NHS
Thurrock
Clinical Commissioning Group

Thurrock Transformation Plan: Delivering our Vision

January 2016

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1. Foreword

This transformation plan outlines our vision for providing health and care closer to or at home for the population of Thurrock - **For Thurrock in Thurrock**, in line with our strategic direction set out in our 5 year Strategic Plan 2014-19, and acts as a refresh to that plan in terms of building on that vision.

This plan also aligns with the local Health and Wellbeing Strategy and builds on the aims of the Better Care Fund (BCF) as a new model of care emerges from the vision and local ambitions through the course of the transformation programme in line with the NHS England document the "Five Year Forward View".

Patients often tell us that they find the health and care system overwhelmingly complex and disjointed. While there have been major improvements in health and care services recently, these improvements have not kept pace with changes in society over the years, and if these are not addressed we know the system will struggle to meet future needs.

In recent public engagement events, a recurring theme is the desire for health and care services to be more accessible for Thurrock people.

We also know that the system is not currently set up to cope with the rapid growth in demand for health and care service. By developing our vision and the enhanced neighbourhood based teams, we will be in a better position to meet that demand.

While we are in a more stable financial position than some of our system partners, maintaining that position gets more challenging every year. We recognise that there are still efficiencies that we can make across the system and we are committed to working together to get the most for the Thurrock pound.

We already work closely with our local authority partners and neighbouring CCG in Basildon and Brentwood as well as our provider organisation Basildon and Thurrock University Hospital Foundation Trust (BTUH) our acute provider, North East London Foundation Trust (NELFT) our community provider, and South Essex Partnership Trust (SEPT) our mental health provider. We will continue to work in partnership with each of them to develop a more integrated workforce with the skills, experience, capability and capacity to provide care closer to home in a more holistic way as we develop our new care models for the future.

We are fortunate in that NHS England launched 50 vanguard sites in 2015 to test new models of integrated care and we will learn from their experience as we more forward on our journey towards delivering new models of care.

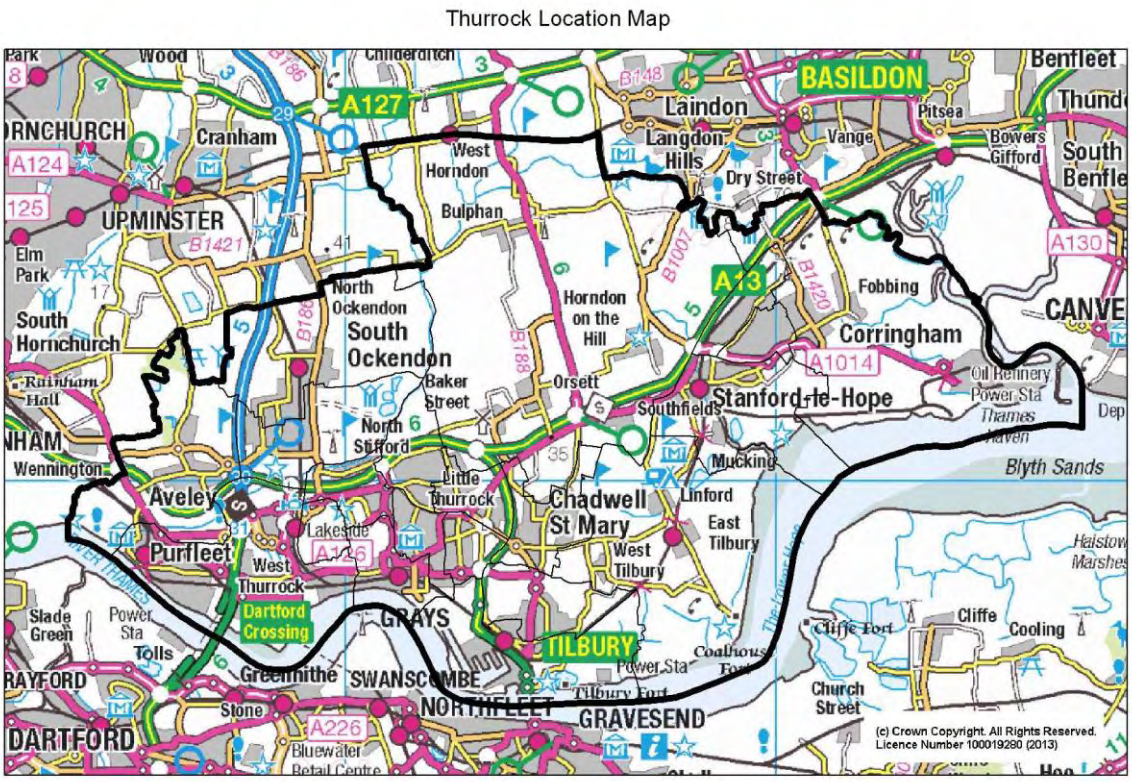
Anand Deshpande, Chairman

Mandy Ansell, Acting Accountable Officer

2. About us

Thurrock Clinical Commissioning Group (CCG) is situated in the south of Essex and lies to the east of London on the north bank of the River Thames. It has a diverse and growing population with a population density of 976 persons per square kilometre.

Figure 1 Map of Thurrock



The CCG is made up of 32 GP practices, clinicians, nurses and NHS managers and staff and is responsible for buying and delivering local health care services for its population.

The services include healthcare from hospitals, community and mental health services and some specialist services however service contracts with GPs, dentists, pharmacists and opticians are managed by NHS England, and Thurrock Council is responsible for all social care services in Thurrock.

2.1 Locality Overview

The CCG is broadly made up of four localities (neighbourhoods), situated in Tilbury, Purfleet, Grays and Corringham and surrounding areas. We serve a population of just over 163,000, which is increasingly ethnically diverse, and there has been substantial movement of people from London to Thurrock, particularly from geographically close boroughs.

2.2 Our Ambitions

Our local Health and Wellbeing Strategy is built on 5 key principles:

Figure 2 Health and Wellbeing Strategy – 5 key principles

Prevention and early intervention: A system wide Primary, Secondary and Tertiary prevention strategy with clear outcomes and key actions for each partner agency, a locality based population health system.

Building strong and sustainable communities: Integrated housing, health, planning and transport policy, building on the "Thurrock revolution", embedding wellbeing into the regeneration agenda

Strengthening the mental and emotional: Wider determinants of mental health, preventing mental ill health, finding and treating the missing thousands, bring services closer to Primary Care.

Health and social care transformation: Improving Primary Care, integrating care around the person (closer to home).

Ensure that all agencies work together to deliver services that collectively improve the lives of all children and young people, ensuring that every child in Thurrock regardless of their circumstances has access to the best services and outcomes.

To achieve these ambitions we need to radically change how our health and care system current works. This plan sets out our journey toward the last of the 4 ambitions (health and social care transformation), which if we are successful will provide the environment for the other 4 ambitions to flourish.

2.3 Our Vision

The Thurrock health and care system is embarking on an ambitious piece of work to align its vision for older people (BCF) with the primary care transformation programme already underway.

The current scope of this programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services **"For Thurrock**

in Thurrock". This will be refined as the programme gains pace in order to align with the context of the Essex Success Regime (ESR) to ensure a comprehensive plan for Essex sustainability going forward.

The focus is on improving the quality and accessibility of service for the local population based on need (identified through health need, social need and deprivation analysis provided by Public Health), with a view to providing a more holistic model of locality based care closer to home for the local population.

Primary care underpinned by primary care needs assessment linked with social needs, in order to cross reference social needs and deprivation with health outcomes to allow us to forecast future health needs in line with demographic changes, and local regeneration and development programmes.

We already know that there are areas where we could improve, and by developing our services and estate for the people of Thurrock within Thurrock, and using a joint health and care community team within a care coordination model of delivery, more formally supported by our local voluntary services we will truly be able to do so.

The more radical element of our transformation programme centres on the current configuration of beds across southwest Essex, which spans 2 CCG catchments (figure 3).

With an open mind and some radical thinking about how current estate and services could be reconfigured to deliver a place based system of care specific to each CCG's local population, an alternative model has emerged (figure 4).

Figure 3

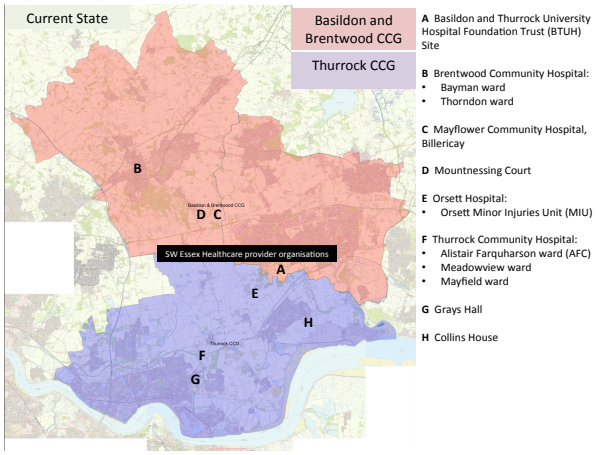
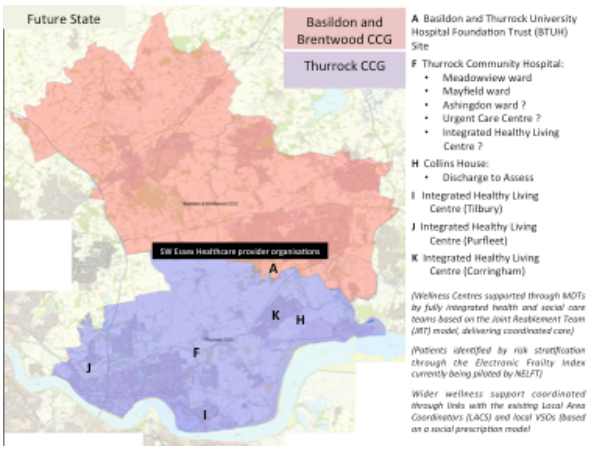


Figure 4



The focus of the alternative model is based on shifting patient flows into appropriate beds (clinically) where a bed is needed, and into an appropriate environment to meet each individual patient's needs (a key factor of good quality care for people with dementia or challenging behaviour). Where a bed is not the best solution in helping to maintain independence and wellness, patients will be supported by the integrated health and care community teams, in other words: right care, right place, right time.

2.4 Our Corporate Commitment

As commissioners, we are responsible for buying and delivering local health care services for our population and in doing that we have a statutory obligation to balance our financial accounts.

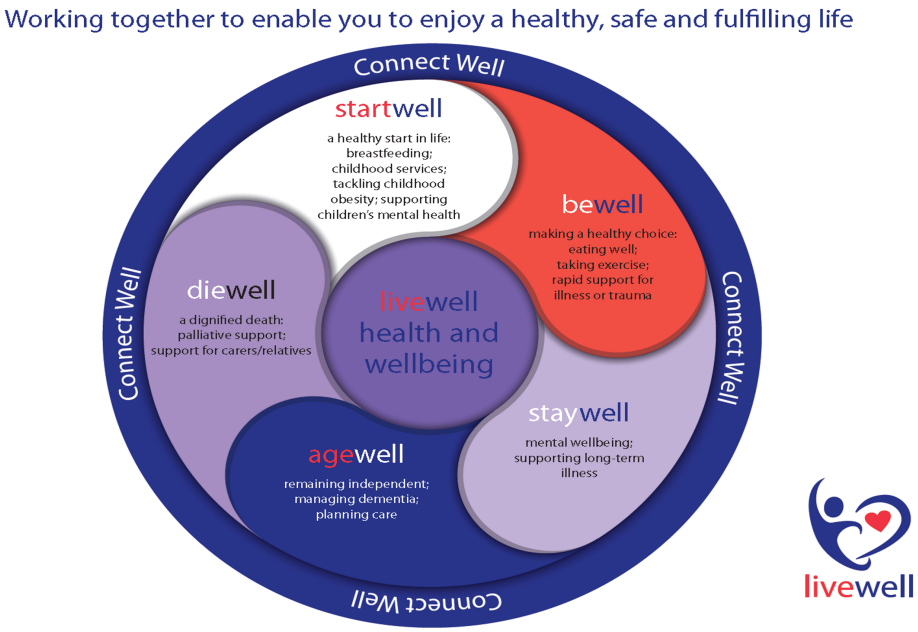
Whilst we are in a more stable financial position than some of our system partners, maintaining that position gets more challenging every year. We recognise that there are still efficiencies that we can make across the system and we are committed to working together to get the most for the Thurrock pound.

2.5 Quality, Safety and Patient Experience

We are committed to improving the health and wellbeing of our population and to working together with our system partners to enable them to enjoy a healthy safe and fulfilling life at every stage of their life journey, ensuring that the services we commission support that life journey (figure 5), are safe, and offer a good patient experience.

We know our patients find the current system overwhelming complex and disjointed and we aim to address this by bringing care closer to home by developing locality (neighbourhood) based integrated community health and care teams which will be extended and enhanced to increase current staff numbers and to provide a wider skill mix to enable care closer to or at home whenever it is clinically relevant. Helping our people to be well, live well and stay well at every stage of their lives as outlined in the "Live well health and wellbeing life cycle" at figure 5 below.

Figure 5 Live well health and wellbeing life cycle



To further support this end we will be working with CCG colleagues and partners to agree a set of whole-system outcomes which apply across organisational boundaries in the form of a multi-agency incentive scheme through the co-alignment of CQUINs / Enhanced Payments. The details of the proposed scheme are outlined in Section 5 below (figures 12, 13 and 14).

3. Why do we need to change?

We know that the system is not currently set up to cope with the rapid growth in demand for health and care service. By developing our vision and the enhanced locality (neighbourhood) based teams, we will be in a better position to meet that demand.

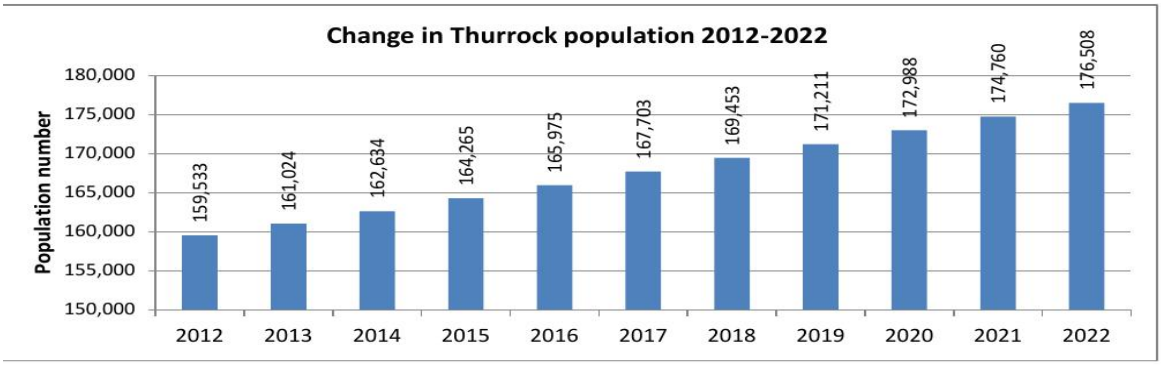
3.1 Expected Population Growth

The CCG has a larger young population aged 0-19 years – particularly 0-4 year olds, and a larger population in their 30s and early to mid-40s than both East of England and England.

There has been a 47.5% increase in the over 85 population between 2001 and 2011, equating to 846 more residents in this age group, and it is estimated that the total population will increase to 176,500 by 2022 and 192,535 by 2032.

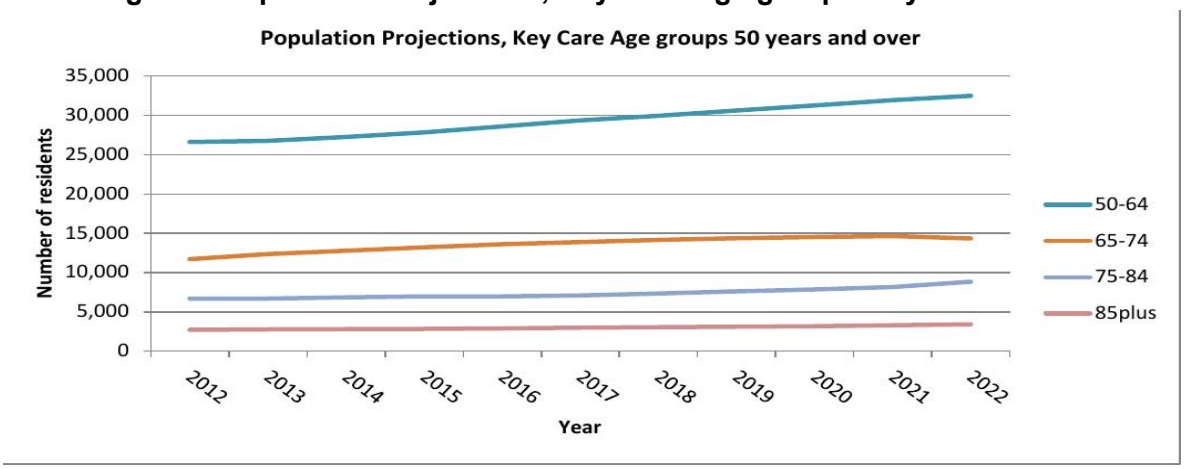
Figure 6 shows the projected change from 2012 to 2022, by five year age group. There is predicted to be a rise in number for almost every age group however the most significant rises occur in age groups clustered in the 0-14, 25-29, 50-59 and 70 plus age groups.

Figure 6 Population Projection Age Structures 2012-2022



The age and sex distribution within our population has an impact on the level of need for health services. Older people and the very young tend to have a greater utilisation of health services. An increase in a younger population indicates opportunities to maximise an early offer of help and prevent future ill health, in line with local authority public health responsibilities. Whilst an increase in the older population has implications for service provision and the levels and ways that care and social services are provided to meet needs.

Figure 7 Population Projections, Key Care Age groups 50 years and over



This plan sets out the journey through which we aim to address those needs and should be read in conjunction with our Primary Estates Strategy which set out our plans for developing local primary care services which dovetail into delivering our vision for transformation change.

3.2 Current Financial Position

The true financial implications and risks will not become be clear until the rebasing has been completed and we have received sign-off by each of the providers to the proposed plan. This is not likely to be achieved until into February when the contracts are being finalised.

3.3 Future Financial Position

The programme of work will be a key part of delivering financial sustainability and we will work through the detail of each strand of the programme so that they contribute to this overall aim.

We are working on transformational change which will lead to a rationalisation of estate, less duplication, better coordination and ultimately better care for the patient in the right place at the right time.

3.4 Achievement of Constitutional Targets

We have a statutory obligation to meet a range of constitutional targets including: A&E transit times, Referral to Treatment Times, Cancer waiting times, mental health access targets and others, in addition to meeting our financial obligations.

- Our system is currently under pressure with a range of targets such as:
- IAPT standard for entering treatment, dementia diagnosis rates
- Cancer 31 and 62 day targets
- A&E four hour waiting times
- Ambulance response rates
- 18 week referral to treatment time target

We are working with system partners to address these immediate pressures and in longer term planning linked to delivery of our vision so that sustainable systems and processes are in place to better manage these pressure in the future.

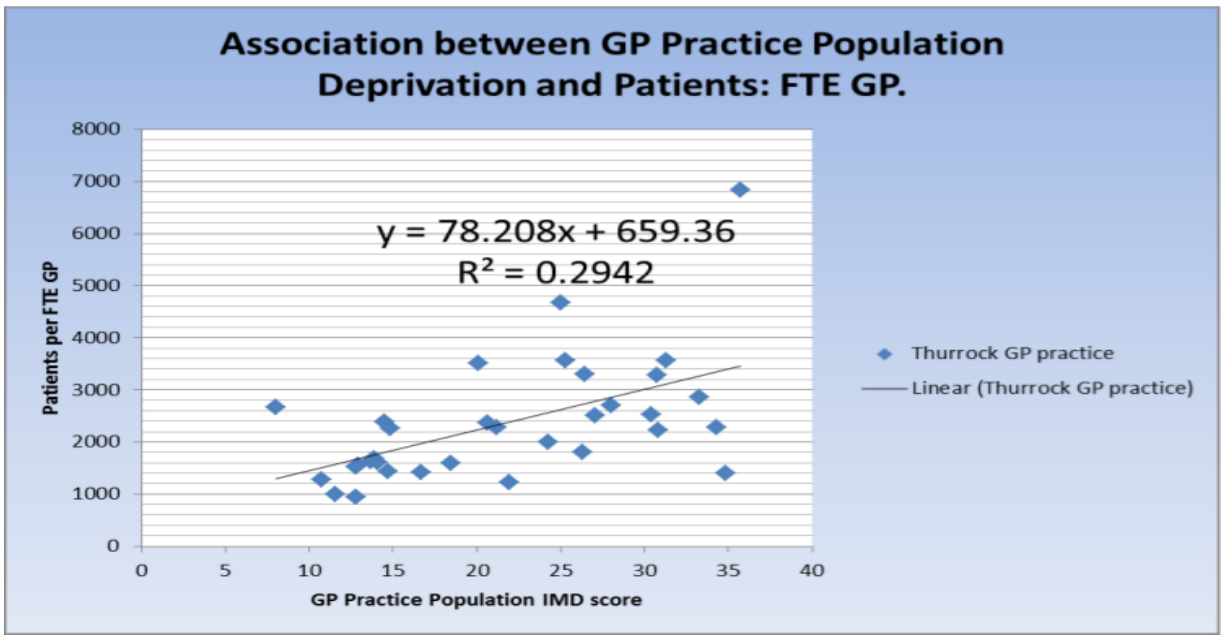
3.5 Workforce Constraints

Thurrock is significantly ‘under doctored’ with an average of 2,032 patients per FTE in 2014/15. All but four GP practices have list sizes per FTE GP that are greater than England’s.

The average number of patients cared for by a FTE GP in England is 1391.

Figure 8 (below), shows the association between GP practice population deprivation and ratio of patients: FTE GP in Thurrock.

Figure 8



We know that under-doctoring and nursing is a huge issue and people are waiting for an unacceptable length of time in order to obtain a GP appointment. We also know that if people cannot get a GP appointment they are more likely to use more expensive parts of the system such as A&E, and that under- doctoring leads to a reduced ability of GP practices to care proactively for patients with long term conditions, increasing the risk of patients experiencing an emergency event such as diabetic coma, stroke or other such event.

In Thurrock our vision is to provide more integrated health and social care services, and provide a more holistic population health approach to the way in which we commission services.

We are working with Health Education England (HEE) on a range of workforce transformation initiatives, in partnership with other Essex CCGs and healthcare providers to support recruitment, training, workforce development and specific projects to alleviate workforce-related pressures in the short, medium and longer term. Workforce planning will be a key part of our strategy in order to implement our vision, and create a sustainable care system for the future.

3.6 National Drivers for Change

3.6.1 Five Year Forward View

The Five Year Forward View (2014) sets out a clear direction for the NHS and how future services could be configured, including outcomes based commissioning. There is an expectation that when people do need health services, patients will gain far greater control of their own care. In addition the Care Act (2014) has a clear focus on wellbeing, preventing, reducing and delaying people's needs from developing. The Care Act sets out the integration agenda between local authorities and the NHS by making it a default position for the design and delivery of services.

3.6.2 Success Regime (Essex)

On 3 June 2015, the NHS Chief Executive announced that Essex (including Southend and Thurrock) is part of the first ever NHS Success Regime. The aim of the Success Regime is to provide increased support and direction to the most challenged systems in order to secure improvement in three main areas:

I. Short-term improvement against agreed quality, performance or financial metrics;
II. Medium and longer-term transformation, including the application of new care models where applicable;
III. Developing leadership capacity and capability across the health system.

Unlike under previous interventions, this success regime will look at the whole health and care economy: providers, such as hospital trusts, service commissioners, clinical commissioning groups and local authorities will be central to the discussions.

4 Our Vision for Care in the Future

The current system is built on a “reablement” ethos across all health and care services where the emphasis of all providers is to support the service user to gain or maintain their optimal potential level of independence however this is often not achieved.

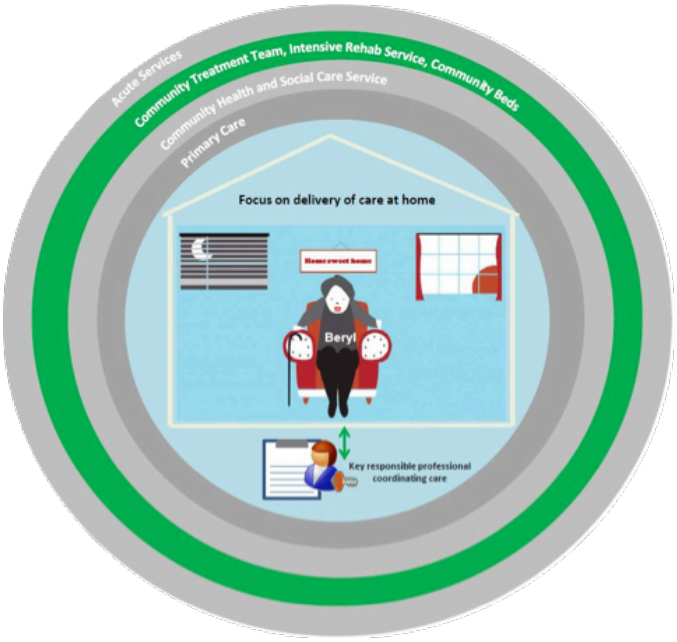
Successful delivery of our vision will require a range of out of hospital services which flex during changes in demand e.g. winter/summer, are based around local patient need as opposed to pre determined service models, and prioritise domiciliary care packages over bed based care but offer bed based care where required.

Our new models of care will be locality (neighbourhood) based and will be delivered through MDTs by fully integrated health and social care teams (based on the Thurrock local authority Joint Reablement Team (JRT) model, delivering coordinated care closer to or at home (see figure 9 below).

The locality (neighbourhood) based teams will align with the existing health hubs taking a virtual ward approach to providing care closer to or at home within each locality (neighbourhood), and with new developments in primary care estate as they emerge, and as outlined in the Primary Care Estate Strategy.

Patients will be identified by risk stratification through the Electronic Frailty Index currently being piloted by NELFT our community provider, and will received wider support to maintain wellness through links coordinated with the existing Local Area Coordinators (LACS) and local voluntary services, based on a social prescription model.

Figure 9 Our vision for Care Closer to home through integration and care coordination



This new model means that district nursing, pharmacy, dentistry, domiciliary care teams will work in partnership to develop care plans that are personalised, holistic, and are delivered by specialists from across the health and care system. Care will be co-ordinated around the patient as opposed to traditional organisational and service structures.

The voluntary sector will also play a key part in helping communities to support and maintain the independence.

4.1 What this will mean for patients

Our patients often tell us that they find the health and care system overwhelmingly complex and disjointed. While there have been major improvements in health and care services recently, these improvements have not kept pace with changes in society over the years, and if these are not addressed we know the system will struggle to meet future needs.

We also know that the system is not currently set up to cope with the rapid growth in demand for health and care service. By developing our vision and enhanced locality (neighbourhood) based teams, we will be in a better position to meet that demand and to offer care closer to or at home for our local population.

4.2 Patient and Service User Involvement

We are committed to providing the best services we can for our population to meet their current and future needs, and recognise that we will only know if we are doing this if we ask.

We are fortunate in that our local Health and Social Care Engagement Group which meets monthly includes members of Thurrock Council, Thurrock Coalition, the CCG, HealthWatch and Thurrock CVS and we have been using this forum as a sounding board during the developing phase of the vision to ensure we continue to get the message right, and communicate it in the best way possible.

With their advice and feedback we produced a Public Facing Document, which will give people the opportunity to tell us whether they think that our vision is right for the Thurrock population.

We will also work with them to engage our local population (tapping into and learning from engagement currently underway to gauge views on the refreshed Health and Wellbeing Strategy), and will be commissioning support from HealthWatch and Thurrock Coalition to help us gain feedback from a widely representative group of at least 1% of our local population over the first quarter of this year.

The results of our engagement will be published on our website.

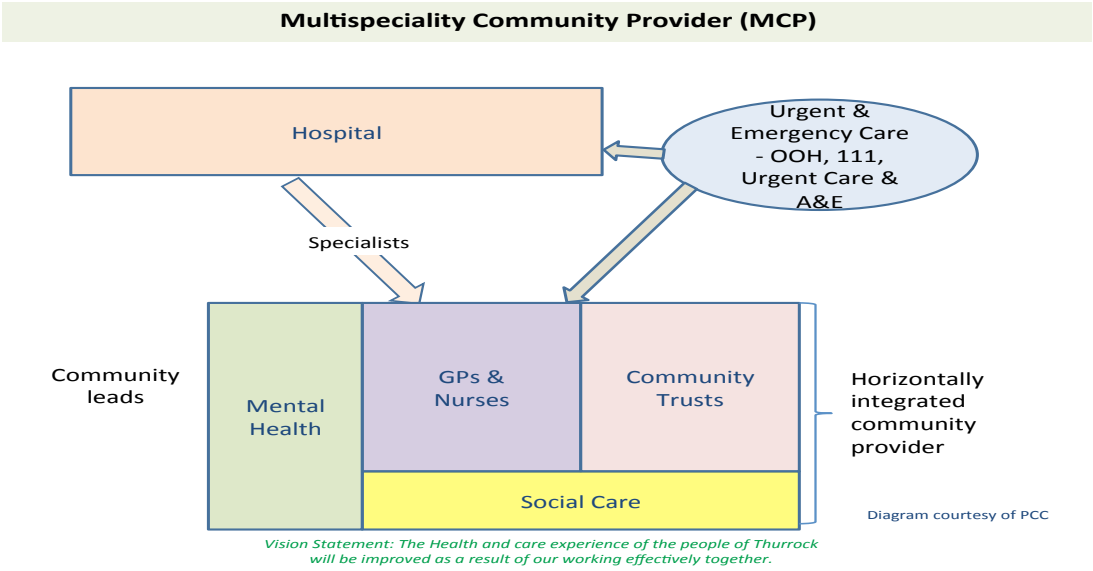
5 New Models of Care

NHS England's Five Year Forward View invites local systems to propose co-creating new models of care and organisation locally.

The document identifies (but does not limit us to) four possible models:

- Multispecialty community providers (MCPs), including a number of variants
- Integrated primary and acute care systems (PACS)
- Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms such as specialist franchises and management chains
- Models of enhanced health in care homes.

Figure 10 Multispecialty Community Provider (MCP) Model



5.1 Our New Service Model

Our model of care whilst not designed specifically as such does seemingly predominantly match the makeup of a Multi-speciality Community Provider (MCP) and as such organically take us into the realms of the types of models currently being tested through the national vanguard sites (see figure 10 above and what that might look like for Thurrock at figure 11 below).

Under this new care model outlined in the Five-Year Forward View, groups of practices would expand bringing in nurses and community health services, hospital specialists and others to provide integrated out of hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out of hospital settings.

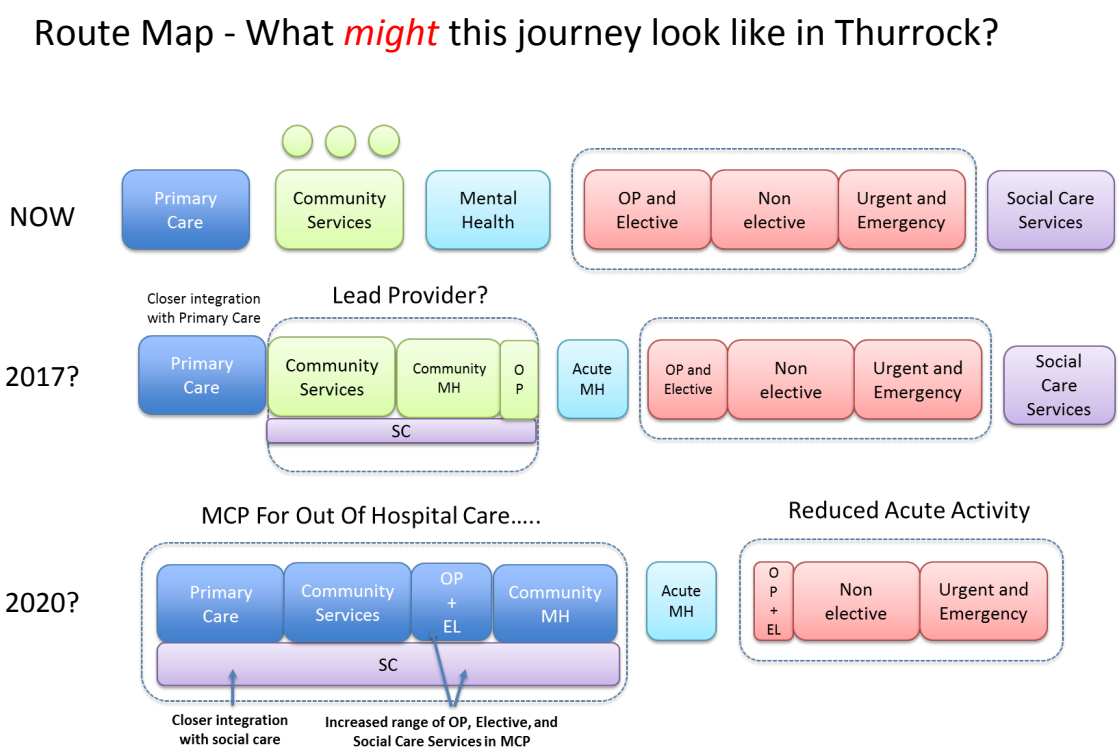
Over time, these providers might take on delegated responsibility for managing capitated NHS budgets (or combined health and social care budgets) using a place based commissioning model to commission outcomes based services for their registered patients.

This model also offers the opportunity to reduce the number of contracts and thereby, the associated administration, monitoring and management costs incurred in keeping them on track.

We have the opportunity to shape and deliver a future model of care, which works for the population of Thurrock (and southwest Essex), rather than subsequently receiving direction in later years on a model of care which we should adopt and there was wholehearted support at the recent Board Seminar for the Thurrock transformation approach.

We also have the opportunity to review and reshape how and where our urgent care is provided and this will form another strand of work within the transformation programme.

Figure 11 What the journey to an MCP Model might look like for Thurrock
(developed by Attain for a Board Seminar Session November 2015)



Vision Statement: The Health and care experience of the people of Thurrock will be improved as a result of our working effectively together.

5.2 Objectives for our New Service Model and greater focus on Outcomes

We have been working with CCG colleagues and partners to agree a set of whole-system outcomes which apply across organisational boundaries in the form of a multi-agency incentive scheme through the co-alignment of CQUINs / Enhanced Payments.

The proposed scheme (outlined in figures 12, 13 and 14 below) is currently being shared with partners and provider colleagues.

Figures 12, 13 and 14: Development of whole-system outcomes in the form of a multi-agency incentive scheme through the co-alignment of CQUINs / Enhanced Payments.
Figure 12 Background and Current Position

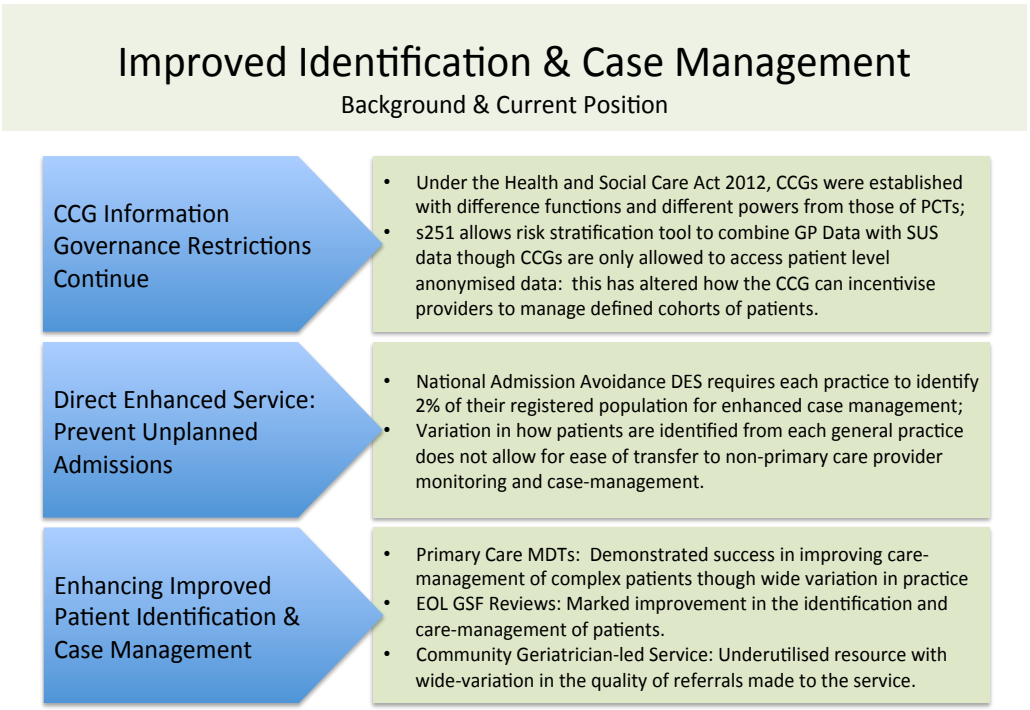


Figure 13 Whole-system Service Improvement

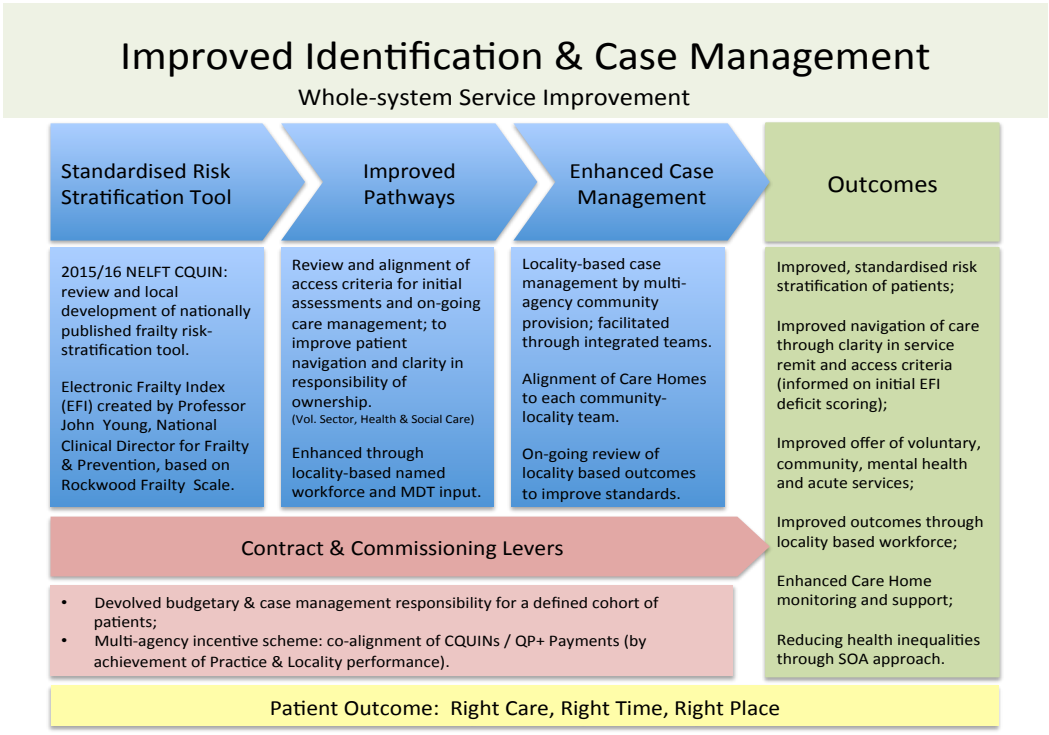


Figure 14 The Framework

Integrated Health Incentive Framework

2016/17

	QP+	CQUIN
Attendance & Support of EOL GSFs & Primary Care MDTs; with routine EFI reporting.	Y	Y
Co-authorship of integrated clinical directory (with clearly defined clinical access criteria and demarcation of responsibilities (tiers); with complimentary VSO services.	N	Y
Assessment, review and enhanced care management of HIUs of non-elective care *(identified though combined frailty scoring & NEL activity (acute, comm, MH)).*	Y	Y
Percentage* reduction of HIUs activity in: Q2,Q3, Q4 *(by Locality to into second component of QP+ payment structures).*	Y	Y
Increased identification of patients in the last year of life *(with focus on cohorts defined in 'Actions on End of Life' published: November 2014)*	N	Y
Q1 publication of integrated DOS / community leads / contact methods & process	N	Y

*Percentage without inclusion of those deceased within each reporting period

6 Our Service Development Process

We have already defined what we thing our new care model should look like, and have been working through the impact of this on our current health and care system with our system partners.

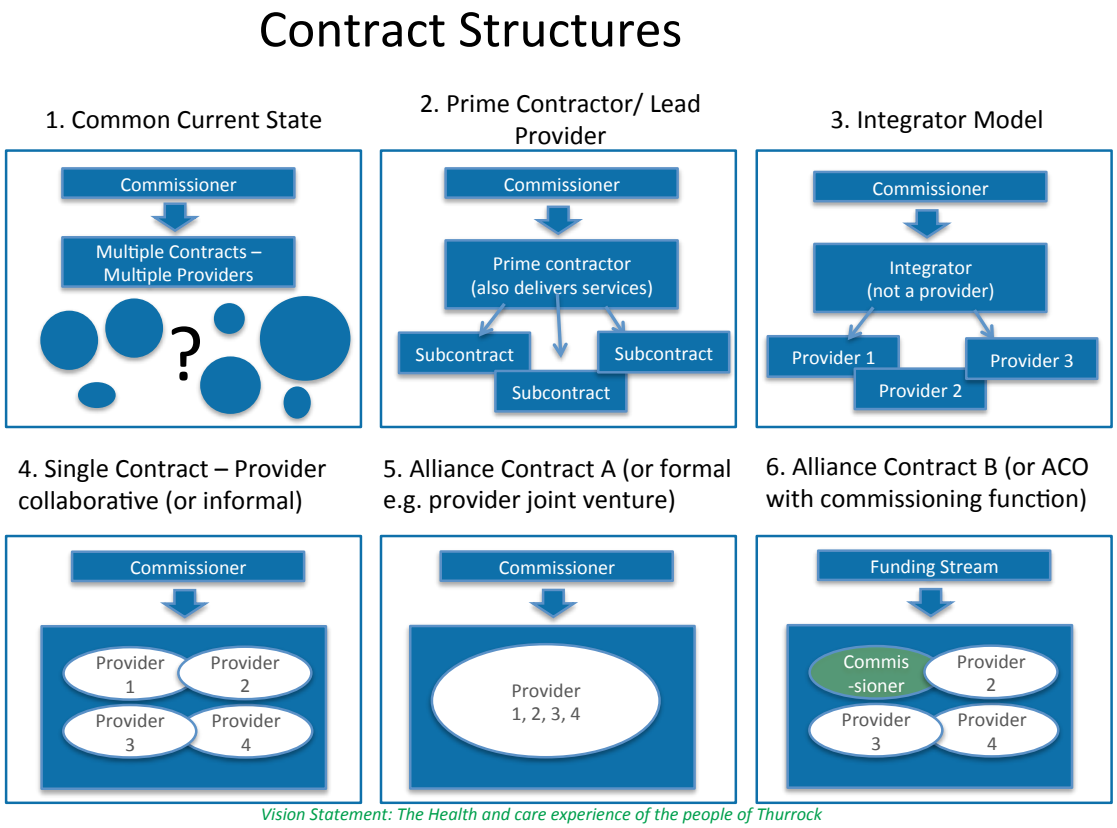
Our future care delivery system will include detailed pathway redesign, activity and financial modelling, workforce planning, and working through the full range of enabling infrastructure such as estates and IT connectivity. We have started the process of developing a plan that sets out the high level timeline required to develop the new care model through 3 phases over the next 3 years, and for phase 1 over the first 9 months.

A more detailed programme plan has also been developed to set out the tasks and actions required to further develop the new care model. This informs our governance for the programme.

6.1 New Financial Flows

We recognise that integrated care delivery models will require radical changes to the way we fund care and we are already exploring how as part or our integrated community teams we deliver co-ordinated care for our frail and elderly population. Our neighbouring CCGs are working on developing capitated models for frail and older people, and in addition pilot "Vanguard" sites are testing a range of different models. All of these will contribute to our work on developing appropriate funding and contracting methods for the integrated co-ordinated care model that might resemble one of the structures outlined in 15 below.

Figure 15 Contractual structures supporting the delivery of new models of care
(developed by Attain for a Board Seminar Session November 2015)



6.2 User Engagement / Involvement

We are committed to providing the best services we can for our population to meet their current and future needs, and recognise that we will only know if we are doing this if we ask.

We are fortunate in that our local Health and Social Care Engagement Group which meets monthly includes members of Thurrock Council, Thurrock Coalition, the CCG, HealthWatch and Thurrock CVS and we have been using this forum as a sounding board during the developing phase of the vision to ensure we continue to get the message right, and communicate it in the best way possible.

We are also fortunate in having the support of a Patient Champion for the programme.

In addition, our Commissioning Reference Group (CRG) is providing supportive challenge as a critical friend to help guide us on our journey. The CRG is an advisory body to the CCG and helps us to fulfil our statutory duty to engage with and involve the public and patients in healthcare decisions. The chair of Thurrock CRG also serves on Thurrock CCG's Governing Body as a Lay Member (Patient and Public Involvement) and sits on the Thurrock Health and Wellbeing Board.

6.3 Engagement with our Partner & Provider Organisations

We have already been working closely with our system partners on a range of service developments and are committed to continue to work with them as we embark on our transformational journey.

The first phase of the transformation programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services **"For Thurrock in Thurrock"**. To this end are already taking steps to further scope the development of the out of hospital adult care model by working with our local authority and provider colleagues to identify workforce needs with a view to jointly commissioning fully integrated locality based health and care teams.

The locality based health and care teams will need to be mobilised before implementation of the vision can formally commence and we are working closely with our acute, community and mental health providers to map and gap what we currently have and what workforce capacity, skills and capability we will need for the future.

The locality based health and care teams will work through multi disciplinary teams (MDTs) to delivery coordinated care as part of community offer to support the proposed locality (neighbourhood) Integrated Health Living Centres (outlined in 6.5 below), and provide care closer to or at home.

6.4 IT and Infrastructure

Timely, accurate and relevant Information supported by a robust and responsive infrastructure, which is confidential and ensures data security is critical to the commissioning and delivery of good health and social care.

We are currently working with other CCGs and the Local Authorities in Essex on a shared vision that will provide a patient focussed approach to information and technology that:

- Ensures that clinicians can access health records regardless of provider
- Uses technology to help patients manage their own health and wellbeing

- Allows patients to access various services using digital options
- Enables patients to navigate to the right service and book online appointments
- Allows patients to own and see their health records online.

We are also exploring alternative options to support better primary care access through the use of technology.

6.5 Estates

Thurrock is currently developing its Primary Care Estate Strategy with local health and social care partners across south west Essex. The strategy includes work already underway to look at new and innovative ways of ensuring the long term sustainability of Thurrock's more deprived localities highlighted in the local Joint Strategic Needs Assessment (JSNA), the localities being Tilbury and Purfleet.

Work to date has included a Tilbury Integrated Healthy Living Centre Needs Assessment from which, based on the needs identified in the report, a 'blue print' of recommended services has been provided for commissioners to consider providing/co-locating within any new facility.

Learning from the development of the Tilbury Integrated Healthy Living Centre will be used to inform future development options in Purfleet, Grays and Corringham over the next 3 years outlined in figure 17 in section 7 below.

We have also been in discussion with our local acute, community and mental health providers to explore the "art of the possible" to see whether we can come up with innovative ideas of how we might be able to use existing estate to support the proposed new care model going forward.

7 Timescale for Change

The High Level Plan below at figure 16 sets out the steps Thurrock CCG and its neighbour in Basildon and Brentwood will be taking in partnership with provider colleagues through the first 3 phases of the transformation programme, over the next 3 years. This includes work currently underway:

- Primary care estate development to support the provision of new models of care.
- Development of the new commissioning model to enable the new models of care.
- A joint outcomes based CQUIN signed up to by all providers to improve quality and standards, and to drive integration.
- A focus on education and workforce development to build capacity and capability to support the new models of care.
- Regeneration of Thurrock Community Hospital, developing the case for change whilst considering our population's urgent care requirements for future.

Figure 16 High Level Timeline for the next 3 years

Timeline	Now	2016-17	2017-18	2018-19
Commissioning Model	- Business Case - Support plan - Engage plan	Dialogue for Thurrock MCP	Appoint MCP for Thurrock - Locality 1	- Locality 2 - Locality 3 - Locality 4
Primary Care Estate	- Develop specification based on JSNA	Planning process based on Blueprint	Finalise plan and build Tilbury	Finalise plan and build Purfleet (tbc)
Locality Teams	- Draft and negotiate CQUIN	Locality CQUIN – Complex care team	Locality based integrated teams – Tilbury	- Locality 2 - Locality 3 - Locality 4
Thurrock Community Hospital Regeneration	- Business case and engagement	Phase 1 and 2 - Intermediate Care Review	Phase 3 – Functional mental health	
Urgent Care Requirements	- NELFT and SEPT negotiations	Joint working protocol (RRAS, DCST, CRHT)	Review and consult on MIU	Develop Urgent care centre (tbc)
Essex Success Regime	- Detail Feb 16	(tbc)	(tbc)	(tbc)
Workforce and Education	- Identify current capacity/gaps			
Governance and Engagement	- Southend and CPR re SW/SE Dementia - Provider Exec Sign-off - Future use of Buildings - MPs/HOSC etc - Public Facing Document			

We have also developed a high level timeline highlighting our priorities over the next 9 months (figure 17 below).

Figure 17 High Level Timeline for the next 9 months

	Governance (Board and H&WB)	Engagement	Commissioning Model	Primary Care Estate	ICR	Locality teams	Workforce	Thurrock Community Hospital	Success Regime
Dec	Project Mandate and plan	Stakeholder		Tilbury JSNA		Draft CQUIN	Review Baseline Staffing	Shape MIU Review	Shape ESR
Jan	Monthly update/ sign-off engagement Plan	Shape H&WB engagement and public facing document	Exec to Execs		Staff engagement, Community Spec (IC)	CQUIN Workshop		Review TCH estate	
Feb	Transformation strategy	First newsletter	Provider engagement	Thurrock JSNA	Recruit to IC posts	CEG CQUIN follow up	Shape ESR workforce plan		ESR Plan sign off
Mar	H&WB Strategy	Public engagement	Provider engagement	Building Blue Print	Staff engagement	Contract sign off		Orsett Estate Review	
April	Monthly update and sign-off	Public engagement	Outline Business Case		Divert IC patients				
May	Monthly update and sign-off	Public engagement						Consider opportunities	
June	Monthly update and sign-off	Outcome			Possible closure of ward	Risk Strat, DoS, Care co-ord.			STP sign-off
July	HWBB Update								
Aug	Monthly update and sign-off		Dialogue						

A more detailed programme plan has also been developed to set out the tasks and actions required to further develop the new care model. This informs our governance for the programme.

8 What does this mean for our Providers?

We have already been working closely with our system partners on a range of service developments and are committed to continue to work with them as we embark on our transformational journey. We know that to deliver our vision we will need to change the way we commission and deliver care and we are keen to work with our local providers to find new and innovative way of doing this. We need to be able to reduce current pressures on acute services and an enabler for this will our integrated locality (neighbourhood) based teams providing care closer to or at home for our local population.

We also know that delivering an integrated care delivery model will require radical changes to the way we fund that care and we are already exploring how we can do this by learning from the vanguards and their experiences, whilst at the same time ensuring we follow public sector procurement rules.

We recognise that like the CCG, our providers are also exploring the new models landscape and are considering its implications for their futures, and are committed to continue working with them to find the best solution (new model of care) for our population.