Better Care Together Thurrock:
The case for further change 2022-2026

EXECUTIVE SUMMARY

Acknowledgements

Introduction

This document provides an Executive Summary of Better Care Together Thurrock - Case for Further Change strategy. The main strategy sets out Thurrock's ambitious and collective plans to transform, improve and integrate health, care and third sector services for adults and older people. in order 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.

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 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.
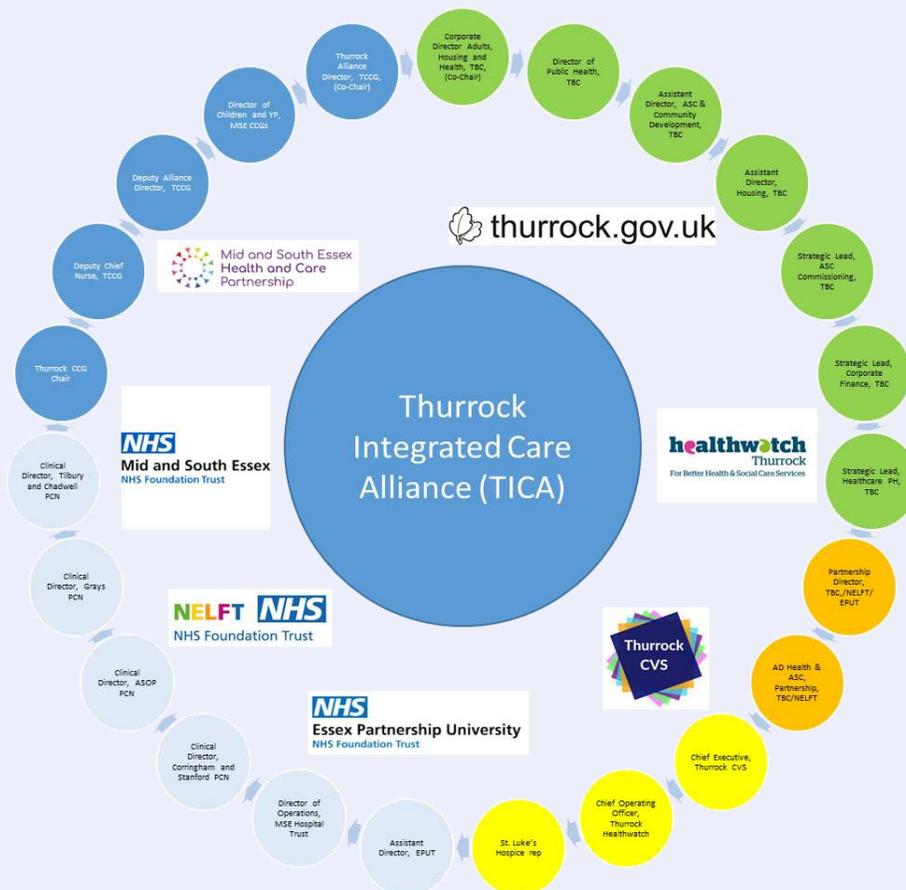
How the main *Case for Further Change* strategy is structured.

The main document starts by providing an overview of Thurrock and the health and wellbeing needs of is population. It sets out the collective vision, aims, principles and values that all TICP partners have developed jointly and which underpin our approach. These are based on a Human, Learning Systems approach, which is also described.

The current health, care and wellbeing landscape is complex comprising of a series of different elements that interact together in a whole system approach. We have developed a new model of care for Thurrock that describes how these elements will interact seamlessly moving forward, set out in the strategy.

The main document then dedicates six individual chapters that describe our detailed plans for transforming the six key elements of the system. It is, in effect a collection of six interconnected strategies in one document, setting out our ambitious plans for each element:

1. Our strengths and assets based approach to community engagement and development, and how we will put residents, communities and the third sector at the heart of our plans to co-design and co-produce new models of care.
2. Our plans to transform primary care to improve the access and quality of General Practice in the context of the new Primary Care Networks.
3. Our approach to shifting the focus of our system from reactive care, to proactive and preventative using Population Health Management.
4. How we will build an integrated health, housing care and wellbeing workforce around each PCN, to deliver proactive, strengths based, integrated care solutions to our residents, maximising the opportunities of the new Integrated Medical Centres and other community assets.
5. How we continue to transform and integrate care delivered at home, building on the successes of our Wellbeing Teams model..
6. How we will re-imagine and deliver new models of intermediate and residential care through our proposals for an "Extra Care Plus" facility at the Whiteacres site in South Ockendon.

The main document also sets out further details on a new governance structure and implementation, to support the transition of the Thurrock Integrated Care Partnership to act as Thurrock's Place/Alliance Board for the Mid and South Essex ICS's Integrated Commissioning Board, with delegated resources and decision making responsibilities.

The complexity of the task of transforming and reimagining our entire system, together with the scale, depth and breadth of our ambition has resulted in a comprehensive and detailed main Case for Further Change document. The six main chapters are designed to be read in isolation and give a detailed explanation of our transformation plans for each element of the system that will be of interest to different system actors.

Conversely, this document has been designed to give the reader a high level overview of the strategy as a whole, and capture the key strategic actions set out in each chapter of the main document.

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

How the strategies fit together

Thurrock Joint Health and Wellbeing Strategy 2022-2026

- High level
- All age
- Aspirational
- Engage all partners in wellbeing agenda
- Coherent vision for 'Thurrock the place'
- Threads everything together
- Focus on the 'what' and ouctomes

Brighter Futures Strategy

Focuses on children and young people's wellbeing and how services for children and young people will integrate and improve

Better Care Together Thurrock: The Case for Further Change

Focuses on adults' wellbeing and the transformation and integration of adult health, care and third sector services with the community

Other Health and Wellbeing Topic Specific Strategies

For example:
Violence and Vulnerability
Housing
Addictions
Whole Systems
Obesity

- More detailed
- More topic, age, setting focused
- Mechanics of the 'how'
- Explains impact at place and system level
- Outcomes at topic/locality/individual level
- Explains impact on overall place / system level
- Describes resources and financial impact

The Thurrock Joint Health and Wellbeing Strategy 2022-2026 is the highest level strategic document that describes are collective plans 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 under the Joint Health and Wellbeing Strategy, of which, this is an executive summary of 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.

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.

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.

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 position on the M25 and A13 corridors with excellent transport links west into London, north and east into Essex, and south into Kent.

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.   It will include film and art studios, 2,850 new homes, upgraded transport and leisure facilities and an attractive new waterfront commercial and residential space.

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.

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. 19% of our residents are from a non-white British background.

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

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 1.1 shows life expectancy and disability free life expectancy for females in Thurrock by IMD 2019 deprivation decile. It demonstrates the clear health inequity link 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. A similar pattern can be observed in men.

Comparative Health Need

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

Figure 1.3 (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 needs of Thurrock residents compared to more affluent communities within our ICS geography.

Figure 1.1
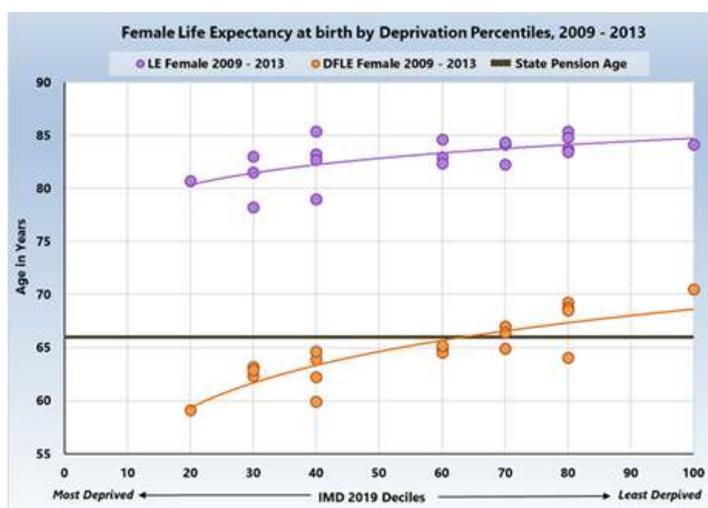
1.3 Thurrock's Transformation Journey

Thurrock has a national reputation for excellence and innovation in health and social care, and has been transforming its services since 2011. They key milestones and programmes that make up our transformation journey to date are shown in figure 1.2 below.

Figure 1.2: Thurrock's Transformation Journey
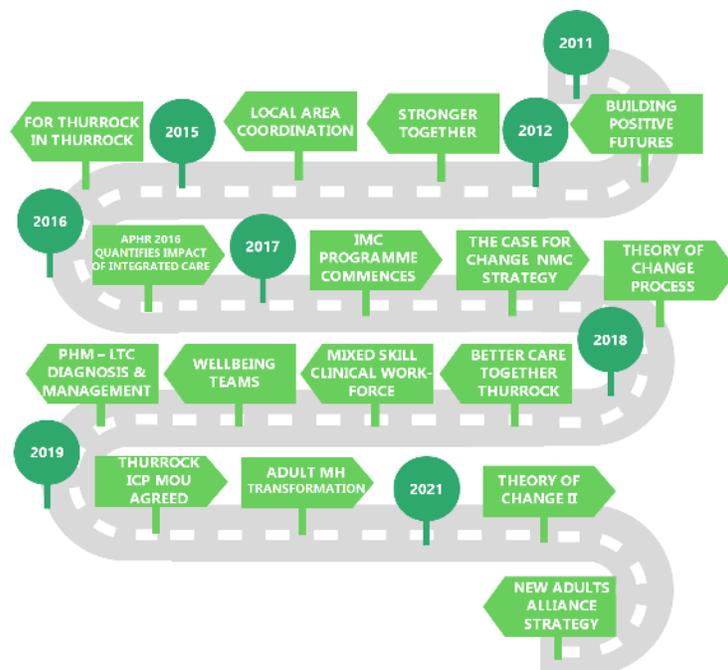
Figure 1.3: Comparative Health Need of Thurrock Residents to East of England and England

	Thurrock	East of England	England
Male life expectancy	78.3	80.2	79.4
Female life expectancy	82.6	83.8	83.1
Premature (<75) mortality rate per 100K	328.6	297.6	326.0
Cancer <75 mortality rate per 100K	137.0	126.0	132.3
CVD mortality rate per 100K	74.5	62.9	70.4
Hip Fractures in those aged 65+ per 100K	673	556	572
Excess Winter Deaths Index	23.8	16.3	17.4
% of Adults who smoke	17.5	13.7	13.9
% of Adults overweight / obese	69.4	62.3	66.4
Hospital Admission Rate for Alcohol Per 100K	658.0	634	664

KEY:
Significantly worse than England
Not statistically different to England
Significantly better than England

Chapter 2: Our Vision, Aim, Principles and Values

Chapter 2: Our Vision, Aim, Principles and Values

2.1 Introduction

The space in which health, care and wellbeing providers operate is complex and messy because it is based on human relationships, and each one of our residents is unique and complex. If we want to contribute to creating positive social outcomes for our residents, we must learn to embrace this complexity.

- People are complex: everyone's life is different, everyone's strengths and needs are different.
- The issues we are trying to solve are complex; whether it be diabetes, obesity, mental health or homelessness, with many tangled and interdependent causes and drivers
- The systems that respond to these issues are complex: the range of people and organisations involved in creating 'outcomes' for residents are beyond the management control of any one single person, team or organisation.
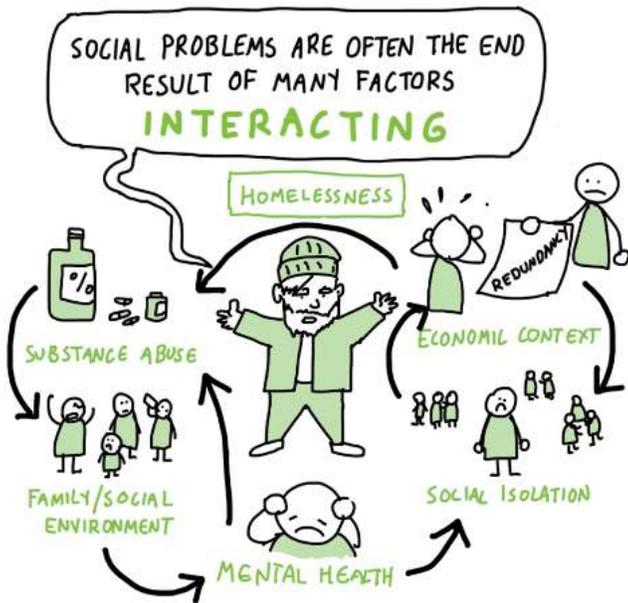
Complex problems need integrated solutions, yet the way we have designed our system requires residents to access help from many different teams and services that each deal with only one element of the solution. This help is often only available through referrals, assessment and meeting 'threshold' criteria. The more in need the resident is, and the more complex their problem, the more difficult we make it to access help because the greater number of services that need to obtain help from.

## 2.2 Human Learning Systems

In Thurrock, we share a collective passion to move from a 'one size fits all', fragmented, top down, centralised and deficit driven approach, to one that recognises human uniqueness and the need to co-design integrated human solutions based on strengths and assets in the context of a whole system managed through learning. This is called a Human, Learning Systems Approach

Human

A human approach to public service 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 to the relationship and working to create a trusting space from which solutions drop out.

It is about liberating workers from assessments, thresholds, procedures and onward referrals, and empowering them to co-design bespoke integrated solutions with residents that solve their problem. Those solutions are likely to include elements of what has traditionally been delivered by many different teams and organisations. They will also draw on the resources that the resident, their family, friends and community can bring. Commissioners and managers must give up the illusion of control that they can specify solution in advance through detailed service specifications or standard operating procedures.. For example, what works to solve one person's mental health problem may not be effective for another person.
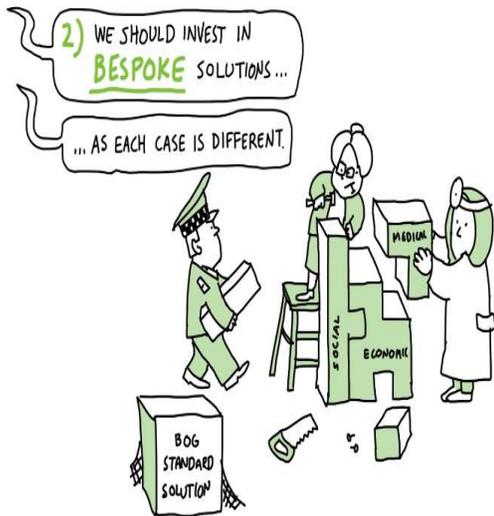
LEARNING

An HLS approach to Learning recognises that in order to design bespoke solutions with residents rather than predetermined interventions, a continuous process of learning is required to discover the right solutions in the context of the individual resident's life, needs and strengths. It also recognises that systems we operate in are in a constant state of change. What works in one neighbourhood may not work in another. What works will change over time. *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.

SYSTEM

Finally, people adopting an HLS approach recognise that interaction of many variables, services and people working within a whole system that produces outcomes to complex problems, rather than individuals, services, programmes or organisations. Consequently, to improve outcomes, we must create healthy systems in which people are able to coordinate and collaborate more effectively.

The role of leaders and commissioners shifts from one of specifiers and performance managers to 'system stewards', improving the health of the system and fostering trust and collaboration between all of the actors within it. It means agreeing the scope of the system, and developing a shared vision and purpose amongst the all within it.

Implementing an HLS Approach in Thurrock

Many of the most successful elements of our local transformation programme to date are already working using HLS principles. These include Local Area Coordinators, Community Led Solutions, Wellbeing Teams and our new Integrated Primary and Community Mental Health Teams. They are delivering outcomes for residents by freeing staff from pre-defined service specifications, KPIs and bureaucracy and empowering them to co-design solutions with residents.

However, our successes still operate within a wider context of 'old world' *New Public Management* thinking with too many fragmented services delivering pre-defined tasks based on deficits that we determine are important to 'fix'. Moving forward, we will transform our entire Alliance on HLS principles. The change we will create is set out overleaf.

|	New Public Management Historical Approach	Human Learning System
Culture	Top down hierarchy Centralised Professional & deficit driven Bureaucratic	Bottom up Empowering Devolving Asset based Strengths driven
Focus	Functional intervention	Bespoke solution
Ethos	Control	Learning
Concept of Health	Biomedical. Deficit. "Fix the machine"	Holistic. Asset based Wellbeing in context of place, wider determinants and social connections as well as disease.
Learning	Done once in advance through pilots or from published evidence base. Scale up what works.	Embedded within commissioning and delivery. Continuous, iterative & adaptive.
Commissioning	Specifier and Performance Manager Pre define activity through service specification. advance. Monitor compliance against KPIs.	System Steward High level principles and values. Outcomes determined by residents based on quality.
Front line staff	Deliver the service specification. Limited freedom to act outside this.	Build a relationship with the resident to allow co-design of a bespoke solution.
Front line delivery	Multiple teams based on service / clinical specialties and thresholds. Onward referral. Reactive	Place/locality based. Fewer teams and professional roles upskilled to deliver more functions Fewer handoffs. Flexible. Preventative.
Resident	Passive recipients of pre-determined care interventions	Active participants in co-designed bespoke solutions
Patient/ Resident Engagement	Through specific discrete exercises. Based on pre-determined topics, proposals, strategies or policies. Consultative.	Continuous conversation. On-going, interactive and binding.
Management	Performance management of people, providers and budgets to deliver pre-determined goals.	Coaching, empowering and cooperative. A conduit to deliver 'what matters' through relationship building.
Budgets	Fragmented. Aligned to specific programmes and services.	Locality, place and system based. Integrated and aligned to populations
Accountability	Prove you've hit the target?	Prove you've done the right thing?

2.3 Our Shared Goal and Principles

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.

Our Overarching Goal

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

Our 12 Principles

1 **AN EQUAL RELATIONSHIP WITH RESIDENTS**	Responsibility for wellbeing is shared between individuals, neighbourhoods and our workforce. We do *"with"* not *"to"*. We constantly co-design and co-produce.	**2** **BESPOKE BY DESIGN**	We work in partnership with residents to design the best bespoke integration solution for them in the context of their lives and the neighbourhood in which they live.
3 **A STRENGTHS AND ASSETS APPROACH**	Our solutions look to use the assets within neighbourhoods and don't just consist of the services we provide.	**4** **PREVENTION**	Our starting point is to prevent, reduce and delay residents from requiring a health or care service; but where required we ensure it is appropriate, easy to access and high quality.
5 **EMPOWER OUR WORKFORCE**	We empower resident facing staff to make decisions in the context of each resident they serve rather than being constrained by thresholds and *one size fits all* service specifications.	**6** **INTEGRATED SOLUTIONS TO COMPLEX PROBLEMS**	We deliver integrated solutions that minimise handoffs and referrals with fewer roles and services upskilled to deliver more tasks. Our mantra is *not wasting residents' time.*
7 **LEARNING IS THE KEY STRATEGIC ACTION**	We create learning environments as the primary mechanism to manage our constantly evolving system. We empower staff to innovate and share learning.	**8** **FLEXIBILITY**	We are flexible enough to respond and adapt delivery to changes in individual, neighbourhood and place circumstances
9 **BUREAUCRACY LIGHT**	The amount of resource we spend on bureaucracy is kept to a minimum ensuring maximum resources are available to provide people with the solutions they require.	**10** **WHOLE SYSTEM APPROACH**	We recognise that it is systems not services that deliver outcomes. We focus on creating healthy systems based on trusting relationships to where cooperation between actors is easy.
11 **SUBSIDIARITY**	We plan, transform and deliver at the lowest geographical level possible in the context of on-going engagement with residents.	**12** **ADDRESSING HEALTH INEQUALITIES**	We will relentlessly focus on reducing health inequity. We will ensure that resources are distributed in a way that accounts for variation in need at neighbourhood level.

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:

Thurrock Integrated Health & Care System

- Primary Care
- Secondary Care
- Population Health Management
- Support in the Home
- Residential and Intermediate Care
- Integrated Working

Chapter 3:
Our Integrated Wellbeing Model

Chapter 3: Our Integrated Wellbeing Model

Figure 3.1
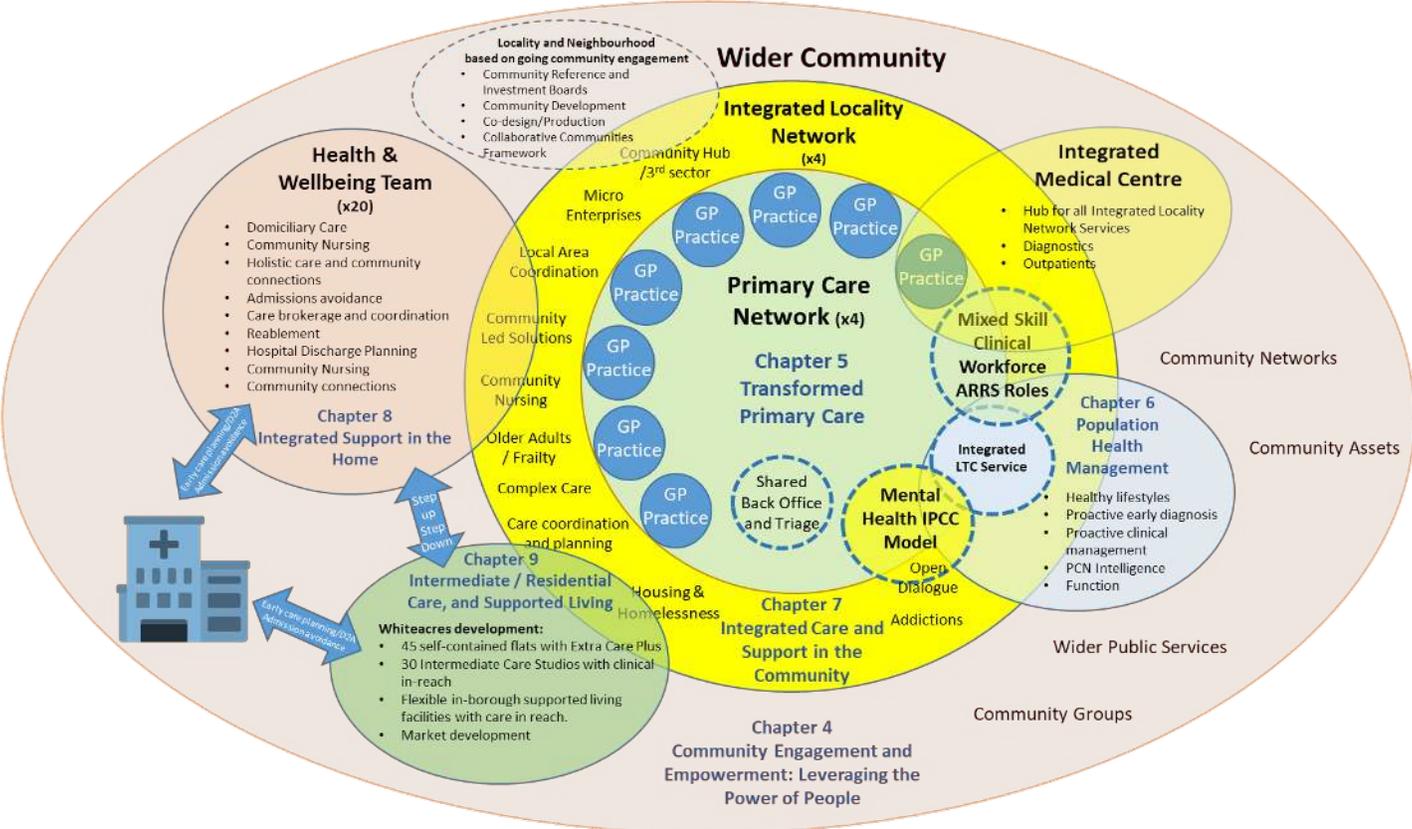
Our overall model of integrated care is set out in figure 3.1. Its constituent elements are described in detail in the main strategy and summarised in Chapters 4 to 9 of this Executive Summary.

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

At the heart of our model sits transformed Primary Care Networks (PCN) (Chapter 5) and an Integrated Locality Network of Community Support (Chapter 7) that wraps around it. Our approach to transforming care from reactive to proactive and preventative is set out in Chapter 6.

Care at Home is delivered via our new Health and Wellbeing Teams model (Chapter 8), that brokers support from the Integrated Locality Network, and also encompasses reablement and proactive hospital discharge planning. Our new vision for Residential and Intermediate Care is set out in Chapter 9, and like Wellbeing Teams, the model also encompasses clinical in reach from the Integrated Locality Network and supports hospital discharge.

The power of people, communities and assets, and of 'doing with' not 'doing to' runs through the entire strategy, but our approach to community development, co-design/production and leveraging the power of communities is also described in the next chapter. (Chapter 4).

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, cemented recently through Thurrock Council's Collaborative Communities Framework.

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. Power and influence sharing techniques, such as co-production and co-design, have a been proven to deliver better services and outcomes for residents.

4.2 Asset Based Community Development

Asset Based Community Development (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. Its premise is that communities themselves can drive real improvement in wellbeing by mobilising existing but often unrecognised assets. As a challenge to established forms of commissioning and delivery 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?

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 including:

- Community Builders
- Social Prescribers operating from GP surgeries
- Talking shops based within the community led by our Community Led Solutions Teams

- Community Hubs that allow residents to meet, access information and support and reflect on local issues and solutions.
- Micro Enterprises; support to residents to set up small businesses that provide community support.

Communities of Practice (CoPs)

We will build on this success by setting up two Community of Practice (CoPs), one resident led and a second for staff involved in the direct delivery of care. A CoP 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.

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 inform priority setting and future transformation. We will deliver this through procurement and use of the Air Table system that captures and analyses themes from intelligence gathered from resident facing staff.

Resourcing the Community

In order to break down silo 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 4.1 sets out our approach. We will create four Community Reference and Investment Boards and pooled funds through which local priorities can be agreed and solutions to address them commissioned, with a wide range of community representatives to oversee the process. A shared fund provides the opportunity to commission genuine solutions at place and neighbourhood level to address resident concerns and represents genuine power sharing. A fund held by the third sector also has the opportunity to attract additional grant and private sector funding.

Figure 4.1
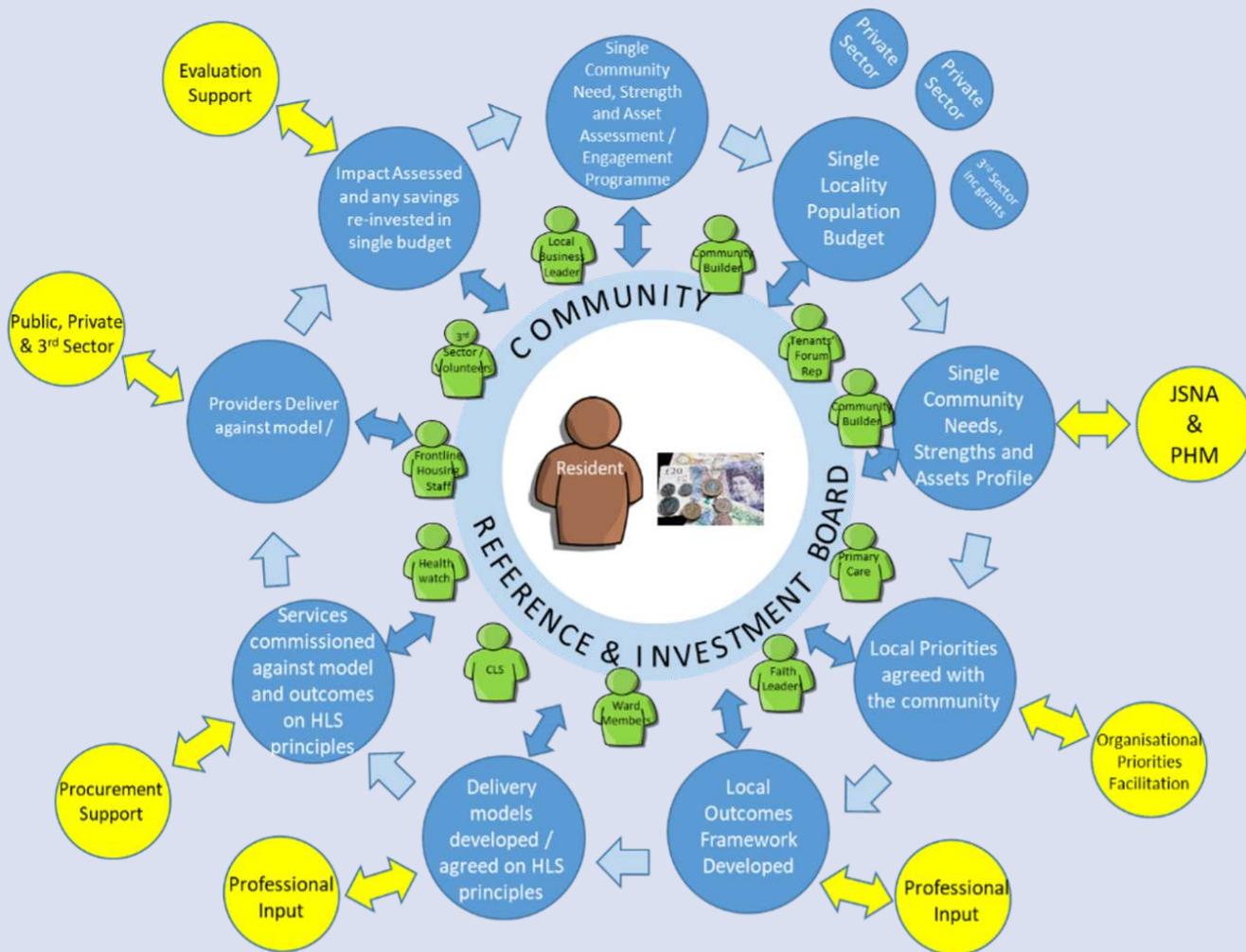
Micro Enterprise Development

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. The programme supports the local economy with bespoke, person centred services and has social benefit for both the people both receiving and providing the service.

Thurrock currently has one full time officer supporting this programme who is becoming increasingly stretched as more services require support. 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. CEUs will work closely with the new Community Reference and Investment Boards.

SUMMARY OF STRATEGIC ACTIONS

4.1 We will adopt a new approach to integrated commissioning and delivery of health, housing and third sector services based on Human Learning System principles.

4.2 We will build *User-Led* and *Direct Delivery* Communities of Practice within each PCN footprint, piloting in one PCN locality and scaling up as the mechanism to foster innovation and continuously learn and adapt 'what works'.

4.3 We will commission the *Air Table* system to provide the infrastructure to capture intelligence from resident facing staff and residents to inform our transformation continuously.

4.4 We will create four Community Reference and Investment Boards and four pooled funds at PCN/locality level to drive integrated commissioning and power sharing with residents.

4.5 We will build on the success of the Micro Enterprises scheme to create a Community Economic Unit (CEU) within each PCN/locality geography to drive community economic development.

Chapter 5:
Transforming Primary Care

Chapter 5: Transforming Primary Care

5.1 Introduction

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 resources 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.

There are 27 different GP practices in Thurrock, operating over 38 premises. Quality in terms of CQC ratings has improved significantly during the last six years but since the inception of the NHS in 1948, the model of primary care has changed little, with surgeries operating as separate small businesses. This model worked well for much of the last century, where the primary needs of patients related to acute illness and episodic care. However, in today's world where the majority of the NHS budget is spent on treating long term chronic conditions, it is no-longer fit for purpose:

- There are too many different operating models between practices making it difficult to adopt best practice borough wide
- There is significant variation in workforce skill and speciality between practices, with barriers to sharing workforce skills
- Resilience at individual surgery level remains low in some cases.
- Investment and capacity in individual surgeries varies and does not necessarily adequately reflect variation in practice population need. Too often, the most deprived populations face the worst ratio of clinicians to patients.

The inception of new Primary Care Networks where surgeries come together over a larger geographical footprint to collaborate and share resources provides an opportunity to reimagine how we deliver a general practice model fit for the 21st century. We need to drive improvement in access and quality and address variation, levelling up the provision of care within all of our surgeries around best practice and capitalising on the 'at scale' opportunities that PCNs bring.

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 in conjunction with other community services.

Thurrock has four PCNs based around the four locality geographies set out in figure 5.1. Each has a designated Clinical Director, who are General Practitioners from local member practices, to drive their development. We will seek to organise all future health and care services around these four localities wherever possible.

Figure 5.1 - The four Thurrock Primary Care Networks
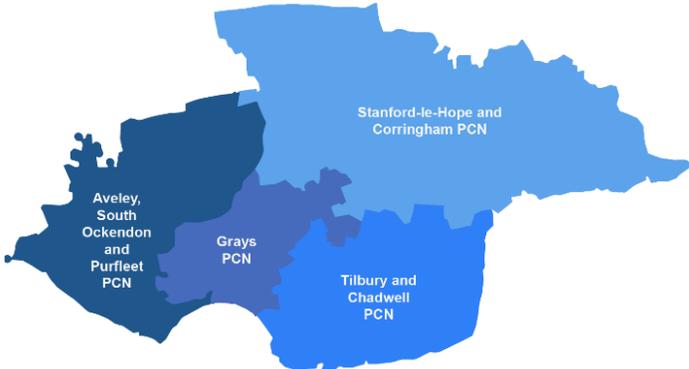
5.2 Improving Primary Care Access

Primary Care is currently under enormous pressure with demand for appointments are currently at record highs. 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 non 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.

Old telephony systems have been unable to cope with new demands placed upon them caused by the increased demand and increased use of telephone consultations. 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.

The national patient satisfaction survey shows satisfaction amongst our residents with GP access to be significantly worse than England's with dissatisfaction on four key access metrics being lower than England's in every PCN area except Stanford le Hope with the lowest levels found in ASOP PCN area.

Analyses by the Thurrock Public Health Team also showed that appointment availability correlated poorly with overall population health need within different PCNs, with the greatest level of inequity between appointment availability and population health need found also in ASOP. By triangulating these data, we can see that in order to improve resident satisfaction with access, we need to both ensure that appointment availability adequately reflects variation in need, and ensure that as a minimum, the same level of equity between need and availability enjoyed by Stanford-le-Hope residents is replicated in every PCN area.

How We Will Improve Access

Levelling Up Through Investment to Close the Equity Gap

We will 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". As future growth funding becomes available, we will prioritise investment in a way that first closes the equity deficit between ASOP and Thurrock and then brings appointment availability of all PCNs up to the level of equity against population need found in Stanford-le- Hope.

Integrated Medical Centres

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. Each IMC will contain at least one GP practice and will act as a locality hub from which a wide range of additional services for all practice populations and staff within the PCN can benefit.

IMCs will provide wrap around services to the entire PCN and be an attractive place for clinicians to practice, making it easier to attract the brightest and best to the borough.

The wide range of additional support provided from each IMC working in a coordinated way to a single integrated model will make most efficient use of resources, ultimately impacting positive on access and freeing GP time to concentrate on more complex patients.

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.

Since 2017, we have made considerable investment into these additional clinical roles, initially in Tilbury and Chadwell, and more recently within other PCNs. We will build on this existing workforce through the new NHS England Additional Roles Reimbursement Scheme to recruit a wide range of additional clinical roles to each PCN including physiotherapists, clinical pharmacists, mental health practitioners, nursing associates, OTs, and paramedics. Recruitment will be based on a workforce skills gap analyses.

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. We are piloting an innovative project incorporating cloud-based telephony run by specialist staff in care navigation in two PCNs. Operating at PCN rather than practice level, this also frees up individual practice telephone lines for virtual consultations. If successful we will seek to roll out across the borough.

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.

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

Although there has been concern raised both nationally 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 will be accelerated to meet demand.

We will also seek to leverage the positive impact that our single point of contact - *Thurrock First* has on preventing avoidable demand on primary care by delivering a comprehensive communications campaign to increase resident knowledge of the service and what it can offer.

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.
The reasons behind variation in outcome are likely to be complex and multifactorial and include differences in practice population based need and behaviour. However variation in funding, workforce, estate, operating models and silo working are likely to also be causes.

5.4.2 How we will Reduce Variation in Outcome and Improve Quality

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

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. We will use the newly formed Clinical Professional Forum and Network meetings as a mechanism to share best practice and facilitate collaboration.

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.

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 will allow ARRS staff to access the record of any patient registered within the PCN without the need to travel to the individual surgery to which the patient is registered, reducing travel time and empowering staff to design and deliver PCN wide clinical services. We will also develop single integrated Long Term Conditions Management Services at PCN level providing a 'one stop shop' where patients with multiple long term conditions can receive holistic treatment for all conditions in one go, reducing duplication and allowing better cohorting of patients at different levels of risk.

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. We will support surgeries to develop clinical operating models at PCN level 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 drive standardisation and inequity in outcome. We will start by commissioning our Stretched QOF contract at PCN level.

Quality & Patient Safety and Education

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.

We will prioritise performance improvement on LD and SMI health checks, connecting practices with additional support through Thurrock Lifestyle Solutions and by ensuring EPUT Mental Health Practitioners are embedded in every PCN.

Alongside national and MSE wide communications strategies, we will undertake further work ito communicate new models of care locally to residents by various methods of patient education. We will use the Community Reference Boards and Communities of Practice to involve patients in co-designing new service models.

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
- At scale provision of many 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.

SUMMARY OF STRATEGIC ACTIONS

5.1 We will prioritise future investment to close the equity gap experienced by ASOP PCN and bring all PCNs to at least the same level of equity currently only enjoyed in Stanford-le-Hope PCN.

5.2 We will leverage the opportunities of the new integrated Medical Centres to attract the best and brightest primary care clinicians to Thurrock, and to develop integrated models of clinical care.

5.3 We will continue to invest a broader clinical skill mix in Primary Care through the ARRS programme, and undertake a skills audit in 2022/23 to determine the most appropriate additional roles to recruit.

5.4 We will pilot new Cloud Telephony technologies in two PCNs in the borough and use the learning to roll out a new telephony approach system wide

5.5 We will work with MSE ICS to encourage greater adoption of on-line consultation platforms by giving a greater choice of providers to individual practices.

5.6 We will leverage Thurrock First imact on reduced demand for Primary Care through a comprehensive communications campaign in 2022/23 to increase resident knowledge and use of the service.

5.7 We facilitate collaboration between practices, delivering more services 'at scale' at PCN level, including ARRS services and Long Term Conditions Management

5.8 We will offer every PCN a single SystmOne unit to allow sharing of patient medical records PCN wide to facilitate integrated and 'at scale' service delivery.

5.9 We will integrate PCN clinical capacity into broader Integrated Locality Networks, and empower staff to collaborate to co-design single integrated solutions in conjunction with residents

5.10 We will support PCNs to improve continuity of care

5.11 We will align commissioning to support integration at PCN rather than practice level, starting with revision of our Stretched QOF contract to focus on PCN level population outcomes

5.12 We will reinstate face-to-face proactive practice quality visits and action planning, at PCN and practice level and replacing annual profile cards with real time data.

5.13 We will proactively engage with practices to improve performance of Learning Disability Health Checks and SMI health checks.

5.14 We will ensure that resident voice is at the heart of service redesign and transformation through Community Reference and Engagement Boards and Communities of Practice

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

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 and a detailed PHM strategy for Thurrock. This Executive Summary is only able to pick out some of the highlights.

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). It demonstrates that almost 50% of the total Adult Social Care, A&E attendance and Hospital Inpatient budgets is attributable to only 1% of the population, with a 6% consuming a further 35% of the budget. The characteristics of the different population segments are different and in order to deliver better health outcomes for residents and make our system more financially and operationally sustainable we need to tailor different care interventions at different population cohorts, and act in a proactive way to prevent residents health deteriorating and moving upwards through the segments.

Figure 6.1
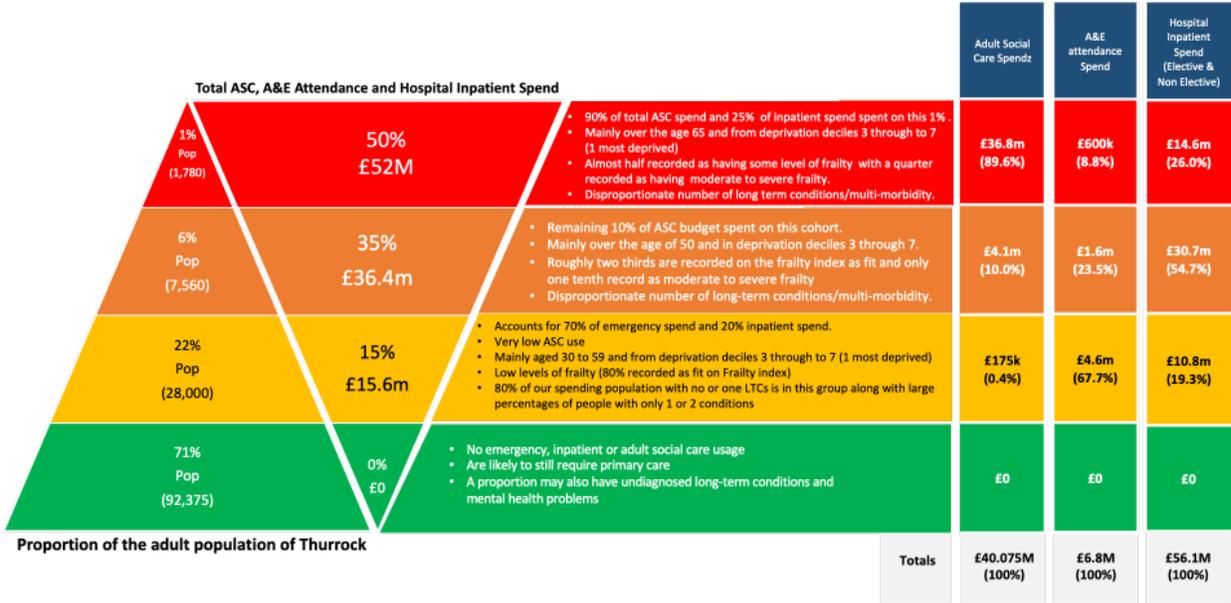
Figure 6.2
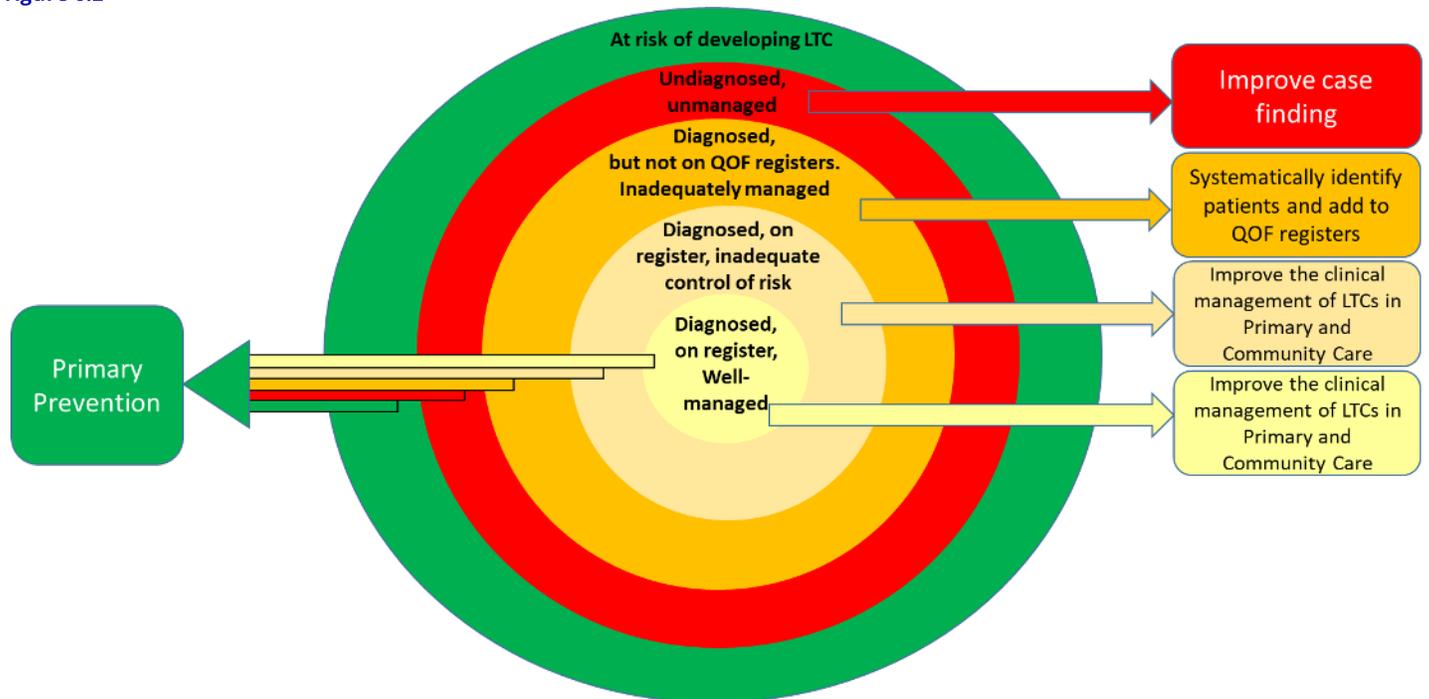
As a population, we are living longer but not necessarily healthier lives. Increasingly, residents are living with one or more chronic health conditions like diabetes or high blood pressure that can be treated but not cured. 70% of the NHS budget is now spent on managing these types of condition.. More than one-third of our residents have already been diagnosed with at least one long-term condition, and of this cohort, 43% have been diagnosed with two or more conditions. Many more have conditions that remain undiagnosed or treated, or have behavioural risk factors like smoking and obesity that put them at elevated risk of developing long-term conditions in the future.

We can further segment our population into risk cohorts based on long-term condition risk, as shown in figure 6.2 and tailor different proactive interventions to them in order to help them stay as well and independent for as long as possible.

6.3 Primary Prevention

Primary prevention refers to programmes or activity that prevent disease occurring by modifying risk. As noted in chapter 2, the two biggest risk factors within our population of smoking and obesity where Thurrock has significantly greater prevalence compared to England and regional averages. We calculate the cost of smoking along in Thurrock to be £42.6M

Both of these issues are complex and multifactorial. We need to address them through whole system approaches.

Both of these issues are complex and multifactorial. We need to address them through whole system approaches.

On smoking, we will bring forward and implement a whole systems strategy to Tobacco Control based on the detailed analyses contained within our recent Tobacco Control JSNA. We will also re-launch the Tobacco Control Alliance to oversee the implementation of the strategy and provide system leadership to reduce smoking prevalence. We will also embed a smoking cessation offer within clinical pathways in community and secondary care services, prioritising mental health, cardio-vascular and respiratory services. Finally, we will align our current Thurrock Healthy Lifestyles Service within the four integrated care models that we will build around the four PCNs.

On obesity, Thurrock has already developed a Whole Systems Obesity Strategy and approach, centred around five goals relating to children and young people/schools, community activity, improving the food environment, increasing physical activity, and the better identification and treatment of obesity.

We will refresh and review the action plans that sit under the strategy in light of the COVID-19 pandemic and restart the approach based on Human Learning System principles.

We will also build on the successful pilots in Stanford and Corringham PCN to use Population Health Management techniques to deliver holistic and personalised responses to residents at high risk of obesity.

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

We know that many residents in Thurrock are living with long-term health conditions that remain undiagnosed and therefore untreated. Over 11,000 of our residents have undiagnosed high blood pressure, over 8,000 have undiagnosed Coronary Heart Disease and over 7,000 have undiagnosed depression.

Our analyses also shows us that these undiagnosed cohorts of residents are at significantly increased risk of hospital admissions and that the majority of hospital admissions for the most common long term conditions are in those who were not on GP Quality Outcomes Framework Disease registers and so were not getting proactive treatment and management for their conditions to keep them well (the orange bars in figure 6.4 below). More extraordinarily, even after a hospital admission for their condition, only a small minority were placed on the correct QOF register to ensure they received systematic preventative care (the green bars), with the vast majority (the red bars) remaining untreated.

Figure 6.3

Level of successful addition to QOF registers following emergency hospital admission for different Long Term Conditions (2019/20)
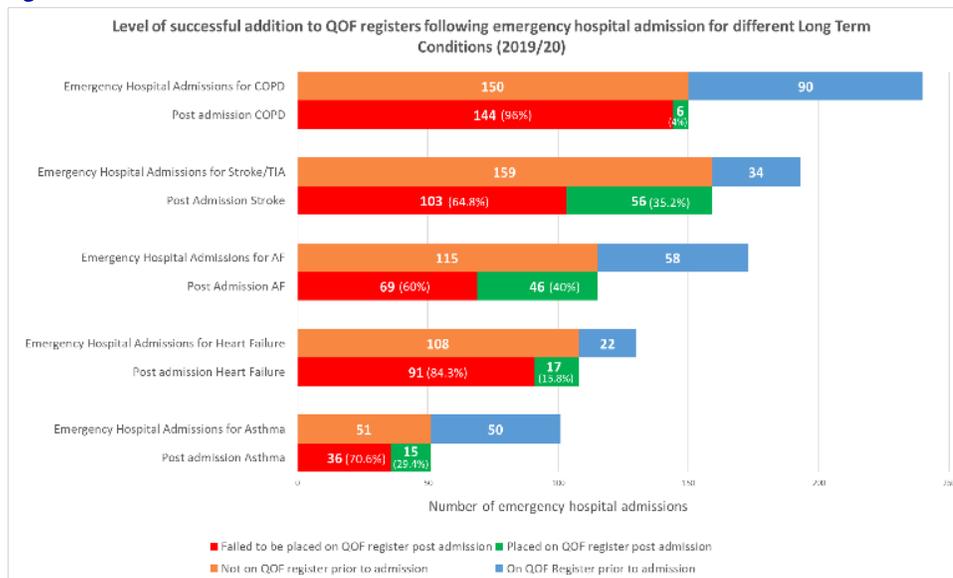
Diagnosing and treating residents with undiagnosed chronic conditions highly cost effective in preventing serious health events and avoidable hospital demand. For example, for every 15 residents with undiagnosed high blood pressure that we diagnose and treat, we prevent one hospital admission that year for stroke.

We calculate that **there is a total opportunity to prevent up to 546 hospital admissions for stroke**, **heart failure, COPD, atrial fibrillation, diabetes and high blood pressure** amongst Thurrock residents by more effective diagnoses and treatment of the undiagnosed. **We estimate that this would save over £5.4M to NHS and almost £2.6M to adult social care budgets in Thurrock every year.**

Action we will take to improve the diagnoses of undiagnosed long-term conditions (Case Finding).

The main strategy sets out detailed action that we will take systematically to improve the diagnoses of long term conditions. This includes expanding our existing successful hypertension case-finding programme to include Atrial Fibrillation and depression through use of our Stretched QOF contract and bringing forward a detailed Case Finding strategy in 2022/23 co-designed with local clinical leaders. We will embed opportunistic case-finding in settings where evidence suggests it yields the greatest results including AF case-finding as part of flu vaccination clinics and community podiatry clinics.

We will also exploit the capabilities of integrated data to improve diagnoses and treatment. For example, we will construct automated reports that will interrogate prescribing, primary care and hospital datasets to identify patients likely to have been diagnosed with long-term conditions but who have not yet been added to QOF disease registers and so will not be receiving systematic preventative care. We will also use linked patient data set and informatics capabilities to flag for review or automatically write patients details where diagnosis is confirmed in hospital, back onto GP QOF records to ensure systematic preventative care starts within the community following a hospital admission.

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

Almost four in ten of our adult residents have already been diagnosed with a long-term condition and are receiving clinical management in primary care via the QOF contract. The majority are well managed and their conditions well controlled, a significant minority do not receive the most effective care to keep them well. Our analyses shows that it is this cohort that remain at greatest risk of hospital admissions.

This can be demonstrated in figure 6.4 below, which through Thurrock's integrated data capabilities can now identify multiple 'up-stream' prevention failures in those 193 residents admitted to hospital because of a stroke/TIA in 2019.

Figure 6.4
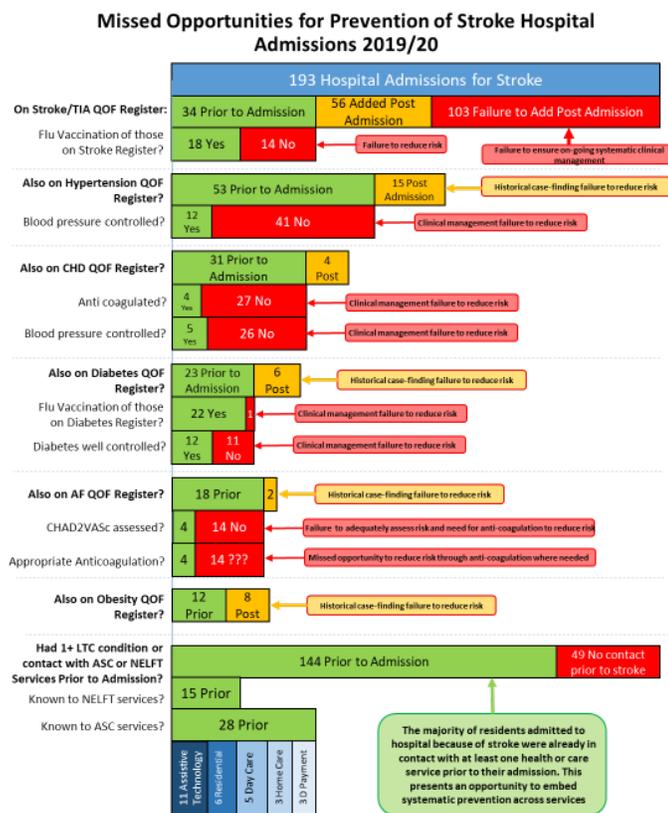
There were a total of 91 case finding failures pre admission and a further 103 stroke patients failed to be added to the Stroke/TIA QOF post admission, substantially increasing the risk of on-going failure of secondary preventative activity, systematic clinical management and further strokes.

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. These included failure to control high blood pressure, failure to control diabetes, and failure to assess vascular risk score and anti-coagulate appropriately.

It is also striking that of the 193 admissions, 144 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, rather than delivering it through silos within primary care.

Through analyses set out in the main strategy using our linked data, we estimate that **there is a potential total opportunity to prevent 384 hospital admissions** in Thurrock residents for stroke, heart failure, atrial fibrillation, high blood pressure and diabetes through optimising long-term condition management and that in doing so **we could prevent £2.1M of cost to local NHS budgets and a further £837K of cost to Adult Social Care budgets.**

Action we will take to improve the clinical management of long-term conditions

This main strategy details a comprehensive set of actions that we will take to build on Thurrock's existing PHM programme that operated before the COVID-19 pandemic and had already halted and reversed the historical upward trend in cardio-vascular admissions.

Historically every GP surgery has managed long-term conditions in isolation, and usually treating different conditions in different appointments. The advent of PCNs allows us to deliver a more integrated model. We will embed integrated long-term conditions clinics at PCN level, starting with cardio-vascular and diabetes, and integrating wider behavioural and lifestyle support as 'one stop shops'. We will revise our Stretched QOF contract to support this approach, rewarding practices on the basis of outcomes across multiple long-term conditions and at PCN as well as practice level.

Our long-term conditions profile cards and practice visits have supported surgeries to action plan and improve outcomes but are based on year-old data. We will use new integrated data capability and enhanced informatics capability built at PCN level to provide data on long-term conditions management in near real time dashboards as a clinical support mechanism to better management. We will also encourage PCNs to share workforce capability and deliver new integrated models of care for different patient cohorts with different risk profiles.

SUMMARY OF STRATEGIC ACTIONS FROM MAIN STRATEGY

6.1 We will develop and implement a whole systems Tobacco Control Strategy based on the analyses and recommendations of the Thurorck Tobacco Control JSNA

6.2 We will lreconstitute and relaunch the Thurrock Tobacco Control Alliance to oversee the implementation of the strategy and provide system leadership on the issue of tobacco control.

6.3 We will embed a smoking cessation offer within clinical pathways in community and secondary care inpatient and outpatient services, prioritising cardio-vascular, respiratory and mental health.

6.4 We will align and embed the Thurrock Healthy Lifestyles Service within the four Integrated Care models built around our four PCNs.

6.5 We will collate and analyse feedback from the recent community engagement exercise on the Whole Systems Obesity Strategy to understand the impact of COVID-19

6.6 We will refresh our Whole Systems Obesity Strategy action plan in the light of the above and continue to implement a whole system approach to obesity based on Human Learning System principles

6.7 We will build on the successful pilots in Stanford and ASOP PCNs to use Population Health Management techniques to deliver holistic and personalized responses to residents at risk of obesity

6.8 We will expand the successful hypertension screening programme to include AF and depression through use of stretched QOF and by identifying PCN and practice clinical leads

6.9 We will embed opportunistic case-finding into the day job of a broad range of resident facing staff including Wellbeing Teams and the Integrated Locality Networks

6.10 We will embed opportunistic case-finding in settings where evidence suggests the best results are yielded including AF screening in flu vaccination clinics and community podiatry.

6.11 We will co-design and implement a detailed case-finding strategy with PCN, NELFT & EPUT clinical leaders setting out revised screening protocols for hypertension, AF and depression.

6.12 We will create PCN Intelligence functions to provide near real-time intelligence to GP practices on long-term conditions and secondary care discharge to improve clinical management

6.13 We will use the new intelligence functions to systematically interrogate patient data sets against QOF to identify patients that need to be added to QOF registers.

6.14 We will develop clinical protocols with local PCN clinicians allowing the most obvious patients from the above to be automaticall re-written to QOF, for example those with a confirmed hospital diagnosis.

6.15 We will bring forward a business case for PCN level Clinical Review Resource, to support the review and where appropriate, addition to QOF of patients identified through remote digital clinical audit.

6.16 We will encourage individual surgeries to share workforce across PCNs to deliver LTC PCN level LTC integrated care models with cohorting of patients based on risk profile.

6.17 Through use of PCN level Intelligence Functions & real-time PHM data, we will create LTC dashboards that identify patients in need of review & intervention as a replacement to current profile cards.

6.18 We will re-design and recommission stretched QOF to incentivise practices to collaborate at PCN level based on care bundle outcomes, maximising impact on hospital admission avoidance.

6.19 We will create single PCN level multi-morbidity LTC clinics starting with cardio-vascular diseases and diabetes, with Consultant and Specialist Nursing Input and access to diagnostics.

6.20 We will embed behaviour risk modification services, social prescribing & ASC support into multi-morbidity models, providing holistic services and motivational interviewing.
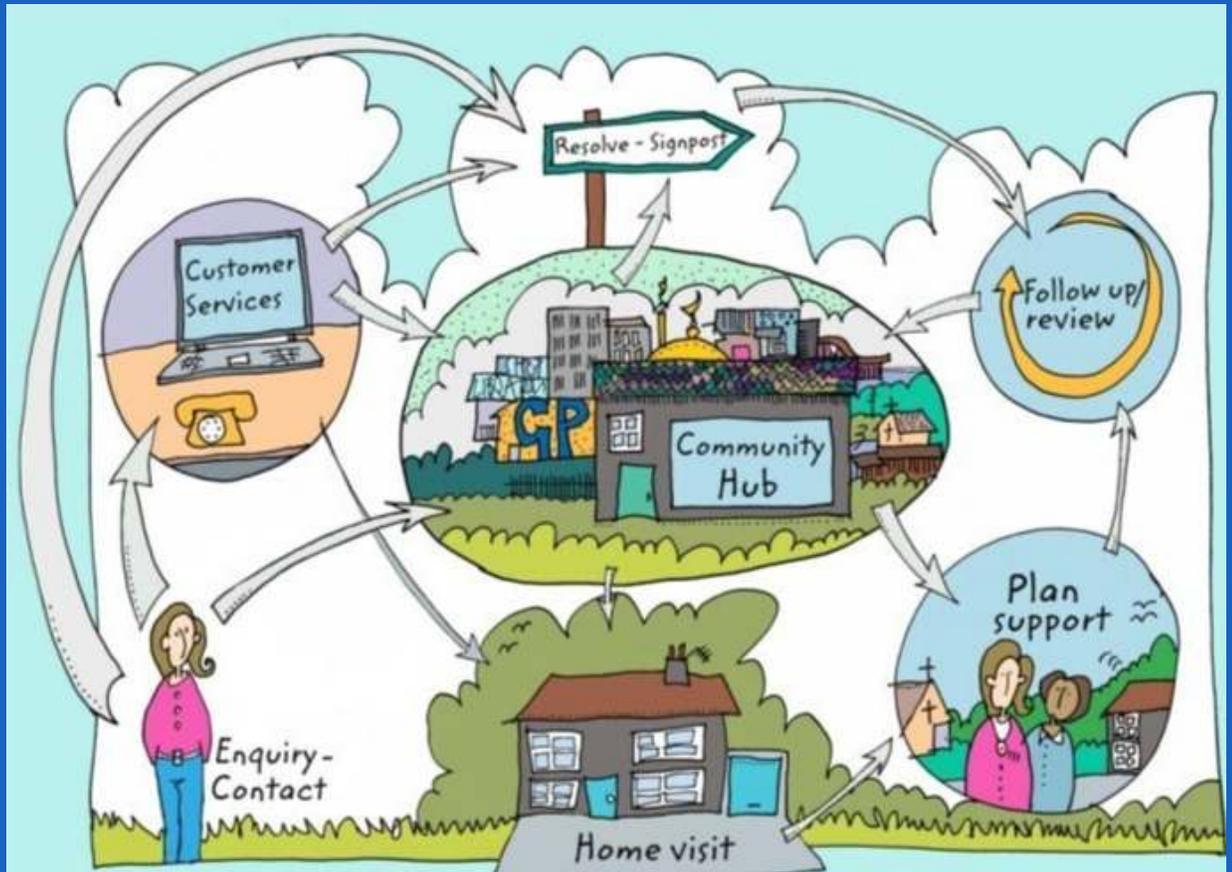
Chapter 7:
Integrated Care and Support in the Community

Bespoke solutions in a complex world

Chapter 7: Integrated Care and Support in the Community

7.1 Introduction

Within the community, there currently exists a dizzying array of individual teams and services, provided by different organisations, each with their own referral criteria, thresholds 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.

We have told ourselves that the way to manage demand is to restrict care based on thresholds. In reality, this way of working increases rather than manages demand, waiting for residents to deteriorate until they need a more expensive intervention. 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.

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 recent case study (right) of an actual Thurrock resident, demonstrates the impact that the current design of our system 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.

7.2 Learning from Transformation Undertaken to Date

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.

In order to work in this way, we need to focus resource at locality level. We reject fundamentally reject the maxim that efficiency is always gained by delivering services over a larger geographical footprint. Our experience tells us that often the reverse is true. Place and locality working allows professionals to form relationships with each other rather than making onward referrals, design integrated solutions and use community assets as part of those solutions rather than always prescribing services or interventions. This is cheaper, more effective, less bureaucratic and most likely to prevent 'failure demand'.

Thurrock has already transformed many services to work in this integrated, strengths-based, holistic and ultimately more human way as shown in figure 7.1

Figure 7.1
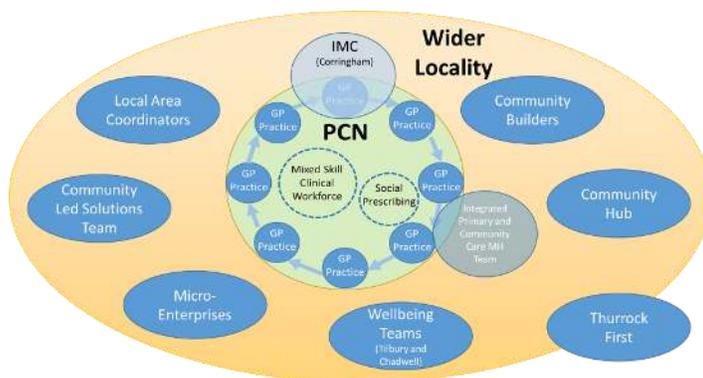
Thurrock First

Thurrock First is our single point of access across community health, mental health and adult social care. Operating 365 days a year, it provides integrated first point of contact provision across primary care, community and mental health care and adult social care.

Operating 365 days a year, the service provides integrated first point of contact provision across primary care, community and mental health care and adult social care. It reduces, prevents and delays the need for more significant care by intervening earlier and working closely with the Urgent Care Response Team who can be mobilised to attend residents' houses when they are in crisis.

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.

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

Mental Health Integrated Primary and Community Care Locality Model

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 normally provide but don't meet the threshold for traditional secondary services. It delivers a holistic offer that allows wider determinants of mental health such as housing, employment and social support to be addressed alongside specialist psychiatric nursing, psychology, and Consultant input.

7.3 A New Model of Integrated Locality Working

However, these models of best practice sit within a wider landscape of too many individual and fragmented teams and services, delivered on too big a geography to enable place or strengths-based working, all with different referral criteria and thresholds, as shown in figure 7.2. We need to reform and transform these based on our principles, values and learning to date, so that they too can operate in a way that empowers professionals to work alongside residents to design bespoke, integrated solutions.

Figure 7.2

Current Service Landscape
Majority of Functions Delivered by Separate Teams with Different Thresholds and Referral Criteria
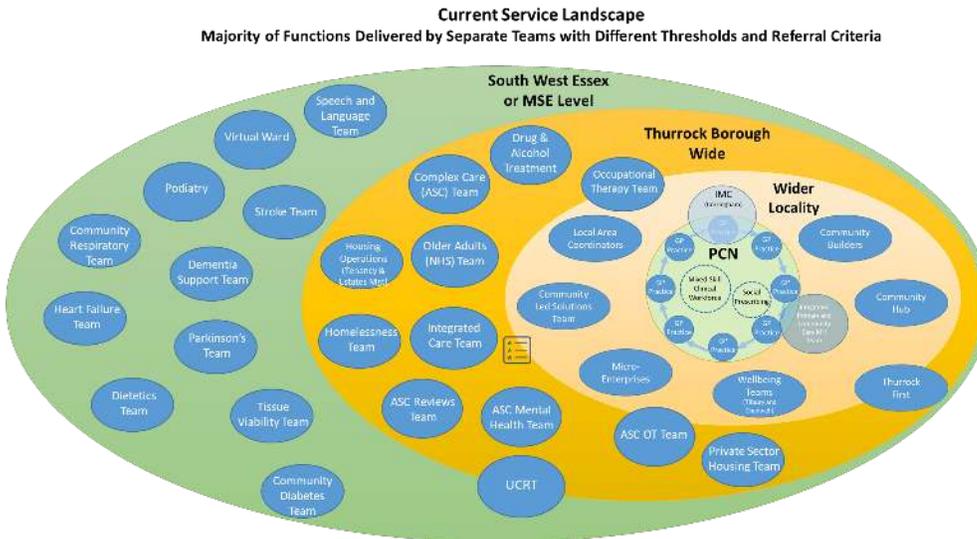
To achieve this change, we will embed as many services as possible into four Integrated Locality Networks, around each of our four PCNs. Where services cannot be fully embedded, named professionals within them will be aligned to one of the four Integrated Locality Networks. The networks will allow professionals to build relationships with each other and residents to co-design integrated solutions rather than making assessments or referrals. For residents with more complex needs, a single care plan will be developed and one named professional will be responsible for coordinating all care. The new Integrated Locality Network is shown in figure 7.3 and Chapter 7 of the main strategy gives a detailed explanation of how services will be embedded and aligned.

Figure 7.3

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

Our model for integrated care and support will be underpinned by the three key pillars set out in figure 7.4 based on our learning to date and the values and principles set out in Chapter 2.

Integrated Locality Working

Pillar 1: Place as an Organising Principle

Pillar 2: Adopting a New Working Culture

Pillar 3: Coordinated, Bespoke Care

Place as an Organising Principle

PCN Locality as the Planning Footprint. Health, Care, Housing, Third Sector multi-disciplinary team approach at locality (PCN) and neighbourhood (sub-locality) level.

The Integrated Medical Centre acts as the locality 'hub'

A Single Integrated Locality Network. Staff build relationships and collaborate to co-design, develop and deliver single integrated solutions rather than refer on or sign post.

Larger teams organised on and based at the locality footprint. Smaller teams that can't be fully embedded have named staff aligned to each Integrated Locality Network

Support from small specialist teams brokered in by the locality network. Specialist teams used to upskill locality network.

A New Working Culture

Empowered Staff free to use their professional judgement to 'do the right thing' within a broad framework of principles rather than being constrained by standard operating procedures.

Solutions not services. Staff build relationships with communities and use community assets and third sector support and embed within solutions rather than automatically prescribing a statutory service.

A Learning Culture adopted as the way of managing and transforming the complex system. Staff encouraged to innovate and share learning across the network.

Focus on what matters to residents. Staff start by building relationships, finding out what matters to them, and let solutions drop out of the relationship. The resident will define their own goals.

Coordinated, Bespoke Care

Bespoke Solutions to Complex Problems Residents with problems requiring different types of support will access it in one integrated solution at the same time. Solutions will be bespoke and potentially broader than traditional NHS or ASC interventions.

Care Coordination. A single named person within the Integrated Locality Network coordinate and broker all care required as part of the solution. This is likely to be the person whom the resident has the best relationship with.

Single Integrated Care Plans will be developed for the most complex individuals, linked to the goals that the resident has set for themselves. The plan will set out all input required from NHS, ASC and 3rd sector services.

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.

In phase two, we will use the learning from small 'test and learn' pilots based on Human Learning Systems methodology to seek to create new 'blended roles'; staff with skills and responsibilities to deliver health and care functions historically delivered by different teams or organisations, for example a Complex Needs role that can deliver addictions, mental health and housing support.

SUMMARY OF STRATEGIC ACTIONS FROM MAIN STRATEGY

7.1 We will create four new Integrated Locality Network of professionals aligned around each IMC/ PCN 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 aligned staff.

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 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.

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. Many different teams and people undertaking different tasks are required to enter a resident's home; services focus only on bio-medical needs - fixing people rather than focusing on what really matters to them. They are reactive rather than preventative and offer inadequate scope for long-term care relationships and care continuity and to spot when a resident may be improving or deteriorating. Lack of integration adds cost and results in avoidable 'failure demand to the wider system.

In Thurrock almost 60% of those in receipt of home care received it from a private sector provider, with the remainder receiving care from Thurrock Care at Home, the council's in-house care provider.

Externally commissioned providers operate on low margins, care staff often receive low rates of pay, and the existing home care provider market is extremely fragile. Workforce recruitment and retention remains challenging. Providers are commissioned to deliver the same pre-determined set of tasks each day, with no flexibility to respond to the varying needs of residents. Traditional commissioner-provider relationships based on contract management reinforce outdated delivery models and stymie innovation.

8.2 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.

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 from traditional home care, using from the four building blocks of the Dutch Buutzorg model 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.

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.

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 in a flexible way. Care plans are reviewed regularly so that changes can be made as often as is required.

The sub-locality geography allows Wellbeing Workers to develop a detailed understanding of the community assets and networks within their neighbourhood and connect service users into them. The small nature of the team allows the formation of long-term care relationships and strong continuity of care. Workforce challenges are addressed by creating more interesting and flexible salaried roles, with staff empowered to make decisions based on the best interests of their clients.

Evaluation of Impact

Early evaluation of the programme suggests some significant positive differences in outcomes for residents receiving care from a Wellbeing Team. Those cared for by a Wellbeing Team had up to a 32 fold lower rate of GP appointment use compared to standard home care and were three times less likely to be admitted to hospital.   When they were admitted, their length of stay was considerably lower and 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, extrapolated across all Thurrock residents in receipt of a domiciliary care package, is significant.

Figure 8.1 demonstrates this potential impact of replacing historical domiciliary time and task care models with Wellbeing Teams in terms of avoided GP appointments, hospital admissions and excess bed-days. It shows the significant potential opportunity of the Wellbeing Teams model in reducing GP appointment usage and hospital admissions and excess bed days, and the associated potential savings.

Figure 8.1
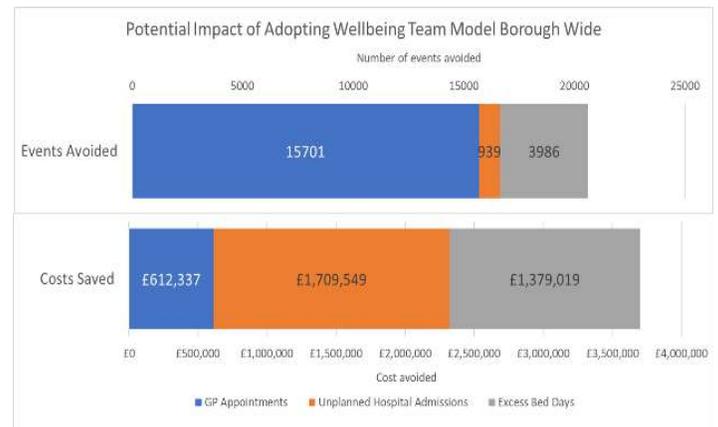
8.3 Further expansion of the Existing Wellbeing Teams Model

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

The first phase of the approach will see eight 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, *Thurrock Care at Home* Community Teams will move in phase two to adopt the full Wellbeing Teams model.

For 2022/23, **Wellbeing Teams will cost £32.12** per hour of direct care provided. This is significantly less than the **Thurrock Care at Home overall direct care rate of £41.67** per direct care hour, and so transforming Thurrock Care at Home has the opportunity to deliver better outcomes at a chapter cost. However, externally commissioned home care costs significantly less at £19.00 per hour, making roll out of a directly provided service borough wide, unaffordable.

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, the model is more expensive and a mixed in-house and externally commissioned approach provides the best solution. We will therefore undertake future market developed to shape the local care market and to deliver Wellbeing Teams through a mixed market model including external commissioning, starting with some preferred providers who have expressed interest. 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.

As our 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, 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. Figure 8.2 shows the potential financial impact of this mixed externally commissioned and directly provided model. At system finance level, it may be possible to deliver Wellbeing Teams across the borough whilst delivering system savings of over £1.6M.

Figure 8.2
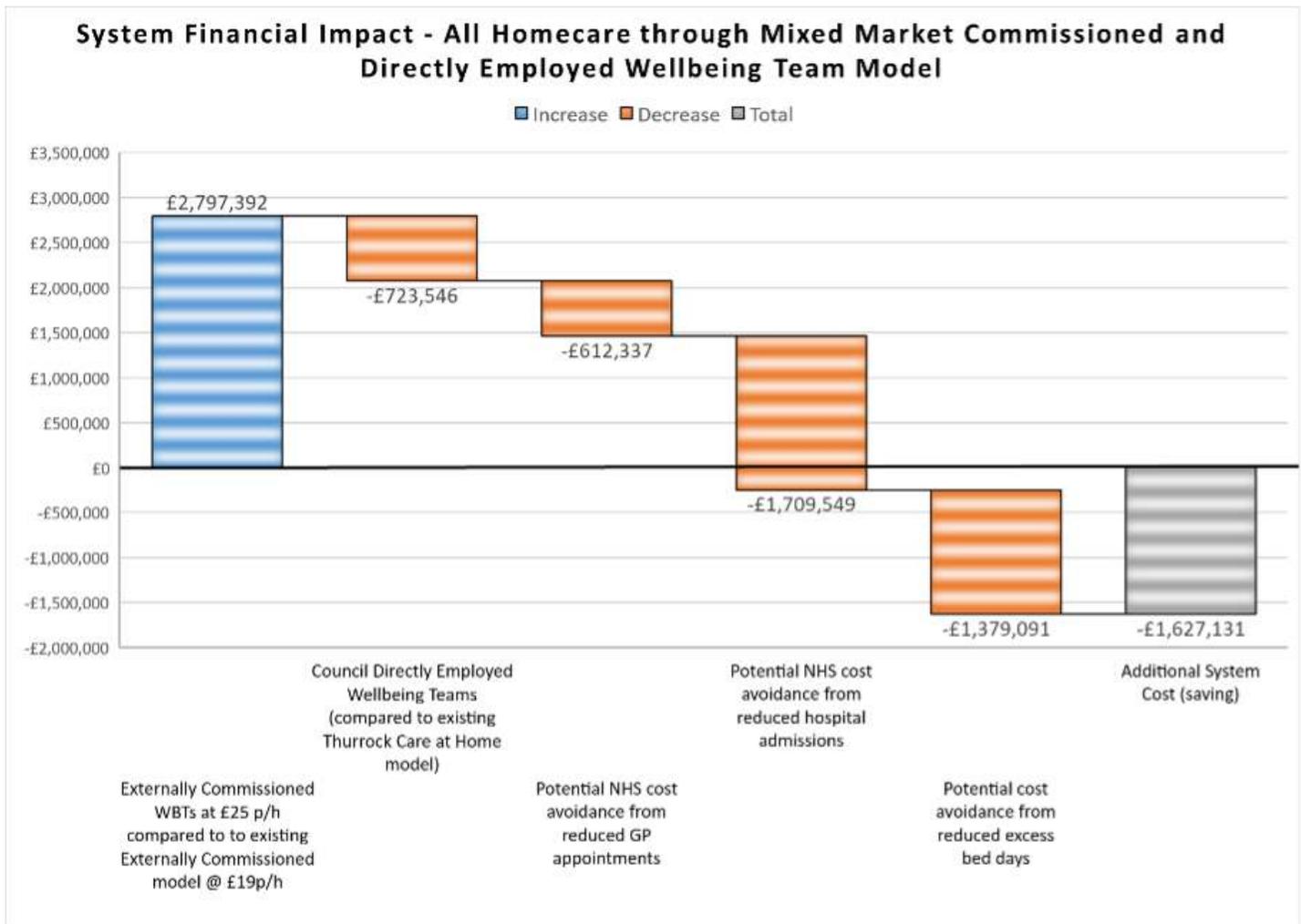
As previously stated, the current model has been built using evaluation data over only one year based on a relatively small sample size. In order to ensure that any future commissioning is based a more robust model, we will continue to collect evaluation data over 2022/23 with the view to bringing forward a system business case for roll out of Wellbeing Teams borough wide from the last two quarters of 2023/24.

8.4 Further Transformation of the Existing Wellbeing Team Model

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, reducing the overall number of visits needed, freeing up NHS capacity and rationalising the number of people involved in a residents care. This will improve care continuity, helping us to spot problems earlier and avert crises.

Blended *"Health and Care Wellbeing Worker"* roles will require staff training and skills development but also offer 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.

Hospital Discharge Planning and Reablement

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 home care package. In future, we envisage Wellbeing Teams taking responsibility 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, allowing proactive 'pull though' of residents from secondary care back into the community.

We will also 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.

Specialist Clinical Support

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. Our Integrated Care Team nurses will work alongside Health and Wellbeing Workers with named nurses aligned to each Wellbeing Team to undertake more specialist clinical tasks and provide clinical leadership and supervision.

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.

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 for example the Older Adults Health and Wellbeing Team and Dementia Crisis Support.

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.

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.

8.5 Implementation and Impact

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

Figure 8.12

Wellbeing Teams Model

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'.

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. As discussed in the last chapter, we recognise the value of supporting people for as long as possible in their own homes. However, for some, there remains a need for more round the clock intensive support. This needs to be provided to the highest standard in settings that enable to retain control, independence and dignity.

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.

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.

Bruyn's Court: An Exemplar Scheme

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.

Developments of this type also enable people to "right size", often freeing up larger homes which can be more costly to heat and maintain. We will continue to encourage development of similar schemes in all parts of the Borough.

Planning, Regeneration and Partnership with Private Sector Developers

Thurrock is committed to working in partnership with local developers to stimulate to market to deliver a plurality of more specialist housing for our residents. We recently held a Developers' Summit to mobilise support for a private sector housing development programme specifically targeted at older people. We are committed to support developers by:

- 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
- Providing 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.

We will also continue to ensure new housing development supports older people's independence through Thurrock's Housing & Planning Advisory Group (HPAG); 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 group aims to influence planning policy and ensure that planning applications, when received, have already considered impact on health and wellbeing. From 2022, HPAG will be guided by Thurrock's JSNA for the Built Environment.

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 take forward the recommendations in the APHR, developing and implementing an Older People's Housing Strategy based on its finding.

9.3 Reimagining Residential and Intermediate Care

Whilst our current residential care offer is of high quality, 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.

Like home care, the residential care market remains fragile, with a recent Competition and Market's Authority report concluding that many were not in a financially sustainable position.

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.

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:

We have appointed architects who have developed vision for the proposed scheme - *Whiteacres* at the Dilkes Wood site in South Ockendon, including addressing how the development may be phased to deliver the new residential offer for older people based on the Park Place, Portland Oregon model above, and also, potentially, the redevelopment of the adjacent 1950s era health centre should that be agreed with NHS partners.

The architects' report 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 new facilities would also encompass the existing community hub, that provides a wide range of popular services and activities, creating a strong community focus.

The Whiteacre / Dilkes Wood scheme will provide 45 self-contained, easily maintained one and two bedroomed flats designed for frail elderly people, with associated care facilities (loungers, restaurant, treatment rooms, laundry etc. The accommodation is designed to a high standard and includes underfloor heating and separate ventilation systems for each unit.

Our vision is to provide specialised, care-ready accommodation, where residents can enjoy all the comfort and privacy of a self-contained home specifically designed for older age with the availability of on-site social care and nursing care services when residents need them at a level consummate with traditional residential care. This will enable residents with high levels of care need who would traditionally be placed in residential care, to retain (and regain) their independence and live well.

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.

The scheme will also include 30 studio flats for Intermediate Care use, supporting earlier hospital discharge, CHC assessment in a residential rather than hospital setting, and short stays for those requiring intensive reablement services.

Initial financial modelling set out in main strategy suggests that through use of rental income (through housing benefit for those eligible) and savings realised through reduced use of community hospital beds, there is an opportunity to deliver a better care model at a cheaper over all system cost. We will bring forward a full business case early in 2022/23.

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. The current model also fails to integrate with other key health services including mental ill-health treatment and addictions services, and placements often break down as a result.

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 a more flexible, holistic and integrated model of care. Fixed commissioned hours will be replaced by care that flexes in response to the needs of each resident on a daily basis. 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 as a pilot in 2022/23 with a view to broader market development based on the evaluation.

SUMMARY OF STRATEGIC ACTIONS

9.1 We will develop and implement an Older People's Housing Strategy based on the findings of the 2018/19 Annual Public Health Report to ensure development of housing and wider community regeneration to support older people's independence.

9.2 We will ensure that planning policy encourages future development of a plurality of housing that supports older people's independences through use of the Health Planning Advisory Group, 2022 JSNA on the Built Environment and Local Plan

9.3 We build an exemplar model of residential care at the Whiteacres site containing 45 self-contained flats, giving residents the dignity and independence of their own home, but with the same level of care currently provided in residential and nursing facilities

9.4 We will include 30 self-contained studio units within the Whiteacres site for intermediate care and reablement use, facilitating earlier discharge from hospital, with 24/7 specialist care on site and clinical in-reach from our Virtual Ward model

9.5 We will bring forward and agree a business case with Cabinet and NHS partners for Whiteacres in 2022/23.

9.6 We will develop and implement a new flexible exemplar model of supported living for residents with mental health problems, starting by purchasing two dedicated properties in 2022/23, with flexible care 'in-reach'.

**Chapter 10:
Making It Happen**

Integrated Governance, Delivery and
Commissioning

Chapter 10: Making it Happen: Integrated Governance, Delivery and Commissioning

10.1 Introduction

The establishment of good governance arrangements is essential to delivering the vision and aims set by any organisation or contained within any strategy. These arrangements are core to being successful. Chapter 10 of the main strategy document sets out detailed proposals on governance between the ICB and Thurrock integrated Care Alliance (TICA), a place-based delivery mechanism for the strategy, and a new integrated commissioning approach to support delivery.

The arrangements set out within this Chapter reflect how the health and care system at a place-based level (Thurrock) will be governed – meaning how the system will ensure the delivery of our Strategy's vision and aims. This will include the adoption of a new 'learning' culture by all partners involved.

10.2 Governance between the MSE ICB and TIA

Thurrock's health and care system will be based on the principle of subsidiarity and be governed through Thurrock's Integrated Care Alliance (TICA). Arrangements will confirm how Thurrock's system will co-exist with the broader Mid and South Essex Integrated Care System – with the relationship and responsibilities between the two systems to be contained within a devolution and delegation agreement. Governance must be enabling and focus on delivering the best outcomes for Thurrock people at all times. The devolution agreement will set out clear expectations on both sides and will establish 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.

## 10.2 Governance and Delivery at Thurrock level

With system funding being managed through a reviewed Better Care Fund, TICA will have the responsibility for ensuring resources across Thurrock are used to ensure required outcomes are achieved. This includes decisions about de-investment and re-investment.

Most organisational and partnership governance arrangements correspond to the attributes of New Public Management (NPM). This reinforces a system based on 'command and control' and on outputs over outcomes. Our arrangements will be underpinned by the attributes of Human Learning Systems – meaning that they will start and end with the individual and the outcomes they wish to achieve. We will develop governance that is collaborative – working across organisations and communities alike and sharing the power often held by the few. Most importantly, the organisations responsible for the health and care system will be held to account by communities.

Delivery structures too will shift away from NPM and embrace a collaborative and distributive format. An Alliance representing all key partners will act as a 'steward' for the local system, with a range of mechanisms, including boards and focus groups to facilitate and enable good delivery. Figure 10.1 overleaf sets out draft arrangements which will be kept under review.

Figure 10.1

Better Care Together Thurrock: Governance & Delivery Structure
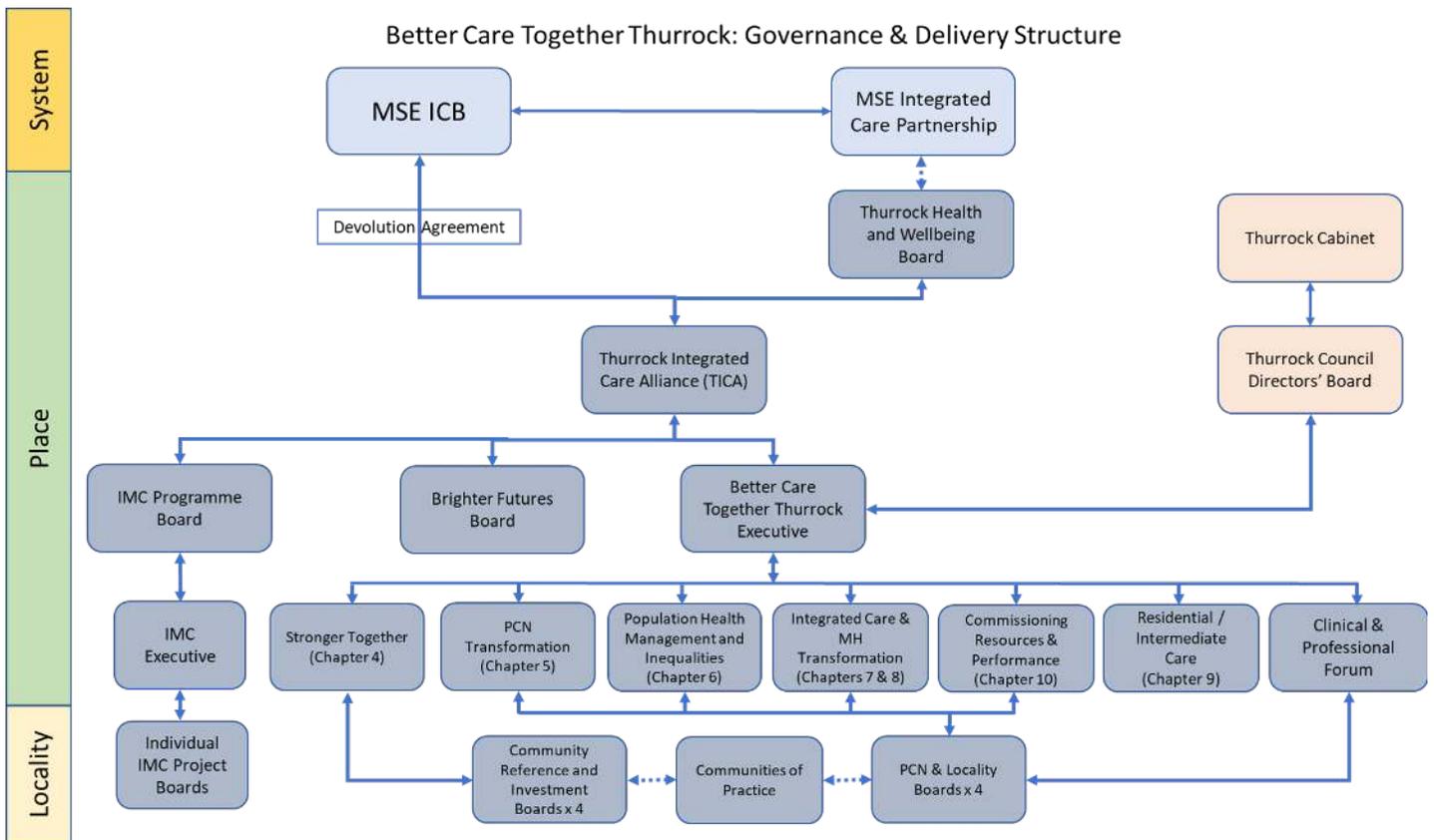
Governance and delivery arrangements are not about one board or group, but about a set of inextricably linked functions underpinned by certain conditions – conditions that epitomise an enabling and person-led approach.

The functions essential for good governance include, amongst others, performance, risk, financial management, information and data, policy and procedure, and commissioning.

10.3 Changing the Commissioning Landscape

One of the foremost governance functions considered within the chapter is 'commissioning'. A new model of commissioning will be adopted that aids the move away from traditional silo model to one that works to deliver bespoke solutions for people requiring support. The shift will mean:

- Flexibility within contracts – building trusting relationships with and between providers;
- Operating around complexity – across service and organisational boundaries;
- Commissioning for learning – enabling providers to be part of testing and changing what they deliver – including doing so collaboratively with other providers;
- Pooling of funding – introducing the pooling of resource across 'place' through use of the Better Care Fund to enabling commissioning solutions that are multi-faceted and cut across organisations and services more easily;
- Broadening the market place and the breadth of choice; and
- Ensuring communities can have a direct role in the commissioning process – shifting to a 'community-led' approach to commissioning.

A number of bespoke pieces of work will be carried out to take the chapter forwards, and these are detailed under the 'Strategic Actions' section.

10.4 Summary of Strategic Actions from Main Strategy

SUMMARY OF STRATEGIC ACTIONS

GOVERNANCE

10.1 We will develop and agree a 'Devolution Agreement' between the ICB and TICA that sets out respodevolved commissioning and delivery responsibilities, outcomes, and resources

10.2 We will develop a new Alliance agreement between all partners for the Thurrock Alliance setting out local governance arrangements, a place based outcomes framework and any financial risk and reward share between partners

DELIVERY

10.3 We will establish the delivery structure set out in 10.1 of this strategy, with named chief officers accountable for delivery of each of the boards and clear TORs

10.4 We will develop and implement one year Thurrock Integrated Care Alliance Delivery Plans based on the strategic actions within this strategy with named SROs for each action and associated business cases

COMMISSIONING

10.5 We will devise a series of 'learning experiments' to shift the working practice of commissioners and providers to one based on HLS principles – establishing 'learning cycles' as a way of working between commissioners and providers

10.6 We will establish a 'learning infrastructure' and mechanisms to capture and share learning between all system actors to inform commissioning, delivery and practice

10.7 We will implement 'system steward' training for all existing commissioners

10.8 We will refresh our existing Market Development Strategy to take into account the principles of HLS and place-based commissioning.

10.9 We will undertake a full review of the Better Care Fund to establish it as the financial delivery mechanism for Thurrock single pooled place and locality budgets and the strategic actions set out within this strategy.

10.10 We will test, evaluate and establish single models of commissioning the span a number of different service areas across the NHS & council, with accompanying pooled budget and governance arrangements