Thurrock Adults' Integrated Strategic Commissioning Strategy 2024-2026

Ceri Armstrong
Head of Adult Social Care Commissioning & Transformation

Les Billingham
Assistant Director of Adult Social Care & Community Development

Ian Wake
Executive Director of Adults & Health

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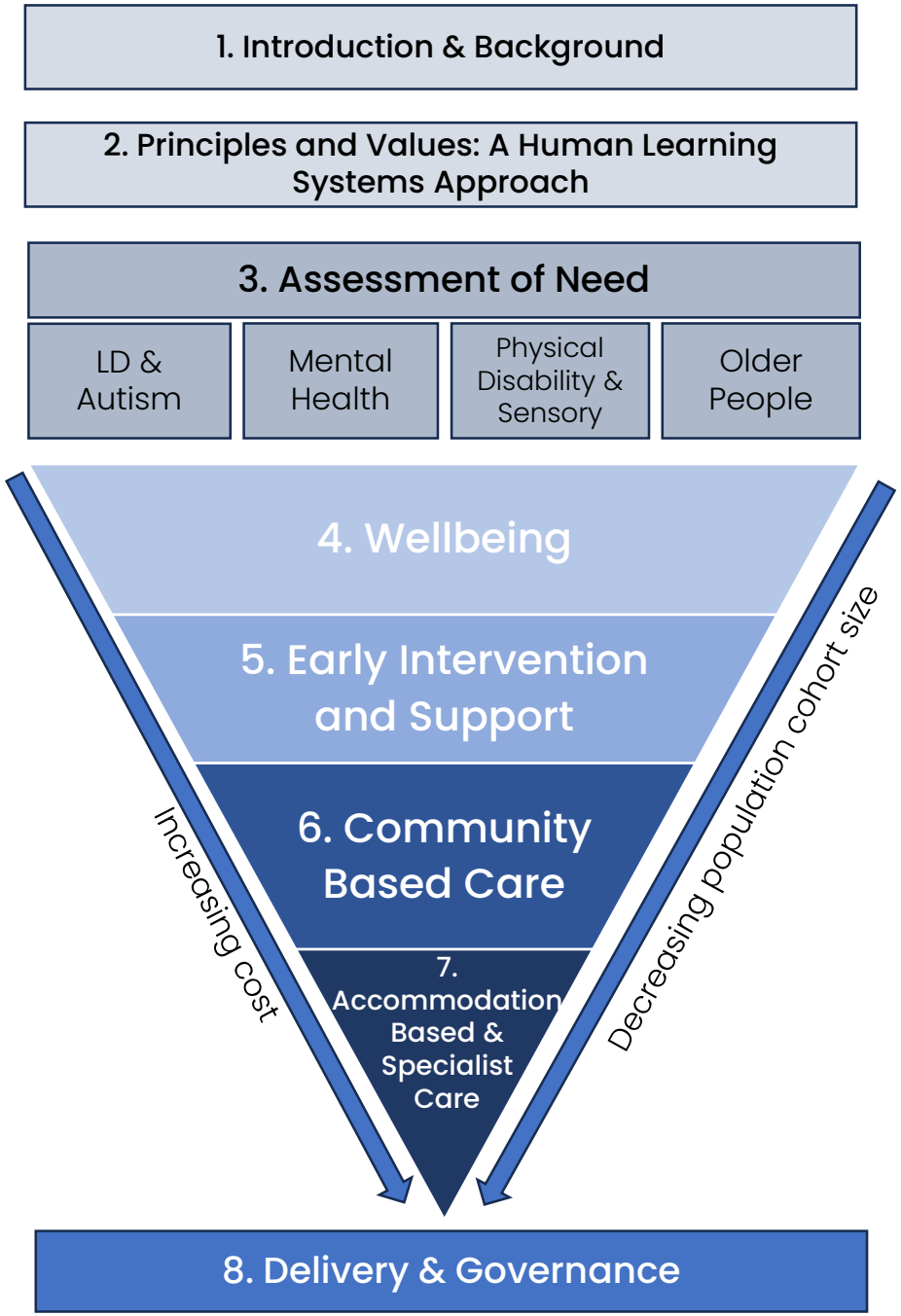
The following people have contributed to the content and/or development of this pack:

Sue Church, OD Change Lead
Peter Doherty, Head of Housing Operations
Tina Dempsey, Assistant Director of HR and OD
Ryan Farmer, Housing Strategy Manager
Rebecca Lee, Community Development Team Manager
Marc Mageean, Communications and Engagement Lead
Pete Pawson, Interim Change Director
Natalie Smith, Head of Community Development
Lynette Young, Senior Project Manager, Change Team

1. Introduction and Background

How this document is structured



Chapter 1 describes the purpose of this document, what we mean by strategic commissioning and market shaping. It also considers the legislative, regulatory, and local strategic framework in which this strategy sits.

Chapter 2 of this strategy sets out the principles and values that underpin our approach based on Human, Learning Systems theory.

Chapter 3 presents a high-level analysis of the need, demand and demographic growth in key care populations of LD & Autism, residents with mental health problems, residents with physical disability and sensory problems, and older people.

Chapters 4 sets out our strategic commissioning approach to Wellbeing services aimed at entire populations including those without specific care and support needs with a view to enhancing their wellbeing and preventing health and care problems from manifesting

Chapter 5 details our strategic approach to commissioning of early intervention and support for people who may have lower-level health, care and support needs or require information, advice, and guidance. The purpose of these services is to maximise independence and prevent and delay the need for longer term or permanent care solutions. It includes sheltered accommodation and refuges and secondary preventative activity aimed at those with existing long-term health conditions.

Chapter 6 describes our strategic commissioning approach and intentions for commissioning of care services within the community aimed at people who are able to remain living in their own homes

Chapter 7 sets out our strategic commissioning approach and intentions for accommodation-based services such as supported living, residential and nursing provision for people with more complex care needs that require care and support in more specialist accommodation.

Chapter 8 discusses our delivery mechanisms and governance and next steps in developing the detailed commissioning work plans that will accompany and deliver the strategic approach described in this document. It will also set out our approach to market shaping, how we will interface with the council's new Strategic Commissioning Function, and how we will work with providers and stakeholders to ensure a high quality and sustainable market.

1. Introduction and Background

1.1. Introduction

This strategy sets out Thurrock's strategic integrated commissioning approach for adult services. Commissioned services represent the largest proportion of Thurrock Council's Adult Social Care and Public Health budgets totalling £Xm for ASC and £Ym for Public Health per annum. The Mid and South Essex NHS Integrated Care Board (ICB) spends a further £Zm purchasing healthcare services for Thurrock residents, and the pooled NHS and Adult Social Care Better Care Fund for Thurrock represents £Am of commissioned spend.

In the context of government intervention for the council and significant financial challenge faced by the ICB and a Section 114 notice, it is essential that an effective approach to strategic commissioning is developed and implemented to ensure best value from every pound spent.

The MSE Integrated Care Board through the Alliance team in Thurrock is a strong partner in the Better Care Together Strategy implementation, and has agreed that the best endeavour to meet increasing and complex needs of Thurrock residents, is through developing an integrated commissioning unit with Thurrock Council, and advocates that this integrated commissioning strategy will be a blueprint for future, collaborative working.

This strategy sets out our approach to strategic commissioning over the next three years.

1.2. What is Strategic Commissioning?

Strategic Commissioning consists of the following elements:

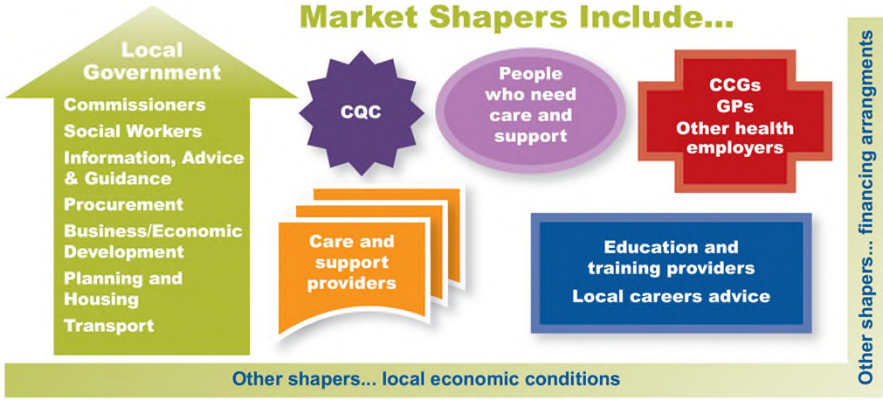
1. Understanding the current needs and strengths of individuals and communities in order to ensure that health, care, and wellbeing requirements can be met and also prevented, reduced or delayed (including meeting statutory requirements).
2. Developing and influencing strategy, including that of partners, in order to achieve what is required.
3. Shaping and developing the marketplace so that it can meet the needs and outcomes identified and provide both choice and flexibility.
4. Working with people with lived experience throughout the commissioning cycle and life of contracts to ensure that services and solutions that are developed and delivered reflect what residents need and want
5. Ensuring that what is procured provides good value, ensuring that quality does not suffer at the expense of cost.

Market Shaping

Whilst neither local authorities nor the NHS has direct control over the market, their actions can influence it, both positively or negatively. Commissioners have a duty to work alongside providers, service users, carers, and partners to engage in mature dialogue to find shared and agreed solutions to shape a market that will meet resident need, provide choice, and deliver quality and best value.

Market shaping describes two key sets of tasks that commissioners should undertake to ensure a health and care market that delivers diversity of choice for all who need care and support, including unpaid carers:

1. **Market Intelligence**. Collection and analysis of intelligence on need, demand and supply to determine 'the health of the market', whether it is likely to meet future population need, what additional provision needs to be developed, and how sustainable the market is both now and in the future.
2. **Market Influencing**. A spectrum of activity that seeks to influence the current and future range of care and support available based on market intelligence.



All of stakeholders in figure 1.1 have influence on the shape and health of the market whether or not health or care commissioners directly purchase services from them. For example, a local authority may not directly purchase companionship services in a local area aimed at people with lower levels of need to reduce social isolation but can still be influential in ensuring their success through publicising them through Information, Advice, and Guidance services.

Similarly, it is essential for commissioners of care and wellbeing services to be in dialogue with education and skills providers to influence activity to ensure a well-trained workforce for health and care services, and with transport providers to ensure that the care workforce can access affordable routes to work.

Communicating strategic commissioning intent to providers is essential in allowing them to develop future services that will meet market need. Providing ongoing support and dialogue throughout the life of the contract helps ensure provider and market sustainability and quality.

1. Introduction and Background

1.3. The Legislative and Regulatory Framework

Legislative Framework

The Care Act (2014) sets out the legislative framework for market development in adult social care. Section 5 of the act sets out duties on local authorities to facilitate a diverse, sustainable, high-quality market for their whole population including those who pay for their own care, and to promote effective and efficient operation of the adult social care and support market as a whole.

Sections 48-56 places a legal duty on local authorities to ensure that no one goes without care if their provider's business fails and their services cease. It covers:

- CQC market oversight
- Local authority duties for ensuring continuity of care in the event of provider failure and service cessation including the provision of a 'provider of last resort'.

Department of Health and Social Care guidance on market shaping describes the role of Local Authorities as follows:

- meet needs of people eligible for care, support them and their carers, and fund care for those people with needs who meet financial eligibility criteria
- local market shaping to encourage quality, choice and sufficiency of provision
- local contingency planning in case of provider failures
- ensure care is maintained where provider fails financially and services cease – for everyone, including self-funders, to ensure people's needs continue to be met.
- work with NHS to promote integration including integrated commissioning and joined up services.
- at national level, Association of Directors of Adult Social Services (ADASS) has a role in supporting contingency planning for provider failure and collaboration on market shaping regional collaboration (via ADASS) on market shaping.

Section 6C of the NHS Act 2006, inserted by section 18 of the Health and Social Care Act (2012) places a legal duty on local authorities to commission sexual health services and NHS Health Checks. Section 73A(1) of NHS Act (2006), inserted by section 30 of the Health and Social Care Act (2012) places a legal duty to councils to take steps to improve public health. This typically requires commissioning of additional health improvement services including those to address smoking, obesity, and addictions.

Regulatory Framework

Adult Social Care is regulated by the Care Quality Commission (CQC). The CQC has recently introduced a new assessment framework based on four themes and two to three *quality statements* under each theme. Councils providing Adult Social Care will be assessed against these themes over the coming months.

Theme 2 *Providing Support* covers the following areas:

- Market shaping
- Commissioning
- Workforce capacity and capability
- Integrated
- Partnership working

Quality statement 2.1 states:

We understand the diverse health and care needs of people and our local communities so that care is joined-up, flexible and supports choice and continuity'.

In summary, 2.1 assesses the following:

- That the local authority understands the care and support needs of the people and communities. There is a good variety of care providers, provision is resilient and there is sufficient capacity to meet demand now and in the future.
- Local people have access to a diverse range of safe, effective, high-quality support options to meet their care and support needs. This includes unpaid carers and those who fund or arrange their own care. Services are sustainable, affordable and provide continuity for people.

Whilst there are other elements of the four themes, 2.1 is the key quality statement that this strategy will aim to meet and maintain.

1. Introduction and Background

1.4 Local Strategic Framework

Thurrock's Joint Health and Wellbeing Strategy is the highest-level strategic document governing the joint plans of all local partners to improve population health and wellbeing of our residents. It is high level, all-age and covers all factors that influence health and wellbeing including wider determinants of health. Oversight of implementation is provided by the Thurrock Joint Health and Wellbeing Board that contains both chief officers and elected members.

Under the Health and Wellbeing Strategy sit two key strategic documents:

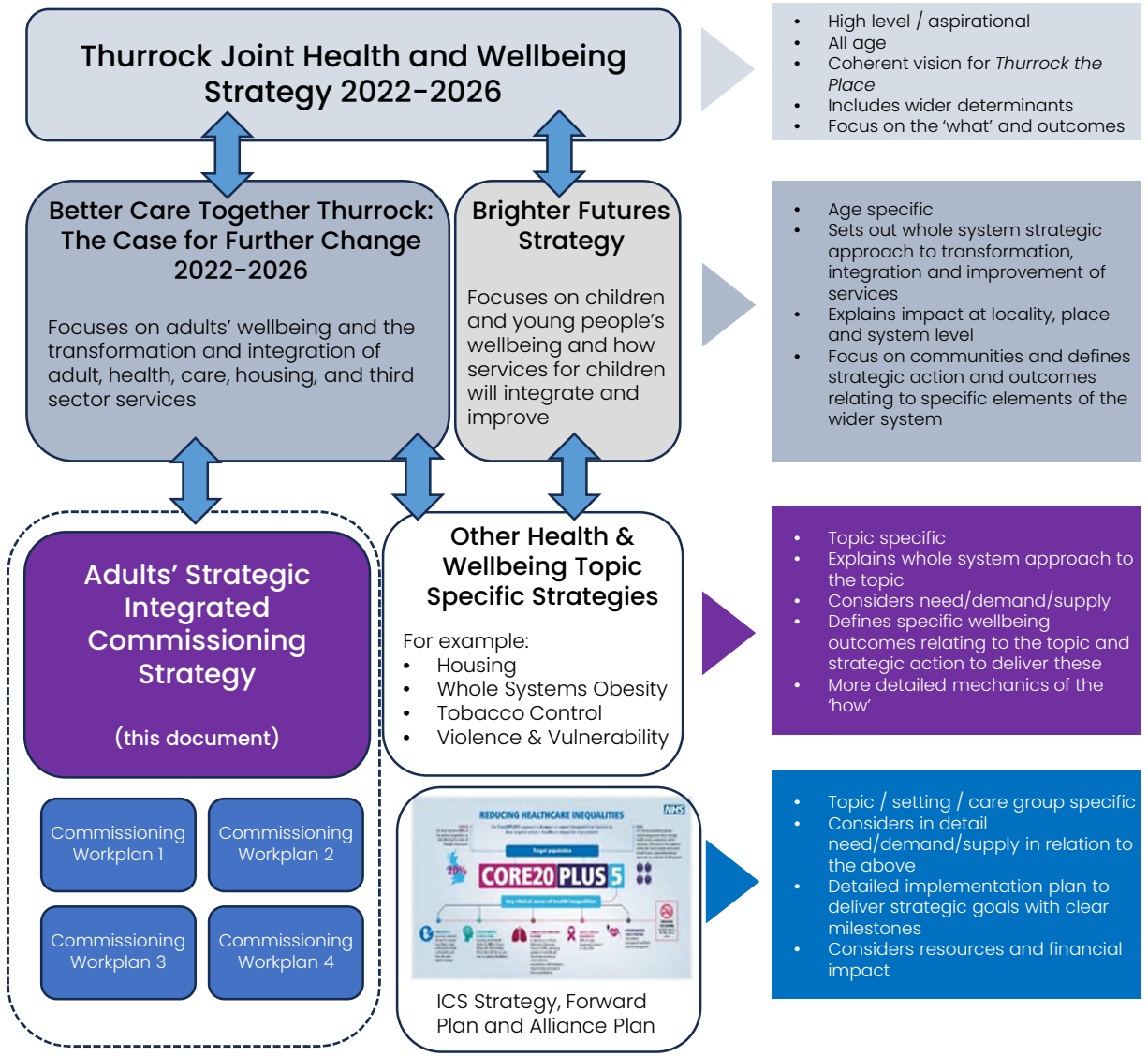
- The *Brighter Futures Strategy* focuses on children and young people's wellbeing and implementation is overseen by the Brighter Futures Board.
- *Better Care Together Thurrock: The Case for Further Change* is a four-year strategy developed between the council, the ICB, NHS providers, the third sector and based on consultation and engagement with residents that sets out our shared strategic vision and plans to integrated and transform health, adult social care, wellbeing, and housing services for adults. The strategy sets out shared principles and values, a single integrated model of care and has specific chapters dealing with the transformation and new care models in key elements of the system:
    - Leveraging the power of communities
    - Primary Care
    - Population Health Management
    - Integrated Care in the Community
    - Integrated Homecare
    - A new model of residential care and Supported Living

Implementation of *Better Care Together Thurrock: The Case for Further Change* is overseen by the Thurrock Integrated Care Alliance (TICA) – the highest-level officer only strategic partnership with chief officer representation from all key partners responsible for the integration and transformation of adult services. TICA acts as both a sub-committee of the ICB Board and Joint Health and Wellbeing Board.

This integrated commissioning strategy forms one of a series of more topic specific strategies that support *Better Care Together Thurrock: The Case for Further Change (BCTT:C4FC).* It aims to describe our overall approach to strategic commissioning of services to support the approach described in BCTT:C4FC.

Underneath this strategy, we will develop commissioning work plans that set out in detail our commissioning approach to different services to support different cohorts of residents in different settings.

Figure 1.2 shows out the strategic framework fits together.



2. Principles and Values: A Human Learning Systems Approach

There is an increasing recognition that the current paradigm, particularly within the public sector, does not enable people to respond effectively to the challenges of a complex world.

People's lives are complex, our places are complex systems. Unfortunately, in complex environments, making funding and performance management choices based on outcome-metrics produces a paradox: when funders make choices on that basis, it makes producing real world outcomes in people's lives more difficult. [1]

2.1 Introduction

Over the last 35 years, the operating model for public service has been heavily influenced by *New Public Management* that has focused commissioning and service delivery on discrete functional interventions, determined in a 'top down' way in advance, commissioned through competitive tender in silos, with eligibility criteria, and measured through process KPIs also determined at the start of the contract.

Whilst this approach may be effective for 'complicated tame' problems that can be effectively process engineered, it is demonstrably failing in issues subject to 'complex' systems where it is the combination of a wide variety of factors in a constant state of dynamic change in the lives of individuals and communities that deliver outcomes. Issues like mental health, homelessness, obesity, diabetes, antisocial behaviour, educational outcomes, and need for care are all subject to complex systems, and most are subject to an upward demand trajectory.

New Public Management has resulted in a public sector that too often waits until residents are in crisis before acting. A significant proportion of our residents who require health and care services live with complexity; the overlapping problems of poverty, poor educational and skills, debt, poor mental and physical health, homelessness, addictions, and care needs are common. In response, siloed pathways, processes, and budgets have evolved that underpin a fragmented and confusing system that is difficult for residents with complex and overlapping needs to navigate.

Paradoxically, the more complex a resident's needs are, and the greater their need is for help, the more difficult it is for them to access a solution because the system is designed in a way that requires them to navigate an often-bewildering service landscape of multiple teams and services, all with different thresholds, referral criteria, and waiting times. We call this the need paradox. Different services within the system often fail to talk to one another. This has resulted in a system that fails see 'the whole person', often falling short of delivering what residents and communities require to improve their wellbeing and life chances and adopting an inflexible 'tick box' mentality.

It is a system that fails to harness the operating capacity; skills, ingenuity, human resource, and assets within communities themselves, focusing solely on the narrow resources of the organisation and turning residents and communities into passive consumers of functional interventions that the public sector has defined in advance.

Finally, the entire system is unnecessarily and overly complex, bureaucratic, inefficient and expensive to commission and deliver – and does not, on the whole, deliver what people want or how they want it. Governance is fragmented across different teams and organisations and system governance often inadequate

The acknowledgement that the lives of individuals are complex and not linear has raised significant issues for current commissioning approaches within services focused on human relationships. Commissioning and market development has tended to focus on commissioning 'one size fits all' services – mostly aligned to need and condition. This approach enables councils to meet their statutory obligations, however, because it does not recognise complexity, variation, and context in the lives of individuals and therefore does not necessarily recognise the unique circumstances of residents, it is not fit for purpose.

In the late 1980s, 'New Public Management' (NPM) ideology began to be applied to commissioning services provided by the public sector. Doing so meant the introduction of competition and therefore the externalisation of provision. Alongside this came increased bureaucracy, top-down decision-making, silo-planning, and output-driven performance management. The move to outcomes has improved things somewhat but are still insufficient to deliver positive change in people's lives.

Funders and commissioners cannot prescribe in advance what a good outcome looks like because they are different for each person and will change over time, and so cannot know what bespoke support each person needs. [1]

Historical commissioning has reflected the following unhelpful characteristics based on New Public Management ideology:

- Task and service-focused service specifications;
- Contract management based on restrictive, predefined, and transactional measures;
- Commissioning and procurement processes that favour larger organisations and restricts smaller and grass-roots local providers;
- One size fits all service specifications that fail to identify or allow the flexibility to respond to individual resident context or deliver what is required by different communities;
- Limited or non-existent engagement with communities or 'co-production with a very small group of *go-to* users of services;
- Lack of variety or flexibility within the marketplace;
- Lack of power sharing or transfer of power with communities and users of services; and
- Lack of innovation.

2. Principles & Values: A Human Learning Systems Approach

2.2 Human Learning Systems (HLS)

A Human Learning Systems approach addresses the failings of New Public Management by embracing the reality of how outcomes are really made in the lives of residents and communities. Figure 2.1 summarises the key principles that underpin an HLS approach. All partners of the Thurrock Integrated Care Alliance have already signed up to adopting HLS practice and it is the theory that supports *Better Care Together. The Case for Further Change.*

The capacity to respond to human variation:
Each resident is recognised as an individual with different strengths, needs, and wants. At the heart of *human public service* is relational practice; form a relationship with the resident and let the solutions drop out.

Staff are empowered to co-design bespoke, strengths based, solutions. Those solutions may require the input of several different services.

Commissioners must give up the illusion of control that effective solutions can be specified in advance.

The ability to adapt to change
The context in which effective social interventions take place is constantly evolving; from individual changes in personal circumstances, to large scale social, societal, or environmental change. This means that the nature of the challenges and '*what works*' to address those challenges is also constantly evolving. This operates at an individual level and a community level. *What works* to improve the mental wellbeing of one individual or community may be different for another individual or community.

As such, the primary strategic aim of a system leader is to ensure that all system actors are involved in constant learning and experimentation to respond to the dynamic nature of *what works.* Commissioners should commission a requirement for learning, co-production, and flex as part of service specifications. Leaders should signal that it is *learning* and not top-down performance management that it the primary strategic mechanism to manage the system.

The ability to shape and refine a healthier system
If we accept that it is the system itself rather than individual programmes or services that deliver outcomes for residents with complexity, the role of the system leader and commissioners is to create a healthier system, because healthier systems deliver better outcomes.

A healthy system is one where there is a shared vision and values between system actors, where power is shared, where all of the system actors can collaborate easily with each other, where prevention is prioritised, where capacity is sufficient for demand, and where constant learning and reflection drives adaption and improvement.

2.3 What does a Human Learning System Approach mean for Commissioning?

For commissioning to adapt to an HLS based operating model, it needs to work in a fundamentally different way that represents a radical departure from how local authorities have commissioned using New Public Management principles. The following are key features of an HLS approach to commissioning:

- Commissioners must recognise the variety of demand within a complex system. This requires a strong relationship and understanding of the variety of different human contexts at individual resident and community level.
- Commissioning must be flexible enough to allow providers to have the autonomy to respond to that variety. There are no 'one size fits all' services. Service specifications require providers to deliver relational practice, forming relationships with residents from which co-produced bespoke solutions drop out that respond to resident context.
- The role of the commissioner changes from specifier-monitor/evaluator to one of *system steward;* they look after the health of the system. This means building a system where there is a high degree of trust, where all voices are heard and where providers collaborate with each other.
- Management of the system moves from top-down control and assessment against a narrow set of predefined KPIs to one of collaboration through experimentation and learning. Results from learning experiments are used to adapt the system and hence service specifications throughout their lifecycle. Commissioners and providers work together to undertake this. Commissioners 'commission for learning', requiring providers to adopt this approach. For example, this could include co-producing and adapting service models with communities during the contract. Providers are also required to collaborate with other system actors and share learning.
- Innovation is encouraged and facilitated. Commissioners commission for innovation, encouraging experimentation within safe parameters.
- Commissioners promote a *positive error culture* to encourage all system actors including providers to report when things don't work or stop working and adjust accordingly. This is essential in complex systems that will change over time. Conversations about performance and funding are always separated.
- In order to enable those providing support to coordinate and collaborate effectively, commissioners must change historical 'control' models of governance that has been used to define and measure effectiveness. Providers are required to demonstrate that they have done the right thing in the context of each resident they serve rather than deliver against predefined metrics.

2. Principles & Values: A Human Learning Systems Approach

2.4 Delivering Human Learning Systems

Some elements of the market have grown to meet demand without this being best managed through a strategic commissioning approach – for example supported accommodation aimed at working-age people. Spot contracts have been used as a way of finding provision that best meets a broad range of requirements for individuals. The council must ensure that an HLS approach to commissioning can provide sufficient market stability – regardless of the way that the provision is secured – e.g. via a framework agreement or via spot. The council must be able to shape or manage the market effectively. This strategy therefore sets out how a strategic commissioning function for adults and health will shift to a new way of working based on HLS principles and how we will work with the marketplace to ensure that it is able to deliver for all our residents.

In working with the local working age adults' market, there is currently insufficient choice and diversity to enable a bespoke, person-centred model to develop and deliver quality services that respond to individual resident context. Traditionally, this market has grown through ad hoc and opportunistic development, with services emerging to meet demand, driven by the closure of an institutional learning disability hospital, the creation of two specialist schools for young people with disabilities, and the significant growth in mental ill-health that has been exacerbated by the COVID-19 pandemic.

To address this gap, we will look at a range of options, including the consideration of adopting a single framework agreement that gives primacy to providers, either currently contracted or who have a desire to enter the Thurrock market, who can evidence a commitment to learning and collaboration with the whole system. Solutions may include input from multiple providers. The strategic commissioning approach developed will aim to ensure more diversity and choice for individuals across a wider scope of provider types from micro-enterprises up to and including large scale organisations. Providers will be required to demonstrate on-going commitment to HLS principles. How this is achieved will be set out in a commissioning plan for working age adults that will sit under this strategy.

2.5 Co-production with Communities

Central to creating the HLS model for commissioning and provider base is the need to put co-production and design at the heart of all we do. It is also vital that we see the commissioning function as one of system stewardship, empowering our communities to take equal responsibility for improving health and well-being in Thurrock and, importantly, addressing the significant health inequalities that exist locally.

The Social Care Institute of Excellence describes co-production as:

- **Co-design**, including the planning of services
- **Co-decision making** in the allocation of resources
- **Co-delivery of services** including the role of volunteers in providing the service
- **Co-evaluation** of the service

Our vision for commissioning includes developing a different way of engaging with Thurrock's communities. This reflects the agreed approach set out in Chapter 4 of *Better Care Together Thurrock: The Case for Further Change*. The council is also adopting this approach in the locality element of its new Operating Model.

We believe that communities, whether defined by geographical locality or across particular care groups must be central to developing, defining, and delivering commissioning solutions

Historically, the council has often engaged in silos through set pieces of consultation on issues it has deemed important, liaising with a narrow set of groups or individuals. Co-production where it has occurred has sometime been ad-hoc and some engagement activity labelled as co-production has fallen short of the way co-production is defined.

Conversely, over the past decade, Adult Social Care has transformed our operating model deliver a different approach to enabling care solutions that leverages the strengths assets available within communities. We have also developed a vibrant Micro-enterprises Programme that has helped to improve diversity within provision as well as giving local people employment opportunities based around what works for them. However, there is still far more to do.

A new model of engagement will be comprised of a number of factors:

- Work with localities and communities to understand what is important to them – and the differences and synergies in and between priorities for different localities and communities;
- Use of on-going engagement opportunities as a means of gathering intelligence in addition to quantitative intelligence – e.g. with front line staff who have regular contact with those who need support or who may be likely to need support in the future;
- Development of partnership boards that are representative of each of the four localities – and using other techniques to ensure the voices of those not on the boards are heard and understood (through a robust engagement plan and framework developed by Thurrock's User-Led Organisation;
- Developing a robust and inclusive co-production and co-design approach that is integrated within the commissioning cycle;
- Development of Community Investment Boards in each of Thurrock's four localities – enabling communities to influence and direct decisions about how resource should be used and to have opportunities to directly deliver solutions that support those living in the local area.

2. Principles and Values: A Human Learning Systems Approach

2.6 Working in Partnership

The factors impacting on the improvement and delivery of outcomes are multifactorial as expressed by the Human Learning Systems approach. This means commissioning solutions cannot be developed or delivered in isolation.

We will therefore work closely with partners across the health and care sector and beyond to identify how to best understand, design, plan, and resource commissioning solutions for residents requiring or likely to require care and support. This will include preventing, reducing, and delaying the need for health and care support. Where it makes sense to do so, we will require providers to operate as part of one of our four Integrated Locality Teams (ILTs) at locality level. This will enable single integrated solutions to be co-produced with other professionals and residents, where a resident has overlapping issues.

The Better Care Fund and Better Care Together Thurrock governance arrangements provide a platform from which integrated commissioning solutions can be developed and agreed.

Our Overarching Goal

To work closely with individuals, communities, and the market to co-design and co-produce bespoke commissioning solutions based on Human Learning System Principles that are focussed on prevention, choice and control, quality and efficiency and respond to the individual context of each resident we serve.

The outcomes that this strategy will support are the same as those specified within our *Better Care Together. The Case for Further Change* integrated care strategy:

Our Desired Outcomes

- **Residents are able to achieve more of what matters to them**
- **Support is provided in collaboration with the community and focuses first and foremost on what the community can offer**
- **Residents maximise opportunities to stay as healthy as possible for as long as possible and require fewer interventions from services**
- **Residents are able to find the right solution for them, first time and in the right place**
- **Residents are empowered to achieve their version of 'a good life'.**
- **Our Thurrock Integrated Care Alliance and system resources achieve better outcomes through earlier intervention and preventative solutions that reduce failure demand.**

2.8 Our 10 Principles and Values

We will achieve our overarching goal and desired outcomes by working to ensure that our commissioning practice is based on the following agreed principles, again underpinned by Human Learning Systems theory:

1. BESPOKE STRENGTHS-BASED SOLUTIONS	that take account of the resident's individual context and expressed need and give residents choice and control. Solutions will capitalise on community strengths and assets as opposed to the historical approach of commissioning 'one size fits all' services.
2. INTELLIGENCE-LED	We will triangulate a wide range of qualitative and quantitative data sources including learning from localities to build a clear picture of need, demand, current supply, and resident experience of care. We will use this to ascertain what the market needs to deliver in the future and to inform strategic commissioning decisions
3. MARKET SHAPING	We will continually review the current market against our latest intelligence and use all strategic levers available to the local authority to further develop and shape the market so that it continues to respond to community need and offers diversity and choice.
4. RIGHT SOLUTION, RIGHT TIME, RIGHT PLACE	We will seek to commission integrated solutions that respond to all resident needs in one go, at one time, and in the right setting for them.
5. PLACE-BASED COMMISSIONING BASED ON SUBSIDIARITY	We will commission services based on the lowest possible geographical footprint that makes sense.
6. FLEXIBILITY	We will ensure that support is able to adapt with and to the requirements of the resident, recognising that these may change over time.
7. CO-PRODUCTION	We will co-produce services with those who use them and their families. We will both co-produce commissioning – involving residents in the commissioning process, and co-produce commissioning, requiring providers to co-produce delivery models as part the service specification.
8. COMMISSIONING FOR LEARNING	We will build this principle into all service specifications, requiring providers to test new approaches, undertake and share continuous learning and adapt services in response throughout the lifecycle of the specification.
9. SYSTEM STEWARDSHIP	Commissioners' role will shift from 'specifier-performance manager' to system steward with responsibility to look after the health of the system and ensure all system actors find it easy to collaborate, innovate, and learn.
10. QUALITY, EFFECTIVENESS & VALUE	We will commission the highest possible quality, most effective services from the budget envelope that we have available to us.

3. Assessment of Need and Cost Benchmarking

3.1 Introduction

This chapter provides a high-level analysis of our benchmarked commissioning costs against population need. It also provides an overview of demography and need for the four key care groups of learning disability and autism, mental health, older people, and physical disability and sensory. More detailed needs assessment will be developed within the individual commissioning work plans that sit below this strategy.

3.2 Underlying Population Health Need

Underlying levels of health need within a given population correlate strongly with levels of deprivation within that population and as such, population deprivation is an excellent measure of overall underlying need.

Perhaps the most accurate way of assessing deprivation within the cohort of the Thurrock population requiring Adult Social Care is by considering the outcome of financial assessments as all councils are required to undertake a financial assessment on residents requiring care and support to determine whether or not they are required to contribute towards the cost of their care. Figures 3.1 and 3.2 show the percentage of the population requiring community and residential adult social care placements who were assessed as being financially affluent enough to self-fund their own care for all local authorities in England by quartile in 2023/24.

Figure 3.1

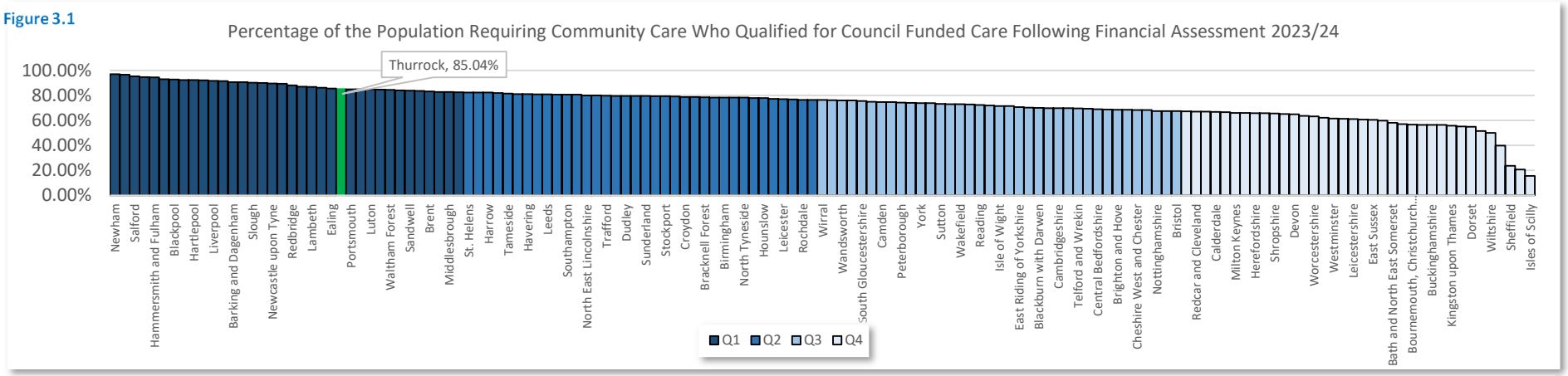
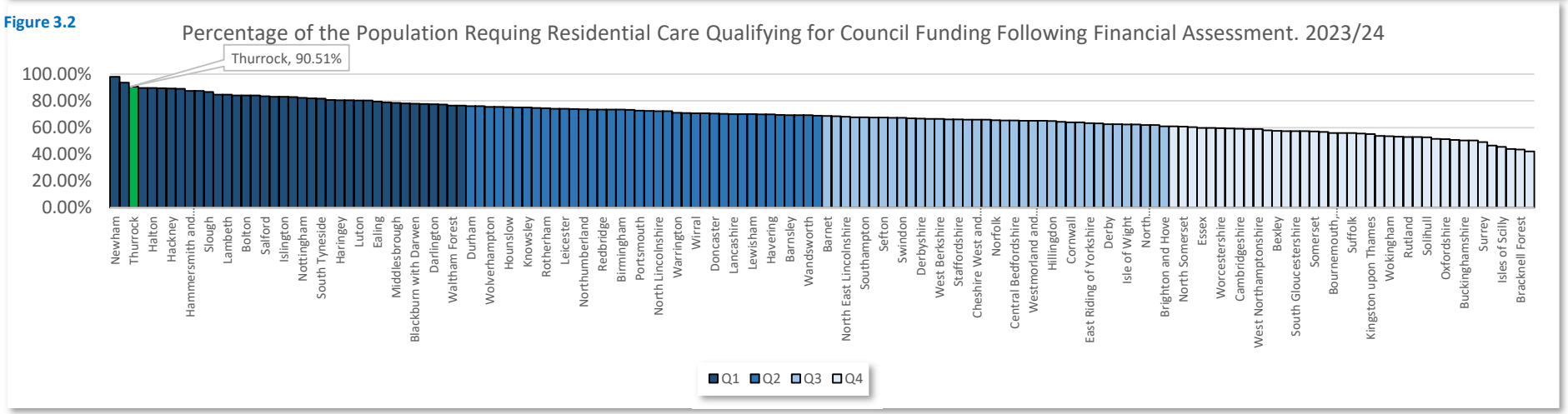


Figure 3.2



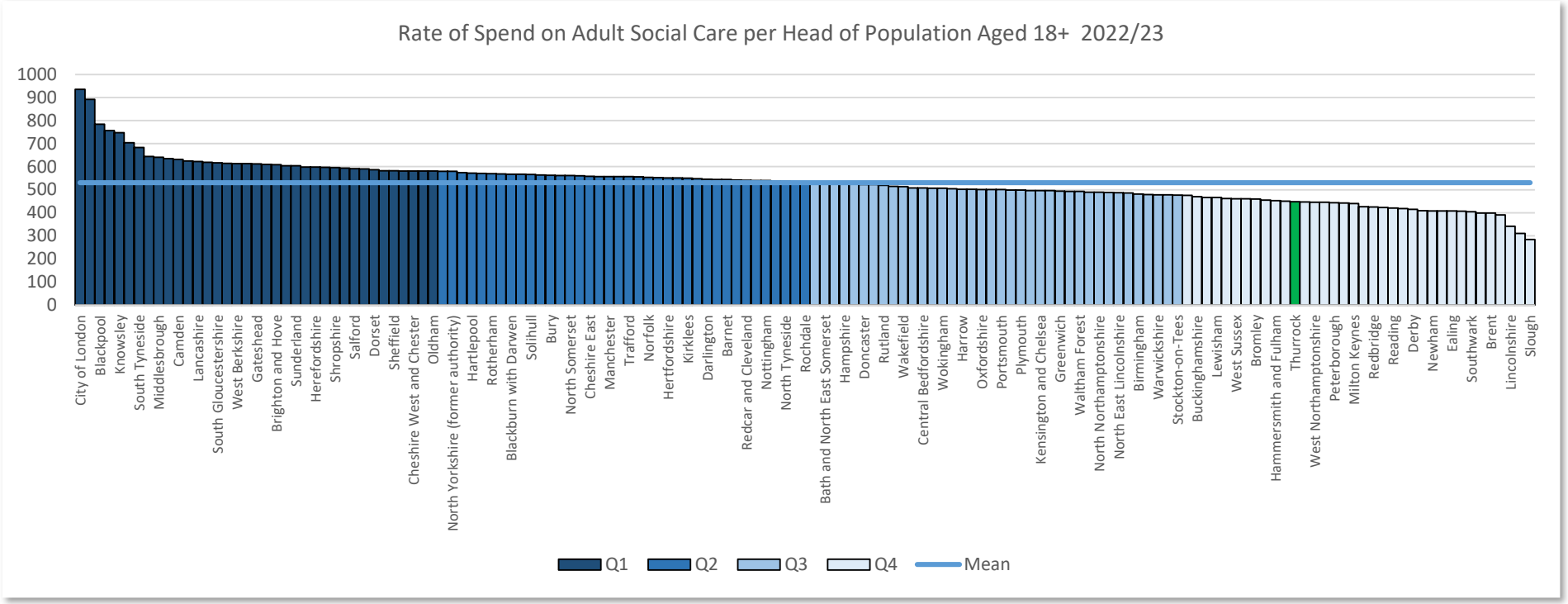
3. Assessment of Need and Cost Benchmarking

Figures 3.1 and 3.2 show that Thurrock as comparatively very low proportions of its population who were financially assessed as being able to afford to fund their own care. Both figures are in the lowest quartile of self-funders, and for residential care, Thurrock has the third lowest proportion of self-funders in England. This suggests that the population requiring Adult Social Care statutory care packages has comparatively very high levels of deprivation and hence high levels of underlying health need.

3.3 Overall Rate of Spend

Figure 3.3 shows overall rate of spend on Adult Social Care per head of population aged 18+ for all local authorities in England. Despite high levels of underlying population health need in the population accessing adult social care, Thurrock has a rate of spend per head of population in the lowest quartile in England, significantly below the England mean. This suggests that the local system is effective at controlling cost.

Figure 3.3



3.4 Comparative Demand

Figures 3.4 to 3.6 (overleaf) show comparative rate of demand for community and residential care placements for all age and older people (aged 85+) for every local authority in England. Despite high levels of underlying health need in the populations requiring adult social care, Thurrock has the lowest level of statutory placement demand in all four categories. This suggests that the local system is extremely effective at preventing and delaying the need for statutory care placements. **Thurrock is the only local authority in England to have a need/demand pattern of the highest quartile of underlying population need in both need categories considered here and the lowest quartile of overall spend and statutory care placement demand in the five spend/demand categories considered.**

3. Assessment of Need: Demand Cost Benchmarking

Figure 3.3

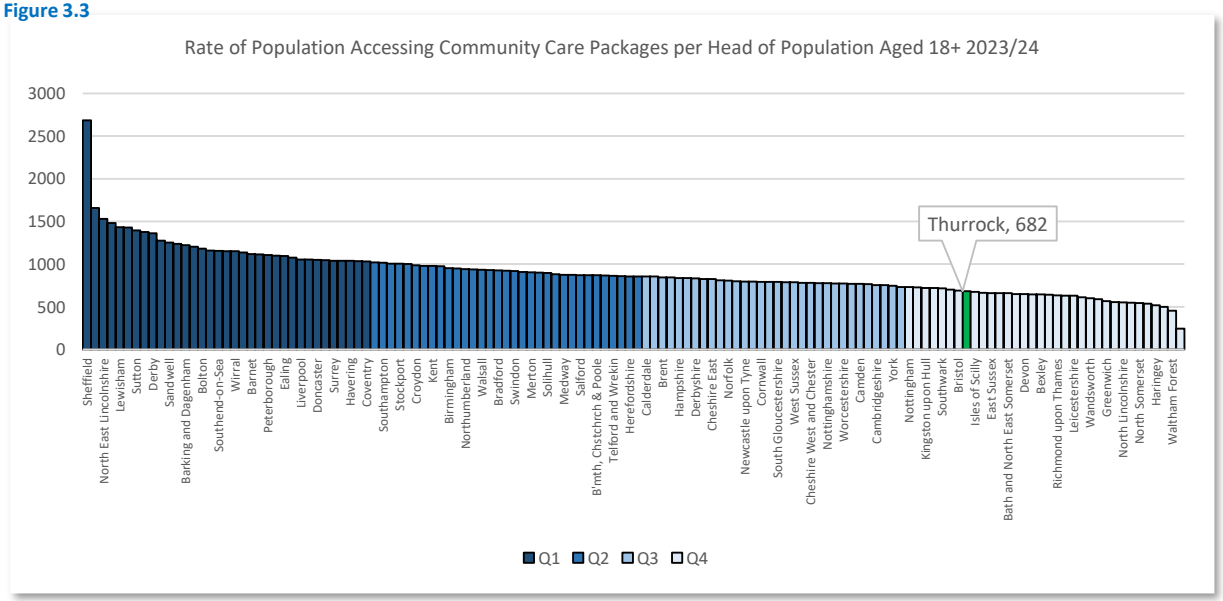


Figure 3.4

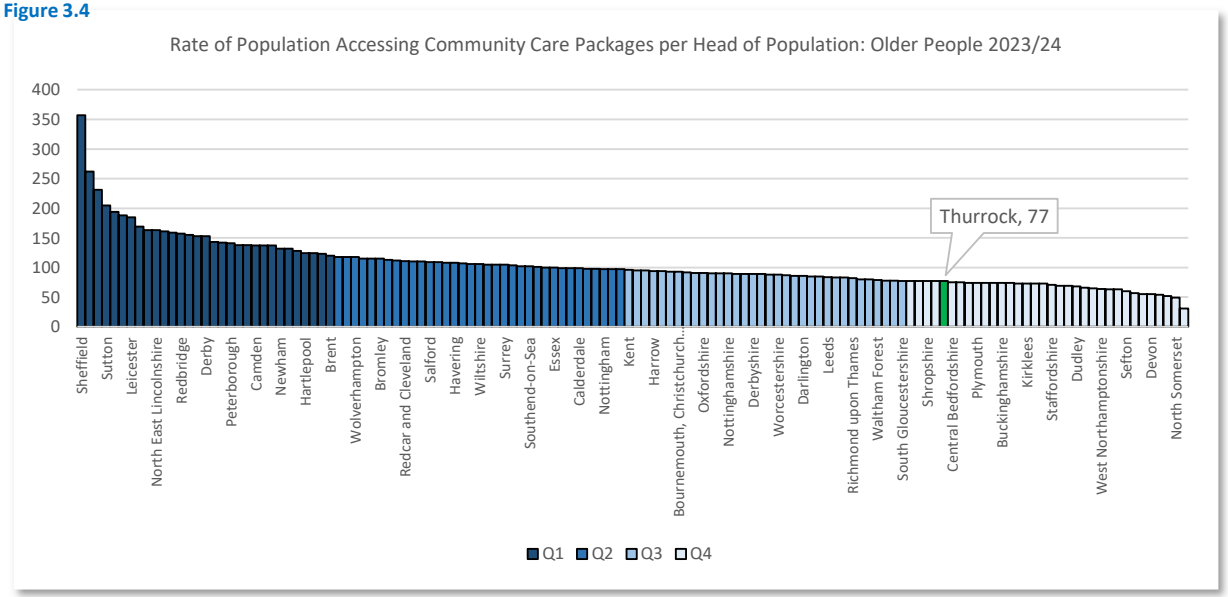


Figure 3.5

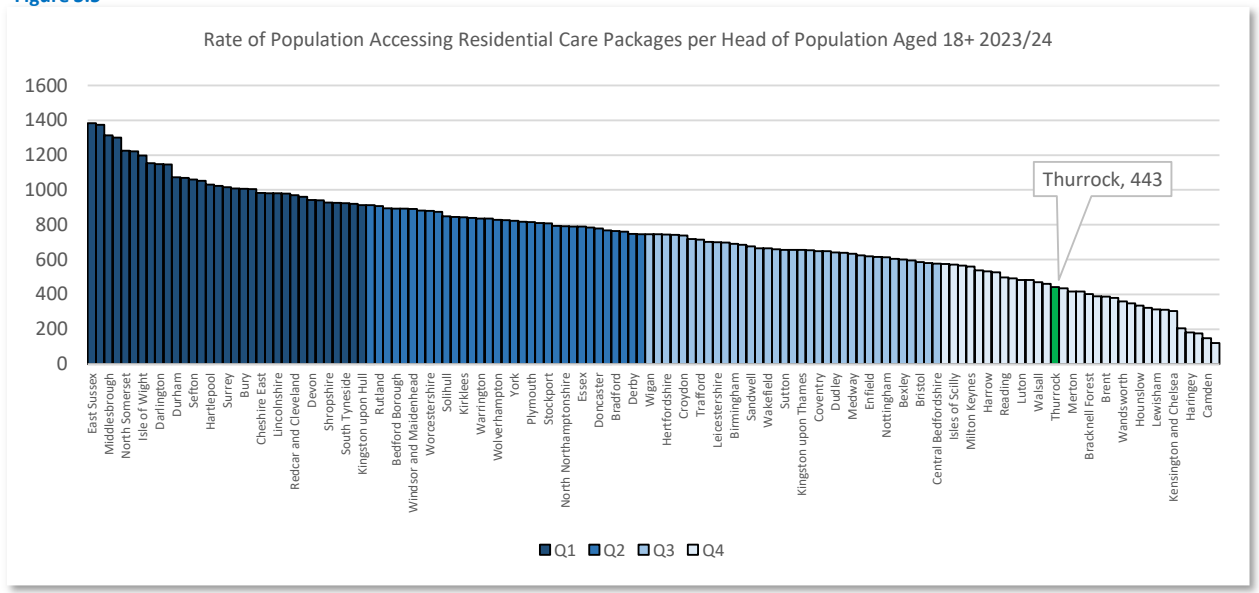
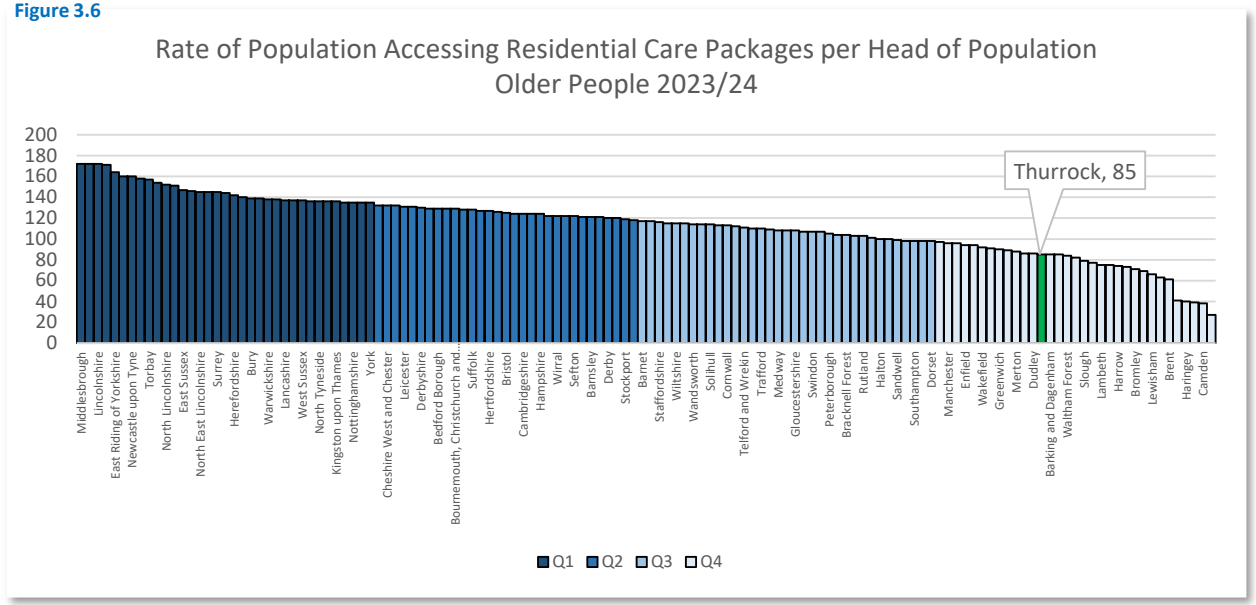


Figure 3.6



3. Assessment of Need:

Learning Disability & Autism

3.5 Learning Disability and Autism

There is a wide variance of conditions within learning disabilities but in general, it is defined by three core criteria:

1. Lower intellectual ability (usually defined as an IQ <70). A severe learning disability is defined as an IQ of between 20 and 34, and a moderate learning disability is defined as an IQ between 35 and 49.
2. Significant impairment of social or adaptive functioning (age-appropriate skills that people need to live independently e.g. social skills or personal care).
3. Onset in childhood.

Autism is defined as a lifelong developmental disability that affects how people perceive, communicate, and interact with others. Autism is not a learning disability, however four in 10 people with lived experience of autism also have a learning disability.

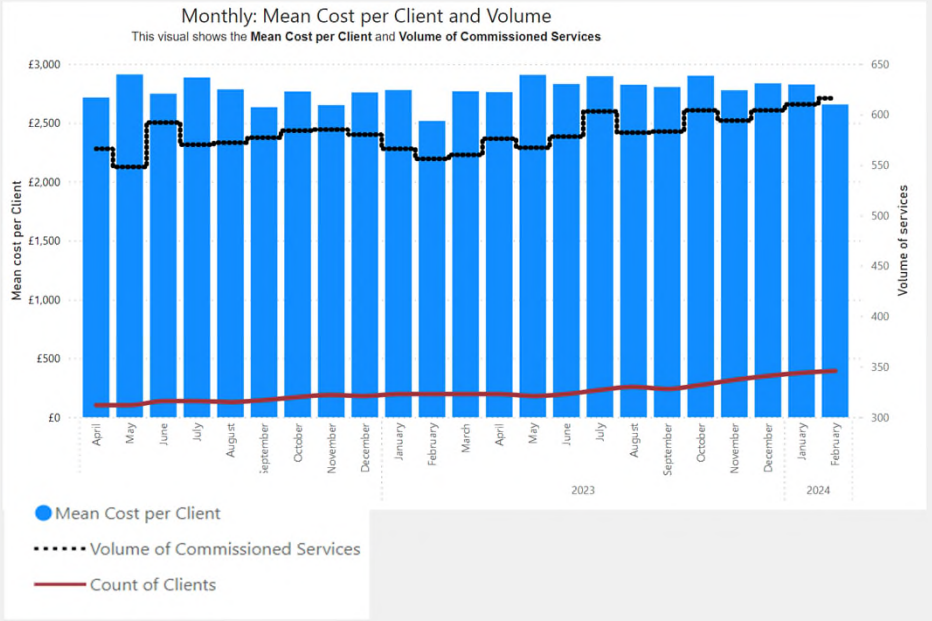
"Disabled people's aspirations for their lives are no different from non-disabled people's aspirations. We all want to live fulfilling lives. We want to be safe and healthy. We want autonomy about where we live, how we live, and with whom we live. We want to go outside, meet other people, and go places. We want to access the support we need to live an independent life easily and to feel confident that we won't lose it. We want to be able to participate in society, to be valued, to go to work."
National Disability Strategy (2021)[2]

Our main aim is to support people with a learning disability and/or autism to have a good life including a good home near circles of support. NICE recommends that commissioners carry out several activities in order to make this a reality:

- Ensure that there is a sufficient range of provision locally to meet current and future need
- Enable people with a learning disability and/or autism to live close to family and friends unless they choose not to
- Ensure that people have the security of tenancy in line with 'Real Tenancy Test'.
- Offer people the opportunity to live alone if they prefer and this is suitable. If it is not their preference to live alone, there should be an option to live with a small number of people in a setting that has a domestic feel.
- Ensure that the impact of environmental factors is considered

Figures 3.5 shows trends in number of commissioned services of learning disabilities, volume of individual clients supported, and mean cost per client (representing the level of care package acuity) for the previous two financial years to February 2024.

Figure 3.5



There has been an increase in volume of commissioned services and total number of clients reported since April 2023 (6.9% and 7.1% respectively) but care package acuity represented by mean cost per client has remained relatively stable.

Figures 3.6 and 3.7 (overleaf) show the predicted demographic growth trend in residents with learning disabilities and moderate/severe learning disabilities between 2023 and 2040 respectively. Overall numbers of residents with learning disabilities are due to grow by 4% in the next five years. Numbers of those with moderate or severe learning disabilities are due to grow by 4.1%.

3. Assessment of Need

Learning Disability & Autism

Figure 3.6

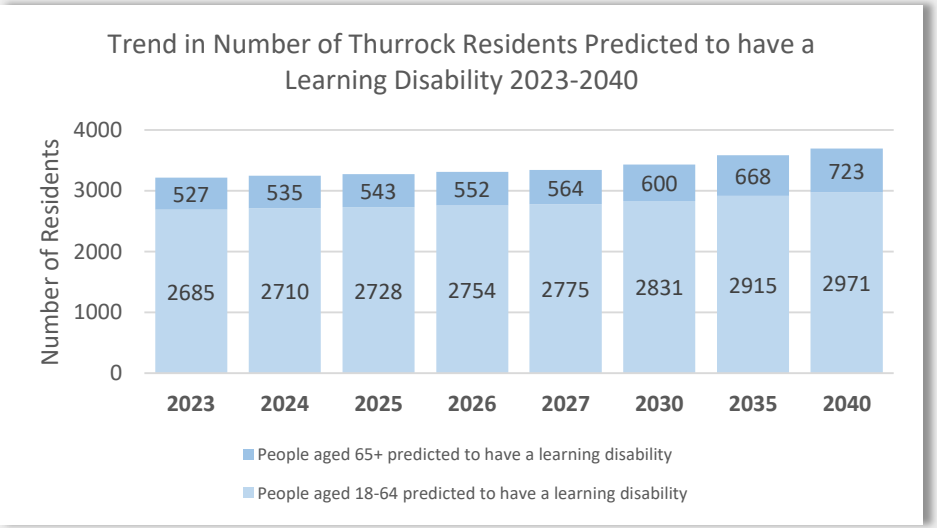


Figure 3.7

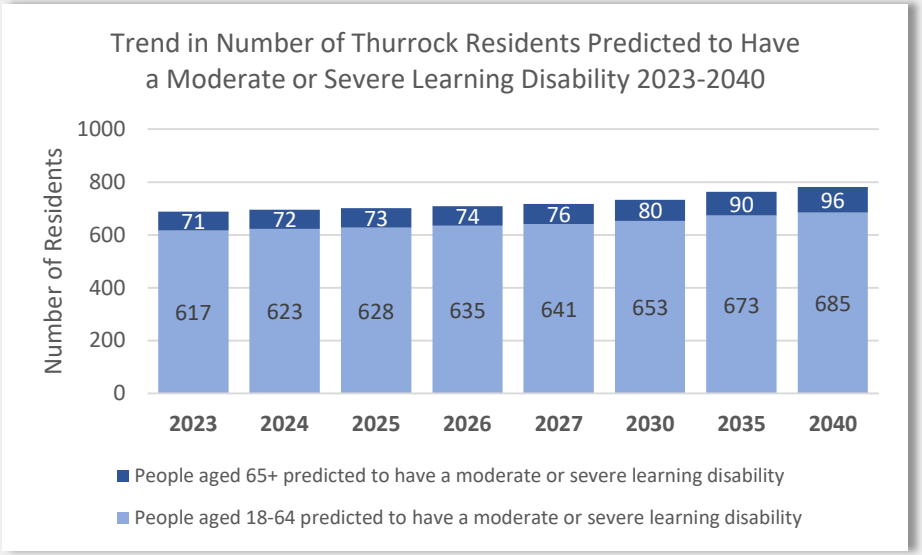


Figure 3.8 shows the predicted trend in number of residents with Learning Disability who live or don't live with a parent. Only just over 8% of residents lived with a parent in 2023. The proportion is predicted to decrease very slightly over time.

Figure 3.8

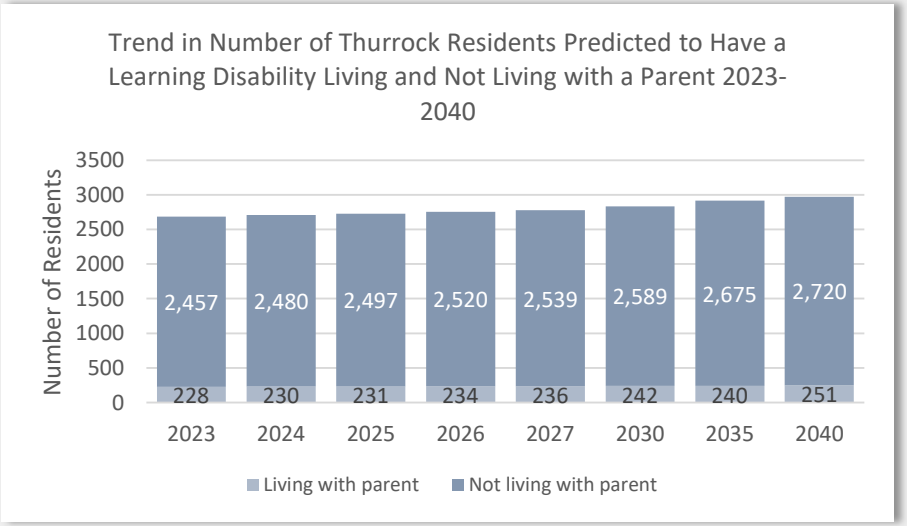
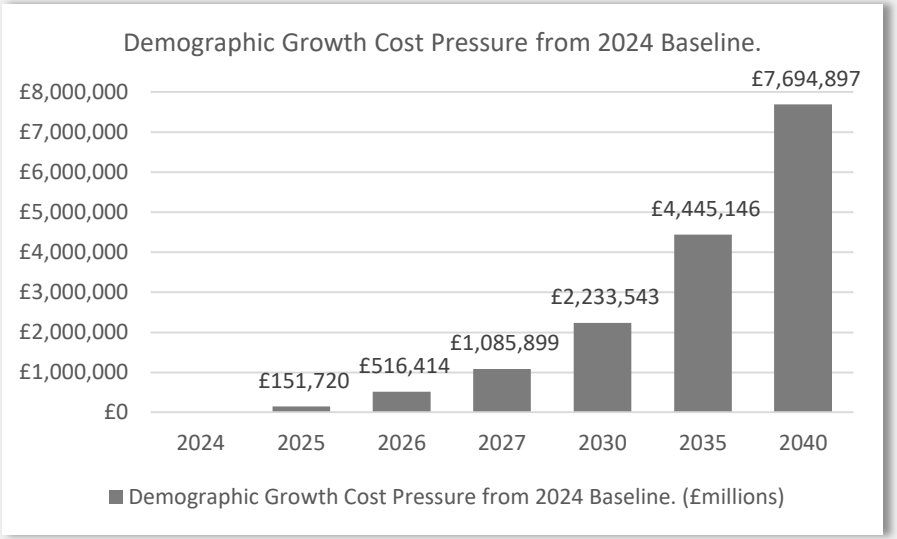


Figure 3.9 shows the predicted growth pressure on Learning Disability commissioning budgets from demographic growth compared to the April 2024 placement commitment.

Figure 3.9



3. Assessment of Need: Learning Disabilities / Mental Health

A further £1.086M demographic growth pressure on Learning Disability Commissioning budgets is predicted by 2027. This does not allow for inflation and assumes all models of care remain in their current configuration.

The analyses presented in figures 3.6 to 3.9 are based on national population projections but do not take account of local context. Thurrock has two specialist schools located within the borough. Thurrock's 2018 Special Educational Needs and Disabilities Joint Strategic Needs Assessment evidenced that Thurrock had a higher proportion of pupils with learning disabilities within its primary, secondary and special schools than national and statistical neighbour comparators. It also highlighted a rise in the number of disabled children with complex needs and/or life limiting conditions locally. These disabled children are likely to require support throughout their lives. As such, Thurrock's current higher than average prevalence of people with learning disabilities and/or autism is likely to be explained in part by the presence of specialist school provision and may increase further with the planned expansion of one of our specialist schools. This could have a significant impact on the amount and type of provision that will be needed in the future, particularly in terms of provision that can respond to complexity.

3.3 Mental Ill Health

Mental health is *'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.*

Mental ill-health is not seen across the population uniformly. Certain population groups are at higher risk of developing a mental health condition. These populations include residents who are on low incomes; those who are not in stable accommodation or employment; carers; black and minority ethnic populations; and those who are lesbian, gay, bisexual or transgender. In addition, the access and experience of support can also vary for these individuals when they do enter services.

Socio-economic factors such as poor housing and poverty, discrimination, traumatic experiences such as neglect, or abuse can have a detrimental effect on our physical and mental health. There is a correlation between deprivation and premature mortality rates for people with SMI (Severe/serious Mental Impairment), and people with SMI are more likely to have one or more long term physical health conditions. Thurrock has a statistically significantly higher rate of premature mortality compared to England.

Nationally, people with a SMI have a life expectancy of up to 20 years less than the general population. This disparity is linked to physical health problems and research suggests that those with physical long-term health conditions that are co-morbid with mental ill health experience poorer outcomes and consume more health services than those not diagnosed with a mental health problem.[3] Loneliness and a lack of social interaction are also risk factors and can increase the risk of premature mortality by 30%. Drug and alcohol misuse are also common in people with mental illness. "Research shows that mental health problems are experienced by the majority of drug (75%) and alcohol (85%) users in community substance misuse services".[4]

However, just as there are risk factors, there are equally protective factors that must be integral to future service design and delivery. For example, stable housing in a safe area is an important part of the recovery pathway, as is stable employment. The ability to live in and belong in a neighbourhood that enables people to create good social networks and have access to healthy foods and activities are essential if we are going to address the inequalities in mortality. Services that collaborate to meet the needs of people with co-occurring mental health and alcohol/drug use conditions rather than excluding people from accessing the help they need are also integral.

For those people who require an accommodation-based service, NICE recommends that commissioners ensure the following:

- Provide support appropriate to the person's mental and physical health needs
- Promote stability and avoid unnecessary moves
- Be in a familiar place close to the person's social and cultural networks if this is clinically appropriate
- Include support with tasks such as managing money and everyday living while encouraging independence and participation in society
- Give the person the option (if they are eligible) to have a personal budget or direct payment so they can choose and control their social care and support
- Give the person a safe place that feels like their own
- Recognise and safeguard individual vulnerability, risk, loneliness, and exploitation.

In England poor mental health equates to approximately 550,00 adults with a SMI such as schizophrenia or bipolar disorder, and one in six adults reporting a common mental health disorder (CMHD), such as depression, obsessive compulsive disorder and anxiety. People with SMI live with psychological problems that are often so debilitating that it severely impacts their ability to engage in functional and occupational activities.

Impact of Demographic Growth

Figures 3.10 and 3.11 (overleaf) show trend in predicted numbers of Thurrock Residents with a Common Mental Health Disorder, and personality or psychotic disorders respectively. Predictions are based on population growth alone and do not take account of changes in local context.

Prevalence of CMHDs, personality disorders, and psychotic disorders is predicted to rise in line with population growth that will place further demand on services unless this demand can be addressed through effective prevention and early intervention.

3. Assessment of Need: Learning Disabilities and Mental Health

Figure 3.10

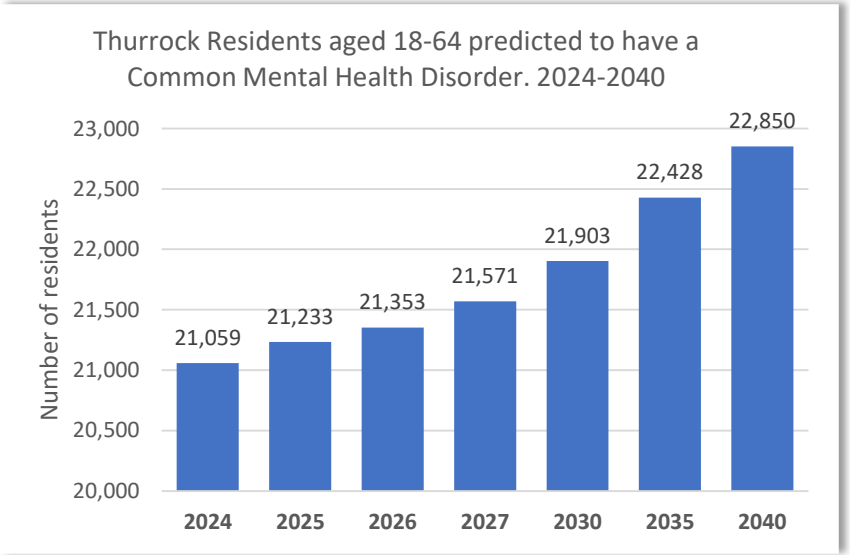
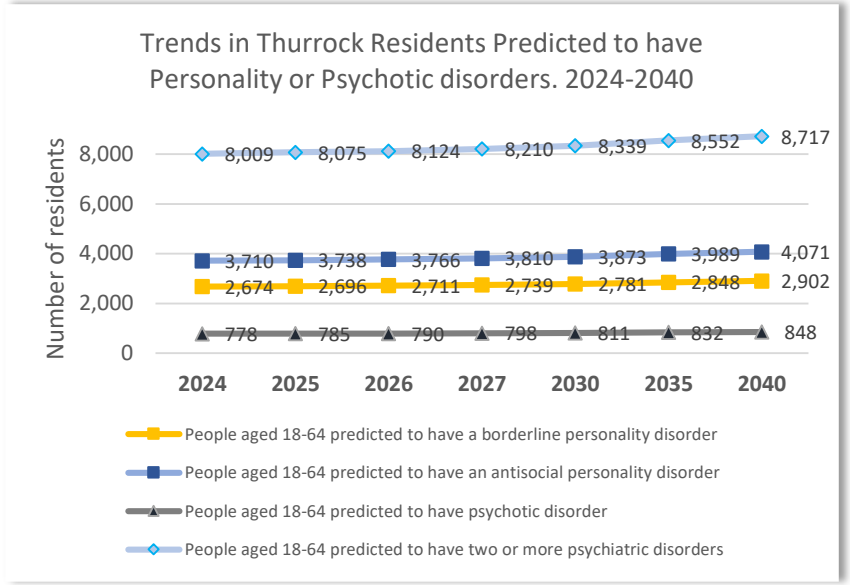
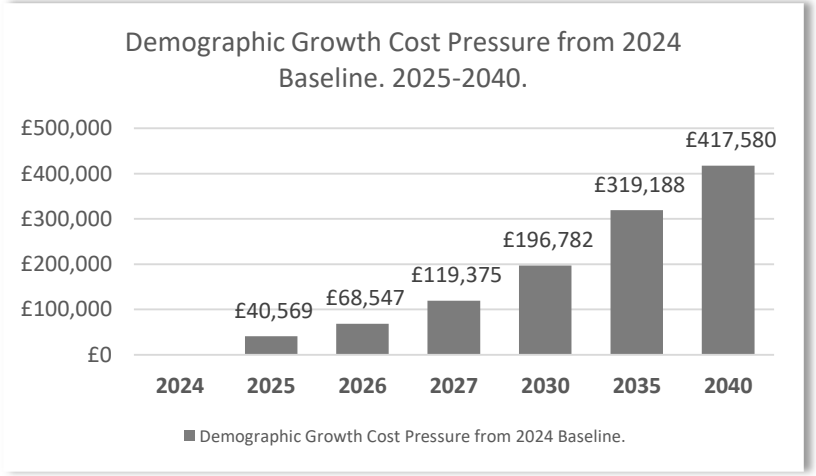


Figure 3.11



Demographic growth is predicted to create a further circa £200K cost pressure to mental health placement budgets by 2030 (figure 3.11).

Figure 3.11



Impact of Declining Population Mental Health

However, the demand pressures through demographic growth are likely to significantly underestimate the true level of demand increases for mental health services in Thurrock. Population mental health has declined as a result of the COVID-19 pandemic.

Prior to the COVID-19 pandemic, during the period July 2019 to March 2020, the Office for National Statistics (ONS) reports that the prevalence of 'moderate or severe depressive symptoms' was 10%. This rose to 21% during the pandemic. Despite prevalence falling to 17% at August 2021, this remains a significant increase in a relatively short period of time.

It is estimated that 17.3% of people aged 16+ in Thurrock have a CMHD, which equates to 23,234 individuals. (source: APMS and ONS Mid-Year Estimates). The Thurrock population is increasing annually, at an approximate rate of 1.0% per year. If there were no other change to prevalence of common mental health conditions or SMI, this alone could equate to an additional 1,030 adults with a common mental health disorder in the next five years and an additional 65 with a SMI.

Figures 3.12 and 3.13 show growth in prevalence in depression and serious mental ill-health as derived from the number of Thurrock patients on GP Practice Quality Outcomes Framework (QoF) registers from 2018/19 to 2022/23. These represent the cohorts who have been diagnosed and are being clinically managed through their GP practice and potentially other mental health services. They are likely to be an underrepresentation of the size of the population with mental ill health in Thurrock as not all residents seek support from their GP practice.

Figure 3.12

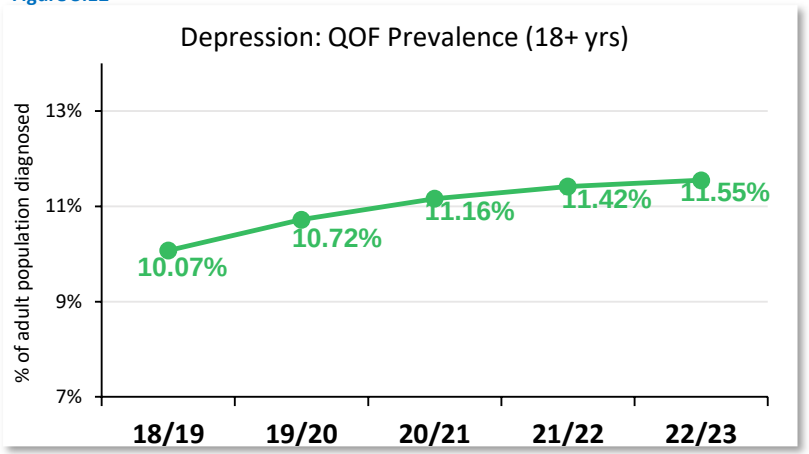
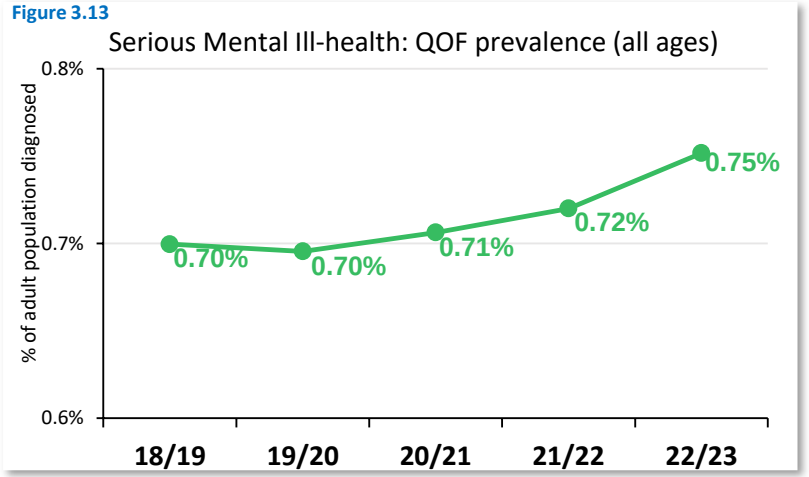


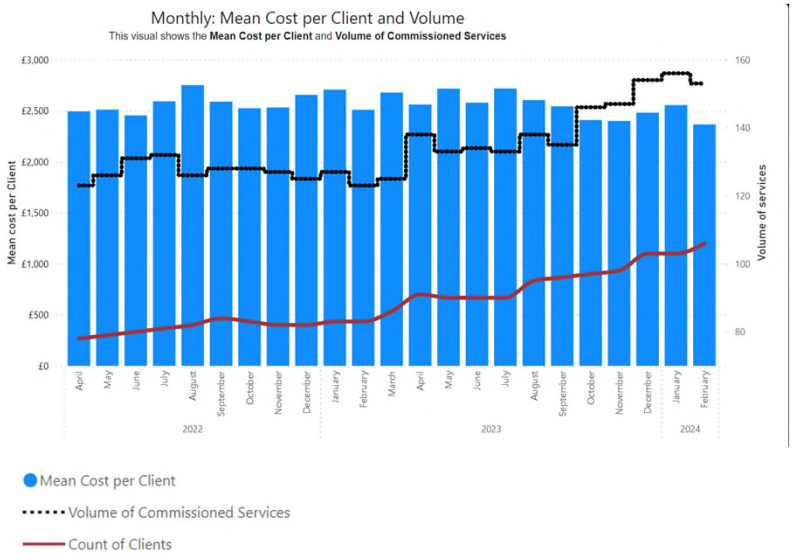
Figure 3.13



3. Assessment of Need: Mental Health / PD & Sensory Impairment

Declining population mental health is manifesting in increasing demand pressures on local services. Demand has risen significantly in Thurrock over the past two years in line with national trends Figure 3.14 shows an upward trend in volume of clients supported and volume of commissioned services. The number of unique individuals supported by ASC has risen by 39.5% from 76 in April 2022 to 106 by February 2024. Overall spend has been mitigated somewhat by a falling cost per client since May 2023 suggesting that the new approach to integrated care implemented in 2023/24 may be having a positive impact on preventing residents with mental health issues from deteriorating and requiring care packages of a higher level of acuity.

Figure 3.14



Anecdotally, both the Essex NHS Foundation Partnership Trust (EPUT) and the Adult Mental Health Social Work Team report an increase in acuity and complexity of new individuals presenting to mental health services for the first time. Trauma is a consistent contributory factor with presentations, which is reflected in the Survey of Mental Health and Wellbeing in England; 4.4% of respondents confirmed experiencing PTSD compared to 0.7% who had experienced a psychotic disorder.

3.4 Physical Disabilities and Sensory Impairment.

The term physical disability is generally understood as the limitations on a person's physical functioning, mobility, dexterity or stamina. Other physical disabilities include impairments which limit aspects of daily living, such as respiratory disorders, visual impairment, hearing impairment and epilepsy. Under the Equality Act 2010, to be considered as physically disabled, a person's physical condition will have a substantial and long-term effect on their ability to carry out normal daily activities. The social model of disability makes the distinction between impairment and disability and considers that disability is caused by the way society is organised, rather than a result of a person's impairment. The focus of this approach is to remove barriers that restrict life choices and disable people, with the aim to improve life experiences of people with impairment.

Figure 3.15 shows the predicted growth in the Thurrock population with serious and moderate physical disabilities and sensory impairment over the five years to 2027 and then to 2030, 2035, and 2040 due to demographic growth

Figure 3.15

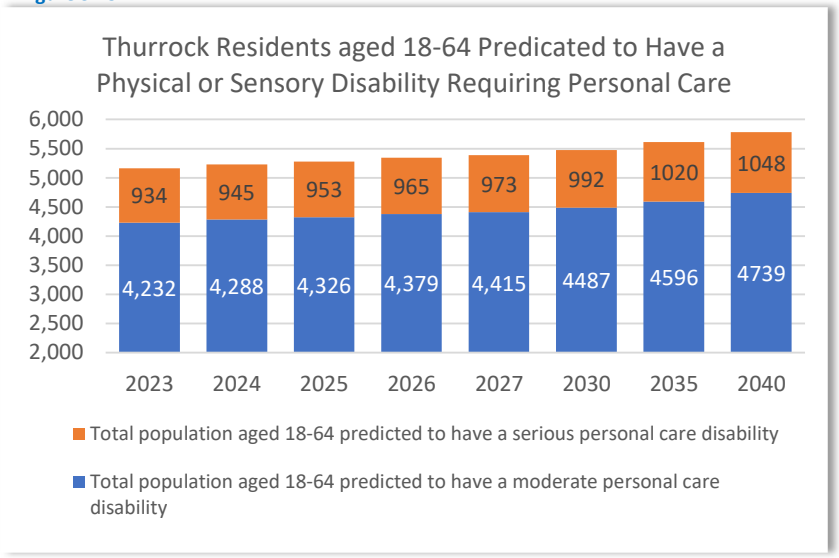


Figure 3.16 shows the impact of this demographic pressure on cost. Budget growth due to demographic pressures are predicted to increase 3% from 2024 baseline in the next three years.

Figure 3.16

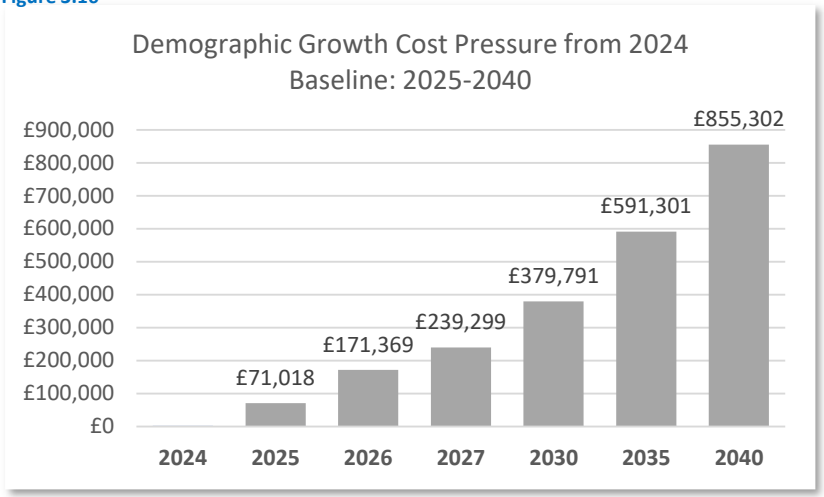
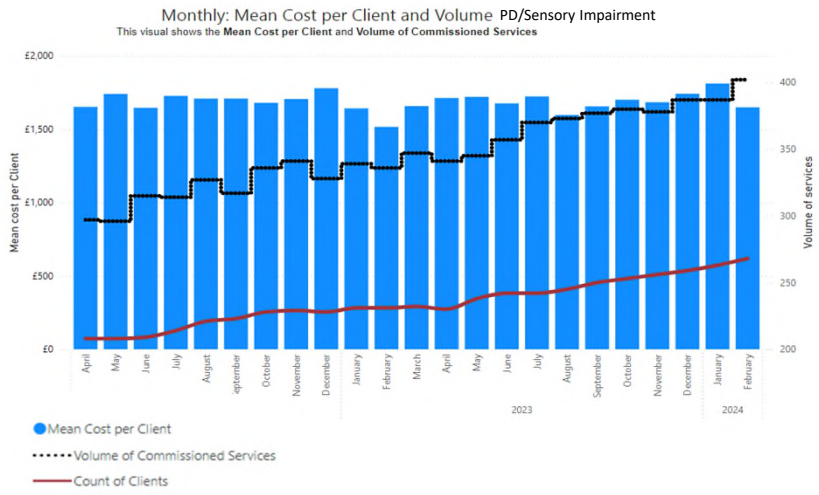


Figure 3.17 (overleaf) shows trend in volume of individual clients supported, volume in commissioned services, and cost per individual client (acuity of care package) over the last two years to February 2024. Volume of commissioned services and volume of individual clients supported have both risen significantly from April 2022 baselines: (35.3% and 28.8% respectively). The associated costs have been partly mitigated by a falling trend in cost per client.

The ICB through the Alliance team is focusing on driving up the numbers on LD/SMI health checks in 2024/25 to meet national targets, and developing quality markers with primary care and CVFSE partners to be implemented in 2025/26 to increase the number of PWLD who have a health care plan in Thurrock.

3. Assessment of Need: PD & Sensory / Older People

Figure 3.17



3.5 Older People

For the purposes of this strategy, older people are defined the population aged 65+. The majority of spend on older people is related to providing care and support needs as a result of advancing frailty and decline in physical functioning. Care is provided by in residents' homes and in residential settings including supported living, residential care, and nursing care.

Figure 3.18 shows predicted trend in older people's population growth across different age bands between 2024 and 2040. The population aged 65+ in Thurrock is predicted to increase by 12% by 2030 and by 34% by 2040 compared to 2024 baseline. The fastest growing age band is those aged 80-84. This is predicted to grow by 36.3% by 2030 and 39.4% by 2040.

Figure 3.19 shows predicted growth in the population of older people living in a residential care home with or without nursing care. Numbers of residential care home residents are predicted to grow by 35 (7.5% increase) by 2027 and 191 (43.3%) by 2040 compared to the 2023 baseline.

Figure 3.18

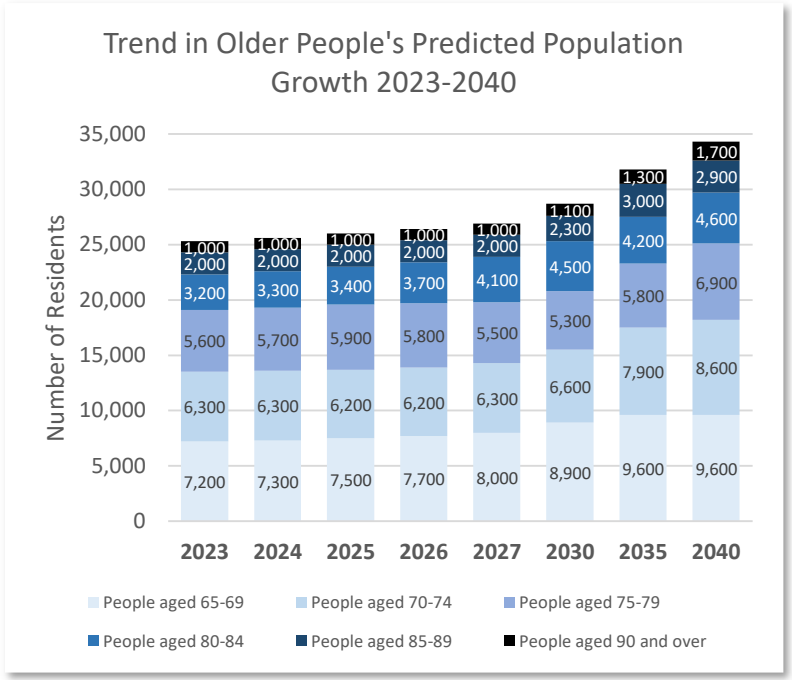


Figure 3.19

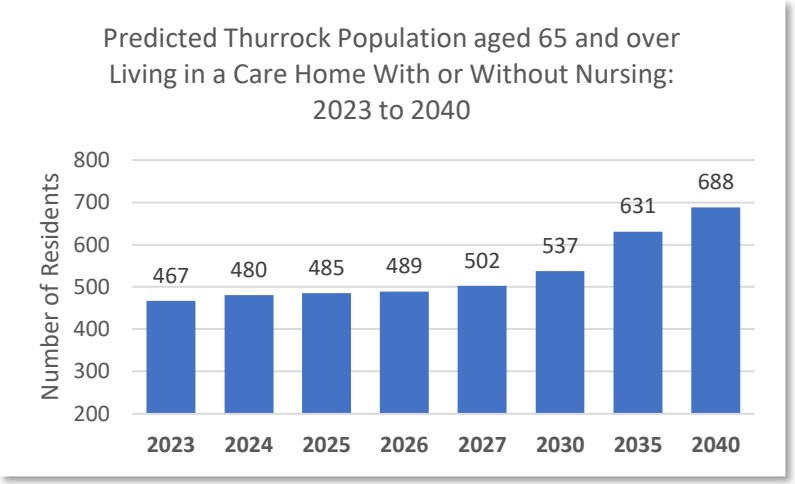


Figure 3.20 shows the predicted growth pressure on Older People's commissioning budgets from demographic growth compared to the April 2024 placement commitment. Population growth in older people is predicted to create almost £1.2M of additional cost by 2027 (an increase of 24.2%) compared to the 2024 baseline. However, this does not into account changes in other local factors.

Figure 3.20

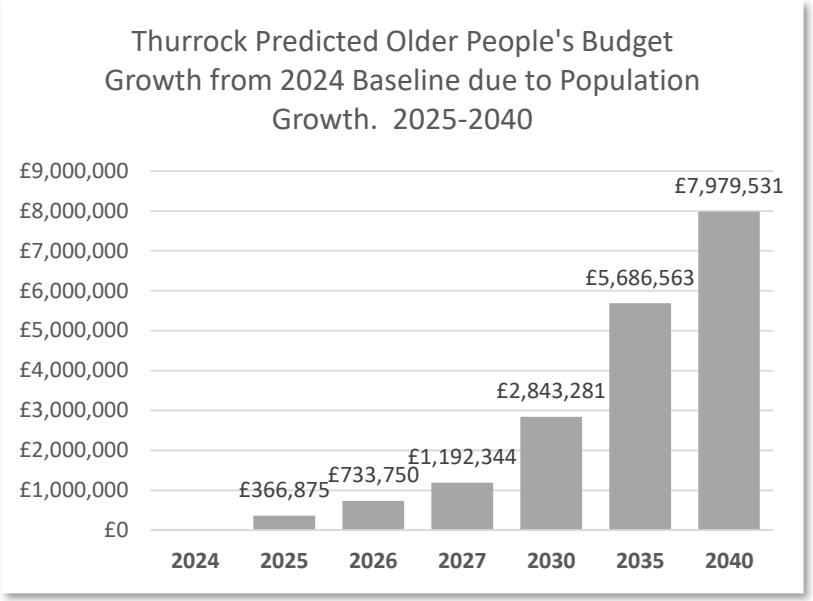


Figure 3.21 (overleaf) shows the actual growth in demand on Older People's placements from April 2022 to February 2024. There has been a month-by-month significant growth in volume of both numbers of older people requiring support and number of commissioned care packages. Volume of unique individuals has increased by 76% since April 2022 and volume in commissioned services has increased by 73.5%. Mean cost per client (a measure of care package acuity) has also increased slightly.

3. Assessment of Need: Older People

Figure 3.21

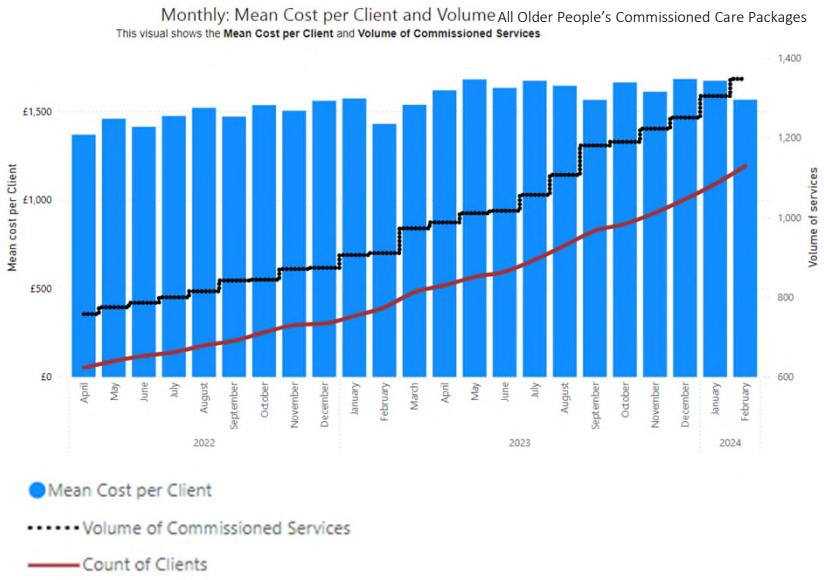
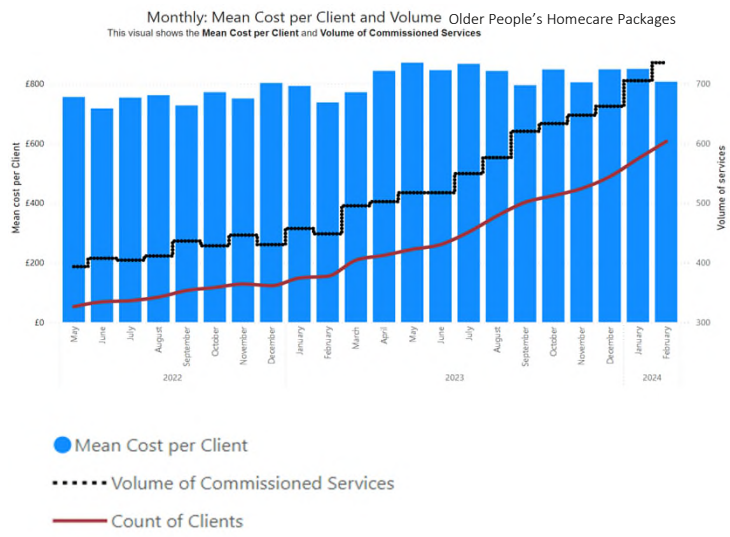


Figure 3.22

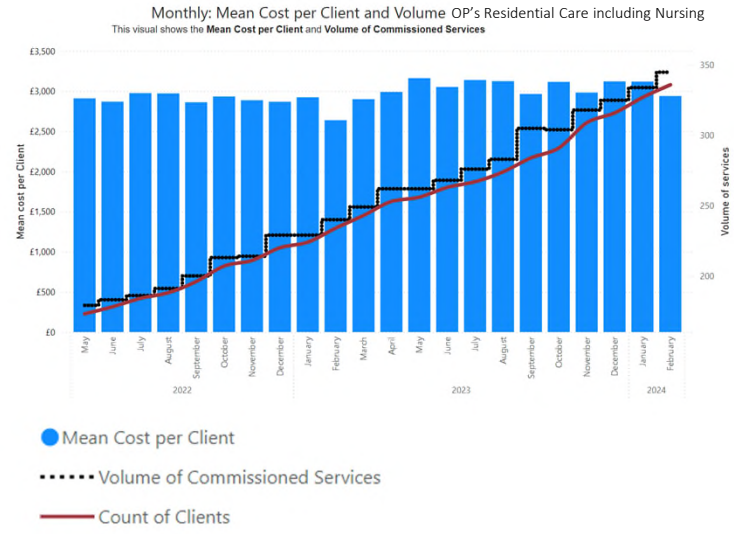


Primary care and out of hospital services are focusing on primary and secondary prevention, with the intention of reducing hospital admissions. Investment in new posts to improve care co-ordination functions and to avoid hospital admissions and to better manage discharge arrangements with the hospitals.

The main drivers of increased volume have been a change in hospital discharge criterion from 'medically fit' to 'medically optimised' and the ongoing impact of COVID-19 lockdown measures where the NHS paused a range of secondary prevention activity aimed at managing patients with existing health conditions in the community. The financial impact on council budgets to this increased volume has been at least in part mitigated in 2023/24 by additional funding provided through the hospital discharge grant.

This impact of increased demand caused by increases in volume can be seen both in demand for homecare (figure 3.22) and demand for residential & nursing care (figure 3.23). Monthly volume of homecare packages increased by 342 between April 2022 and February 2024 (87% increase). Similarly, monthly volume of residential/nursing placements increased by 166 over the same time period (128% increase)

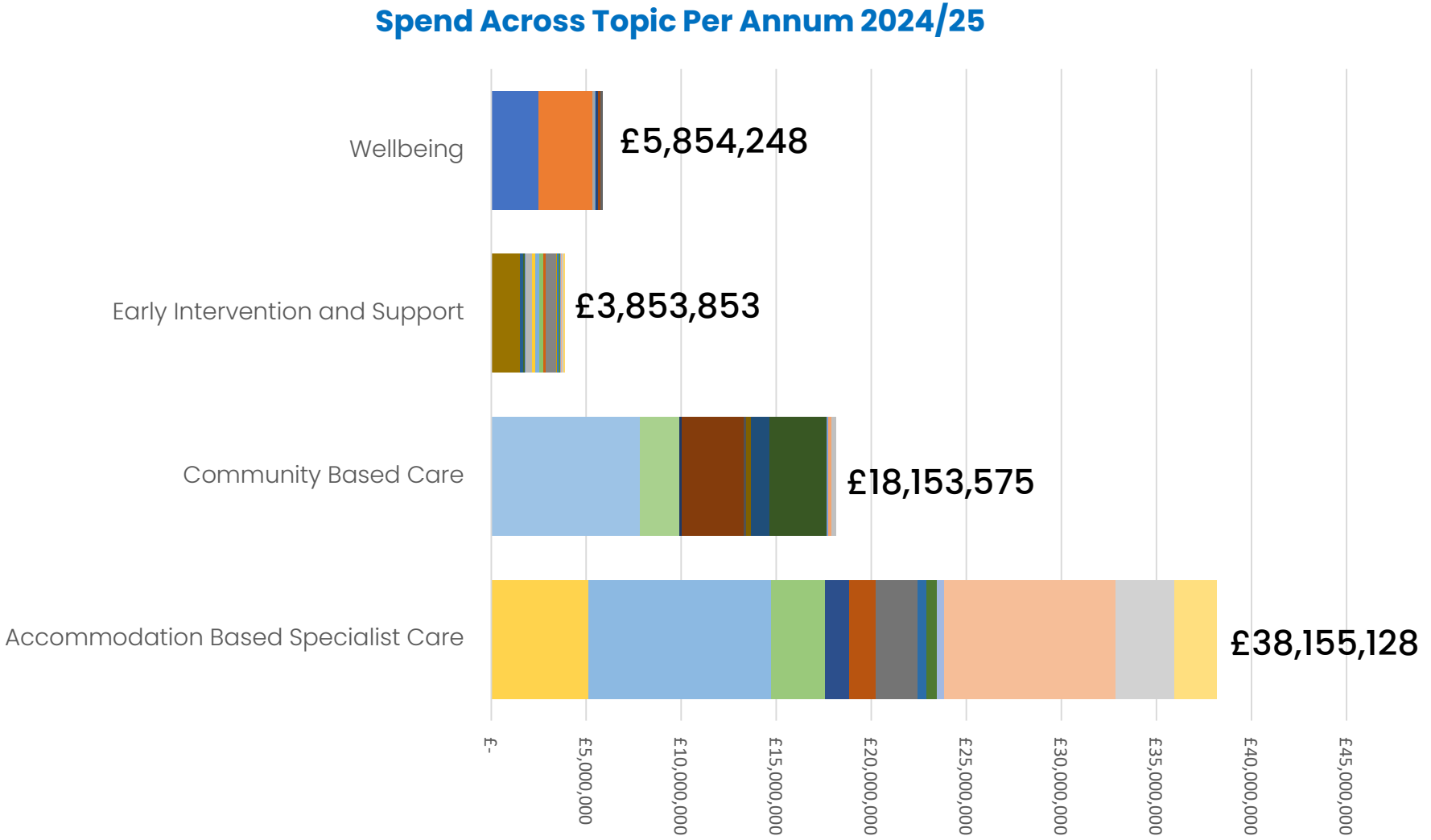
Figure 3.23



4. Spend across categories analysis

Figure 4.1 shows the total annual spend in 2024/25 on each of the four categories discussed in chapters 5 to 8. Each coloured section of each bar represents an individual contract, and a detailed breakdown of these contracts is given at the start of each chapter. These figures represent gross spend and do not account for income that the council receives including from residents who do not qualify for fully funded council care and pay towards the costs of their care.

Although the proportion of the population eligible and requiring each category of care decreases as we move down the categories, figure 4.1 demonstrates that the total spend on Accommodation-Based Specialist Care is the greatest, followed by Community-Based Care. This reflects the significant additional costs related to commissioning higher acuity care packages. It also highlights the importance of commissioning models of care that prevent and delay the need for these higher acuity care interventions.



5. Wellbeing

5.1 Introduction

This chapter discusses the commissioning of Thurrock's wellbeing offer. Wellbeing services are universal services aimed at entire population cohorts including those without specific care and support needs with a view to enhancing their health and wellbeing and preventing health and care problems from manifesting. Activity delivered by these services is also referred to as primary prevention.

5.2 Commissioned Spend on Wellbeing

Commissioning of wellbeing services include contracts primarily focused on lifestyle risk modification including the delivery of: addictions services, sexual health services, smoking cessation, weight management, motivational interviewing, and NHS health checks. These are all funded from the Public Health Grant. In addition, the council's general fund commissions Healthwatch Thurrock to act as the resident's voice for health and care services in Thurrock, and there is a small software contract that supports the library loans system through the internet.

The total value of all contracts currently in place is £28,562,400 although this is spread over contracts of differing length from one to seven years. Figure 5.1 shows the total value of all contracts across different spend categories of wellbeing services and figure 5.2 shows the mean annual spend per category (by dividing the total contract value by the contract length in years). The ICB contributes £225k per year from Health Inequalities funding to support wellbeing services in Thurrock.

Figure 5.1

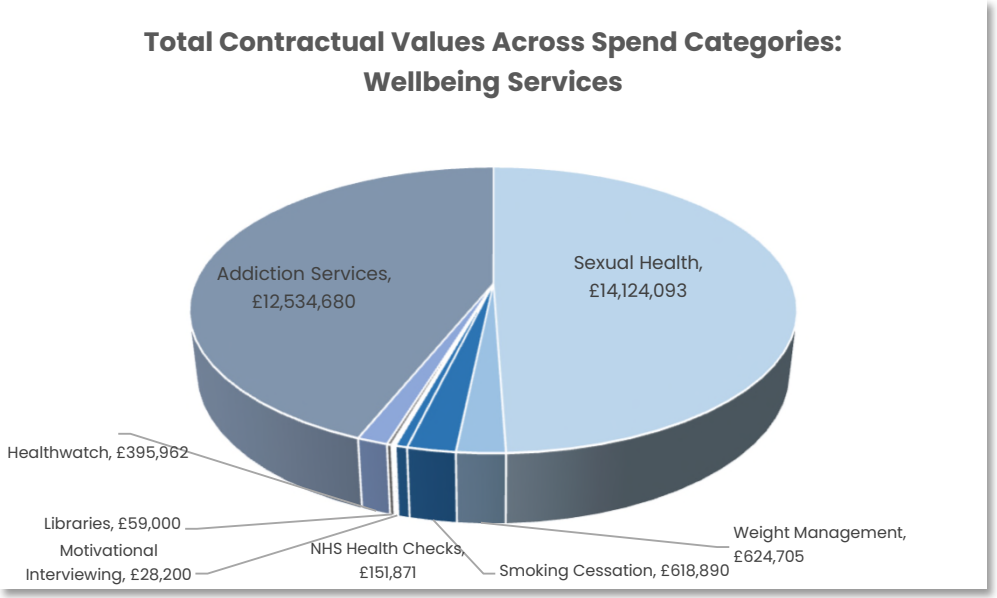
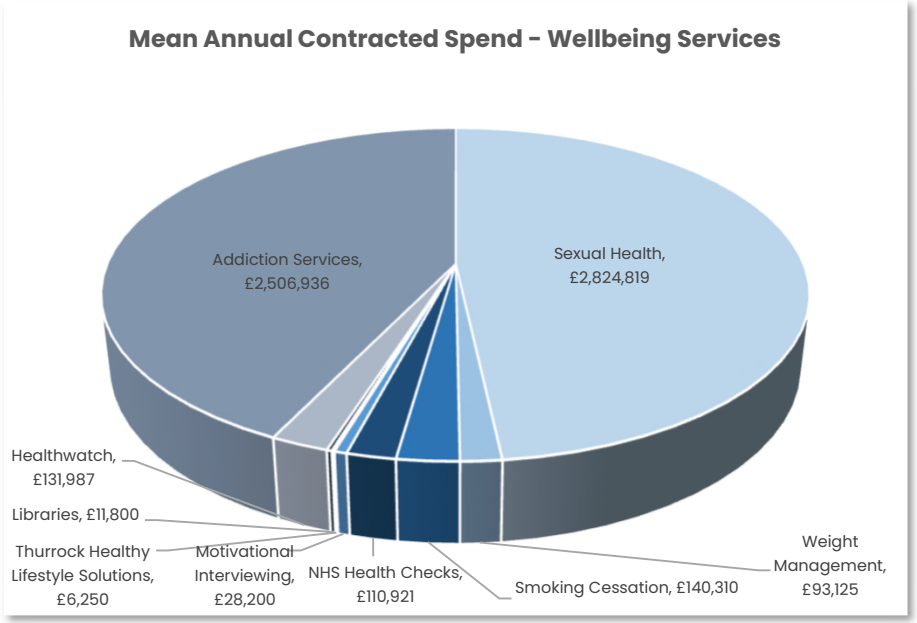


Figure 5.2



91.1% of mean annual spend on wellbeing services funds two key contracts delivering Addiction Services (42.8%) and Sexual Health (48.3%). Whilst spend on other risk modification services is relatively low in comparison, it is worth noting that elements of smoking cessation, NHS Health Checks, and Weight Management is delivered by an in-house Public Health Team – *Thurrock Healthy Lifestyle Services* not captured in the figures in Figures 5.1 and 5.2.

5.3 Sexual Health and Substance Misuse Providers

Contracts for the vast majority of spend on wellbeing: sexual health and addiction services were retendered in 2023/24 with new providers in place from April 2024. At time of writing of this strategy both providers are in the initial mobilisation phase of their contracts.

Thurrock's Integrated Sexual Health Service, delivered by Brook, was chosen as it offers bespoke solutions that cater to individual strengths and needs. The service prioritises non-judgmental and confidential services, providing open access with extended hours and accessible locations. By empowering staff to respond to human variation, the service can adapt to changing attitudes, sexual practices, and behaviours in the community. This approach has already shown its willingness to be part of the community, working towards a comprehensive service that decreases barriers to access.

5. Wellbeing

Thurrock chose the provider for substance misuse services based on their ability to deliver flexible and adaptive services. The provider's commitment to continuous process of learning and adaptation allows for interventions to be tweaked depending on circumstances, recognizing that what works today may not work in the future. By collaborating with other service providers, the provider can shape chaotic human systems through emotionally intelligent engagement, increasing visibility, and building relationships. This approach prioritises co-production around service users' voices, needs, goals, and outcomes, allowing for long-term goals and visions to be achieved.

Both contracts require the providers to work with residents to co-produce their service models with residents and to demonstrate continuous learning throughout the lifecycle of the contract and adaption in response to this, again reflecting Human Learning System commissioning principles.

5.4 Addressing Other Behavioural Risk Factors

Thurrock Healthy Lifestyle Services (THLS) provide Thurrock residents with the opportunity to improve their health and reduce their risk of disease and ill-health, through access to assessment for cardiovascular disease risk (NHS health check programme) and lifestyle modification interventions (smoking cessation, referral and triage into weight management and exercise programmes). THLS provision is aligned to each of the Integrated Locality/Neighbourhood Teams, working alongside services and agencies to embed prevention of ill-health into their referral pathways. In addition, THLS provides training and support to aligned PCNs and primary care colleagues to increase capacity in delivering lifestyle interventions.

The Director of Public Health is currently leading a review of the healthy lifestyle services available to Thurrock residents with a view to developing a more integrated and holistic approach to addressing behavioural issues that impact on people's health and wellbeing such as smoking, diet and nutrition, alcohol, physical activity, stress and anxiety. The current arrangements for delivery of NHS Health Checks, stop smoking support, weight management and exercise referral programmes will form part of the review.

6. Early Intervention and Support

6.1 Introduction

This chapter discusses commissioning of services that provide early intervention and support. Such services are aimed at residents who may have lower-level health, care and support needs. They aim to provide information, advice, and guidance or other interventions that maximise independence and prevent and delay the need for longer term or permanent care solutions. The category includes sheltered accommodation and refuges and secondary preventative activity aimed at those with existing long-term health conditions. Collectively, the commissioning offer aims to prevent residents' health, wellbeing, and independence deteriorating to the point where they require more expensive statutory provision such as homecare, supported living, or residential and nursing care. Interventions of this type are often also known as secondary prevention.

5.2 Commissioned Spend on Early Intervention and Support

Thurrock's Early Intervention and Support commissioned offer includes a range of contracts that promote independence and wellbeing including floating support in the community, community equipment and adaptions including telecare, occupational therapy, refuges, information advice and guidance services for carers and those with autism, and advocacy services. A cardio-vascular locally enhanced service for Primary Care Networks incentivises GP practices to find and treat residents with a range of cardio-vascular conditions through integrated long-term conditions management clinics with a view to preventing serious adverse cardio-vascular events like strokes and heart attacks and has delivered the best CVD outcomes in England.

The total value of all contracts currently in place is £13,350,076 although this is spread over contracts of differing length from one to seven years. Figure 6.1 shows total value of all contracts across different spend categories of Early Intervention and Support services and figure 6.2 shows the mean annual spend per category (by dividing the total contract value by the contract length in years). The council spends just over £3.5M per annum on Early Intervention and Support contracts. The largest annual spend category is for community equipment and adaptions including assistive technology, accounting for 43.1% of annual spend.t

In addition, the council provides a further £341,167 per year in direct grants to organisations for Early Intervention and Support programmes. These are shown in Figure 6.3 overleaf. These largely run only to March 2025 and are either being reprocured as contracts or will need to be in 2024/25.

Figure 6.1

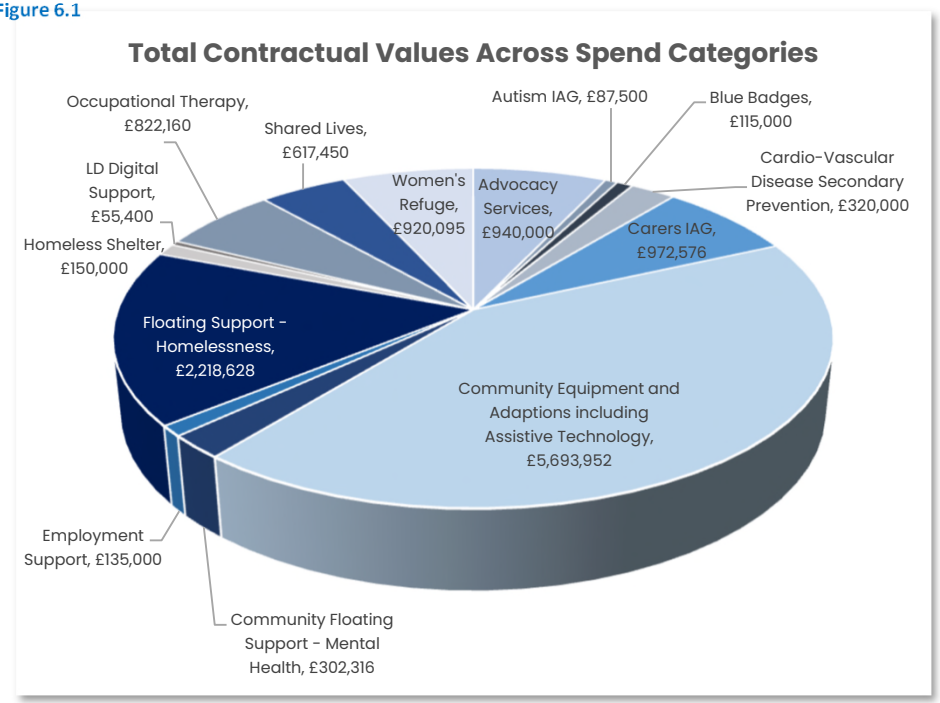
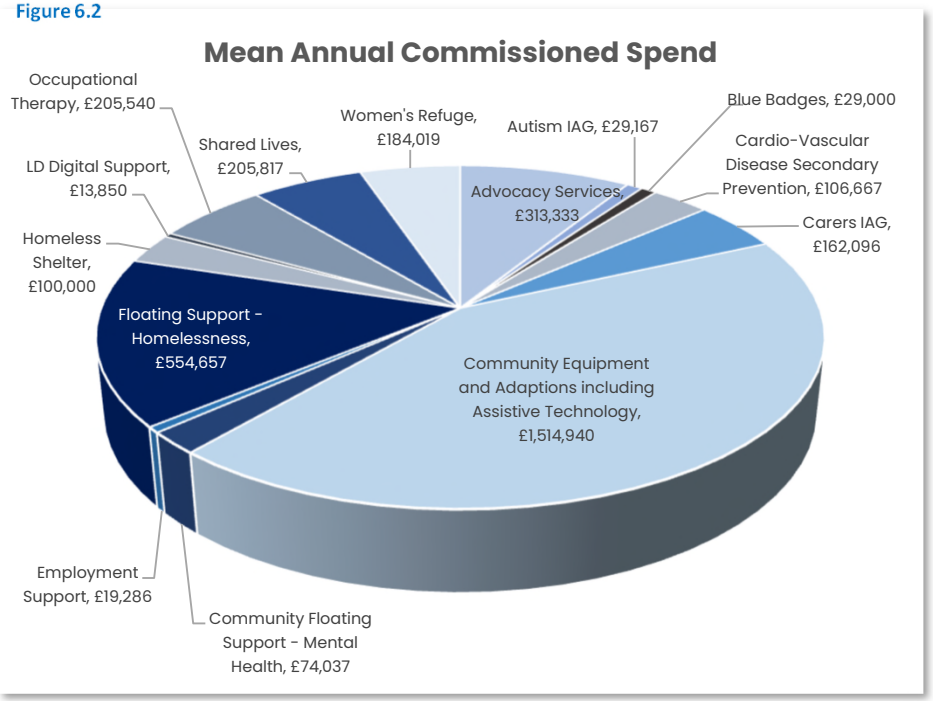
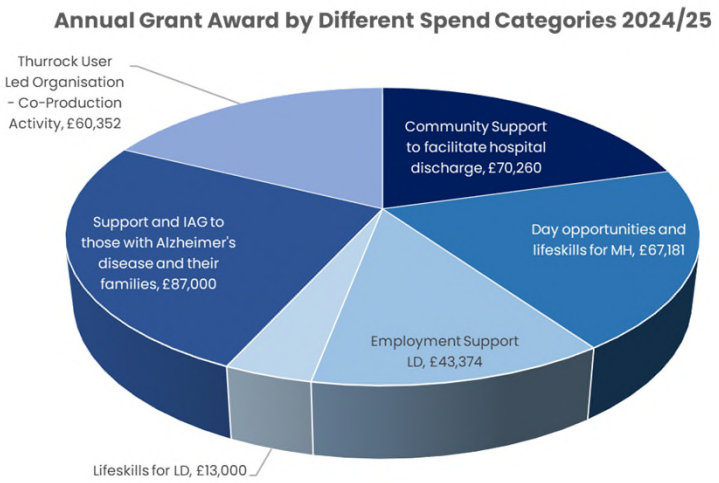


Figure 6.2



6. Early Intervention and Support

Figure 6.3



6.3 Reshaping the Care Market: Early Intervention and Support

The council adopted a preventative approach in relation to adult social care several years ago, shifting away from a deficit-based view of individuals requiring care and support. This is reflected within the assessments we currently carry out; these are based on strengths as well as needs, with a focus on what individual deem a "good life" would be for them. In this way co-production informs every aspect of our approach, with care planning being a truly collaborative process, devolving power away from credentialled individuals and firmly towards those who require us to assist in agreeing positive solutions.

Since social work teams have been based in the community, there has been a greater focus on individuals being able to access information and advice as early as possible, towards solutions that avoid the need of formal care and support.

The spend benchmarking data presented in Chapter 3 demonstrates that the success of our focus on prevention and early intervention with Thurrock being in the lowest quartiles for overall spend, and for for all categories relating to rate of statutory placement uptake, yet quality remains high. This achievement is especially impressive when reflecting on the comparatively high proportion of Thurrock's residents who qualify for council funded care on account of their low income and wealth levels.

In terms of adult commissioning, there are specific areas linked to preventing, reducing, and delaying the need for care and support:

6.4 Assistive Technology and Technology Enabled Care

The current programme focuses on prevention of hospital admissions and the enabling and support of independent living through the sourcing and purchasing of a multitude of devices. These include: motion sensors; bed and chair sensors; ambient heat monitors; medicine dispensers; night lights triggered by motion; smoke, gas, and flood sensors; watches that provide multiple prompts a day, wrist-worn epilepsy sensors, door exit sensors, as well as pendant alarms available in a variety of designs.

Commissioning activity includes the provision of devices to ensure that Thurrock residents can remain in their own homes for as long as possible by mitigating the risk within the home.

As such, assistive technology and TEC can and is used creatively as an attractive and cost-effective solution to often far more restrictive and expensive alternatives.

Residents access a broad range of TEC solutions from a variety of support sources including practitioners from Careline, the Council's Alarm Receiving Centre (ARC), social care practitioners, and prescribers outside Adult Social Care such as Occupational Therapists, Nurses, and Housing Officers. All provision is dependent on eligibility criteria being satisfied.

Many of the devices are monitored remotely through an Alarm Receiving Centre (ARC) currently run by the council. There are just under 3,000 residents who have equipment requiring monitoring.

The council has recently made the decision to charge for the monitoring of devices requiring this services. Devices themselves are free of charge under £1,000 as they are seen as a preventative measure. The review of those in receipt of a monitoring service currently underway will enable commissioners to understand how effective the current strategy is and the impact of charging, and if necessary, alternative solutions will be considered.

With the digital switchover of national telephone landlines planned for 2025, many existing pieces of equipment will become obsolete meaning that alternatives will need to be and are being considered. The Technology Enabled Care Group currently in place will lead procurement of a new digitally compatible solution in 2024.

Further expanding Technology Enabled Care may offer additional potential to leverage prevention and deliver savings. As such, a detailed Assistive Technology Commissioning workplan will be developed in 2024/25 to accompany this strategy, setting out detailed commissioning plans for the next three years.

6. Early Intervention and Support

6.5 Occupational Therapy and Community Equipment.

Occupational Therapy is a key part of our approach to 'Prevent, Reduce and Delay' the need for health and care – aiming to keep people independent and well for longer, and helping to maintain effective use of available resource.

In 2023/24 wating times for Occupational Therapy Assessments deteriorated to up to six months as a result of significant increases in demand and Thurrock benchmarked poorly compared to regional comparators. The council used part of its Market Sustainability Fund to expansion of Occupational Therapy (OT) and blue badge assessments through increased capacity (via the contracting of an external provider to undertake assessments). This provided increased system capacity to address peaks of demand. As such waiting times for an assessment have been reduced significantly.

The service has also been expanded to deal with Housing OT requirements and to address increased market complexity to reduce reliance on double handed care provision due to skill shortages in the labour market and increased demand in the two service areas.

Thurrock is part of an integrated Essex-wide consortium across Health and Care to provide occupational therapy equipment that:

- Enables and supports people to live, age and die well.
- Provides the right solution, at the right time, in the right place, the first time.

The Consortium is made up of the Council, Essex County Council and local NHS Partners who work together under partnership arrangements set up pursuant to Section 75 of the National Health Service Act 2006 and Section 101 of the Local Government Act 1972 Sections (as applicable to the relevant Partner) to provide community equipment services to Essex residents in the administrative areas of the Consortium who are eligible for such community equipment.

This enables increased purchasing power and uniform approaches to system wide charges (such as MRHA or LOLER guidance) that improves customer experience and speeds up hospital discharge and preventative works.

6.6 Home Adaptions

The Occupational Therapy service reviewed the Disabled Facilities Grant (DFG) service in 2016 and has since hosted the DFG service. The service has adopted an integrated service approach that enables speed of access to the DFG for Thurrock residents requiring home adaptions. In addition to providing a timelier assessment and support compared to that prior to the review, the DFG service has also adopted a self-service approach for DFG applicants that enable greater choice and control in identifying end outcome of home adaptations, the contractor or builder they would like to undertake the works, and when they are progressed. The approach was recognised by Housing LIN and published to advocate strengths-based approach to delivering DFG services. A strengths-based approach to delivering the Disabled Facilities Grant – Thurrock Council - Resource Library - Resources - Housing LIN). Adaptions for council owned properties held in the Housing Revenue Account are undertaken through a dedicated commissioned contract that is due to expire in November 2024. Moving forward, this service will be commissioned through a new Housing Assets Partnership model currently being procured by housing colleagues.

6.7 Unpaid Carers

A carer is a child, young person or adult who looks after a family member, partner or friend who needs their help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

In Thurrock, it is estimated that more than 20,000 people are carers and census data shows that we have a higher than regional and national average of carers providing more than 50 hours per week. Those carers providing the highest amount of care are twice as likely to be permanently sick or disabled as the general population.

In addition, the impact of caring on children and young people can be significant and have a lasting influence on their life chances and their physical and mental wellbeing.

The COVID-19 pandemic highlighted what was working well but also that some improvements were needed. One of the identified improvements was the need to improve the support to carers at the two main points of transition (young carers becoming an adult carer and support to parents whose children are transitioning to adult services).

To improve transitions, Adult and Children's social care agreed it would be prudent to develop for the first time an all-age carers strategy.

As so much had changed since the pandemic, we agreed to carry out a widescale engagement exercise to inform the strategy. Due to the low level of identification of adult and young carers (including self-identification of carers) and because we were committed to developing a strategy that was informed by all carers (not only those already known to services) we asked Healthwatch Thurrock to carry out the engagement on our behalf.

They were able to speak to hundreds of carers (all ages) known and unknown to social care by utilising a wide range of engagement techniques (video interviews, social media, school assemblies, diaries of people new to a caring role etc).

6. Early Intervention and Support

This exercise was so successful in capturing the voice of Thurrock carers that the Health and Wellbeing Board agreed to accept the evaluation report as the basis of our all-age 'strategy'. It was felt that the voice of Thurrock carers was so strong in this report that any attempt to formalise the findings into a traditional strategy would dilute its impact. As such, it was agreed that an action plan would be developed and that this in conjunction with the Healthwatch report would form the 'strategy' for carers in Thurrock.

As many of the improvements identified by carers related to improved working across partners, the 'strategy' was then expanded to be both a health and social care strategy in addition to all age.

Most actions in the plan have been agreed and the draft published for public comment. However, nearly all actions identified by young carers relate to schools and colleges and these are currently in progress due to the complexity of engaging with a large number of educational establishments.

https://www.thurrock.gov.uk/adult-care-strategies-and-plans/unpaid-carers-strategy

The actions that carers prioritised are an example of why a system stewardship approach, rather than tradition commissioning, is important to effect change. A more traditional commissioning process would not have considered, and influenced, various aspects that were import to carers.

These areas (further detail is available within the Strategy document) are:

- **Training** including developing an improved training offer; joined up working across organisations and improved contingency planning; increased identification of carers.
- **Transitions:** An all-age approach that includes a review of existing approach, promotion of better joined up working for parents and young carers; facilitating a peer support group for young carers who are/will be transitioning to adult services; a 'no wrong doors' approach to facilitate seamless support; a Memorandum of Understanding across Children's and Adult services.
- **Council-wide approach:** Unpaid Carers provide £132 billion of support (that would potentially have to be met for formal/paid services) to vulnerable people in the UK, an average of £19,336 per carer. In recognition of the value of unpaid carers but also the adverse impact a caring role can have, the council has recently agreed to incorporate young and adult carers into the CEIA process. This is significant as it means that the needs of carers will be considered by the Council when changing or developing any service or policy.

The commissioner as a system steward therefore ensures that the needs of carers are considered in how the council operates and not just social care.

The main reason that working age carers live in poverty is the barriers to work due to their caring responsibilities. Flexible 'carer friendly' employment practices are an important step to improve the outcomes of carers.

Adult Social Care has worked with colleagues in Human Resources to introduced carer friendly working policies and practice (including a carers passport). As a large local employer this will enable us to help our employees with caring responsibilities remain in employment.

Traditionally, we may have seen employment practices external to the council as sitting outside of a narrower commissioning focus. However, we recognise that improved employment practices in Thurrock could have a greater impact on the wellbeing and outcomes of carers than any service we could 'commission'. As such, our next step is to try to utilise the council's corporate links with local businesses. These links (and our umbrella membership with Carers UK - which smaller organisations can receive advice and support on employment practice through) should enable us to promote/support SMEs to offer more flexible 'carer friendly' employment practices. This is a further example of a shift in approach away from traditional commissioning that costs little but delivers significant impact and gain.

Nearly all the activity to support the improvements carers have identified have entailed little (traditional) commissioning. Instead, the system steward role has been one of navigation – working across multiple departments, organisations and systems to pull together resources, expertise and to raise the agenda wider and also ask 'how can you help?'

Moving forward, the council will tender for a formal carer support service in 2024, however, the specification for this will be designed with the lessons learned from the development of the carer's strategy firmly in mind.

The ICB Alliance team is in the process of commissioning a new carers intensive support service aimed at preventing carer breakdown and avoiding admission to hospital or care homes for either the carer or cared for person and reducing the need for costly community-based packages of care for the council.

6. Early Intervention and Support

6.8 Housing with Community Floating Support

The council commissions a range of housing/homelessness provision with community support for residents who can live largely independently but have additional needs that require lower-level community support. This includes a women's refuge, homelessness hostel, and *Housing First* scheme where residents with a level of complexity are offered a council house with additional floating support offer to help them maintain the tenancy.

In additional floating support for residents with mental ill health or learning disabilities is commissioned that aims to support this cohort maintain the necessary life and self-help skills to live well in the community. This service also provides in reach support to residents who reside at Scott House in Chafford Hundred and Balfour Court in Grays. This provision has been shown to be effective in both preventing more expensive statutory community or residential placements and avoiding hospital admissions, and in allowing residents who no-longer need supported living accommodation to live more independently in general needs housing.

There may be further opportunities to reduce statutory care placement demand and deliver a more effective and integrated provision. As such, the council will develop an integrated commissioning plan that sets out proposals for Housing for Vulnerable Residents and Floating Support in 2024/25 that will sit beneath this strategy.

6.9 Community Life Skills Development and Support

The council currently provides a series of relatively small grants to organisations that support residents with learning disabilities and / or mental health develop life skills within the community. This includes support for residents with learning disabilities find employment. There is an opportunity to combine the funding from these individual grants into single contracts that provide a more comprehensive offer. We will therefore procure new community employment support and life skill services for residents with learning disabilities and mental ill-health in 2024/25.

Further grants are currently provided to two organisations that offer befriending services for older people and support to residents and their families who have Alzheimer's disease. In 2024/25 we will reprocure both services via contracts.

6.9 Community Support to Facilitate Hospital Discharge

During the COVID-19 pandemic, the council piloted an approach to facilitate hospital discharge by commissioning the third sector in Thurrock to deliver the *By Your Side* initiative. The approach recognised that often relatively low-level practical obstacles relating to a patient's home delayed or prevented safe discharge from hospital and aimed to address these. Trained volunteers now undertake a variety of tasks to ensure that the home of the patient being discharged from hospital is ready and safe for example collecting home adaption equipment, cleaning the house and turning the heating on, and ensuring that there is appropriate bedding and food.

The volunteers also support the resident in the early stages of recouperation at home including making regular welfare calls, undertaking food shopping, dog walking, and signposting residents to other community support.

Evaluation of the scheme has shown significant benefit and has supported Thurrock's very low levels of delayed hospital discharges. We will therefore expand the scope of the scheme in 2024/25 with further funding from the Better Care Fund.

The ICB Alliance team has provided additional funding to expand the BYS service which now operates 7 days a week.

6.10 Detection and Management of Cardio-Vascular Disease and other Long-Term Conditions.

Thurrock has implemented a successful Population Health Management Programme aimed at improving the diagnosis and clinical management of cardio-vascular disease including hypertension, atrial fibrillation, coronary heart disease, heart failure, and stroke in the community since 2017. The original programme included a range of measures to diagnose these long-term conditions including blood pressure monitoring in primary care and the community, use of Alive-Corr technology to detect Atrial Fibrillation, a clinical audit of GP patient records to identify patients being prescribed medication to treat CVD but who were not on GP long-term condition (QoF) registers and embedding of depression screening into clinical care pathways.

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It also included a coordinated programme of support to GP practices to improve clinical management of CVD including a 'Stretched QoF' contract that incentivised GP practices to treat up to 100% of patients on their long-term condition disease registers, practice profile cards that benchmarked performance against peers on clinical management of long term conditions, and supportive practice visits and action planning to improve performance, led jointly by the Public Health Team and NHS commissioners.

As part of the *Better Care Together. The Case for Further Change* strategy refresh, the programme was further developed the capitalise on the opportunities to deliver general practice at scale through Primary Care Networks. A new CVD Locally Enhanced Service contract was commissioned at PCN rather than practice level that required all practices within the network to deliver enhanced diagnosis and clinical management of cardio-vascular disease. This has led to the implementation of PCN level multi-morbidity clinics that provide a 'one stop shop' to deliver enhanced clinical management of all patients' cardio-vascular conditions in a single clinic.

The programme has delivered the best CVD outcomes in England and has been recognised nationally by DHSC as a model of best practice with Thurrock delivering performance that is a significant positive outlier on all 12 key outcome metrics on CVD management, and best national performance on six of the 12. (Figure 6.4).

Figure 6.4

Moving forward, we will seek to expand the contract and approach to cover other long-term conditions, prioritising respiratory disease and cancer. We will also expand the scope of the contract to encompass primary prevention including delivering support to address behavioural risk factors such as smoking, weight management and alcohol misuse.

6.11 Falls Prevention

Falls and fall-related injuries are a common and serious problem for older people. People aged 65+ have the highest risk of falling, with 30% of people older than 65 and 50% of people aged 80+ falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence, and mortality. Falls cost the NHS more than £2.3 billion annually and a major contributor to the need for higher acuity adult social care interventions such as entry into residential care.

Over the past 50 years, evidence has shown the need to transition from accepting falls as an inevitable consequence of ageing, to something that can and should be prevented. Numerous studies have demonstrated effective approaches to detection of falls risk and falls prevention in older people including those with cognitive and physical impairments.

Multifactorial falls risk assessment should include assessment of: falls history; gait, balance, and mobility; osteoporosis risk; the older person's perceived functional ability; visual and cognitive impairment; urinary incontinence; home hazards; and cardiovascular risk and medication review.

The National Institute of Clinical Effectiveness (NICE) guidelines recommend that multifactorial falls prevention interventions should include: strength and balance training; intervention to address home hazards; interventions to address vision impairment; medication review with modification/withdrawal. Cardiac pacing is also recommended for consideration for older people with cardioinhibitory cartoid sinus hypersensitivity.

Figure 6.5 (overleaf) shows the Directly Standardised Rate of Emergency Admissions for Falls in those aged 65+ per 100,000 population for Thurrock, its CIPFA comparator local authorities and England in 2022/23.

As figure 6.5 shows, Thurrock has a rate of hospital admissions for falls that is statistically significantly higher than England's and the third highest amongst its comparator local authority groups. This suggests that there is an opportunity to strengthen our local preventative approach to falls.

Falls prevention activity is currently commissioned as part of the Better Care Fund. The council in ICB recognise the importance of reviewing current provision and commissioning a more comprehensive and integrated model. Moving forward, as part of the review of the Better Care Fund review, we will review current commissioning arrangements and commission a single and comprehensive assessment and integrated falls prevention model.

6. Early Intervention and Support

Figure 6.5

Emergency Hospital Admissions due to Falls in People Aged 65 and over, Directly Standardised Rate.
Thurrock, CIPFA Comparators & England. 2022/23

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	209,989	1,933	1,925	1,941
Neighbours average	↓	-	-	-	-	-
Salford	→	15	990	2,770	2,599	2,950
Rochdale	↓	4	780	2,197	2,045	2,358
Thurrock	↓	-	505	2,162	1,976	2,360
Tameside	→	5	785	2,040	1,898	2,189
Milton Keynes	↓	14	760	1,999	1,859	2,147
Oldham	↓	9	745	1,996	1,854	2,146
Bolton	→	7	995	1,989	1,867	2,118
Blackburn with Darwen	→	13	430	1,980	1,796	2,177
Bury	↓	10	675	1,910	1,768	2,060
Middlesbrough	→	11	450	1,871	1,702	2,052
Peterborough	↓	3	560	1,760	1,617	1,913
Medway	→	1	780	1,725	1,605	1,851
Havering	→	8	830	1,655	1,544	1,772
Telford and Wrekin	↓	2	525	1,641	1,503	1,789
Stockton-on-Tees	→	12	580	1,573	1,447	1,707
Swindon	↓	6	480	1,258	1,148	1,376

Statistically significantly higher than England | No statistically significant difference to England | Statistically significantly lower than England

6.12 Summary of Key Strategic Actions

6.1 We will develop a detailed Assistive Technology (AT) Commissioning Workplan in 2024/25 that sets out commissioning action for the next three years to leverage the opportunity of further use of AT to prevent placement demand and to prevent, reduce and delay the need for further support where possible

6.2 We will tender for a formal carer support service in 2024 using the learning from development of the Carers' Strategy and HLS principles to inform the service specification.

6.3 We will develop an Integrated Commissioning Plan for Housing Vulnerable Residents including provision of floating support in the community.

6.4 We will procure a comprehensive offer of employment and life skills support for residents with learning disabilities and mental ill-health through contract or a framework agreement, moving away from grant funding of individual organisations. We will also look at how community assets can be better utilised to achieve required outcomes

6.5 We will re-procure an early intervention and support offer for older people and for those affected by Alzheimer's Disease

6.6 We will provide further funding through the Better Care Fund to expand capacity and reach of the *By Your Side* project, and we will better use the information and data provided by By Your Side to learn more about what people need when they return home

6.7 We will the scope of the PCN CVD Locally Enhanced Service contract to cover other long-term conditions, prioritising respiratory disease and cancer and to encompass primary prevention including delivering support to address behavioural risk factors such as smoking, weight management and alcohol misuse.

6.8 We will review the current commissioning arrangements for falls detection and prevention and commission a new integrated falls prevention offer through the Better Care Fund.

The ICB Alliance team is in the process of commissioning a new carers intensive support service aimed at preventing carer breakdown and avoiding admission to hospital or care homes for either the carer or cared for person and reducing the need for costly community-based packages of care for the council.

7. Community Based Care

7.1 Introduction

This section describes our strategic commissioning approach and intentions for commissioning of care services within the community aimed at people who are able to remain living in their own homes.

Most people in receipt of a care service in the community do so for one of the following reasons:

- They are in need of urgent care, responding to a crisis or acute need
- The require reablement and recovery, usually following a stay in hospital
- They have long-term support needs, requiring ongoing long-term community- based support.

7.2 Commissioned Spend on Community Based Care

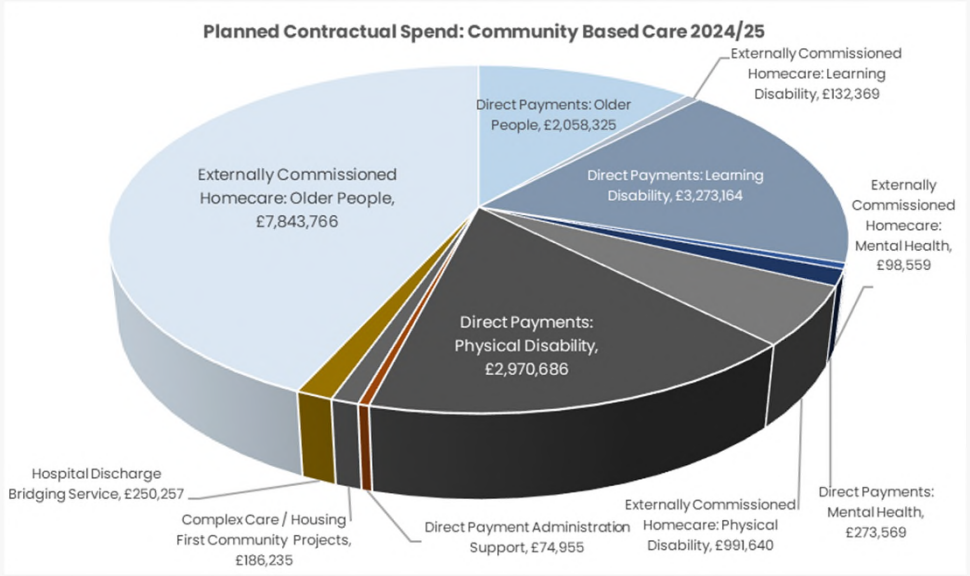
Services that are currently commissioned that fall into the Community Based Care category include homecare, direct payments, the hospital bridging service which provides immediate and short-term care at home for patients being discharged from hospital, and community support delivered through an MDT approach for residents with complex housing, addiction, care, and mental health needs. Reablement is currently provided by the council's in-house adult social care provider service *Caring for Thurrock.* This service also currently delivers some of the overall homecare provision for residents.

Figure 7.1 shows the planned overall commissioned spend across these categories for 2024/25. In total, the council plans to spend £9,087,191 on community-based care in 2024/25 with the majority of spend used to support older people.

7.3 Current Position and Future Direction: Homecare

The market for homecare has been precarious for many years. Providers have been working with very tight margins and external factors, such as the rise in fuel costs and the introduction of the National Minimum Wage, have exacerbated their challenges. Pressures to recruit and retain staff have grown with competition of similar or better paid work in other sectors such as retail and hospitality, along with a significant rise in complexity and acuity amongst residents who require care and support at home due to demographic pressures and the impact of the COVID-19 pandemic.

Figure 7.1



Homecare is currently externally commissioned from providers via a framework which specifies an hourly rate and ensures a series of quality standards are adhered to. Providers are also subject to regular internal quality inspections by the council's ASC Contracts and Brokerage Team. These replicate the external CQC inspection regime of providers. Providers on the framework then bid to deliver new individual care packages that are offered to all providers on the framework each day and are paid according to the hours delivered. This 'time and task' model, whilst still standard across the sector, is far from ideal. Commissioning providers to deliver the same number of hours of care each day affords little flexibility to respond to the varying and holistic needs of residents. There may also be a lack of care continuity as different people deliver the same tasks on different days. As such, opportunities to spot when a resident is either deteriorating or improving may be missed.

To address these issues, in 2018/19, the council developed a place-based self-managed and holistic model of homecare until the title of *Wellbeing Teams*. Based on the Buurzorg model of community nursing, self-manged teams of 12 Wellbeing Workers take responsibility for delivering care in the home within a neighbourhood. Wellbeing Workers are recruited on values and skills of self-management, authenticity, a person-centred outlook, and a commitment to co-production. They are then matched with those requiring care based on interests and three to four *Wellbeing Workers* form long-term care relationships with those in receipt of care maximising the benefits of continuity of care relationships.

7. Community Based Care

The model provides flexibility, allowing workers to adjust the level of care given on a daily basis dependent on need and to 'bank' hours that may not be required, if for example, a resident's family may be supporting or taking them out on a given day.

Wellbeing Workers deliver the same care tasks as those undertaken within the traditional 'time and task' domiciliary care model but have also been upskilled to undertake additional routine clinical interventions traditionally undertaken by a Health Care Assistant or other professionals. These include equipment assessment, wound care, stoma care, and insulin injections. This both raises the status of the work, allowing better recruitment and retention, and rationalises the number of different people entering the resident's home. The teams are also trained to deliver reablement for those who are discharged from hospital, reducing the need for referral to a different team and set of carers.

Operating at neighbourhood level, Wellbeing Team Workers develop a strong understanding of wider community support and assets that they can connect the resident with. 'Banked hours' are also used to deliver more holistic support dependent on the resident's interests, for example trips out, pedicures, companionship, and games.

Two Wellbeing Teams have been operating in the Tilbury and Chadwell locality delivered by *Caring for Thurrock*. Early evaluation suggested significant reductions in GP appointment usage and hospital admissions in those cared for by a Wellbeing Team compared to externally commissioned homecare using a 'time and task' model.

This model will form the basis on which all homecare will be reprocured during 2024/25 to go live in April 2025. We will procure based on four contracts aligned to the four Primary Care Network and Integrated Locality Team geographies set out in *Better Care Together Thurrock, the Case for Further Change.* The commissioning exercise that we will undertake to complete the new homecare tender has followed a Human Learning Systems approach:

- The specification has been developed using the learning from the Wellbeing Teams' experiments and on-going evaluation. This way of delivering homecare will represent a radical departure from the traditional model. We are therefore working on a specification that allows for adaption over time to take advantage of all learning that takes place throughout the life of the contract.
- To facilitate flexibility, contract length will be for ten years (with break clauses in case of any issues). This will also facilitate the potential for inward investment into Thurrock to build operational infrastructure; providers are often reluctant to open local offices or recruit local management when only a relatively short-term contract is secured.
- We will build in a longer than usual lead time pre-tender. This will allow for ongoing open dialogue with providers and people with lived experience (within procurement legislation), which will ensure that the specification takes full account of the voices of those within the system, is predicated upon what is achievable at the present time and what will be developed throughout the life of the contract.
- The contract will be supported by a new performance framework that moves away from the traditional process and output KPI model; a model that is heavy on data and light on proof of meaningful success, and towards one that promotes a culture of learning and collaboration within the provider system. This will allow for more bespoke service delivery, recognising and responding to the unique qualities of the individual supported. This radical change from the status quo will enable space for an iterative process of performance management of the life of the contract.

In 2024./25 we will develop a domiciliary care commissioning work plan setting out in more detail how we will implement and develop the wellbeing team model. This is likely to start initially with identifying areas for experimentation – and each locality may respond differently dependent upon requirements.

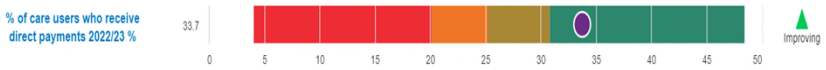
7. Community Based Support

7.4 Direct Payments

Direct payments are regular payments that the council makes to residents (or their carers) assessed as eligible under the Care Act (2014), so that they can arrange, manage and pay for their care and support needs themselves as an alternative to accessing a council commissioned service. Direct Payments enable residents with care and support needs to have more freedom, flexibility and control over how their support is provided, who provides the support and when it is provided, supporting a personalised care approach. The council agrees with the resident what you they like to spend the money on, but aims to give as much choice as possible.

During 2022/23, 33.7% of care users on Thurrock opt to receive care and support via a direct payment as opposed to a directly commissioned service. Comparatively, this places the council in the best performing quartile of all local authorities in England (figure 7.2).

Figure 7.2



Evidence suggests that those in receipt of care services are more likely to opt for a Direct Payment if they are supported to do so by social work staff at time of assessment, where there is a well-developed market of support options and where there is ongoing support in the procurement and management of care providers.

We will continue to support and encourage care users and their carers to access Direct Payments through the strengths-based approach to adult social care delivered through our Community Led Support and Integrated Locality Teams. We will also continue to develop a plurality of providers through our Micro-Enterprises programme (see section 7.5).

In order to ensure a high-level support in terms of managing direct payments, the council is in the process of procuring a new provider that will:

- Provide a personal account manager who will track the individual direct payment account to be able to resolve any issues quickly.
- Provide a Direct Payment holding account for funds.
- Provide a regular statement of client funds in an accessible way to assist the service user to manage their life.
- Monitor spending information at agreed times.
- Process payroll and pay invoices within appropriate timeframes including providing payslips for directly contracted employees.
- Liaise with HM Revenue and Customs (HMRC) on the client's behalf as the agent including submitting all HMRC monthly and annual returns as required by law and making required monthly payments direct to HMRC.
- Provide assurance that monies exceeding the eight-week tolerance level are returned promptly to the council after all relevant deductions and payments are made.

During 2024/25 we will develop a dedicated commissioning workplan setting out future plans to maximise use of Direct Payments and Individual Support Plans.

7.5 Micro Enterprises

Thurrock council, in partnership with Community Catalysts, has driven the development of a Micro Enterprise scheme locally for the past four year. Micro enterprises are small, local businesses, very often sole traders, who provide a vast range of needed care and support services to their community. They are generally funded by individuals with care and support needs through their Direct Payment budget.

Typically, micro enterprises (Micros) are often started by people who are marginalised, either through underlying factors such as ill health or loss of a long-term career, consequently they are individuals who struggle to enter, or return, to employment.

"Carpy-Viking" is an angling Micro-Enterprise set up by a young man who was supported after recovering from mental health and addition problems who found fishing assisted his recovery. The micro now supports others in a similar situation in their recovery journeys.

Developing micros has a number of key benefits:

- They create supply that is needed in the local economy.
- This supply is often "bespoke". For example, in the care field, the partnership between the cared for and the carer creates a service based on the unique situation of the person supported, not on the restrictions that inevitably exist with large provider organisation.
- The money flow stays within the local economy.
- The impact upon the well-being of the person running the micro is very significant. This results from a growth in sense of purpose that was not previously present, or which returns, as a result of making a positive contribution.

Since the inception of the programme, we have supported the development of well over 100 micros with a single Micro Enterprises Development Manager who has become increasingly stretched.

7. Community Based Care

Over the life course of the programme, there has also been a shift in the type of provision, at times moving away from the usual individual who wishes to start a micro, towards people who have very innovative ideas, but whose start-ups would be best suited to establishing a Social Enterprise or charity and not a sole trader type of provision. There are several local schemes that can provide support: CVS, the School for Social Entrepreneurs, Business Link, DWP etc., but none of these provide the longer-term practical support required to give these start-ups a good chance of success. There is a danger that we are missing out on the establishment of a range of local entrepreneurs, with excellent ideas, who could provide exciting and much needed local economic activity, whilst also creating a very positive impact upon their own, and others, well-being and sense of purpose.

We will therefore expand the programme and develop a "Community Economic Unit" (CEU), that can support both the ongoing development of Micro Enterprises and provide the kind of practical advice and guidance needed to support other forms of community economic development.

7.6 Summary of Key Strategic Actions

7.1	We will commission four new homecare contracts across each of the four Integrated Locality Team geographies based on the successful Wellbeing Team approach developed through *Caring for Thurrock* with ten-year flexible contracts that will adjust in response to learning.
7.2	We will continue to promote direct payments as a mechanism for delivering personalised care and will reprocure a new direct payment support service. We will set out future commissioning plans in a dedicated Direct Payments and Individual Support Plans work plan.
7.3	We will work with health partners and communities to identify how we can develop an integrated approach to delivering outcomes for people requiring support in their home – e.g. via the development of blended roles, providers working with and identifying community assets as part of the solution etc.
7.4	We will continue to develop the maket for Community Based Care through an expanded Micro Enterprise programme and drevelop a "Community Economic Unit" (CEU), that can support both the ongoing development of Micro Enterprises and provide the kind of practical advice and guidance needed to support other forms of community economic development.

8. Accommodation Based Specialist Care

8.1 Introduction

This section describes our strategic commissioning approach and intentions for commissioning of care services provided in residential settings. Residents receiving these services have levels of care acuity that mean that they are unable to live independently in general needs housing.

8.2 Commissioned Activity & Spend on Accommodation Based Specialist Care

Services that are currently commissioned that fall into the Accommodation Based Specialist Care category include the following:

- Extra Care housing where residents live independently within their own self-contained flat within a dedicated block with additional flexible care provided by a care provider. The council has both its own in-house Extra Care facility at Piggs Corner with care provided by the council's in-house provider – *Caring for Thurrock,* and its own facility at Elizabeth Gardens where an externally commissioned care provider delivers care on site. Both services are aimed at older people.

- Supported Living where personal care is provided alongside but separately to the housing element of the provision. In Supported Living schemes residents will typically live in smaller shared accommodation units but pay their own housing costs (or claim housing benefit) and live relatively independently. Care is available in the event of physical or mental health challenges or simply for support in everyday life and can include budgeting and home maintenance tasks. Effective Supported Living aims to build life skills and self-esteem to build independence and can result in allowing residents to move onto independent living in general needs housing in time. The council commissions all supported living from the private sector.

- Intermediate Care, which are typically beds provided in a residential care home and allow a step-up facility for residents needing short term higher intensity care as an alternative to a hospital or residential/nursing care home admission. The council has intermediate care beds available within its in-house residential care home – Collins House.

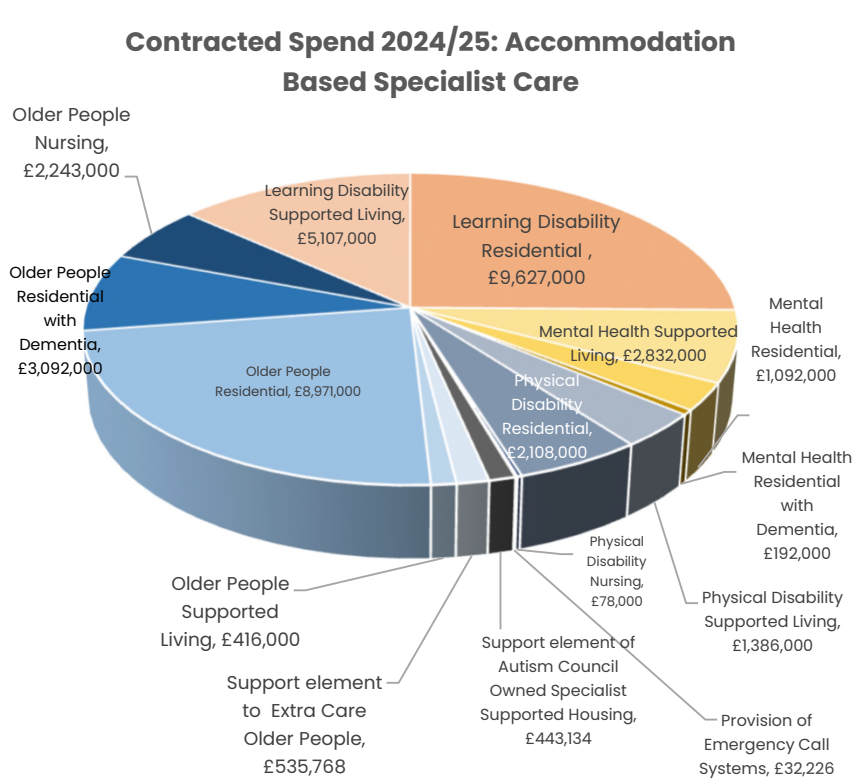
- Residential Care Homes that allow people with relatively high care needs to live, on a permanent basis in a residential setting where they can be provided with care and support at all times administered by specialist staff who understand the unique approaches different individuals require and have specialist training to keep them safe and in the best possible health. The accommodation, food, and care costs are included in a single charge either paid by the resident or partly/fully funded by the council depending on financial eligibility. Some higher acuity residential care facilities provide care for residents with dementia. The council commissions that vast majority of this provision from the private sector but retains an in-house residential care home – Collins House.

- Nursing Care Homes, which are generally intended for those who are particularly frail or have physical and mental health conditions that require day-to-day medical attention. Residents receive the same kind of care that they would in a residential care home together with nursing care to meet their more advanced needs. A registered nurse creates and monitors care plans and provides some treatments and medical interventions for example administering injections or intravenous medication or treating wounds. The council commissions this provision from the private sector.

Whilst services have historically often been commissioned in silos according to specific and individual needs, the implementation of a Human Learning Systems approach is shifting how we will need to commission these services moving forward.

Figure 8.1 shows the planned overall commissioned spend on accommodation-based specialist care for 2024/25. In total, the council plans to spend £38.155M on these services.

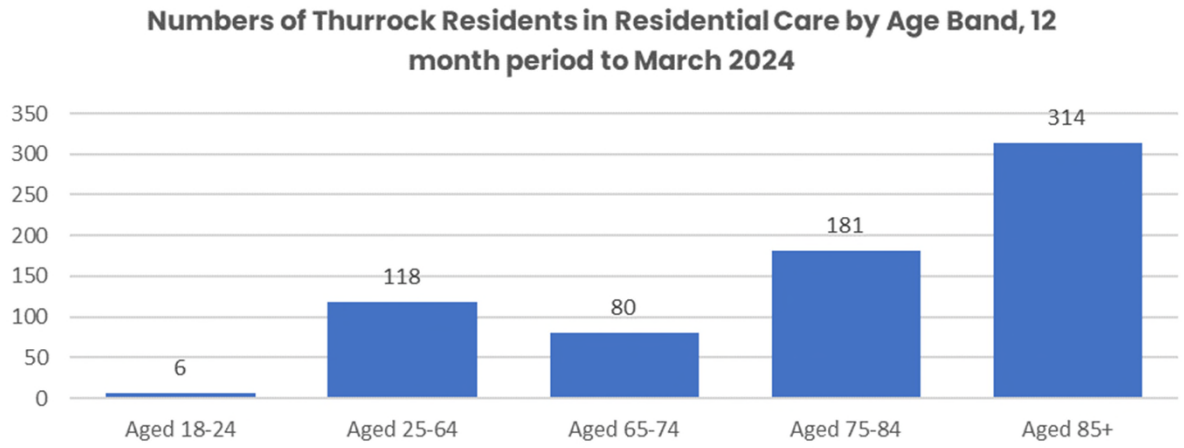
Figure 8.1



8. Specialist Accommodation Based Care

In the 12-month period ending March 2024, in total, 28 care homes provide support for 698 people in Thurrock, with 622 (89.1%) qualifying for council funding. Figure 8.2 shows number of residents supported in residential or nursing care by age band in the 12-month period to March 2024.

Figure 8.2



The majority (82%) of residents supported in residential or nursing care are aged 65+, with almost half being aged 85 or over.

8.3 The Need for Specialised Housing and Care

The Thurrock Public Health Team has undertaken an in-depth assessment of the need for residential care in the borough using the Department of Health and Social Care planning tools to estimate the number of people aged 65 and over in Thurrock who cannot undertake even one mobility activity alone and may therefore require adult social care. Whilst the total number in 2017 was 4,201, this is projected to increase to 6,801 by 2035 (an increase of 61.9%). The largest growth is seen in the 85+ age group, which sees an increase of 95.4% between 2017 and 2035. In relation to dementia, the assessment shows that the estimated number of people aged 65+ living with the condition could increase from 1,503 in 2015 to 2,401 in 2030 (an increase of 59.7%) with the largest proportional increases found in the 80-84 year-olds and 90+ age groups.

In Thurrock, as figure 8.2 demonstrates, residents in their 80s are already the largest users of residential care. Without effective intervention to mitigate demographic trend pressures of increased morbidity, the need for additional residential care homes is likely to increase substantially over the longer-term. The Public Health Team estimate that a further 410 beds in residential care is likely to be needed in Thurrock by 2035.

Specialist accommodation-based care is delivered across four major adult social care user groups: older people, learning disabilities, mental health, and physical disabilities. There are some other specialist categories within these groups, such as dementia services, however for the purposes of development of a commissioning strategy, we will make use of these four categories as each user group has different market requirements that will require different responses.

8.4 Older People

Over the last decade, there has been a national policy push for reductions in the use of residential care for older people with a preference to use community-based-care as an alternative wherever possible. This is evident in the national performance (ASCOF) metric on numbers of older people (aged 65+) entering residential care as a proportion of the total population of older people.

As a result of increased use of community-based care options, the care acuity of those who now do enter residential care has increased significantly from in the past. Indeed, research, both nationally and locally demonstrates that frailty levels are such that it would be difficult to see how those now entering residential care could be cared for adequately in a community setting. This has been exacerbated by the significant rise in people with dementia and by the rise in acuity resulting from the impact of the COVID-19 pandemic and the national policy response to it (for example temporarily pausing secondary prevention activity within the NHS to free up capacity).

Older people's residential, residential with dementia, and nursing care is commissioned via a framework of providers. The framework specifies quality and weekly rates.

Once on the framework, individual placements are brokered by the council with the most appropriate provider in consultation with the resident and their family. Quality is maintained through a strong and supportive relationship between the council's Adult Social Care Contract Compliance Team and providers on the framework. This includes a rolling programme of internal inspections by the team via the PAMMS framework that mirrors the CQC inspection process. Providers that fail to achieve at least a rating of 'Good' under the process receive additional support and more regular inspections until quality improves.

8. Specialist Accommodation Based Care

Figure 8.3 shows how Thurrock's residential and nursing care home provision benchmarks against national comparator local authorities.

Figure 8.3

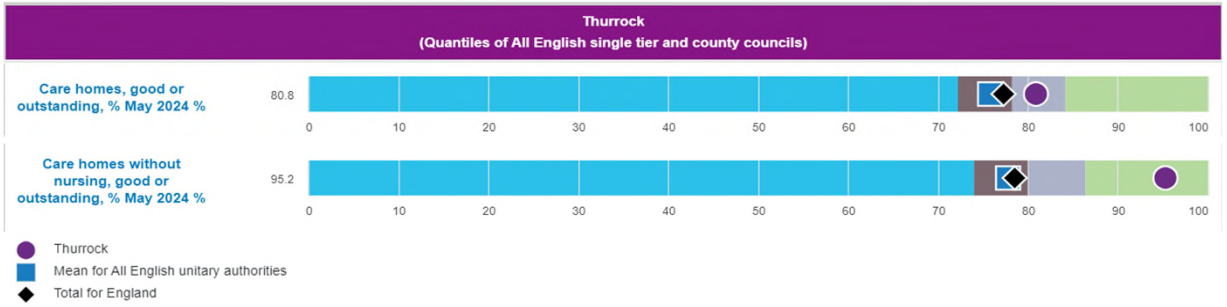
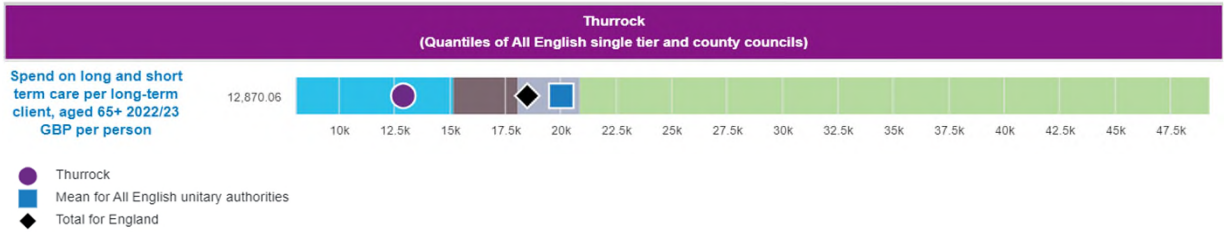


Figure 8.3 shows strong national benchmarking against CQC assessed quality. As of May 2024, 81% of care homes are CQC rates as 'Good' or 'Outstanding' with this figure rising to over 95% for those care homes who do not offer nursing care. Both figures are above national and CIPFA comparator local authority group averages.

Rates are reviewed annually in consultation with providers taking into account inflationary and other cost pressures, for example increases in the minimum wage.

Thurrock's rates benchmark amongst the lowest in the region and providers often state that they opt to continue with contract with the council despite lower fee rates because they appreciate the supportive relationship. Figure 8.4 demonstrates that spend on long term care per client aged 65+ in 2022/23 was in the lowest quartile nationally and significantly below the England and CIPFA comparator local authority group mean.

Figure 8.4



8.5 Older People: The Case for *White Acres*

The council has in-house one purpose built residential home – *Collins House* in Springhouse Road, Corringham. It is designed to the standards for residential care in the 1970s and is registered to provide personal care and accommodation in single rooms for a maximum of 45 older people, some of whom may be living with dementia related needs.

Collins House is well regarded by residents and their families, and the Care Quality Commission awarded the home an overall rating of *Good* in its latest inspection report in February 2019, which was reviewed in August 2022. However, the home does have significant limitations: its bedrooms are small and none have en-suite facilities. Moreover, the building places limitations on the care that can be provided; it is not possible to place some older adults in Collins House who cannot weight bear because the size of some rooms prohibits the use of hoists to allow residents to transfer from bed to chair or bath/WC.

A report on the development options for Collins House was presented by Pollard Thomas Edwards on 26 February 2020 exploring the constraints of the current site, and the wider redevelopment opportunities in Corringham. It was noted that re-configuring the existing design merely to create ensuite accommodation would be likely to result in the loss of 6 bedrooms. This would be uneconomic.

The limitations of the existing building, and the constraints of the site in a busy town centre, mean the options for re-developing the home (both renovation and rebuilding) have been discounted as unaffordable and unlikely to meet planning requirements. For these reasons, it was concluded that a new residential facility on the Whiteacre / Dilkes Wood site would allow the residents of Collins House to move and avoid the health issues for elderly people living on a 'building site', as well as to better address the wider care and accommodation needs of the older population in Thurrock.

The project aims to provide social care and nursing care in a specialised setting of 47 self-contained dwellings (the current design includes two more than the original estimate), and 30 en-suite bedrooms, with associated care facilities (lounges, restaurant, treatment rooms, laundry etc). There are three accommodation types:

- Type 1 – Intermediate Care Unit - 27m2 care bedroom with en-suite bathroom. Storage space for wheelchairs, MEP, personal belongings, etc. Good visibility from bed to bathrooms, door and window.
- Type 2 – Older Persons Flats - 1B2P 56m2 self-contained apartment including bedroom, living/ dining/kitchen and bathroom provided. External private balcony and storage space provided. Possibility for open plan or more traditional layouts.
- Type 3 – Older Persons Flat 2B3P - 67m2 self-contained apartment including two bedrooms, living/dining/kitchen and bathroom. External private balcony provided. Storage space provided. Possibility for open plan or more traditional layouts.

8. Specialist Accommodation Based Care

Partnering Delivery Model

The council proposes to tender the Whiteacre / Dilkes Wood sites to registered providers of social housing for the development of the site. This disposal will generate the first capital receipt. The terms of the disposal will specify that the registered provider must apply for specialised housing grant from Homes England to build the scheme which the council's architect has already designed to RIBA stage 2+.

The terms of the disposal would also specify that the council, as a strategic housing authority, has nomination rights to the 75 units in perpetuity. On completion, and using its nomination rights, the council would offer the current residents of Collins House the choice of moving to the new scheme. The nominations for the remaining units would be frail older people from the borough who have been assessed as needing permanent residential care or intermediate care. We envisage that care services at the new scheme will be mainly domiciliary care using the established Well-Being model.

The residents at the new scheme (unlike Collins House) will have exclusive occupation of their home and so be able to claim all benefits to which they are entitled (including Housing Benefit which will contribute to the rents and service charges set by the new landlord). They will also be subject to the council's charging policy and so, where applicable, will contribute to the costs of their care. This new funding model has the potential to deliver significantly higher quality of care at a reduced cost as housing benefit income is maximised.

Following completion of the new scheme, and the transfer of residents and staff, the vacant Collins House site will be available for disposal, and it is assumed a second capital receipt will be secured.

It should also be noted that the council will soon itself be subject to an assessment by the Regulator under its new powers to assess how well local authorities meet their duties under the Care Act (2014). Having a plan to address the deficiencies in Collins House is a vital part of the evidence we have assembled in preparation for the assessment.

Architect's Impression of Whiteacres Development

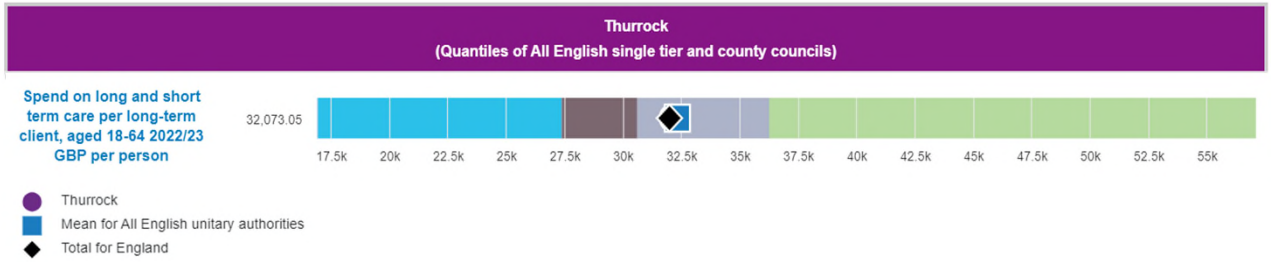
8. Specialist Accommodation Based Care

8.6 Working Age Adults: Establishing the Case for a Framework

At present, accommodation-based care aimed at working age adults is provided predominantly for those with a learning disability or significant mental health challenges. As referenced in Chapter 2, this is generally commissioned at an individual client level via spot purchase. We recognise that this is not always an efficient way of commissioning and procuring care and is dependent on what is available and what can be negotiated at the time of procurement. This is often because the ability to meet the needs of working age adults required very specialised support. It is also possible that Supported Accommodation has been used increasingly to provide support for those who require greater support – which adds additional costs to core care costs. This may indicate that the structure for Supported Accommodation payments requires a review.

Figure 8.5 shows Thurrock's benchmarked spend per client aged 18-64 against all single and top tier local authorities in England in 2022/23 by quartiles.

Figure 8.5



Whilst in line with national and CIPFA comparator local authority means, Thurrock's spend on working-age adults benchmarks in the second highest quartile nationally.

Supported Accommodation

The supported accommodation market was adversely affected by the ending of the Supporting People programme in 2012. This programme managed the expansion of supported accommodation within a commissioning and quality assurance framework, overseen by central government, focusing upon all the main user groups who required tenancy related support. Key Adult Social Care groups such as Mental Health and Learning Disabilities' supported accommodation was part of the Supporting People programme.

Since the programme ended these categories of supported accommodation have developed in an ad-hoc manner, with little strategic oversight from local authority commissioners. This had led to a blurring of the distinction between the provision of tenancy related support and personal care services within the sector. This has resulted in a lack of specialist support being delivered within supported accommodation, and, to a significant growth in costs driven by increases in 1:1 support, as the providers attempt to manage behaviour that challenges the stability of the accommodation themselves although improved commissioning practices and a programme of more regular and targeted reviews of supported living care packages as reduced reliance and costs associated with additional 1:1 support in supported living accommodation over the last two years.

As figure 8.1 (at the start of this chapter) demonstrates, the council plans to spend £9.741m in 2024/25 on supported living accommodation (54% on learning disability, 30% on mental health, 15% of physical disabilities, and 1% on older people).

In order to improve and strengthen our strategic commissioning of supported living accommodation, we will develop a specific Supported Accommodation commissioning workplan in 2024/25 (as part of a broader Working Age Adults Commissioning Strategy) that will:

1. Review the current market for supported accommodation for people with learning disability, autism, and mental ill-health. This will include:
    - Mapping the current market
    - Identifying future requirements
2. Produce and implement a market development plan for a remodelled service that gives more choice and control to residents and better value for money. This will include:
    - Identification and testing of new models of care
    - Implementation of new ways of working
3. Prepare for the Supported Accommodation (Regulatory Oversight) Act 2023.

The new act requires all providers of supported accommodation to be licensed with the local authority. Collaborative working with the council's Housing and Enforcement Teams will enable us to implement the licensing scheme and ensure expected guidance is enacted.

The Act also requires the development of a supported accommodation strategy, giving guidance to providers and ensuring a consistent and financially sound direction. This document with form part of the commissioning workplan.

4. Set out longer-term commissioning plans for the two current joint council/EPUT test and learn pilots – *The Complex Housing Intervention Project* (CHIP) and *Enhanced Housing First (EHF)* pilot to give intensive support to people living the most chaotic lives due to complexity including those with drug and alcohol misuse and enduring mental ill-health.

Evaluation of the pilot test and learning projects will enable an understanding of potential financial savings across the whole system including housing, social care, health, the criminal justice system, and emergency services along with individual life improvements of those supported. These two experiments are being developed and evaluated within a Human Learning Systems framework and will inform the workplan.

8. Specialist Accommodation Based Care

Residential Care for Residents with a Learning Disability

There are 105 units of residential care in-borough (excluding dedicated respite provision) for people whose primary need is learning disability and/or autism. There are 13 homes run by 10 different providers.

The average size of each care home in Thurrock is eight units. By contrast most of placements out of borough are in small residential care homes – between one and four people. NICE guidance recommends that care homes for people with a complex learning disability and/or autism should be 6 units or less.

Although 52% of residential care usage is outside of Thurrock – 77% are within neighbouring authority boundaries.

Although there has been a growth in the number of people with a learning disability and/or autism within the borough over the last twelve years, Thurrock has maintained a relatively consistent level of usage of residential care (94 people per annum). Over the last decade, an average of four new people with LD/autism per annum require residential care to meet their needs. Nearly half of residential care service users have resided in a care home for 12 years or more.

This consistency considering population growth has largely been to increased usage of supported living over the period. The council is committed to always use the least restrictive option to meet needs and as such residential care is used when all other service types have been explored.

People with LD are living longer and therefore their needs will be different as they grow older – e.g. some people will develop diseases associated with old age such as dementia. It is unclear as to the extent that care homes are able to adapt. It may also be that people with LD who have lived fairly independently need what a residential care home provides when they are older. Again, there needs to be more discussion about whether existing homes for Older People can develop further or whether homes for people with LD, which are often extremely specialised, should be used.

Residential Care (Mental Health)

Compared to the learning disability residential care provision, the mental health in-borough market is small. There are two homes in Thurrock whose primary client group is mental health (although there are other homes with a dual learning disability/mental health registration although the majority of users primary need is learning disability and as such have been included in that section). In addition, some older people residential and nursing care homes do meet the needs of people with mental ill health where this is the most appropriate placement – again this is for a small amount of people.

There are other homes with a dual learning disability/mental health registration although the majority of users primary need is learning disability and as such have been included in that section.

In addition, some older people residential and nursing care homes do meet the needs of people with mental ill health where this is the most appropriate placement – again this is for a small amount of people. Most residential places are in neighbouring authorities. This is due to the specialist nature of the places required.

The cohort of people requiring a residential placement is small and fluid.

A New Commissioning Approach

There is a need to review the use of spot purchasing of working age adult accommodation-based care and to consider the development of a framework that offers improved personalisation and better value for money. We will work with users of accommodation-based support to co-design the best approach to commissioning and provision for this form of support.

As such, in 2024/25 we will develop a new Working Age Adults Commissioning Strategy based on Human Learning System principles that sets out the new approach and responds to the issues already highlighted in the sections on Supported Accommodation and Residential Care for those with Learning Disability and Mental Health.

8.7 Summary of Key Strategic Actions

8.1	**We will take forward the partner delivery model for Whiteacres in 2024/25 by tendering the Whiteacres site to obtain a delivery partner to build the scheme.**
8.2	**We will develop a Supported Accommodation Workplan to review and further develop the SA market for residents with LD, autism, and mental ill-health, prepare for the new regulatory framework, and set out longer commissioning plans for the CHiP/ EHF programmes**
8.3	**We will develop a new Working Age Adults Commissioning Strategy based on HLS Principles that creates an approach to accommodation-based care for LD, Mental Health, Physical Disabilities, and Autism, that delivers more personalised and cost-effective care.**

9. Delivery & Governance

9.1 Introduction

This chapter sets out our approach in more detail to developing the specific commissioning workplans in 2024/25 that will support this strategy. It also discusses development of an integrated commissioning function, work to review and align the Better Care Fund to this strategy, and more widely, the Better Care Together Thurrock transformation programme, and supporting governance mechanisms.

9.2 Integration of Commissioning

It remains a priority for the Thurrock Integrated Care Alliance (TICA) and the Joint Health and Wellbeing Board, who together constitute the strategic governance of the local health, care, and wellbeing system, to develop a single commissioning function across Adult Social Care, Public Health, Housing (people elements), and NHS ICB commissioning functions devolved to the Thurrock Alliance. Whilst the design and nature are yet to be agreed and further discussion is required with the ICB, the principle is one that all partners have signed up to. During 2024/25, we will further develop options for a new operating model.

9.3 Better Care Fund Review

Work is currently underway to undertake a fundamental review of the Thurrock Better Care Fund (BCF) and is being delivered with the assistance of the regional BCF Partnership with support from the Local Government Association (LGA).

The twin aims of this review are to ensure that the current work programmes are fit for purpose an delivering good outcomes for the residents of Thurrock and best value, and that they facilitate and align to the delivery of key priorities contained within the *Better Care Together Thurrock: Case for Further Change* integrated care strategy.

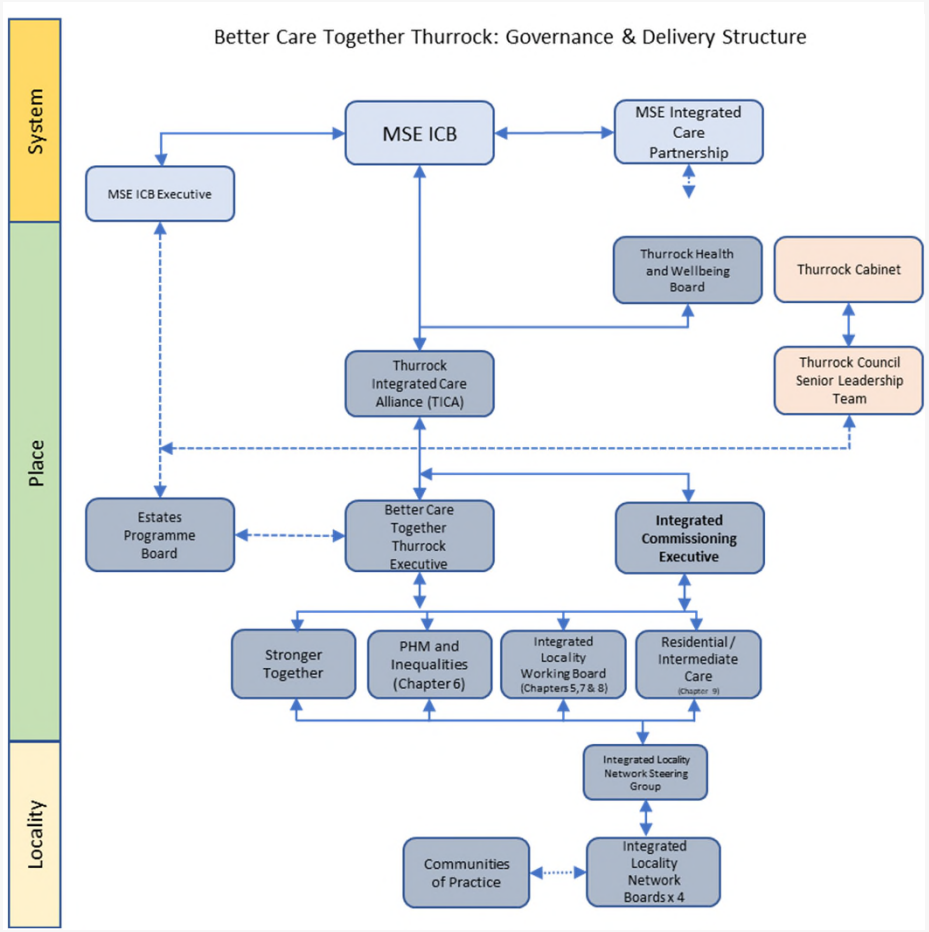
Once the review of the BCF is completed, this fund will provide the resources to deliver current programmes that are performing well, and the necessary short-term 'invest-to-save' funding to deliver further strategic system transformation. A non-recurrent cash-injection of £3.4M into the BCF from the ICB creates significant opportunity to both test new approaches and provides potential capital to refurbish shared estate space to support Integrated Locality Teams.

Once the review is complete, we will develop and agree an investment strategy that will set out longer-term plans to spend both recurrent and non-recurrent BCF funding to deliver maximum benefit to residents through prevention and system integration/transformation.

9.4 Governance

The Integrated Commissioning Executive is a joint council-ICB sub-committee of the Thurrock Integrated Care Alliance and will act as the single strategic board through which all adult commissioning decisions are taken. Figure 9.1 shows the wider system governance in which the Integrated Commissioning Executive operates

Figure 9.1



The Integrated Commissioning Executive (ICE) is accountable to the Thurrock Integrated Care Alliance and through this to the Thurrock Health and Wellbeing Board and ICB Board. Whilst the Better Care Together Thurrock Executive has overall responsibility for oversight of Better Care Together Thurrock delivery, ICE has relationship with the four delivery boards that sit under the Executive in terms of monitoring of performance of commissioned contracts relating to them, for example the CVD LES.

9. Delivery & Governance

The key functions of the Integrated Commissioning Executive are

- To have oversight of the development and implementation of this Integrated Commissioning Strategy
- To act as the single strategic officer board that agrees commissioning proposals across adult social care, public health, housing (people), and the NHS ICB, seeking synergies between and across contracts and (where necessary) makes recommendations to TICA, Cabinet and the ICB Board.
- To have oversight of the development, delivery and effectiveness of the Better Care Fund including realigning it to the Better Care Together Thurrock programme.
- To develop and have oversight of commissioning proposals against the ICB's Health Inequalities Fund.
- To develop a single integrated commissioning function for adults across housing, Adult Social Care, Public Health, and the ICB's Thurrock Alliance

9.5 Relationships

The relationships commissioners build are key to being able to deliver the right commissioning outcomes. This is because teams and partners such as the Integrated Locality Teams, Community Led Support Teams and Providers have information and feedback that will help to influence and shape what needs to be commissioned and how it needs to be commissioned. Gaps can also be identified and addressed this way. Commissioners must build and maintain these key relationships if the Strategy is to be effective.

9.6 Development of Commissioning Workplans

As referenced throughout this document, in 2024/25, we will develop nine dedicated commissioning workplans that support this strategy and set out detailed commissioning plans for different population cohorts and topics. Figure 9.2 shows how these support the chapters in this document. Four of these will be cross cutting dealing with older people, working age adults, co-production, and workforce.

Figure 9.2