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Health and Wellbeing Board(s)

Thurrock

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Thurrock Integrated Care Alliance comprising Thurrock Council, Healthwatch Thurrock, Thurrock CVS, Essex Partnership University NHS Foundation Trust, NELFT NHS Foundation Trust, Mid and South Essex NHS Foundation Trust, and Mid and South Essex Health and Care Partnership.

How have you gone about involving these stakeholders?

The foundation of this Better Care Fund plan is our new strategy for health and well-being for adults, 'Better Care Together Thurrock – The Case for Further Change', approved by Thurrock Health and Well-Being Board on 24 June 2022 [Agenda for Health and Wellbeing Board on Friday, 24th June, 2022, 10.30 am | Thurrock Council](#) and Thurrock Council Cabinet at its meeting on 13 July 2022.

This strategy, that sets out a hugely ambitious and collective plan to radically transform, improve and integrate health, care, housing, and third sector services, is an approach aimed at the borough's adult population and designed to improve their wellbeing. The strategy sits under the refreshed Thurrock Joint Health and Wellbeing Strategy as it is responsible for delivering or contributing to the delivery of its high-level goals and objectives related to transformation and integration of health, care, wellbeing and housing services.

The Strategy has been developed through a process led by the Council's Corporate Director of Adults, Housing and Health, extensive consultation and collaboration with NHS, housing, adult social care and third sector partners, and more broadly through resident engagement.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

The focus of the Better Care Fund to date has been reshaped by our new strategy for adults: Better Care Together Thurrock - The Case for Further Change 2022 - 26. www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026

The schemes chosen for the Fund reflect this focus. The future plans are likely to continue this focus, and will include elements that are population wide including initiatives linked to preventing, reducing and delaying the need for health and social care intervention.

Priorities for 2022/23 include a focused review of all our schemes with a view to ensuring they closely reflect our new strategy and also:

- Continue to have maximum impact
- Reflect the changes in patterns of health and care needs which have resulted from the pandemic
- Reflect the needs of our communities in the face of unprecedented demand for health and social care services, and significantly reducing resources in real terms.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

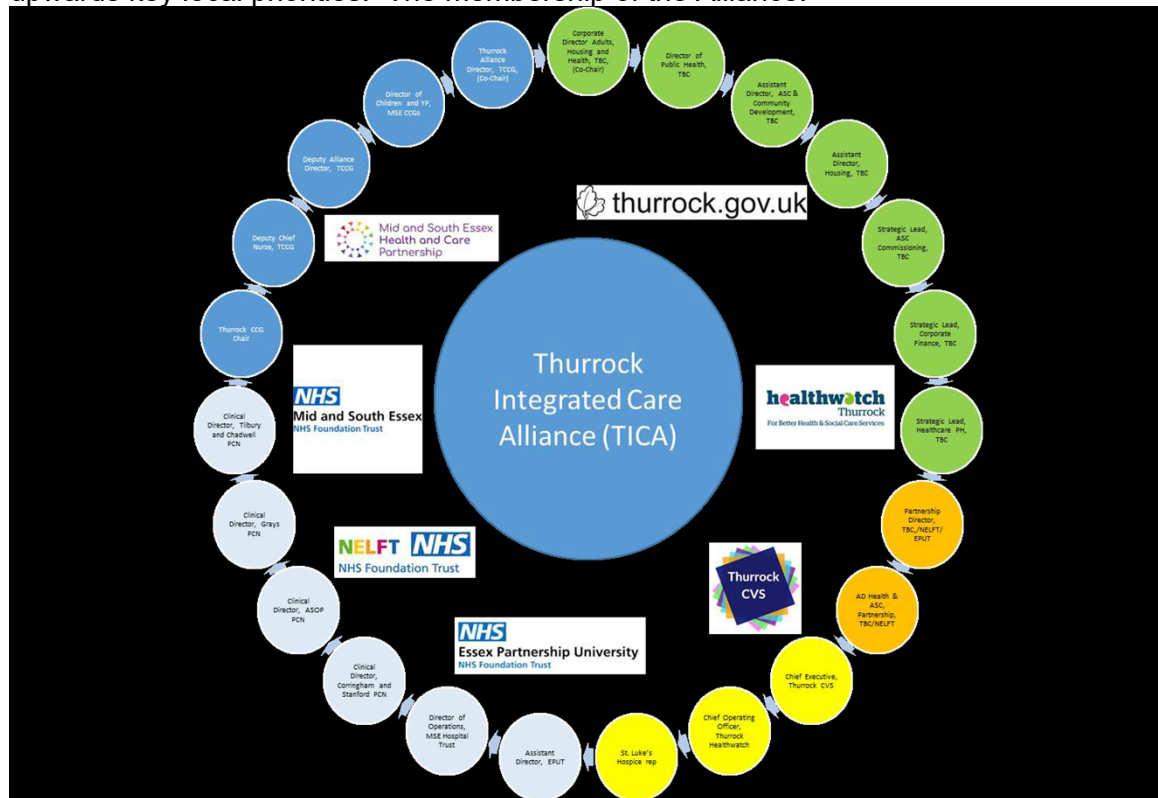
HWBBs across Mid and South Essex have reviewed their functions in the light of legislation on Integrated Care Systems. In Thurrock the review addressed the future governance functions, and the delivery of improved health outcomes through 'Better Care Together Thurrock - The Case for Further Change'.

Accordingly, revised Terms of Reference for the Health and Well-Being Board were approved at its meeting on 24 June 2022: [Report Template \(thurrock.gov.uk\)](https://www.thurrock.gov.uk)

The review also specified how the governance arrangements required between 'place' (Thurrock), and the ICS should operate – including potential areas of conduct, overlap and responsibility. This will shape the devolution and delegation agreement between the ICB and Thurrock Integrated Care Alliance (TICA).

The current governance arrangements continue to include:

- a single Thurrock Integrated Care Alliance with strategic oversight of the health and care transformation agenda - including the Better Care Fund (the plan is synonymous with the transformation agenda), the commissioning agenda and acting as the financial delivery mechanism for health and care integration
- a finance group reporting to the Alliance which has responsibility for financial monitoring and oversight of the BCF and other system level financial modelling, integration of health and care budgets, and identification of system-level savings which could inform issues such as risk and reward in an alliance contract
- a Better Care Together Thurrock Operations Delivery Board sits under the Partnership with responsibility for the delivery of the transformation programme
- to support integrated working at locality level, a Locality Working Programme Board - which oversees a combined strategic programme of integrated health and care at locality level. This includes scaling up across the Primary Care Networks' mixed skill workforce, Wellbeing Teams, and Community Led Support Teams
- four Locality Delivery Groups where clinicians, Adult Social Care professionals and other front line staff can refine individual locality integrated models. Locality Groups have a key function in driving the priorities of the Alliance by identifying and communicating upwards key local priorities. The membership of the Alliance:



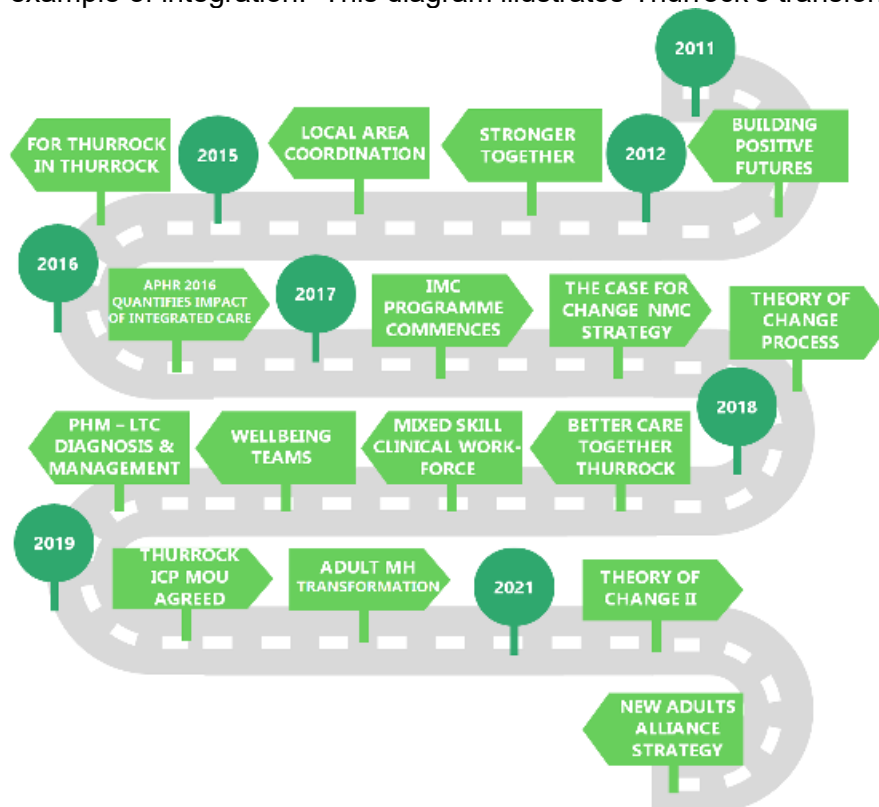
Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning

- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from

The BCF plan for Thurrock is collaborative and is focused on an integrated approach. The whole system works together to deliver the priorities within our plan ensuring the right support at the right time and the right place. As a system we have developed a joint strategic approach through our Case For Further Change narrative that focuses on an individual, their place in their own community, and a response to that person through either community strengths or commissioned services that meet the needs of that individual. We are adopting a human learning systems approach which further supports the already very mature collaborative working of our local systems. This approach will enable a fundamental change to how we commission based on continual learning and understanding the impact of system behaviour. All partners and providers will work in this way as we move forward and the BCF will support this approach as an already positive example of integration. This diagram illustrates Thurrock's transformation journey:



In section 2.2 of the Strategy Better Care Together Thurrock we describe how people have different strengths and skills and face different challenges that they respond to in a myriad of different ways. Challenges such as obesity, diabetes, mental ill health or homelessness are caused by a tangled web of different interdependent causes. The systems designed to respond to these challenges are complicated and are not necessarily designed to deliver the outcomes people want – they often deliver interventions in silo and have traditionally applied a ‘one size fits all’ approach to an issue. We need to commission a learning environment to constantly test, embed and refine. 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 residents’ stories. We need to bring different professionals together to reflect regularly and share learning.

There are no changes planned to the BCF services commissioned this year as they remain focused on high quality discharge and support for individuals to remain at home wherever possible.

The Thurrock approach to collaborative and joint commissioning is set out in section 10.2 of our new strategy for adult care. Adopting the principles of Human Learning Systems and developing a people-led health and care system means developing a very different model of commissioning. Providers will be able to provide flexible, bespoke support that responds to an individual's specific circumstances.

This commissioning model will promote providers who:

- Build effective and meaningful relationships with those they serve;
- Understand and respond to the unique strengths and needs contained by each person; and
- Act collaboratively with others to deliver what is required by the person.

Service specifications, contract management and market development have been remodelled to be consistent with these new conditions, and types of partnership.

Commissioning for complexity for the bespoke and varied outcomes of individuals means:

- The ability to pool commissioning budgets across different service areas (and organisations);
- Commissioning of integrated contracts and specifications that span different functions – e.g. Adult Social Care, Mental Health, Housing;
- Enabling flexibility within contracts to enable providers to have the freedom and autonomy to use resource as required to deliver on outcomes;
- Expecting providers to collaborate in order to provide integrated functions and solutions – or for providers to potentially be asked to provide a broader set of functions on the behalf of a number of commissioning partners;
- Enabling providers to 'buy in' support that they do not directly provide – for example through an Individual Service Fund type approach; and
- Adopting success indicators that are based upon whether people are achieving the outcomes they have identified as being important to them.

Communities of Practice are being established across Thurrock – aligned with each Primary Care Network (PCN) area. User-led CoPs are charged with agreeing priorities, designing strategies and solutions to meet those priorities and ensuring local intelligence feeds into all decision-making processes from a neighbourhood to a system wide scale.

With budgets aligned to localities, and pooled across different functions, the aim is to get to a point where resources can be shifted to communities and to CoPs (becoming Community Investment Boards), with communities having a direct say in how resources are used.

The market in Thurrock is being developed to enable providers to respond to intelligence gathered through the new model of engagement, and to be able to reflect the principles of Human Learning Systems. This includes supporting smaller grass roots providers as well as existing providers to deliver an offer bespoke to the individual. The marketplace must also develop to encompass less traditional provision – including that which the community itself can offer.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach, and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Our Thurrock BCF Plan delivers the requirements of the national condition 4 to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

The schemes within the BCF deliver the preventative aspects of the objectives, and the ability to provide the right care at the right time in the right place.

The BCF plan enables the local health and care system to ensure support is available for early detection of health needs and, through voluntary sector provision, support and sign posting for families.

Throughout the last 2 years the collective responses from the system have developed further really positive working relationships across health and care in Thurrock. Daily meetings support the understanding of the system and enable speedy responses to challenges across the locality.

Within Thurrock we work closely with providers who are always willing to try and increase capacity to enable timely discharge or prevent hospital admission. This year our internal reablement service have been very challenged due to high levels of referral and some of our external providers have responded by offering reablement. Residential provision is also responsive to the system pressures and providers are willing to work with health and social care partners to support discharge and return home for individuals. We provide responsive community support enabling higher levels of health need to be supported at home.

Thurrock First is our single point of access across community health, mental health and adult social care. The service consists of a team manager who is a qualified social worker, two senior co-ordinators, 17 Thurrock First Advisors who take telephone calls, a Community Psychiatric Nurse, a Mental Health Act Assessment Coordinator plus casual bank staff. It aims to reduce, prevent and delay the need for more significant care by intervening early and works closely with the Urgent Care Response Team (URCT) who can be mobilised to attend residents' houses where they are in crisis. Early discharge planning and preadmission discharge planning continues to work well to enable timely discharge from hospital. Thurrock have very minimal delayed discharges due to the responsive Hospital Social Work Team who continue to provide 7 day a week working and are based at Basildon and Thurrock Hospital. Our effective approach to hospital discharge planning is described on page 128 of our Strategy Better Care Together Thurrock.

Systems to monitor patient flow continue to develop through our Mede Analytics facility which allows us to analyse activity, supporting our understanding and development of positive integrated responses.

The Home First approach is key, and we have a system wide task and finish group to support the approach. In Thurrock we ensure wherever possible that people are able to return home with the same supports in place and with reablement available.

We continue to invest in domiciliary care to build sufficient capacity and reduce the likelihood of people waiting for care. The provision of intermediate care beds at Collins house again support timely discharge. We have a Home from Hospital Service, 'By Your Side' which ensures people's homes are ready for them when they come out of hospital.

We are focused on a place-based response in Thurrock and through our Better Care Together agenda we have multi-disciplinary responses through our PCN's and community health and social care teams. Our Community Led Support (Social Work) Teams and Local Area Co-ordinators work in an integrated way with health to ensure the right support is available.

The High Impact Change Model self assessment process has been integral to improved discharge planning. The attached report remains a true reflection of the system:



BCF Q4 19-20.xlsx

Thurrock has developed, and is developing, a range of initiatives to support independence. This includes greatly enhancing the offer we make to our older residents and other groups who cannot be supported in general needs housing. It means ensuring genuine accommodation choices that meet the aspirations of our residents for their later life, and high quality intermediate care and supported living facilities when residents need them.

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 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. Examples include our HAPPI housing schemes [[HAPPI - Design - Topics - Resources - Housing LIN](#)] in South Ockendon - Bruyns Court, and Beaconsfield Place which opened this spring in Tilbury.

Following a summit with private developers Thurrock has made a commitment that if developers will work with the Council to improve the quality of housing for older people, the Council will offer a range of help including:

- Providing profiles of the housing needs of older people in Thurrock's communities
- Engaging with local people so that they understand the benefits of specialised housing for older people
- Flexibility in relation to planning requirements, for example, parking if the site is well served by access to local facilities and transport
- Exploring the potential for joint ventures with private sector developers
- A one-stop service to facilitate scheme discussions at any point, not just at the pre-planning application stage.

There is also a multiagency 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.

Thurrock is also developing the Whiteacre / Dilkes Wood site in South Ockendon to provide a range of homes for older people needing care: from small easy to maintain flats designed for frail elderly people, to retirement living for those who wish to downsize to a care ready environment, including potentially a mix of one and two bedroom dwellings for rent. The project aims to provide social care and nursing care in a specialised setting of 45 self-contained dwellings with associated care facilities (lounges, restaurant, treatment rooms, laundry etc.). In addition to the permanent homes on site, the 30 self-contained studios for intermediate care will widen the housing and care offer locally, so that we can more readily avoid admissions by offering a home from home, and step up/step down care for those who need it.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Thurrock is currently refreshing the Carers Strategy, undertaking detailed consultation regarding carers' experiences. There is an excellent carers Information Advice and Support service in Thurrock, together with a short breaks service funded through our external purchasing budget which sits within the BCF. Carers services are offered through our internal Friendship Club, as well as sitting services and residential respite which are all funded through the budgets within the BCF. Direct payments and individual budgets are offered to ensure there are a range of options and choice for carers. Outcomes for carers are improving and the new Better Care Together Thurrock strategy, which will be a joint health and social care approach, will give additional direction and will be framed within a human learning system approach to ensure it is coproduced and responsive.

We know early identification and support is imperative in improving the physical and mental well-being outcomes of carers. The Carers Information, Advice and Support Service carries out a whole host of activities during Carers Week/Carers Rights day and throughout the year to increase the number of people identifying as a carer. As a result of this activity, we have seen a significant increase in the number of carers coming forward – largely self-identifying as having mental health issues as a result of caring through the pandemic (in quarter 1 2022/23 the service identified twice as many carers compared to the same quarter in the years leading up to the pandemic). Carers Officers have also started to be part of the locality Test and Learn project – we hope after we have we have trialled this approach that the service will move to delivering in a place based way. This will aid both the identification and support to carers within the communities in which they live.

Disabled Facilities Grant (DFG) and wider services

Transformation of the DFG services continues with a greater understanding and promotion of health equality. It is acknowledged that there is a primary focus to support people through home adaptations via the mandatory grant; recognising the home environment can have a considerable bearing on people's safety, independence and overall health and wellbeing. It is also recognised that an integrated and holistic approach across health, social care and housing is essential to not only realise the benefits of accessible housing, but also achieve an understanding of, and subsequent approach to, meeting an individual's needs and the needs of the wider community in which they live.

The Council has completed a review of the DFG service and implemented a strength-based approach to service delivery, which has greatly enhanced the support available for the residents of Thurrock. Our approach has improved awareness and accessibility, with a newly introduced pathway meaning DGF applicants can do more for themselves with self-service, which provides significant benefits for all. The service is now hosted alongside the Occupational Therapy Service within Adult Social Care. This has enabled the DFG service to be more accessible and complement integrated approaches already established across health, social care and housing, such as the integrated first point of contact service, placed based support services across health, social care and housing, and the established Integrated Community Equipment Service. The Council has recently implemented its new DFG RRO policy, initiating phase two of the intended transformation of the DFG Service. This includes greater opportunities to support wider services within health, social care and housing, especially where there is a recognised crossover with DFG services in supporting individuals to remain in their home and meet their wider housing needs. Furthermore, the Council can now provide additional support by virtue of the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002, which enables the Council to provide Thurrock residents with financial assistance from a range of discretionary grants. The council is drafting a communication strategy to inform residents and key stakeholders across social care, housing and health services to promote and encourage the uptake of additional support the DFG service intends to provide residents.

Examples include:

- 'top up' to a mandatory grant and / or to fund unforeseen works
- adaptations for a child's second home where the parents live separately
- adaptations for a child / young person in foster care
- adaptations for an adult supported in "shared lives" or similar supported living scheme
- assist a disabled person or their family to move to more suitable accommodation
- dispense financial assessment for works below £5000
- facilitate timely discharge from hospital or other non-residential settings (individual and schemes)
- avoid unnecessary hospital admission or other non-residential settings
- facilitate fast track adaptations for end of life / life limiting conditions
- improve accommodation of a nature that supports residents in supported living and step down / rehabilitation services, or in need of interim support
- provide non-fixed solutions, including, but not limited to TEC and ICES
- explore and provide innovative housing solutions / schemes for a range of client groups, such as dementia, autism etc (purpose built housing solutions)
- support safe / warm homes initiatives
- support complementary services in meeting an individual's wider housing needs
- support handyman / minor adaptations schemes

The DFG service will strive to make a greater contribution to the Better Care Fund, Thurrock Integrated Care Alliance transformation programme, and the Better Care Together Thurrock strategy, where further opportunities and strategic development for DFG can be explored.

to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Equality and health inequalities

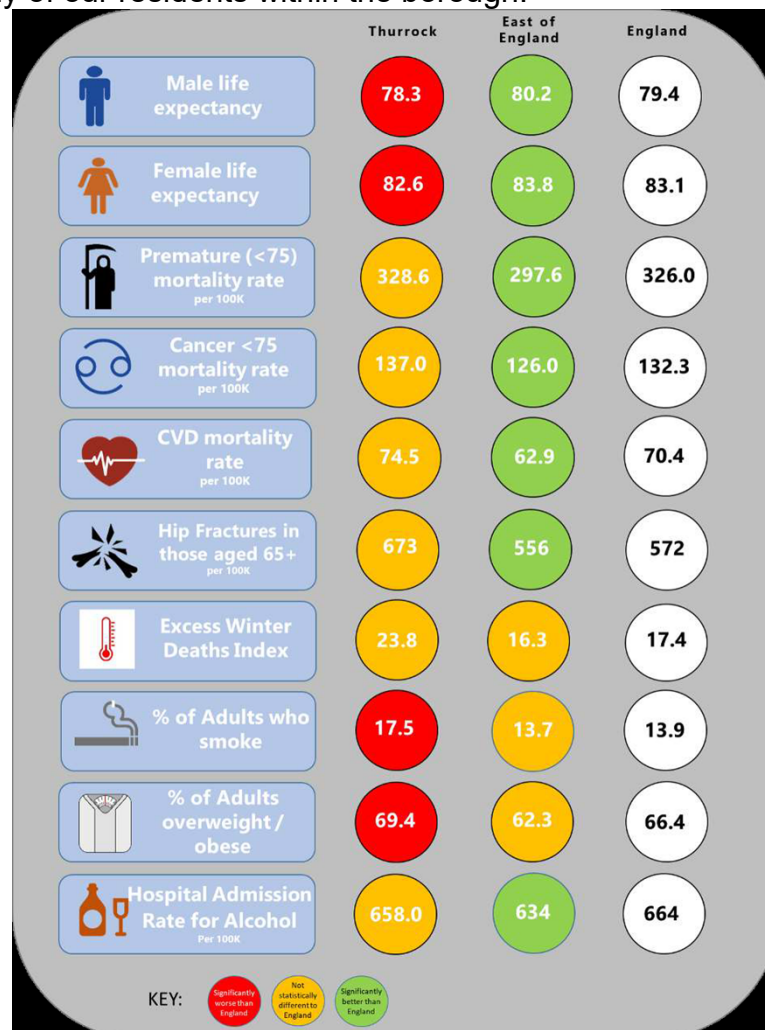
Health inequalities remain a significant issue in Thurrock with our more deprived populations suffering lower levels of both total life expectancy and the numbers of years of their life that they can expect to live without disability.

There is clear health inequity between both total life expectancy and disability free life expectancy linked to deprivation, with both measures increasing as deprivation decreases. Only the least deprived 35% of our population are likely to reach retirement age before reaching the end of disability free life.

Thurrock has the third worst Mortality Attributable to Socioeconomic Inequality (MASI) index in Mid and South Essex with 2,522 deaths being attributable to socio-economic causes between 2003 and 2018.

Thurrock's main cause of death due to socio-economic inequality in cardiovascular disease. This differs from Mid and South Essex where cancer is the most common cause of death driven by socio-economic inequality.

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 will in future allocate resources presents an opportunity to distribute funding in a fairer and more equitable way to address the higher health needs of Thurrock residents compared to more affluent communities within our local system.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

The prevailing ethos of our approach remains to ensure all individuals and communities have a health and care system that is equitable and designed around their specific requirements. For example, ensuring that the system looks to deliver a broad range of solutions that meet the outcomes most important to the individual. The focus on shifting the system upstream by redesigning it around principles relating to early intervention and prevention ensures that significantly more activity takes place within the community. This in itself will not only reduce health inequalities, but increase the health and wellbeing of the population. The approach is whole-population meaning that all protected characteristics (Equalities Act 2010) will benefit from the principles of redesign. Thurrock has the third worst Mortality Attributable to Socioeconomic Inequality in Mid and South Essex, with 2,522 deaths being attributable to socio-economic causes between 2003 and 2018. Thurrock's main cause of death due to socio-economic inequality is cardio-vascular disease. The Alliance will support integration at PCN level by ensuring that future enhanced non-core services are commissioned on PCN footprint. This will encourage greater integration of PCN member practices and will drive standardisation of care and reduce health inequality. Development of the BCF plan is aligned with the MSE ICS approach to ensuring the national Core20Plus5 priorities are considered within local schemes addressing digital exclusion, data quality and accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes.



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Detailed work has been undertaken by the Council and Alliance partners to increase COVID vaccine uptake, with community health champions in place along with community vaccine buses.

Due to complexities in regional demographics across Thurrock, in the development of our aligned BCF plan, the Equalities Impact Assessments are managed at a scheme level. In principle, there are no expected implications for any one section of the community, but inevitably when any process or access route to services changes, there may be an impact that is unintended. Therefore, all changes will be aligned with our Public Sector Equality Duty and subject to ongoing review to consider the EIA implications.

As a collection of initiatives, there will also be a review to ensure that the cumulative effect of changes has not, or does not unduly, affect any one cohort of people.