



Summary

Thurrock health and care system partners have developed a whole systems approach to integrated care based on HLS principles.

The strategy defines a single model of integrated care as well as an ambitious transformation plan for each key element of the system:

- Community engagement and empowerment
- Primary Care
- Population Health Management
- Integrated Community Care
- Support in the home
- Residential and supported accommodation
- Commissioning

The strategy describes a new operating model, based around the person and the area in which they live.

Thurrock Integrated Care Alliance and Integrated Care and Wellbeing model

| Overview and history

This is a new Example of Practice. This document describes the HLS approach that health, housing, adult social care, and third sector partners have adopted as a framework for the development and implementation of an integrated care strategy and operating model.

Thurrock Integrated Care Alliance (TICA) is the highest-level strategic partnership at borough level responsible for the integration and improvement of health, care, housing, wellbeing, and third sector services. It contains very senior and chief officer representation from the council's adult social care, public health, and housing functions, the Mid and South Essex NHS Integrated Care Board (Thurrock Alliance), Mid and South Essex Hospital Trust, NHS Community and Mental Health Trusts, and Thurrock Council for Voluntary Services and Thurrock Healthwatch.

The Alliance is one of four place-based alliance partnerships that sit within the geographical footprint of the Mid and South Essex NHS Integrated Care Board (ICB)

Thurrock Council is a unitary authority with a geographical footprint that sits within that of the wider geography of the ICB.

The Thurrock Integrated Care Alliance (TICA) is a sub-committee of the ICB Board and of the Thurrock Joint Health and Wellbeing Board. Describe your context and what you do.



Historical Context

In 2021, partners within TICA committed to refreshing their shared Integrated Care Strategy and model in the context of NHS reorganisation and the creation of Integrated Care Boards. Partners at Thurrock level had a long history of strong partnership working and strengths based community practice including Local Area Coordination, asset based community development approaches, and Community Led Support which is a strengths based model of community/locality based adult social care operational teams. However the community and mental health provider landscape was more traditional with a significant number of specialist teams delivering functional clinical interventions organised on New Public Management principles. The model of housing delivery was similarly fragmented and traditional with little joint working between housing, health, and care professionals.

Around this time, the newly appointed Executive Director of Adult Social Care, Housing, and Health (who was the council's former Director of Public Health) came across the concept of Human Learning Systems and felt it was an excellent theoretical framework on which to build a new strategic approach to whole systems integration at TICA level. He also reflected that the concept could be used to explain the success of the existing strengths based elements of the system; largely because they were already operating to *human* principles, and to explain why elements of the system operating on New Public Management principles were far less effective.

Better Care Together Thurrock: The Case for Further Change

Throughout 2021 the Exec Director AHH led a process with system partners of developing a whole systems approach to integrated care based on HLS principles. The resultant strategy can be found here: [Case for further change, 2022-2026 | Health and well-being strategy | Thurrock Council](#)

The strategy defines a single model of integrated care set out in Chapter 3, but also contains specific chapters that set out ambitious transformation plans for each key element of the system:

- Chapter 4 describes the next phase of asset based community development and leveraging the power of communities and residents
- Chapter 5 describes Primary Care Transformation
- Chapter 6 describes the next phase of Population Health Management
- Chapter 7 sets out a new model of integrated community care
- Chapter 8 describes a new model of homecare
- Chapter 9 describes a new model of residential care and supported living.

The strategy describes a new operating model, based around the person and the area in which they live, which is driven by HLS principles and values as described below.

Do you use the language of 'Human Learning Systems' to describe your approach? If not, what other language do you use?

Yes, absolutely. A significant amount of work was done at the start of the strategy refresh to explain the concepts of Human Learning Systems and gain buy in from both senior leaders and staff at all levels of the system including multiple workshops and presentations.



HLS is explicitly and repeatedly referenced within the strategy. Staff across multiple services now reference HLS and its concepts when explaining their work.

| HLS Approach

| Human

Describe what is ‘Human’ about how you work [with reference to the ‘[Human](#)’ chapter’ of “Human Learning systems: public service for the real world”]

Relational practice sits at the heart of the strategy, building on learning that the council had already gained from its successful implementation of Local Area Coordination and previous strength-based transformation programmes. Local Area Coordinators are neighbourhood based, self-managed, community case workers. Their primary function is to form relationships with residents with complexity, determine resident goals, and then walk alongside the resident to help them achieve those goals. They operate through self-managed teams to the principles set out below:

- 01 **Don't break the law**
- 02 **Don't break the bank**
- 03 **Do no harm**
- 04 Build a relationship to determine what is important
- 05 Hold the case. Do not refer on. Pull help in.
- 06 Rooted in the community. No assessment. Open access
- 07 No set intervention or service delivery
- 08 No targets, metrics or bureaucracy but capture the learning
- 09 As long as it takes
- 10 20% time spent on understanding and building community capacity

The strategy and resulting integrated care model takes these principles and applies them to a wide range of staff operating at a locality level. At the heart of the strategy sits the concept of the Integrated Locality Team. Rather than delivering functional interventions and making referrals, staff from a broad variety of health, housing, adult social care, and third sector services come together within four ‘localities’ (sub borough geographies) to form relationships with each other and with residents. The aim is to co-design bespoke single integrated solutions with residents that respond to individual resident context. Our hypothesis was that by fundamentally shifting practice to a model focused on solutions rather than services, we could leverage the assets of all partners, plus the resident themselves and the entire community. In doing so, we would be able



to deliver single integrated solutions that were more effective at delivering the outcomes required by and important to the individual – e.g. their version of a ‘good life’. This in turn would reduce onward referrals and prevent residents with complexity from ‘bouncing around the system’ consuming resources but without their issues being addressed effectively – and often leading to an increased requirement for support or time spent in crisis. Achieving this shift would reduce and prevent ‘failure demand’, improve outcomes, and save money. Success would also help to shift the system ‘up stream’ – catching people before they fell and preventing, reducing and delaying the need for care and support.

The Integrated Locality Teams currently consist of professionals working within the following teams:

- Community Led Support Teams (ASC community front line teams)
- Integrated Community Nursing
- Older Adults Mental Health
- Housing Solutions (homelessness support)
- Tenancy and Neighbourhood services including anti-social behaviour
- Local Area Coordination
- Community Hub staff
- Addictions services
- NHS Community Mental Health support
- Primary Care Network Mental Health Support
- NHS Dementia Crisis
- Primary Care Networks – including GPs, Practice Managers
- Thurrock Alliance Clinical Leads
- Primary Care Network ARRS roles (mixed skill clinical workforce supporting GP practices)
- Third sector organisations
- Public health improvement services e.g. obesity and stop smoking support

The same concepts can be seen within the Chapter on Integrated Care at Home. We have moved away from the concept of ‘time and task’ domiciliary care at home and created Wellbeing Teams where self-managed teams of 12 wellbeing workers form long-term care relationships with residents allowing the workers to really understand and respond to the unique context of each resident rather than simply delivering care tasks determined from an assessment. This allows a more flexible approach to delivering care meaning that on days where residents may not need all of the prescribed care hours, these can be banked, and the wellbeing worker can use these to undertake more holistic activities with those they care for at a later date. The long-term relationship element of the model also means better continuity of care meaning that when a resident’s health is deteriorating, this is spotted and addressed early.

Aligning Community Nursing functions into the team, and training Wellbeing Team Workers to undertake routine clinical tasks historically delivered by a Community Healthcare Assistant, will see the creation of a ‘blended role’. The vision is that wellbeing workers will act as a hybrid of a Local Area Coordinator, traditional domiciliary care worker, and HCA in a homecare setting. Functions historically delivered by health providers including wound care, stoma care, and insulin injections are such tasks that are likely to be undertaken by Wellbeing Team workers, rationalising the number of different professionals entering the resident’s home and improving continuity of care relationships further. Through the new domiciliary care contract, we will work



with external providers to shift towards a new operating model – one that reflects the principles of Human Learning Systems. The contract specification has changed to reflect this desire and the length of the contract has been lengthened to secure the investment and commitment required to deliver this change.

| Learning

Describe how you have enacted Learning as a management strategy [with reference to the ‘[Learning](#)’ chapter’ of “Human Learning Systems: public service for the real world” or the [Practical Guide for the Curious](#)]

- We have sought to embed learning in all elements of the new system as we have built its elements.
- We have set up Communities of Practice both focused on staff, and between staff and residents (currently through a user-led partnership board) where professionals/residents come together to reflect on what is working well, what is working less well and what needs to change
- Housing and Mental Health Teams set up a learning experiment to understand each other’s roles and processes and how better they could work together that resulted in regular MDTs
- We brought together colleagues in housing operations, homelessness, addictions services and adult social care in a learning experiment designed to understand and better respond to residents with overlapping housing, addictions, and mental health and care issues. This resulted in a new model of care known as Complex Housing Intervention Programme (CHIP) with a multi-disciplinary team of psychology support, addictions, local area coordination, and care with a wraparound service to support residents who are at the point of eviction and need a bespoke solution to help them remain in permanent and secure housing. The other initiative is Housing First Plus (linked to CHIP), where a dedicated Community Psychiatric Nurse works with those who are often in inappropriate placements due to lack of bespoke solution. A property is secured for the individual and work is carried out with them with the view of them remaining in the property and securing a permanent tenancy.
- We are in the process of building an outcomes matrix of high level population health variables to demonstrate the impact of the new way of working at a population health level.
- We have also collected resident stories and are developing case studies that show both a positive impact of where the new approach has delivered better outcomes for residents and also where the system hasn’t worked well. These have been discussed at the operational boards (see governance section), Integrated Locality Team Steering Groups (see Systems section) and at times at the Thurrock Integrated Care Alliance itself. We have used learning from case studies to further refine and adapt the system, and to celebrate success as a mechanism to further enhance trust and buy in from all system actors.
- In addition, we are shifting the way that we commission to build learning into our specifications. This means that we are commissioning for learning and will work with providers differently and in partnership to develop and test ideas and hypotheses that develop what is offered over the life of the contract – rather than a static way of operating to contract. Commissioners will act as system stewards. This is currently reflected in our new domiciliary care specification.



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We are also developing more of a learning culture within Adult Social Care. We have successfully bid for a researcher in residence, and we have members of staff who will gain the skills to conduct a greater level of research and impact measurement. This will help to embed learning and identify the impact of the experiments we conduct and changes we make.

| Systems

What is the ‘system’ that you have worked with/brought together? (i.e. who are the people/organisations involved? What work have you done to help them learn together?) [with reference to the ‘[Systems](#)’ chapter of “Human Learning Systems: public service for the real world”]

The system encompasses all functions covered by the strategy. These include:

- Adult social care
- NHS community services
- NHS mental health services
- The Thurrock Alliance Team of the Integrated Care Board
- The hospital discharge pathway
- Primary Care services including Primary Care Networks
- Public Health including health improvement and population health management.
- The local third sector including Thurrock CVS and Thurrock Healthwatch
- The ‘people’ elements of housing including homelessness, housing allocations, and housing operations e.g. tenancy management, estate management, housing safeguarding.

A huge amount of preparatory work was undertaken with all system partners to co-produce and agree the strategy and system that we wanted to create:

- The Executive Director ran multiple sessions on Human Learning Systems to gain understanding and buy in to the concepts. These were aimed at different audiences including senior managers, front line teams, managers, and elected members
- The senior leaders that make up TICA participated in a series of ‘Theory of Change’ processes facilitated by Thurrock Council for Voluntary Services. Through these workshops we agreed the scope

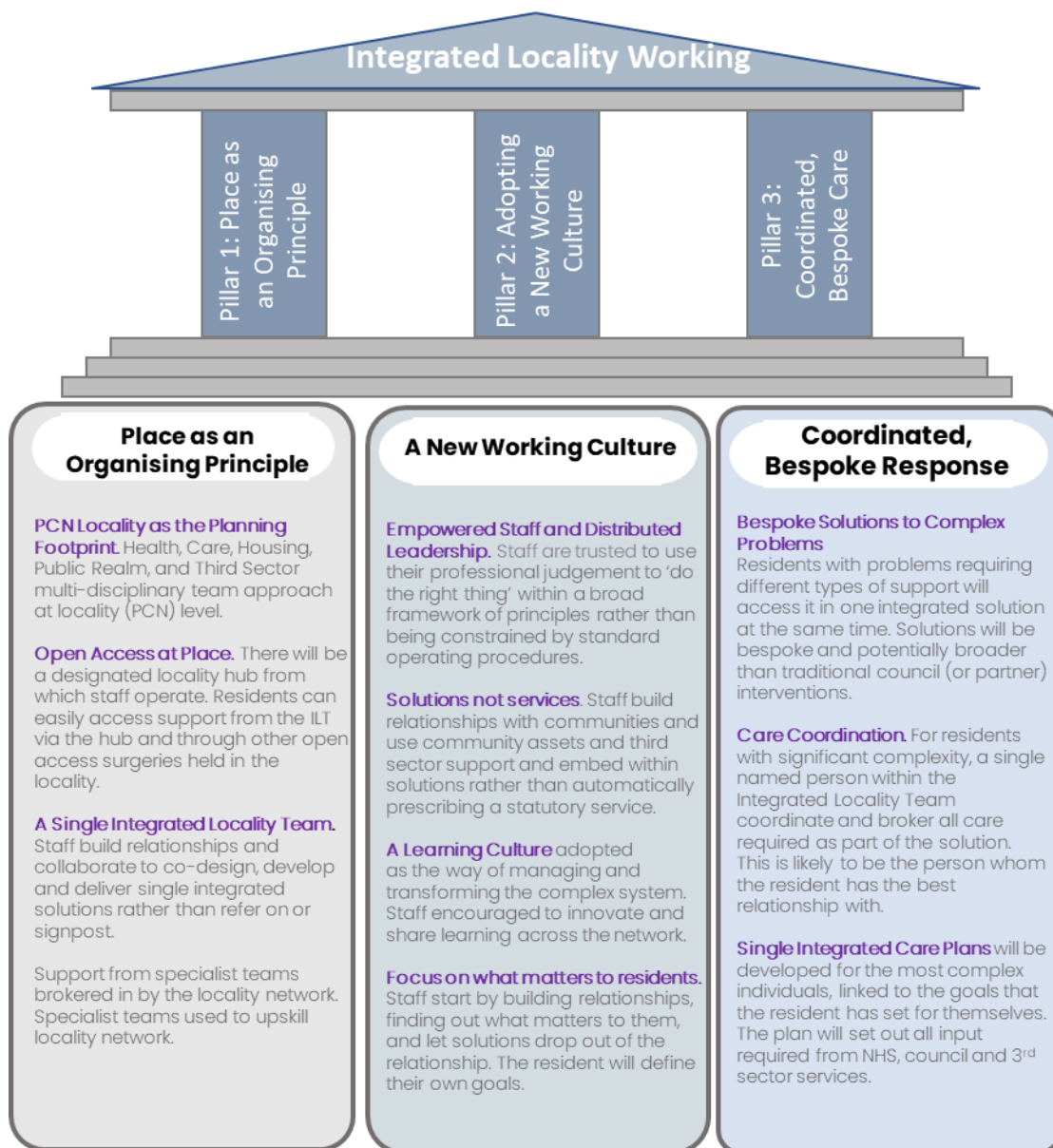
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of the system, our overall vision and purpose, and 12 key principles and values that underpin the system

- We undertook focused workshops with key stakeholders to co-produce each of the six key chapters within the strategy that focused on each of the six key system element (Chapters 4 to 9)
- We undertook a comprehensive engagement exercise with residents that collected over 1000 responses. This was commissioned through Thurrock Healthwatch

Through this process we agreed three key pillars of Integrated Locality Working that set out how colleagues will work differently in our new HLS system set out overleaf:



During the past 12 months, as the new models of care have come into operation, we have continued to focus on building an architecture to make collaboration between professionals easy. The focus has been strongly on



building relationships between professionals, eliminating the need for onward referrals, a focus on solutions not services, devolving power and decision making downwards to create a 'distributed leadership approach'. For example:

- Each Integrated Locality Team has its own MS Teams Channel with a list of contact details of all professionals in the team. We have instigated a process where any professional encountering a resident with complexity that needs input from multiple different functions or agencies can call an MDT
- We have set up Integrated Locality Team Steering Groups where colleagues meet monthly to capture learning and intelligence around issues, look for themes, and plan a strategic work programme to address issues within the locality, improve collaboration, and improve population health and wellbeing – HLS experiments can be readily identified through these meetings
- We have held launch events for each Integrated Locality Team that have been hugely well attended with real excitement in the room. Colleagues across a wide range of functions and organisations have worked together to build and develop processes to make collaboration easier
- We run 'Talking Shops' within community venues including village halls and supermarket cafes where professionals across the Integrated Locality Team come together in one place to hold open access surgeries with residents. Anyone can turn up and access the support of the entire Integrated Locality Team. There are no referral or eligibility criteria.

| Governance/Accountability

How is this work being governed? How have your governance or accountability processes changed to work in a Human Learning Systems way?

We set up a governance structure that sits under the Thurrock Integrated Care Alliance to manage the programme of change. This included dedicated sub-boards for:

- Chapter 4 – Leveraging the Power of Communities
- An Integrated Care in the Community Sub-Board that oversees work of Primary Care, Community Care, and Integrated Care at Home (Integrated Locality Working Board)
- A health inequalities board that oversees the Population Health Management elements of the strategy
- An operational group for the Supported Living elements
- An Integrated Commissioning Executive

We held two workshops at the start of 2023/24 to agree an annual work programme including phasing of the overall strategy.

A Better Care Together Executive Group that meets monthly oversees progress of the sub-boards and unblocks any system issues.

| Barriers and Tensions

What difficulties did you encounter? How did you respond to them?

At a strategic level, the approach has worked well. Senior leaders at Thurrock level have been very invested in the approach. There has been some tension between the Thurrock Alliance and the wider NHS Integrated



Care Board (that is also responsible for three other Alliance areas outside Thurrock that have not adopted the approach). The ICB at Mid and South Essex level is less invested in HLS and periodic tensions have arisen when the ICB has attempted to impose 'one size fits all' transactional or functional models of care in silos that it has developed. This was particularly true at the start of the programme.

We have managed this tension through development of an MOU with the ICB that defines responsibilities at ICB system level, alliance level, and locality level. As part of this, we agreed the key principle of 'Subsidiarity' with the ICB. The NHS focus on Integrated Neighbourhood Teams as a policy directive has also made things easier as the Thurrock model fits better under this national direction.

At an operational level, staff are generally very invested in the new way of working and there has been lots of positive feedback. There remain some practical barriers in terms of identifying shared space from which Integrated Locality Teams can operate in some localities. One of the four localities has an Integrated Medical and Wellbeing Centre with significant shared space available for professionals across organisations and teams to operate within. This has accelerated relationship building and the Integrated Locality Team operating in this locality is further developed as a result.

We also encountered some clinical governance concerns from managers in the NHS Community Trust relating to the Wellbeing Worker blended role and training Wellbeing Workers to undertake routine clinical tasks such as insulin injections, although these have now been overcome.

A lack of an integrated place based budget between the council and NHS remains a barrier. In further developing and scaling the model there are likely to be incidences where one organisation needs to make an investment but another may reap the financial benefit, for example investing in further community prevention is likely to reduce demand on the hospital front door. We have tried to manage and mitigate this through creative use of the Better Care Fund but it remains an ongoing tension.

| Enablers and 'top tips'

What were the factors/conditions which enabled you to adopt an HLS approach?

We have reflected on this a great deal. There are a series of fundamentals that have supported the success of the programme:

1. We have a maxim in Thurrock that **'progress happens at the speed of trust'**. Continuous investment in long term trusting relationships between system partners at a senior level is absolutely critical. This allows organisations to take risks and share sovereignty and risk. At an operational level, our focus has been very strongly on building structures and opportunities that make it easy for staff across functions to form relationships with each other rather than make onward referrals. Collaboration is key.
2. **The approach is essentially a values and principles one.** The Theory of Change workshops that senior leaders went through collectively where we agreed our key values and principles based on HLS was fundamental to ensuring strong foundations for the success of the work. When there are difficulties, tensions, or differences of opinion, having agreed values shared between partners has provided a very useful reference point that we can refer back to and hold each other to account against.

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3. **Getting the strategy right in the first place is fundamental.** We spent an entire year developing ours. We co-produced the key elements with a wide variety of stakeholders. We have also spent a number of years testing and delivering new ways of working and innovative solutions based on asset based community development. The experience gained through a number of years of transformational activity has helped us to identify how to develop and deliver change.
4. **Locality working is essential.** We have focused the model at geographies below borough level. This facilitates relationship building across functions and a strengths and assets based approach. The borough is generally too big and complex to do this once. We challenge the maxim that efficiency is gained by scale. Our learning suggests the opposite; efficiency and effectiveness is gained through integration and relationship building at smaller geographies.
5. **Distributed leadership is key.** We have focused throughout on empowering professionals at all levels to build relationships and processes that work for them, and through ongoing learning to adjust these. The strategy sets out high level principles and strategic actions, but no one person can have adequate oversight of a system as complex as health, care, housing, and wellbeing to have all the answers. Our focus has been on self-management, empowerment and permission giving to staff to take the concepts set out in the strategy, build on them, and innovate



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6. **Changing our approach to commissioning has definitely been an enabler.** All newly tendered specifications have a requirement for providers to work in a collaborative way with other stakeholders as part of the Integrated Locality Network, to co-produce their care models with communities, and to collect and share learning with an explicit expectation that they will adapt and evolve their care model in response to this learning throughout the lifecycle of the contract in consultation with commissioners. We have sought to keep KPIs (particularly process KPIs) to an absolutely minimum.
7. **Joint appointments.** We recruited a Partnership Director as a joint appointment between the Council, the Community NHS Trust, and the Community Mental Health Trust, and an Assistant Director for Integrated Care as a joint appointment between the Council and the Community NHS Trust. These senior leaders have direct responsibility for staff across multiple organisations. This has made integration much easier. At an operational level, we have single teams jointly funded with staff

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responsible for functions across different organisations. For example Thurrock First – our Single Point of Contact has advisors that are jointly responsible for (and have access to) NHS Community Services, NHS Mental Health Services, and Adult Social Care. This enables them to co-design single integrated solutions with residents who have multiple needs. Similarly, we have health and adult social care staff working as one Urgent Care Response Team.

8. **Use qualitative and quantitative data to make your case.** Thurrock Council is in the process of developing a new Operating Model based largely on the learning from our Adults' Integrated Care approach. In shifting the council, and particularly members to a point of significant buy in, we have presented a series of case studies that show positive impact on residents, and global metrics that demonstrate very low spend and statutory placement use in both residential and community placements despite high levels of population need. Using outcome data triangulated with positive resident stories makes a compelling case to gain further buy in.

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| What have you achieved?

What has adopting an HLS approach enabled you to do?

We have numerous case studies showing positive impact on the lives of residents together with positive impact and feedback from staff who feel enabled and trusted. One Thurrock GP recently described the Integrated Locality Team approach as 'having revolutionised the way that I am able practice medicine'.

The approach shows in much of our high level outcome metrics:

- When considering the cohort of residents accessing Adult Social Care, Thurrock's cohort is in the highest quartile of comparative need in England in terms of deprivation for those access community care and residential care. However, we are in the lowest quartile in terms of rate of spend on care per head of population, and rate of statutory placement use per head of population for both residential and community care for both all age and older people. We are the only one of 152 top and single tier local authorities to show this need vs spend/service usage pattern, suggesting our system is highly effective at preventing demand.

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- Initial evaluation of our Wellbeing Team model suggests that those cared for by a Wellbeing Team had a seven fold reduction in GP usage and a three fold reduction in emergency hospital admissions compared to standard care.
- Our integrated approach to cardio-vascular disease management as resulted in Thurrock having the best outcomes in England on six of the 12 key Quality Outcomes Framework CVD indicators.
- Our recent evaluation of our Complex Housing Improvement Programme (CHIP) shows significant savings achieved through the development and delivery of a different approach to working with a particular cohort of people.

| What next?

What is the next challenge for this work?

We will continue to implement the strategy including further integration of additional functions into Integrated Locality Teams. As referenced above, the council is adopting the approach in a broader New Operating Model including moving Public Realm Functions into a locality model.

We are also reviewing our governance arrangements following a field trip to Newcastle. This will help to ensure that we have the right balance between the 'human', 'learning' and 'system' elements and that learning cycles are embedded as a way of working.

