3 September 2024	ITEM: 5
People Overview and Scrutiny Committee	
Better Care Together Thurrock Integrated Care Strategy – End of Year Report 2023/24	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Councillor Mark Hooper, Portfolio Holder for Health and Wellbeing	
Accountable Assistant Director: Les Billingham, Assistant Director of Adult Social Care and Community Development	
Accountable Director: Ian Wake, Executive Director of Adults and Health	
This report is Public	
Version: Final	

Executive Summary

Better Care Together Thurrock (BCTT) is the Partnership through which the local (borough-wide) health and care system is being redesigned – ensuring that it is person-led, locally organised where it makes sense to do so and focused on preventing, reducing and delaying the need for health and care support. Thurrock's blueprint for health and care redesign is set out within the Integrated Care Strategy – *Better Care Together: The Case for Further Change*. This brings together the learning from over a decade's worth of transformation and development activity. The delivery of the commitments within the strategy is supported by an annual plan containing key actions and milestones. A delivery structure, led by Thurrock Integrated Care Alliance, ensures that milestones are delivered and expected outcomes achieved.

This report summarises activity for 2023/24 – the first year of delivery for *Better Care Together: The Case for Further Change*.

Commissioner Comment:

Not applicable for this report.

1. Recommendation

1.1 That the Committee comment on and endorse the report and the programme of health and wellbeing transformation described within it, and provide scrutiny of its key elements.

2. Introduction and Background

2.1 Thurrock's Integrated Care Strategy *Better Care Together: The Case for Further Change* sets out a collective plan to transform, improve and integrate health, care and third sector services aimed at the borough's adults and older people to improve their wellbeing.

2.2 The strategy has been developed and agreed by the Thurrock Integrated Care Alliance (TICA) and Thurrock's Health and Wellbeing Board and contributes to key objectives set out within Thurrock's Joint Health and Wellbeing Strategy 2022-2026. TICA is the highest level strategic partnership responsible for health, wellbeing, care, housing, and third sector service transformation and integration and is a subcommittee of both the Mid and South Essex ICB Board and Thurrock Health and Wellbeing Board. The Alliance and its approach brings together commissioners, providers and colleagues from Thurrock Council, the NHS, third/voluntary sector and Healthwatch. It also reflects on-going comprehensive engagement with residents including co-design and co-production approaches.

2.3 The focus of the strategy is the transformation and redesign of the whole health and care system, taking the learning from over a decade of innovation experience, and setting out a collective plan for delivering a health and care system that focuses on how to ensure that people requiring care and support can achieve the outcomes that are most important to them. This means moving away from the 'top down' and 'silo focused' operating models that have dominated public services (known as New Public Management).

2.4 Thurrock's strategy uses *Human Learning Systems* as the framework to drive forward the change required. Human Learning Systems works on the premise that people are not linear but that they are complex and require a system that recognises and fits with their unique situation and requirements. This means developing a system flexible enough to do this – one that operates on a very different set of principles. This includes an organisational development strategy based on learning. The principles and specifics about Human Learning Systems are set out in more detail within the strategy.

2.5 The strategy sets out the changes needed to achieve the system transformation required. These are described through themed chapters. This report details progress against the chapters detailed above – all of which have delivery plans linked to them and delivery plan owners.

3. Issues, Options and Analysis of Options

3.1 Progress 2023/24 – the following paragraphs detail progress highlights from each of the main delivery chapters (chapters four through to nine).

3.2 **Chapter Four – Community Engagement and Empowerment**
Chapter four sets out a new model of engagement and empowerment – based on leveraging the power of people and communities. This is based primarily on the strengths and assets that individuals and communities can offer, the importance of co-production and co-design, and the desire to shift power away from organisations and to communities.

The purpose of this chapter is to develop and deliver a single model of locality engagement – and in doing so create greater opportunity for community empowerment and delegated decision-making.

Over the course of 2023/24, the council has developed a new corporate plan and is developing a new operating model. The single model of locality engagement set out in

chapter four is central to the delivery of key elements of the corporate plan and in influencing the new operating model, which will see the Council as an ‘enabling’ authority. Key activity to test the new model of engagement and empowerment will take place during 24/25 – which will include testing a Community Reference and Investment Board in one neighbourhood of the borough with a view, dependent upon the outcome of the initial pilot, to expanding to all geographical areas. This approach seeks to employ ward councillors as ‘conveners of place’ and engage local residents at neighbourhood level to agree priorities for their neighbourhood to be set out in a neighbourhood plan. It also seeks to devolve budget and commissioning responsibilities against the plan at neighbourhood level through a neighbourhood Community Reference and Investment Board. Each of Thurrock’s ‘four’ localities (based around the four Primary Care Networks for Chadwell and Tilbury, Aveley, South Ockendon and Purfleet, Grays and West Thurrock and Stanford and Corringham) are likely to have more than one Community Reference and Investment Board due to the number of communities being represented.

As part of plans to establish greater community empowerment and to better meet individual outcomes, Adult Social Care has developed a thriving micro enterprise scheme. Over 100 micros have been supported in Thurrock – providing greater choice for people requiring care and support as well as providing employment opportunities for Thurrock people – including people who have themselves required some form of care and support. A new Micro Enterprise Development Manager is now in place and will work alongside locality structures to identify how micros can be developed to meet the needs of individuals and communities – to reflect the different priorities of different communities. The priorities identified through Community Reference and Investment Boards will help to identify and drive the further development of micros – in doing so providing employment and volunteering opportunities for local people that make best use of their skills and strengths. The use of Micro Enterprises also ensures that money spent on health and wellbeing services remains within Thurrock.

3.3 **Chapter 5 – Transforming Primary Care**

Throughout 2023-24 significant work has been undertaken to build clinical leadership in Primary Care provision in the Borough, focusing on the development of Integrated Locality Teams (ILTs). This new development sits in each of the four Primary Care Network Areas. As of June 2024, all of the ILTs have been launched with Primary Care at the heart of the initiative. The anticipated impact of this development is to improve outcomes for local residents by integrating primary care, community health, adult social care, children’s services, the community and voluntary sector, housing, mental health and a wide range of other services in order to reduce waste and duplication and reduce health inequalities across the Thurrock population. This accords with the intentions of Better Care Together Thurrock and is part of its implementation plan. Evidence of the success of this approach is already being seen, with different case studies showing how integrated solutions are improving outcomes – including one recently involving Housing, MIND and the local GP surgery.

New telephony systems have been introduced into Primary Care (GP Practices) in order to Improve the range of options for patients in contact and access. This is delivered on a digital platform and allows practice staff to directly assist patients in not only making appointments to see a GP but to be directed to the most appropriate professional based on their specific request (e.g. a pharmacist, practice nurse, social prescriber etc). One GP practice has added a wide range of additional services through this mechanism, and the system can translate the patient’s voice from one of 130 different community languages.

This also supports primary care to be able to meet the national standards for the “modern general practice” model which is being Implemented across England.

A review of Thurrock First’s (the single point of contact for Adult Social Care, Primary Care, North East London Foundation NHS Trust (NELFT) community health services, and Essex Partnership University NHS Trust (EPUT) mental health services) support to Primary Care was conducted and this has led to new funding to continue this well used and highly valued frontline service.

A multi-morbidity clinic has been established in Corringham IMWC to identify and triage for a range of conditions and to support the weight management programme in the Borough. This has resulted in Thurrock being acknowledged as one of the top three performing areas in the detection and management of Cardio-Vascular Disease (CVD), and high blood pressure in the country.

A new Shared Care Record (digital platform to link all statutory services together), is in development and will go live with the first tranche of data/information in July 2024. Thurrock Council has been a significant partner in this development, and it is intended that this innovation will reduce duplication and time spent in appropriately supporting local people with health and care needs.

Work to understand and appropriately support people who are high intensity users of services involving primary care, secondary community health, mental health services and adult social care to reduce their attendances will be a focus of all ILTs in 2024/25 to ensure that Thurrock residents can receive the right solutions without the need for repeated contact (i.e. right care, right time, right place). The approach will also aim to increase capacity by reducing duplication and developing integrated solutions across a range of partners.

A further new initiative is the development of the Transfer of Care Hub (TOCH) in each Alliance area. This is a further step towards the integration of health and care services and is focused on improving the experience of hospital discharge back into the community, and on improving the number of avoidable admissions. NELFT is a key partner as are Primary Care, Adult Social Care and associated therapy services. The *By Your Side* service also makes a significant contribution to the ongoing approach. This development has provided an opportunity for Thurrock Healthwatch to evaluate the individual’s experience of hospital discharge. The learning from this will be used to support Human Learning System experiments in 2024/25.

GP Fellows have been brought into Primary Care in Thurrock with an additional six GPs placed in surgeries. This is an ongoing programme to strengthen the provision of General Practice in the Borough.

An Early Years Oral Health programme was started towards the end of the 2023/24 year and will run for two years. This has been provided through NHS England funding and is working closely with Thurrock’s Family Hubs to deliver education and training to parents, carers, and other professionals working with children and their families. It will also provide a supervised toothbrushing programme for around 9,000 children aged between birth and eight years of age. This programme will link with 10 primary schools in the most deprived areas of the borough, and all the Family Hubs. It will also work with foodbanks and other community services.

3.4 **Chapter 6 – Improved Health and Wellbeing through Population Health Management**

Chapter 6 commits partners to work in an integrated way to reduce the risks associated with preventable long-term conditions for Thurrock's populations. The initiative uses a framework that prioritises primary prevention, detection, early intervention, and good management. For 2023-24, this has included:

- producing health in all policies place-shaping guidance which sets out a strategic framework for creating change to policy, guidance and practice which will contribute to improving the health of the population.
- identifying, testing, diagnosing and treating as appropriate hundreds of people who had a previous high blood pressure reading and had not been followed up.
- co-designing and implementing multi-morbid, holistic care clinics for patients with two or more CVD conditions who are at a medium risk of cardiac or stroke events - results suggest a reduction in the risk of an adverse cardiovascular event in more than 60% of patients reviewed.
- Undertaking a programme of multi-agency outreach visits to traveller sites and commencing pilot outreach at sites to target the homeless population – these are populations with some of the worst health outcomes.

These achievements to date, collectively, will reduce health risks in the population. However, there is still more to do and the focus for 2024-25 is:

- Embed the health in all policies place-shaping guidance across the Council.
- Publish a co-produced CVD Case finding strategy which identifies both opportunistic and targeted approaches to early identification and early intervention for cardiovascular conditions.
- Work with system partners to develop a delivery plan for achieving a smoke free generation in line with national policy objectives and the aims of the tobacco control strategy.
- Refresh the whole systems obesity strategy and develop future commissioning intentions for the prevention and management of overweight and obesity based on population need and in consultation with system partners.

3.5 **Chapter 7 – Integrated Care and Support in the Community**

The purpose of chapter seven is to develop an integrated care model that operates on a 'locality' footprint. As expressed by Chapter 4, communities have a variety of differing needs and priorities and therefore require solutions that can reflect that difference. *Better Care Together* has been working on developing integrated health and care systems around the four Primary Care Networks. Having a locality-based system will ensure greater flexibility and accessibility for local people as well as ensuring that front-line staff can work together to develop solutions that are bespoke to individuals and their unique circumstances and requirements.

As part of achieving this goal, work has taken place to redesign previously centralised and silo-focused teams. For example, most of the Adult Social Care fieldwork (social work) teams are now organised around the four localities (with the exception of teams where it makes sense to continue to be organised centrally – e.g. Safeguarding, Preparing for Adulthood).

Work has also taken place to remove existing silos – with social work teams including previously separate specialist teams such as Complex Care and Adult Mental Health. Over the last few months, the design of the Hospital Social Work Team has been changed to enable discharge cases to be managed from within the community. Making these changes has helped to reduce 'hand offs' as well as ensuring all staff work as one team. Services and functions working from within the community have also enabled local people to gain access to information, advice, and support far easier and has helped teams to look at solutions for people that include local strengths and assets – based on better knowledge of communities.

Integrated Locality Teams (ILT) have now been launched in all four localities. The teams are 'networks' that comprise all front-line health and care-related services operating in each area (including those services and organisations that are key to the delivery of wellbeing – e.g. Housing). Those representing services and organisations working in the locality come together to examine how improvements could be made to how solutions are delivered for individuals – including identifying and overcome barriers to doing what is most required. There is a steering group to oversee the development of the networks which sits as part of the Integrated Locality Working Board (the Board responsible for overseeing the delivery of chapters 5, 7 and 8). During 2024-25, ILTs will have identified their priorities appropriate to their locality and the work required to achieve those priorities. There is a significant link between the establishment of Communities of Practice and Community Investment Boards (Chapter 4) and the continued development of ILTs and ILT priorities, as these must reflect the communities each ILT represents.

Human Learning Systems (HLS) sets the framework for health and care redesign in Thurrock. HLS seeks to ensure that services and systems are arranged around people and how they live their lives. Doing this requires system leaders to test different approaches (which HLS call 'experiments'). The learning from experiments enables system owners to implement real change based on the premise of 'don't break the law, don't break the bank and do no harm'. Adopting this approach is enabling the health and care system to embed 'learning' as a culture of organisational development. Thurrock has worked in this way for some time and has a reputation for innovation. Continuing with this approach, 23/24 saw the launch of Thurrock's Complex Housing Intervention Programme (CHIP). Under the leadership of a Senior Psychologist, a team (containing adult social care, housing, mental health, substance misuse and local area coordination) has been brought together to develop and test a different approach to people who have enduring mental ill health and behavioural challenges who, despite many attempts by mainstream statutory services, have not achieved improved outcomes or stability. These people are often facing eviction and often cost the wider health and care system significant amounts of money – which can last throughout the life of the individual. Whilst the team has only been in place for just over a year, a significant difference in how people are worked with and how they are responding is already being seen – for example a reduction in crisis of those supported and an increase in engagement where there had not been engagement with professionals for a significant amount of time.

24/25 will see a greater number of experiments identified – with learning used to further ongoing system redesign. Experiments will be identified through several routes – including ILTs. Staff will continue to be empowered to identify and test new ways of working – with the focus being solutions and systems that work to improve the lives of individuals. More teams – including those from Housing and Health will operate from each of the four localities this year. Teams that are too small to work in localities will link in with each locality so that they can still ensure that what they offer is part of an integrated solution and reflects the priorities of that particular locality's communities and the individuals being supported.

3.6 **Chapter 8 – Integrated Support in the Home**

This chapter articulates the desire to shift from a traditional 'time and task' operating model for providing care in the home, to one that focuses on delivering outcomes specific to the individual.

The Council has been developing and testing an alternative delivery model to traditional domiciliary care for some time. The model, known as 'Wellbeing Teams' has developed a way of delivering support in the home that looks at matching support with the outcomes someone wishes to achieve. The Team itself operates on a self-management model, empowering staff to organise themselves in the best way. During 2023/24, further work has been taking place put plans in place so that staff can be upskilled to deliver what are currently 'health' tasks – e.g. administration of insulin. Significant work has taken place to get clinical governance approval. The appointment of a nurse will support the training of staff and work with the team to identify any further opportunities. The ability of care staff to undertake a broader range of tasks and functions will reduce the number of people required to enter someone's home, will enhance the carer role, and will help to release capacity for Health.

Work has taken place during 23/24 to enable a greater number of staff to carry out tasks usually not part of their role – to explore and develop the concept of *'blended roles'*. For example, in addition to Wellbeing Workers being able to administer insulin following specific training, council and health staff have been trained to carry out low-level Occupational Therapy assessments. This is known as a 'Trusted Assessor' approach. Staff trained to deliver OT assessments can also order equipment following the assessment – cutting down waiting time for both an assessment and equipment. Staff trained in the approach include Housing Staff and Local Area Coordinators. Where it makes sense to do so, staff will have the opportunity to be trained on tasks currently not part of their existing role. These will continue to be identified.

Finally, a key piece of work for 23/24 was the development of the specification and procurement process for domiciliary care. The majority of domiciliary care is provided by external providers (the Council has a very small in-house care offer). The approach has been a traditional 'time and task' one. The new contract specification for externally provided domiciliary care has been based on HLS – asking for providers tendering to commit to developing a different operating model over the life of the contract – e.g. one based on the learning from Wellbeing Teams. Providers will take responsibility for a locality and also become part of the respective Integrated Locality Team. The Domiciliary Care model will therefore be able to reflect the unique requirements of the locality in which it is based. The specification will prioritise learning as an expectation of providers, and learning will become a key part of the contract monitoring process. The contract itself has a longer than usual ten-year lifespan. This allows for potential providers to invest in the necessary local infrastructure in Thurrock - such as providing office space and support staff locally and allowing the time for learning and development to take place over the life of the contract. There are break clauses within the terms and conditions, so the council is not tied to a long-term contract if there are issues with a particular provider. This providing the stability for developing meaningful and mutual relationships with providers, whilst ensuring the council has sufficient protections in place to react to poor performance.

3.7 **Chapter 9 – Reimagining Supported Living, Residential and Intermediate Care**

Whilst the aim is to support people as far as possible in their own homes, inevitably some people will require more specialist accommodation and care that cannot be provided within the home. Where this is the case, it is imperative that the accommodation and care provided supports people as individuals in a way that works for them.

Just like domiciliary care; the supported living, residential and intermediate care model has been unchanged for some time. Some of the accommodation is no longer fit for purpose, and other accommodation allows insufficient flexibility to be able to provide what people need at different times of their life or care journey. Chapter nine focuses on outlining proposals that meet the aspirations of people requiring care that cannot be met within their own home.

Key activity for 2023-24 has included the review of Supported Accommodation as a prelude to presenting options for a completely new operating model. Supported Accommodation provides accommodation for working age adults, predominantly for people with mental ill health or learning disabilities, who are unable to live independently but are able to live as independently as possible with some specialist support. The aim is to get people to the point where they are able to live independently with or without some level of support. 2024-25 will focus on getting the proposed model agreed and identifying 'test and learn' activity – for example use of an integrated multi-agency team to provide support as required (which may enabled more people to be in their own home). The learning from test and learn activity will be used to finalise the model.

In addition, the business case for Whiteacres is being refreshed, with an outline business case to be finalised during 2024-25. Whiteacres provides a modern updated residential care facility at the heart of the community – providing both intermediate and residential options. People residing at Whiteacres will have their own self-contained flats – this will include the provision of flats for intermediate care. The model will include care provided via a Wellbeing Teams approach (as described in chapter 7).

3.8 Chapter 10 – Integrated Governance, Delivery and Commissioning

Chapter ten focuses on the governance arrangements for the Strategy – with reporting to Thurrock Integrated Care Alliance - TICA (a committee of Mid and South Essex Integrated Care Board. Boards sitting beneath TICA have responsibility for delivering milestones and outcomes and for assessing impact and success – for example, the Integrated Locality Working Board has responsibility for the delivery and oversight of chapters seven and eight.

The main focus of 23-24 and into 24-25 has been the development of an Integrated Commissioning Strategy – based on the principles of HLS. This will ensure that external provision can be delivered in line with the aims of Thurrock's Integrated Care Strategy. The Strategy will be underpinned by a number of separate delivery plans (e.g. Working Age Adults, Older People, Specialist Accommodation).

The Strategy has recently been finalised and work to deliver a new model of strategic commissioning is already being progressed as opportunities arise. As already mentioned, the new domiciliary care contract starting in 2025 will follow a specification that focuses on shifting the current traditional model of domiciliary care to one that is flexible and individualised and develops in response to ongoing learning. Contract monitoring too will shift away from a traditional model focusing on output-based measures, to measures predominantly focused on learning and outcome delivery for individuals being supported.

4. Reasons for Recommendation

4.1 The recommendation enables People Board to: understand progress on delivering the Integrated Care Strategy, scrutinise key elements of the programme and gain assurance that the delivery of the strategy is enabling the achievement of better outcomes for local people.

4.2 Furthermore, the recommendation enables People Board to identify how Adult Social Care is achieving value for money.

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

5.1 Chapter four sets out a new model for engagement and community empowerment. The model seeks to ensure that the development and delivery of the Strategy is carried out with the involvement of local people – for example the establishment of Community Reference and Investment Boards, with priorities established for each locality or sub-locality.

5.2 Co-production and co-design will be at the heart of shaping how the Strategy is delivered. A new charter is being developed for this purpose and has been endorsed by Thurrock Integrated Care Strategy.

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

6.1 Thurrock Integrated Care Strategy is key to the delivery of a number of key policy documents including: Thurrock Health and Wellbeing Strategy, Thurrock's Corporate Plan – in particular 'Enabling' and 'People' priorities and Thurrock Council's new operating model.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Head of Finance – Adults and Health

16th July 2024

The strategy was delivered within the 2023/24 budget, which after accounting adjustments and movements to reserves resulted in a £2.674m underspend.

Service	Revised Budget £'000	Revised Outturn £'000	Variance to Budget £'000
Assistive Equipment & Technology	699	782	83
Better Care Fund (BCF)*	0	(1)	(1)
Commissioning & Service Delivery	(1,110)	(1,271)	(161)
Community Development	2,149	2,186	37
External Placements	38,843	36,945	(1,898)

Fieldwork Services	5,067	5,012	(55)
Provider Services	9,123	8,444	(679)
Total	**54,771**	**52,097**	**(2,674)**

The Strategy will continue to be delivered within the 2024/25 budget allocation for the Adults and Health directorate. The summary of the overall budget is detailed below.

Service	Revised Budget £'000
Assistive Equipment	856
Commissioning & Delivery	(1,867)
Community Development	2,248
External Placements	39,453
Fieldwork Services	6,158
Provider Services	8,905
Grand Total	**55,753**

There is a forecast underspend position projected for 2024/25 of circa £1.5m.

This also includes the Better Care Fund which is a pooled funded governed by a section 75 agreement containing both Adult Social Care and Integrated Care Board budgets.

The value of the 2024/25 Better Care Fund budget is detail below:

Pooled Budget Value	2024-25
DFG	£1,438,181
Minimum NHS Contribution	£14,240,144
iBCF	£5,569,460
Additional LA Contribution	£27,011,372
Local Authority Discharge Funding	£1,301,383
ICB Discharge Funding	£1,374,222
Total	**£50,934,762**

The Strategy is being delivered within existing budgets – including the Better Care Fund which is a pooled funded governed by a section 75 agreement containing both Adult Social Care and Integrated Care Board budgets.

7.2 **Legal**

Implications verified by: Sarah Okafor
Barrister (Consultant) on behalf of Thurrock's
Chief Legal Officer

On behalf of the Chief Legal Officer. I confirm that I have read this paper and attachments referred to therein. As set out in section 5 of the Care Act 2014, local authorities have a duty to promote the efficient and effective operation of a market in services for meeting care and

support needs, with a view to ensuring services are diverse, sustainable, and high quality for the local population, including those who pay for their own care.

Thurrock's Integrated Care Strategy appears to meet the section 5 CA 2014 duties, insofar as it is key to the delivery of a number of key policy documents including: Thurrock Health and Wellbeing Strategy, Thurrock's Corporate Plan – in particular 'Enabling' and 'People' priorities and Thurrock Council's new operating model for the provision of adult social care services.

Accordingly, there appears to be no adverse legal implications arising from the recommendations set out within this paper, and they are consistent with the expected obligations upon the Council.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager – Community Development Team

16th July 2024

The Strategy aims to reduce inequity by ensuring that the resources available across the health and care system can be used to deliver outcomes identified by individuals. This includes identifying how priorities may differ from community to community – Ensuring that the health and care system can flex accordingly around those differences.

Age, disability, health and wellbeing, workforce and socio-economic outcomes are all impacted by the Integrated Care Strategy. The Strategy's CEIA outlines the impact on these groups and communities.

7.4 **Risks**

There is a risk that the external marketplace is unable to develop significantly to deliver to the new operating model. There is also a risk that the Strategy fails to deliver expected outcomes.

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

The Strategy contributes to the reduction of health inequalities.

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):

- Thurrock Integrated Care Strategy – the case for further change

9. Appendices to the report

- None

Report Author:
Ceri Armstrong

Head of Adult Social Care Transformation and Commissioning- Adult Social Care and Community Development.