

### The Provider Perspective

<b>Our ambitions: what should outstanding look and feel like?</b>		
On range from 0 – 10 where are we now?		On range from 0 – 10 where do we need to be in 12 months
4	<ul style="list-style-type: none"> <li>• Care Plan [should be available] across all agencies at point of access</li> <li>• Single place where different services can be accessed – e.g. day care and other older people’s services</li> <li>• Housing [needs to be considered at an early stage]</li> <li>• Single point of access – ‘phone number</li> </ul>	7

<b>Opportunities</b> What is working well? (www) Things we can build on to take advantage of to make our ambitions a reality	<b>Challenges</b> Even better if...(ebi) What has prevented us or might prevent us from making our ambitions a reality
<p>Assets:</p> <ul style="list-style-type: none"> <li>• House</li> <li>• Relationships</li> <li>• Social networks</li> </ul> <p>Needs assessment should take place at home and [the aim should be to] reduce hospital based interventions</p>	<p>Firefighting vs Firedrill</p> <p>‘George’ would not admit he needs help</p> <ul style="list-style-type: none"> <li>• Coaching to support [him to accept his condition]</li> <li>• [knowledge of] What to expect from the condition [would help him plan and make decisions]</li> </ul> <p>Assess the family’s ability to support</p> <p>Cost of the ‘system failure’ to whole economy General Practice Whole Person Tool developed</p>

<b>Action Planning on our priorities</b>		
<b>Identify 2 priority 'www' and 2 priority 'ebi'. What are our 90 day mobilisation actions – what could we do in the next 90 days to gain momentum – building on a 'www' or tackling an 'ebi'</b>		
<b>Priority – an action statement</b>	<b>Mobilising – what we will have achieved within 30 days</b>	<b>What we will have achieved in 90 days</b>
<ul style="list-style-type: none"> <li>RRAS</li> </ul>	Co-ordinate input of all providers	Effective pathways [mapped out] for each crisis
<ul style="list-style-type: none"> <li>See the whole picture – e.g. of both Florence and George</li> </ul>	Co-ordinated 'family plan' shared by all providers	
<ul style="list-style-type: none"> <li>Carers Group – access to and use of</li> </ul>	What services [or support] can be delivered by a community asset	Comms Strategy/ Local Social Networks [to enable local community to understand how they can help]

<b>Key Messages Our role as a leadership group</b>	<b>Key Messages Building Community Resilience</b>	<b>Key Messages Implications for Primary and Community Services</b>
<ul style="list-style-type: none"> <li>Framework with triggers to assess the couple against</li> </ul>	<ul style="list-style-type: none"> <li>LAC/Community Hubs</li> </ul>	<ul style="list-style-type: none"> <li>££ - VFM if the care plan works: less amputations, falls, blindness</li> </ul>
<ul style="list-style-type: none"> <li>Learning from 'vulnerable adults' work</li> </ul>	<ul style="list-style-type: none"> <li>Support Groups – Dementia UK, Diabetes UK</li> </ul>	
<ul style="list-style-type: none"> <li>5 year planning now [so that crisis can be anticipated and responded to effectively]</li> </ul>	<ul style="list-style-type: none"> <li>Data Sharing</li> </ul>	
	<ul style="list-style-type: none"> <li>Social Isolation [is a major risk factor]</li> </ul>	
	<ul style="list-style-type: none"> <li>Shopping and Cleaning [and practical help at home needs to be considered]</li> </ul>	

## The Commissioning Perspective

<b>Our ambitions: what should outstanding look and feel like?</b>		
<p>On range from 0 – 10 where are we now?</p> <p style="text-align: center;">5</p>	<ul style="list-style-type: none"> <li>• Providing what people need at the right time (timing) – e.g. information and advice; sign-posting/ supporting people to navigate through the system; pre-service support</li> <li>• Early intervention and prevention</li> <li>• Solutions not services [are what we need to offer]</li> <li>• Single point of contact – one person co-ordinating care</li> <li>• Single information system [available to all providers]</li> <li>• Building the solution around the whole person and where they live – including carers</li> <li>• Integrated Commissioning Model</li> <li>• Focus on ‘social model’ rather than pure medical model response – e.g. undertake a broader assessment (including wider social determinants – e.g. housing)</li> <li>• Accessible and high quality services when required</li> <li>• Strength-based approaches – move away from deficit model</li> </ul>	<p>On range from 0 – 10 where do we need to be in 12 months</p> <p style="text-align: center;">6</p>

<b>Opportunities</b> <b>What is working well? (www)</b> <b>Things we can build on to take advantage of to make our ambitions a reality</b>	<b>Challenges</b> <b>Even better if...(ebi)</b> <b>What has prevented us or might prevent us from making our ambitions a reality</b>
<ul style="list-style-type: none"> <li>• CCG/LA working under HWBB</li> <li>• Co-terminosity</li> <li>• Housing and planning part of HWBB and HWB considerations</li> <li>• RRAS/JRT</li> <li>• Acceptance that the system is broken and needs to be</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthened HWBB</li> <li>• Population increase</li> <li>• Capacity – need to watch changing demographic</li> <li>• Organisational culture/arrangements – governance/decision-making; planning; procurement; £ and tariffs</li> </ul>

<p>different</p> <ul style="list-style-type: none"> <li>• Technology – assistive, social media etc.</li> <li>• Role of communities – LAC, ABCD</li> <li>• 3<sup>rd</sup> sector and user-led organisation</li> <li>• VFM</li> </ul>	<ul style="list-style-type: none"> <li>• Marketing/ [communicating] change to the public – changing behaviour and encouraging greater personal responsibility</li> <li>• Education – via public health etc.</li> <li>• Chance to redesign the system</li> <li>• Move away from [purely] service-based focus</li> <li>• Funding</li> <li>• People unaware of entitlements – welfare rights</li> <li>• Health inequalities</li> <li>• VFM</li> </ul>
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<p align="center"><b>Action Planning on our priorities</b>  <b>Identify 2 priority ‘www’ and 2 priority ‘ebi’. What are our 90 day mobilisation actions – what could we do in the next 90 days to gain momentum – building on a ‘www’ or tackling an ‘ebi’</b></p>		
<p><b>Priority – an action statement</b></p>	<p><b>Mobilising – what we will have achieved within 30 days</b></p>	<p><b>What we will have achieved in 90 days</b></p>
<ul style="list-style-type: none"> <li>• Getting bottom-up approach – engaging community at large to develop Vision and Direction of Travel</li> </ul>	<ul style="list-style-type: none"> <li>• Identify the ‘how’ collectively</li> </ul>	<ul style="list-style-type: none"> <li>• We will have engaged (although [engagement will need to be on-going) – understand what the DoT is</li> </ul>
<ul style="list-style-type: none"> <li>• Agree what we mean by ‘whole person’ particularly in terms of early intervention and prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Business case developed [for change]</li> </ul>	<ul style="list-style-type: none"> <li>• Early intervention/prevention ‘offer’</li> </ul>
<ul style="list-style-type: none"> <li>• Success criteria – how will we know we’re going in the right direction?</li> </ul>	<ul style="list-style-type: none"> <li>• Workshops to identify/ start to identify [how change should be managed]</li> </ul>	<ul style="list-style-type: none"> <li>• Draft integrated framework</li> </ul>
<ul style="list-style-type: none"> <li>• Governance arrangements: must have oversight of system/organisational and delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Clarify potential options</li> </ul>	<ul style="list-style-type: none"> <li>• Agree changes</li> </ul>

<b>Key Messages</b> <b>Our role as a leadership group</b>	<b>Key Messages</b> <b>Building Community Resilience</b>	<b>Key Messages</b> <b>Implications for Primary and Community Services</b>
<ul style="list-style-type: none"> <li>• United vision/principles/DoT</li> </ul>	<ul style="list-style-type: none"> <li>• Having different conversation with the community – including marginalised [citizens]</li> </ul>	<ul style="list-style-type: none"> <li>• VFM – smarter and better working to give more</li> </ul>
<ul style="list-style-type: none"> <li>• Making change happen</li> </ul>	<ul style="list-style-type: none"> <li>• Remove hierarchy [where this impedes decision making]</li> </ul>	<ul style="list-style-type: none"> <li>• Do nothing is not an option</li> </ul>
<ul style="list-style-type: none"> <li>• Lead by example</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage active citizenship</li> </ul>	<ul style="list-style-type: none"> <li>• Prevention and rehabilitation – providing a service [may equate to] failure</li> </ul>
<ul style="list-style-type: none"> <li>• Shared responsibility and risk</li> </ul>	<ul style="list-style-type: none"> <li>• Co-production in commissioner process – broaden commissioning based – e.g. micro-enterprises/Community Interest Companies</li> </ul>	<ul style="list-style-type: none"> <li>• Stronger together – sum of the whole is better than individual parts</li> </ul>

### The Patient, Carer, and Community Perspective

<b>Our ambitions: what should outstanding look and feel like?</b>		
On range from 0 – 10 where are we now?		On range from 0 – 10 where do we need to be in 12 months
6	<ul style="list-style-type: none"> <li>• Personalised packages [of support and health care]</li> <li>• Communication of [my needs to all] services</li> <li>• 3<sup>rd</sup> sector voluntary groups/ housing [contribution is understood in my plan]</li> <li>• Access to individual packages /pathways</li> <li>• GPs/[an Early opportunity [to get a wide range of help]</li> <li>• Public understanding – awareness</li> <li>• Assessment of required needs at home</li> </ul>	8

<b>Opportunities</b> What is working well? (www) Things we can build on to take advantage of to make our ambitions a reality	<b>Challenges</b> Even better if...(ebi) What has prevented us or might prevent us from making our ambitions a reality
<ul style="list-style-type: none"> <li>• Access to social services</li> <li>• Multi-Disciplinary Team</li> <li>• [If the] Quality of housing is good [it can make a big difference]</li> <li>• Housing support</li> <li>• Voluntary Sector</li> <li>• Better Care Fund +</li> </ul>	<ul style="list-style-type: none"> <li>• Range of community options</li> <li>• Building new homes – more appropriate homes</li> <li>• Age of the housing stock</li> <li>• Sheltered accommodation</li> <li>• Family structure</li> <li>• Support for carers</li> <li>• Recognise the mental health needs of older people</li> </ul>

<b>Action Planning on our priorities</b>		
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<b>Priority – an action statement</b>	<b>Mobilising – what we will have achieved within 30 days</b>	<b>What we will have achieved in 90 days</b>
<ul style="list-style-type: none"> <li>Mobilise all services within a geographical area</li> </ul>	<ul style="list-style-type: none"> <li>Community hub to develop a neighbourhood commissioning model</li> </ul>	<ul style="list-style-type: none"> <li>Agreed model with a roll out of plan – LAC</li> </ul>
<ul style="list-style-type: none"> <li>Review carer support</li> </ul>	<ul style="list-style-type: none"> <li>Mapping out the support organisation [needed to deliver co-ordinated care]</li> </ul>	<ul style="list-style-type: none"> <li>Strong Comms Plan</li> </ul>
<ul style="list-style-type: none"> <li>Freeze Payment by Results: Incentivise primary/community care to keep people out of hospital</li> </ul>		

## Themes

Theme	Issues/Aims
Get the Governance Clear	<ul style="list-style-type: none"> <li>• Clear governance structures including responsibilities/obligations</li> <li>• Evaluation of services</li> </ul>
Visible working together – walk the talk at each level	<ul style="list-style-type: none"> <li>• Visibly working together (as shown in this event)</li> </ul>
Many channels, opportunities and touch points, but behind that a united response	<ul style="list-style-type: none"> <li>• Multiple opportunities to connect within the community at all stages of life in a meaningful way and easy to get and give support - mutuality</li> </ul>
Break the boundaries – give GPs ability to ‘prescribe’ not just medicines, but social prescribing [for example, further education, lunch clubs, self-help groups, befriending, hobby clubs, gardening, sports, book groups, art or dance classes	<ul style="list-style-type: none"> <li>• Alternative prescriptions – remove the idea that GPs can only prescribe health</li> </ul>
Great engagement at all levels, respect and listening	<ul style="list-style-type: none"> <li>• Trust and honesty</li> <li>• Collaborative working with all agencies keeping the need of the recipient at the top</li> <li>• Building trust between each other</li> <li>• Audit and learn from failures so that the care can be improved and reduce bureaucracy</li> <li>• Co-produced system of integrated services with service users as equal partners in system design</li> <li>• Include everyone in the conversation</li> <li>• Involve everyone in planning care – patients, carers, providers, commissioners, the community</li> <li>• Develop mutual appreciation of differences in organisational culture</li> <li>• Bottom-up approach</li> <li>• Valuing community / Engage all levels of the community</li> </ul>



	<ul style="list-style-type: none"> <li>• Marketing public campaign that involves telling the community that integration is coming, have your say etc.</li> </ul>
Focus on delivery/ rigorous delivery	<ul style="list-style-type: none"> <li>• Keep actions SMART</li> <li>• Ensure all work action points are done</li> <li>• Set out and agree process, milestones, review and action</li> </ul>
Care at home is default position – delivered by localities	<ul style="list-style-type: none"> <li>• Community first – everything at a local level unless by exception</li> <li>• Care at home unless intervention cannot economically and practically be delivered at home</li> </ul>
Be clear how money flows – do not fudge it!	<ul style="list-style-type: none"> <li>• Respectful joint commissioning</li> <li>• Value for money</li> <li>• Get control of processes and cash flows</li> <li>• Change finance costing systems and budgetary arrangements</li> </ul>
Build our single support offer around the person	<ul style="list-style-type: none"> <li>• outcomes rather than services</li> <li>• Local Area Co-ordinators to work along side GPs</li> <li>• Patients select who need highest level of care – priorities</li> <li>• Give power to LAC to supervise/ agree changes to care plan etc all other service providers, in consultation with service users</li> <li>• Joined up care with single point of contact</li> <li>• Build [and co-ordinate] care and support around the person</li> <li>• Build on what we have together – joined up well</li> <li>• Community development approach to involve community in 'care' – inclusive approach (services)</li> <li>• Care plans covering all aspects of the needs of the person</li> </ul>

	<ul style="list-style-type: none"> <li>• Single plan for whole person which directs the interventions of all providers and connects people to their communities</li> </ul>
Prevention/ anticipation focus	<ul style="list-style-type: none"> <li>• Incentivise primary and community services for keeping people out of hospital/ residential care</li> <li>• Person centred and 'led' in a preventative and anticipatory way</li> <li>• Choice of provision by service user where services are needed</li> <li>• Prevention is better than cure</li> </ul>
Shared Information is core to a unified response to a comprehensively personal plan	<ul style="list-style-type: none"> <li>• Clear systems of communication within and across agencies</li> <li>• Focused and useful easy to understand and negotiate</li> <li>• Patient-led plan which all relevant parties can access</li> <li>• Understand information governance 'rules' and how to prevent them from becoming barriers to integration</li> <li>• Good acceptable tool to allow information sharing across historic boundaries</li> </ul>
Shared purpose	<ul style="list-style-type: none"> <li>• Shared principles with an agreed unified vision</li> <li>• Common goals</li> </ul>
A single joined up plan from bottom (the individual care plan) to top – our single Thurrock Plan	<ul style="list-style-type: none"> <li>• Joined up plans (despite legislation barriers)</li> <li>• Focus on whole patient</li> <li>• Needs to start at the beginning of the patient's pathway to prevent crisis</li> <li>• From diagnosis, a live (reviewed and responsive) care plan considering all areas of health and wellbeing for both patient and carer(s)/family</li> <li>• Community care developed</li> </ul>

	<ul style="list-style-type: none"><li>• Planning with stakeholders</li></ul>
Principle from top to bottom – from single commissioning to single point of contact	<ul style="list-style-type: none"><li>• Commission a single economy of health and social care as well as investment in the community – neighbourhoods, and the built environment</li><li>• Single commissioning arrangement for H&amp;SC in Thurrock</li><li>• Identify responsible persons who are accessible</li></ul>