HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Thurrock

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

Thurrock Integrated Care Alliance (the 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 NHS Mid and South Essex Integrated Care Board.

How have you gone about involving these stakeholders?

The foundation of our 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..

Governance

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

Health and Well-Being Boards 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)
The review also specified how the governance arrangements required between 'place' (Thurrock), and 'system' (Mid ad South Essex Integrated Care System) should operate – including potential areas of conduct, overlap and responsibility. This has shaped the devolution and delegation agreement between the Integrated Care Board and Thurrock Integrated Care Alliance.

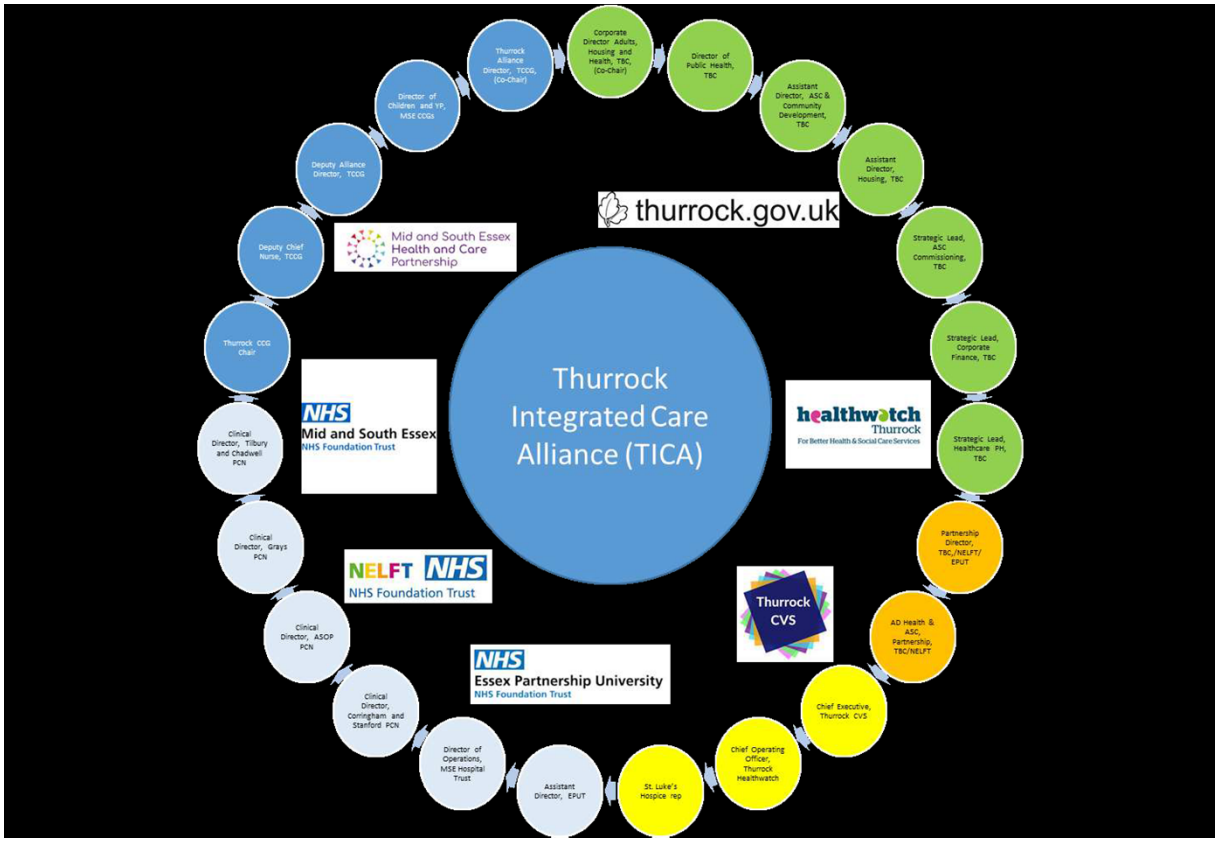
The current governance arrangements continue to include:

- ✓ a **Thurrock Integrated Care Alliance** (the Alliance) with strategic oversight of the health and care transformation agenda - including the Better Care Fund (the BCF plan is synonymous with the transformation agenda), the commissioning agenda and acting as the financial delivery mechanism for health and care integration;
- ✓ a **BCF Finance and Performance Delivery Group** reporting to the Alliance which meets on the last Thursday of each month to oversee the Better Care Fund, and to review the performance of services. It has responsibility for financial monitoring and oversight of the BCF and other system level financial modelling, integration of health and care budgets, performance, 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 Alliance with responsibility for the delivery of the transformation programme, new including a new Integrated Commissioning Strategy;
- ✓ to support integrated working at locality level, an **Integrated Locality Working 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.

In July 2022, with the Mid and South Essex Integrated Care Board replacing Thurrock Clinical Commissioning Group, and inevitable personnel changes, it took only a short time for effective working relationships to be established, and for new systems to bed in. This was particularly tested by the need to formulate at short notice a commissioning plan for the Discharge Fund. Following the announcement on 22 September the plan was developed by the Alliance and approved by the Health and Well-Being Board on 9 December 2022. The plan was executed

successfully, performed well, and all in a timely manner. That is itself a testament to the strength of the new Alliance, and the effective governance of our local strategies and plans.

The full membership of the Alliance is shown in the diagram below:



Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Thurrock's record in 2022/23 shows it performs well in relation to the objectives of the Better Care Fund:

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

An example is our investment in population health management which shows that whereasThurrock had the highest rates for strokes in the 75 and over age group, it now has the lowest (in MSE sub ICB localities).

This was despite significant financial pressure on the Councl's services as a result on the change in the hospital discharge criteria and the ending in March 2022 of the funding to support discharge from the Hospital Discharge Initiaitve. The situation was rescued by the announcement of the Adult Sosicla Care Discharge Fund in September 2022. The Alliance worked effectively to commission the additional service required for the winter 2022/23.

The priority for our Better Care Fund Plan 2023/25 is to build on this success by translating our new strategy for adults, Better Care Together Thurrock into an effective investment programme for greater integration of health and care. To realise our objectives we plan, with the assistance of the LGA BCF Offer of Support, to

- Review and refresh local ambitions for the BCF and integrated care, within the context of the new strategy for adults, and significant financial pressure on the Council and the ICB;
- Review its BCF plans and expenditure to ensure value for money and to target improvement;
- Review the implementation of the High Impact Change Model for Managing Transfers of Care in order to update our Plan and to support the system in focusing on future actions.

This work will also be guided by the Hospital Discharge Policy, especially the stipulation that 'NHS bodies and local authorities should agree the discharge models that best meet local needs that are affordable within existing budgets available to NHS commissioners and local authorities'.

Consequently there are no significant changes planned to the BCF services commissioned at this point in the year (June) as we are to undertake the review of the whole plan in July and August 2023, with the aid of the LGA BCF Offer of Support. However, we believe, and evidence shows, our services remain focused on high quality discharge, and support for individuals to remain at home wherever possible.

And the Alliance has further ambitions to develop an integrated commissioning strategy. The intention is that, in time, this single strategy will encompass all health

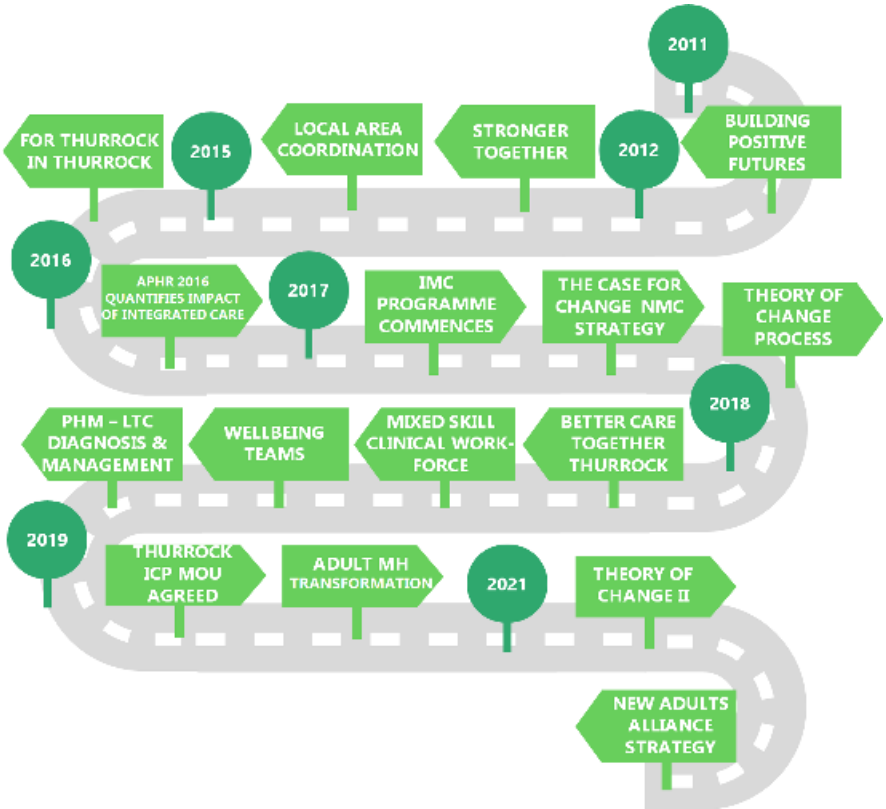
and care services in Thurrock, maximising the benefits of pooled funding through a single commissioning unit.

National Condition 1: 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 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

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 (housing, health ans social care) 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 our 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.

Health inequaities remain a significant issue in Thurrock: the population is generally less healthy that the East of England and England. Our more deprived populations suffer lower levels of both total life expectancy, and the numbers of years life that they can expect to live without disability. The main causes of death in 2020 were cancer, cardio vascular disease, COVID-19, dementia and respiratory disease. With a more flexible Integrated Care System, able to allocate resources in a fairer and more equitable way, we will be able to address the higher health needs of our population, including those living with higher levels of deprivation related to age, race, gender, and sexual orientation, as well as disability, and mental illness

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 silos and have traditionally applied a 'one size fits all' approach to an issue. We know we need to commission a learning environment to constantly test, embed and refine the solutions to produce the desired outcomes. 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. We need to ensure greater take up of community equipment and Technology Enabled Care for all those who can benefit from managing their health conditions, and their living environment.

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 arrangements, and market development have been remodelled to be consistent with these new conditions, and types of partnership working.

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 resources as required to deliver the desired 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 communities of practice 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 communities of practice (becoming Community Investment Boards), with communities thereby 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 new 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.

To give one example of our new approach to engaging the market, Mid & South Essex Integrated Care Board (the ICB), through the Alliance, is developing a Pseudo Dynamic Purchasing Framework (PDPF), which will be available for local Voluntary, community, faith and social enterprise (VCFSE) organisations.
The PDPF has two functions:
Firstly, it creates a more streamlined and quicker route for VCFSE providers to 'sign up' to the framework, thus allowing them to be contracted with, for local service provision.
Secondly, it provides a learning and support environment to VCFSE organisations to become contract-ready. This will be a key market shaping tool moving forward in Thurrock.

While these structural changes are being taken forward, (and as we believe, and evidence shows, our services remain focused on high quality discharge, and support for individuals to remain at home wherever possible) there are no significant changes planned to the BCF services commissioned at this point in the year (June) as we are to commence a review of the whole plan in July and August 2023, with the aid of the LGA BCF Support Offer. Changes in service after September 2023 will be informed by the priorities and recommendations of the BCF Review.

Beyond the BCF review, our priority in 2023-25 is to change our approach to integration and joint commissioning. This work is at an early stage (and will be

informed by the outcome of the Review) but the following outline sets out the scope of our ambition:

Chapter 1: Description of new approach - HLS - single framework and collaboration - co-design/co-production with communities.

Chapter 2: Children and Young People
- *Services that provide the best start in life from conception to school age*
- *Integrated approach to early help and specialist support for children at risk of poor outcomes*

Chapter 3: Wellbeing
- *Support people and communities to be and stay healthy through advice and guidance, primary prevention and planned care services for people of all ages across the whole life journey and covering physical and mental wellbeing*

Chapter 4: Community
- *Support people with multiple care and support needs*
- *Support people in need of urgent care, responding to a crisis*
- *Reablement and recovery*
- *Supporting people with long term support needs, needing ongoing long term support*

Chapter 5: Enhanced Specialist Care
- *Provide the 'top tier' of care covering individual patient placements*
- *Care homes for working age adults and those over 65*
- *End of life care*
- *Acute hospital services*
- *Specialist and tertiary services*

Chapter 6: Delivery Mechanisms:
- *New aligned single commissioning team/network across ASC, PH, Housing, ICB Alliance*
- *Revised BCF to act as financial delivery mechanism for Alliance Adults' Commissioning/CF4C*

As an Alliance we have agreed needs assessment data would be built into Chapters 2-5. We agreed that each Chapter should conclude with key strategic commissioning intentions for providers. We agreed that we would develop an initial scoping paper that could be socialised with to gain broader sign up to the new strategy development. The scoping paper would:
- Describe HLS approach in the context of commissioning
- Describe the rationale for the new approach
- Explains and unpacks the key elements of each chapter and what it will cover
- Seek approval for approach
- Set out next steps in terms of wider workshops and engagement

The further ambition is to move to:
- Single Multi-agency commissioning Unit
- Single budget

The reduction in the Better Care Fund pooled fund in 2023/24

At the end of 2022/23 Mid and South Essex ICB reviewed its system wide expenditure on the Better Care Fund inherited from the three CCGs in mid and south Essex. It identified a different approach had been taken to the BCF pooled fund in Thurrock. The CCG contributions to the BCF pooled fund budgets for Southend on Sea, and Essex County, had been the minimum health contribution, whereas in Thurrock, additional NHS contributions over and above the mandatory minimum had always been made. The ambition in Thurrock was advancing opportunities for integration, and joint commissioning to improve outcomes for local people, and was reflected in the fact that Thurrock Council has itself also always made a substantial additional contribution to the BCF pooled fund.

The Central team in the ICB took a decision to remove the previous CCG additional funding from the BCF pooled fund in Thurrock in 2023/24, in order to ensure that the financial commitment to Thurrock was consistent with the other Alliance areas in relation to audit processes, and to divert that funding to existing health contracts which are captured in the BCF. There is no loss of funding to the system. The reduced contribution by the ICB to the Thurrock BCF pooled fund does, however, create a disparity in the funding by the parties, with implications for the risk sharing arrangements, and the treatment of underspends as set out in the agreed Section 75 Agreement which the ICB and Thurrock Council will jointly review. Thurrock Council has decided not to make a corresponding reduction in its additional contributions to the BCF pooled fund in 2023/24.

The ICB and the Council remain committed to the continued integration of health and social care, as well as joint/collaborative commissioning including the opportunities afforded by pooled funding arrangements to improve outcomes. The contributions of the ICB and the Council to the pooled fund for 2024/25, and future years, will be examined during the course of the review of the Thurrock Better Care Fund Plan and Section 75 Agreement being undertaken between July and September 2023 with the assistance of the LGA Offer of Support.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Our Better Care Fund Plan is underpinned by an understanding that personalised care is at the heart of quality interactions with people, leading to better outcomes. It relies on people who use services being empowered to ask questions and identify things that are important to them, as well as those involved in their care actively listening and using this information to tailor and personalise their care, support and treatment. An essential element of prevention that allows people to enjoy their best possible health and wellbeing is supported self-management to make positive lifestyle changes - this is part of personalised care.

Personalised care also supports the reduction of health inequalities by looking at how to make the system more equitable for the individuals trying to access services and adapting to their needs. These broad principles are challenging to deliver as change relies upon shifts in culture, facilitated by subtle influencing over long periods of time. The use of training and education, good communication through our system and compassionate challenge will support delivery of the personalised care model.

In Thurrock we work creatively with personal health care budgets, social prescribing and green space social prescribing to be innovative in our delivery of these principles. As personalised care is about people, the work is co-produced with individuals with lived experience to ensure it meets the needs of our population.

Our health and care professionals work to make personalised care an essential driver in health and social care service improvement across all commissioned services in Thurrock. To ensure our new strategy for adults (Better Care Together Thurrock) is delivered, it sets out the priorities as commitments that the local providers and commissioners are asked to acknowledge and accept as vital to the successful provision of system-wide high quality personalised care through the Human Learning System approach. The strategy outlines how we will change the way we work to ensure personalised care is embedded across our transformation plans, new services and existing services, and how we will work together as a

system to bring a culture of personalised care. This work builds on years of committed joint working, work that has recognised us as national leaders in the field of personalisation of services and working at place. Partnership working with health and care, our coproduction in community groups, and asset-based approaches have remained central to our approach. Listening and learning from people with lived experience, ensuring their voice is heard and working in partnership at a senior and strategic level, is an essential component of our personalised care agenda. Our strategy is not a standalone document. The overarching aim of the personalised care workstreams is to ensure that personalised care becomes everybody's business and runs throughout transformation plans, workstreams, partner plans and commissioning. Thurrock's ambition is to maintain our status as national leaders in personalised care and to deliver the Universal Comprehensive Model of Personalised Care, making it a golden thread through everything we do and an everyday reality for the people of Thurrock

Improving the management of Cardiovascular Disease (CVD) in Thurrock

Thurrock has been on a journey to improve cardiovascular disease (CVD) management and outcomes since 2016. In 2014/5, a large proportion of Thurrock practices had CVD quality measures (QoF) below England average. Thurrock Council Public Health team co-produced with GP practices a systematic, data-led population-based approach to reducing CVD risk and disease in primary care, using Population Health Management principles. This has resulted in 2021/22 in Thurrock having the best QoF results in England for a range of CVD quality measures including: hypertension management; heart failure management; and recording of smoking status. Additionally, compared to other mid and south Essex footprints early indications that emergency admissions for CVD and Stroke conditions in Thurrock are lower but more work needed to confirm this. This has been achieved against a background of Thurrock having the third highest list size per GP in England (2022, Nuffield Trust data). Next steps include:

Improving detection in Thurrock

1. Shift focus from management to improving detection in 23/24 so that those who are currently not diagnosed or not coded can also receive this excellent quality of care
    - Reduce rates of emergency admissions in the younger age groups
2. Expect that this may initially cause a reduction in the management figures (newly diagnosed)
3. Keep monitoring statistics on previously diagnosed to ensure that drop in performance is due to newly diagnosed

Holistic care for multi-morbidities in Thurrock

1. Motivational interviewing training delivered to a range of front-line staff
2. UCLP risk stratification model used to identify medium risk patients for holistic review in practices
3. Development of a multi-organisational, co-designed CVD case finding strategy underway – expected October 2023
    - Expected to include recommendations on expanding target cohort for NHS health Checks
    - In addition to recommendations to integrate currently silo'd approaches across the system

Rolling out best practice across MSE

1. Continue to refine and role out our CVD approach across Mid and South Essex ICS – concentrating on core20 and plus groups
2. Learn from Castle Point and Southend – reducing strokes in younger age groups

Additional analyses and evidence review for MSE – PHM team and Stewardship

1. What is driving increases in Strokes in younger age groups?
2. Look at elective admissions also
3. Characteristics of the cohorts

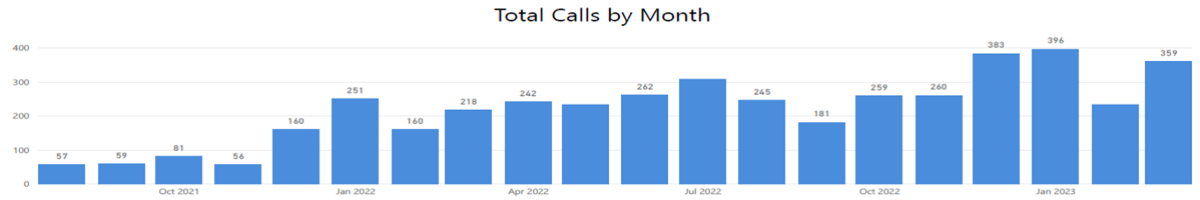
Integrated, jointly commissioned support to help people to remain independent at home has also been a feature of Thurrock's Better Care Fund Plan for a number of years. These services have proved highly effective in supporting supporting independence, reducing admissions to acute settings, and enabling safe and timely discharge. Our new Strategy, Better Care Together Thurrock, articulates our ambition and plans to go much further. This will be realised via the new Integrated Commissioning Strategy outlined above.

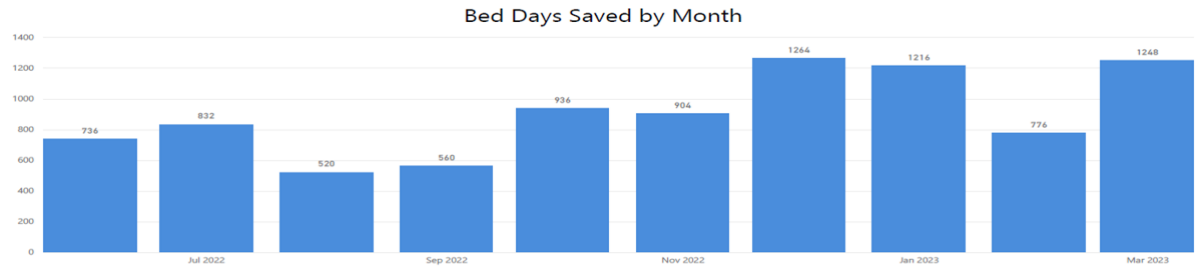
The schemes jointly commissioned from the BCF Pooled Fund for supporting people to remain independent at home for longer include (not an exhaustive list):
Thurrock First, our seven day a week, first point of contact for adults needing support with social care, mental health, and health care needs, provided by EPUT, NELFT and the Council
Early intervention and prevention, with carers grants, an exercise referral scheme, Stretched Quality Outcomes Framework provided by GPs, and stroke prevention
Crisis Intervention with a Dementia Support Crisis Team, Urgent Care Response Team (formerly the Rapid Response and Assessment Service), and Safeguarding Team
Care co-ordination in the community) including technology enabled care, community equipment, day care, and Local Area Co-ordinators.

The Urgent Community Response Team (UCRT) is the entry point to our virtual hospital, providing better experiences and outcomes for people. UCRT is one of the first community services to be operating as an MSE Community Collaborative service which was formed in October 2021 to explore how by working together we can best meet the needs of our local communities. Prior to 2021, this service was know and provided locally as the Thurrock Rapid Response and Assessment Service (RRAS).
Thurrock is the only locality within the MSE with social care embedded in the UCRT
The Benefits of having social care alignment include:

- Holistic care for patient/service user including housing, TEC, equipment and adaptations
- Speedy reablement post discharge due to team skillset
- Other ASC teams are able to refer directly for physical health support
- Budget savings to LA, with better health need for social care input is reduced.
- Quick access to social care and records
- Peer learning and support
- Collaborative working is more assured between NELFT and Thurrock Council

Performance speaks for itself:



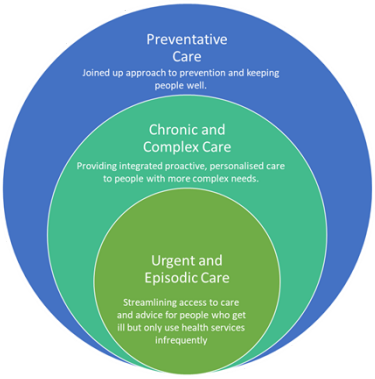


Bed Days Saved - this measure has been calculated by mulitpying all calls where advice was given that did not result in a hospital admission within 7 days of the patients call by the average length of stay of an 80 year old patient. Average length of stay of an 80 year old patient across MSE = 8 days.
Average length of stay of an 80 year old patient – 6 days at Southend/ 10 days at Basildon/ 6 days at Chelmsford.
This measure should be used as a guide and is not definitive in deducing effectiveness of the Frailty Hotline.

Further detail on jointly commissioned services is contained in the Planning template.

While the majority of demand can be met, a comparison of the demand and capacity for Thurrock shows that there is a gap in reablement at home services for community referrals. The Alliance is aware that the demand and capacity plan has highlighted the need for increased reablement at home, and additional home-based reablement is being commissioned through our Joint Reablement Team (JRT) to address this gap (scheme 12 on the expenditure sheet). We are also exploring utilising the Discharge Funding to increase re-ablement capacity at home with the Council's in-house homecare providers. Overall, the demand and capacity plan demonstrates that BCF-funded services will ensure that there is sufficient capacity to meet the demand from community referrals, thereby supporting our aim to keep people independent and at home for longer.

For primary care, the 4 Primary Care Networks (PCNs) in Thurrock are completing detailed plans to develop Integrated Neighbourhood Teams, to deliver the 3 pillars of the Fuller Stocktake:



The Vision - Building our services and aligning our resources around our neighbourhoods *“What matters to me, not what’s the matter with me?”*

We would do this by agreeing core components of the neighbourhood teams based on population health needs. Building from a core of General Practice; PCN roles (ARRS); Pharmacy; all Community services, community mental health teams and IAPT; Adult Social Care (including domiciliary care and care homes); some children’s services; outpatients social prescribing; local VSFCE groups in health and care sector. Then expanding from a coalition of the willing.

We will determine the focus by considering:

- Health, Care and societal needs and wants of the population. Need driven by the effective use of data and insights to segment populations based on their needs
- Which groups of the population need the most support and when do they need it? Where is the high level of demand?
- Existing inequalities
- Wider community engagement

The intention is to deliver:

- Streamlined access to care and advice for people who get ill but only use health services infrequently, providing them with much more choice about how they access care and ensuring care is always available in their community… when they need it.
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals, to people with more complex needs, including (but not limited to), those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joind up approach to prevention.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Demand for hospital discharge services in 2022/23 was derived from Health Data provided from the Activity Plan submitted as part of the NHS Operational Planning round 2022/23. The discharge activity relates to three hospital sites in the system, covering 3 upper tier authorities - as a result the discharge activity was apportioned 75%, 15% and 10%. With 10% of the overall activity falling within the Thurrock position. This split has been derived from the Deloittes Out of Hospital Demand and Capacity modelling which received input from all stakeholders.

Demand for community services in 2022/23 was derived from Bed Based Intermediate Care data and estimations based on new clients in 2019/20 (as an average per month) as more current year figures have been significantly impacted by Covid causing home closures. The assumption was that Oct 2022-Mar 2023 will not be impacted by further home closures.

Council data on reablement was based on the average number of new clients from the community into reablement services over the last 3 years. The majority of our Reablement service is supporting hospital discharge.

Health capacity data was extracted from the NHS Planning return for 2022/23 and includes bed based capacity apportioned to Thurrock and our virtual ward capacity apportioned 75%, 15% and 10% across upper tier authorities in the system.

Bed-Based Intermediate Care is Council data only. These figures were calculated based on Caseload as actual number of beds, Occupancy % from 2019/20 actuals, and ALOS from a median of actual ALOS from 19/20 and targeted LOS. The figures were then apportioned to Community. 2019/20 figures were used due to subsequent years being significantly impacted by Covid and home closures. The assumption was that Oct 2022-Mar 2023 would not be impacted by further home closures.

Community services figures were based on Caseload and Occupancy - as average number of people supported as at month-end over the last 3 years, Occupancy - as 100%, and ALOS - as an average of the last 3 years. The figures were then apportioned to Community based on the average split of Discharge/Community over the last 3 years.

In spite of the demand and capacity planning in 2022/23 the Council experienced significant cost pressures for services to support safe and timely discharge in the first half of the year. This was related to the decision by the hospital trust to change the discharge criteria from medically fit to medically optimised, and the end of the Hospital Discharge Initiative funding in March 2022 The Council and the ICB worked together to attempt to address the resultant financial crisis but it was not resolved until the Ministerial announcement of the Adult Social Care Discharge Fund, with additional resources being made available, on 22 September 2022.

With the announcement of the Discharge Fund, and with the approval of the new plan by the Health and Well-Being Board, the Council and ICB were able to mobilise resources to alleviate the financial pressures, and to deploy addition support required for services for hospital discharge.

During the development of the Better Care Fund Plan 2022/23 it was not possible to address the requirements of the Hospital Discharge Policy, especially the stipulation that 'NHS bodies and local authorities should agree the discharge models that best meet local needs that are affordable within existing budgets available to NHS commissioners and local authorities'. It was agreed during the assurance of the 2022/23 Better Care Fund plan that this, alongside a review of the High Impact Change Model locally, would be a priority for the review of the Better Care Fund Plan for Thurrock to be undertaken with the LGA Offer of Support.

The Alliance mobilised capacity to meet demand in line with the Better Care Fund Plan for 2022/23. As a significant volume of capacity is spot purchased by the Council there was little difficulty (workforce issues nowithstanding), beyond the affordability issue, in meeting demand. The Adult Social Care Discharge Fund addressed the affordability issue from September 2022.

A review of post discharge related expenditure demonstrated there was less demand for some Discharge Fund schemes than originally anticipated and therefore spend was moved to areas with higher demand that met the necessary criteria. All

contingency funds and underspends where directed to high demand scheme types - especially domiciliary care to support hospital discharge.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Evidence shows our services remain effective on avoiding unplanned and emergency admissions, and ensuring safe and timely discharge, and support for individuals to remain at home wherever possible.

In relation to safe and timely discharge from hospital:

- In Quarter 4 2023, 38 out of 43 discharges from hospital for people 65+ into re-ablement/rehabilitation were at home 91 days later, which equates to 88.4%. This is 1.3% above target and is an improvement on the previous quarter.
- Of the 5 discharges where the individual was not at home 91 days later, 3 were deceased, and 2 were in hospital. If the deceased were not counted in the cohort, the performance would have been 95%. Of the 5 not at home, 3 had their reablement service ended early, 1 went to residential short break and 1 went to home care.

In relation to admissions to care homes in 2022/23:
- There were 162 new permanent admissions to residential/nursing care for people 65+ in the year, which equates to 676.3 per 100,000 population. This is 16 under target.
- In this period, 72 individuals were full costers (44%). If full costers were not included there would be 90 admissions, a rate of 375.7 per 100,000 population.
- In the same period last year there were 157 admissions; therefore there has been an increase of 5. (NB New population figures were published by ONS in December 2. 65+ has reduced from 24,098 to 23,953. The rates per 100,000 population have been recalculated using the new rate.)

In relation to reablement services:
- The average age at the start of reablement was 82 years old. The average length of stay in reablement was (broken down by reason not at home): - Hospital = 23 days; - RIP = 12 days; - Overall = 16 days

Whilst reablement aims to improve independence to keep individuals at home for longer, some individuals have health conditions that might mean that full independence is not possible. Individuals can also have a loss of independence during reablement (causing the reablement to end earlier than planned), or after reablement has taken place, due to new or worsening conditions. For these reasons, even though some individuals may not be at home on the 91st day, this does not necessarily indicate the service has been ineffective.

Although the target for reablement has been met, it should be noted that there were fewer people in the cohort compared to other quarters. Only 43 people 65+ were discharged from hospital into reablement for the period October - December (the cohort used for Q4). It was planned that this would be approx. 85 through the Better Care Fund Plan. This does appear to be an anomaly as the numbers were higher in previous quarters (average of 72 per quarter) and have increased again in January-March to 80. The following should be noted:
- There were fewer older people (65+) discharged from hospital in general October-December that were in contact with the Hospital Social Work Team. There was a 27% reduction in contacts for older people and a 24% reduction in FAR's for older people completed by the Hospital Team in October-December this year compared to the same period last year;
- The Hospital Social Work Team advises there were more service restarts in the period, rather than new service users (who would be more likely to require reablement);
- Only 2 individuals since June who had reablement potential did not receive a reablement service but instead went to a long-term service.

In the light of current performance, no significant changes planned to the BCF services commissioned at this point in the year (June) as we are to commence a review of the whole plan in July and August 2023, with the aid of the LGA BCF Offer of Support. However, the Alliance is commited to ensuring any potential improvements which are identified during the course of the BCF Review, and in particular the review of the High Impact Change Model, will be implemented without delay.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

During winter 2022/23 the additional ASC Discharge Fund was deployed to prevent avoidable admissions and to ease the pressure on hospital discharges by commissioning additional beds to allow people to be discharged to a place of "convalescence" before returning home, and where detailed assessment of the person's needs (based on an asset-based approach), could be made to help the person determine their options and preferences for future care and support.

The Discharge Fund investments in 2022/23 included:
- Provider Incentives (1).– an extra £100 per shift for shifts worked on Bank Holidays over the period
- Provider Incentives (2). Premium to cover additional pressures £2 per hour
- Extended Bridging Service Capacity
- Funding to support complex discharge (e.g. need for 1 to 1 support)
- Over time funding for placement / SW staff to support 7 day discharge
- Increased in By Your Side funding (and potentially to other CVS initiatives to support discharge)
- Payments for sessional AMHP cover to support MH discharge and Support
- A contingency for flexibility and other initiatives which result from performance monitoring, and lessons learned reviews.

Community Welfare Hubs were also established to provide immediate, low level resettlement support to older people being discharged from hospital, where there were no/low level ongoing needs.

The spending plans for the Discharge Fund for 2023/24 draw on the impact and learning from the schemes as set out in the Discharge Fund Year End Template submitted on 2 May 2023. The spending plans for the Discharge Fund for 2023/24 will also be included in the BCF Review.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

- how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Alliance in Thurrock is keen to review and refresh local ambitions for the BCF and integrated care, within the context of significant financial pressures for both the Council and the Integrated Care Board.

The system will review its BCF plans and expenditure in July and August 2023, with the assistance of the LGA BCF Offer of Support, to ensure value for money and to target improvement. It has asked for a review of its section 75 agreement, in particular to understand the balance of risk-share across partners, and of value for money around BCF expenditure, with a view to suggesting cost savings and improvements and aligning with the Better Care Together Thurrock strategy for adult services.

In our 2022/23 BCF plan, we acknowledged that the plan's review of implementation of the High Impact Change Model for Managing Transfers of Care would benefit from updating, to support the system in focusing on future actions.

This LGA BCF review will be guided by the Hospital Discharge Policy, especially the stipulation that 'NHS bodies and local authorities should agree the discharge models that best meet local needs that are affordable within existing budgets available to NHS commissioners and local authorities'.

As noted on the Capacity and Demand tab in the Planning template the analysis informing our commissioning decisions and consequent investment in BCF schemes includes the following:

- **Social Support** - LA data is derived from the 2-year average number of referrals into the Home from Hospital Service (where we have full data), split by the 2-year average % split between hospital discharge and community. Please note that there are no set caseloads for this service and we do not have information on average length of stay to be able to use the capacity calculation, therefore our demand and capacity figures are the same.
- **Urgent Community Response** - LA data is derived from the monthly average number of referrals for the past 3 years into the UCRT service for social care interventions. Please note we do not have a set caseload and there is no 'length of stay' in service because the UCRT is an assessment service, so we are unable to use to capacity calculation. Therefore our demand and capacity figures are the same.
- **Reablement in a Bedded Setting** - LA demand data is derived from the monthly 3-year average number of new placements into our Interim Beds, split by Hospital Discharge and Community. Capacity is derived from the following calculation: Caseload (number of interim beds available)*calendar days in month/3-year average length of stay, split by the 3-year average % split between hospital discharge and community. Please note that the interim beds do not strictly provide reablement but are intermediate care step up/step down beds).
- **Reablement at Home** - LA demand data is derived from the monthly 3-year average number of new care packages into our Reablement services, split by

Hospital Discharge and Community. Capacity is based only on our commissioned service, the Bridging Service, which provides Reablement and Short Term Home Care). The Bridging Service only provides support for hospital discharge, not community; all other reablement services are spot purchased so are not included in the capacity calculations. The Bridging Service provides short term reablement to prevent delayed discharges, and individuals are commissioned a more longer term (up to 6 weeks) reablement service from another provider through spot purchasing. If the Bridging Service does not have capacity to meet demand from hospital discharge, the reablement service is spot purchased from another reablement provider. Capacity for the Bridging commissioned service only is derived from the following calculation: Caseload (average number of care packages that can be supported at any one time based on a calculation of commissioned hours per month/average hours per care package per month)*calendar days in month/average length of stay last year. This was then split by the % of packages that were reablement. Please note that as the Bridging Service provides both short-term domiciliary care and reablement, there are no set caseloads for each service type and the service will flex to provide more/less reablement and home care to meet demand.

- **Short-Term Domiciliary Care** - LA demand data is derived from the number of new care packages per month last year (where we have full data) into our commisioned Bridging Service for home care only. Capacity is derived from the following calculation: Caseload (average number of care packages that can be supported at any one time based on a calculation of commissioned hours per month/average hours per care package per month)*calendar days in month/average length of stay last year. This was then split by the % of packages that were home care. Please note that as the Bridging Service provides both short-term domiciliary care and reablement, there are no set caseloads for each service type and the service will flex to provide more/less reablement and home care to meet demand.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

The LGA is engaging a BCF Offer of Support to work with the Alliance in Thurrock during July and August 2023 to include a discharge to assess review. The review encompasses:

- Self-assessment of what is working well in D2A, guided the Hospital Discharge Policy, through an online survey of system leaders and workforce
- Review and exploration of options to develop an affordable model for discharge, one which supports joint budget management, shared decision-making and shared risk sharing
- Findings from above activity presented to leaders in peer-led facilitated conversations to agree priorities and next steps
- The D2A support slides include an example survey output as well as details of other support activity available

Last winter (through the ASC Discharge fund), the Alliance attempted to re-open a residential home, which had previously been used as a designated setting, to provide a step down/step up facility for hospital discharge so that more expensive and out of area placements could be avoided. The short lead in time of the Discharge Fund frustrated this ambition. A small number of discharge placements were made by the hospital to homes outside the Borough, and the Council was not consulted on these placements. The placements continued after the initial period at significant financial cost to the Council. In order to prevent Thurrock residents being discharged from hospital to out of area placements in future, in-area step-up & step down beds are being commissioned to assist with the discharge to assess pathway and to support system flow during the winter period.

In September, when the full BCF review has been completed, an implementation plan addressing each of the recommendations received will be developed including a detailed time and resource plan.

.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

The High Impact Change Model was last reviewed in Thurrock in 2019/20, shortly before the pandemic. Inevitably the pandemic changed the nature of admissions and discharges for a period. The Thurrock Better Care Fund Delivery Group continued to meet on a monthly basis to review performance, and to develop annual Better Care Fund Plans etc as required.

A significant development in response to the pandemic was the change in the hospital discharge criteria from medically fit to medically optimised. This led to an affordability crisis

for the Council, and to the decision in the Batter Care Fund Plan 2022/23 to bring forward a review of the High Impact Change Model.

An assessment of the High Impact Change Model on the Thurrock BCF projects will be carried out as part of the LGA Offer of Support to the BCF programme. This will be undertaken betwen July and September 2023. It is hoped the outcome of the review will be implemented in time for the winter 2023/24.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The Better Care Fund is a key enabler of the Alliance's ambition, and the Council's duty, to prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. Consequently, the Better Care Fund Plan, including the Discharge Fund, invests in a range of social work, day care and carers services to achieve the objective – as set out in the Expenditure sheet in the Planning template.

To give an example, the independent (non-for-profit run) Carers Information, Advice and Support service in 2022/23 identified and supported 514 NEW carers,

- an increase of 27% compared to 2021/22
- 72% were unknown to the Council.
- 84% of carers primary reasons for referral was for Information and Advice.
- 314 new and existing carers attended a peer support group.
- This year including the development of a peer support group for young carers transition to adult services.

But the Care Act has also engendered an all-encompassing strengths and assets based approach to delivering services in partnership. Consequently the Alliance is reshaping its investment programme to bring the vision of the Care Act, and the duties contained within it, to influence all our services.

As we note in our strategy for adults, Better Care Together Thurrock, the impact of such a wide scale cultural and delivery transformation will be system wide and extensive. It will achieve the following significant but far from exhaustive outcomes:

- Making co-design a reality
- Achieving massive cultural change from 'doing to' to 'doing with'
- Transforming the commissioning landscape – moving to collaboration and stewardship
- Radically changing the current performance colture that encourages organisational performance 'gaming' and is largely meaningless to the people we support
- Encouraging culture change in providers – moving from competition to co-operation in the pursit of the best outcomes
- Improving preventative services – reducing demand
- Reducing duplication – improving efficiency
- Creating more resilience in communities and individuals

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.

The Thurrock ICB Alliance team is engaged with GP practices in establishing an easy and reliable system for formally registering unpaid carers with GP practices.

This includes 'myth busting' with practice managers about when a person may be registered formally as an unpaid carer

Health is also represented at carers boards and is engaged in reviewing the Thurrock Carers Strategy

Additionally, the Alliance team is also beginning work on creating a guide for unpaid carers on hospital discharge, in an attempt to overcome the disparity and fragmented arrangements in how hospital discharge is managed

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

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

Our DFG service received 132 applications for the period April 2022 to March 2023, evidently returning to pre-pandemic levels, where 161 applications were received between April 2019 and March 2020. There were 70 installations for the period (excluding HRA funded adaptations)
Technology Enabled Care service performance by our provider Red Alert in 2022/23 includes:
Total No of installs – 272
Total No of replacements / repairs – 477
Total No of maintenance & de-installations – 334
Our in-house Careline service reported approximately 500 engagements, inclusive of new installations, replacements and deinstallations.
The total number of users with Careline is approx. 4300

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, including integrated and joint commissioning.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

No

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Click or tap here to enter text.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

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.

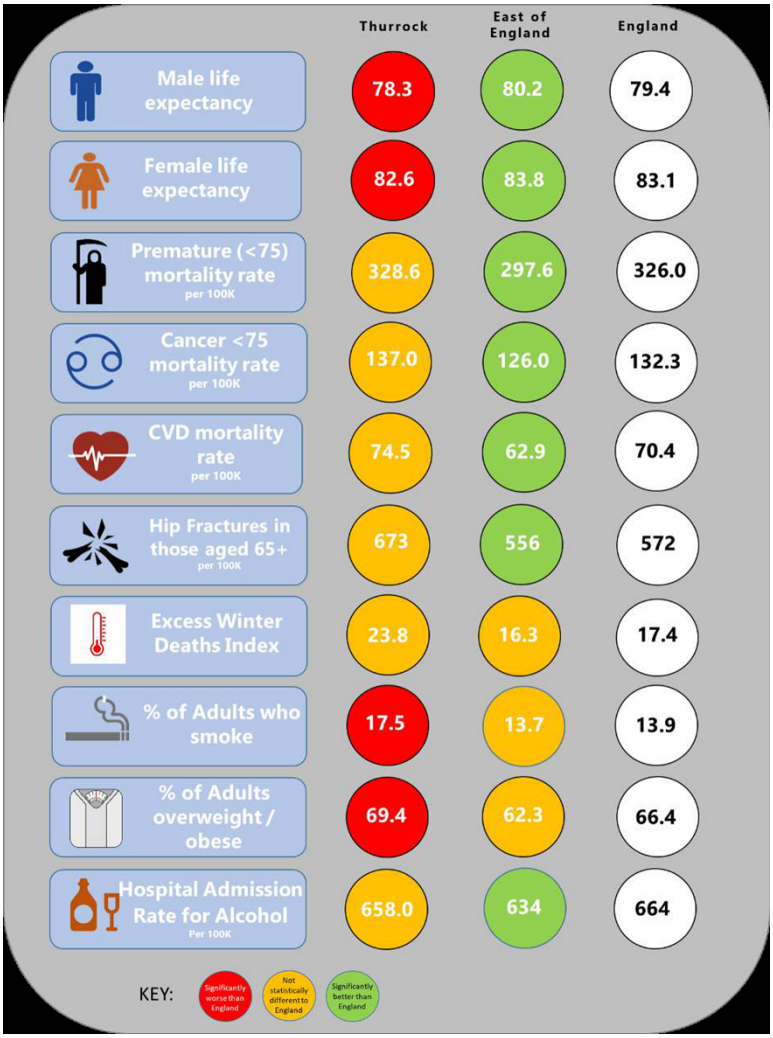
There is clear health inequity between both total life expectancy and disability free life expectancy linked to deprivation, with both measures increasing as deprivation decreases. Only the least deprived 35% of our population are likely to reach retirement age before reaching the end of disability free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

Thurrock has the third worse 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 cardio-vascular 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.

Discussions are under way to re-focus areas of expenditure to be more closely aligned with population health management and addressing health inequalities in 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.

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 worse 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.

Hi Stocktake Q2 Aug22 V0.1SM P...

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.

The Alliance has agreed that arrangements for contracting with all providers will be undertaken with due regard to equality and diversity considerations. This will include adherence to the relevant 'Equality' Codes of Practice on Procurement. These require consideration of the equality arrangements of all such providers; that they have relevant policies on equal opportunities and are able to demonstrate a commitment to equality and diversity. These arrangements will also be subject to a full review as part of the contract management of the services to be provided using the Provider Assessment and Market Management Solution (PAMMS) Monitoring System.