The Provider Perspective

Our ambitions: what should outstanding look and feel like?		
On range from 0 – 10 where are we now?		On range from 0 – 10 where do we need to be in 12 months
4	• Care Plan [should be available] across all agencies at point of access • Single place where different services can be accessed – e.g. day care and other older people's services • Housing [needs to be considered at an early stage] • Single point of access – 'phone number	7

Opportunities **What is working well? (www)** **Things we can build on to take advantage of to make our ambitions a reality**	**Challenges** **Even better if…(ebi)** **What has prevented us or might prevent us from making our ambitions a reality**
Assets: • House • Relationships • Social networks Needs assessment should take place at home and [the aim should be to] reduce hospital based interventions	Firefighting vs Firedrill 'George' would not admit he needs help • Coaching to support [him to accept his condition] • [knowledge of] What to expect from the condition [would help him plan and make decisions Assess the family's ability to support Cost of the 'system failure' to whole economy General Practice Whole Person Tool developed

Action Planning on our priorities Identify 2 priority 'www' and 2 priority 'ebi'. What are our 90 day mobilisation actions – what could we do in the next 90 days to gain momentum – building on a 'www' or tackling an 'ebi'		
Priority – an action statement	**Mobilising – what we will have achieved within 30 days**	**What we will have achieved in 90 days**
• RRAS	Co-ordinate input of all providers	Effective pathways [mapped out] for each crisis
• See the whole picture – e.g. of both Florence and George	Co-ordinated 'family plan' shared by all providers	
• Carers Group – access to and use of	What services [or support] can be delivered by a community asset	Comms Strategy/ Local Social Networks [to enable local community to understand how they can help]

Key Messages **Our role as a leadership group**	**Key Messages** **Building Community Resilience**	**Key Messages** **Implications for Primary and Community Services**
• Framework with triggers to assess the couple against	• LAC/Community Hubs	• ££ - VFM if the care plan works: less amputations, falls, blindness
• Learning from 'vulnerable adults' work	• Support Groups – Dementia UK, Diabetes UK	
• 5 year planning now [so that crisis can be anticipated and responded to effectively]	• Data Sharing	
	• Social Isolation [is a major risk factor]	
	• Shopping and Cleaning [and practical help at home needs to be considered]	

<u>The Commissioning Perspective</u>

Our ambitions: what should outstanding look and feel like?		
On range from 0 – 10 where are we now? 5	• Providing what people need at the right time (timing) – e.g. information and advice; sign-posting/ supporting people to navigate through the system; pre-service support • Early intervention and prevention • Solutions not services [are what we need to offer] • Single point of contact – one person co-ordinating care • Single information system [available to all providers • Building the solution around the whole person and where they live – including carers • Integrated Commissioning Model • Focus on 'social model' rather than pure medical model response – e.g. undertake a broader assessment (including wider social determinants – e.g. housing) • Accessible and high quality services when required • Strength-based approaches – move away from deficit model	On range from 0 – 10 where do we need to be in 12 months 6

Opportunities **What is working well? (www)** **Things we can build on to take advantage of to make our ambitions a reality**	**Challenges** **Even better if…(ebi)** **What has prevented us or might prevent us from making our ambitions a reality**
• CCG/LA working under HWBB • Co-terminosity • Housing and planning part of HWBB and HWB considerations • RRAS/JRT • Acceptance that the system is broken and needs to be different • Technology – assistive, social media etc. • Role of communities – LAC, ABCD • 3rd sector and user-led organisation	• Strengthened HWBB • Population increase • Capacity – need to watch changing demographic • Organisational culture/arrangements – governance/decision-making; planning; procurement; £ and tariffs • Marketing/ [communicating] change to the public – changing behaviour and encouraging greater personal responsibility • Education – via public health etc.

• VFM	• Chance to redesign the system • Move away from [purely] service-based focus • Funding • People unaware of entitlements – welfare rights • Health inequalities • VFM

Action Planning on our priorities **Identify 2 priority 'www' and 2 priority 'ebi'. What are our 90 day mobilisation actions – what could we do in the next 90 days to gain momentum – building on a 'www' or tackling an 'ebi'**		
Priority – an action statement	**Mobilising – what we will have achieved within 30 days**	**What we will have achieved in 90 days**
• Getting bottom-up approach – engaging community at large to develop Vision and Direction of Travel	• Identify the 'how' collectively	• We will have engaged (although [engagement will need to be on-going) – understand what the DoT is
• Agree what we mean by 'whole person' particularly in terms of early intervention and prevention	• Business case developed [for change]	• Early intervention/prevention 'offer'
• Success criteria – how will we know we're going in the right direction?	• Workshops to identify/ start to identify [how change should be managed]	• Draft integrated framework
• Governance arrangements: must have oversight of system/organisational and delivery	• Clarify potential options	• Agree changes

Key Messages Our role as a leadership group	Key Messages Building Community Resilience	Key Messages Implications for Primary and Community Services
• United vision/principles/DoT	• Having different conversation with the community – including marginalised [citizens]	• VFM – smarter and better working to give more
• Making change happen	• Remove hierarchy [where this impedes decision making]	• Do nothing is not an option
• Lead by example	• Encourage active citizenship	• Prevention and rehabilitation – providing a service [may equate to] failure
• Shared responsibility and risk	• Co-production in commissioner process – broaden commissioning based – e.g. micro-enterprises/Community Interest Companies	• Stronger together – sum of the whole is better than individual parts

The Patient, Carer, and Community Perspective

Our ambitions: what should outstanding look and feel like?		
On range from 0 – 10 where are we now?		On range from 0 – 10 where do we need to be in 12 months
6	• Personalised packages [of support and health care] • Communication of [my needs to all] services • 3rd sector voluntary groups/ housing [contribution is understood in my plan] • Access to individual packages /pathways • GPs/[an Early opportunity [to get a wide range of help] • Public understanding – awareness • Assessment of required needs at home	8

Opportunities **What is working well? (www)** **Things we can build on to take advantage of to make our ambitions a reality**	**Challenges** **Even better if…(ebi)** **What has prevented us or might prevent us from making our ambitions a reality**
• Access to social services • Multi-Disciplinary Team • [If the] Quality of housing is good [it can make a big difference] • Housing support • Voluntary Sector • Better Care Fund +	• Range of community options • Building new homes – more appropriate homes • Age of the housing stock • Sheltered accommodation • Family structure • Support for carers • Recognise the mental health needs of older people

Action Planning on our priorities Identify 2 priority 'www' and 2 priority 'ebi'. What are our 90 day mobilisation actions – what could we do in the next 90 days to gain momentum – building on a 'www' or tackling an 'ebi'		
Priority – an action statement	**Mobilising – what we will have achieved within 30 days**	**What we will have achieved in 90 days**
• Mobilise all services within a geographical area	• Community hub to develop a neighbourhood commissioning model	• Agreed model with a roll out of plan – LAC
• Review carer support	• Mapping out the support organisation [needed to deliver co-ordinated care]	• Strong Comms Plan
• Freeze Payment by Results: Incentivise primary/community care to keep people out of hospital		

Themes

Theme	Issues/Aims
Get the Governance Clear	• Clear governance structures including responsibilities/obligations • Evaluation of services
Visible working together – walk the talk at each level	• Visibly working together (as shown in this event)
Many channels, opportunities and touch points, but behind that a united response	• Multiple opportunities to connect within the community at all stages of life in a meaningful way and easy to get and give support - mutuality
Break the boundaries – give GPs ability to 'prescribe' not just medicines, but social prescribing [for example, further education, lunch clubs, self-help groups, befriending, hobby clubs, gardening, sports, book groups, art or dance classes	• Alternative prescriptions – remove the idea that GPs can only prescribe health
Great engagement at all levels, respect and listening	• Trust and honesty • Collaborative working with all agencies keeping the need of the recipient at the top • Building trust between each other • Audit and learn from failures so that the care can be improved and reduce bureaucracy • Co-produced system of integrated services with service users as equal partners in system design • Include everyone in the conversation • Involve everyone in planning care – patients, carers, providers, commissioners, the community • Develop mutual appreciation of differences in organisational culture • Bottom-up approach • Valuing community / Engage all levels of the community • Marketing public campaign that involves telling the community that integration is coming, have your say etc.

Focus on delivery/ rigorous delivery	• Keep actions SMART • Ensure all work action points are done • Set out and agree process, milestones, review and action
Care at home is default position – delivered by localities	• Community first – everything at a local level unless by exception • Care at home unless intervention cannot economically and practically be delivered at home
Be clear how money flows – do not fudge it!	• Respectful joint commissioning • Value for money • Get control of processes and cash flows • Change finance costing systems and budgetary arrangements
Build our single support offer around the person	• outcomes rather than services • Local Area Co-ordinators to work along side GPs • Patients select who need highest level of care – priorities • Give power to LAC to supervise/ agree changes to care plan etc all other service providers, in consultation with service users • Joined up care with single point of contact • Build [and co-ordinate] care and support around the person • Build on what we have together – joined up well • Community development approach to involve community in 'care' – inclusive approach (services) • Care plans covering all aspects of the needs of the person • Single plan for whole person which directs the interventions of all providers and connects people to their communities
Prevention/ anticipation focus	• Incentivise primary and community services for keeping people out of hospital/ residential care

	• Person centred and 'led' in a preventative and anticipatory way • Choice of provision by service user where services are needed • Prevention is better than cure
Shared Information is core to a unified response to a comprehensively personal plan	• Clear systems of communication within and across agencies • Focused and useful easy to understand and negotiate • Patient-led plan which all relevant parties can access • Understand information governance 'rules' and how to prevent them from becoming barriers to integration • Good acceptable tool to allow information sharing across historic boundaries
Shared purpose	• Shared principles with an agreed unified vision • Common goals
A single joined up plan from bottom (the individual care plan) to top – our single Thurrock Plan	• Joined up plans (despite legislation barriers) • Focus on whole patient • Needs to start at the beginning of the patient's pathway to prevent crisis • From diagnosis, a live (reviewed and responsive) care plan considering all areas of health and wellbeing for both patient and carer(s)/family • Community care developed • Planning with stakeholders
Principle from top to bottom – from single commissioning to single point of contact	• Commission a single economy of health and social care as well as investment in the community – neighbourhoods, and the built environment • Single commissioning arrangement for H&SC in Thurrock • Identify responsible persons who are accessible