of recognising and promoting individual and community strengths, early support and prevention of need arising, improving accessibility by reducing bureaucracy, and fostering innovative thinking and practice across statutory services and community organisations.

For the last few years, practitioners in Thurrock have been encouraged to view technology, in its widest sense, as both an enabler of independent living and an approach to support individuals to achieve their goals and aspirations.

Social Care practitioners are able to explore and support access to an identified technology solution from a conversation, rather than leading an individual through a formal assessment processes. Access to support will be quicker, and will be supported where the rationale for support can achieve the best possible outcome for the individual; even where eligibility may not be satisfied, and reduces or delays the need for both formal and informal care in the future.

This does not prevent individuals from being able to access more complex or expensive technology solutions, with practitioners still able to directly commission these following a simple and quick approval process via team managers, or in the case of very complex or expensive solutions, via the Principal Occupational Therapist in Adult Social Care.

An information suit and package of training has been developed, and has been rolled out to many practitioners. A practitioner led group has also been established, which together cultivates trust and empowers staff to access and self-approve the provision of reasonably priced technology solutions.

The new principles and processes have been in place for some time for core social care teams, and the adoption of this model continues to evolve. There is a desire to improve accessibility and promote technology further through place based Community Led Support and an integrated approach to supporting local communities. This will enable housing officers, health partners and eventually wider community teams to support individuals to access technology solutions.

There is an emerging evidence base showing that this change can deliver better outcomes, increased independence and cost savings; especially through the use of exciting technology such as "Brain in Hand", and with greater awareness and accessibility, these can be realised sooner.

Primary Care Networks and Enhanced Primary Care Teams

Primary Care has suffered locally from acute capacity shortages. Responding to this led to the creation of enhanced teams operating within and around four locality-based Primary Care Networks (PCNs). Enhanced teams are made up of posts such as paramedics, pharmacists, assistant physicians and physiotherapists. PCNs started to bring professionals together, working at place and sharing both knowledge and resource. Through the development of PCNs, professionals have been able to better understand the area they serve and the issues faced by the local population. The development of and learning from PCNs in Thurrock has helped the workforce start to organise themselves in to locality-based health and care system networks – ensuring that the whole system can provide an integrated and coordinated approach that is responsive to the requirements of local people.

Mental Health Service Transformation and the Mental Health Integrated Primary and Community Care Locality Model

Mental illness is the single largest cause of disability in the UK and a major driver of health inequalities. In response to Thurrock's Adult Mental Health JSNA, LGA Peer Review, and extensive community engagement research led by Healthwatch Thurrock, we have piloted a new integrated model of holistic mental health care embedded within PCNs.

Our analysis of the historical model of mental health service delivery showed that of the circa 2,000 residents a year receiving secondary care services, 65% of need was related to social as opposed to clinical demand. The majority of these patients had a diagnosis of Personality Disorders. A high proportion who received a referral to EPUT from Primary Care were discharged back into the care of their GP as they failed to meet threshold criteria. Consultant Psychiatrists routinely questioned the need to keep people on caseload when they are receiving little medical intervention. This was inefficient for the system and bad for residents.

We also identified a cohort of residents whom we called *'the missing middle'*, too unwell to be treated within Primary Care or by IAPT but not unwell enough to receive a secondary mental health care service. They were often left without adequate support and were high users of A&E.

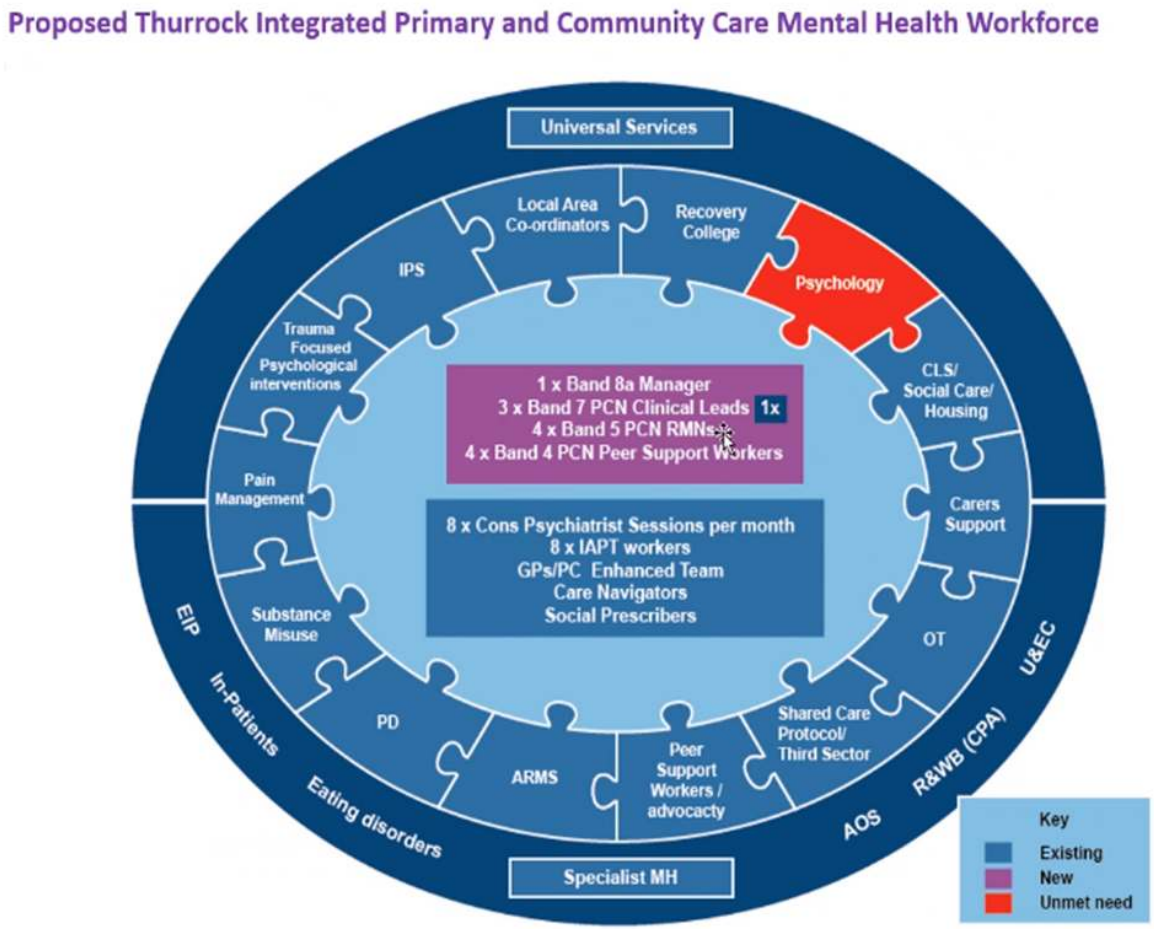
Practitioners such as social workers and LACs often felt frustrated as they would often be a point of contact for people defined as the 'missing middle' but would be unable to help until people were ill enough to meet the thresholds in place. More broadly, we recognised that the way mental health services had been organised left residents with a service that was difficult to access, fragmented and that focused on only bio-medical aspects of treatment.

Through an extensive process of co-production, we have transformed and completely reimagined how we deliver mental health services through an Integrated Primary and Community Care Mental Health service offer at PCN level. The process brought together clinicians from primary and secondary care, users of services, carers and families, the voluntary sector organisations, public health specialists and commissioners from both NHS Thurrock CCG and Thurrock Council.

The new model has focused on:

- Developing a seamless offer for those who need more support than primary care would provide but don't meet the thresholds for secondary care,
- Defining care packages to meet the needs of those in Outpatient caseloads to enable clinically safe transfer of care to the Primary Care Network Integrated Mental Health Teams with an embedded step-up and step-down function with a particular focus on psychological interventions,
- Releasing capacity for the consultants to provide additional support to the Primary Care Networks and develop a more therapeutic service offer for those with complex needs ensuring quality specialist and personalised care.
- Developing a holistic offer that allowed wider determinants of mental health such as housing and employment to be addressed together with the positive role that social and community connections can play in recovery.

Figure 7.6: Our our new model of care.



The model consists of a core specialist mental health team within each PCN consisting of specialist psychiatric nursing support, mental health practitioners, peer support workers, IAPT workers, care navigators, with additional clinical supervision and clinical in-reach from Consultant Psychiatrists. Around this sits a comprehensive array of additional support services from which input can be brokered.

As part of the transformation approach, a number of Mental Health Nurses have been employed to be part of each PCN, establishing relationships with professionals working within the local area and ensuring that mental health is both holistic and also integrated within health and care.

The new model provides a holistic and integrated service that blurs the previous hard referral boundaries between primary and secondary care, providing specialist support to practices, holistic support to residents and reduces the number of onward referrals and fragmentation within the previous system.

Having successfully piloted the model in one PCN, we are currently in the process of rolling out to all four at pace.

Dementia Friendly Communities

People with dementia and their family carers want to be able to do everyday things in their community. It is important to them to continue to go to the shops, socialise, access leisure and outdoor spaces and feel confident to use transport. However, due to concerns around stigma and misunderstanding, people with dementia often withdraw and lose the confidence and ability to live the life they want.

Fewer than half of people with dementia feel a part of their community and this becomes lower the more advanced a person's dementia is. 9% of people with dementia have stopped doing everything they did within their community before their diagnosis.

One third of people with dementia say they are lonely, and a quarter of carers of people with dementia say they have become 'cut off' from their community.

With the predicted increase in people with dementia in Thurrock, it is imperative that Thurrock becomes a community where people with dementia, feel valued and understood. This will not only improve wellbeing but delay the reliance on expensive statutory services. Due to the asset and strengths-based approaches in Thurrock, we have firm foundations on which to build a more inclusive community, ensuring that a person with dementia and their carers live a good life,

Thurrock has reenergised its Dementia Action Alliance and is hoping for reaccreditation this year. A wider group of stakeholders, from care, health, police, fire, community and voluntary services, retail have come together to take action to remove the stigma and ensure people with dementia and their carers remain a part of their community rather than lonely and isolated (loneliness has even further impacts on health and wellbeing.

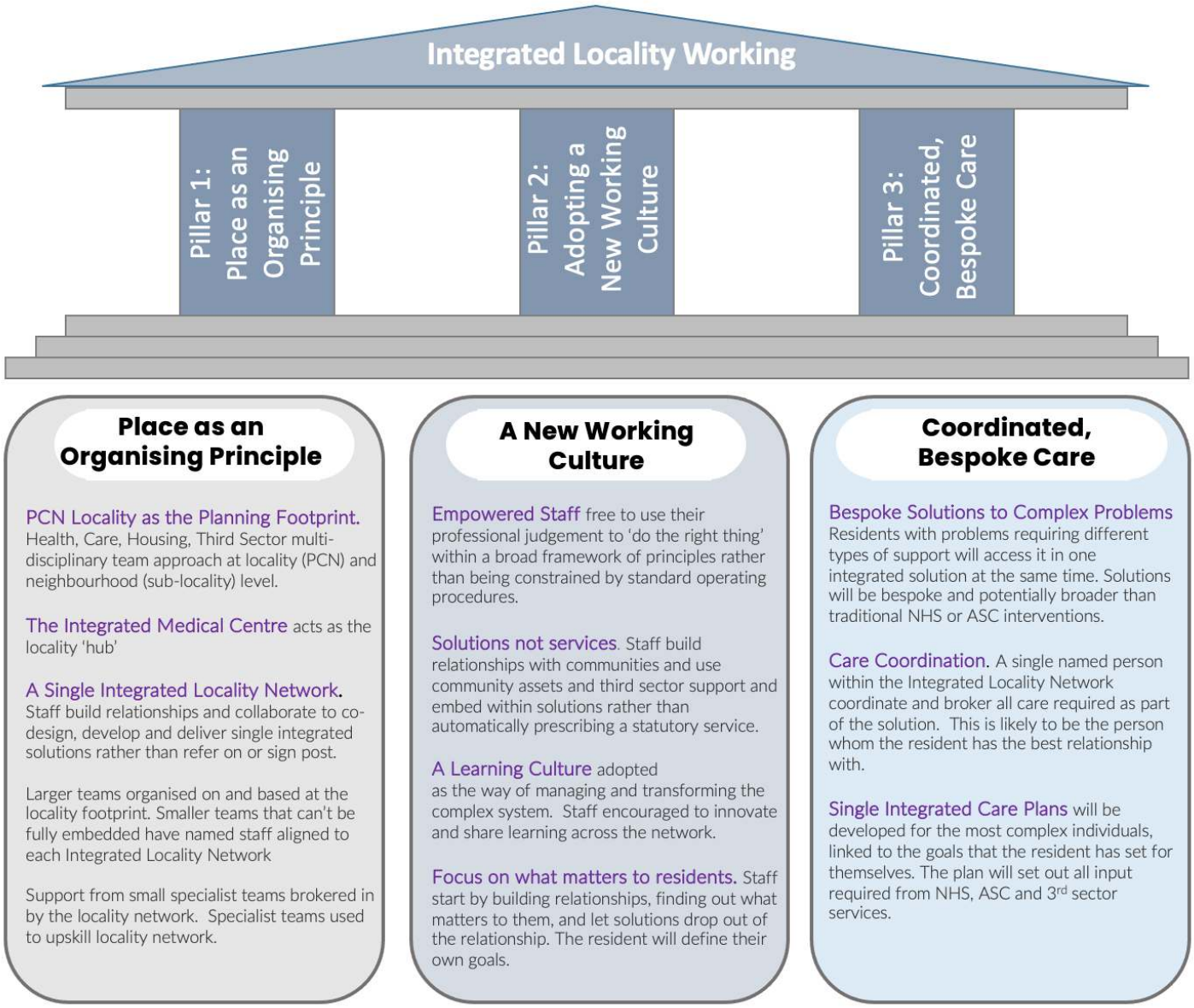
7.5 Further Locality Based Transformation: Integrated Locality Care and Support

Our plan is to focus on expanding and joining up the work we have tested, applying our learning to developing an integrated and coordinated health and care model that wraps around each Primary Care Network and core services delivered by GP practices. The model will operate in line with the principles discussed in chapter 2.

7.5.1 The Three Underpinning Pillars of our new Locality Model

Our model for integrated care and support will be underpinned by the three key pillars set out in figure 7.7 based on our learning to date and the values and principles set out in Chapter 2.

Figure 7.7



7.5.2 Further Transformation – Phase I (first 18 months): Locality Working and Integrated Locality Networks

We envisage the transformation from the current system architecture to integrated locality teams occurring over two phases. We estimate the first phase taking 12 to 18 months during which we will further develop our existing locality architecture and create a single *Integrated Locality Network* of professionals who will be able to collaborate more easily and effectively with each other.

Our overall aim will be to embed the maximum amount of care at locality and neighbourhood level within a multi-disciplinary network of staff who can collaborate to design integrated solutions with residents rather than make onward referrals.

Community Led Support

We will expand the functions of CLS teams to include the current discrete Adult Social Care Complex Care, Reviews and Mental Health team functions. Through further testing, we will seek to encompass other functions within CLS, for example housing, mental and community health colleagues and LACs. Work will also take place as part of phase I to integrate further the role of CLS within the out of hospital care pathway and ASC hospital team.

Drug and Alcohol Treatment

As the first case study of Owen demonstrated, the way we have commissioned drug and alcohol treatment services in the Borough historically as a separate service accessed through a different referral pathway inhibits other resident-facing staff from delivering integrated solutions.

Moving forward, we will recommission an integrated treatment service with drug and alcohol treatment and outreach workers aligned to and operating within Community Led Support teams, with assertive outreach and timely access to treatment for those with the most complex needs.

Integrated Community Teams (ICT) Community Nursing Teams

Our ICT Teams currently operate across Thurrock but we recognise the value of aligning this resource both at PCN/locality level and into our Wellbeing Teams (discussed in detail in Chapter 8) in order to integrate their work with all elements of health and care.

In order to facilitate this integrated locality based working model, we have recruited two senior nurses to work with PCN localities to identify how ICTs can shift to a locality-based operation and how existing ways of working will alter – for example working alongside care providers to deliver blended roles and to enhance knowledge and skills and working as part of an integrated locality network.

The learning from this initiative will be incorporated within the next phase of transformational activity.

Older Adults Wellbeing Teams

NELFT's Older Adults Wellbeing Team provides a wrap-around service for frailty both within the home and to care homes. The service undertakes Comprehensive Geriatric Assessments (CGAs), and provides falls prevention.

There is strong evidence of the significant impact that community based CGAs and community geriatrics teams can have on improved outcomes for older people, maintain independence, and prevent failure demand and need for higher cost care services as shown in the box below. If a new drug that could deliver the same impact were brought to market, there would be a population wide clamour for approval of its use and availability.

Impact of Community Geriatric Teams

Researchers from the University of Minnesota studied 568 men and women over the age of 70 who were living independently but at high risk of becoming disabled because of health problems, recent illnesses or cognitive changes. With their permission, they assigned each person to one of two groups: those who would continue to receive standard medical care, and those who would receive care from a dedicated team of geriatric nurses and Consultant Geriatricians.

Within 18 months, 10% of both groups had died. However, patients receiving care from the Geriatrics Team were a quarter less likely to become disabled, half as likely to develop depression, and 40% less likely to require adult social care services.[4]

The service currently operates on a Borough-wide level. We will prioritise expanding the capacity and reach of this service through future growth funding and through re-investing savings from prevention and seeking to align it to the four Integrated Locality Teams.

Long Term Conditions (LTC) Management Clinics – Diabetes, Respiratory and Heart Failure.

These three discrete teams currently receive referrals from Primary Care and other community professionals of more complex patients and undertake direct management, patient education and self-care advice (including Pulmonary Rehabilitation), prescribing advice and medicines review, and in the case of the respiratory team, oxygen therapy. They are currently organised on a South West Essex level.

We will seek to align capacity within these teams to the Integrated Locality Networks, and transform care to be delivered as part of the PCN Long Term Conditions Management services set out in Chapter 6.

Dementia Crisis Support Team.

This team supports those in the community with dementia, offering initial support, occupational therapy, and supports early discharge. It is currently organised at South West Essex level. We will seek to integrate it fully within the Integrated Locality Network. We are also using an Asset-Based Community Development approach to introduce dementia friendly communities.

Virtual Wards

Phase I will see the testing of 'Virtual Wards' in Thurrock (respiratory and frailty Virtual Wards will be tested initially). The initiative will see people with urgent care needs (high levels of acuity) being treated and supported within their own home. People who are part of the scheme will be monitored daily by a multi-disciplinary team against goals that are personal to the individual. The Team will be overseen by a consultant.

Learning from Virtual Wards will support the development of other schemes such as Wellbeing Teams and CLS and will help to ensure that the acute sector is part of any community-based integrated care and support model.

Integrated Primary and Community Care Mental Health Teams and Open Dialogue

In 2021, Thurrock Council moved its team of Mental Health Social Workers from Grays Hall to work within the community on the basis that this would allow them to deliver a more strengths based and holistic approach. The Team will integrate within CLS teams and the new IPCC model of care within each PCN.

Open Dialogue is a social network approach to support and treatment for residents experiencing serious mental ill-health and crises that also includes family members, friends and others who are concerned. It was developed in Finland in the 1980s and is being piloted in other areas of the UK at present and is summarised in the box to the right.

Open Dialogue is an approach that very much reflects the principles of our health and care redesign being that it is a) strength-based; b) shifts away from a 'clinical' view of treating the person; c) is holistic – in that it features the wider determinants of health and wellbeing that may impact the individual's ability to achieve a good life; and d) is person-led.

We will also work with the Mental Health Social Workers and other professionals within the IPCC model to test an Open Dialogue approach, initially within one of our four localities.

Open Dialogue Approach to Treating Residents with Serious Mental Ill Health

Open dialogue shifts the conceptualisation of mental ill-health from something that is going wrong in the brain, to something that is going wrong in the space between the patient and their environment. The approach operates by providing a team of two or three trained therapists who meet the person in crisis within 24 hours of first contact, daily until the crisis is resolved.

Hospitalisation is rejected on the grounds that it is an untherapeutic environment, and people are usually treated within their own home. The use of anti-psychotic medication is also avoided wherever possible.

The same team of therapists work with the person in crisis throughout the intervention and the family and friends of the resident are also encouraged to participate.

The main purpose of meetings are to encourage dialogue between the person in crisis, their family and friends and therapists, giving a voice to all concerned, putting the person in crisis at the centre and letting solutions emerge from the conversations. Broader holistic therapies and support are also offered including employment support, individual therapy and occupational therapy.

Mental health experiences are understood as something (usually traumatic or stressful) for which there has been no language. Over time, a shared meaning is developed that establishes a context for those experiences and bespoke solutions that aid recovery.

The results of follow up studies have been remarkable, for example a five-year follow-up by Seikkula et al.[5] found that compared to standard care, the Open Dialogue approach delivered:

- A decline in DUP (duration of untreated psychosis) to three weeks
- Two-third reduction in antipsychotic drugs
- 83% of patients in the Open Dialogue cohort returned to full employment
- Few new schizophrenia patients: Annual incidence declined from 33 (1985) to 2-3 /100,000 (2005)
- Almost no usage of mental health in-patient secondary care beds.

Care and Support in the Home

Our model for transformed home care is set out in Chapter 8, based on the same principles set out in this chapter.

Housing Solutions (Allocations, Registrations, Homelessness Prevention)

The Housing Solutions service is responsible for preventing homelessness as a priority, and relieving homelessness when homelessness cannot be prevented. They are also responsible for reducing and ultimately eliminating rough sleeping within the borough. Overall the service seeks to understand the challenges and complexities around homelessness today, the impact on families and single people, as we seek to ensure that Thurrock residents are catered for. They support residents threatened with homelessness by agreeing personal housing plans; taking action to prevent them from becoming homeless and where this is not possible, identify alternative accommodation before the eviction takes place. They also provide employment advice and casework and work with external partners such as Friends of London, Essex Homeless, Beam and Open Door.

Allocations staff within the *Housing Solutions* function administer the process of matching those eligible for council properties with suitable stock and support people who need to move when their current property no-longer meets their needs.

We will align named staff from the Housing Solutions function into each of the four Integrated Locality Networks to allow housing need to be more easily addressed as part of single integrated solutions.

Estate Services

Estates Services Teams are responsible for reporting of repairs and maintaining the cleanliness of both internal and external areas of estates, signposting residents to appropriate services.

Estates Officers have a unique and often detailed understanding of the needs of residents. They are in an excellent position to work in line with locality model principles and we will align them to the Integrated Locality and Neighbourhood networks.

Tenancy and Neighbourhood Services

The Tenancy Management Team is responsible for managing General Needs Tenancies, resident engagement and neighbourhood inspections on Housing owned land without a caretaking service. The Team support residents in maintaining their tenancies/ licences in a prompt and proactive way including sheltered housing provision. This includes undertaking property audits, signposting residents to other services and presenting cases to a range of panels to ensure they are adequately housed and supported in line with their needs.

Tenancy Management Officers currently work on a patch basis. They report to three area managers: Central, East and West. This team is well poised to align their working to the locality model and start delivering services within the localities in greater partnerships.

Private Sector Housing Team

This Team is responsible for keeping private sector housing conditions under review for improvement and provides support and advice to residents and landlords. This includes landlord/owner occupier liaison, improvement grants and loans, housing enforcement, tackling rogue landlords, licensing houses of multiple occupation/caravan sites and supporting the wellbeing of residents and helping save energy in their homes.

A Well Homes Team, which forms part of the Private Sector Team (manager and 3 officers), works in a way that can easily be aligned to the Locality Network model.

Blended Role Test and Learn Small Scale Pilots

We will use HLS principles and methodology to understand the most appropriate generic functions that could be better combined into single blended roles. The two case studies below demonstrate how Gateshead and Plymouth have achieved this

We will undertake a similar 'test and learn' HLS approach in Thurrock, creating a two or three dedicated multi-agency teams with small caseloads of specific categories of high intensity service users or complex individuals, likely to be homelessness, repeat hospital admissions and mental health supported housing. These will take place with the support of the Human Learning Systems network.

Plymouth's HLS Approach to Residents with Complex Needs

Plymouth Integrated Care Partnership, through a process of appreciative enquiry with residents and staff, noticed a significant overlap between residents with mental health problems, addiction problems, homelessness and offending. However the system responses to these issues sat in four different discrete teams/organisations, each with their own specialist staff, commissioned separately.

Through a similar HLS approach, they were able to create a new "Complex Needs Specialist" role, with competencies to undertake the most common value activities in all four functions, commissioned from a single pooled budget.

The approach saw significant reductions in overall drug and alcohol treatment costs, a 90% improvement in drug and alcohol DNA rates, improved outcomes and a significant reduction in 'failure demand' from this cohort of residents in other high cost areas of the wider system including A&E attendances and hospital admissions. Total savings of £750,000 were delivered whilst improving outcomes. These savings were re-invested in further integrated prevention work.

Gateshead Council's HLS Approach to Create Community Case Worker Blended Roles

Gateshead Council used HLS to imagine their system response to debt. They identified a cohort of residents with the highest levels of council tax debt and used this debt level as an indicator of other wider problems. Rather than responding in a traditional 'New Public Management' process way of sending letters, court action, bailiffs and evictions, they formed a multi-disciplinary team consisting of a council tax officer, housing officer, a DWP worker, a CAB worker and mental health worker. The aim of the team was to build a relationship with each family and co-design a solution to their debt problem.

The team were given two high level boundaries in which they must operate - 'don't break the law', and 'don't do any harm', and some high level operating principles:

- Don't assess people
- Start by building a relationship in order to understand the problem
- Make decisions with people not to or for people
- Do not make any onward referrals. Broker expertise into your team if you need it.
- Capture the learning including the current barriers in the system that are preventing you solving the problem

By mapping their learning, the MDT was able to identify barriers where the wider environment prevented them solving residents problems, for example a housing policy determined that they should evict a tenant in rent arrears, but the underlying problem was the tenant's unsolved mental health problem. This allowed wider action to be taken to transform and address systemic barriers.

They also mapped the frequency of 'value activities' - those actions that helped solve resident debt. From this intelligence, they were able to create a "Community Case Worker" blended role with the skill mix to undertake the most frequent 'value activities'. These included the ability to process Universal Credit Applications from start to finish, make housing allocation decisions and provide mental health and debt advice and support.

The pilot concluded that up to 90% of benefits awarded to the cohort had been incorrect. In addition, 70% of people supported by the team reported that their life was better and their was between a 60-90% reduction in demand for wider services in those whom the pilot supported.

Creating Single Integrated Locality Networks to Drive Transformation and Integration

Building and further developing our existing strengths based provision at locality level around PCNs is only the first stage in the process. In order to deliver integrated care, we also need to ensure collaboration and integration between the teams. We see three primary mechanisms to achieve this:

1. Integrated Medical Centres (IMCs)

Four IMCs are planned in Thurrock, one per PCN locality, with the first at Corringham on track to open in July 2022, followed by IMCs for Corringham and Tilbury in 2024 and Grays in 2025. Each IMC will act as the 'hub' for provision of integrated services at locality level and will provide a wide range of community and mental health, care, diagnostic and outpatients services together with space for third sector groups and organisations to operate from and in the case of Tilbury, the library and Tilbury Community Hub. At least one of the existing GP surgeries within the locality's PCN will operate from the IMC, but all other services within each IMC will be available to all residents with the locality, and in many cases, Borough wide.

We see the IMCs as critical to replace ageing existing estate, attracting the best workforce to Thurrock and as a footprint in which front line clinical and resident facing staff can be empowered to deliver further transformation and integration of services.

Once launched, how the buildings function will continue to evolve, constantly reflecting the requirements of the local community. We will use *Local Communities of Practice* and the *Community Reference and Investment Boards* set out in Chapter 4 to ensure that this evolution reflects local interests and the views of residents and staff.

2. Integrated Locality Networks through Communities of Practice (CoPs)

A key aim is to ensure that our health and care workforce can see themselves as part of one locality 'team' regardless of who employs them or what they have been employed to do. We want our staff to work under the same culture and to be united by the same vision and aims, in particular helping to ensure that local people are supported to achieve or maintain what matters to them.

Whilst a change of culture will take time to achieve, there are key steps along the way. Most health and care staff involved in providing community-based care will do so on a locality basis and place themselves within a locality.

Teams will work together as part of a single *Integrated Locality Network*. This will be developed through relationship building, but also through the development of practitioner-based communities of practice who will meet to information share and problem-solve. Staff will be enabled to work across organisational boundaries so that integrated solutions can be developed ensuring the reduction of hand overs and cross-referrals to other services. The first practitioner community of practice will be tested during 2022.

We will also undertake a review of current IT provision including access to and permissions within *SystmOne* in order for staff to more easily view and share information related to the provision of care. Intelligence from our GPs suggests that current restrictions in SystmOne mean that existing teams can only view elements of patient records pertaining to their current team task. This is in duplication of task requests being raised in *SystmOne* by different teams for the same patient, causing unnecessary additional workload and potentially wasting time and resources.

3. Care Coordination and Single Integrated Care Plans.

Delivering genuinely integrated and bespoke solutions to residents may require input for many different elements of the NHS, council and third sector. For complex patients this requires the development of single shared care assessment and planning and excellent care coordination. In Phase I, we will develop and test a single process for assessment and single care plan for residents with complex needs, together with a named care coordinator. The work will link to the HLS pilots as some care coordination will take place through the development and testing of blended and generic roles (see next section).

Whether a specific 'care coordinator' role is required will also be reviewed, but if the starting point is the individual rather than their 'need' or 'condition', we envisage that an integrated and coordinated way of working across functions should enable any one of a number of professionals to undertake the role, with the most appropriate person likely to be the individual who has most contact with the resident. We also discuss care coordination and Single Integrated Care Plans in the context of home care and Wellbeing Teams in the next chapter.

Figures 7.8 (the current service landscape) and Figure 7.9 (an Integrated Locality Model) overleaf demonstrate and summarise the change we want to see at the end of Phase I. There will be fewer teams, and the vast majority of those teams will either be embedded within the Integrated Locality Network, or aligned to it, delivering integrated care at locality or neighbourhood level. Where teams remain separate, care will be brokered by the locality.

Figure 7.8

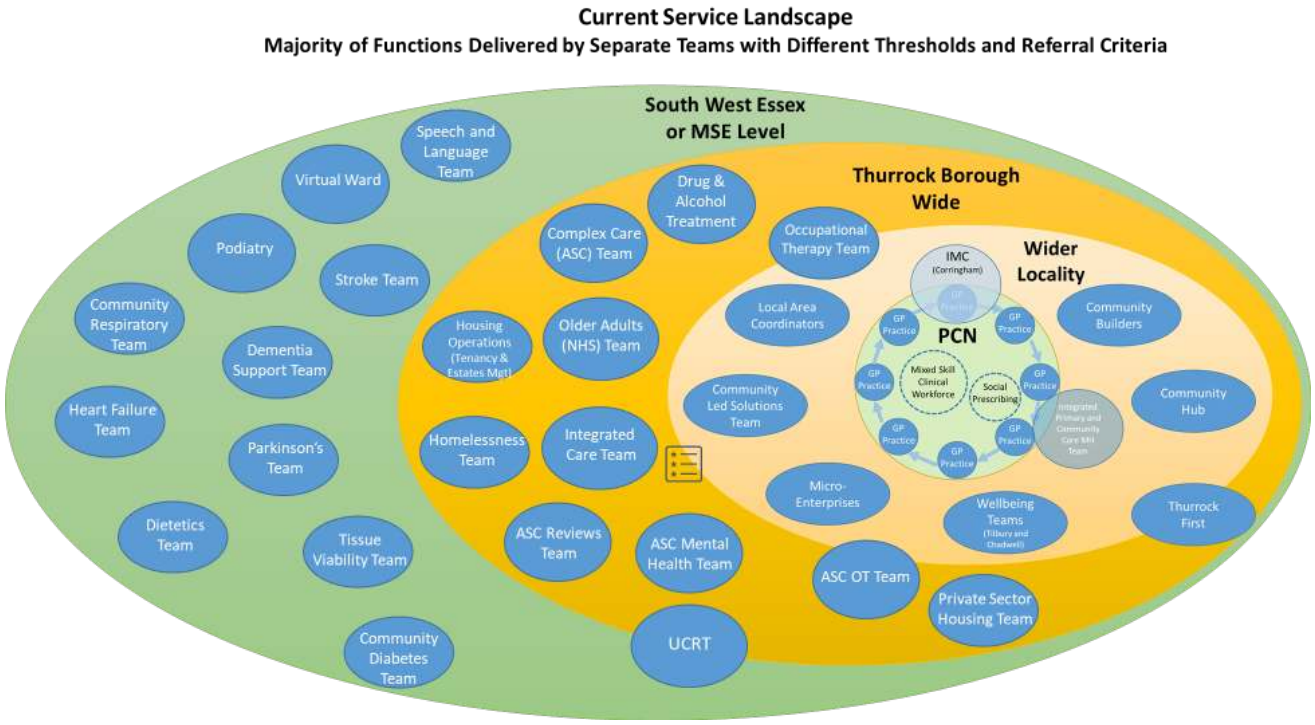
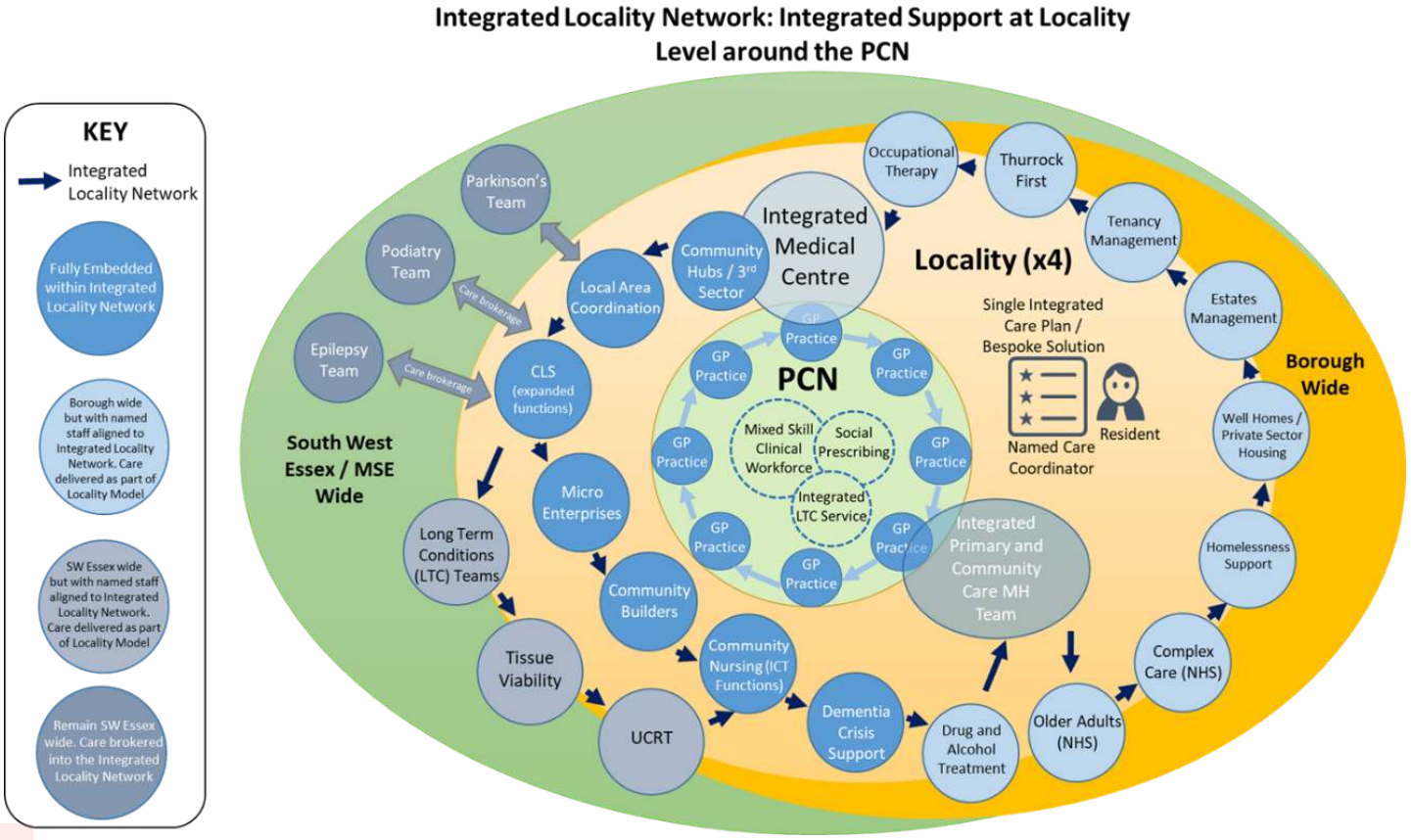


Figure 7.9



7.5.3 Phase II – Further Transformation – Phase II (18 months onwards)

In Phase II we will build on learning from the small scale pilots of Phase I to move from collaboration through the Integrated Locality Network to develop genuinely new blended roles that can deliver a range of common functions currently delivered by different professional roles and organisations, in order to minimise the different numbers of teams and individuals that need to be involved to co-designing solutions with residents.

We will seek to align commissioning, governance and resources at locality level and create single locality or place budgets from which all locality provision is commissioned. This will allow savings from prevention of failure demand to be re-invested in more prevention, creating a virtuous positive feedback loop.

Phase II will also see the establishment, following the testing and learning from Phase I, of a fully locality-based (around each of the four PCNs) integrated and coordinated health and care system. Key elements will include:

- Coordinated and integrated plan of support for those who require it – following any point of access;
- Support plans include a mixture of resources – focusing initially on what is available within the community and only considering formal services once all other options have been exhausted;
- One professional to have oversight for coordinating support when coming from numerous sources;
- Establishment of a number of generic roles with the capability to provide the highest frequency 'value activities' at one time working in collaboration with residents to help solve their problems, preventing onward referral and 'failure demand'.
- All professionals having strength based conversations that focus on how best to deliver what matters to the person;
- Removal of referrals to other services operating within the locality – meaning reduced waiting times and reduction of people getting to crisis point;
- Learning culture embedded within the way staff work – via HLS approach;
- Staff within localities being able to broker specialist support easily as and when required to provide deliver bespoke, integrated care.
- Staff operating across organisational boundaries fluidly and flexibly to provide the best solutions for individuals within the locality;
- Processes for overcoming barriers and challenges to change in place as part of new system governance arrangements;
- IT systems that support the new way of integrated locality working including the sharing of information to all professionals involved in the direct care of residents.

The shape of the care and support system provided by locality will continue to evolve. The development of community engagement as described in chapter 3 will help to ensure that the system reflects what matters to local people.

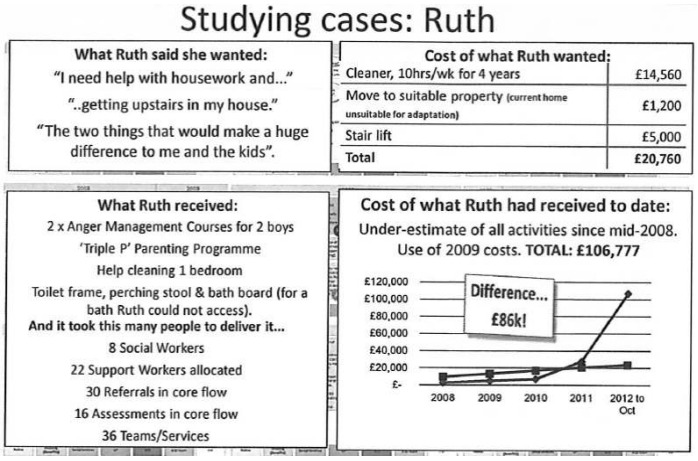
7.5.4 Impact of the Transformation We Will Deliver

The impact of the health and care system working predominantly on locality footprints in a coordinated and integrated way has already been tested. The case study is one of many examples that demonstrate the power of integration at locality level.

The case study reflects the benefit to the individual and the system of a person led and coordinated approach – following CLS and Human Learning System principles.

A more efficient system with better use of resources and a reduction in failure demand.

There are significant amounts of waste in the current system. Mapping how the current health and care system responds to people shows extremely high levels of bureaucracy. For example, Hillary Cottam (Radical Help) mapped the involvement of Public Service with one 'complex' family and showed that up to 80% of time and resource was spent on process and bureaucracy, with only 20% of time spent on direct support. Cottam's challenge to the system was to reverse these figures, so 80% of time and resource was put to good use. The case study below reflects Cottam's observations.



Designing the system around what matters and enabling staff to work in a way that responds to what matters focuses on removing waste and focusing on what adds value. As the last case study demonstrated, the actions of one individual working with the person to have a good conversation and finding the right solution to deliver what mattered to the individual resulted in significant improvement for the person. It also resulted in reduced reliance on services.

Case Study – the Impact of a New Way of Working

D was introduced to the Tilbury and Chadwell CLS Team. Her mental health had declined, she was calling emergency services several times daily, she was also calling the Local Area Coordinator, Adult Social Care, Housing, the GP, Mental Health and numerous other services. She was known to Safeguarding and she had also been arrested twice for misuse of emergency services. She had had several Mental Health assessments but did not fit the threshold. She had been referred for counselling but was not suitable. Her health had declined and she was stuck on one floor of her house and unable to get out. She had ongoing anti-social behaviour issues with neighbours. She was unable to bid for a different property as she was in debt. She was in full crisis.

A member of the CLS team went to see D and had a conversation with her. It was important to build a good relationship and gain trust. Through conversations, it was possible to understand what was important to D and how she might best achieve it. This included a mixture of formal and informal aspects to one overall solution. For example, she wanted to be able to move to a single floored property and enjoy a garden and also regain contact with her family with whom she had become estranged.

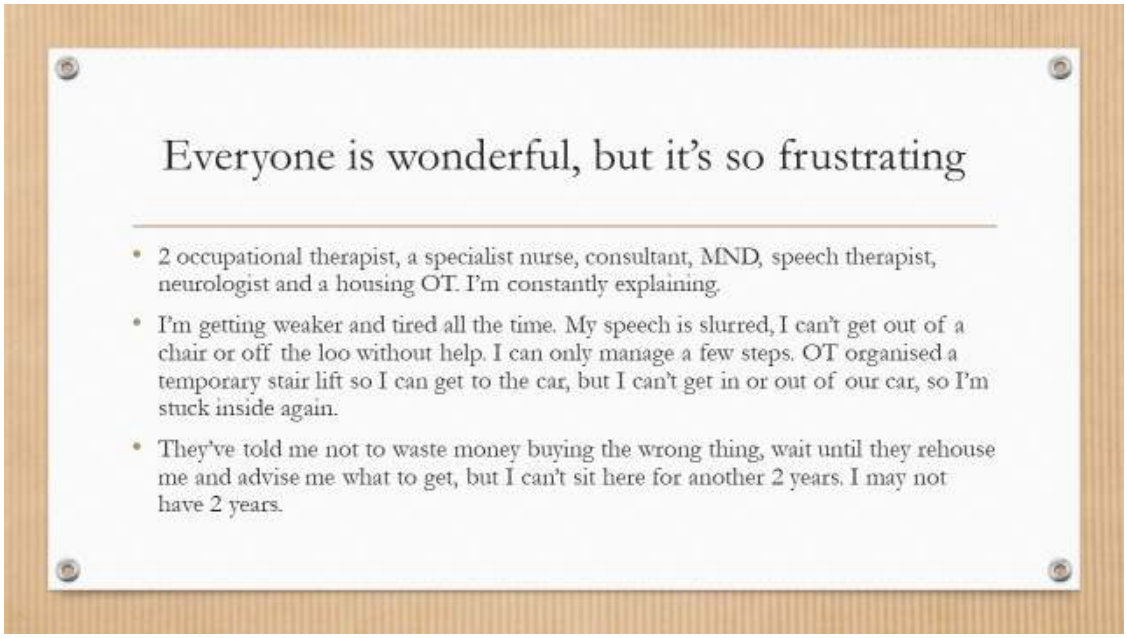
The CLS worker coordinated the response which included liaising with Housing, Mental Health and the Police. It also led to D having a personal budget which mean she could employ and choose who supported her. The solution also provided D with a contact that she could call if she felt she needed to talk to someone.

The CLS worker spoke about D's experience.

'She cried as she reflected on what a bad place she had been in when we first met and how she couldn't see it at the time, she was excited to show me around her flat and all the new things she had brought, she beamed as she spoke about plans for her garden that was her next project. She explained that her family had reached out to her and now once a week her and her sister met for lunch and are building their relationship back up.'

The Impact of failing to change

What do we achieve if we continue to do more of the same?



7.6 Our 'Ask' to Integrated Care System and Alliance Partners

1. Agreement of the principles, values and proposals set out in this chapter including the 'three pillars' of locality working

2. A review of governance and accountability arrangements to support the proposals and as protection from collapsing back in to the 'old' system.

3. A commitment to a distributed leadership approach and devolving decision making authority and accountability down to resident facing staff with freedom to act within an agreed broader principles and values framework.

4. Support of the use of the HLS methodology set out within this chapter to create genuinely new blended roles that can deliver a broader range of high frequency 'value' activities historically delivered by different organisations and teams.

5. Protecting staff when they take a risk, try something new and do not succeed in order to create a culture of innovation.

6. Support for a review of current IT and IG arrangements to create more integrated patient/client record systems to facilitate appropriate sharing of information directly related to patient/client/resident care to all involved in the integrated care of that individual

7. Support in principle of resource between organisations to create single locality/place based budgets and agreement to participate in further work to explore how best to move from current budgeting arrangements to integrated pooled budgets.

8. Agreement to pool sovereignty by organisation to create sovereignty at place and locality level

SUMMARY OF STRATEGIC ACTIONS

7.1 We will create a new Integrated Locality Network of professionals for each of the four Thurrock localities, aligned around each PCN and IMC based on the three underpinning pillars of 'Place as an organising principle', 'Adopting a new working culture' and 'Bespoke coordinated care'. (Phase 1)

7.2 We will embed the Integrated Care Teams, Dementia Crisis Support, Community Builders, Micro Enterprises, Community Led Solutions, Local Area Coordination and Third Sector Support within the Integrated Locality Network (Phase 1)

7.3 We will embed the ASC Review, Complex Care, and Mental Health Teams within Community Led Solutions. (Phase 1)

7.4 We will align borough wide Addiction Treatment, Older Adults, Complex Care, Homelessness Support, Well Homes, Estates & Tenancy Management, Thurrock First and OT Teams to each Integrated Locality Network, with named staff aligned to each network. (Phase 1).

7.5 We will align South West Essex/MSE UCRT, Tissue Viability and Long Term Conditions Management Functions to each Integrated Locality Network, with named staff aligned to each network (Phase 1)

7.6 We will integrated some of the care functions undertaken by Diabetes, Heart Failure and Stroke LTC Teams within an Integrated PCN level CVD & Diabetes Long Term Conditions Service

7.7 We will develop a Community of Practice within each locality as a mechanism through which staff can develop the Integrated Locality Network, collaborate and innovate

7.8 We will build one IMC per locality to act as a 'hub' for service integration and the Integrated Locality Network, informed by the locality Community of Practice and Locality Community Reference and Investment Board

7.9 We will seek to use specialist support from current teams in a different way, with care being brokered into and by the Integrated Locality Network rather than through on-ward referral, and specialist skills within the teams being used to upskill locality clinical capacity.

7.10 We will use HLS 'test and learn' methodology to creae new 'blended roles' upskilled to undertake care currently delivered by different teams and organisations, further rationalising the number of different involved in designing care solutions with residents.

7.11 We will design and implement Single Integrated Care Plans for the most complex individuals, with a named care coordinator.

7.12 We will prioritise investment in the Older Adults Wellbeing Functions, Comprehensive Geriatric Assessments and Frailty Support, expanding the capacity and reach of the function.

7.13 We will build on the success of the IPCC mental health model and pilot an Open Dialogue Approach to managing people with serious mental health problems in crisis.

7.14 We will implement a new flexible and holistic model of mental health supported living.

7.15 We will seek to pool funding between organisations, to create single locality/place budgets from which all services are commissioned and where savings from prevention/failure demand reduction can be reinvested.

Chapter 7 References

1. National Voices, Principles for Integrated Care. 2013 Available at: Principles for integrated care | National Voices ↑

2. Williams, E., Buck, D, and Babola, G. What are health inequalities? Kings Fund. 2020. Available at: www.kingsfund.org.uk/publications/ what-are-health-inequalities ↑

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5. Seikkula, J., Alakare, B., Aaltonen, J., and Holma, J. Open Dialogue Approach: Treatment Principles and Preliminary Results of a Two-Year Follow-up on First Episode Schizophrenia. *Ethical Human Psychology and Pschiatry*. January 2003. 5(3): 163-182 ↑

Chapter 8:
Integrated Support in the Home

Holistic care from fewer people

Chapter 8: Integrated Support in the Home

8.1 Introduction

The home is increasingly becoming a critically important setting in which to deliver health and care to our residents. As our population ages, a greater proportion are likely to need integrated care interventions delivered at home. The home may often be the more appropriate setting in which to deliver care:

- It is the environment in which we live, allowing care assessment and planning to take into account social and environment factors that impact on our wellbeing.
- It is the setting in which we feel most safe, and for most residents, receiving care at home is preferable and more convenient to a hospital or residential care admission
- Delivering care within the home promotes the dignity and independence of our residents, giving them maximum control over their own lives.

In this chapter we discuss the topic of integrated care delivered at home and set out our plans to transform and further integrate home health and care services based on our successful Wellbeing Teams model pilot.

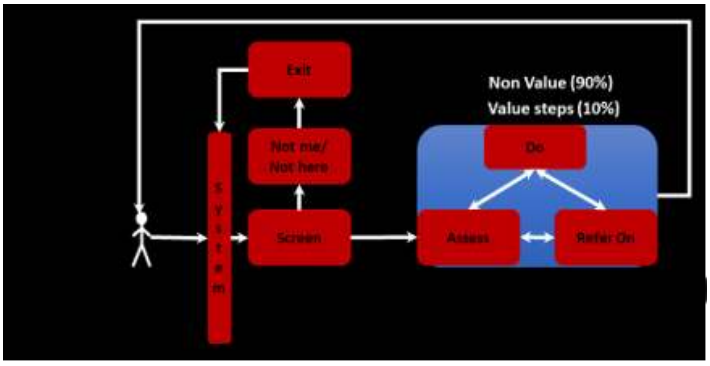
8.2 The historical approach to delivering homecare

Our existing health and adult social care home care providers have done a magnificent job in continuing to deliver care during the extremely challenging circumstances of the COVID-19 pandemic. However, the way we have historically commissioned and delivered care at home is based on a fragmented *New Public Management* time and task model that is outdated and inefficient. Health and care delivered to someone in their home is delivered based on whether the person is eligible for a particular service, with the service being designed to respond to set needs and conditions.

As also discussed in Chapter 7, this approach has led to a fragmented *'one size fits all'* response that focuses on whether someone is 'ill enough' or has sufficient 'need' to qualify for a response. Therefore if a person requires a nurse to change a wound dressing but also needs support with dressing and washing, they will be visited by a community nurse and a domiciliary care worker. If the person has recently left hospital, they may receive a re-ablement service after which their care and support requirements will be passed on to other social care and health teams; this will be after they have been assessed separately. If an individual has both physical and mental health needs, the number of assessments required and individuals to respond to assessed 'needs' will multiply further still, with physical and mental health interventions being dealt with by separate teams.

Lack of integration adds cost and demand to the existing system resulting in significant levels of 'failure' demand.

Figure 8.1



The approach builds significant levels of 'failure' demand in to the system. This means that a great proportion of the resource available is not being used effectively – or could even contribute to someone's deterioration.

Example of failure demand that exist currently within the current model of providing support in the home across different services and functions are:

- Duplication of visits and tasks;
- Carrying out the same task at the same frequency and time;
- Hand overs and referrals;
- Numerous systems (both in terms of IT and processes/policy);
- Failure to find out what matters to people means addressing or focusing on the wrong things – leads to a 'revolving door';
- Separate budgets and thresholds prevent people from doing the right thing and focus on ensuring people are sick enough or in enough need to receive care;
- Lack of partnership working and joint ownership for the person's outcomes means that everyone only does their 'bit' – meaning issues that could have been resolved are not

Led by 'conditions' and 'needs'

As we have discussed previously, eligibility criteria and service thresholds are designed to ensure that people are 'needy' or 'ill' enough to warrant a service response. Until that point, service intervention is largely absent, with little in place to support people who do not fall in to the 'eligible' category. The question of 'what matters to the person' or doing what is required to prevent, reduce and delay the person from needing a service has historically not existed. Perversely, this leads to people declining more quickly and being more likely to require a greater service intervention.

The Homecare Market in Thurrock

In Thurrock, in 2019/20, whilst health providers are relatively static and remain part of the NHS, almost 60% of residents receiving a domiciliary homecare package received it from a private sector provider with the remainder receiving a service from *Thurrock Care at Home*, the council's in-house homecare provider. Externally commissioned providers operate on low margins, care staff often receive low rates of pay, and the existing homecare provider market is extremely fragile. As a result, care providers are at high risk of handing back contracts or financial failure. Due to the nature of how commissioning takes place, larger providers with greater levels of resource are by default more likely to provide care and secure contracts than small grass roots organisations.

Most traditional systems have a process similar to the above to decide whether someone is a) eligible enough to receive support, and b) what support is available to them. That support is then supplied at the same frequency and in the same way until some form of review is carried out – and dependent upon the review, potentially another assessment or form of screening.

For each 'condition' or 'issue' that the individual has, a similar process will be carried out.

Commissioning

The commissioning function is currently delivered by organisation and by service type. This prevents health and care solutions from being integrated and focuses on contract specifications that are determined by time, task and service type rather than being able to flex to deliver an individual's goals and outcomes in their entirety. Providers are commissioned to provide the same pre-determined set package of care hours to residents each day. This allows no flexibility for the provider to respond to the varying needs of residents on a daily basis and can also result in different carers entering a resident's home on different days, minimising opportunities for care continuity and limiting provider opportunity to identify where a resident may be improving or deteriorating.

The relationship built with providers is based on formal 'commissioner' and 'provider' relationships, including contract management, which reinforces traditional delivery methods and stymies innovation.

Finance and Resource

Budgets and resource across health and care are aligned by organisation and service rather than by systems. Performance regimes and additional grant funding serves to reinforce this regime. This has made it difficult to pool monies across organisations and service areas for the purpose of achieving jointly shared outcomes. Shifting budgets so that they are pooled and focused on outcomes will enable providers to behave differently and make it easier for organisations and service areas to work together around the individual. There is a wealth of resource available with local communities that contributes significantly to the delivery of people achieving good outcomes which needs incorporating within the definition of 'finance and resource'.

Workforce

Workforce is currently recruited to respond to and deliver the current system's requirements – e.g. the delivery of tasks often at set times. The health and care workforce has rarely worked across organisational or service boundaries. Teams and services are predominantly designed on traditional structures with little opportunity for empowerment and delegated decision making.

Recruitment and retention is difficult, especially so in the care sector where pay and conditions are poor and the sector is often not seen as a career choice. Health and care organisations will often target the same people to fill posts which puts them in direct competition with each other. This is especially true of providers within the care sector – the majority of staff who leave remain in the sector suggesting that they leave one provider to work for another. In addition, care providers compete in a workforce market with other sectors like retail, which often offer staff better pay and conditions. This is exacerbating the current workforce crisis.

Processes

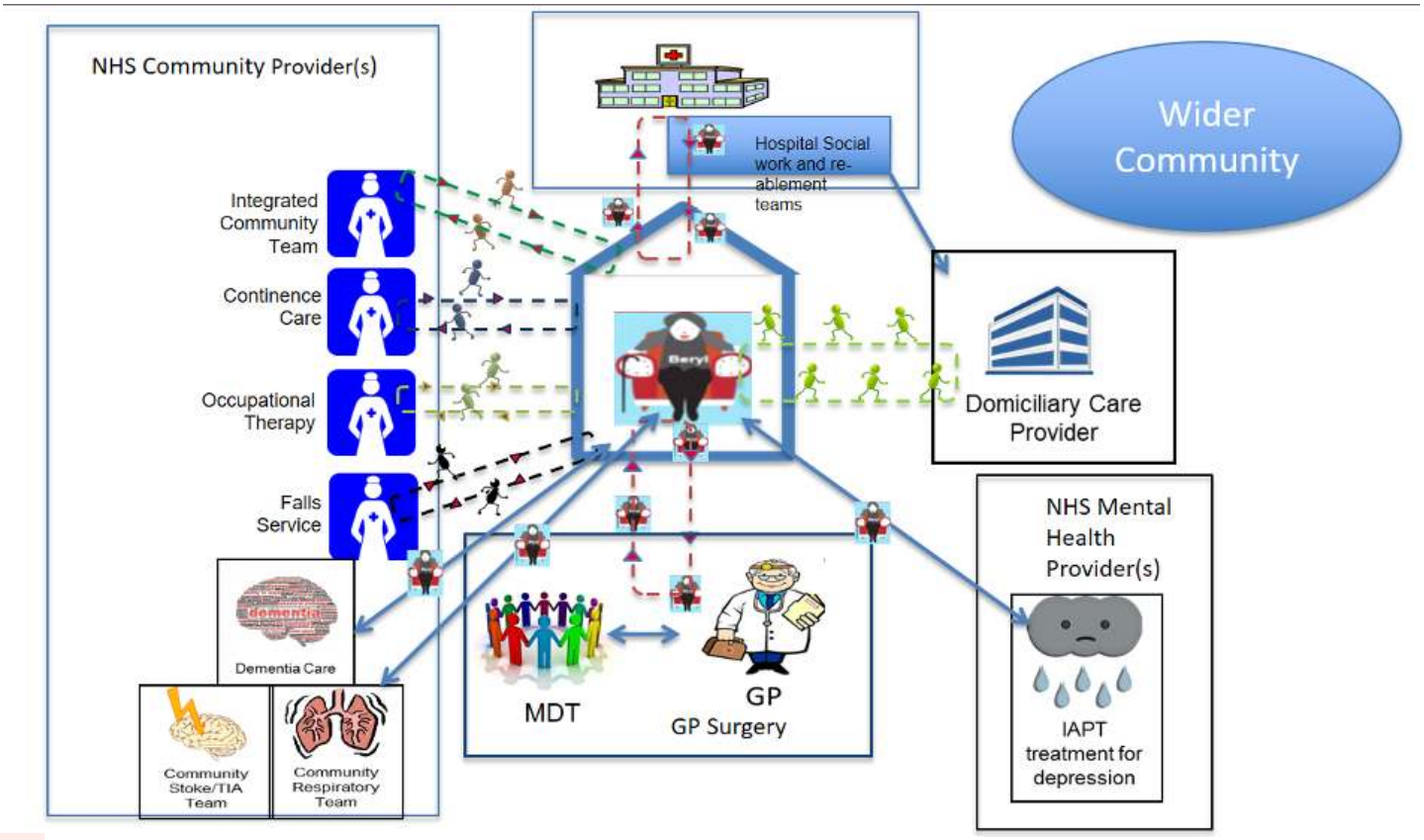
Existing processes enforce a traditional and rigid way of doing things, making it difficult for the system and individuals working within it to deliver the best outcomes for those requiring support. This includes assessments that are specific to organisations and services, referrals from one part of the system to another, performance metrics and targets that focus on throughput and output rather than outcome impact, computer systems that do not talk to one another, and budgets that are specific to that particular team remit or service. Many of the processes in place are disabling and reinforce an approach that requires significant redesign.

The current landscape

There are a number of services provided by health and care in Thurrock to people in their own homes. Due to the current system's design, people with a number of different 'needs' and 'conditions' will be in receipt of services provided by multiple professionals all working to different health and care requirements and specifications.

Figure 8.2, from a real case study, reflects the current fragmentation and duplication in the system – and the detrimental impact to the individual who experiences multiple different types of health and care staff entering her home to 'fix' different parts of her.

Figure 8.2



8.3 Our Vision for Transformed Home Care: Wellbeing Teams

An integrated, flexible and person-centred model

Our engagement work with residents has clearly demonstrated that those in receipt of homecare want a service that is flexible, treats them as a whole person, is based on long-term empowering relationships, and minimises the number of different individuals entering their home. We recognise that it is the system rather than individual services that need changing. Our redesigned system will work as one flexible entity with a focus on supporting people to achieve their version of a good life – regardless of their circumstances. Creating a system focused on people will mean that it will incorporate and respond to any aspect affecting that person's wellbeing. This means that we will have a system that extends its reach beyond the delivery of health and care and is flexible to respond to people and their different situations.

Thurrock has already developed and piloted a home support model that is flexible, person-centred and focuses on delivering what matters to the person. ***Wellbeing Teams*** were first introduced in 2019 in an attempt to deliver what we know as domiciliary care (home care) in a different way.

Wellbeing Teams operate in a completely different way to the traditional domiciliary care model, using learning from the Dutch *Buurtzorg* (literally translated as 'neighbourhood care' model). Buurtzorg is built around four building blocks for independence - based on universal human values:

- People want control over their own lives for as long as possible;
- People strive to maintain or improve their own quality of life;
- People seek social interaction; and
- People seek 'warm' relationships with others.

These values reflect and underpin how Wellbeing Teams operate.

Buurtzorg, and models like it, focus on small neighbourhood based teams (of no more than 12 staff members). They start by considering:

- What the person can do for themselves;
- What informal networks can offer; and
- What 'service' response is required – ensuring that the response if required is flexible and joins up with other professionals.

Teams are self-managed, organising themselves as required to provide the best response to the individual.

Whereas Buurtzorg models in the UK have tended to focus on 'health' provision, Wellbeing Teams provide a model based on the same principles but focus on people in receipt of domiciliary home care.

Thurrock has tested two neighbourhood Wellbeing Teams of 12 people within the Tilbury and Chadwell PCN area. Working with up to 200 hours each, they use the hours allocated to someone following initial assessment to work out the best solution for them. This means working with the individual to devise their own personal support plan – which can involve a mixture of formal and informal options and focuses on what matters most to them. For example it may mean that someone articulates that they want to continue to enjoy their garden or to connect with friends and family. Importantly,

Wellbeing Teams can work with people at all levels of complexity as all people are able to articulate and achieve what is actually important to them. Plans are reviewed regularly so changes can be made as often as is required. Their sub-locality geography allows Wellbeing Workers to develop a detailed understanding of the community assets and networks within their neighbourhood and connect their service users into them.

Because the teams are sub-locality based, Wellbeing Team workers develop a detailed understanding of the community assets within their neighbourhood and connect their service users to them. The small nature of the team allow workers to provide continuity of care and build long term care-relationships with service users, their families and the friends. This maximises opportunities for prevention and allows any deterioration to be spotted and addressed at the earliest opportunity.

The Wellbeing Teams model also responds to the workforce challenges faced by the current care model. It employs team members on salaries rather than hourly pay, and recruits according to values essential to the role, which in doing so attracts a range of people who would not have ordinarily considered a care role (50% of staff recruited to the two Wellbeing Teams had not had a role within the care sector before).

Evaluation of Impact

Early evaluation of the programme suggests some significant positive differences in outcomes for residents receiving care from a Wellbeing Team. Using the Thurrock Medeanalytics Integrated Datalake, we tracked the care journey over the course of the year 2019/20 of a cohort of residents cared for by a Wellbeing Team with cohorts receiving standard domiciliary care services based on the historical model, from either an externally commissioned provider or Thurrock Care at Home. Residents in each cohort were matched at the start of the study on age, other demographic factors and levels of acuity.

Figures 8.3 to 8.6 show the differences in rates of GP service access, unplanned hospital admissions, average length of hospital stay per admission and excess hospital bed days per hospital admission, between the three cohorts.

Figure 8.3

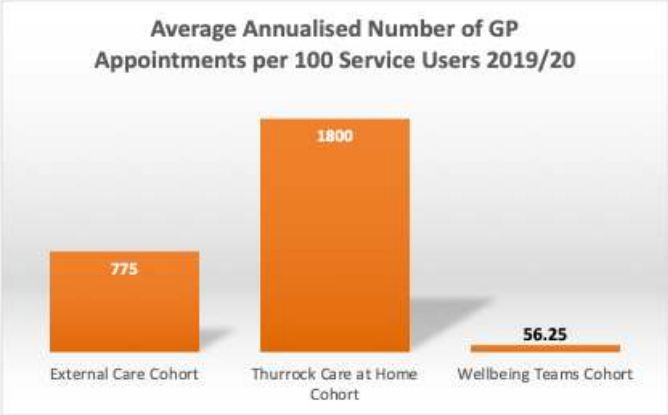
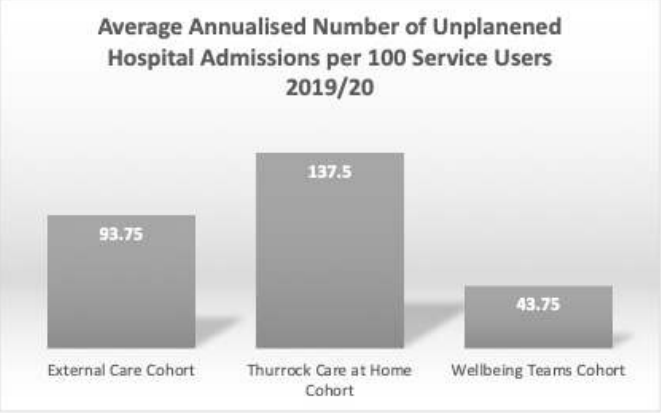


Figure 8.4



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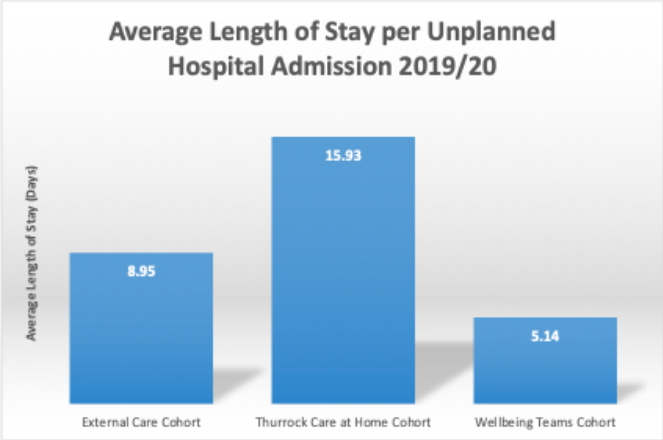
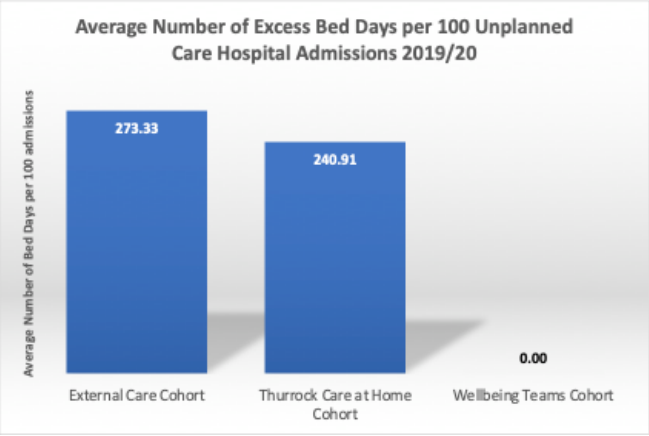


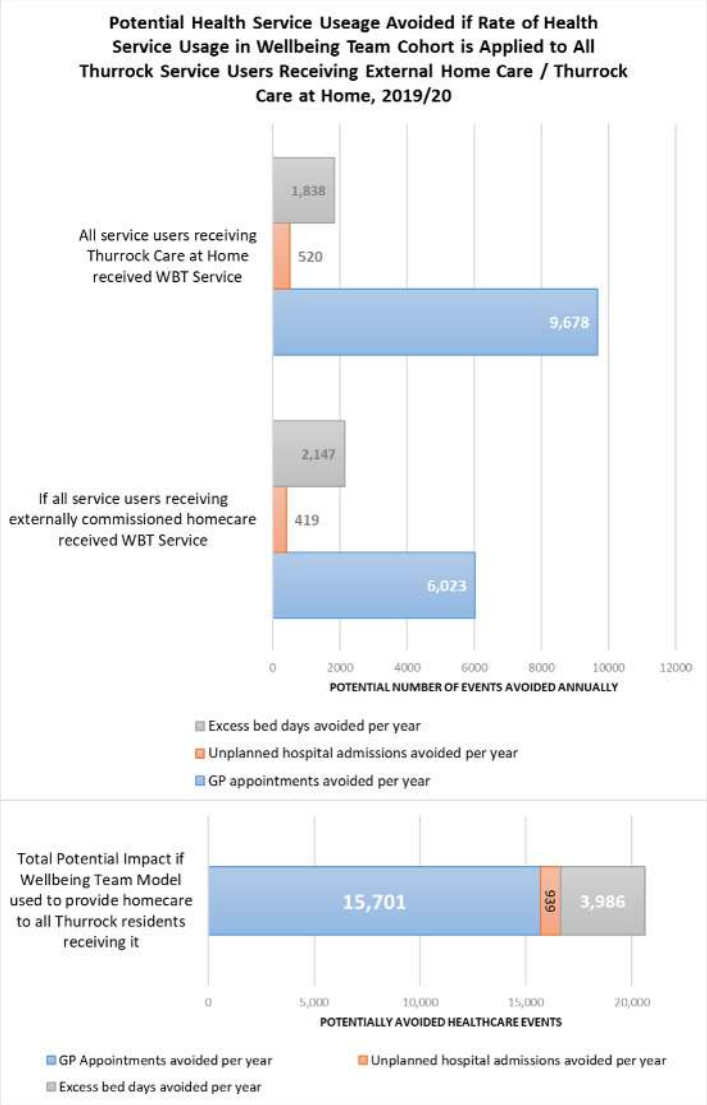
Figure 8.6



The Wellbeing Team cohort had almost a 14-fold and 32-fold lower rate of GP appointment use compared to the External Care and Thurrock Care at Home cohorts respectively. They were also three times less likely to be admitted to hospital as an emergency than the Thurrock Care at Home cohort and more two times less likely to be admitted to hospital as an emergency compared to the cohort cared for by externally commissioned providers. When they were admitted, their length of stay in hospital was considerably lower and unlike the other two cohorts, they experienced no excess bed days.

Whilst highly encouraging, some care needs to be taken before over-interpreting the potential positive impact of Wellbeing Teams compared to historical care models as the numbers in each cohort were relatively small given that the Wellbeing Teams Pilot only consisted of two teams. However, if further larger scale evaluation were to confirm these results, the positive impact, if we extrapolate them across all Thurrock residents in receipt of a domiciliary care package, is significant. Figures 8.7 and 8.8 demonstrate this potential impact of replacing historical domiciliary time and task care models with Wellbeing Teams. We have modelled the low rates of GP and hospital admission/use that the evaluation found in the Wellbeing cohort across all residents in receipt of a homecare package in 2019/20 to estimate the potential total number of GP appointments, hospital admissions and excess bed days that could be prevented and the associated costs saved to the health and care system as a result.

Figure 8.7.



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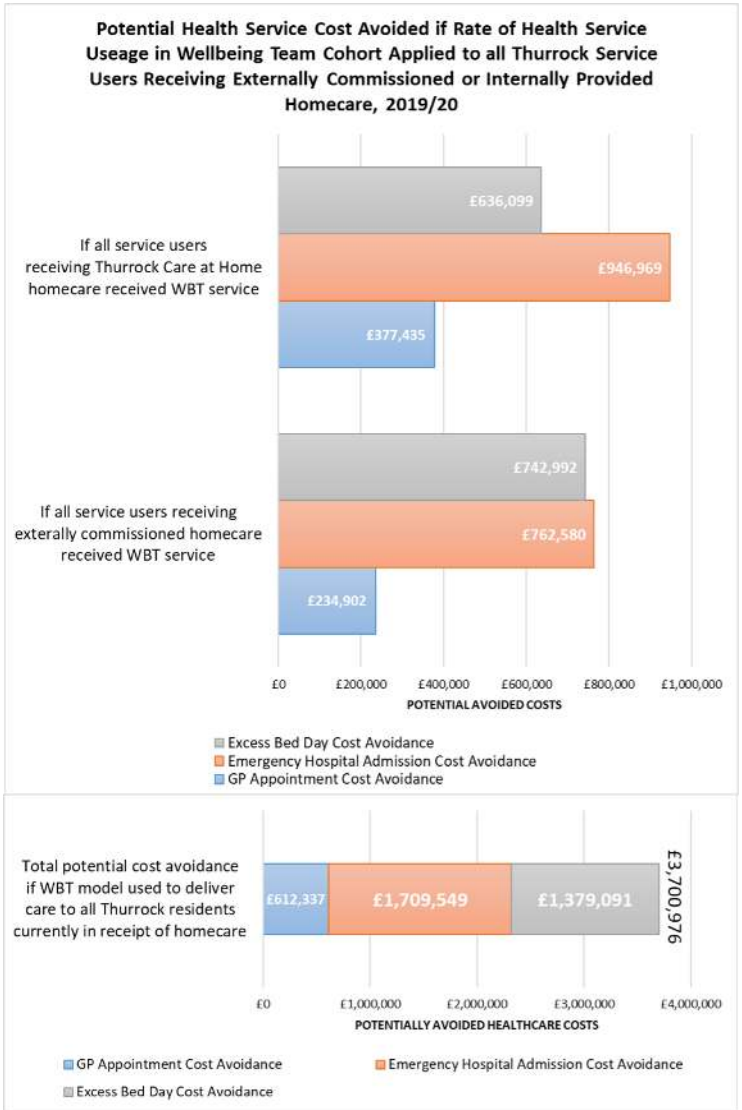


8.4 Further expansion of the Existing Wellbeing Teams Model

Caring for Thurrock (formally called Thurrock Care at Home)

We will start expanding Wellbeing Teams through transforming Thurrock Council's in-house homecare provider - ***Caring for Thurrock*** (formally called 'Thurrock Care at Home') to deliver an approach based on the same principles as Wellbeing Teams – ultimately developing in to Wellbeing Teams.

Caring for Thurrock currently delivers 1200 hours of home care per week – mainly to the Tilbury and Chadwell PCN area. It also acts as the provider of last resort, providing a contingency for external providers who may hand back contracts and hours or fail. *Caring for Thurrock* provides a service based along traditional lines.

Caring for Thurrock suffers with the same workforce challenges as external provision. The majority of staff have less than 5 years' experience, the service relies heavily on overtime to meet demand and 36% of the existing workforce will be eligible to retire within ten years' time.

Caring for Thurrock has a transformation plan in place which aims to respond to current challenges and aims to further test the Wellbeing Teams approach. As a result of current Provider Service structures, a phased approach will be used to move the service to a Wellbeing Teams model.

The first phase of the approach will see four locality based teams being implemented in the Tilbury and Chadwell area. The focus, in keeping with the Wellbeing Teams model, will be on achieving outcomes rather than completing tasks. The service will not be time limited and will therefore not hand over from one team to another; instead, one team offering a more holistic service and ongoing reablement continuously supports the person from day one and promotes their choice, independence and wellbeing. Workers will be upskilled and given more autonomy to enhance their job satisfaction which should assist with job retention and recruitment.

Following testing of the above approach, *Caring for Thurrock* Community Teams will move in phase two to adopt the full Wellbeing Teams model.

External Provision

We will work to shape the market to reflect the home support model we require, developing an integrated commissioning strategy that will enable the market to reflect the vision set out in this strategy.

We will work with our providers to test the development of the integrated support model in the market place. This initially will consist of a pilot project with one of our existing homecare providers. We have already started early discussions with providers to test this new approach.

Through an integrated commissioning strategy we will develop the market to provide choice and flexibility. With 60% of care being provided externally, the market must be sufficiently developed as must the way in which we commission what we need provided.

Cost of Expanding the Current Model Borough Wide

In order to compare the relative costs of current externally commissioned care, Caring for Thurrock and Wellbeing Teams, we have calculated the cost per hour of delivering direct care to residents through each model, incorporating all on-costs including management support and staff development, and expressed this as an hourly cost of care.

For 2022/23, **Wellbeing Teams will cost £32.12** per hour of direct care provided. This is significantly less than the **Caring for Thurrock overall direct care rate of £41.67** per direct care hour, although it is worth pointing out that the current acuity of residents accessing C4T services is likely to be higher as the service also provides care through the Joint Re-ablement Team and to the Piggs Corner Extra Care facility. **Externally commissioned care is the least expensive at an estimated £19.00 per hour** for 2022/23.

We can then calculate the overall cost impact of replacing the current ASC domiciliary home care provision with directly employed Wellbeing Teams for all Thurrock residents in receipt

Table 8.1

	Historic Externally Commissioned Care model @ £19 per hour	TC@H historic model @ £41.67	Directly Employed WBTs @ £32.12 per hour	TOTALS	Difference from Thurrock Council Baseline
Predicted 2022/23 Costs if Current Arrangements Retained	£8,858,408	£3,157,086	£1,125,742	**£13,141,236**	**£0**
Cost to Thurrock Council if only TC@H switched to WBT model	£8,858,408	£0.00	£3,559,281	**£12,417,689**	**(£723,546)**
Cost to Thurrock Council if only externally commissioned care switched to WBT model	£0	£3,157,086	£16,101,114	**£19,258,199**	**£6,116,964**
Cost to Thurrock Council if all care provided through a directly employed WBT	£0	£0	£18,534,653	**£18,534,653**	**£5,393,418**

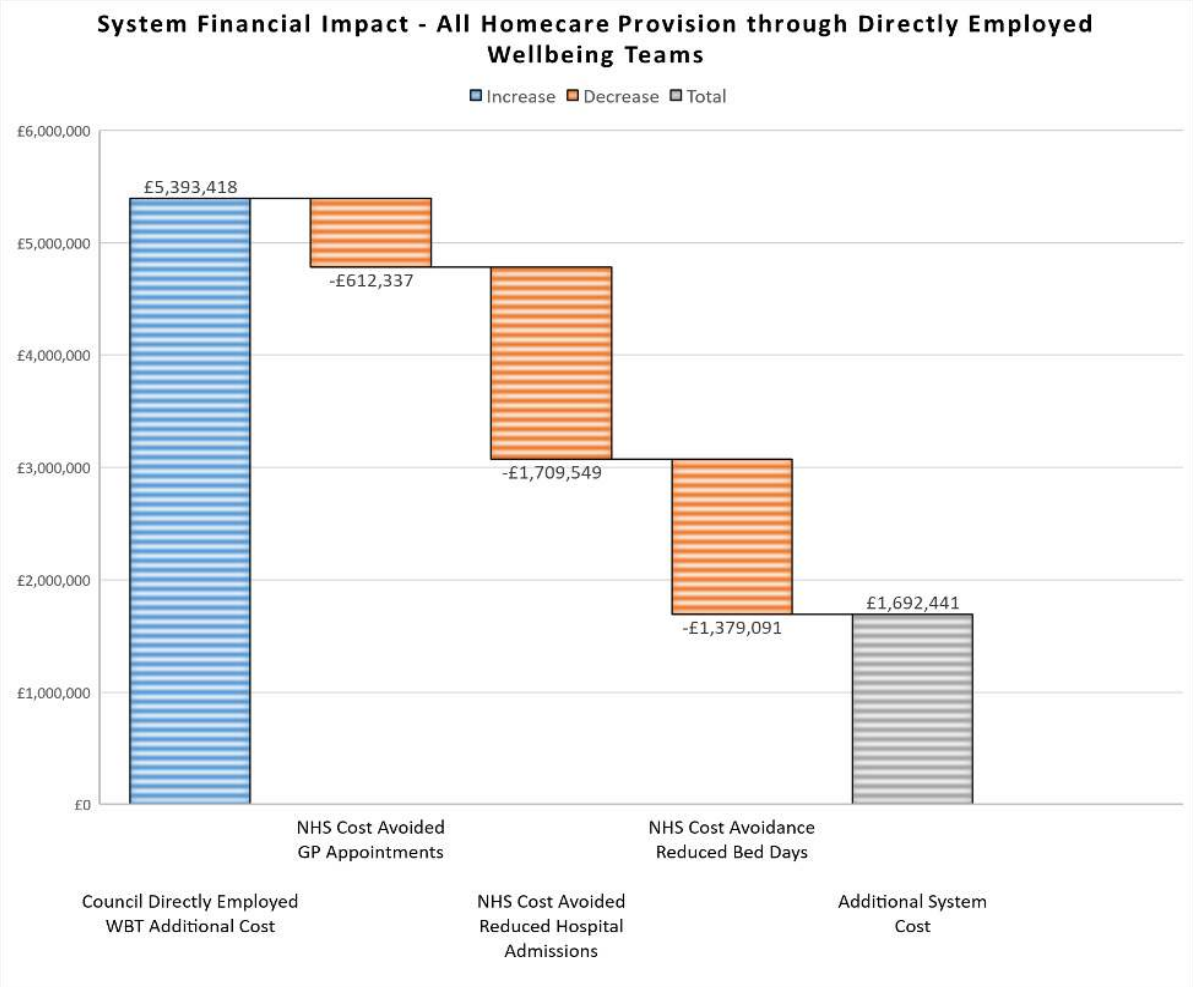
We calculate that replacing the current Caring for Thurrock model with a Wellbeing Team model has the potential to deliver over £723,000 savings. However, if we replaced the significantly cheaper externally commissioned care with a directly employed Wellbeing Team model, this would cost an additional £6,117M. The overall impact of replacing all current homecare provision with a directly employed Wellbeing Team to the council is a requirement to increase the homecare budget by an additional £5.393M per year which is currently unaffordable (Table 8.1).

However, early evaluation suggests that the Wellbeing Teams model has the potential to deliver savings to the NHS through delivery of better outcomes for residents and avoided subsequent GP and hospital usage. By using the modelling set out in figures 8.6 and 8.7 against cost differentials between Externally Commissioned Care, C4T and Wellbeing Teams, and the numbers of hours of care currently delivered by each service model, it is possible to estimate the costs of providing a Wellbeing Service to every Thurrock resident currently receiving domiciliary home care.

With potential new financial freedoms that Integrated Care Systems can bring and a requirement to consider *system* rather than *organisational* budgets, there may be an opportunity to build a system business case to fund Wellbeing Teams, given that they deliver potential cost savings to NHS outcomes as well as better outcomes for residents.

We have therefore modelled the cost of the entire Wellbeing Teams model to the NHS and Social Care system in Thurrock (figure 8.9), including potential savings that accrue to the NHS. This brings the overall Thurrock health and care system cost of providing all homecare through a directly employed Wellbeing Team model down to £1.692M per year which is more affordable to the health and care system than it is to Thurrock Council alone, but still would represent a significant cost pressure.

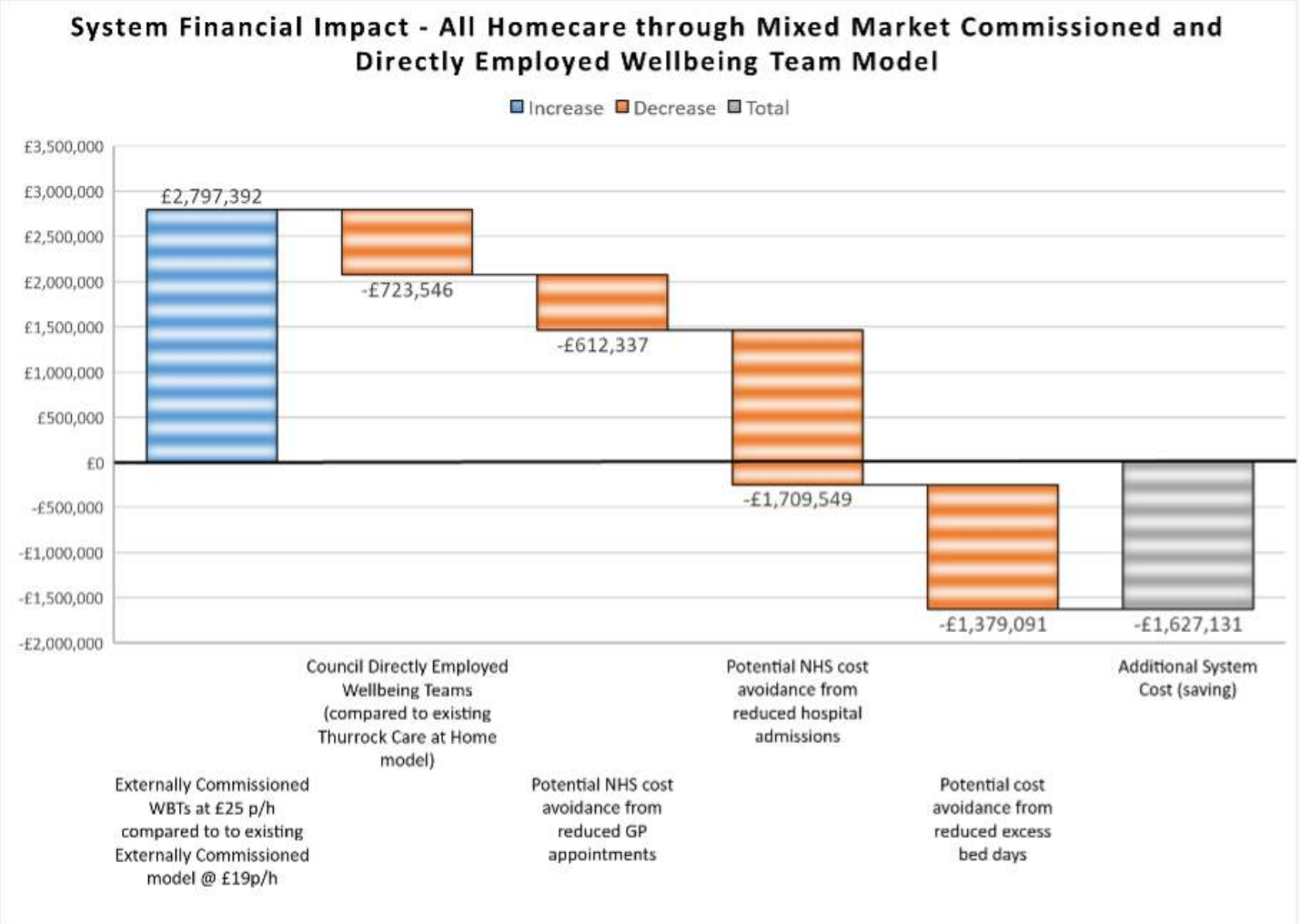
Figure 8.9



Retaining a level of in-house provision for homecare brings significant advantages in terms of control and ability to 'test and learn' new innovation and has served the local health and care system extremely well in being able to mitigate the pressures of the COVID-19 pandemic. However, directly employing staff on Thurrock Council or NHS contracts is usually more expensive than commissioning external care agencies. It may therefore be possible in the future to shape the local care market and to deliver Wellbeing Teams through a mixed market model of directly employing some Wellbeing Teams and commissioning the best external care providers to deliver a Wellbeing Team model. We accept that the costs to commission a Wellbeing Team model are likely to be higher for external care agencies, and we have modelled the overall impact of commissioning Wellbeing Teams through external providers at £25 per hour; a £6 per hour increase on the current rate.

Figure 8.10 shows the potential impact of this mixed externally commissioned and directly provided model.

Figure 8.10



At £25 per hour for an externally commissioned Wellbeing Team provision (a £6 per hour uplift) is set against system savings for all other elements of the model, the overall impact is a potential £1,627M system spend reduction that could be reinvested into further prevention, whilst also delivering a better care model to residents.

As previously stated, the current model has been built using evaluation data over only one year based on a relatively small sample size. In order to ensure that any future commissioning is based a more robust model, we will continue to collect evaluation data over 2022/23 with the view to bringing forward a system business case for roll out of Wellbeing Teams borough wide from the last two quarters of 2023/24.

8.5 Further Transformation of the Existing Wellbeing Team Model

The current Wellbeing Team model describes an approach that relates to people in receipt of a social care domiciliary care service. As it is now, the model does not enable an integrated approach across health and care to be delivered. This means that a number of different professionals could still potentially visit a person, all working to different processes and requirements. To address this, we want to increase significantly the functions of existing Wellbeing Teams to include tasks historically undertaken by health professionals to create truly holistic and self-directed 'Health and Care Wellbeing Teams'

8.5.1 Core Functions of a Transformed Health and Care Wellbeing Team

Blended Roles: *A Health and Care Wellbeing Worker*

There is considerable opportunity both to upskill existing Wellbeing Team workers to undertake certain tasks and activities currently carried out by other health professionals thus improving continuity of care, reducing duplication, and freeing up specialist capacity.

Blended roles across traditional health and care team/organisation functions allow staff to expand their skills to enable them to undertake both routine clinical and care tasks as well as using time allocated to focus on supporting the person to do things that enhance their wellbeing.

In order to implement this, we will undertake a scoping exercise to identify residents who are currently receiving support from different service areas at the same time and ascertain the opportunities for a new *Blended Health and Care Wellbeing Worker* to undertake more of these tasks whilst supporting the resident

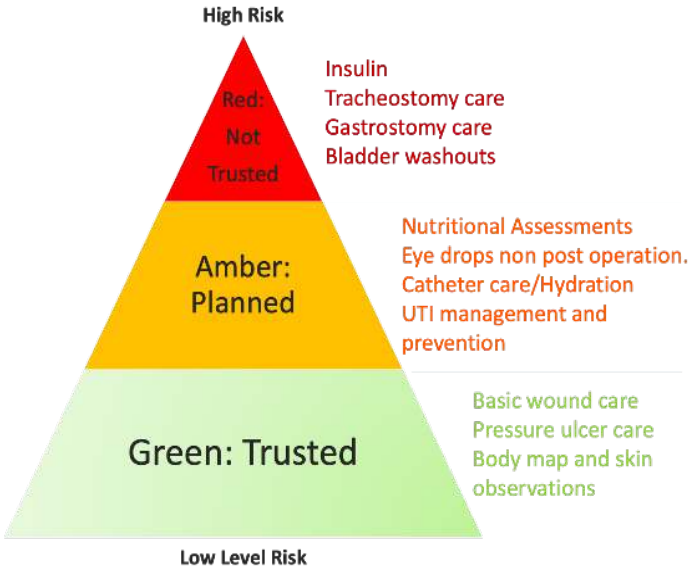
This will reduce the overall number of visits needed, freeing up NHS capacity, and rationalising the number of people potentially involved with the same resident and improving care continuity. In addition, blended roles can have a greater role in identifying signs of deterioration and using technology to monitor vital signs – all helping to prevent, reduce the delay the need for health and care and helping to avoid crises.

In order to create a blended *"Health and Care Wellbeing Worker"* role will require staff training and skills development but also offers the opportunity of career development, higher status, higher pay and more variety and responsibility compared to the traditional domiciliary care worker. This in turn provides a solution to the current workforce crisis in social care, hopefully attracting and retaining staff.

Thameside Council implemented a '*blended roles trail blazer*', looking at high intensity users receiving a service within their home from both health and care providers. They identified tasks, starting with those requiring a low level of expertise – but also identifying tasks of medium and high complexity that with training they felt care staff could deliver (Figure 8.11).

The pilot showed significant 'repurposing of community nurse visits and a positive impact on staff and residents receiving support.

Figure 8.11



We will test a blended roles approach the learning from which will be used to further develop the Integrated Support model. Test and learn work will also take place with existing external providers – again with learning used to develop future commissioning and procurement approaches.

Potential future expansion to the role could see teams taking on responsibility for housing-related issues and Mental Health concerns, forming a truly multi-disciplinary team much more adept at dealing with a number of commonplace issues without requiring the involvement of other parts of the system. These roles would have access to specialist support when required for any complex needs that fell outside of their remit.

In addition, their neighbourhood-based deployment would open up the opportunity to support others, for example those who are socially isolated or those who have recently come home from hospital and are without formal or informal support, maximising their presence on the patch to deliver prevention and early intervention alongside their main function.

Hospital Discharge Planning

Delayed discharges in Thurrock have remained incredibly low throughout the COVID-19 pandemic; testament to our transformation work to date. However the current hospital discharge pathway is fragmented with multiple handoffs. A resident leaving hospital may be discharged into a community bed, then the hospital bridging service, then a separate reablement service and then receive an externally commissioned homecare package.

In future, any resident admitted to hospital will be flagged immediately to the Wellbeing Team, who will be responsible for liaising with the hospital and resident to commence discharge planning, including brokering appropriate health, care and third sector with the aim of early discharge back home.

This will allow proactive 'pull through' of residents from secondary care back into the community as soon as possible

The discharge process from hospital will be reviewed as part of the development and scope of Wellbeing Teams – linked to the deployment of reablement. This will aim to ensure that the:

- Assessment of ongoing support needs is made at home rather than a hospital setting (unless there is a specific reason for this not to happen);
- A period of stabilisation at home prior to a longer term assessment; and
- A multi-agency approach is established so that discharge arrangements are coordinated and integrated from the earliest point.

Reablement

Reablement is the care and therapy process through which residents' physical and mental functionality and wellbeing is maximised following a spell of serious illness. Currently, reablement is provided through a separate Joint Reablement Team following an assessment of individuals typically leaving hospital. The assessment follows a medical model and defines reablement in medical rather than holistic terms.

The existing system incorrectly assumes that not everyone has the capacity to be re-abled and that reablement should be time limited. In reality, almost everyone has some reablement capacity – which may require only a few days or can continue for many months or even years.

We believe that everyone leaving hospital should be seen as having reablement potential. This means that in future, reablement should be unique and tailored to each individual, be articulated by the resident, and form part of an integrated support plan.

Our new model for Integrated Support in the Home will incorporate reablement within Wellbeing Teams, seeing it as integral to on-going care and support rather than a separate, time limited function accessed only by those who meet a pre-defined threshold. Reablement will be explicitly linked to the goals that the resident wishes to achieve; the goals that align with their vision of a good life.

There will be a range of reablement requirements – some requiring support that cannot be offered by the Wellbeing Team itself. Colleagues providing specialist support will be part of the locality network and will work alongside the Integrated Support Team so that the right solution can be delivered and that it is delivered in an integrated and coordinated way. Staff will have the ability to pull in those sitting outside the immediate Team if required – ensuring join up.

Community Nursing: The Integrated Community Team (ICT)

As we discussed in Chapter 7, we will align current community NHS health provision will be aligned with each PCN locality and form part of a health and care locality network. This will include enabling integrated care and support plans and a blended roles approach.

NELFT's Integrated Care Team (ICT) current provides a wide range of nursing care to people who are unable to leave their homes even with the support of family, friends or carers – including people who are likely to decline rapidly or be at crisis point. The service's response includes wound management, administering injections, catheter care and end of life delivered largely by Community Nurses and Health Care Assistants.

We have already discussed how *Health and Care Wellbeing Workers* could be trained to undertake some of these tasks. In our new model of care, ICTs need to be able to work alongside Wellbeing Workers and other resident facing staff in a seamless way. We will also align the current ICTs to Wellbeing Teams with a named Community Nurse for each team able to undertake more specialist clinical tasks and provide clinical advice to the team.

Integrated Care Plans

To support this integrated health and care approach, we will develop single integrated care plans for each resident who needs one, linked to goals that the individual has identified for themselves and their overall wellbeing. Where appropriate, this will include informal support provided by and within the community.

The Integrated Care Plan will have a single named individual to act as care coordinator for the plan. The care coordinator will be the most appropriate person for the resident depending on their needs and wishes and could be a Health and Care Wellbeing Worker, Community Nurse or other professional. If more than one professional is involved in delivering care to residents, a decision will be made about who is best to coordinate the Integrated Care Plan and who is best placed to deliver tasks and outcomes. For example, it may be an upskilled Wellbeing Worker who now delivers a task historically undertaken by a health professional (blended roles).

This new integrated model will improve care continuity, rationalise the number of different people entering the resident's home and shift from time and task focussed community health care to a truly holistic model.

8.5.2 Additional Support that can be brokered into the Wellbeing Team

GPs and PCN Support

GPs and Primary Care Networks play a vital role in the development of integrated support in the home. Linking with other professionals across the network – including providers, social workers and a range of health professionals, they often provide the vital link between all parties and are often the first point of contact for someone requiring additional support.

PCNs and GPs will also be key to providing the advice and support required by others – such as Wellbeing Teams. Whilst time will be required to provide advice and support, benefits should include a reduction in the people supported needing GP appointments or GP interventions with far more taking place in the person's home through teams providing support to the individual.

This will enable far more to be done in the person's home rather than in the surgery – including checking for and monitoring vital signs and deterioration to prevent, reduce and delay the need for greater health and care support and intervention. GPs and PCN staff can also play a key navigation role in identifying the professional who should take the lead in someone's care. GPs will often be aware if someone is requiring some support as they are isolated or recovering from poor health but with no support. This information will be vital if the system is to prevent, reduce and delay the need for care and support.

Specialist Teams

There are currently a number of 'specialist' condition-specific teams that provide support to people in their home – or provide a hybrid model where support in the home will be provided if required. Current provision includes the Older Adult Health and Wellbeing Team; Dementia Crisis Support, Secondary Care Mental Health and the Urgent Community Response Team. The Teams that provide a hybrid model and provide support in the home if required are: Diabetes, Dietetics, Epilepsy, Equipment and Home Loans, Falls, Heart Failure, Pulmonary Rehabilitation, Home Oxygen, COPD, Targeted Lung Health, Tissue Viability Service, Early Supported Discharge, Adult Speech, Parkinsons, Continence Service.

In our transformed model, Specialist Teams although not necessarily locality-based, dependent upon the specialism and size of team, will form part of the Integrated PCN/locality Teams discussed in Chapter 7 and build good relationships with other health and care professionals operating in the patch. Formal referrals to specialist teams will not be necessary and their input will be 'brokered into' the Wellbeing Team by the named individual responsible for coordinating care to provide advice and support rather than residents needing to navigate their way through separate pathways. Any specialist support will form part of the single integrated plan overseen by one professional taking the lead as overall 'coordinator'. There will be a constant focus on reducing or aligning visits, preventing hand-offs and removing the need for onward referrals.

Voluntary and Community Sector

The Voluntary and Community Sector will form a vital part of any support arrangements and be a key part of support delivered within the home. Existing services run by the VCS such as *By Your Side* are already playing a critical role in the borough, facilitating hospital discharge and preventing readmission by providing essentials such as basic food provisions and ensuring appropriate equipment has arrived and making sure residents' homes are safe, warm and ready to welcome them.

The service consists of paid staff and volunteers. Welfare visits also take place so that any arising issues can be dealt with before they lead to or contribute to crisis. Services such as By Your Side will work as part of the Integrated Support in the Home model and not be separate to it. They have had significant success in reducing readmissions.

Technology

Technology is a key enabler and will be used to aid a preventative and integrated approach to the provision of support in someone's home.

Health and care have a successful and innovative Technology Enabled Care group in place. This ensures that a range of technological options can be tried and tested – enhancing existing health and care solutions, or enabling new solutions to be developed. For example this may include tools such as Whizan, which enables the monitoring of vital signs. There are a range of technologies that will be tried and tested as part of the development of integrated support in the home.

8.6 Implementation and Impact

Figure 8.12 shows the overall model for transformed Wellbeing Teams including core and brokered functions.

Figure 8.12

Adopting a Human Learning Systems approach

We are committed to adopting the principles of HLS in delivering this transformation. Being self-directed, resident facing staff working within or providing brokered support into Wellbeing Teams will be freed from constraints of thresholds or standard operating procedures and empowered to deliver human, bespoke solutions based on goals agreed in partnership with the resident. This ultimately will deliver better outcomes, reduce duplication and prevent 'failure demand'.

We will empower front line staff to build on the principles and vision set out in this chapter to develop solutions that work for Thurrock residents. Two senior nurses have already been seconded to a project to test a new way of working alongside other health and care colleagues within PCN areas. Their remit is to challenge and identify how the existing model of community health can and should change and what that looks like at a locality level. The learning gained will inform how best to implement the transformation.

Enabling partners to work together and develop shared responsibility for people requiring their support is key to making best use of available resource and to improving people's outcomes. This means that specialist expertise will only be pulled in when required, and staff having the greatest interaction and relationship with the individual will be able to build a care coordination role. They will also be able to learn from those they are working with so that they have a better understanding of how to improve outcomes and identify issues early.

Some of this will need to be quantified through testing, but the approach will release specialist capacity which in turn will speed up throughput and reduce delay. The approach will also enable partners to work together to develop integrated solutions that prevent referrals and duplication and allow individuals to be far more preventative.

Our 'Ask' of System and Alliance Partners

Achieving what is set out within this chapter requires the following from system partners at all levels:

Integrated Care System

- Delegate necessary responsibilities to the local system;
- Accept the need to change existing 'system conditions' to enable best use of resource and the achievement of best outcomes for the individual – e.g. delegated or redesigned performance and contract management, reporting requirements, delegation of budgets and budget integration etc;
- Work with Thurrock to redesign hospital discharge pathways to support the Wellbeing Team model including early identification and flagging of residents admitted to hospital so that discharge planning can commence at the earliest opportunity.

Local Alliance Partners (Place)

- Enabling and supporting staff to embark on a 'learning' approach to developing alternative ways of delivering support within the home and ensuring people are able to achieve outcomes that are most important to them;
- Overcoming barriers that stand in the way of making necessary change;
- Reducing organisational sovereignty so that people feel part of a single place team rather than just an organisation.

PCN / Locality / Neighbourhood Partners

- Commitment to work as part of a locality network;
- A commitment to genuine co-design. Ensuring that nothing is implemented in a top down way but involves all of the community at the earliest possible stage.
- Full involvement of all working in the locality area and communities themselves (especially those in receipt of services) to ensure the development of community-led solutions and operating models;
- Commitment to adopt a HLS approach to testing and learning;
- Pooled budgets by locality to allow easier integration of support solutions.


SUMMARY OF STRATEGIC ACTIONS
8.1
We will expand Wellbeing Teams through transforming Thurrock Council's in-house homecare provider - Thurrock Care at Home, to create eight additional locality based Wellbeing Teams in Tilbury and Chadwell.
8.2
We will collect wider evaluation data on the impact of the Wellbeing Team model throughout 2022/23 in order to create a robust system impact model.
8.3
We will bring forward a system business case based on our system impact model to allow roll out of Wellbeing Teams borough wide from the last two quarters of 2023/24.
8.4
We will work shape the external care market with a view to commissioning the Wellbeing Teams model externally. This initially will consist of a pilot project with one of our existing homecare providers.
8.5
We will further transform the WBT Model to create *Health and Wellbeing Teams* with a blended Health and Care WBT Worker roll upskilled to deliver both routine health and care tasks
8.6
We will transform the hospital discharge care pathway and embed responsibility for Reablement and Hospital Discharge Planning within the Wellbeing Team in conjunction with the ASC Hospital Team.
8.7
We will align current Community Nursing (Integrated Care Team) functions to Wellbeing Teams with a named Community Nurse for each team.
8.8
We will implement Single Integrated Care Plans between NHS, ASC and the 3rd sector, with a named care coordinator and systems to broker specialist support into the team to minimize referral and handoff.
8.9
We will maximise use of community assets, voluntary sector support and technology enabled care as part of a holistic package of home support within the Wellbeing Team.

Chapter 9: Reimagining Supported Living, Residential and Intermediate Care

Dignity and independence with more intensive support

Chapter 9: Reimagining Supported Living, Residential and Intermediate Care

9.1 Introduction

In this chapter, we describe our plans to re-imagine how we deliver older people's housing, supported living, and residential and intermediate care including our proposals for an "Extra Care Plus" facility at the Whiteacres site in Thurrock.

Thurrock is a place that has an ambitious plan for improvement and growth as illustrated earlier in this strategy. The Thurrock Integrated Care Alliance recognises the need to support people for as long as possible within their own homes, and we have already achieved significant success with this objective as set out in Chapter 8. However, for some, there remains a need for more round the clock health and social care to be available, and these need to be provided to the highest standard, enabling people to retain the independence and control they desire.

This includes greatly enhancing the offer we make to our older residents and other groups who cannot be supported in general needs housing. It means ensuring genuine accommodation choices that meet the aspirations of our residents for their later life, and high quality intermediate care and supported living facilities when residents need them.

In Thurrock, as elsewhere, demand for care is rising inexorably not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia. The total number of years people can expect to live in poorer health is steadily growing. The pressure this is placing on health and care services and budgets has been documented for some time. As an Alliance, we are considering how our whole range of functions, and the strengths and assets within our communities, can enable our older residents to enjoy a good life in old age.

What is needed is new thinking about ageing well in our communities, recognising that the so called baby boomers who have built their homes and lives in Thurrock, will want to look forward to their years in the 21st century, no less in command of their futures. We need to reimagine how we transform and integrate housing and care in older age with a much greater plurality of options to support choice. Factors driving the need for transformation include not just an ageing population but also:

- The increasing complexity of providing for multiple medical conditions;
- Insufficient capacity for the provision of care across the system;
- A residential care market unable to sustain the current levels of care under the current funding model, with an ageing care home estate, and declining investment in new facilities;
- A health care system primarily designed to treat ill health rather than prevent, reduce and delay the need for care;
- Difficulty recruiting and retaining social care staff – carers in particular; and
- The intense pressure on successfully discharging people from hospital to deal with the exponential demand for acute services; particularly as we move from COVID pandemic to endemic status.

9.2 Specialist Housing

There are many gains from a programme of new housing specifically designed for older adults: manageable, accessible, warm homes with low running costs and bringing a lower risk of falls and accidental injury, will enable individuals to maintain their independence, see income go further, and avoid unnecessary admissions to hospital and care homes. For many older people, purpose-built accommodation also brings a social life that protects against isolation and loneliness. And, for some, it also means releasing capital to make life easier in retirement.

Of course many will be safe, healthy and happy growing old in their existing home, adapted if necessary to their health and care needs. This may be the best choice and must be respected. However there are also a significant number who would be safer, healthier and happier moving home, and growing old in a different property more suited to their needs. They should be supported to do that. Whatever their choice, Thurrock recognises that our older citizens will increasingly want to:

- stay in control;
- prepare in good time to step up to the next stage in their lives;
- have a choice of homes that support their health and well-being.

9.2.1 Achievements to date: an exemplar scheme at Bruyn's Court

As part of its ambitious transformation programme, the Council has invested in aspirational housing developments, specifically designed for older people, in South Ockendon and Tilbury.

Designed in line with the recommendations of the report Housing Our Ageing Populations (HAPPI)[1], Bruyn's Court provides 25 self-contained, one and two bedroom flats, located close to South Ockendon town centre amenities, and overlooking a courtyard garden. The flats are designed to wheelchair accessibility standard, are easy to heat, and to keep cool in summer and each has a private balcony or terrace garden. A communal lounge is provided to facilitate art and craft work, and social events. Residents can receive care and support in their home from visiting services, including Well Being Teams and community nurses.

A further benefit of developments of this type is that they enable people to "right size", often freeing up larger homes which can be more costly to heat and maintain. These homes are much needed by families. The Council and its partners are keen to explore the possibility of developing similar schemes in all parts of the Borough.

Bruyn's Court Design Considerations

Ease of access

- The building is designed to be easy to navigate and accessible for all. An open main entrance with direct access/views to the garden room and the garden beyond gives on to the vertical circulation cores.
- Flats are clustered around two vertical access cores. The provision of two cores negates the requirement for corridors. Circulation space benefits from excellent natural light and ventilation.
- Sensitive use of colour differentiation and wayfinding between different areas of the building will be considered as part of the interior design to support residents with dementia.

Garden Aspect

- All flats are arranged with a western view across the adjacent garden.
- Generous, full width balconies provide attractive private amenity looking out across the garden.
- A large proportion of the flats are dual aspect.
- A communal garden room on the ground floor provides residents with a space for socialising with direct views and access to the garden.

Typical Dwelling Plans

- Generously dimensioned hallways.
- Large store, adaptable as a wheelchair storage space.
- Oversized to allow for adaptation into a fully wheelchair accessible bathroom, plus 'soft spot' in master bedroom partition.
- Kitchens are generously proportioned to provide ease of circulation for residents who are mobility impaired or use a wheelchair.
- A sliding screen gives an open, spacious quality. Flexibility of use for second bedroom.
- All rooms open onto a generous external balcony overlooking the new communal garden.
- Windows to the kitchen allow for natural light and allow views to the communal areas.
- Shelving/seating adjacent to flat entrances

9.2.2 The role of the private sector as development partners

Local Housing Authorities and their partners can only provide a small proportion of the new homes that will be needed by an ageing population. In recognition of this Thurrock held a Developers' Summit to mobilise support for a private sector housing development programme specifically targeted at older people. The Summit received presentations from the Homes and Communities Agency, the co-authors of the HAPPI Report, PTE Architects and the Council's Director of Planning, spoke about the need to drive up quality and to address the housing needs of older people. A commitment was made that if developers would work with the Council to improve the quality of housing for older people, the Council could offer a range of help including:

- Providing profiles of the housing needs of older people in Thurrock's communities
- Engaging with local people so that they understand the benefits of specialised housing for older people
- Flexibility in relation to planning requirements, for example, parking if the site is well served by access to local facilities and transport
- Exploring the potential for joint ventures with private sector developers
- A one-stop service to facilitate scheme discussions at any point, not just at the pre-planning application stage.

The Council's Assistant Director of Adult Social Care summarised the challenges and opportunities:

- The health of older people is exacerbated by poor housing, particularly poorly-heated homes, making older people vulnerable to conditions such as respiratory and cardiovascular diseases, more likely to have falls and fractures, and to be less active and, as a result, more socially isolated and depressed
- The opportunity provided by Thurrock's regeneration & housing development programmes to create well designed, well insulated homes to mitigate many of the problems associated with ageing
- Significant numbers of older residents have equity in their homes and, if the offer is right, may want to invest in a new home with all the benefits that will result in terms of positive health outcomes.

Thurrock's previous experience demonstrates a demand for good quality housing for older people; a 65 unit Extra Care Housing scheme had seen the 18 shared ownership flats sold in a very short space of time through the government's Homebuy scheme.

Learning from the Developers Summit: Key Discussion Points

- Flexibility is key; not just in terms of the product but also in financing and management.
- A real obstacle is that we currently don't have the right product and so it is difficult to demonstrate there is a demand for it.
- Significant numbers of older residents choose to occupy two rooms because of the heating costs, so there may be pent up demand for more manageable sized homes.
- There is a real difficulty in describing the product as retirement housing because increasing numbers of people will be expected to work beyond 65.
- Research into the types of housing older residents want would help to refine the range of products which may be needed (from small developments of flats to 150 unit extra care schemes). It could also clarify how best to market them.
- Ideally, specialised housing would be developed on larger sites to ensure a mix of dwelling types and house prices.
- Research could also give useful information about what housing might come back onto the market if older residents move to specialised housing, so helping to inform the broad mix of development needed in an area.
- In terms of support from the Council, there was an appetite for risk sharing, especially where the Council owns the land which it could release at a lower value pending sales, when the return could be adjusted to reflect the sales value achieved.
- A real issue is that specialist schemes cost more to develop and this could affect viability and the cost of borrowing.
- The recommendations of the HAPPI report may need to be applied flexibly in Thurrock, which developers see as very price sensitive. Alternatively there may be a case for subsidy for some of the elements which make the design suitable for an ageing population.
- Developers generally want risk to be minimised although higher risks may be palatable in higher value areas.
- Flexibility on planning gain is needed, particularly in relation to education. This was seen as a major issue which could delay development.
- The case could be made to the Homes and Communities Agency to provide grant to local authorities to release sheltered housing sites to build specialist housing.

Following the success of the Developers' Summit, Thurrock invited developers to join it in a coalition to promote specialist housing for older and vulnerable people.

9.2.3 Keeping a strategic focus: the role of the Housing and Planning Advisory Group

A further example of work to help shape future housing development to better meet the needs of an ageing population is Thurrock's Housing & Planning Advisory Group. This is a multi-agency panel, reporting to Thurrock's Health and Wellbeing Board, that considers the health and well-being implications of major planning applications and provides advice and guidance on the health, social care and community impacts of proposed new developments.

The Advisory Group comprises representatives from Thurrock Clinical Commissioning Group, NHS England, the Community and Voluntary Sector, as well as officers from Planning, Housing, Adults, Health, Public Health, Regeneration, Children's Services and Essex Police. It has a significant role in articulating the Health and Wellbeing Board's vision and priorities in relation to housing and the built environment.

The Group aims to influence ***planning policy*** and thereby developers so that planning applications when received, have already taken into consideration the impact of the proposed development on health and wellbeing. The Group plays a role in promoting good design and sustainable communities as well as specifically influencing ***planning applications*** for the provision of housing for older people and people with disabilities, drawing on a range of exemplary practice including the HAPPI Report, the Secure by Design crime prevention initiative, and the National Planning Policy Framework guidance for housing for older and disabled people.

From 2022 the work of the Advisory Group will also be guided by Thurrock's Joint Strategic Needs Assessment for the built environment, spatial design and health. The aim of the JSNA is:

To systematically address the wider determinants of health, specifically via the built and natural environment, and improve the quality of life of residents through the Local Plan.

The 2018/19 Annual Public Health Report provided a detail assessment of older people's housing need in Thurrock and strategic action that needed to be undertaken to ensure that future housing in Thurrock supported older people's independence but work then paused due to the COVID-19 pandemic.

We will therefore now take forward the recommendations in the APHR, developing and implementing an Older People's Housing Strategy based on its findings. We will also encourage future development of a plurality of housing that supports older people's independence, including HAPPI principles through continued use of the Health and Planning Advisory Group, 2022 JSNA on the the Built Environment, and new Thurrock Local Plan, ensuring planning policy reflects the older people's needs

9.3 Reimagining Residential and Intermediate Care

Our residential care homes are generally of high quality and have done a magnificent job of caring for some of our most vulnerable residents during the incredibly challenging period of the COVID-19 epidemic.

However, the majority of us hope that we will never need the services of a residential care home in old age, and few of us relish the often difficult decision to place a relative into residential care out of necessity because there is no other viable option available. When we enter residential care, we have to trade the loss of privacy, independence, control and choice that we had at home in order to gain the enhanced and intensive care they provide.

The CQC, in its State of Care report for 2017/18, noted that in the face of growing need "The capacity of adult social care provision continues to be very constrained: the number of care home beds dropped very slightly in the year, but what was noticeable were the wide differences across the country. Across a two-year period, from April 2016 to 2018, changes in nursing home bed numbers ranged from a 44% rise in one local authority to a 58% reduction in another. Almost a third of adult social care directors (32%) said they had seen home care providers close or cease trading in the previous six months."

Further, in November 2018 the Competition and Market's Authority reported on its undertaking the most complete study of profitability in the sector in recent years[2]. Amongst its findings was that "many care homes, particularly those that are most reliant on LA-funded residents, are not currently in a sustainable position". Moreover "they are not able to cover any additional investment costs. This means that while they might be able to stay in business in the near term, they will not be able to maintain and modernise facilities". The CMA also found that "the sector is not able to attract the investment required to meet the future increase in demand to serve LA-funded residents."

The pandemic has poses a further challenges for care home providers who experienced volatility in occupancy in the early stages of the pandemic with levels in some cases down to 60%. It is not clear whether care homes, which have generally not been designed for self-isolation, and where facilities for barrier nursing may not be readily available, may face further periods where older people are reluctant to be admitted. Although the speed by which Thurrock care homes have returned to close to full occupancy, suggests strongly that the capacity within Thurrock is, at best, right sized and will quickly become under resourced in view of anticipated demographic growth.

The Thurrock Public Health team has made an assessment of the need for residential care in the Borough. The assessment uses Department of Health planning tools to estimate the number of people over 65 years in Thurrock who cannot undertake even one mobility activity alone, and who may therefore require adult social care. Whilst the total number in 2017 was 4,201, this is projected to increase to 6,801 by 2035, which is an increase of 61.89%. The largest increase is seen in the 85+ year age group, which sees an increase of 95.38% between 2017 and 2035. In relation to dementia, the assessment shows the estimated number of people aged 65+ with the condition could increase from 1,503 in 2015 to 2,401 in 2030 – an increase of 59.7%, with the largest proportional increases are seen in the 80-84 year olds (82.9%) and 90+ year (88.6%) age groups.

Residents in their 80s are already the largest users of residential care, so without effective intervention to mitigate this trend of decreased mobility, the need for additional residential care homes is likely to increase substantially. Another projection of demand growth taken from the Public Health Team's assessment shows a need for a further 410 beds in residential care in Thurrock by 2035:

Our vision is to reimagine older people's residential and nursing care, providing the same levels of care intensity currently available in traditional models, but through a new 'Extra-Care Plus' care complex that provides residents with the dignity, privacy and freedom own self-contained flat and front door coupled with additional communal facilities on site.

We propose that the Whiteacre / Dilkes Wood sites in South Ockendon should be developed to provide a range of homes for older people needing care. This is seen as an opportunity both to address the growing demand for care, and to invest in innovation in care, and so to set new higher standards for housing with on-site care in the Borough. It will also act as a 'proof of concept' scheme that we imagine could be replicated by private sector developers and providers in the future.

The Box overleaf details Park Place, Portland, Oregon that has successfully delivered residential care using a similar model to our vision.

Park Place Portland, Oregon

Inspired by the negative experiences that her mother was having of nursing care in terms of loss of privacy, control and freedom, Keren Brown Wilson built her first Assisted Living Complex of 112 units in Portland, Oregon in the 1980s.

Wilson's mother's had suffered a devastating stroke in her 50s leaving her unable to stand, bathe, toilet or cook and needed intensive physical care support needs but her mental faculties remained unaffected. Over and above her care, Wilson's mother's living needs were modest: she wanted a small place with her own kitchen, bedroom and bathroom where she could lock her own door, control the heat, have her pets, be surrounded by all of her own furniture and things, and get up when she wanted. She wanted to live in a place where no-one would tell her what she could and could not do, and have privacy if she wanted.

Wilson set out creating a new facility, with the primary emphasis on *home* and the agency of residents. Her vision was simple[3]: at Portland Place, each unit was a self-contained apartment where residents had exactly the same amount of control over what they did as someone living in general needs housing. They chose who shared their space with, how they managed their time, what they did each day, their furniture, pets, decorations, possessions and heating.

But residents also had access to all of the additional help they may need on site: food, personal and nursing care, medication that could also be summoned in an emergency by pushing a button. There was also help with maintaining a high quality of life if residents wanted it: having company, keeping up connections with the outside world, continuing the activities residents valued most.

The level of care available matched what was delivered in standard nursing care, but the fundamental differences were *control* and *agency*. When provided, the carers were entering *the resident's home*, and the resident, not the carers, set the schedule, ground rules, and chose the level of risk they were comfortable with.

The concept was immediately widely popular and the 112 units sold out almost immediately and a second complex of 142 units was built and was again almost immediately filled. But the authorities were worried about the safety of what they saw as a radical experiment that was risking the health and safety of residents, and required Wilson to track closely the health, cognitive abilities, physical functioning and life satisfaction of the tenants.

The results of the study were published in 1988 and were a revelation: Not only had the residents not traded their health for freedom; residents' health was maintained whilst life satisfaction had increased significantly. Physical and cognitive functioning improved and incidence of major depression fell. The cost of residents on government support was 20% lower than if they had been cared for in a nursing home.[4]

9.3.1 Whiteacre / Dilkes Wood – our next exemplar scheme:

Pollard Thomas Edwards architects have already been commissioned to develop a vision for the proposed scheme including addressing how the development may be phased to deliver the new residential offer for older people and also, potentially, the redevelopment of the adjacent 1950s era health centre should that be agreed with NHS partners.

Their report showed a number of case study examples in which progressive developers have been exploring new ways of better integrating residential and nursing care with the local community. These approaches are consistent with Thurrock's vision for transformation, with new models of care to ensure people who need residential and/or nursing care can be supported to remain recognisably part of their community, rather than being cared for in an institution. It also reflects the collaboration between Council and NHS partners to develop integrated care pathways for older people, to avoid unnecessary acute admissions and delayed transfers of care, by making more care available closer to home.

Preparatory phase: Design and Realising Development Potential

The appointment of the Design Team enabled detailed plans to be drawn up for the scheme and allow early consultation with a range of stakeholders, including the local community, about both the vision for care and support for an ageing population, and the proposals for the site. The designs will also allow cost consultants to provide firm estimates of the construction and operating costs of the facilities.

Exploring options: site assembly and the potential for a joint venture with NHS partners

The Pollard Thomas Edwards report also concluded that the Whiteacre / Dilkes Wood site offers an opportunity to provide exemplary residential accommodation for people with varying levels of need, while creating a new community-led focus to the town centre. The scheme also unlocks the potential for the phased development of a new community health facility to replace existing provision in the South Ockendon Health Centre.

The South Ockendon Health Centre on an adjacent site on Darenth Lane is currently occupied by a single handed GP Practice, a branch surgery of an Aveley Practice, and a range of other clinical services including Health Visitors and dentists. NHS partners have confirmed the building is no longer fit for purpose, and they see potential benefits in redeveloping the site to create a new health centre. This could bring together other surgeries from the local area, and be equipped with a fuller range of primary care and associated facilities, reflecting the new model of care being pioneered at the Integrated Medical Centres.

The report by Pollard Thomas Edwards noted the existing South Ockendon Centre / community hub has proved popular with residents since its opening in 2013. It has a wide range of services and activities, and creates a strong community focus. However, their report argues the community hub could be better connected to the town centre if it was located on the Whiteacre / Dilkes Wood site.

The proposed mix of housing and care provision

The Whiteacre / Dilkes Wood scheme will provide a range of homes for older people needing care: from small easy to maintain flats designed for frail elderly people, to retirement living for those who wish to downsize to a care ready environment, including potentially a mix of one and two bedroom dwellings for rent.

We aim to replicate and build on the values, ethos and care model already demonstrated at Park Place, Portland, Oregon.

The project aims to provide social care and nursing care in a specialised setting of 45 self-contained dwellings with associated care facilities (lounges, restaurant, treatment rooms, laundry etc.). There are two self-contained accommodation types:

- Type 1 – Older Person's Flat: 56m2 self-contained apartment including bedroom, living/ dining/kitchen and bathroom provided. External private balcony. Storage space provided. Possibility for open plan or more traditional layouts.
- Type 2 – Older Person's Flat: 67m2 self-contained apartment including two bedrooms, living/dining/kitchen and bathroom. External private balcony provided. Storage space provided. Possibility for open plan or more traditional layouts.

In addition, a further 30 studio flats are proposed for Intermediate Care use:

- Type 3 – Intermediate Care Unit - 27m2 care studio with en-suite bathroom. Storage space for wheelchairs, MEP, personal belongings etc. Good visibility from bed to bathroom, door and window..

The accommodation is designed to a high standard, and includes underfloor heating and separate ventilation systems for each unit. The self-contained nature of the accommodation, and separate ventilation will help manage any infection including COVID. Careful consideration is being given to landscaping including the retention of as many trees as possible.

A new capability for independent living, reablement and intermediate care

Supporting independent living for frail older people

Specialised, care-ready accommodation, where residents can enjoy all the comfort and privacy of a self-contained home specifically designed for older age, has much to offer frail older people. The availability of on-site social care and nursing care services when residents need them, will enable them to retain (and regain) their independence. In combination, the facilities and services will help residents to live well, on their own or with their partner, to maintain day to day links to families and friends, to make use of local facilities, and to continue to contribute to their communities.

For frail older people, a single shared assessment, care co-ordination and an on-site wraparound well-being service, based on the model described in Chapter 7, will ensure their care needs are met in a way that promotes their strengths and enables them to make full use of local amenities. Visiting Integrated Locality Teams will provide advice on self-care and assistance with the management of long term conditions including diabetes, respiratory disorders and heart failure. The adjacent health centre will provide a range of GP and other primary care services, and in time will be developed with a wider range of clinical services as a health and well-being hub.

Reablement Away from Home and Intermediate Care

The Whiteacre / Dilkes Wood scheme will also make a major contribution in supporting strategies for reablement, reducing delayed transfers of care, and other initiatives to provide care out of hospital, care closer to home, and virtual wards. In addition to the permanent homes on site, the 30 self-contained studios will widen the housing and care offer locally, so that we can more readily avoid admissions by offering a home from home, and step up/step down care for those who need it. This will include:

- Intermediate care in a residential setting for people who cannot live in their own home at present but have no long term need for care in a residential setting;
- Short stays for those requiring intensive reablement services in a residential setting;
- Short stays to allow assessments (including Continuing Healthcare – CHC assessments) to be undertaken outside an acute setting when they cannot be undertaken in the patient/service user's home.

The provision of specialised accommodation, an integrated assessment and care plan provided by a team with blended roles, and bringing the capability of a range of clinical disciplines, will mean in future fewer older people will require admission to hospital.

And those that have been admitted because of the need for treatment which can only be provided in a hospital can return to a homely setting even if they have to wait for adaptations to be made to their own home, or to have technology enabled care deployed in their home, or if they need to convalesce in a setting which will help them regain the strength and skills for independent living before returning home.

Financing

The costs of developing the Council owned site as a high quality residential facility with on-site care is considerable. However, in the context of a shrinking private sector residential care offer the partnership must be in a position to offer the care required by local residents. The capital funding for the 75 residential units, and associated care facilities, will be funded as part of the agreed capital programme.

Revenue funding to cover the loan costs, as well as management and maintenance of the facility, will be available from rents and service charges for the 45 self-contained flats. Proving care through is tenancy model as the additional advantage that Local Housing Allowance can be claimed (for those eligible), and this additional rental income can be used to offset borrowing (and potentially some care costs). The care and support in the scheme will be provided by Well-Being Teams, and the service provided will be chargeable in line with the Council's policy for domiciliary care.

The revenue funding cost for providing the 30 interim beds is estimated to be circa £1,400 per week. This funding would form part of the business case for the scheme to be agreed with NHS partners as part of a new strategy for Intermediate Care. The interim beds could be offered to other authorities if the local demand profile for intermediate care changes, or if necessary, the service could be remodelled and operated as residential care beds (and so chargeable at the locally declared rate.

Combining the model with the Integrated Locality Network model set out in Chapter 7, where by community clinical teams would provide a model of 24/7 care on-site with clinical in-reach provided from the Integrated Locality Network. This may be attractive to NHS partners in reducing reliance on costly community hospital beds, allowing potential savings from medical on-site staffing to be reinvested within the Locality Network and a virtual ward model.

9.3.2 The Opportunity to Re-think Collins House

The Council has one purpose built residential home, Collins House, in Springhouse Road, Corringham, Stanford-le-Hope SS17 7LE. It is designed to the standards for residential care current in the 1970s and 1980s and is registered to provide personal care and accommodation in single rooms for a maximum of 45 older people, some of whom may be living with dementia related needs. Collins House is well regarded by residents and their families, and the Care Quality Commission gave the home an overall rating of Good in its latest inspection report dated 5 April 2016. However, it does have some limitations: the bedrooms are small, and none have en-suite bathrooms. Moreover, the building places limitations on the care that can be provided: it is not possible to place in Collins House some older adults who cannot weight bear because the size of some of the rooms prohibits the use of hoists to allow such residents to transfer from bed to chair or bath or WC.

The Whiteacre / Dilkes Wood offers an opportunity both to address the growing demand for residential care, and to invest in innovation in care, and to set new higher standards for residential provision in the Borough. It will also provide the opportunity to understand more fully how the facilities and services at Collins House could be improved, building on its existing strengths.

9.4 Supported Housing for Residents with Mental Health Problems

Supported Living placements provide accommodation to residents usually in shared houses with on-site support from carers to assist with daily living. The current model commissions external providers to deliver a core support offer with additional commissioned hours based on a previous assessment of the individual's needs.

Ideally, Supported Living provision should promote independence in the people being supported, with support packages starting at a higher level and then reducing as the resident being supported gains new skills and become more independent. However, the current process of assessment and then commissioning a fixed package of core support and set hours is inflexible and unable to adjust and flex support sufficiently in response to individual circumstances.

Furthermore, feedback from providers suggests that many clients have addiction problems that prevented recovery and that the way we have historically commissioned drug and alcohol treatment as a separate service meant that in many cases, support was fragmented and difficult to access.

A proportion of placements for service users with the most challenging behaviour break down, requiring the council to commission new provision at short notice, sometimes out of borough and usually at increased cost. An analyses of Thurrock's Supported Living data concluded that for the majority of residents with mental health problems placement costs remain static or increase over time, suggesting the current model may not be delivering the outcome of increased independence as well as it could.

We are currently developing a new model of care for Supported Living for people with mental health problems. We will purchase two additional four and three bedroomed houses within the Borough and commission a trusted provider to deliver the model. The model reflects a strengths based approach and the principles of Open Dialogue where all elements key to an individual's care and wellbeing will work together, with a shared understanding of what matters most to the person and a focus on stabilisation and where appropriate, recovery. The model will not be 'one size fits all' with a pre-specified number of care hours, but will flex to the requirements of the individual on a daily basis.

The majority of people accessing supported housing require a multi-agency approach to be able to achieve their goals. Phase I will see the development of a holistic model of care staffed by specialists who can easily and swiftly tap into other elements of mental health to enable the right intensity of care at the right time. The ability for staff to benefit from bespoke support, for example from a dual diagnosis substance misuse worker, will enhance the offer and increase the opportunities for a greater level of integrated care with outcomes including a reduction in relapse and admission to inpatient services. There will be a keen focus on maximising recovery and stability so each individual can reach the maximum level of independence and achieve what is important to them

We will 'test and learn' this new model by purchasing two properties within Thurrock and commissioning a high quality provider to deliver flexible 'in-reach' support to residents in conjunction with a dedicated addictions worker.

Chapter References

1. HAPPI - Design - Topics - Resources - Housing LIN ↑

2. 3 Competition and Markets Authority, Care homes market study, published 30 November 2017 ↑

3. Wilson, K.B. Historical Evolution of Assisted Living in the United States, 1979 to Present, *Gerontologist,* 47, special issue 3 (2007): 8-122.

4. Wilson, K.B., Ladd, R.C., and Saslow, M. Community Based Care in an Institution: New Approaches and Definitions of Long-Term Care, paper presented at 41st Annual Scientific Meeting of the Gerontological Society of America, San Francisco, No. 1988. Cited in Wilson "Historical Evolution" ↑

Chapter 10:
Making It Happen

Integrated Governance, Delivery and Commissioning

Chapter 10: Making it Happen: Integrated Governance, Delivery and Commissioning

10.1 Introduction

The vision and proposals set out in this strategy are ambitious and comprehensive and describe a fundamental shift in the way we have traditionally to delivered health and wellbeing services from one that is siloed and top down to one which is resident centred and integrated.

This final chapter describes the governance and delivery architecture required to turn our vision into a reality, and new high-level principles around commissioning arrangements to support the transformation. This work will be developed further during 2022/23 in negotiation with Mid and South Essex ICS and local health, care and third sector partners, as ICS governance arrangements emerge.

10.2 Background

The recent government white paper *Joining up Care for People, Places and Populations* emphasised the importance of *place* – geographical localities below ICS level as the primary planning footprint for integration of health and care services and budgets supported by single place-based outcomes frameworks.

Governance arrangements between the Mid and South Essex (MSE) Integrated Care Partnership (ICS) and the Thurrock Integrated Care Alliance (TICA) will need to support this national policy direction whilst reflecting two requirements; the need for the ICS, and ultimately NHS England, to be reassured that the use of resources and delivery of well-being services in Thurrock are achieving the outcomes required by these partners, and the need for autonomy in decision making within the Thurrock system. This dichotomy can be seen to reflect the inherent tension in having a top down or bottom-up approach to system oversight.

To fully realise the potential for service transformation inherent in this *Case for Further Change* strategy, a devolution of resource and delivery decision making between Mid and South Essex ICS and Thurrock needs to must be agreed. This is the basis upon which the idea of subsidiarity is grounded, however ultimate accountability for much of the system will remain with the ICS, who must be assured that the Thurrock Strategy is performing well and meeting the expectations of the wider system.

One way of overcoming this tension would be to create two distinctive governance structures: one to cover the devolution arrangements between the ICS and TICA, and another to manage this through a collaborative governance arrangement at the local level.

10.3 Governance

10.3.1 Governance Between the ICS and TICA

Future arrangements need to build upon the existing structures for governance within the wider ICS system and include a formal devolution and delegation agreement that set out clear expectations on both sides and established a series of key high-level place-based outcomes against which performance could be routinely evaluated. The arrangement will need to specify what mitigation would be taken and by whom when performance levels were not being achieved and agree a form of escalation and, ultimately of sanction when mitigation did not drive anticipated improvements.

The arrangement would need to be watertight and contain clear processes to enable the ICS to feel assurance that any perceived risks were mitigated, and that control could be and would be re-established centrally where performance required it.

Similarly, TICA would need to feel that the necessary autonomy required to achieve significant change was enshrined in the agreement, otherwise local decision making could be severely compromised by bureaucratic delay and subject to outside changes over which it had little or no control. In terms of deficit management, it may be necessary to agree a form of gain share so that both parties would benefit from efficiencies generated by new ways of delivery.

10.3.2 Governance Between TICA and Local Partners

This would require a system of Collaborative Governance to be agreed between all partners operating with the Thurrock Alliance, including communities and other user-led or citizen-led associations.

This model is becoming more common place and has been defined as follows:

> *Collaborative governance is most broadly defined as a process involving state and non-state actors jointly addressing an issue, be they civil society, public or private organisations, or individual citizens.*[1]

The Thurrock strategy is based upon a number of key principles including:

- Subsidiarity
- Co-production and design
- Equalising power between citizens and professionals
- Supporting self-help through shared solution finding
- Population health theory and a focus upon the broader determinants of health and
- Ending health inequalities.

It would be impossible to promote these principles in a system that still maintained centralised control and where there was limited autonomy in decision making. This shift requires a fundamental change in culture and mindset:

> *Public managers must revisit their outlook on the roles that they and the public should play in public services. The ways in which organisational cultures mediate patients' empowerment matters. Patients make a transition from simple users and choosers to makers and shapers of health services.*[2]

Working through how this collaborative governance arrangement is established and implemented within the Thurrock system is still being developed, including arrangements on governance, devolution and delegation between the ICS and TICA. However, they are both critical elements of the overall strategy if the transformation of services, with the corollary of improved outcomes and more effective use of resources, is to be realised in Thurrock.

10.3.3 The Role and Function of the Health and Wellbeing Board

Health and Wellbeing Boards (HWBB) are responsible for setting out a plan for improving the health and wellbeing of their local area – known as the Health and Wellbeing Strategy (HWBS). This *Case for Further Change* strategy is responsible for delivering or contributing towards a number of the priorities contained within the newly refreshed HWBS. As such, the HWBB is very much part of the governance arrangements of this strategy.

HWBBs also have a key role in delivering governance and oversight arrangements for the Better Care Fund (BCF) and Better Care Fund Plan. The Better Care Fund is a pooled fund across health and adult social care for the local (HWBB footprint) area. Its purpose is to enable integration across the health and care system and promote the identification and delivery of jointly agreed aims and objectives. This strategy proposes that the BCF is used as a vehicle through which system budgets in their totality are pooled and used to deliver its aims and objectives. This will require a complete review of the current BCF Plan and arrangements.

HWBBs across Mid and South Essex are currently undertaking a review of their functions in the light of forthcoming legislation on Integrated Care Systems. Part of the review will assist Boards to understand future governance and functionality requirements, including how they will influence and support the delivery of improved health outcomes through key strategies such as this *Case for Further Change*. The review will also help to identify the governance arrangements required between 'place' – i.e. Thurrock, and the ICS and how they should operate – including potential areas of conflict, overlap and responsibility. This will help to shape the aforementioned devolution and delegation agreement between the ICS and Thurrock Integrated Care Alliance (TICA).

10.3.4 How is Good Governance enforced?

The HLS principles that shape our governance arrangements must also shape the conditions that drive how the partnership functions and drive how decisions are made. Typically, these are:

- Commissioning arrangements
- Performance management
- Information and data management
- Policy and procedure
- Procurement
- Interpretation of legislation and regulation
- Process
- Risk management
- Finance and resource management

A review of these (to ensure they are set against the principles of HLS) will be carried out as part of a strategic action linked to this chapter.

10.5 Delivery Arrangements

Each of the chapters within this strategy will be accompanied by delivery plans – detailing actions and milestones set over each of the next four years. Delivery plans will be coproduced with staff and communities. Coproduction with communities will take place as set out within chapter four of the Strategy – a new approach to engaging with communities.

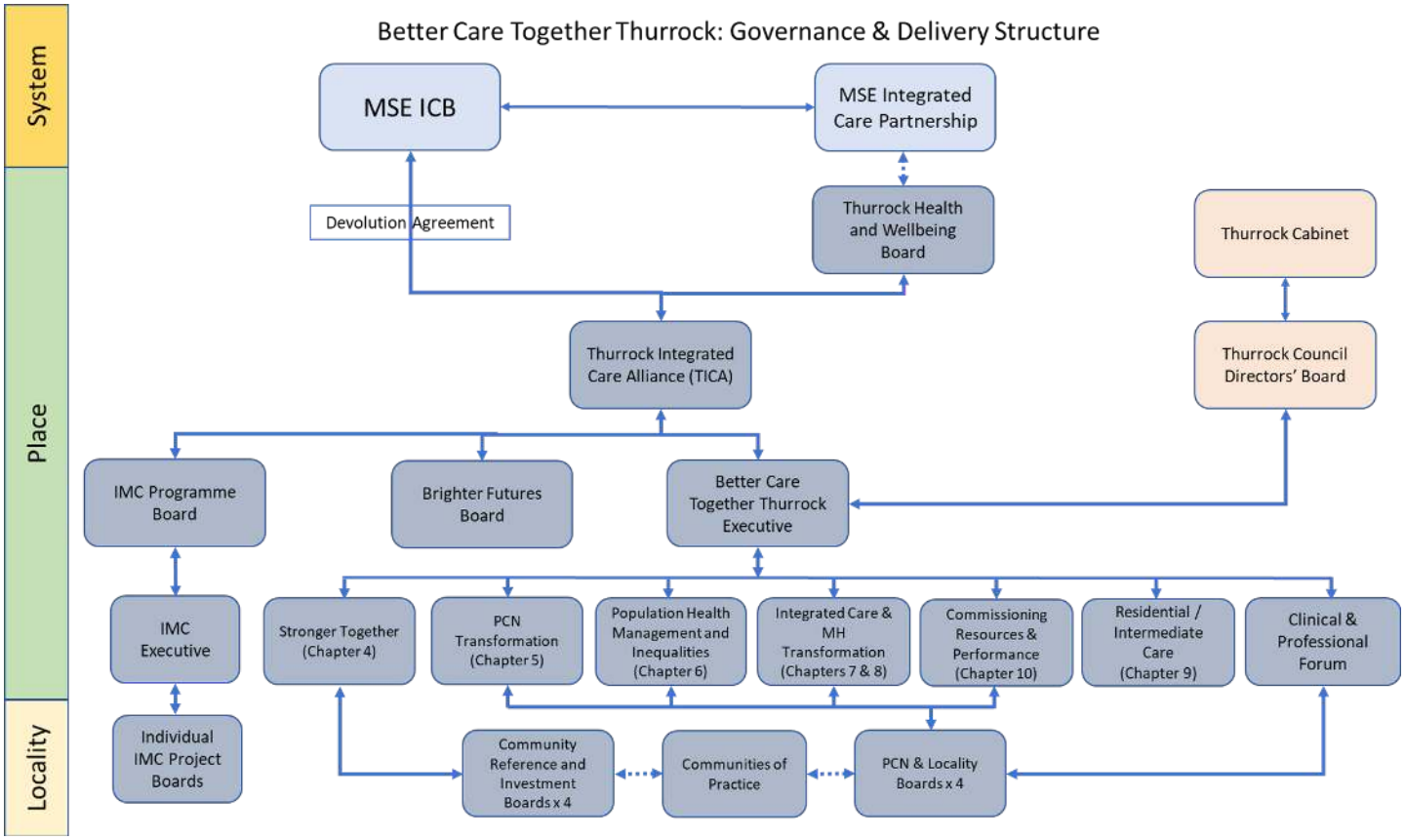
The draft structure, through which the strategy's delivery will be monitored and overseen, is detailed below. This will be for further review and redesign as the strategy starts to be implemented, ensuring that we test and learn and adapt as necessary. Delivery boards will have set responsibilities for different aspects of the strategy and will be responsible for unblocking and escalating barriers to progression. Delivery Boards will a have a system stewardship role, ensuring staff are enabled and empowered to take forward actions and initiatives set out within delivery plans and are able to take forward any learning. In keeping with HLS, delivery boards will form and be part of learning cycles.

All key system partners will be represented on delivery boards and be part of governance arrangements and it is a key principle of the delivery structure that governance and delivery arrangements are not 'top down', but facilitative and inclusive – ensuring appropriate distribution of power and permission. This will mean considering a mix of staff involvement throughout the structure and ensuring that 'leaders' are held to account for their facilitating and enabling role by staff – and communities.

Due to the contribution of this Strategy to the Health and Wellbeing Strategy, reporting arrangements will incorporate those of the Health and Wellbeing Strategy to the Health and Wellbeing Board.

Figure 10.1 sets out the proposed governance and delivery structures:

Figure 10.1



10.5.1 Thurrock Integrated Care Alliance (TICA)

Thurrock's ICA (TICA) has overall responsibility for the 'place' based health and care system in Thurrock and for managing the relationship and responsibilities between 'place' and 'system' – e.g. the interaction between Thurrock health and care and the Mid and South Essex care system (ICS).

TICA will also oversee budgetary responsibilities spanning the health and care system, which will include integrated commissioning via the Better Care Fund.

10.5.2 Better Care Together Thurrock Executive

Better Care Together Thurrock is the name of Thurrock's integrated Health and Care transformation programme. The Executive will be responsible for ensuring that the transformation programme is being delivered and will oversee that delivery through the effective functioning of the delivery boards. The Executive will report to the TICA who oversee the health and care system in Thurrock.

10.5.3 Other Delivery Boards

Delivery Boards will be responsible for overseeing the delivery of particular chapters of the Strategy. This will include the development of action plans spanning the five years – although these will be reviewed and revised at regular intervals. Delivery Boards will be responsible for identifying ways of measuring success and evaluating impact. They will also be responsible for ensuring staff are empowered to test and learn through the development and implementation of learning cycles, and that communities are being engaged through the delivery and development of effective engagement processes (chapter four refers).

10.6 Changing the Commissioning Landscape

If we are to achieve the vision and objectives set out within our Strategy, we must identify and enable the change identified to take place. Doing this requires the review and potential redesign of the functions and 'system conditions' that act to facilitate or prevent success from occurring. Often, transformation programmes fail because the design and operation of key supporting functions remain consistent with *New Public Management (NPM)* operating principles. The focus of transformation is often only on redesigning front-line and operational services.

Success is dependent on our ability to identify and ensure that all functions and conditions within our redesigned health and care system operate to the principles and behaviours of the new operating model – as set out predominantly within chapter two of The Further Case for Change.

The conditions and functions this may apply to have already been referenced earlier and form part of ensuring good governance.

This section focuses on the role and function of commissioning given the importance of this function to ensuring overall success.

> *"If we accept that it is the interaction of the many variables in the system that create positive outcomes for residents, rather than individual services or programmes, then we need to ask ourselves a new question: 'how do we create healthier systems?', because healthier systems create better outcomes.*
>
> *The role of system leaders and commissioners shifts from one of specification and performance management to one of 'System Stewards'; their function is to look after the health of the system."*

Chapter 17 of Human Learning Systems, Public Service for the Real World [3] describes why current forms of commissioning working to traditional NPM do not work. In summary:

- The lives of individuals are complex and not linear – yet we often commission 'one size fits all' services;
- Approaches to commissioning and funding tend to focus on compliance and control as a means of delivering positive outcomes – but this hinders rather than enables bespoke or flexible solutions; and
- Funders and commissioners tend to stimulate competition between providers rather than fostering the collaboration required for joined-up solutions required by individuals.

In addition, NPM has shaped the commissioning models we see in public service today through a reinforcement of the following:

- Task and service-focused specifications;
- Contract management based on restrictive and transactional measures;
- Commissioning that favours larger organisations and restricts smaller and grass-roots local providers;
- One size fits all specifications that fail to identify or allow flexibility to deliver what is required by different communities;
- Limited or non-existent engagement with the relevant communities – or 'co-production' with a small group of go-to users of services;
- Lack of power sharing or transfer of power with communities and users of services;
- Lack of innovation and experimentation.

10.6.1 Adopting a Different Commissioning Model

Adopting the principles of HLS set out in Chapter 2, and developing a people-led health and care system means developing a very different model of commissioning.

Providers must be able to provide flexible, bespoke support that responds to an individual's specific circumstances. Commissioning must operate differently to enable this to take place and the following describes how this will be achieved.

10.6.2. Recognising that Flexible Trusting Relationships are Key to Delivering 'Human' Solutions

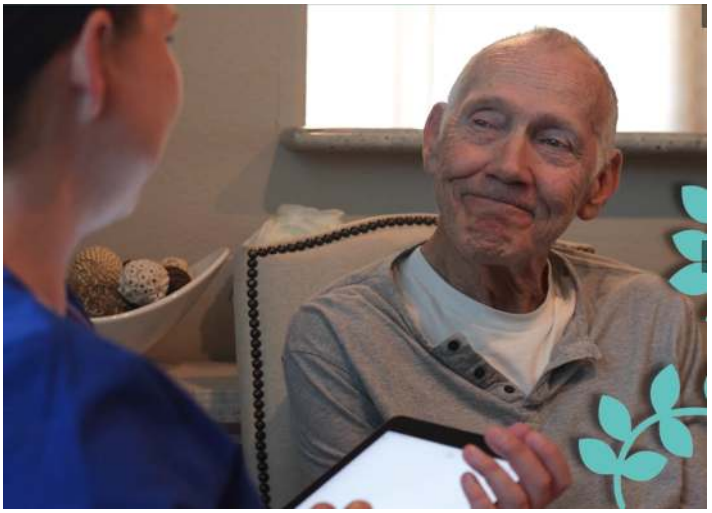
Establishing a commissioning model that enables this to occur by promoting providers who:

- Build effective and meaningful relationships with those they serve;
- Understand and respond to the unique strengths and needs contained by each person; and
- Act collaboratively with others to deliver what is required by the person.

This would mean ensuring that specifications, contract management and market development are consistent with these new conditions, and that a new type of partnership arrangement with potential providers was established.

This also means making sure that we commission for learning and not solely for service provision – ensuring that providers co-design solutions alongside the people they are supporting and, depending upon the circumstances, provide solutions for those people living in the community to whom they are not necessarily directly supporting – e.g. delivering activities designed to reduce isolation and increase connectedness.

> *"Nurturing trusting relationships at all levels, between citizens and providers, between organisations, and between funders and funded, leads to improved outcomes; micromanaging outcomes does not."*
>
> **Public Service for the Real World**



10.6.3 Looking Beyond a Narrow Service Lens: Operating Around Complexity

One of limitation of a NPM model of commissioning is that services are often commissioned in silo. Different commissioning teams will often commission services related to their respective areas of focus – for example Adult Social Care, Housing, Public Health, NHS.

As we know, people do not fit in to the neat boxes NPM operating models have helped to create. Their requirements often span services and can vary from one week to the next. As human beings, we need solutions that reflect us and what matters to us – this is not delivered by a one-size-fits-all service focused on transactions.

Commissioning to complexity and to the bespoke and varied outcomes of individuals means:

- The ability to pool commissioning budgets across different service areas (and organisations);
- Commissioning of integrated contracts and specifications that span different functions – e.g. Adult Social Care, Mental Health, Housing;
- Enabling flexibility within contracts to enable providers to have the freedom and autonomy to use resource as required to deliver on outcomes;
- Expecting providers to collaborate in order to provide integrated functions and solutions – or for providers to potentially be asked to provide a broader set of functions on the behalf of a number of commissioning partners;

- Enabling providers to 'buy in' support that they do not directly provide – for example through an Individual Service Fund type approach; and
- Adopting success indicators that are based upon whether people are achieving the outcomes they have identified as being important to them.

Achieving this will include identifying which budgets to bring together and which commissioning contracts – many of which will currently span a number of different service areas, providers and organisations. Test and learn initiatives will help develop the arrangements required.

Commissioners (and providers) will also have to identify how they can utilise the assets that exist within communities and individuals as part of this model.

10.6.4 Place-Based Funding

The Better Care Fund will be the vehicle through which a place-based commissioning budget will be grown. The Better Care Fund already contains the entire Adult Social Care budget for Thurrock and a significant proportion of the Thurrock CCG's budget for Community Health and Mental Health.

The Better Care Fund is a tool put in place by NHS England and was established initially to manage hospital activity. In Thurrock the Fund has become far more – being aligned with the vision for health and care in Thurrock, placing a significant focus on prevention and early intervention.

A review of the Better Care Fund (and section 75 agreement) will ensure that it operates to the principles of this *Case for Further Change* strategy. It will include considering additional funds currently sitting outside the BCF that need to be part of it – e.g. Housing. In addition, consideration will need to be given to what is commissioned by and for Place, and what is commissioned by and for the ICS and therefore outside the scope of the BCF.

The Governance of the BCF will be through Thurrock Integrated Care Alliance – in addition to BCF sign-off and reporting to the Health and Wellbeing Board.

10.6.5 Commissioning a Learning Environment

One of the three pillars of HLS is 'learning'. This means developing a culture of learning for all involved in the development and delivery of public service.

Commissioning functions can ensure that learning is prioritised through:

- Development of a 'positive error culture' – moving from performance management of contracts and providers that focus on "holding people and organisations accountable for delivering predefined programmes of work and predefined outcome targets" to an approach that uses "honest conversations" between providers and commissioners "about what they are learning and how they need to adapt their approach to do what's best for the people they are supporting."
- Encouraging and promoting on-going learning – both with providers and commissioners, and with learning sessions across providers, commissioners, users of services etc. Learning sessions could include providers having honest conversations with commissioners about what they want and need from them.
- Learning that is built into the commissioning model as a continuous process

10.6.6 Commissioning as a 'System Steward'

Key to building a commissioning function on the principles of HLS is redesigning the function to be able to take on a role as 'System Steward'. The HLS approach (Public Service for the Real World) states that System Stewardship assumes that:

"*those who work in the public and third sectors are motivated in their work to support others, generally can be trusted, and therefore do not require top-down control from managers or from funders and commissioners.*"

This will mean:

- Shifting from a model that focuses on 'the performance management of funding' to a model that engages in and enables complex system change;
- Looking at funding collaborations and partnerships rather than the allocation of resource to single providers – removing providers being in competition with each other and instead looking at what they can collectively offer;
- Taking responsibility for developing trusting relationships with providers and other commissioners;
- Creating space for learning and reflection – including being led by learning rather than 'operational outcome targets';
- Enabling providers to be autonomous and learning from their experiences on the ground;
- Playing a crucial role to remove bureaucracy.

This potentially means a fundamental redesign of how relevant commissioning functions currently operate – especially those commissioning health, social care and housing provision. It may also mean relooking at how in-house provision is 'commissioned'.

We will bring forward an OD programme for existing commissioners to develop system stewardship skills.

10.6.7 Learning about the Community

This Strategy proposes a new approach to community engagement and empowerment (chapter 4). Thurrock's communities must be at the heart of decision making. Traditionally, this has taken place through consultation exercises, user groups, and latterly through Healthwatch Thurrock. Work tends to take place in a piecemeal rather than an ongoing way. Typically, this leads to 'consultation fatigue' or complaints of not working with a broad enough representation of the community. This can mean decisions made about commissioning and developing services are not necessarily made based on the best information and power remains with the Council rather than shared with or transferred to communities themselves.

Communities of Practice are being established across Thurrock – aligned with each Primary Care Network (PCN) area. User-led CoPs will be formed from a wide variety of interested groups and individuals across the locality in question and be charged with agreeing priorities, designing strategies and solutions to meet those priorities and ensuring local intelligence feeds into all decision-making processes from a neighbourhood to a system wide scale. As such it will be the major forum to ensure community interests are represented at every level of decision making.

A direct-delivery CoP will also be established, made up of professionals operating in the locality. This network will ensure, with the information gathered from the user-led CoPs and any other information gathered from people living in the local area, that professionals are aware of any emerging themes and issues and can check that system design reflects what people want and need. This ensures that community intelligence is reflected in what is being commissioned and how it is being commissioned.

With budgets aligned to locality areas and pooled across different functions, the aim is to get to a point where resources can be shifted to communities and to CoPs (becoming Community Investment Boards), with communities having a direct say in how resources are used. This goes back to the principles of Asset Based Community Development, with communities identifying: 1. What they want services to do for them; 2. What they want services to do in partnership with them; and 3. What they want to do for themselves.

Given the significance of the change, this work will be developed over a period of time and take a phased approach – starting with the establishment of Communities of Practice in one area of the Borough.

10.6.8 The Market Place

The development of this Strategy will potentially mean the development of a very different marketplace. As part of the Care Act 2014, Local Authorities have a statutory duty to develop a Market Development Strategy. The purpose of the MDS is to clearly articulate the vision for the future and what Commissioners intend to do to make that vision a reality. The Strategy ensures that the market can offer sufficient choice for people requiring support and tells providers what the Council is likely to be commissioning.

The marketplace for health and social care has changed significantly over the past decade – but still fails to offer sufficient choice and still too often provides services that are traditional and focused on 'time and task' – with a formula of needs (y) equating to service offer (x). Direct Payment and Individual Health Funds have been established but these are typically used to buy services in the same mould as those commissioned by the Council or NHS.

Through our Stronger Together Partnership, work has taken place to establish a successful and growing Micro Enterprise scheme, but this provides a small fraction of the support required by those who need it.

The market in Thurrock must develop to be able to respond to intelligence gathered through the new model of engagement (chapter 4) and must also be developed to be able to reflect the principles of HLS. This includes supporting smaller grass roots providers as well as supporting existing providers to deliver an offer bespoke to the individual. The marketplace must also consider less traditional provision – including that which the community itself can offer.

10.6.9. Case Studies

Plymouth Alliance

The work began with exploring a more systemic approach to complex needs with a view to a radical redesign.

"An HLS approach looking at an Alliance contract was awarded to seven services in 2019 and along with three commissioners the CEOs form an Alliance Leadership Team of 10 members, operating on a principle of one person one vote and unanimous decision making. The contract is for up to 10 years (5+2+2+1) and all of the annual spend (£7.7 million) is devolved into the Alliance which has autonomy to spend it as it chooses.

In addition, the Alliance has a subcontracting relationship with other providers to deliver approximately 20 additional services. The Alliance uses demand-led budgets e.g. Bed and Breakfast and has a risk sharing agreement with the council where overspends are split 50/50. The aim of The Plymouth Alliance is to coordinate a complex needs system which will enable people to be supported flexibly, receiving the right help, at the right time, in the right place."

Liverpool Combined Authority

Liverpool CA introduced HLS as part of delivering a homeless assertive outreach approach.

"To help navigate and understand the system and support a service that is working across six Local Authorities with various needs and requirements, we very quickly understood we would need to employ a Systems Steward – someone who looks after the 'health of the system'. This role is led by the Contract and Review Lead.

As the Assertive Outreach service has been designed to be flexible and responsive, adopting a learning approach to contract monitoring has been imperative over the last six months. To do this, the focus of the Contract and the Review Lead has been the following:

- To develop trusting and honest relationships between all actors involved in the commissioning and delivery of the service, particularly amongst the core providers
- To be led by learning rather than influenced by ensuring operational delivery met outcomes
- To increase understanding of HLS and what it means for the commissioner-provider relationship and contract monitoring
- To create space for reflection and learning within the commissioner-provider-delivery team relationships".

10.6.10. The impact of Forthcoming Changes to NHS Legislation

NHS England and NHS Improvement are in the process of reviewing current procurement rules. The focus is on establishing a set of more flexible arrangements that are currently in place to support the NHS ambition for greater integration and collaboration between NHS organisations and their partners. Changes will be made through regulation made under the forthcoming Health and Care Bill.

There is also an expectation as part of the Bill that even though ICSs have statutory commissioning responsibilities on behalf of the NHS, they will delegate commissioning and budget decision making to place and provider collectives. This means that Thurrock Integrated Care Alliance will be able to make and steer all commissioning decisions that benefit residents and communities of Thurrock.

Establishing arrangements such as a collaborative commissioning alliance in Thurrock, will enable mechanisms to be put in place that shift the commissioning environment from once the commissions 'services' and 'functions', to one that commissions solutions and outcomes for people – through the application of a Human Learning Systems approach.

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