Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Board

The meeting will be held at **11.00 am** on **27 July 2023**

Council Chamber, CO3 Building. Civic Offices, New Road, Grays.

Membership:

- Cllr G Coxshall (Chair)*
- Cllr B Johnson
- Cllr E Rigby
- Cllr S Shinnick
- Corporate Director of Adults, Housing and Health * (Ian Wake)
- Corporate Director of Children's Services * (Sheila Murphy)
- Director of Public Health* (Jo Broadbent)
- Executive Lead Mid and South Essex Health and Care Partnership & Joint Accountable Officer for its 5 CCGs
- MSE representative (Jeff Banks)
- NHS Thurrock Alliance Director, MSE ICP (Aleksandra Mecan)**
- NHS Thurrock Alliance Deputy Director (Margaret Allen)
- Chief Operating Officer HealthWatch Thurrock * (Kim James)
- Director level representation of Thurrock, North East London Foundation Trust (NELFT) (Gill Burns)
- Chair of the Adult Safeguarding Partnership or their senior representative (Jim Nicholson)
- Thurrock Local Safeguarding Children's Partnership or their senior representative (Sheila Murphy)
- Partnership Director, Thurrock Council, EPUT and NELFT (Rita Thakaria)
- Mid and South Essex NHS Foundation Trust (Michelle Stapleton – Acting Managing Director – Care Group 4; Fiona Ryan – Action Managing Director Care Group 1 and Hannah Coffey, Acting Chief Executive).
- Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Alex Green)
- Chief Executive Thurrock CVS (Mark Tebbs)
- Essex Police (Chief Superintendent Jenny Barnett /Chief Constable BJ Barrington)
- Assistant Director for Counter Fraud and Community Safety (Michael Dineen)

* Denotes mandatory organisational representation

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes and Action and Decision Log **5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 23 June 2023.

3 Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4 Declaration of Interests

5 Year End Report for the Better Care Fund **15 - 58**

This report comprises 3 elements:

- A cover report setting out background, recommendations and key information
- The Better Care Fund narrative template which must be completed as part of the national submission
- The Better Care Fund planning template.
  Due to this being a Microsoft Excel Spreadsheet this element of the report has not been published with the papers. It has been circulated to members separately with the papers.

  Should members of public wish to obtain a copy of the document please contact Board Secretariat at DKristiansen@Thurrock.gov.uk

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - AHH by sending an email to DKristiansen@thurrock.gov.uk

Agenda published on: **19 July 2023**

Information for members of the public and councillors

Access to Information and Meetings

Advice Regarding Public Attendance at Meetings:

Following changes to government advice there is no longer a requirement for public attendees to book seats in advance of a committee meeting. All public attendees are expected to comply with the following points when physically attending a committee meeting:

1. If you are feeling ill or have tested positive for Covid and are isolating you should remain at home, the meeting will be webcast and you can attend in that way.

2. You are recommended to wear a face covering (where able) when attending the meeting and moving around the council offices to reduce any chance of infection. Removal of any face covering would be advisable when speaking publically at the meeting.

3. Hand sanitiser will also be available at the entrance for your use.

Whilst the Council encourages all who are eligible to have vaccination and this is important in reducing risks around COVID-19, around 1 in 3 people with COVID-19 do not have any symptoms. This means they could be spreading the virus without knowing it. In line with government guidance testing twice a week increases the chances of detecting COVID-19 when you are infectious but aren't displaying symptoms, helping to make sure you do not spread COVID-19. Rapid lateral flow testing is available for free to anybody. To find out more about testing please visit https://www.nhs.uk/conditions/coronavirus-covid-19/testing/regular-rapid-coronavirus-tests-if-you-do-not-have-symptoms/

Members of the public have the right to see the agenda, which will be published no later than 5 working days before the meeting, and minutes once they are published.

Recording of meetings

This meeting will be live streamed and recorded with the video recording being published via the Council's online webcast channel: www.thurrock.gov.uk/webcast

If you have any queries regarding this, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

Guidelines on filming, photography, recording and use of social media at council and committee meetings

The council welcomes the filming, photography, recording and use of social media at council and committee meetings as a means of reporting on its proceedings because it helps to make the council more transparent and accountable to its local communities.

Thurrock Council Wi-Fi

Wi-Fi is available throughout the Civic Offices. You can access Wi-Fi on your device by simply turning on the Wi-Fi on your laptop, Smartphone or tablet.

- You should connect to TBC-CIVIC
- Enter the password **Thurrock** to connect to/join the Wi-Fi network.
- A Terms & Conditions page should appear and you have to accept these before you can begin using Wi-Fi. Some devices require you to access your browser to bring up the Terms & Conditions page, which you must accept.

The ICT department can offer support for council owned devices only.

Evacuation Procedures

In the case of an emergency, you should evacuate the building using the nearest available exit and congregate at the assembly point at Kings Walk.

How to view this agenda on a tablet device

You can view the agenda on your iPad, Android Device or Blackberry Playbook with the free modern.gov app.

Members of the Council should ensure that their device is sufficiently charged, although a limited number of charging points will be available in Members Services.

To view any “exempt” information that may be included on the agenda for this meeting, Councillors should:

- Access the modern.gov app
- Enter your username and password

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

↓

Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

↓

You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 23 June 2023 10.30am-12.30pm

Present:	Councillor G Coxshall (Chair) Councillor Johnson Councillor Rigby Councillor Shinnick Ian Wake, Corporate Director for Adults, Housing and Health Jo Broadbent, Director of Public Health Margaret Allen, Deputy Thurrock Alliance Director Gill Burns, Director of Children's Services, Northeast London Foundation Trust (NELFT) Fiona Ryan, Managing Director, Mid and South Essex NHS Foundation Trust Rita Thakaria, Partnership Director, Thurrock Council, EPUT and NELFT Michele Lucas, Assistant Director for Education and Learning Kim James, Chief Operating Officer, Healthwatch Thurrock Jenny Barnett, Chief Superintendent, Essex Police
Apologies:	Sheila Murphy, Corporate Director for Children's Services Michael Dineen, Assistant Director for Counter Fraud and Community Safety Aleksandra Mecan, Thurrock Alliance Director Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) Hannah Coffey, Acting Chief Executive, Mid and South Essex NHS Foundation Trust Michelle Stapleton, Integrated Care Pathway Director, Mid and South Essex NHS Foundation Trust BJ Harrington, Chief Constable, Essex Police Mark Tebbs, Chief Executive, CVS Jim Nicolson, Adult Safeguarding Board
Guests:	Jeff Banks, Mid and South Essex Integrated Care System Ewelina Sorbjan, Thurrock Council

1. Welcome, Introduction and Apologies

Colleagues were welcomed and apologies were noted. Michele Lucas confirmed attendance on behalf of Sheila Murphy.

The previous Chair, Cllr Deborah Arnold was thanked for her commitment to driving forward the Board's priorities and reflecting the recommendations of the independent review of the Board in its operation.

Cllrs Ralph, Liddiard and Muldowney were thanked, as well as previous members representing partners, for their commitment to supporting improved health and wellbeing outcomes for Thurrock residents as Board members.

2. Minutes / Action Log

The minutes of the Health and Wellbeing Board meeting held on 10 February 2023 were approved as a correct record.

There were no actions or decisions on the action and decision log for consideration as this meeting was held at the beginning of the new municipal year.

3. Urgent Items

There were no urgent items received in advance of the meeting.

4. Declaration of Interests

There were no declarations of interest.

5. Terms of Reference Annual Review

This item was introduced by Darren Kristiansen, Thurrock Council. Key points included:

- The Health and Wellbeing Board is a statutory partnership board governed by s194 of the Health and Social Care Act 2012 (the Act). The Act specifies who must be a member of the Board and specifies how additional Board members are to be appointed. The Act states that at any time after a Health and Wellbeing Board is established, the Local Authority must, before appointing another member of the Board or amending the Terms of Reference, consult the Health and Wellbeing Board.
- A commitment provided in the Board's Terms of Reference is that it will be reviewed and refreshed on an annual basis. This includes reviewing and amending functions and job titles of Board members, ensuring appropriate representation across partners, and reviewing the operation of the Board such as frequency.
- As part of ensuring that the Board drives forward the refreshed Health and Wellbeing Strategy and effectively monitors progress, each of the six themes (Domains) are considered each municipal year.

Action: The meeting frequency will be updated, as going forward, meetings will now be held on a Thursday.

Decision: Members agreed the changes to the Terms of Reference as outlined within the report.

6. Joint Forward Plan Mid and South Essex (MSE)

This item was presented by Jeff Banks, Mid and South Essex Integrated Care System. Key points included:

- Each Integrated Care Board (ICB) along with its partner NHS Trusts/ Foundation Trusts are required to prepare a five-year Joint Forward Plan (JFP), working with local Health and Wellbeing Boards to ensure that the joint local Health and Wellbeing Strategy and relevant joint strategic needs assessments are reflected in the JFP.
- The JFP has been developed with the Integrated Care Strategy for Mid and South Essex ICS, which was also approved by Thurrock's Health and Wellbeing Board as its starting point.
- There has been a shared desire to ensure that, alongside the varied NHS commitments, the JFP is able to pinpoint the most impactful issues that NHS partners should work together on. The draft JFP is therefore presented as a three-part document:
    - Part One – provides background to the current challenges the NHS is facing in Mid and South Essex, and identifies shared ambitions with partners;
    - Part Two – provides the underpinning aspects of the ICB's approach, outlining work on population health improvement, health inequalities and prevention, and the approach to local delivery via Alliances;
    - Part Three – contains a delivery plan for the NHS Long Term Plan commitments and other statutory duties placed upon the NHS. Each appendix describes the governance arrangements for ensuring delivery, including oversight and assurance arrangements through the relevant system governance mechanisms.
- The JFP provides a continued commitment to engagement with residents and partners.
- The JFP is due to be published by the end of June 2023, following presentation and comment by each of the necessary Health and Wellbeing Boards. A formal letter of support is required following this. The JFP will then be updated on an annual basis.

During discussions, the following points were made:

- Members thanked Jeff Banks for his commitment and efforts to strong partnership working as the comprehensive plan aligns with Thurrock's Health and Wellbeing Strategy which was welcomed.
- The clear commitment to subsidiarity, Alliances and devolving power downwards was noted and reflects Thurrock's ambitions. The Better Care Fund was recognised as the delivery mechanism therefore highlighting the need to ensure collective ambitions are captured via this fund.
- The JFP has a strong focus on prevention and health inequalities by undertaking a population health management approach. For Thurrock, this approach is particularly important for reducing obesity and smoking rates as the main causes of death in the borough are related to cardiovascular disease and diabetes.

- Colleagues noted smoking rates for Thurrock are falling and are now slightly below the national average for England. The national ambition is to reduce smoking prevalence to 5% by 2030.
- It was recognised obesity is a difficult, complex, and multifactorial condition therefore it is particularly challenging to have a local impact as often the drivers relate to national policies.
- However, there are various initiatives in Thurrock to help reduce obesity prevalence, such as ongoing work within the Stanford-Le-Hope Primary Care Network (PCN). The PCN identifies those who are overweight or obese and works with them as part of tier two and tier three weight management services. Furthermore, severe binge eating behaviour services have been established as these behaviours previously resulted in a 30% drop out rate for traditional weight management services.

  Action: Margaret Allen to provide the weight loss and maintenance figures associated with the Stanford-Le-Hope PCN obesity initiative.

- It was noted that historically for tier three weight management services, 100 people were funded each year and over the last two years, NHS England have incentivised GPs to make referrals for tier two services. Thurrock has gone from 100 people per year completing the course to now nearly 500 per year. Furthermore, an alternative offer for weight management is being considered and work is ongoing, with a contract due to be awarded by April 2024.

  Action: Margaret Allen to provide further detail for the alternative weight management offer.

- Members also noted the Thurrock Healthier Futures clinic operating from the Corringham Integrated Medical and Wellbeing Centre. This adult only clinic includes clinicians, dietitians and health coaches working with individuals to ascertain the causes of their weight issues, such as relationships, debt or housing concerns and personal wealth. Colleagues from Thurrock's Housing and Community Led Supports Teams are evaluating the impact of these conversations as part of a human learning systems appreciative enquiry.
- Colleagues recognised that 40% of Year Six students are overweight, which is an increase since the pandemic therefore healthy eating habits need to be encouraged for children and young people. The Whole Systems Obesity Strategy was noted as a key mechanism as it provides an all age approach and will include a Child Weight Management Task Force. Furthermore, the long term plan is to embed weight management services within the 0-19 services offered, although it was noted this service is to be recommissioned by September 2024.
- Mid and South Essex partners will continue to reach out and engage with schools regarding key priorities for children and young people, for example, good connections are being made with the Healthy Schools Programmes. In addition, the cost of living crisis and access to food banks was discussed, as access to fruit and vegetables may be limited.

- Colleagues concluded there are specific actions in the JFP regarding smoking and obesity and that further collaborative work is required as the NHS system will not make progress alone as wider determinants of health considerations are vital for this work.

  Action: A letter supporting the JFP is to be drafted and sent on behalf of the Health and Wellbeing Board chair to Jeff Banks at the earliest opportunity.

  Decision: Members acknowledged receipt of the draft Joint Forward Plan produced by Mid and South Essex ICB and confirms this appropriately takes into account and aligns with the strategies and priorities of the Thurrock Health and Wellbeing Board.

7. Joint Domestic Violence and Abuse (DVA) in the context of sex/gender briefing note

This item was introduced by Ewelina Sorbjan, Thurrock Council. Key points included:

- Following discussions at the Health and Wellbeing Board meeting on 9 December 2022 in relation to Goal 5C, partners have provided a more detailed written report in relation to support provision for male survivors of domestic abuse. Goal 5C aims to provide safe, suitable, and stable housing solutions for people who have or who are experiencing domestic abuse and/or sexual violence or abuse.
- For the year ending March 2022, the Crime Survey for England and Wales (CSEW) estimated that 1.7 million women and 699,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 7 in 100 women and 3 in 100 men.
- Across Essex, Essex Police recorded domestic abuse by gender in 2022 which depicted the disproportionality of women experiencing a form of domestic abuse but that men are also victims.
- The Housing Safeguarding Team (HST) is the borough's community response to domestic abuse and other crimes and behaviours that fall under a safeguarding remit. They have an important role to play in the wider safeguarding agenda concerning many different types of abuse, and work closely with services across the borough, Essex wide and nationally. The HST are uniquely positioned within the Housing Team at Thurrock Council and the Team includes a male staff member.
- The support offered by agencies across Thurrock are available to all residents, and often individuals are supported by more than one agency. The HST can offer advice and support in the first instance, however, they will also seek specialist support assistance if needed from another agency, for example, via Karma Nirvana or the Forced Marriage Unit.
- If someone has contacted an agency that is not best placed to support them, the individual will be helped to speak to the support service for their need. Supporting survivors of domestic abuse can be complicated, intersectionality plays a huge role and prioritising risk over need is a difficult balance.

During discussions the following points were made:

- Members noted safeguarding concerns are to be addressed to the Housing Safeguarding Team and reported to Essex Police. There are specific Domestic Abuse Problem Solving Teams within the Police who focus on getting the best outcome for the victim, regardless of gender.
- Colleagues acknowledged that males often do not follow the same reporting route as females as there is often a big gap in follow up support. However, support is led by the survivor therefore agencies cannot enforce support if this is refused and signposting to other services is often helpful. In addition, there is considerably more information available to female survivors such as support networks and community groups.
- Further work is required as a society to change the perceived stigma around male domestic violence victims.

Decision: Members noted and commented on the contents of the briefing note.

8. Health and Wellbeing Strategy in focus - overview of Thurrock Health and Wellbeing Strategy

This item was introduced by Jo Broadbent, Thurrock Council. Key points included:

- The Health and Wellbeing Strategy focuses on Levelling the Playing Field and aims to tackle the many causes of poor health that are not level across Thurrock. These include individuals' health risk behaviours such as smoking and the quality of clinical care that people receive, but the greatest influences on overall community health are wider determinants of health. These include high-quality education, access to employment and other opportunities, warm and safe homes, access to green spaces and leisure, strong and resilient communities, and effective public protection. Thurrock experiences an unlevel playing field in each of these areas and this Strategy aims to level up those inequities.
- The Strategy sets out goals and actions across six broad domains that influence the determinants of health, these are:
    - Domain1: Staying Healthier for Longer;
    - Domain 2: Building Strong and Cohesive Communities;
    - Domain 3: Person-Led Health and Care;
    - Domain 4: Opportunity for All;
    - Domain 5: Housing and the Environment;
    - Domain 6: Community Safety.
- The domain areas and priority goals were developed through engagement with stakeholders and a public engagement process with residents (facilitated by Healthwatch).
- The delivery of the ambitions within these goals is underpinned by several key topic-specific strategies, including the Better Care Together Thurrock: The Case for Further Change, the Housing Strategy, Brighter Futures and the Local Plan. Progress measures have been identified to monitor impact on high level outcomes over the lifetime of the Health and Wellbeing Strategy, plus activity and process milestones detailing key actions to deliver on the ambitions.

- This Strategy aims to ensure that Levelling the Playing Field is a key consideration across all the Council's strategic agenda of People, Place and Prosperity.

During discussions the following points were made:

- Colleagues discussed the data sources used to inform the Strategy, which included national ONS datasets and data from local services through performance indicators. As part of the engagement process, Healthwatch facilitated qualitative data collection via workshops and questionnaires, as well as via Thurrock's consultation portal. The feedback received was collated and summarised into key themes.
- Concerns were raised regarding access to GP practices in Thurrock, however members were reassured there is significant work underway to address access to Primary Care. The 27 GP practices in Thurrock have been evaluated on their accessibility and a small number will receive intensive support to improve this. The remaining practices will either receive intermediate level support or light touch, depending on their evaluation requirements.
- Furthermore, Thurrock remains an under doctored area, however the GP fellowship scheme aims to increase the number of doctors within the area. The Mid and South Essex wide GP fellowship programme will work alongside the Thurrock programme. Members were reassured that by August 2023 there will be an additional five GPs, with the aim to have 12 posts in total.
- Colleagues recognised the challenges to delivering the aims of the Strategy, for example the cost of living crisis being felt by families. It was noted Thurrock is working with the nationally funded Family Hubs as part of a holistic approach to support families, particularly around the promotion of breastfeeding and Healthy Start vouchers.

Health and Wellbeing Strategy in focus - Domain 1 (Healthier for Longer) report against commitments for year one and new commitments for year two (23/24)

This item was introduced by Jo Broadbent, Thurrock Council. Key points included:

- The aims of Domain 1 (Healthier for Longer) are to improve the prevention, identification, and management of physical and mental health conditions and to ensure people live as long as possible in good health.
- Goal 1A focuses on reducing smoking and obesity in Thurrock. To support the reduction in smoking prevalence, a Whole System Tobacco Control plan will be developed, with prevention, treatment and enforcement identified as key elements. Furthermore, targeted smoking cessation activities are underway which focus on specific cohorts such as those with manual occupations, those with serious mental illness and maternity services.
- In relation to reducing obesity rates, the Whole System Obesity Strategy is due to be refreshed and implemented, with the focus of a life course approach to supporting healthy weight and reducing obesity.
- The commitments for Goal 1A for year one were reported against and included the following examples:

    - A Health in All Policies Place Shaping report is currently under consultation;
    - The Tobacco Control Joint Strategic Needs Assessment (JSNA) was completed and the Strategy final draft under consultation;
    - Targeting of smoking cessation support in place in line with the JSNA;
    - A Weight Management for Children and Families Taskforce established and service to be included within the Healthy Families service re-procurement in 2023/24.
- The commitments and ambitions for year two (2023/24) were outlined as follows:
    - Implementation of the Thurrock Tobacco Control Strategy and amended action plan;
    - Revised weight management pathway in place across the Local Authority and NHS services;
    - Commission an enhanced children and families weight management service;
    - Health in All Policies Place Shaping report findings included in revised Thurrock Local Plan.
- Goal 1B relates to working together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock.
- The commitments for Goal 1B for year one were reported against and included the following:
    - The completion of the Health Needs Assessment for Substance Misuse;
    - A multi-disciplinary Complex Care team pilot is underway, with both specialist Mental Health and Substance Misuse outreach support;
    - Wellbeing calls pathway in place for individuals with a new depression diagnosis;
    - A service transition policy is now in place for young people transitioning to Adult Mental Health Services.
- The commitments and ambitions for year two (2023/24) were outlined as follows:
    - Substance Misuse Service recommissioning completed for new integrated all age service;
    - Complex Care Team Assertive Outreach for substance misuse function commissioned as part of core service;
    - Dual diagnosis pathway for substance misuse and mental health review under way as part of the Case Finding Strategy.
    - Mental health diagnoses in cardiovascular conditions reviewed as part of the Case Finding Strategy development;
    - Publication of Wellbeing Calls Evaluation Report for 2022/23.
- The focus for Goal 1C is to continue to enhance identification and management of Long Term Conditions (LTC). National data for 2022/23 shows that quality of Primary Care for cardiovascular disease (CVD) in Thurrock is among the best in England, although the borough is significantly under doctored.
- The commitments for Goal 1C for year one were reported against and included the following:
    - After a successful pilot, a programme of outreach sessions is in place across all Traveller and Showmen sites in Thurrock;

    - The Integrated Medical and Wellbeing Centre in Corringham is operational and hosting a range of NHS and wider wellbeing services;
    - Cardiovascular Disease Local Enhanced Service (CVD LES) is in place in Primary Care and is building on improvements in previous years;
    - Hypertension detection programmes are underway within Primary Care and the LTC Case Finding Strategy is in development;
    - There is ongoing development work with Primary Care Mental Health Practitioners to maximise the uptake of health checks amongst those with Severe Mental Illness (SMI).
- The commitments and ambitions for year two (2023/24) were outlined as follows:
    - Continuation of outreach programme for the Traveller, Showman and Homeless communities and an impact evaluation is to be completed;
    - LTC Case Finding Strategy co-produced between Thurrock Primary Care, Clinicians and Public Health;
    - CVD Primary Care quality improvement programme agreed with the Mid and South Essex Integrated Care System (MSE ICS), with an aim to roll out to other conditions in due course;
    - MSE ICS Population Health Improvement Board (PHIB) health inequalities initiatives implemented in Thurrock, including physical and mental health, and an all-age approach;
    - Delivery of MSE Action Plan for SMI Health Checks.
- As part of reporting against each of the commitments for each goal, a monitoring framework of key metrics has been developed.

During discussions the following points were made:

- Members welcomed the integrated working and commitment of partners to drive forward the Health and Wellbeing Strategy. The Strategy remains a live document which is constantly evolving.
- Colleagues noted Thurrock is the third best in the country in relation to diagnosis and treatment of high blood pressure to reduce cardiovascular disease. The programme is embedded within the Better Care Fund and has resulted in a reduction of hospital admissions and a considerable number of lives being saved.
- It was recognised that an all-age approach to commissioning of services to reduce health inequalities is important. For example, the substance misuse service is due to be recommissioned as an all-age service, whereby education and outreach will be available to schools.
- Members were advised that according to the World Health Organisation (WHO), children who are breastfed are up to 25% less likely to experience obesity therefore highlighting the need to support mothers with breastfeeding. Thurrock is working closely with the national Family Hubs programme and funding has been allocated to encourage breastfeeding peer support, along with closely working with CVS partners.
- It was noted that a wider range of long-term conditions will be reviewed alongside the prevalence of cardiovascular disease. For example, diabetes and those with mental health concerns will be reviewed holistically to further reduce health inequalities and improve life expectancy.

Decision: Members noted the overview provided on the Health and Wellbeing Strategy.

The Board reviewed, commented on and approved progress made against domain one commitments for year one, as previously approved by Board and commitments for year two.

The meeting finished at 12:22pm.

CHAIR……..

DATE……

27 July 2023	ITEM: 5
Health and Well-Being Board	
Better Care Fund Plan 2023 to 2025	
Wards and communities affected: All	**Key Decision:** Not Applicable
Report of: Cllr George Coxshall, Cabinet member for Health, Adult Social Care, Community and Public Protection	
Accountable Assistant Director: Les Billingham, Assistant Director of Adult Social Care and Community Development	
Accountable Director: Ian Wake, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75 Agreement between the Council and NHS, was approved in 2015. The arrangement has allowed the creation of a pooled fund, to be operated in line with the terms of the Plan and the Agreement, to promote the integration of health and care services. The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home.

The planning requirements for the Better Care Fund Plan for 2022/23 were published by NHS England on 4 April 2023, with a deadline for submission of the Plan of 26 June 2023. The Plan has been submitted, and scrutiny by NHS England is underway, with approval letters expected in the week of 8 September 2023. The Total BCF Pooled Budget 2023/24 is £49,139,875

The Better Care Fund Plan 2023 to 2025 has been developed to reflect the new strategy for adult services – Better Care Together Thurrock – The Case for Further Change 2022-26. The Plan also includes the Discharge Fund, first introduced in mid 2022. A programme of reviews has commenced which will ensure that all services commissioned fully reflect the new strategy, as well as meeting the National Conditions, and demonstrating best value for money.

1. Recommendation(s)

1.1 For the Board to approve the Better Care Fund Plan for 2023 to 2025.

2. Introduction and Background

2.1 Thurrock's initial Better Care Fund Plan, and Section 75 Agreement between the Council and the then NHS Thurrock Clinical Commissioning Group, was approved in 2015. The Agreement allowed the creation of a pooled fund, to be operated by the Council as Host Partner in line with the terms of the Agreement, to promote the integration of health and care services.

2.2 The Host Partner is the Partner responsible for:

- holding all monies contributed to the Pooled Fund on behalf of itself and the other Partner; and
- providing the financial administrative systems for the Pooled Fund.

2.3 The pooled fund is overseen by the Thurrock Integrated Care Alliance made up of officers from the Council and NHS Mid and South Essex Integrated Care Board (NHS MSE ICB). The Alliance receives regular reports on expenditure, quality and activity. The Alliance reports, as required, on the performance of the Better Care Fund to the Health and Wellbeing Board, as well as Cabinet and the Board of NHS MSE ICB. The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home. The Better Care Fund Plan for 2022/23 was approved by the Board on 28 October 2022 and, following a national assurance process, by NHS England on 10 January 2023.

2.4 On 18 November 2022, the Minister for Social Care announced the £500 million Adult Social Care Discharge Fund to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital awaiting social care. The guidance published by the Department of Health and Social Care stipulated that 'the local authorities and ICB funding allocation should be pooled into local Better Care Fund section 75 agreements with plans for spend agreed by LA and ICB chief executives and signed off by the Health and Wellbeing Board (HWB) under national condition 1 of the BCF.' Condition 1 is a jointly agreed plan between local health and social care commissioners and signed off by the HWB. The Board received a report on the Adult Social Care Discharge Fund on 9 December 2022, and welcoming the additional funding, signed off the spending plan for the Fund for 2022-23.

2.5 The Better Care Fund Scorecard for Adult Social Care in 2022/23 shows:

- There were162 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 Quarter 4 2022/23, 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 had deceased and 2 were in hospital. If the deceased were not counted in the cohort, the performance would have been 95%.

2.6 An end of year report on the ASC Discharge Fund 2022/23 was submitted as required to NHS England on 2 May 2023. The Board may wish to note that the Discharge Fund received by the Council was fully committed by year end, and the schemes were successful in alleviating winter pressures.

3. Issues, Options and Analysis of Options

The Better Care Fund Policy framework 2023 to 2025

3.1 The Better Care Fund Policy framework for this year and next, published on the 4th of April 2023, sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations. The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives, which are 2 of the 3 National Conditions for the BCF:

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

The Discharge Fund in 2023/24 (and 2024/25)

3.2 The planning requirements state 'In 2023-24, the Government is providing £600 million (£300 million for ICBs, £300 million for local councils) to enable local areas to build additional adult social care (ASC) and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. As in 2022-23 the ICB will agree with relevant local HWBs how the ICB element of funding will be allocated rather than being set as part of overall BCF allocations, and this should be based on allocations proportionate to local area need. Local areas should use the discharge funding as part of BCF plans, particularly in relation to National Condition 3, and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvements for patients.'

3.3 The Better Care Fund for 2023/24 comprises:
Disabled Facilities Grant – £1,318,254
Local Authority Discharge Funding - £780,830
ICB Discharge Funding £988,577
Improved BCF Contribution £5,569,460
Local Authority Additional Contribution £27,005,157
NHS minimum contribution £13,477,327
The Total BCF Pooled Budget 2023/24 is £49,139,875
Details of the contributions to the Pooled Fund are shown on Tab 6 (Income) of the Planning template. This includes indicative values for 2024/25.

3.4 The Better Care Fund planning submission for Thurrock 2023 to 2025 (including intermediate care and short term care capacity and demand plan;

and discharge spending plan) was made on 28 June 2023 which was set as the national deadline.

The review of the Better Care Fund

3.5 The attached BCF Planning and Narrative templates address the core objectives of the Better Care Fund 2023/25, and the Plan for has been developed with a view to implementing the new Strategy for Adults: Better Care Together Thurrock – the case for further change 2022-26. In the light of current performance, no significant changes are planned for BCF services commissioned at this point in the year (July) as a local review of the whole plan is commencing in July and August 2023, with the aid of the Better Care Fund Support Programme which is delivered through the LGA.

3.6 The review encompasses:

- Self-assessment of what is working well in Discharge to Assess (D2A), guided by 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 activity presented to leaders in peer-led facilitated conversations to agree priorities and next steps

The Alliance is committed 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. The Health and Well-Being Board will be advised of the outcome of the review, and the implications its the Better Care Fund Plans.

Section 75 Agreement

3.7 Thurrock has had a Better Care Fund Plan and associated Section 75 Agreement in place since 2015-16. The NHS England Planning requirements for 2023/25 stipulate that the section 75 agreement for 2023/24 is to be signed and in place (following approval of the Plan by NHS England) by 31 October 2023.

3.8 Cabinet agreed in July 2021 (Decision: 110575) to give delegated authority to the Corporate Director of Adults, Housing and Health, in consultation with the Cabinet Member for Adults and Communities, to agree annual Section 75 Agreements and Better Care Fund plans and proposals for applicable periods as required, effective from 2021/22. The Agreement is subject to the Council's annual budget setting arrangements, and any changes to the Section 75 can be made with agreement of both parties – Thurrock Council and NHS MSE ICB. The terms of the Section 75 agreement are subject to review as part of the work of the LGA Better Care Fund Support Programme as noted above.

Overspends and Underspends in the Better Care Fund

3.9 The Section 75 Agreement sets out arrangements for overspends and underspends to the Fund. The arrangements to date have been that any

expenditure over and above the value of the Fund will be the responsibility of either the Council or NHS MSE ICB depending on whether the expenditure is incurred on social care functions or health functions. Arrangements for monitoring expenditure and managing any overspend in an individual scheme are set out in detail within the Section 75 Agreement. Underspends have stayed within the Pooled Fund unless otherwise agreed by both parties. The arrangements for overspends and underspends will be considered as part of the review of the terms of the Section 75 agreement noted above. Any changes to the current agreement will be agreed by both parties.

4. Reasons for Recommendation

4.1 Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

4.2 The NHS England Planning requirements for 2023/24 stipulate, that as a National Condition, BCF Plans must be agreed by the ICB(s) (in accordance with ICB governance rules) and the local council chief executive, prior to being signed off by the HWB. Once the plan is agreed and approved, the funding must be placed into one or more pooled funds under section 75 of the NHS Act 2006.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services, as required under the terms of the Health and Social Care Act 2012, was held in September and October 2014.

5.2 There has also been extensive consultation on the new strategy for adults - Better Care Together Thurrock – The Case for Further Change - which forms the foundation of the plan.

6. Impact on corporate policies, priorities, performance and community impact

6.1 A key aim of the Better Care Fund, and the Discharge Fund, is to reduce emergency admissions, which brings within it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services. This will contribute to the priority of

‘Improve Health and Wellbeing’ and the vision set out within the refreshed Health and Wellbeing Strategy.

6.2 Achieving closer integration and improved outcomes for patients, services users and carers is also seen to be a significant way of managing demand for health and social care services, and so manage financial pressures on both the NHS MSE ICB and the Council.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Finance Manager

The Better Care Fund comprises contributions from the Council and NHS MSE ICB as shown in paragraph 3.3 of this report.

The total value of the pooled fund in 2023/24 is £49,139,875. The nature of the expenditure is an agreed ring-fenced fund. Financial risk is therefore minimised and governed by the terms set out in the Agreement. Paragraph 3.9 refers. The Fund will be accounted for in accordance with the relevant legislation and regulations, and the agreement between the Local Authority and NHS MSE ICB.

Financial monitoring arrangements are in place, ensuring that auditing requirements are met, as well as disclosure in the financial statements.

The value of the pool can change by mutual agreement between the two parties.

7.2 Legal

Implications not received at the time of publication.

7.3 Diversity and Equality

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and

social care services. The commissioning plans developed to realise this vision will be developed with due regard to the equality and diversity considerations.

7.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- 2023 to 2025 Better Care Fund policy framework 2023-25, Published 4 April 2023 Available via the following link: 2023 to 2025 Better Care Fund policy framework - GOV.UK (www.gov.uk)
- Better Care Fund planning requirements 2023-25, Published 4 April 2023 Available via the following link: PRN00315-better-care-fund-planning-requirements-2023-25.pdf

9. Appendices to the report

- The Thurrock Better Care Fund Plan (comprising Planning template, and Narrative template) for 2023-25.

Report Author:

Christopher Smith
Programme Manager
Adults, Housing and Health

This page is intentionally left blank

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.

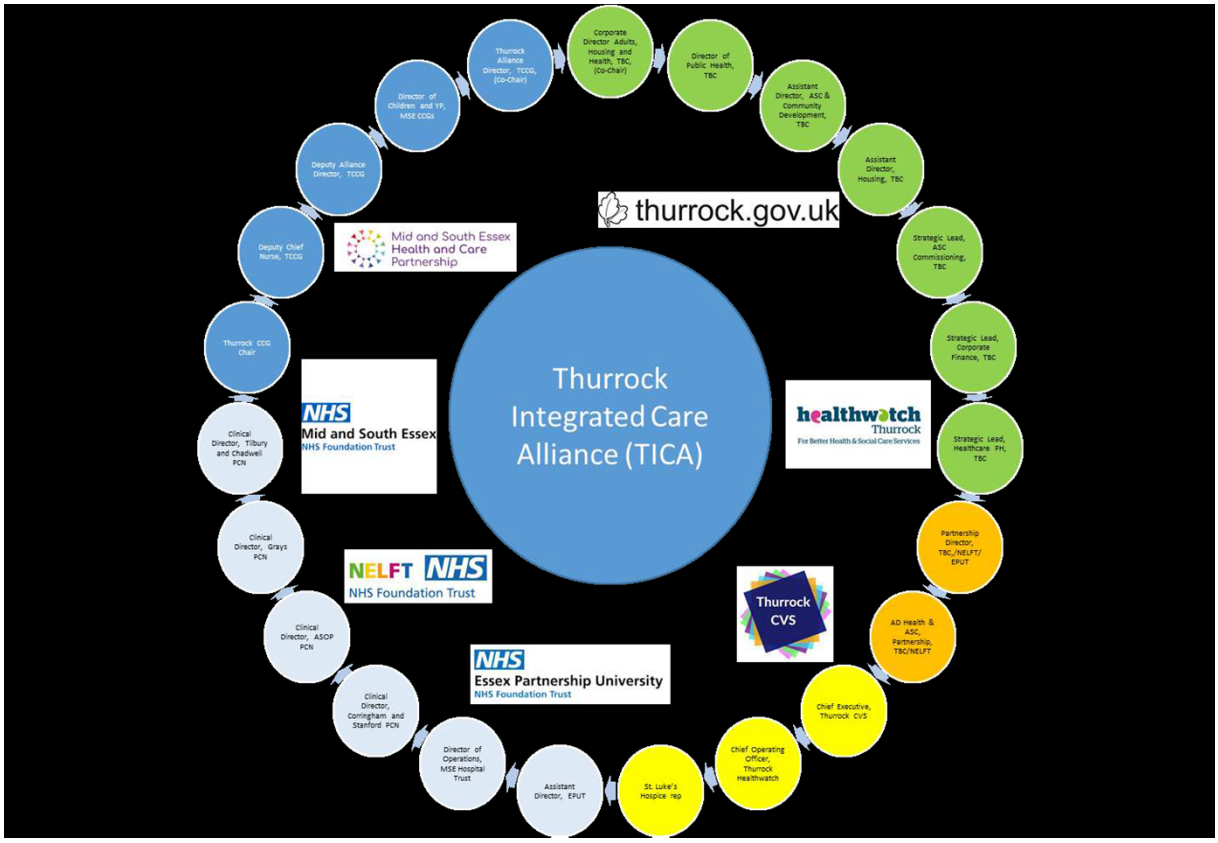
The current governance arrangements continue to include:

- ✓ 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

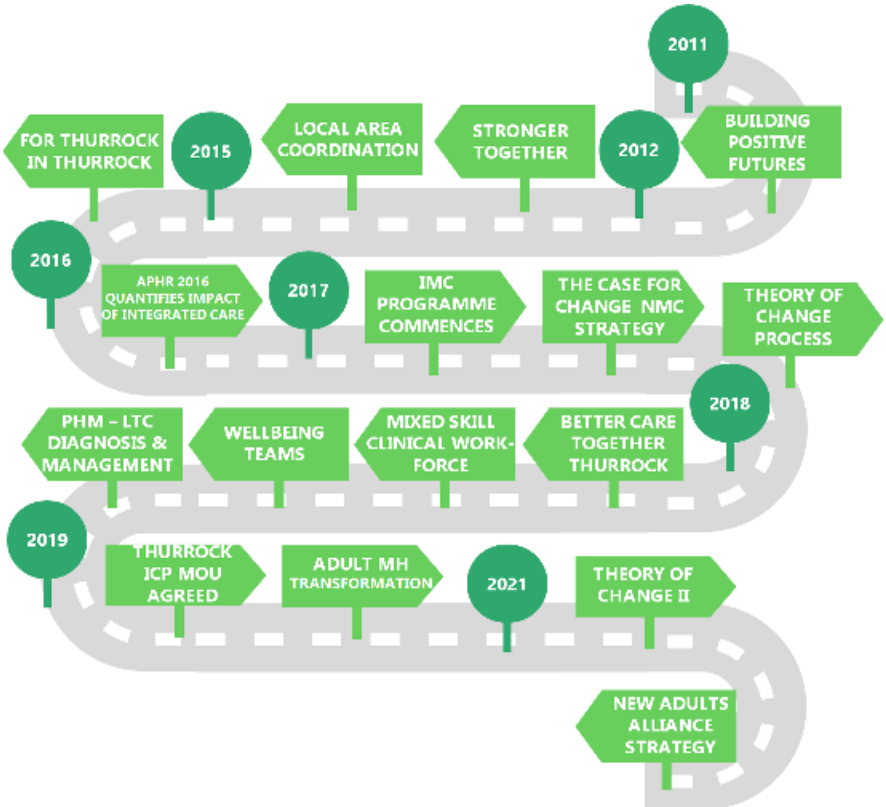
and care services in Thurrock, maximising the benefits of pooled funding through a single commissioning unit.

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

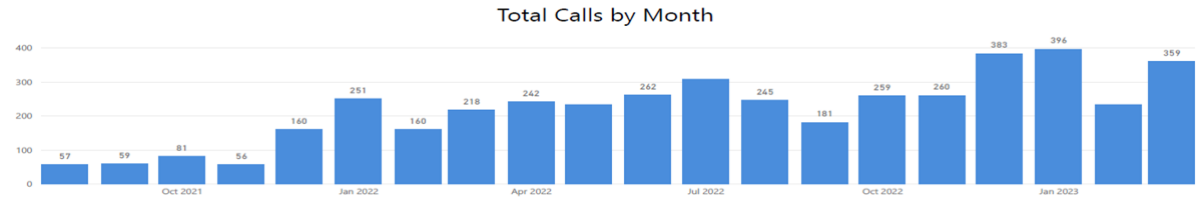
Integrated, jointly commissioned support to help people to remain independent at home has also been a feature of Thurrock's Better Care Fund Plan for a number of years. These services have proved highly effective in supporting supporting independence, reducing admissions to acute settings, and enabling 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.

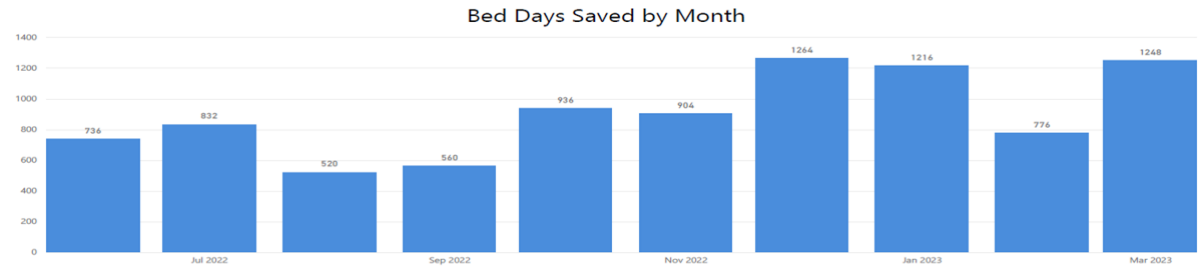
The schemes jointly commissioned from the BCF Pooled Fund for supporting people to remain independent at home for longer include (not an exhaustive list):
Thurrock First, our seven day a week, first point of contact for adults needing support with social care, mental health, and health care needs, provided 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:



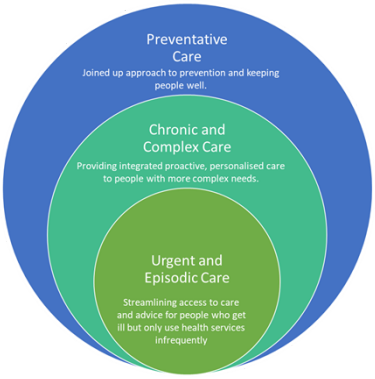


Bed Days Saved - this measure has been calculated by mulitpying all calls where advice was given that did not result in a hospital admission within 7 days of the patients call by the average length of stay of an 80 year old patient. Average length of stay of an 80 year old patient across MSE = 8 days.
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.

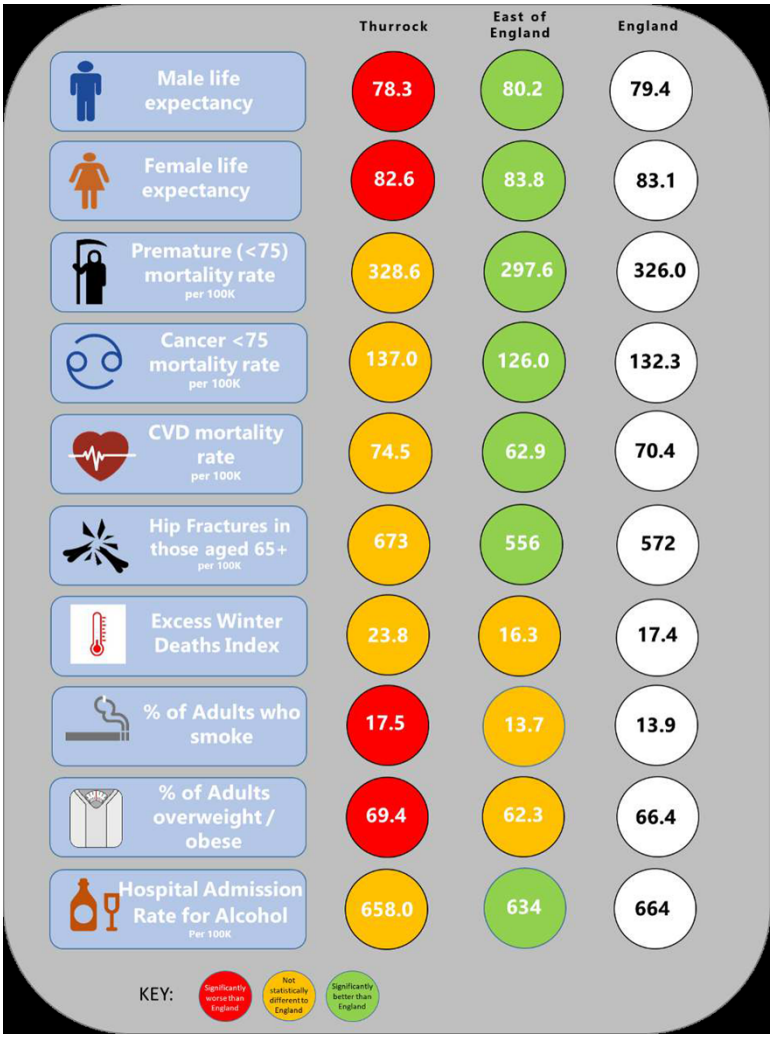
There is clear health inequity between both total life expectancy and disability free life expectancy linked to deprivation, with both measures increasing as deprivation decreases. Only the least deprived 35% of our population are likely to reach retirement age before reaching the end of disability free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