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

# Health and Wellbeing Board

The meeting will be held at **1.30 pm** on **20 July 2018**

**Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL**

**Membership:**

Councillors James Halden (Chair), Robert Gledhill, Tony Fish, Barbara Rice and Susan Little
Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board
Steve Cox, Corporate Director for Place
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Roger Harris, Corporate Director of Adults, Housing and Health
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust
Rory Patterson, Corporate Director of Children's Services
David Archibald, Independent Chair of Local Safeguarding Children's Board
Andrew Pike, Chief Executive Basildon and Thurrock Hospitals Foundation Trust
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust
Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust
Gillian Ross, Lay Member, Thurrock CCG
Ian Wake, Director of Public Health
Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways
Adrian Marr, NHS England - Essex and East Anglia Region.

**Agenda**

Open to Public and Press

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| **1** | **Apologies for Absence** | |
| **2** | **Minutes** | **5 - 10** |
| | To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 8 June 2018. | |
| **3** | **Urgent Items** | |
| | To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972. | |
| **4** | **Declaration of Interests** | |
| **5** | **STP Update** | |
| | A verbal update will be provided to members | |
| **6** | **Primary Care Strategy** | **11 - 64** |
| | Item to be presented by Rahul Chaudhari, Director of Primary Care, Thurrock CCG | |
| **7** | **Mental Health Peer Review Findings** | **65 - 108** |
| | Item will be presented by Roger Harris, Corporate Director Adults Housing and Health, Thurrock Council | |
| **8** | **Thurrock Dementia Local Action Plan** | **109 - 150** |
| | Catherine Wilson strategic Lead Commissioning and Procurement Adult Social Care<br>Irene Lewsey Head of Transformation Thurrock CCG will introduce the item to members | |
| **9** | **Thurrock Health and Wellbeing Strategy Annual Report 2017-2018** | **151 - 226** |
| | A PowerPoint presentation will be provided to members | |
| **10** | **Health and Wellbeing Board Terms Of Reference Annual Refresh** | **227 - 234** |
| | Item will be introduced by Darren Kristiansen, Business Manager, | |

Adults Housing and Health Directorate, Thurrock Council

| | | |
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| **11** | **Housing and Planning Advisory Group Report and Terms of Reference** | **235 - 244** |
| | Item to be introduced by Leigh Nicholson, Strategic Lead - Development Services, Place Directorate, Thurrock Council | |
| **12** | **Integrated Commissioning Executive (ICE) Minutes** | **245 - 248** |
| | To consider and be provided with an opportunity to comment upon ICE minutes from meeting of 26 April 2018 | |
| **13** | **Work Programme** | **249 - 252** |
| | To provide Board members with an opportunity to consider and inform the Board's work programme | |

**Queries regarding this Agenda or notification of apologies:**

Please contact Darren Kristiansen, Business Manager by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **12 July 2018**

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# DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

## Helpful Reminders for Members

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

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

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

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**Does the business to be transacted at the meeting**

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

### Pecuniary

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

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

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

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

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

### Non- pecuniary

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

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

# Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

**Minutes of the Meeting of the Health and Wellbeing Board held on 8 June 2018 at 10.30am – 1:00pm**

| | |
|---|---|
| **Present:** | Councillors James Halden (Chair), Susan Little, Tony Fish and Barbara Rice<br><br>Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group (Thurrock CCG)<br>Roger Harris, Corporate Director of Adults, Housing and Health<br>David Archibald, Independent Chair of Local Safeguarding Children's Board<br>Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust<br>Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways<br>Clare Culpin, Managing Director BTUH<br>Jeanette Hucey, Director of Transformation, Thurrock CCG |
| **Apologies:** | Cllr Robert Gledhill<br>Dr Anjan Bose, Clinical Representative, Thurrock CCG<br>Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board<br>Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG<br>Kristina Jackson, Chief Executive Thurrock CVS<br>Kim James, Chief Operating Officer, Healthwatch Thurrock<br>Clare Panniker, Chief Executive Basildon and Thurrock Hospitals Foundation Trust<br>Rory Patterson, Corporate Director of Children's Services<br>Andrew Pike, Director of Commissioning Operations, NHS England - Essex and East Anglia Region<br>Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust<br>Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust<br>Ian Wake, Director of Public Health<br>Julie Rogers Gillian Ross, Laymember, Thurrock CCG<br>Tom Abell, Deputy Chief Executive and Chief Transformation Officer Basildon and Thurrock University Hospitals Foundation Trust<br>Steve Cox, Corporate Director for Place |
| **Did not attend:** | Dr Anand Deshpande, Chair of Thurrock CCG |
| **In attendance:** | Maria Payne, Public Health<br>Rita Thakaria, NELFT<br>Geraldine Rogers , NELFT |

## 1. Minutes

Apologies were noted. The Chair welcomed Cllr Fish and Cllr Rice as Health and Wellbeing Board members.

## 2. Urgent Items

There were no urgent items raised in advance of the meeting. However, the Chair wished to raise and welcome Cllr Little's work with partners to provide support for looked after children. Cllr Little showed members the new personal health passport that provides advice and guidance on various matters including information about local services and advice on areas such as contraception and support services.

## 3. Declaration of Interests

There were no declarations of interest.

## 4. STP Update

Mandy Ansell provided members with a verbal update. The following points were made:

- The STP is currently in a decision making phase following public consultation which closed on 23 March. As part of the consultation exercise a range of materials and suite of documents were made available that included supplementary documentation specifically focussed on proposals for Orsett hospital and an easy read STP consultation document.
- A recent review of the STP undertaken and led by Paul Watson, NHS England, received positive feedback
- The CCG Joint Committee will take decisions in July 2018 taking into consideration consultation responses received.
- Members were reminded that the STP continues to engage strategic partners across the STP footprint and a joint HOSC will meet on a monthly basis.

## 5. Basildon & Thurrock University Hospital End of year position 2017/18

Clare Culpin presented the item to members. Key points included:

- A reduction in severe injurious falls has been delivered (15 compared to 21 in 16/17). The Trust remains just below the national average
- A&E has experienced a challenging year seeing approximately 35,000 patients per quarter. To address the increase the following measures have been introduced:
    - New frailty & AEC units introduced
    - AEC hours extended over winter 17/18
    - Established Urgent & Emergency Care village in purpose built areas

- Overall all ED Performance for 17/18 is 87.72% (6th out of 13 hospitals across the East of England. The East of England ED performance is 87.00%
- The KPI for cancer around the 2 week wait national standard is 93% and is now being achieved.

During discussions the following points were made:

- Reassurance was provided to members that BTUH endeavours to address understaffing. Actions include:
    - Encouraging and supporting staff to work flexibly
    - Given the increase in people attending A&E members supported the new approach adopted whereby patients are streamed to the appropriate service, ensuring they follow an appropriate care pathway.
- Action is being taken to reduce delay discharges of care, which is monitored effectively and robustly. Members acknowledged that DTOC is a shared social care and health responsibility and partners are working closely together.
- Consideration was provided as to whether Sepsis is increasing and the positive impact of awareness raising campaigns by BTUH and NELFT on site and on patient care pathways.
- A GP has been employed at BTUH since October 2017 to ensure patients requiring the local GP service can be seen immediately or be advised to see their own GP.
- It was acknowledged that the 62 day cancer standard was not being achieved and members were reassured that the cancer lists is considered daily and proactive action is being taken to improve performance.
- Concerns were raised about some of the experiences of patients in A&E, particularly during busy periods. Some Board members set out concerns about their personal experiences. Members learned that additional action has now been taken to create additional capacity in A&E including changing the patterns of ambulance arrival at the site.
- Members were reassured that the retention of Executive Management team and changes in leadership and/or roles has not adversely impacted upon performance.

RESOLVED: Health and Wellbeing Board members:

- Noted the contents of the update.

**6. Mental Health JSNA for children**

Maria Payne, Senior Public Health Programme Manager, Health Intelligence public Health presented the item to members. Key points included:

- We know that the mental health of our children and young people is a major concern for young people, parents, teachers and other professionals. One in ten young people has some form of diagnosable mental health condition (DoH & DfE, 2017). Between a quarter and half of all adult mental health disorders could be averted with effective childhood interventions (COI, 2011).
- The Joint Strategic Needs Assessment (JSNA) process involves an assessment of the current and future health and social care needs of

the local community – these are needs that could be met by the local authority, Clinical Commissioning Groups (CCGs), or NHS England. It is intended to provide a shared, evidence-based consensus about key local priorities and support commissioning to improve health and wellbeing outcomes and reduce inequalities.

- The JSNA focuses on the mental health of Thurrock's children and young people in a broad sense – addressing the protective factors for positive mental health and risk factors for poor mental health, rather than focusing solely on diagnosed mental health conditions. This JSNA aims to:
    - Understand the main protective factors and risk factors for mental health and wellbeing in children
    - Provide analyses from the Brighter Futures Survey conducted in a number of Thurrock schools last year to demonstrate young people's needs
    - Provide an overview of what is currently being done in Thurrock in relation to these broader factors
    - Provide an overview of the evidence on what works to improve children and young people's mental health including key case studies
    - Identify priority areas for action to improve children and young people's mental health in Thurrock
    - mental ill health which is being addressed through the Long Term Condition profile card.

During discussions the following points were made:

- The JSNA included limited references to looked after children. Reassurances were provided to members that a JSNA which focusses on looked after children is currently being considered by Public Health which will include mental health.
- Members were advised about action being taken that recognises and supports positive parenting and positive role models
- Members welcomed the involvement of schools in the Brighter Futures Survey which helped to inform the JSNA by asking children about their emotional health and wellbeing.

RESOLVED:

- The contents of the JSNA document be approved by the Health and Wellbeing Board including the recommendations found in the report and that Board members use the contents and recommendations of this JSNA product to drive local commissioning decisions around children and young people's mental health.
- The Health and Wellbeing Board agreed the work on this JSNA is pivotal to a wider programme of partnership working around this topic

**7. The Big Conversation. Feedback on child and adolescent mental health summit**

*Due to the due items 8 and 9 being interlinked and discussions on the Mental Health Summit being intertwined with the discussion on the Information Portal and Self Harm Management Toolkit Suicide Prevention both items are reported together*.

The Chair introduced the item advising members that the Summit had taken place on 18 May and had been very positively received. The Summit was jointly chaired by Cllr Halden and the Chair of the Schools Forum.

Malcolm Taylor, strategic lead, inclusion, provided members with a presentation. Key points included:

- Feedback from Summit workshops suggested
  - That there is a demand for treatment, as highlighted in JSNA,
  - Capacity of agencies to support complex needs must be suitable,
  - Waiting times should be as short as possible
  - There should be a flexibility of treatment approaches
- Positive feedback was provided about individual programmes and there was strong support for collaborative working arrangements and some focus being provided to approaches based on prevention.
- An outcome of the Summit was agreement to establish a New Partnership School- Based Model for Thurrock that:
  - Supports schools in coping with children and young people with signs of poor mental health.
  - Builds capacity within existing services through ongoing support and training
  - Provides a strong focus on the preventative factors and universal approaches to emotional wellbeing
- An online portal has also been launched that supports schools with effectively supporting children with emotional wellbeing and mental health in young people. The portal includes advice and guidance on self-harm and suicide prevention

During discussions the following points were made:

- Members welcomed the work undertaken on mental health by all partners.
- It was agreed that schools and youth services should be supported to identify and manage mental ill health and have the confidence to do so.
- Support for staff health and wellbeing within the online portal was strongly welcomed by members.

**8. Children's Self-Harm Toolkit and Online Portal**

Key discussion points are set out under previous agenda item

**9. Update on LD Targeted Health-checks and preliminary results**

Mandy Ansell provided members with an update:

- NHS England and NHS Improvement have set a target for GPs and Clinical Commissioning Groups (CCGs) to improve access to healthcare for people with a learning disability so that by 2020, 75% of people on a GP Learning Disability register in England will be receiving an annual health check. In 2017/18, 77.4% of people registered with a Learning Disability in Thurrock received a health check.

Board members acknowledged the increase in LD Health checks and congratulated the CCG and partners on performance

**10. Integrated Commissioning Executive Minutes**

RESOLVED: Members noted the Integrated Commissioning Executive (ICE) minutes for meetings that took place in February, March and April 2018.

**11. Work Programme**

RESOLVED: The Board noted the future work programme. Cllr Halden requested the future planner includes items on:

- Cancer care
- Air Quality and
- The East of England Ambulance Service

**The meeting finished at 12.31pm**

Approved as a true and correct record

**CHAIR**

**DATE**

**Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk**

| 20th July 2018 | ITEM: 6 |
|---|---|
| **Health and Wellbeing Board** | |
| **Primary care Strategy. Thurrock Clinical Commissioning Group** | |
| **Wards and communities affected:** All | **Key Decision:** N/A |
| **Report of:** Rahul Chaudhari- Director of Primary Care | |
| **Accountable Head of Service:** Mandy Ansell- Accountable Officer | |
| **Accountable Director:** Mandy Ansell- Accountable Officer (Thurrock CCG) | |
| **This report is** public | |

**Executive Summary**

Current high level modelling across the STP shows that there is an existing, and growing, demand and capacity gap for Primary Care services. This is more prominent in Thurrock as we are one of the most under-doctored borough nationally.

Thurrock CCG has been working with the CCG's, practices and the LMCs across our STP. The system has collectively developed a primary care strategy. We believe our plan has the potential to regenerate and revitalise primary care locally, reducing workload, especially for GPs, improving the service we offer to patients and making mid and south Essex a place where staff want to come and work.

This paper aims to appraise the committee on the:

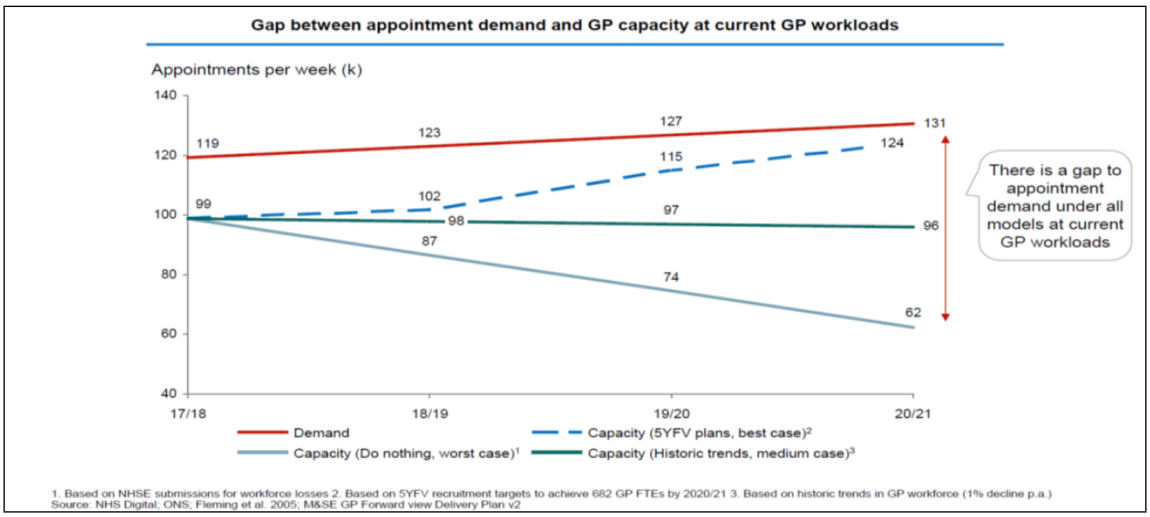
- STP primary care strategy

## 2. Introduction and Background

### i) Overview

General practice in mid and south Essex is at a crossroads. We know that if we carry on as we are, with some of the lowest staffing levels in England, poor morale, excessive workload and difficulty recruiting the staff we need, practices – and individual GPs - will collapse and the quality and safety of the service we provide to local people will deteriorate.

Current high level modelling across the STP shows that there is an existing, and growing, demand and capacity gap for Primary Care services. Getting an accurate picture of the local situation will be a key first step of the implementation plan, but early analysis shows this mid and south Essex scenario is reflected across Thurrock.



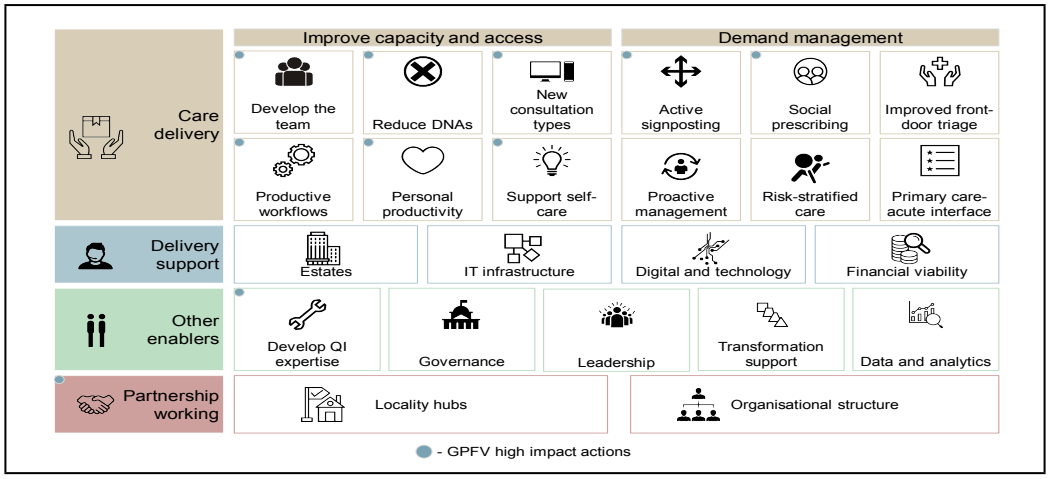

This is not a future anyone wants. That is why, Thurrock CCG has been working with the CCG's, practices and the LMCs across our STP, the system has collectively developed this strategy and the supporting *narrative*. We believe our plan has the potential to regenerate and revitalise primary care locally, reducing workload, especially for GPs, improving the service we offer to patients and making mid and south Essex a place where staff want to come and work.

Three key themes lie at the heart of our strategy. Firstly, to expand and change the primary care workforce so that we move from a service that is GP delivered to one that is GP led. We want to recruit more GPs and nurses, but also a wide range of other professionals so that we have vibrant, multi-disciplinary teams in general practice.

Secondly, we want practices to accelerate progress in coming together to form localities covering populations of roughly 30-50,000 people. As seen through local examples by working together in localities that they own and control, practices are able to support one another, benefit from economies of scale, improve access for patients and provide a strong foundation for locally integrating a wide range of services.

Thirdly, we plan to do all we can to quickly support practices to manage demand and reduce workload. Our plans include more systematic deployment of proven methods of triage and care navigation, as well as widespread use of digital technology to promote and enable new models of care delivery and reduce bureaucracy.

At its heart it focuses on increasing capacity, improving access and managing demand through the implementation of a range of solutions.




The strategy will help us to build that the solid local foundations that are essential for the further expansion of, and integration with, a wide range of out of hospital services, including community nursing, social care and voluntary organisations.

This work has been overseen by the Joint Committee of the five CCGs - and a work programme specific steering group and working group, consisting of local CCG staff and with local GP input - and the Committee have now endorsed the Strategy and the approach to delivery. Whilst the strategy has been developed collectively, the document should be a locally owned strategy, and requires a local implementation and investment plan.

**iii) Associated paper**

- The 'umbrella' STP strategy

**3.**

**Report Author: Rahul Chaudhari**

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NHS Basildon and Brentwood Clinical Commissioning Group

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Mid Essex Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

NHS Thurrock Clinical Commissioning Group

# *INVESTING IN OUR FUTURE*

# MID & SOUTH ESSEX STP PRIMARY CARE STRATEGY

## GENERAL PRACTICE

## JUNE 2018

## FINAL

# CONTENTS

# EXECUTIVE SUMMARY

General practice in mid and south Essex is at a crossroads. We know that if we carry on as we are, with some of the lowest staffing levels in England, poor morale, excessive workload and difficulty recruiting the staff we need, practices – and individual GPs - will collapse and the quality and safety of the service we provide to local people will deteriorate.

This is not a future anyone wants. That is why, working with practices and the LMCs across our STP, we have developed this strategy and our supporting *narrative*. We believe our plan has the potential to regenerate and revitalise primary care locally, reducing workload, especially for GPs, improving the service we offer to patients and making mid and south Essex a place where staff want to come and work.

Three key themes lie at the heart of our strategy. Firstly, to expand and change the primary care workforce so that we move from a service that is GP delivered to one that is GP led. We want to recruit more GPs and nurses, but also a wide range of other professionals so that we have vibrant, multi-disciplinary teams in general practice.

Secondly, we want practices to accelerate progress in coming together to form localities covering populations of roughly 30-50,000 people. By working together in localities that they own and control, practices will be able to support one another, benefit from economies of scale, improve access for patients and provide a strong foundation for locally integrating a wide range of services.

Thirdly, we plan to do all we can to quickly support practices to manage demand and reduce workload. Our plans include more systematic deployment of proven methods of triage and care navigation, as well as widespread use of digital technology to promote and enable new models of care delivery and reduce bureaucracy.

Our strategy will help us to build that the solid local foundations that are essential for the further expansion of, and integration with, a wide range of out of hospital services, including community nursing, social care and voluntary organisations.

We know that we need to increase investment in general practice to deliver our future model of care. We estimate that fully implementing this strategy will require additional recurrent investment of £35m a year by 2020/21, as a result of significantly increased investment in workforce, estate and digital solutions. We also know that we need to invest in estate; this plan sets out the 'pipeline' that each CCG has developed.

We have already made progress in many areas. What we set out in this plan is not new or unique. What we have lacked until now, however, is a unified strategy that sets a clear direction for all parts of our STP.

This plan has been developed by the five CCGs in our STP working in partnership, as well as with local practices and the LMCs. We will build on this partnership and the momentum we have generated as we implement this plan; doing some things once across the STP where it makes sense to do so, and co-ordinating and sharing our local delivery plans.

# 1. INTRODUCTION

This strategy has been developed by the five CCGs within the mid and south Essex, working alongside practices and the LMCs. It was initiated by the Joint Committee of the CCGs, who recognised that while our STP now has a clear plan for the future of hospital services, we do not have plans of equivalent depth and rigour for primary care.

Its purpose is not to recreate or supersede work already underway in CCGs; rather it is intended to provide a single unifying vision and strategy that can be shared and owned by practices, LMCs, CCG Boards and external partners.

Although the strategy is set at STP level, the drive and energy required to implement it must come locally, from CCGs working together with practices, patients, councils and local organisations.

It is important to clarify terminology at the outset. Although in this document we regularly refer to 'primary care', our scope is limited to general practice; we do not consider in any detail other primary care services such as dentistry or optometry.

We also recognise that general practice is only part of a much wider local care system; providing effective, patient-centred care involves close integration with a wide range of other services, including social care, housing, mental health, community nursing and colleagues in hospital. We have not attempted to address this wider out of hospital picture here: our approach is to focus on re-establishing strong general practice first, as we believe this is a prerequisite for effective local integration.

We have also endeavoured to keep this document reasonably short so it is as accessible as possible. Further detail on the work that supports our strategy is available in both the *narrative* that has been developed in partnership with practices, and the *detailed technical appendix* that supports this paper.

The document is organised in eight main sections:

- Case for change
- Future model of care
- Workforce
- Digital
- Estates
- Finance
- Communications and engagement
- Implementation

This strategy will be finalised by early May 2018. It is then our intention to ask the Boards of each of the five CCGs to formally agree it, together with their local implementation and investment plan.

# 2. CASE FOR CHANGE

**About this section**

In this section we set out why we believe we need to take a new approach if we are to create a secure and stable future for general practice. We show how our STP has exceptionally low staffing levels, how this is likely to worsen in the future, and the impact this has on workload, morale, recruitment and our ability to provide consistently high quality services for patients.

There is a powerful case for change for general practice across our STP:

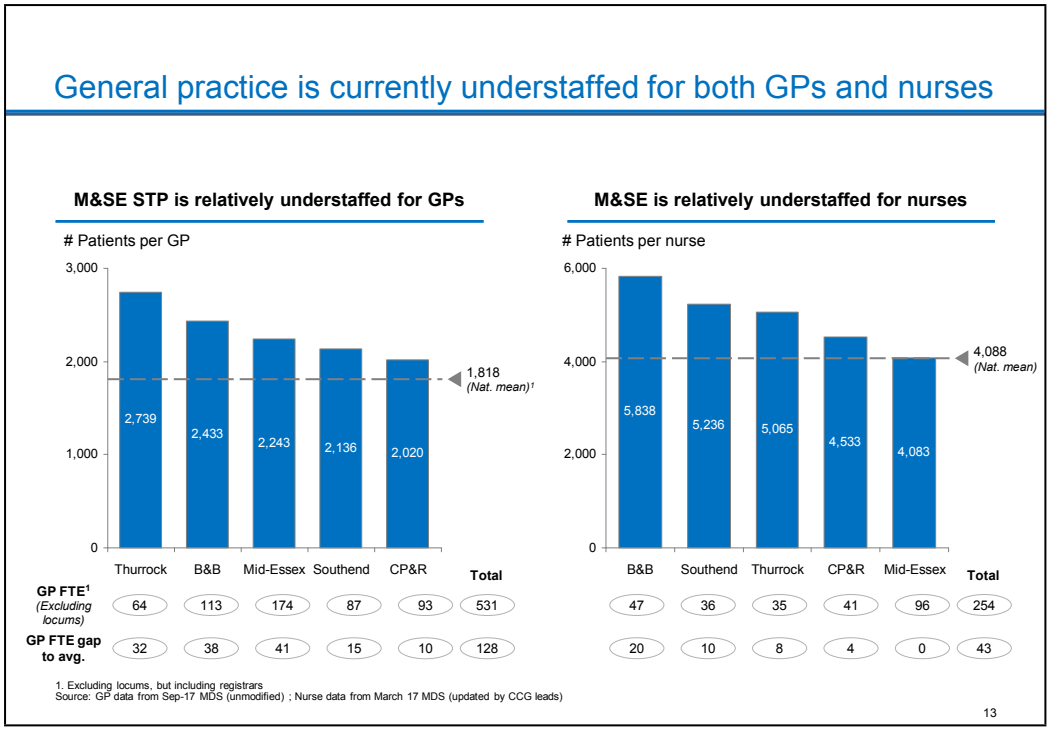
- General practice is understaffed, resulting in high workload
- Retirements will further reduce staffing levels
- Morale is low and we face long running recruitment challenges
- There is insufficient capacity to meet current demand
- The gap between demand and capacity will widen in future
- The service experienced by our patients is variable

**General practice is understaffed, resulting in high workload**

We know that against most of the key measures, primary care in mid and south Essex has significantly fewer clinical staff than the national average. This is the biggest challenge we face, and risks creating a downward spiral that is difficult to escape from:

- Low staffing levels increase workload, making staff in general practice vulnerable to burnout and, in extreme cases, possibly jeopardising safety
- High workload in turn negatively affects morale and makes mid and south Essex a relatively unattractive place for people to come and work in
- The resulting turnover and difficulties in recruitment lead to overall staffing levels reducing further – adding to the workload of those that remain.

On two of the key measures, the number of GPs per head of population and the number of practice nurses, our STP had significantly fewer staff per head of population than average. In the case of GPs, all five CCGs are below average, with Thurrock and Basildon & Brentwood having particularly low staff numbers. The overall pattern for practices nurses is similar, four of the five CCGs having significantly fewer staff than average.

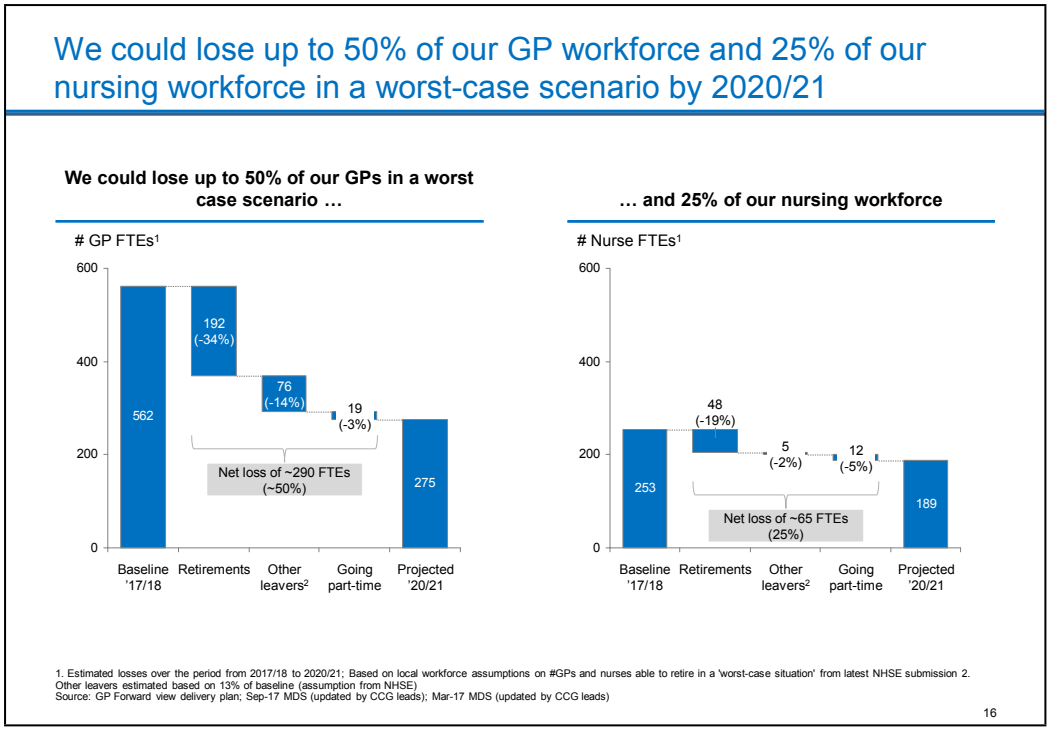



One consequence of the low level of 'core' staffing in general practice is that our STP relies much more heavily on locums and temporary staff than other areas. As well as being expensive, this can negatively impact on some patients by reducing continuity of care. This issue is considered further in the section on Workforce.

Workforce shortages in primary care are further compounded by staffing shortfalls in other local community services. Although we do not yet have STP level data, we do know that in many parts of our area there are significant vacancy rates in key services, such as community nursing.

**Retirements will further reduce staffing levels**

A further challenge for our STP is that the profile of our primary care workforce is relatively old, meaning that there is the potential for significant levels of retirement in the years to come. Health Education England has concluded that that this challenge is more significant in our STP than in any other part of England. Without mitigating action, this will further reduce staffing levels in general practice, exacerbating the problems outlined above.




**Morale is low and we face long-running recruitment challenges**

One consequence of the low staffing levels and high workload is a negative impact on morale. There is no uniform measure of morale or wider staff satisfaction in general practice (an anomaly that we are keen to address, as set out in the following section of this document), but we know from anecdotal evidence, as well as from high levels of turnover and early retirements, that morale in general practice in our STP is at a very low level.

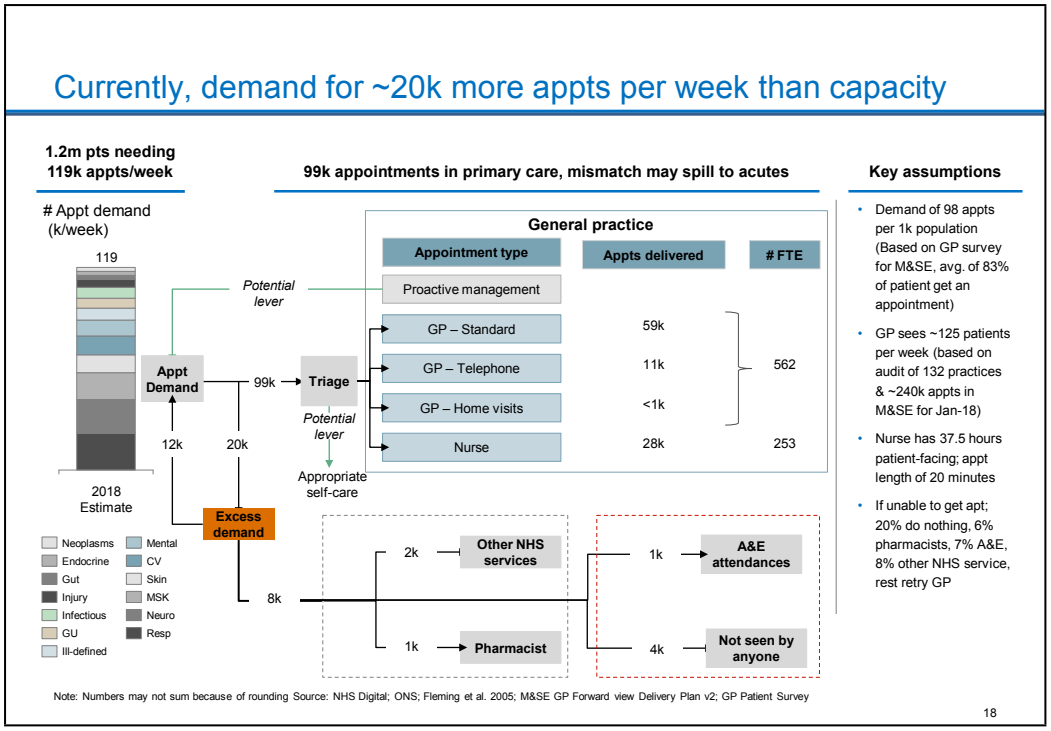
This challenge is compounded by the difficulty we experience in recruiting new, permanent staff. This affects all staff groups, but is more pronounced for GPs – a number of practices across our STP have vacancies that they have been unable to recruit to for a long period of time.

**There is insufficient capacity to meet current levels of demand**

As a result of the low level of staffing in our STP, we know that demand for care in our STP exceeds capacity. However, until now we have not been able to quantify this gap.

We have for the first time calculated the balance between demand (as expressed by patients seeking an appointment in primary care) and capacity (measured as appointment slots available). We carried out this exercise across the whole STP in early 2018.

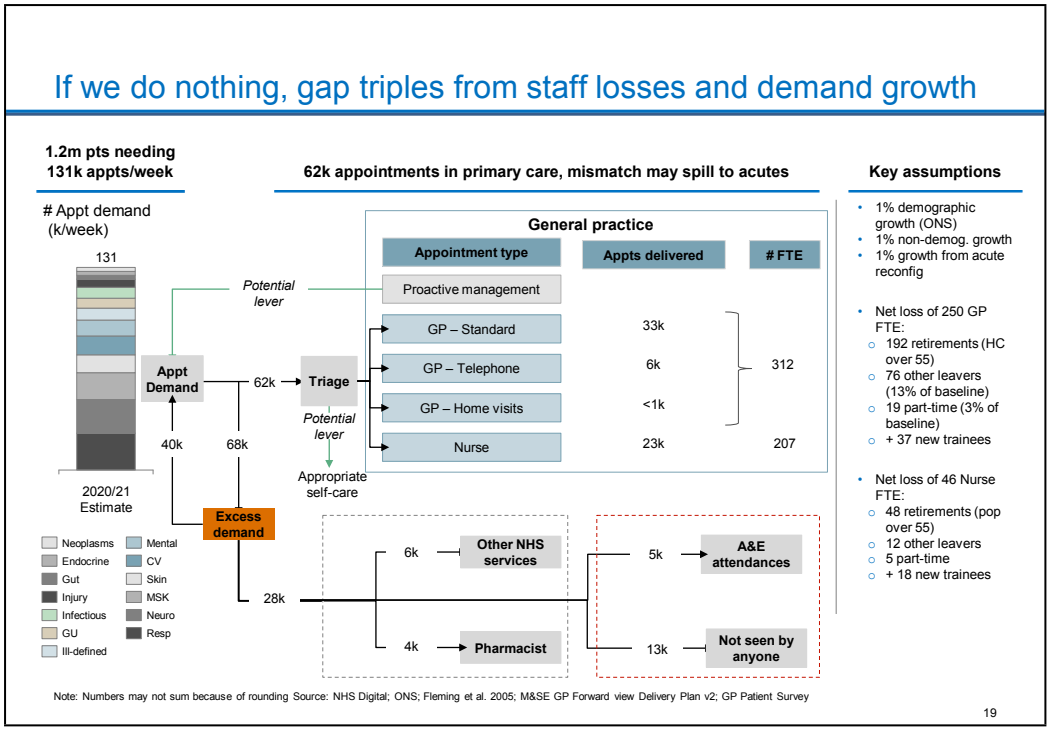
The results show that we have a very significant imbalance at present, with demand for appointments outstripping the available capacity by 20,000 a week. Taking data from the national patient survey, we estimate that in an average week there is demand for approximately 119,000 appointments in general practice. By reviewing data held by each practice, we know that on average there are 99,000 appointment slots available, largely split between GPs and practice nurses.




We do not know what the 20,000 patients per week who are unable to get an appointment do next. However, it is reasonable to assume that a significant proportion will attend A&E, increasing pressure on that service. This hypothesis is supported by survey evidence, which frequently highlights 'could not get an appointment with my GP' as a reason given by patients for attending A&E. In addition, it is also plausible that there are some people who do not get an appointment who really need medical attention – and in those cases their condition may deteriorate markedly before they are able to access treatment.

**The gap between demand and capacity will widen in future**

It is also clear that, without action, this gap will widen in future years. This is driven by two main factors. Firstly, demand will grow, as a result of population growth, demographic change and the impact of some services shifting from a hospital setting into primary and community care. Secondly, capacity will reduce, as the impact of losing clinical staff (partially to retirements) feeds through. We estimate that if we carry on as we are by 2020/21 in a 'worse case' scenario the gap between the demand for appointments and the capacity available could have widened from 20,000 to over 60,000.




Prior to the development of this strategy, we agreed plans to address the capacity shortfall in general practice, with a particular focus on increasing staffing levels. This includes a detailed plan to recruit more GPs, as part of our local response to the national *GP Forward View* strategy.

However, we know that there are significant risks associated with this element of the plan, not least the fact that we are relying heavily on overseas recruitment to find the additional GPs we need, and that we are in effect in competition with other areas to attract staff whose skills are in short supply. For this reason, out new model of care (set out in the following section) emphasises the importance of creating a much broader workforce in primary care.

**The service experienced by patients is variable**

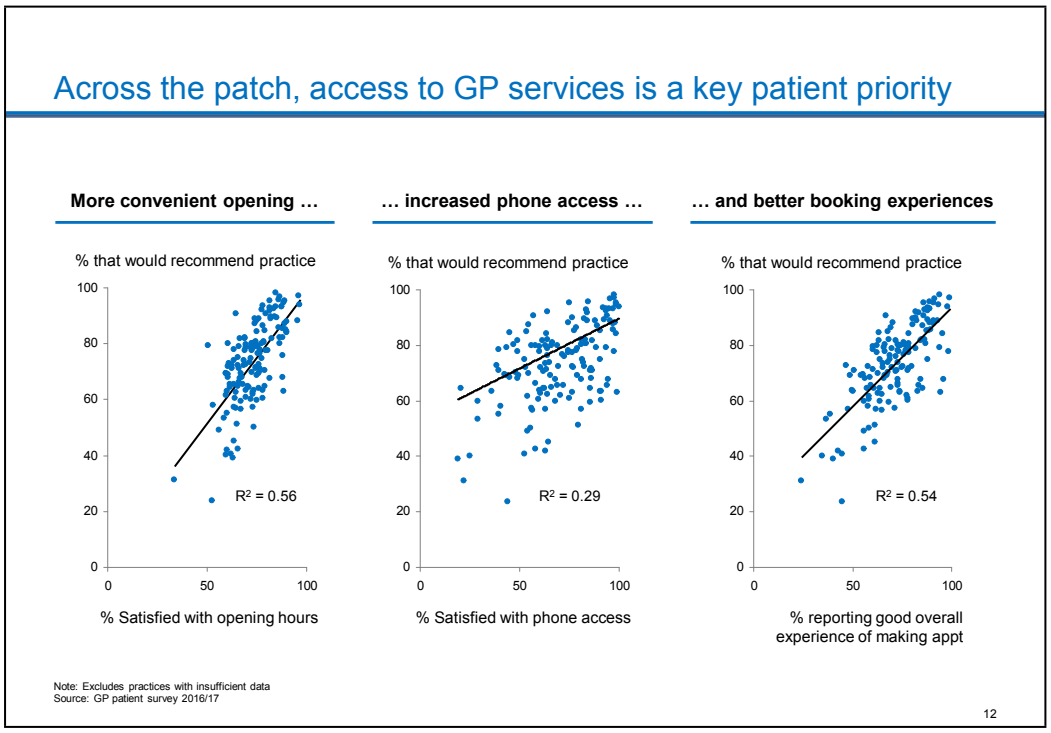
As a result of the challenges set out above – low staffing levels, high levels of retirement, low morale and problems recruiting – we know that the service currently experienced by patients is highly variable.

For example, patient surveys show that all five CCGs are below the national average in the percentage of patients who would recommend their practice; only one CCG is higher than the average for the percentage of patients who are happy with opening hours; and one CCG – Basildon – is below the national average on all of the key measures.

| Metric | Mid Essex | Basildon | Thurrock | Southend | CP&R | STP Avg. | National Avg. |
|---|---|---|---|---|---|---|---|
| % Who would recommend the practice | 76 | 71 | 67 | 72 | 76 | 72 | 77 |
| % Satisfied with phone access | 65 | 70 | 72 | 72 | 70 | 70 | 71 |
| % Satisfied with opening hours | 72 | 71 | 71 | 73 | 77 | 73 | 76 |
| % Who saw/spoke to nurse or GP same or next day | 52 | 46 | 48 | 48 | 54 | 50 | 50 |
| % Reporting good overall experience of making appointment | 71 | 68 | 69 | 72 | 76 | 71 | 73 |

We know that one of the key drivers of patient satisfaction is access to services. As set out in the following exhibit, there is a clear correlation between three of the key measures of patient access – satisfaction with opening hours, with phone access and with experience of making an appointment – and how likely a patient is to recommend their practice to others.

This is a particular challenge in our STP, where there is a significant – and widening – gap between demand for services and capacity.




Although many factors affect overall health outcomes - and at an aggregate level our STP has better than average outcomes - there is considerable variation at CCG level. For example, Southend has significantly worse mortality rates for liver disease than average, and Thurrock and Basildon both have higher mortality rates for cancer.

| Metric | Mid Essex | Basildon | Thurrock | Southend | CP&R | STP Avg. | National Avg. |
|---|---|---|---|---|---|---|---|
| Potential years of life lost from amenable causes per 100k pop - Female | 1,567 | 2,009 | 2,186 | 1,782 | 1,801 | 1,825 | 1,869 |
| Potential years of life lost from healthcare amenable causes per 100k pop - Male | 1,780 | 2,265 | 2,207 | 2,307 | 2,204 | 2,099 | 2,266 |
| Under 75 mortality rates from cancer per 100k pop | 107 | 127 | 130 | 116 | 112 | 117 | 120 |
| Under 75 mortality rates from CV disease per 100k pop | 50 | 59 | 76 | 65 | 62 | 60 | 64 |
| Under 75 mortality rates from liver disease per 100k pop | 11 | 11 | 15 | 21 | 9 | 13 | 16 |
| Health related QOL for people with long term conditions | 0.77 | 0.74 | 0.75 | 0.74 | 0.76 | 0.76 | 0.74 |

This variability, together with other the factors set out above, led us to conclude that we needed to go further and develop a different model of care for general practice. Our conclusions are set out in the following section.

# 3. FUTURE MODEL OF CARE

**About this section**

This section sets out the key elements of our future model of care; the detail behind this overview is contained in the *strategic narrative* which complements this document.

We describe how we plan to move to a GP led, rather than GP delivered, service, and to encourage practices to increasingly work 'at scale' by coming together in localities. We detail and quantify our plans to reduce workload and close the demand-capacity gap by expanding the workforce on primary care, managing demand and eliminating bureaucracy.

**Overall approach**

We have developed our future model of care in discussion with practices from across mid and south Essex, and have also tested our thinking with a wide range of partners including the LMCs. We have captured the detailed thinking **in our strategic narrative for general practice** which accompanies this document.

Our approach to transforming primary care seeks to protect and build on the strengths of general practice that are greatly valued by patients, whilst also ensuring that practices are resilient, flourishing and an integral part of a wider network of health and care services.

There are two key proposals at the heart of our future model:

- Moving away from a system in which services are principally GP delivered to one where services are GP led
- Encouraging and enabling practices to come together to form and lead localities serving populations of approximately 30 - 50,000 people

**From GP delivered to GP led services**

Although many practices have for some time employed a range of clinical staff (such as practice nurses and health care assistants), in many instances the norm remains for almost all care to be delivered by a GP, often in quite traditional ways – for example, with almost all consultations being face to face and in undifferentiated appointment slots.

Given the imbalance between demand and capacity and the recruitment challenges outlined in the previous section, it is clear that this model will be difficult, if not impossible, to sustain. There are also other reasons to think it could and should change:

- A model where the default is for patients to directly access a GP (and usually for a standard amount of time) is not tailored to an individual patient's need or circumstances
- When GP capacity is outstripped by demand, as it has been locally for some time, then it is important that highly skilled GPs are able to focus their time on the patients with the most complex needs, such as those with long term conditions
- A range of studies have demonstrated that having improved or direct access to a wider range of clinical skills such as nurses, physiotherapists and mental health workers can improve patient care and reduce pressure on GPs
- Most practices are, on their own, too small to be able to integrate effectively with other statutory services, such as social care

Our new model would see practices employing, or having direct access to, a much wider range of disciplines than is presently the case, including nurses, support workers, physiotherapists, clinical pharmacists and mental health specialists. While GPs would remain accountable for the care delivered to the patients on their list, only patients who really need the 'specialist generalist' skills of a GP would be directly seen by them; many other patients would be triaged and directed to another member of the team.

We recognise that changing the care model in this way may require other developments to make it as effective as possible; for example, building in opportunities for trust to be built within new teams, and enabling members of the extended team to refer patients where appropriate.

Under this model, we envisage that a range of new ways of seeing patients would develop, including telephone consultations, increased use of e-consult systems and remote monitoring.

Over time, we also envisage that GPs could play a wider leadership role in integrating local services, for example bringing together council led services like social care, as well as those provided by the voluntary sector.

**Developing hubs/localities**

The second key aspect of the future model we have developed is to encourage practices to come together and form hubs or localities serving a population of roughly 30,000 to 50,000 people. This is already happening in many areas across the STP, but progress is variable and lacks a common framework.

In our discussions with practices, we have emphasised that a key aspect of a successful locality will be to serve the practices that are within it; we believe this will be key if our new model is to be successful. Equally, we have been clear that joining or forming a locality is voluntary for practices – we think it is essential that practices *want* to join.

We anticipate that practices will in general lead and make the key decisions about their locality. One core function will be to ensure that the locality supports individual practices, for example by reducing workload or taking on some work on its behalf where this is appropriate.

Localities will have a key role in:

- Managing and reducing demand, for example through common triage processes and the deployment of Care Navigators
- Providing a common 'building block' for integration of other services, such as community, mental health and social care
- Ensuring that at a locality level there is consistent modelling of demand and capacity
- Providing tools to help practices manage workload
- Supporting practices with the recruitment of staff, potentially building on the existing expertise built up through the EPIC programme
- Creating the critical mass that will enable some services that have traditionally been provided in a hospital setting to be redesigned and re-provided in the community
- Supporting practices to reduce bureaucracy by, for example, sharing back office functions and implementing digital solutions
- Leading patient education on accessing services and self care

Localities could take many forms, however to be effective they will need to have some core features, including:

- Coherent geographical coverage
- Clear governance and decision making processes, such as a memorandum of understanding
- Strong and credible leadership and an enthusiasm for working with partners
- Demonstrable practice sign up

We anticipate that localities will operate differently in different localities, and we will encourage them to innovate, develop new models and evolve. We believe that having thriving will localities help us to unlock the potential offered by integrating health, care and voluntary services locally.

Over time, some localities could, in discussion with their CCGs and local partners, take on a range of additional budgets and functions. More detail on how localities might over time progress through several 'levels' is set out in our overall STP plan.

**Reducing practices' workload**

In discussions with practices, we have emphasised the need to move quickly to reduce workload. Over the medium term, this will largely be achieved by increased recruitment, the development of the wider workforce and working together in localities, as set out above.

We know we cannot wait until new staff are in place, however, particularly given the skills shortages that currently exist and that slow recruitment to vacant or new posts. Therefore, we want to move quickly to help practices reduce pressure in the coming months, for example by:

- More consistent triage
- Clearer navigation of patients to alternative services
- Reductions in bureaucracy
- Quicker access to the wider support team, such as district nurses
- Enabling emerging localities to share resources
- Seeking opportunities for improving integration with and access to key services, such as social care.

We anticipate that addressing this issue will be a key element of CCG's Implementation and Investment Plans (see Section 9).

**Closing the demand – capacity gap**

The Case for Change identified that at present there is a gap of almost 20,000 appointments a week between demand for care in general practice and its current capacity, and that this is likely to widen considerably in the future. Closing this gap is one of the key drivers for developing this strategy.

In developing our future model, we have identified four main ways in which we can close this gap:

- Manage the demand for primary care more effectively
- Recruitment of additional GPs and a range of other clinicians to significantly create capacity
- Work together in localities to enable the benefits of operating at scale to be realised
- Harness the opportunities that digital solutions could offer

The following exhibit sets out, at a high level, both the key elements of each of the four main 'solutions' and where relevant the possible impact on closing the capacity gap that we face. More detail on each of these areas, and the supporting evidence we have drawn on, is available in the appendix.

| 'Solution' | | What solutions could we offer to practices in a locality? | Potential impact |
|---|---|---|---|
| Manage demand | Improved front-door triage | • Training for reception care navigators and social prescribers<br>• Training for nurse/GP-led telephone triage systems<br>• Access to free/subsidised e-consult and AI triage systems<br>• Opportunity for shared triage in community hubs/via NHS 111 | • 3–15% reduction in appointment demand<br>0 — 50 |
| | Proactive management and risk-stratified care | • Enhanced care home services, with support from acutes<br>• Improved EOL care in the community, with support from acutes<br>• Self-care tools and Apps proven to drive behavioural change<br>• Targeted outreach calls reduce primary & secondary care activity | • Up to 4% reduction in appointment demand<br>• Future benefit from improved LTC case finding<br>0 — 50 (0, 4) |
| Create capacity | Improved use of the wider workforce | • Pump-priming to hire wider workforce roles, with minimum effective uptake req. per role (e.g., no less than 0.5 FTE/practice)<br>• Tailored needs analysis and skills audit per locality<br>• Training to up-skill existing staff | • Up to 24–40% reduction in GP clinical appointments based on model used<br>0 — 50 (24, 40) |
| | Reduced GP admin burden | • Pump-priming to hire GP admin assistants<br>• Access to free/subsidised personal productivity tools and training<br>• Opportunity for shared back-office functions in locality hub | • Up to 3–16% reduction in GP workload<br>0 — 50 (3, 16) |
| Operate at scale | Locality hub model of working | • Infrastructure to support working in virtual or physical hubs<br>• Community hub estates and co-location of services to support MDT working | • Demand redistribution and reduced locum use<br>• Increased staff satisfaction and retention |
| Digital opportunities | Harness new technology to improve efficiency | • Use of technology to enable and promote self care<br>• Automated systems to extract key data enabling reduced bureaucracy | • Reduced demand for appointments<br>• Reduced bureaucracy |

We think that practices, by working together in the locality model and with appropriate support, could reduce the pressure by managing demand for care more effectively. This has two main components: improving the 'front door' triage so that patients access services (and the professional) that is right for them and their needs; and by making more systematic use of existing tools such as predictive modelling and care planning to improve care for people with complex needs such as long term conditions. There is good evidence from elsewhere in the country that a systematic approach to this area is effective in managing demand in general practice.

The second and by far the most significant 'solution' is to expand capacity, principally by increasing the workforce – both of GPs and other clinical staff. As set out below, to close the capacity gap we need to recruit another 120 GPs (in line with our STP's *Forward View* target), as well as more clinical practitioners, physiotherapists, mental health and social care professionals and a range of other support staff.

The staffing mix outlined below has been built up by modelling the additional staff required to close the gap, and testing this model against the projections made previously as part of our response to the *GP Forward View*, as well as with localities that have already begun to implement this model.

| | | | Essex draft strategy (2020/21)[1] | |
|---|---|---|---|---|
| **Skill mix** | **Baseline** *(2017/18)* | **Est. cost per FTE (£K)** | **FTE Δ to baseline** | **Additional cost (£M)** |
| GP | 562 | 101 | 120 | 12.2 |
| Clinical practitioner | 256 | 48 | 69 | 3.4 |
| Physical | 0 | 48 | 42 | 2.0 |
| Mental | 0 | 48 | 20 | 1.0 |
| Social | 0 | 48 | 12 | 0.6 |
| HCA | 77 | 27 | 29 | 0.8 |
| Other DPC | 63 | 27 | 13 | 0.3 |
| Admin | 990 | 23 | 87[2] | 2.0 |
| Total | 1.9k | | 0.4k | 22 |

**Mapping of roles to skill mix**

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Physical — Physio
- Mental —MH Therapist; CPN

A further strand in creating capacity is to support practices to reduce bureaucracy in order free up clinical capacity. This includes streamlining back office processes by operating at scale across localities; working with other partner such as hospitals to reduce demands on practices; and increased use of administrative assistants to release clinical time.

The third broad 'solution' we have identified are a range of benefits that we believe will flow as a result of practices operating at scale in localities. Although we have not at this point attempted to quantify the benefit of these measures, we think it is likely to be considerable; key aspects include:

- Sharing capacity at time of peak demand
- Rolling our common technologies and approaches to risk stratification
- Developing physical hubs to accommodate wider professional teams

Finally, we consider there to be considerable opportunity to improve efficiency by taking a more systematic approach to the adoption and spread of digital technology. Once again, in order to be prudent we have not counted on a direct benefit of these changes, but key aspects include:

- Care navigation tools
- Self-care and community support
- Shared care records
- Process and productively improvement tools

Taken together, we believe the four 'solutions' outlined above – managing demand, creating capacity, operating at scale and digital opportunities - could close the capacity gap identified in the previous chapter.

However, we recognise that whilst we need to expand capacity now, we also need to support practices to manage and where possible reduce the existing workload. We set out in Section 3 some of the steps we believe we can take quickly in order to help practices, including more consistent triage, better care navigation and reducing bureaucracy.

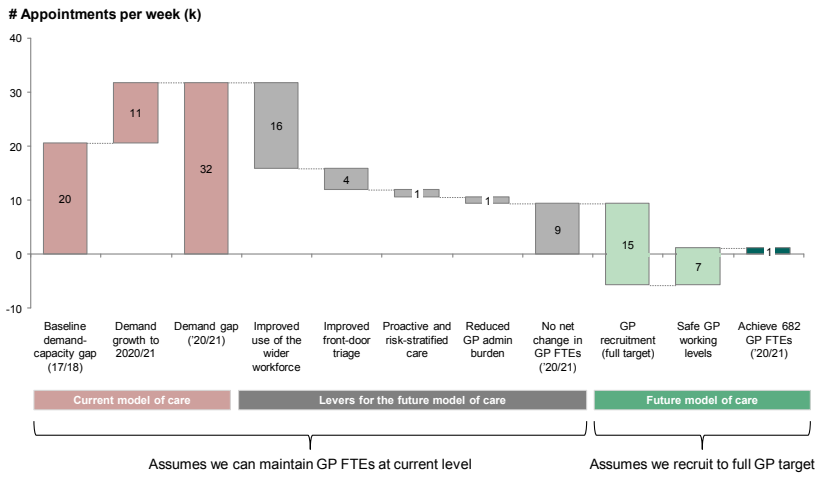
The following exhibit shows our predicted demand-capacity gap of 32,000 appointments a week by 2020/21, made up of our current estimated gap (20,000 appointments) and the projected increase in demand (11,000 appointments). We then factor in the positive impact of key aspects of the four solutions outlined above by 2020/21:

- Increases to the non-GP workforce and the development of a wider mix of staff – resulting in 16,000 more appointments available
- Better demand management though more effective front-door triage – results in a predicted gain of 4,000 appointments
- Consistent use of risk stratification and proactive care - results in a capacity gain of 1,000 appointment
- Reductions in bureaucracy - result in freeing up capacity of about 1,000 appointments.

Taken together, these measures result in a remaining gap of about 9,000 appointments. This residual gap is addressed recruiting the additional GPs that we need to implement our future model of care. If we then hit our *Forward View* target for GP recruitment, we will have an excess of capacity over demand, which would then enable us to reduce GP workload to BMA safe working standards (see below).

## Closing the gap between demand and appointments

**We can close the est. 32k appointment gap, and achieve safer GP working levels by 2020/21**




**Key assumptions**

- Demand of 98 appts per 1k population in '17/18; growth of 3% p.a. to '20/21
- Safe working GP levels of 115 appts per week
- Uptake of 50% of the wider workforce model across M&SE
- Front-door triage reduces apt demand by 3%
- Proactive care reduces apt demand by 1%
- Reduced GP admin burden increases apt capacity by 2%

Source: NHS Digital; ONS; Fleming et al. 2005; M&SE GP Forward view Delivery Plan v2

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**Safe working in general practice**

One of our main objectives in rebalancing demand for care and capacity in primary care is to enable us to move towards safe working levels for GPs. At present, due to our historically low levels of staffing, we believe many GPs are working above the levels recommended by the BMA with most GPs seeing well over 30 patients per working day. By fully implementing our new model, we think this will enable a full time GP to see approximately 23 patients per day, in line with BMA guidance.

**Measuring outcomes**

At present, we do not systematically track outcomes in primary care at either an individual practice or locality level. This means that the priorities and targets we are aiming for are not always clear, and it is difficult to track and understand levels of progress.

However, we are clear that it would not make sense to try and set a single 'binding' set of outcome measures on all localities. To do so would risk alienating some areas and would also fail to capture the legitimate differing priorities across the footprint. Therefore, our emerging approach is to develop a menu of outcomes that localities can choose from (and that can be added to if necessary), together with a small set of core indicators that we will agree across our STP.

Types of outcome measure

In developing this work, we have identifying three main categories of outcomes that we think each locality should use: patient impact; practice level impact; and system impact. There is a wide range of indicators that it may be appropriate to use in each of these categories; some examples are set out below:


In measuring patient impact, we anticipate drawing primarily on the data that is available from the national survey, as this is a robust data set on how patients view their local practice. Over time, as we expand capacity in general practice and introduce the new model of care set out in this section, we would anticipate improvements in most or all of these measures. We are also keen to work with localities to develop further metrics that 'build out' from measures of access and capture other aspects of the patient experience.

We are also very keen to measure practice level impact, with a particular focus on staff satisfaction and morale. General practice is an anomaly in the NHS, in that there are at present no routine staff surveys in place. We are keen to correct this anomaly, and have identified one tool – the Maslach Inventory – that we are keen to pilot using across our STP. The Local Medical Committees are supportive of this approach and we plan to work with them to run a baseline assessment in the summer of 2018.

Our third category – system impact – seeks to determine how effective practices and localities are in supporting the overall effectiveness of the wider health and care system. There are several measures that could be used here, but we are particularly keen to focus on those that consider rates of hospital utilisation. In general, we would expect that increased investment in, and the improving capacity of, primary care will lead to a narrowing in the present variation in acute utilisation.

Clinical outcomes

As localities develop, we are keen that they obtain the expert advice of their local Director of Public Health to take advice on and set appropriate clinical outcome indicators. We anticipate that by focusing on a small number of clinical outcome indicators, rooted in a thorough needs assessment, localities will be able to focus their services and interventions on meeting specific local needs. Discussions to date suggest that the most fruitful measures are likely to be those that focus on the effective management of long term conditions such as diabetes or heart disease.

**Developing our approach to outcomes**

As we work with existing and emerging localities to complete a self-assessment and then subsequently agree a development plan (see section on implementation), one of the areas for discussion will be outcomes measurement. In any final agreement between a locality and its CCG, we would expect to see clear statement on the outcomes that have been selected as local priorities, together with target level of achievement and how they will be reviewed.

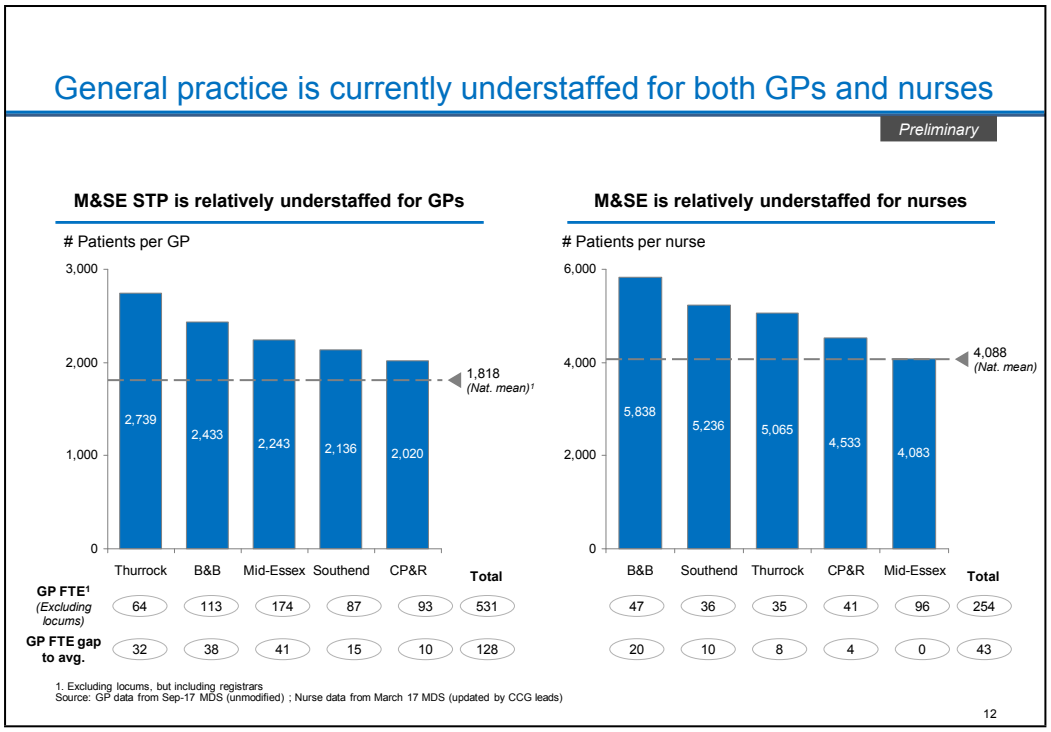
# 4. WORKFORCE

**About this section**

This section sets out our plans to expand and change the workforce in primary care. It outlines the challenge posed by our starting point, together with the importance of developing and implementing our new approach to workforce in order to differentiate our STP from others and make mid and south Essex an attractive place for staff to come and work in.

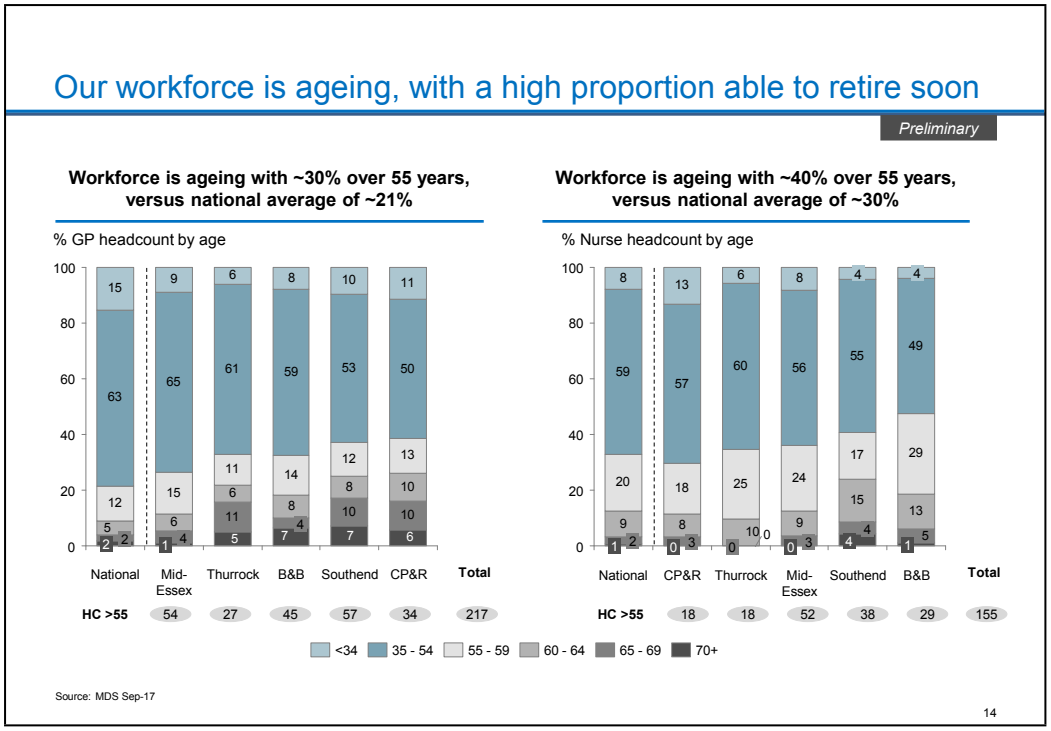
**The Challenge**

One of the main reasons we have developed this strategy is because we face a workforce crisis in primary care. One of the underlying – and longstanding – factors is that we have significantly fewer doctors and nurses per head than the national average:

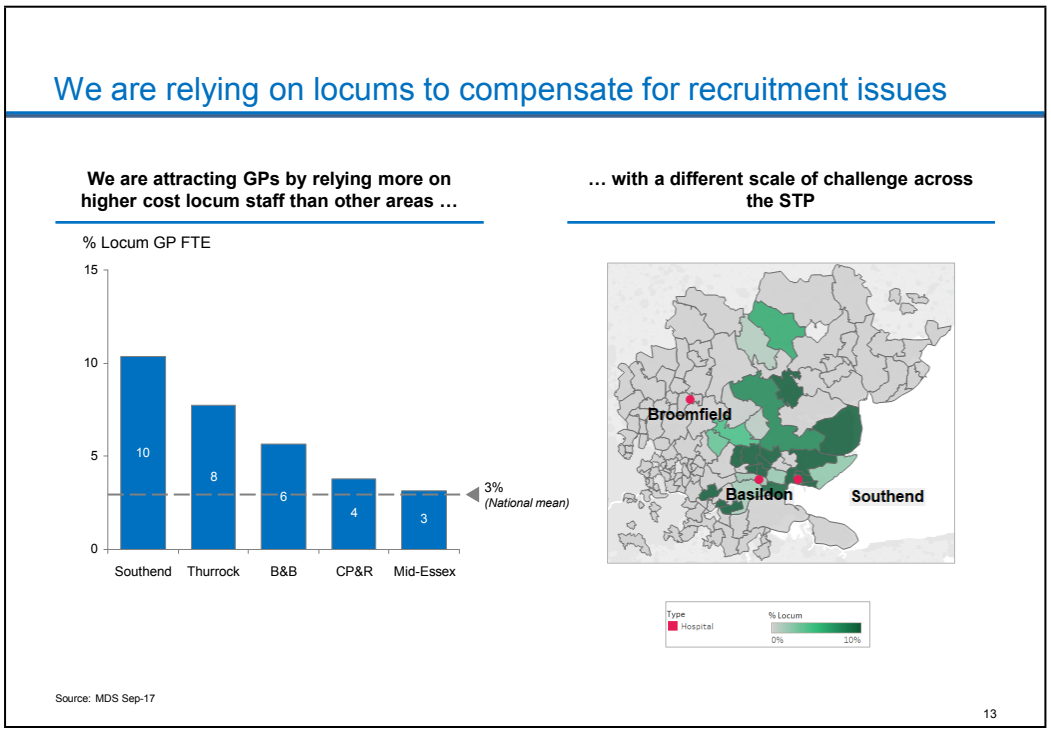



This clearly exacerbates the demand-capacity gap that we outlined in the case for change, as well as increasing the workload of and pressure on existing staff.

In addition, this position is likely to get worse in the coming years due to the age profile of our primary care workforce, which results in exceptionally high levels of predicted retirement. In fact, Health Education England recently identified that the retirement challenge in mid and south Essex as the greatest in England.




As a result of these pressures, as an STP we are heavily reliant on locums, with the challenge most pronounced in the south of the patch. As well as being expensive, this affects continuity of care for patients and potentially impacts on the quality of consultations.



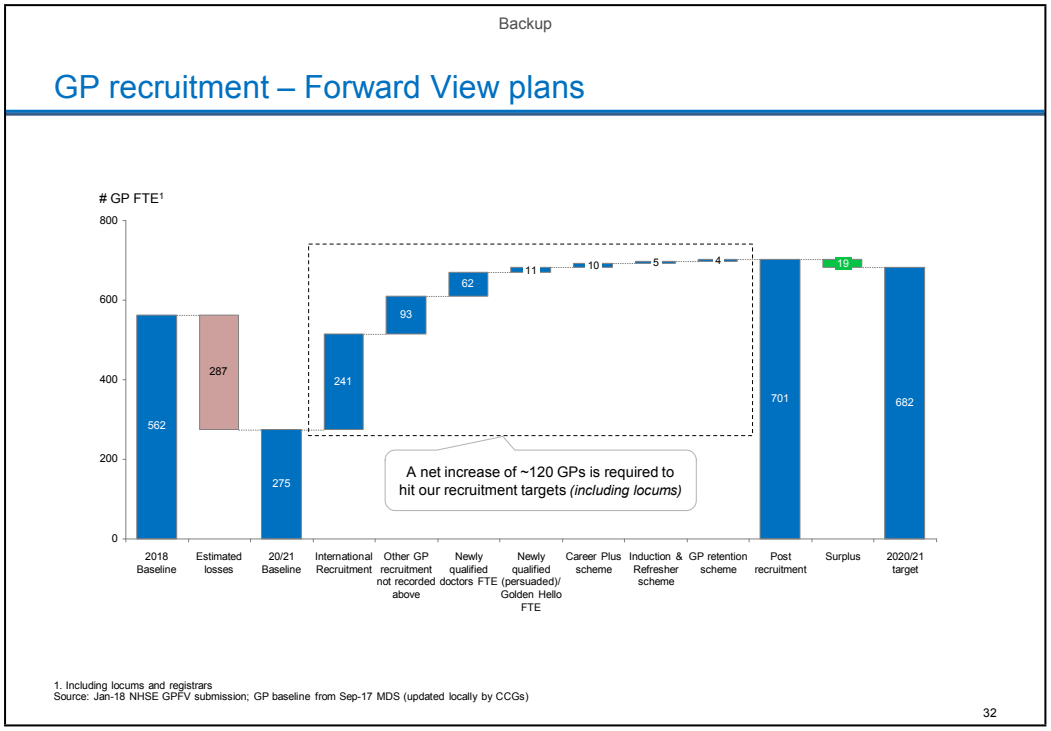

**New model of care – workforce implications**

As set out in the previous chapter, our new model of care has three key implications for our future workforce:

- Firstly, we need to recruit and retain significantly more GPs and practice nurses, building on our *GP Forward View* plans
- Secondly, we need to develop new roles and recruit a wider set of skills and disciplines into primary care, including pharmacists, GP assistants and mental health specialists, as well as think more creatively about possible new roles, particularly at the boundary of health and social care
- Thirdly, we need to reduce workload and make current roles more attractive, so that we have a competitive advantage in recruitment.

GP Forward View

As part of our pre-existing plans, we are aiming to recruit significantly more GPs across mid and south Essex. If successful, these plans will enable us to hit our national target of having 682 Full Time Equivalent (FTE) GPs in post by 2020.




However, it can be seen that we are heavily reliant on international recruitment in order to achieve our target and, although we have experience of running successful local programmes in the past, we recognise that this is a considerable risk. This is one of the reasons why, in this strategy, we advocate moving away from a service that is predominantly GP delivered to one that is GP led, building up a primary care workforce that includes a much wider range of professional disciplines.

Wider primary care workforce

At an STP level, in addition to recruiting additional GPs, to fully implement the new model of care we know we need to recruit or redeploy almost 200 additional staff, drawn from a wide range of professional disciplines:

| Skill mix | Baseline *(2017/18)* | Essex draft strategy (2020/21)[1] FTE Δ to baseline |
|---|---|---|
| GP | 562 | 120 |
| Clinical practitioner | 256 | 69 |
| Physical | 0 | 42 |
| Mental | 0 | 20 |
| Social | 0 | 12 |
| HCA | 77 | 29 |
| Other DPC | 63 | 13 |
| Admin | 990 | 87 |

**Mapping of roles to skill mix**

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Physical — Physio
- Mental —MH Therapist; CPN

At this point, this is a top down estimate at STP level, albeit based on previous work as part of implementing the *GP Forward View* and tested with localities that are already developing a similar model. We plan to refine this model over the coming months as CCGs work in detail with their practices and emerging localities to determine the skill mix that is best able to meet local needs. We also anticipate that many localities will want to work with local partners, such as councils, to design new, flexible and innovate roles that are best able to meet individual's needs, rather than be designed around traditional organisational silos.

**STP general practice workforce strategy**

It is clear that expanding and changing the workforce in our STP is the biggest challenge we face. We believe that implementing our future model of care will be crucial in differentiating mid and south Essex from other areas, and make it easier to recruit the staff we need.

We have also identified a number of areas where, working together across the STP, we need to do more. We have recently agreed to establish a single resource (a workforce 'hub' or PMO) to co-ordinate our work across the STP.

<u>Recruitment</u>

We know that in some cases, such as the recent international recruitment of GPs, there is a benefit to recruiting on a larger footprint such as an STP. As we get a clearer 'bottom up' picture of the additional staff that practices and localites are looking to recruit, we will develop STP wide recruitment campaigns, including holding information evenings and running regular assessment centres for cohorts of staff. In this way, we think we will achieve a higher profile for our STP, encourage more applicants for local roles and be able to establish and 'at scale' approach to recruitment.

The recent establishment of the new Medical School at Anglia Ruskin University will be of huge benefit to our STP, and will greatly support recruitment. The new School has a specific focus on training general practitioners, which should help establish a local source of new recruits. In addition, the establishment of the Medical School will support a range of other workforce initiatives, including improving research opportunities and strengthening continuing professional development.

Retention

We will explore the further steps we can take to encourage and enable existing staff to continue to work and contribute locally. This will include looking at further financial incentives for key groups, better meeting development needs and identifying clearer opportunities for career progression.

Workforce intelligence

We recognise that having clear, timely and accurate local workforce data is key if we are to plan effectively at CCG and STP level. We will work more closely with HEE, the Local Workforce Action Board and practices to develop our workforce intelligence function, and see this as a vital role for the hub/PMO that we are establishing.

New roles and job design

Our new model of care relies on recruiting a wider range of staff, but also on developing new roles, such as physician assistants, generic care workers and support staff. In order to minimise duplication, we plan to work with practices and stakeholders to develop a common approach to these roles, such standardised job descriptions, person specifications and competency frameworks.

Role rotation

We are keen to expore how we can make all primary care roles in our STP more attractive and rewarding. One aspect we will look at is designing roles that enable staff to move across localaities and care settings, building on previous work to develop staff 'passports'. We think that such a development will lead to higher job satisfaction, improved professional development and better recruitment and retention.

Training and development

Our new model of care places considerable emphasis on all primary care staff working to the top of their skill set; for example, over time we envisage that the majority of direct pateint contact for many GPs will be with patients with the most complex needs. As a result, having comprehensive, ongoing training and development programmes for all staff groups will be vital.

As practices are in general relatively small orgnisations, training and development programmes can be fragmented. Working with practices and emerging localities, we plan to address this by building STP wide training and development programmes, and will seek to identify how we can support practices and localities to release staff, for example by helping with backfill.

# 5. DIGITAL

**About this section**

This section sets out our plans to accelerate the deployment of digital solutions. We view digital as a key enabler that will support practices to reduce workload, manage demand and provide a better service for patients. We outline the main areas in which we think digital can make a contribution, and summarise our approach to prioritisation.

We know that the use of digital and other technologies will be a key enabler for our future model of care. Digital and other technologies have the potential to help with the better management of demand, create capacity in general practice, reduce bureaucracy and support localities to operate at scale. We also know that to date we have made limited progress in this key area; work has been somewhat fragmented and we lack a unifying vision and architecture.

**Digital as an enabler**

In section 3 of this document – future model of care – we identified a number of potential solutions which, taken together, could help practices reduce their workload and close the gap between demand and capacity. Several of these solutions are dependent upon, or would be significantly enhanced by, the systematic deployment of digital solutions. Examples include:

<u>Managing demand</u>

- *Self-care and community support*. These tools are well developed and have a range of applications, including apps and software that support behaviour change (for example people with diabetes) as well as providing online support for people with a wide range of conditions including anxiety and depression
- *Care navigation and triage*. These technologies support self-care, such as by navigating patients to appropriate sources of information and support, as well as by providing opportunities for rapid access to consultations, often via computers or smartphones
- *Prediction and risk stratification*. There are a number of established tools that can support practices to risk stratify patients on their list and identify those patients that have 'rising risk'. This enables comprehensive care plans to be put in place for these individuals, enabling them to stay well for longer

<u>Creating capacity</u>

- *Patient pathways and treatment*. These tools can support patients and professionals to provide improved on-going care and reduce the need for regular consultations, for example through remote patient monitoring where the patient's readings are constantly logged and reported automatically, with anomalies or concerning patterns flagged to the patient and their GP

- *Processes and productivity*. There is considerable scope to better harness technology to reduce bureaucracy in primary care. Solutions that are already available include digital dictation that is integrated with clinical systems, and tools that enable automated data extraction from primary care platforms such as SystemOne.

Operating at scale

- *Communication across settings*. Having access to patient level information across a range of care settings is vital, especially as patients are frequently in contact with multiple services. As well as a core shared core record, further digital solutions now enable summary records to be held on smartphones, and for automatic communication with patients (such as appointment reminders, medication alerts etc.)

More detail on some of the digital solutions that we have reviewed in developing this strategy are included in the appendix.

**Implementing Digital Solutions**

There are many reasons why our uptake of digital solutions has been relatively slow. One key aspect is that there are now so many technologies and solutions available, and this makes it difficult to prioritise and sequence any roll out. A second factor is that in general decisions to purchase or roll out any particular solution rest with individual practices, which inevitably results in a somewhat disjointed approach and makes 'at scale' decisions problematic. Thirdly, there is a recognised lack of skills and capacity in this area: we do not yet invest in roles whose prime purpose is to support practices and partners to implement digital solutions.

To help address the first issue, in developing this strategy we have found it helpful to segment digital solutions into three main areas:

- Core to implementation of our strategy and system wide – such as shared care records
- Well-developed technologies that are low cost, easy to implement and with a clear impact – such as those that reduce bureaucracy for practices
- 'Big bet' opportunities that are not yet proven but have the potential to have a significant impact – such as AI based triage systems

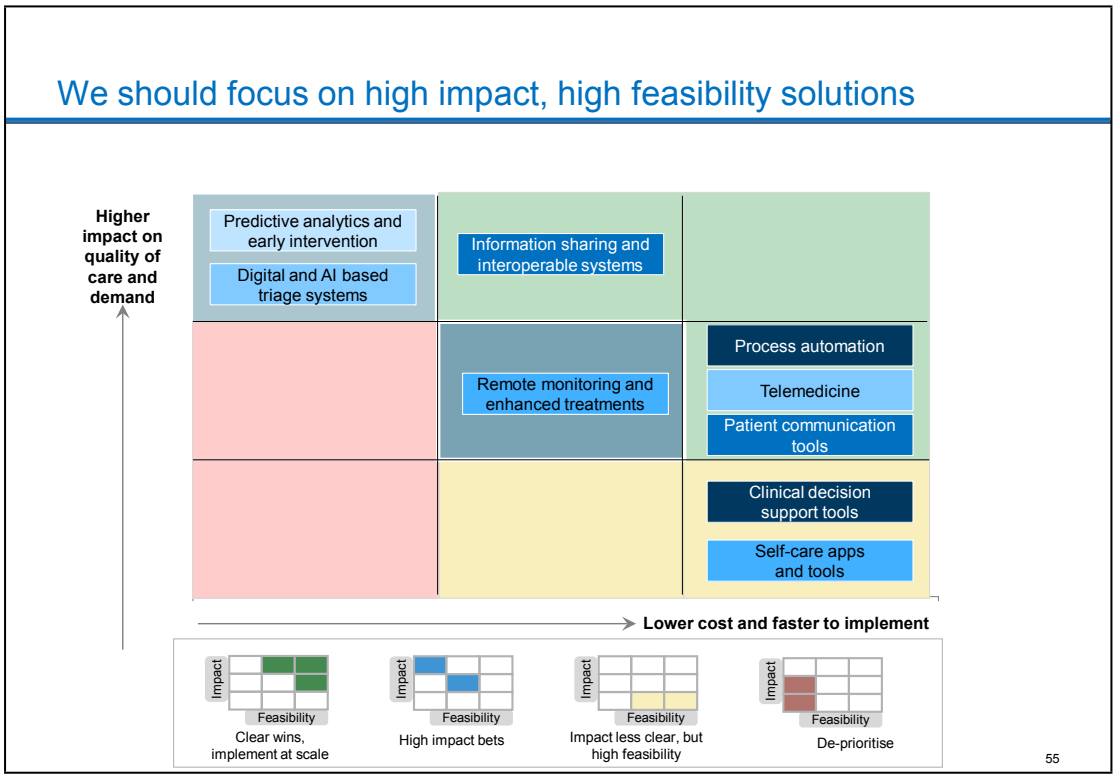
Segmenting in this way helps to break the solutions down into more manageable categories, and should also help our STP to prioritise.

We think that our approach of encouraging practices to come together to work in localities will help address the issue of fragmentation. We are developing a diagnostic tool for localities so they can assess where their strengths and weaknesses lie, with the intention that this then results in a development plan. One aspect of this tool is considering digital solutions, so that in future we hope to see whole localities agreeing a clear approach to rolling out the digital solutions that will best meet their needs.

The final issue – capacity and capability – has been recognised across the STP. As the five CCGs within our footprint increasingly share management capacity, addressing this deficiency will be a priority.

**Approach to decision making and implementation**

In order to help prioritise possible digital solutions that could support practices, localities and our STP, we have developed an approach to determining which areas to focus on. This considers both the potential impact of the technology on quality of care and demand, and the cost and likely speed of implementation:




We know we need to think 'digital first' as we implement this strategy. Our priorities to help ensure this happens are:

- Build appropriate capacity and capability within the STP to support localities and practices
- Work with existing and emerging localities to develop and agree a digital roll out plan
- Complete a prioritisation exercise to identify solutions which, in agreement with localities, could be developed STP wide
- Set aside investment to support the roll out of digital technologies (set out in the Finance Chapter).

# 6. ESTATES

**About this section**

This section highlights the importance of improving and developing the quality of the estate in primary care. It sets out the current position, details the proposed capital 'pipelines' that have been developed by each CCG to support delivery of this strategy and highlights the areas in which our STP will need support if we are to accelerate progress.

**Our existing primary care estate**

Having modern, fit for purpose buildings is a central part of our vision for the future of primary care. As a starting point, all practices need to be able to provide services in premises that are accessible, attractive and of high quality. But to fully deliver our new model of care we need to go further, by developing physical or virtual hubs that support locality working, provide accommodation for the additional staff we plan to recruit and enabling services to be integrated and - where possible - co-located.

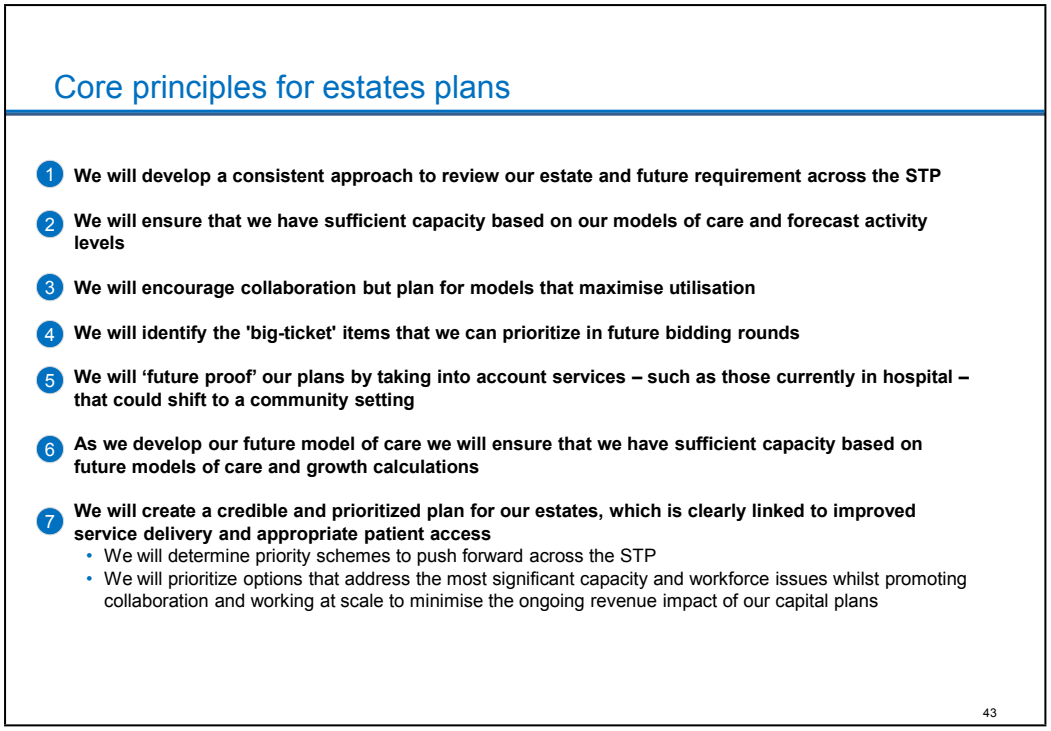
Our starting point is some way from this vision. Our existing primary care estate is below current benchmarks for our region:

- Although at present services are currently provided from 220 premises across the STP with a total internal area of almost approximately 62,000 square metres, we estimate that we have a current space deficit of over 21,000 square metres
- We estimate that population growth, shifting demography and the development of new models of care may require up to an additional 14,000 square metres
- A number of premises are well below the standards expected of a health care facility
- Current utilisation of buildings is poorly understood, but is highly variable across the STP

Although CCGs already have plans in place to address many of these issues, in developing this strategy we have refined our approach and developed more detail on the developments that are being planned in each CCG.

**Principles for estates development**

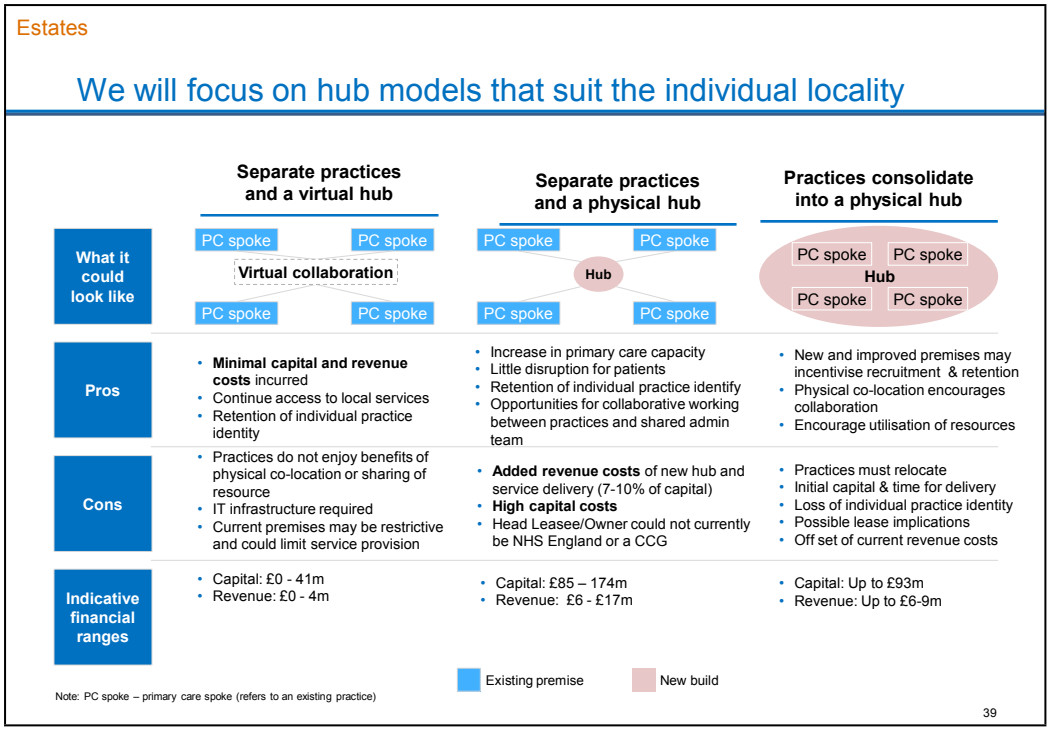
In developing our work on estates, we discussed and agreed a set of high level principles that we have used to guide our work:




**Our approach to developing hubs**

As set out in our new model of care, in future we want practices to work together and from localities. Over time, we anticipate that a wide range of services will 'wrap around' or integrate with these localities, including community nursing, social care and voluntary organisations. We have agreed that we will prioritise estates solutions that directly support delivery of this vision.

However, at the same time we recognise that building a physical hub potentially housing several practices and a wide range of other services is not practical in all areas, particularly in the more rural parts of our footprint. As a result, we have developed a broad model that is flexible, and is able to support the development of hubs at three different levels:




In some instances, geography will determine that we will need to establish a virtual hub, with distinct practice premises remaining but with significantly improved facilities and an upgraded IT infrastructure to enable joint working. In other cases, the best solution may be to retain separate practice premises but supplement these with a single hub (which could be an existing building that is repurposed or a new build) to form the base for the wider team and for the delivery of a broader range of services. Finally, in some areas it will be possible to establish a physical hub, bringing together two or more practices and a wider range of services into either a new or existing building. A number of our CCGs have plans to develop this type of hub.

**Our development 'pipeline'**

As part of our work on estates, each of the five CCGs in our footprint has been reviewing its approach to potential future capital development, and has established a draft development pipeline. At an aggregate level, the total capital cost of the entire programme (spread over the next 12 years) is £242m, with the peak years profiled to be 2019/20 – 2022/23:

| CCG | Scheme | Value £m Total Capital | Profile Dates - Capital Spend 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 | 2028/29 | Future |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Scheme Summary: | | | | | | | | | | | | | | |
| Mid Essex | CCG led primary care and LHC developments | 68.24 | 1.80 | 20.74 | 11.34 | 3.99 | 6.00 | 0.00 | 0.00 | 0.00 | 1.17 | 2.33 | 9.17 | 1.83 |
| B&B | CCG led primary care and LHC developments | 28.65 | 0.45 | 9.34 | 9.52 | 2.01 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Thurrock | CCG led primary care and LHC developments | 48.54 | 7.31 | 16.59 | 11.19 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Southend | CCG led primary care and LHC developments | 48.40 | 1.60 | 3.05 | 12.93 | 14.52 | 5.70 | 5.40 | 3.20 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| CPR | CCG led primary care and LHC developments | 49.13 | 1.60 | 2.00 | 19.03 | 15.82 | 3.80 | 4.38 | 1.87 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | | **242.95** | **12.76** | **51.73** | **64.02** | **36.33** | **15.50** | **9.78** | **5.07** | **0.00** | **1.17** | **2.33** | **9.17** | **1.83** |

The tables that follow set out the latest position in each CCG, including the estimated capital cost and which year it is likely to fall in, the estimated on-going revenue consequences and an assessment of progress to date in identifying the source of capital, developing a business case and identifying the development (note the practice names have ben removed).

**Mid Essex CCG**

| Scheme | Scheme Capital £m | Annual Revenue Cost £m | TBC £m | 2018/19 £m | 2019/20 £m | 2020/21 £m | 2021/22 £m | Future £m | Source of Capital Identified | Progress with Business Case | Development Costs Identified |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Community Hospital | 10.60 | 0.74 | 0.00 | 0.00 | 8.48 | 2.12 | 0.00 | 0.00 | R | A | G |
| Health Hub | 7.90 | 0.55 | 0.00 | 0.00 | 0.99 | 5.93 | 0.99 | 0.00 | A | A | G |
| GP Practice | 5.50 | 0.55 | 0.00 | 0.00 | 0.00 | 0.00 | 1.83 | 3.67 | R | R | R |
| GP Practice | 5.50 | 0.39 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 5.50 | R | R | R |
| GP Practice | 5.50 | 0.39 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 5.50 | R | R | R |
| GP Practice Hub | 5.00 | 0.50 | 5.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | R | R | R |
| GP Practice | 5.00 | 0.50 | 0.00 | 0.00 | 4.00 | 1.00 | 0.00 | 0.00 | R | R | R |
| GP Practice | 3.50 | 0.35 | 0.00 | 0.00 | 2.57 | 0.93 | 0.00 | 0.00 | R | A | R |
| GP Practice | 3.50 | 0.25 | 0.00 | 0.00 | 0.00 | 0.00 | 1.17 | 2.33 | R | R | R |
| GP Practice | 3.50 | 0.25 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 3.50 | R | R | R |
| GP Practice | 3.00 | 0.11 | 3.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | R | R | R |
| GP Practice | 2.10 | 0.21 | 0.00 | 1.40 | 0.70 | 0.00 | 0.00 | 0.00 | A | R | R |
| GP Practice | 2.00 | 0.07 | 0.00 | 0.40 | 1.60 | 0.00 | 0.00 | 0.00 | A | R | R |
| GP Practice | 2.00 | 0.20 | 0.00 | 0.00 | 1.33 | 0.67 | 0.00 | 0.00 | A | R | R |
| GP Practice | 1.00 | 0.04 | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | A | R | R |
| Other schemes (Capital <£1m) | 2.64 | 0.14 | 0.86 | 0.00 | 1.08 | 0.70 | 0.00 | 0.00 | | | |
| **Total** | **68.24** | **5.21** | **9.86** | **1.80** | **20.74** | **11.34** | **3.99** | **20.50** | | | |

**Basildon & Brentwood CCG**

| Scheme | Scheme Capital £m | Annual Revenue Cost £m | TBC £m | 2018/19 £m | 2019/20 £m | 2020/21 £m | 2021/22 £m | Future £m | Source of Capital Identified | Progress with Business Case | Development Costs Identified |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GP Practice | 5.00 | 0.18 | 5.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | R | R | R |
| Health Centre | 5.00 | 0.50 | 0.00 | 0.00 | 0.00 | 3.89 | 1.11 | 0.00 | R | R | R |
| GP Practice | 4.75 | 0.48 | 0.00 | 0.32 | 3.80 | 0.63 | 0.00 | 0.00 | A | A | G |
| GP Practice | 4.50 | 0.45 | 0.00 | 0.00 | 3.60 | 0.90 | 0.00 | 0.00 | A | R | G |
| Health Centre | 4.50 | 0.32 | 0.00 | 0.00 | 0.00 | 3.60 | 0.90 | 0.00 | A | R | R |
| Community Hospital | 2.00 | 0.20 | 2.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | R | R | R |
| GP Practice | 2.00 | 0.20 | 0.00 | 0.13 | 1.60 | 0.27 | 0.00 | 0.00 | R | A | G |
| Other schemes (Capital <£1m) | 0.90 | 0.01 | 0.32 | 0.00 | 0.34 | 0.24 | 0.00 | 0.00 | | | |
| **Total** | **28.65** | **2.32** | **7.32** | **0.45** | **9.34** | **9.52** | **2.01** | **0.00** | | | |

**Thurrock CCG**

| Scheme | Scheme Capital £m | Annual Revenue Cost £m | TBC £m | 2018/19 £m | 2019/20 £m | 2020/21 £m | 2021/22 £m | Future £m | Source of Capital Identified | Progress with Business Case | Development Costs Identified |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Healthy Living Centre | 12.00 | 0.42 | 0.00 | 6.40 | 5.60 | 0.00 | 0.00 | 0.00 | G | G | G |
| Healthy Living Centre | 15.00 | 1.05 | 0.00 | 0.00 | 6.00 | 9.00 | 0.00 | 0.00 | A | A | G |
| Healthy Living Centre | 15.00 | 1.50 | 0.00 | 0.00 | 7.00 | 8.00 | 0.00 | 0.00 | A | A | G |
| Community Hospital | 5.00 | 0.50 | 5.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | A | R | R |
| Health Centre | 4.80 | 0.34 | 4.80 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | R | R | R |
| Health Centre | 3.66 | 0.13 | 3.66 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | R | R | R |
| Community Hospital | 2.00 | 0.07 | 0.00 | 0.13 | 1.60 | 0.27 | 0.00 | 0.00 | A | A | G |
| Other schemes (Capital <£1m) | 2.28 | 0.05 | 0.00 | 0.77 | 1.34 | 0.17 | 0.00 | 0.00 | | | |
| **Total** | **59.74** | **4.05** | **13.46** | **7.31** | **21.54** | **17.44** | **0.00** | **0.00** | | | |

**Southend CCG**

| Scheme | Scheme Capital £m | Annual Revenue Cost £m | TBC £m | 2018/19 £m | 2019/20 £m | 2020/21 £m | 2021/22 £m | Future £m | Source of Capital Identified | Progress with Business Case | Development Costs Identified |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Integrated Care Hub | 10.00 | 1.00 | 0.00 | 0.00 | 0.00 | 4.00 | 6.00 | 0.00 | R | R | R |
| Primary Care Spoke | 4.00 | 0.40 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 4.00 | R | R | R |
| Primary Care Spoke | 4.00 | 0.28 | 0.00 | 0.00 | 0.00 | 0.50 | 3.00 | 0.50 | R | R | R |
| Primary Care Spoke | 4.00 | 0.40 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 4.00 | R | R | R |
| Primary Care Spoke | 3.00 | 0.21 | 0.00 | 0.00 | 1.40 | 1.60 | 0.00 | 0.00 | R | R | R |
| Primary Care Spoke | 3.00 | 0.30 | 0.00 | 0.00 | 0.00 | 0.00 | 1.80 | 1.20 | R | R | R |
| Integrated Care Hub | 3.00 | 0.30 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 3.00 | R | R | R |
| Integrated Care Hub | 3.00 | 0.30 | 0.00 | 0.00 | 0.20 | 2.40 | 0.40 | 0.00 | R | R | R |
| New Integrated administrative Hub | 2.50 | 0.09 | 0.00 | 0.00 | 1.00 | 1.50 | 0.00 | 0.00 | R | R | R |
| Primary Care Spoke | 2.00 | 0.07 | 0.00 | 0.00 | 0.25 | 1.50 | 0.25 | 0.00 | R | R | R |
| Primary Care Spoke | 2.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.20 | 0.80 | R | R | R |
| Integrated Care Hub | 2.00 | 0.20 | 0.00 | 0.00 | 0.00 | 1.33 | 0.67 | 0.00 | R | R | R |
| Primary Care Spoke | 2.00 | 0.20 | 0.00 | 0.00 | 0.00 | 0.00 | 1.20 | 0.80 | R | R | R |
| Primary Care Spoke | 1.50 | 0.00 | 0.00 | 1.50 | 0.00 | 0.00 | 0.00 | 0.00 | G | A | R |
| Other schemes (Capital <£1m) | 2.40 | 0.07 | 2.00 | 0.10 | 0.20 | 0.10 | 0.00 | 0.00 | | | |
| **Total** | **48.40** | **3.82** | **2.00** | **1.60** | **3.05** | **12.93** | **14.52** | **14.30** | | | |

**Castle Point & Rochford CCG**

| Scheme | Scheme Capital £m | Annual Revenue Cost £m | TBC £m | 2018/19 £m | 2019/20 £m | 2020/21 £m | 2021/22 £m | Future £m | Source of Capital Identified | Progress with Business Case | Development Costs Identified |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Integrated Care Hub | 8.00 | 0.80 | 0.00 | 0.00 | 0.00 | 3.20 | 4.80 | 0.00 | R | R | R |
| Integrated Care Hub | 8.00 | 0.80 | 0.00 | 0.00 | 0.00 | 3.20 | 4.80 | 0.00 | R | A | G |
| Integrated Care Hub | 6.00 | 0.60 | 0.00 | 0.00 | 0.00 | 4.80 | 1.20 | 0.00 | R | R | R |
| Primary Care Spoke | 5.00 | 0.50 | 0.00 | 0.00 | 0.00 | 3.00 | 2.00 | 0.00 | R | R | R |
| Primary Care Spoke | 4.00 | 0.40 | 0.00 | 0.00 | 0.00 | 0.00 | 0.75 | 3.25 | R | R | R |
| Health Centre | 3.00 | 0.30 | 0.00 | 0.00 | 0.60 | 2.40 | 0.00 | 0.00 | R | R | R |
| Primary Care Spoke | 2.00 | 0.20 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2.00 | R | R | R |
| Primary Care Spoke | 2.00 | 0.20 | 0.00 | 0.00 | 0.00 | 0.93 | 1.07 | 0.00 | R | R | R |
| Primary Care Spoke | 2.00 | 0.20 | 0.00 | 0.00 | 0.00 | 0.00 | 1.20 | 0.80 | R | R | R |
| Primary Care Spoke | 2.00 | 0.20 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2.00 | R | R | R |
| Primary Care Spoke | 2.00 | 0.20 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2.00 | R | R | R |
| Health Centre | 2.00 | 0.00 | 0.00 | 1.60 | 0.40 | 0.00 | 0.00 | 0.00 | A | A | R |
| New Integrated administrative Hub | 1.50 | 0.05 | 0.00 | 0.00 | 0.60 | 0.90 | 0.00 | 0.00 | R | R | R |
| New Integrated administrative Hub | 1.00 | 0.04 | 0.00 | 0.00 | 0.40 | 0.60 | 0.00 | 0.00 | R | R | R |
| Other schemes (Capital <£1m) | 0.63 | 0.00 | 0.63 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | |
| **Total** | **49.13** | **4.49** | **0.63** | **1.60** | **2.00** | **19.03** | **15.82** | **10.05** | | | |

**Accelerating progress - support required**

We know that the pipeline outlined above is ambitious, and recognise that our STP will require support from NHSE, as well as system partners, to deliver it.

Capital

The majority of the schemes that are well developed do not rely on accessing additional public sector capital over and above existing ITTF funds, as there are a range of other sources of funding available for these developments, including:

- Councils (for example Thurrock Council investing in Integrated Medical Centres)
- Third Party Developments
- Section 106 funding
- Development grants

However, it is possible that there may be an increased demand for public sector capital in the outer years of the programme, as a number of the these proposals included in the CCG schedules do not yet have a confirmed source of capital.

Capacity and cost of development

A significant barrier to accelerating progress with the delivery of our capital programme is a lack of expertise in the local footprint to develop the business cases to the required level of detail, and the limited access to non-recurrent funding to commission expert support, such as the completion of feasibility studies. We are however making progress in this area, with the establishment of a senior post to focus on estates across our STP.

These twin issues are clearly challenges for most STPs; we plan to discuss possible solutions – such as devolving capacity currently held in NHSE or a more innovative approach to the use of ETTF funding – with partners in the system.

Meeting recurrent costs

Perhaps the biggest single barrier to implementing the estates solutions outlined above is a lack of revenue to support each scheme's on-going costs. Although the exact cost varies scheme by scheme – and in some cases can be offset by other savings – we estimate that the average revenue cost of is circa 8% of the capital cost. Although the revenue consequences do not feed through to CCGs for some time, meeting these costs is clearly a concern and acts as a brake on the delivery of the capital programme.

In the following section (finance) we have included an estimate that up to £8m of additional revenue will be required to support the costs of the major schemes identified by the CCGs. However, if the *entire* capital pipeline were to be delivered, the revenue consequences would likely exceed this sum.

**STP estate strategy and workbook – next steps**

All STPs are required to prepare and submit to NHSE a comprehensive estate strategy (covering the entire estate, not just primary care) by July 2018. We will be building on the work completed as part of preparing this strategy to review the overall capital pipeline for primary care and complete further prioritisation of proposals, drawing on the principles set out above. We anticipate that this work will be co-ordinated by the primary care estates group that we plan to establish (see Implementation section, below), and in liaison with local partners such as councils.

# 7. FINANCE

**About this section**

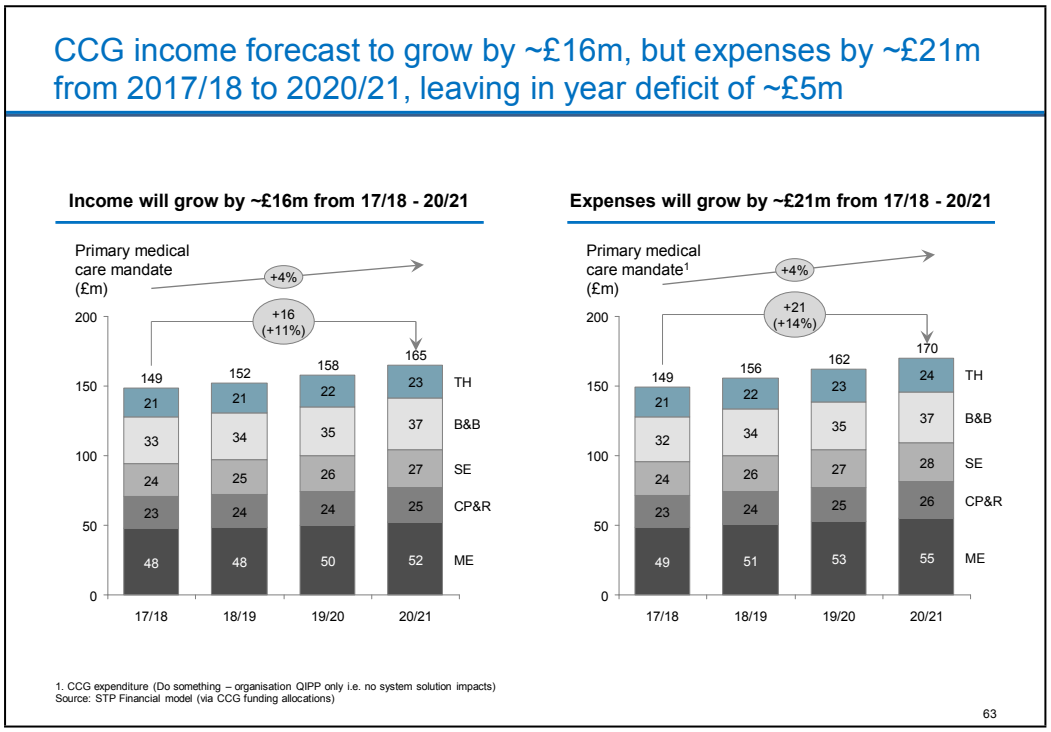
In this section, we set out how much we estimate implementing our new model of care is likely to cost, and identify how we might be able fund the increased expenditure on workforce, estates and other enablers. Although we can see a path to a balanced financial position, there are a range of risks; mitigating these will need CCG Boards to take some difficult decisions about priorities as well as the support of NHS England.

## Current and planned levels of expenditure

At present across the STP we invest approximately £149m in core general practice services. As we have a mixed commissioning landscape, these budgets are split across the five CCGs and NHS England. Based on likely increases to funding that have been announced nationally, we anticipate that this total budget will increase by approximately £16m to £165m in 2020/21.

In developing this strategy, we have used national growth assumptions to estimate how much the cost of our existing model is likely to increase during this same period (2017/18 to 2020/21); our modelling suggests that costs will go up by approximately £21m to £170m.

Taking the anticipated increases in funding and expenditure together, it can be seen that by 2020/21 there is likely to be a 'do nothing' deficit of approximately £5m in these core services.



**Costs of new model of care**

However, as set out in the case for change, we know that we cannot continue with the same model of care, and we have worked with a wide range of practices and other stakeholders to design a new approach. Once the broad outline of the model had been developed, we were then able to estimate its likely cost.

We believe that the additional costs associated with the new model fall into three main areas:

- Workforce – the cost of the additional staff that the system is likely to require in order to close the capacity gap set out in the case for change
- Estates – the additional *recurrent* costs associated with building new or refurbishing existing premises, with a focus on those developments that will make the most significant contribution to delivering this strategy (set out in detail in the previous section)
- Other key enablers – focusing in particular on the likely cost of digital solutions and the change management capacity that may be required

Workforce

In our new model of care, we move from a principally GP delivered service to one that is GP led, supported by a much wider range of clinical and other disciplines than is presently the case. Based on a range of discussions, we have estimated how many additional staff we would require (over the 2017/18 baseline) across the key staff groups. We have then been able to estimate the additional cost of these staff.

At this point this is a 'top down' analysis and will change as CCGs and localities develop detailed plans. It can be seen from the below that if half of our practices have introduced the new model by 2020/21, then this will cost an additional £22m over the current baseline.

## Based on the model chosen, the future model workforce could have recurring costs of between £16–£22M

Preliminary

| Skill mix | Baseline *(2017/18)* | Est. cost per FTE (£K) | Flat GPs and mixed skilled workforce (2020/21) FTE Δ to baseline | Flat GPs and mixed skilled workforce (2020/21) Additional cost (£M) | Current GPFV targets (2020/21) FTE Δ to baseline | Current GPFV targets (2020/21) Additional cost (£M) | Essex draft strategy (2020/21)[1] FTE Δ to baseline | Essex draft strategy (2020/21)[1] Additional cost (£M) |
|---|---|---|---|---|---|---|---|---|
| GP | 562 | 101 | - | - | 120 | 12.2 | 120 | 12.2 |
| Clinical practitioner | 256 | 48 | 142 | 6.9 | 84 | 4.1 | 69 | 3.4 |
| Physical | 0 | 48 | 84 | 4.1 | 17 | 0.8 | 42 | 2.0 |
| Mental | 0 | 48 | 40 | 1.9 | 0 | 0.0 | 20 | 1.0 |
| Social | 0 | 48 | 24 | 1.2 | 0 | 0.0 | 12 | 0.6 |
| HCA | 77 | 27 | 29 | 0.8 | 29 | 0.8 | 29 | 0.8 |
| Other DPC | 63 | 27 | 13 | 0.3 | 13 | 0.3 | 13 | 0.3 |
| Admin | 990 | 23 | 26 | 0.6 | 26 | 0.6 | 87[2] | 2.0 |
| **Total** | **1.9k** | | **0.4k** | **16** | **0.3k** | **19** | **0.4k** | **22** |

**Suggested mapping of roles to skill mix**

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Mental —MH Therapist; CPN
- Physical — Physio

1. Based on 50% of practices moving to the proposed locality workforce model 2. Assume uptake of 0.5 GP Assistant FTE per practice; GP cost—2015/16 GPMS income; £48k for AFC 7 and 24% uplift to FLC; HCA and other DPC—AFC4 and 24% uplift; Admin—AFC3 and 24% uplift
Source: M&SE NHSE submission; Agenda for Change Pay Scales; Sep-17 MDS and Mar-17 MDS (corrected by CCG leads – based on individual practice submissions)

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Estates

As set out in the previous section, to implement the new model of care we have assumed we will need to invest in premises, in particular to enable the working at scale which is at the heart of our strategy.

As part of our work we have developed a detailed general practice capital 'pipeline' at CCG level. We have estimated that if every scheme in this multi-year pipeline were to be delivered, the total capital cost would be in excess of £240m, although we anticipate this will fall markedly as we prioritise developments. There are a number of options open to CCGs in order to raise the capital required, including third party developments, collaboration with partners – especially local authorities - and public sector capital.

In order to create a sustainable recurrent financial strategy, we have focused on the ongoing costs of increased capital investment. At this point it is difficult to be certain about the exact costs (as this depends on the a range of factors, including how much of each CCGs pipeline in progressed, who owns and runs any new buildings, the cost of facilities that are being replaced etc.), but we have assumed that we will want to develop a number of hubs and other improvements over the coming years, and estimate that the direct additional recurrent estates costs will be between £3m and £9m.

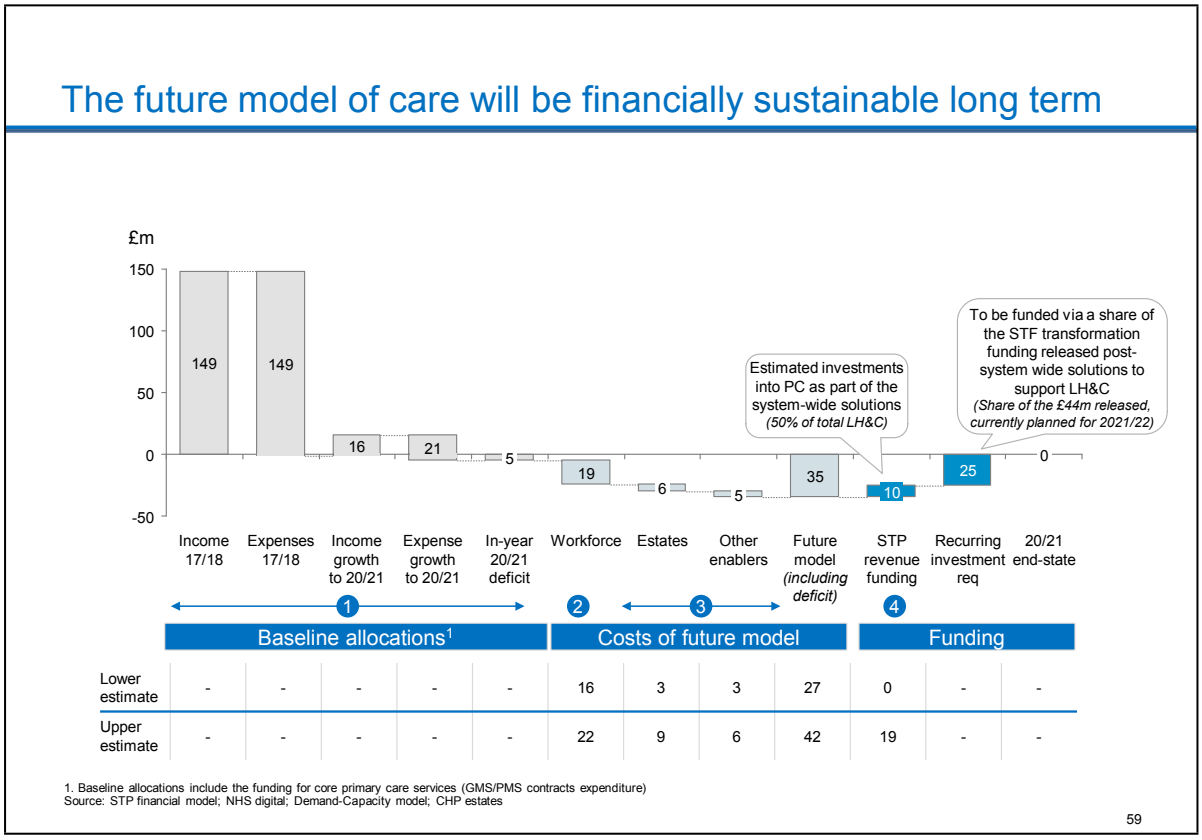
Other enablers

To fully implement this strategy, we think we will need to invest in a small number of other enablers, in particular digital solutions and change management capacity. At this point we do not have detailed plans across each of the five CCGs, but a 'top down' assessment suggest that we will need to invest between approximately £3m and £6m to support the introduction of these key enablers.

| Category | Potential schemes | Recurring costs (£m) | Comments |
|---|---|---|---|
| Other enablers | Population health and data analytics support | £0.3 - £0.6m | • Lower – Assume 1 FTE per CCG at £50k FLC<br>• Upper – Assume 2 FTE per CCG at £50k |
| | Technology enablers | £2 – 4m | • Lower – Assume ongoing cost of ~£2m (as planned for 2018/19 GPIT spend)<br>• Upper – Assume twice '18/19 spend for provision of additional digital services |
| | Management resource to engage GPs | £0.6 – 1.6m | • Lower – assume 0.5 FTE per locality at £50k FLC<br>• Upper – assume 1 FTE per locality at £65k FLC |
| | **Total** | **£2.9 – £6.2m** | |

**Overall financial position**

We have combined our estimates of current and planned increases in expenditure and the anticipated cost of introducing our new model of care so that there is a clear overview:




Section 1 (the first five bars) shows that after taking into account anticipated growth in income and expenditure over the period 2020/21, there is a likely deficit of approximately £5m if we continue to provide these services with no major changes to the delivery model. Sections two and three (the next four bars) show the anticipated additional cost of introducing the new model, which is approximately £30m by 2020/21. Taken together, this suggests an overall deficit position after

moving to our new model of care of £35m by 2020/21. The final section (4 – the three bars on the right) set out how this financial gap could be closed; this is outlined below.

We have broken down the STP financial bridge into each CCG in order to understand the local position. These are included in the detailed annex to this strategy.

**Funding our new model of care**

There are three main elements to our plan to close the financial gap identified above and ensure we have a financially sustainable system. However, it is important to emphasise that there are risks associated with each element; addressing these will require CCG Boards to make some difficult decisions about priorities, and will also require the support of NHSE (see below).

Firstly, all CCGs have in 2017/18 and 2018/19 invested additional resources in primary care over and above core GMS and PMS, in particular to support extended access. Although some of these funds are non-recurrent, we anticipate similar levels of funding to be future years so should be available for investment in primary care. We have estimated this will be £9m a year across the STP. We believe the risk of these funds not being available for investment is relatively low, and CCGs laregely control where they are invested.

Secondly, we know from national planning guidance that our STP is scheduled to receive an additional £78m in Sustainability and Transformation Funds (STF) in 2020/21. These are funds that are currently top sliced nationally by NHS England to pay for a range of programmes such as the Vanguard initiative.

These funds are not earmarked specifically for primary care and there will be competing demands for investment. Therefore, in order to be prudent we have assumed that approximately £16m is available to support this strategy, which is consistent with national estimates on the likely cost of implementing the *GP Forward View*. We believe that this level of funding is likely to be made available and within the control of CCGs, but recognise that there is a significant risk that they will be required to address other pressures (e.g. overspends in hospitals or funding new national imperatives).

Taken together, we have assumed that these two elements (other CCG funds of £9m and STF funding of £16m) provide an additional £25m to support the implementation of this strategy.

Thirdly, we have identified that an additional £10m may be available by 2020/21 as a result of wider changes to the way in which services are delivered. In our STP's overall plan, we agreed a model that would see some services (principally outpatients) that are traditionally provided in hospital move into a community setting, allowing our acute providers to concentrate on services which can only be delivered in a hospital setting. The funding released from providing these services in a community setting enables us to both pay for those new services and also invest a proportion into our core community and primary care services. We have estimated the element for investment into primary care services will be circa £10m.

However, we know that this element of funding is the riskiest: experience tells us that releasing real savings from the hospital sector for investment in the community is far from straightforward.

**Support required from NHSE to deliver this strategy**

Although we have developed a financial strategy that indicates our new model of care is affordable, we know there are significant risks to this plan. These risks, together with the support that we think we need from NHSE to mitigate them, are set out below:

| **Funding source** | **Approx. amount (20/21)** | **Level of risk** | **Support required** |
|---|---|---|---|
| CCG baseline funding (in addition to core PMS/GMS) | £9m | **Low** – funds are largely either included in CCG baselines or available via bidding process | CCGs supported to 'ring fence' current expenditure on primary care<br><br>CCGs encouraged to increase primary care spending from within allocations (e.g. an element of 0.5% investment fund)<br><br>Allocations that are currently made following bidding processes moved to CCG baselines, to maximise local flexibility |
| Additional STF allocation | £16m | **Medium** – the amounts to be allocated to our STP in 2020/21 are clear, but there is a risk that these are either ring fenced or tied to delivering additional requirements | Full STF allocation made without any ring fencing of funds or tied to the delivery of new or additional commitments |
| Funding released from re-provision of acute services | £10m | **High** – if acute demand exceeds our wider STP plan, or if services are not successfully re-provided in an out of hospital setting, these funds will not be available | Explore other funding options with CCGs, such as repayment of historic debt, prioritising primary care for investment of any additional growth received, development of STP investment pool |

# 8. COMMUNICATIONS AND ENGAGEMENT

**About this section**

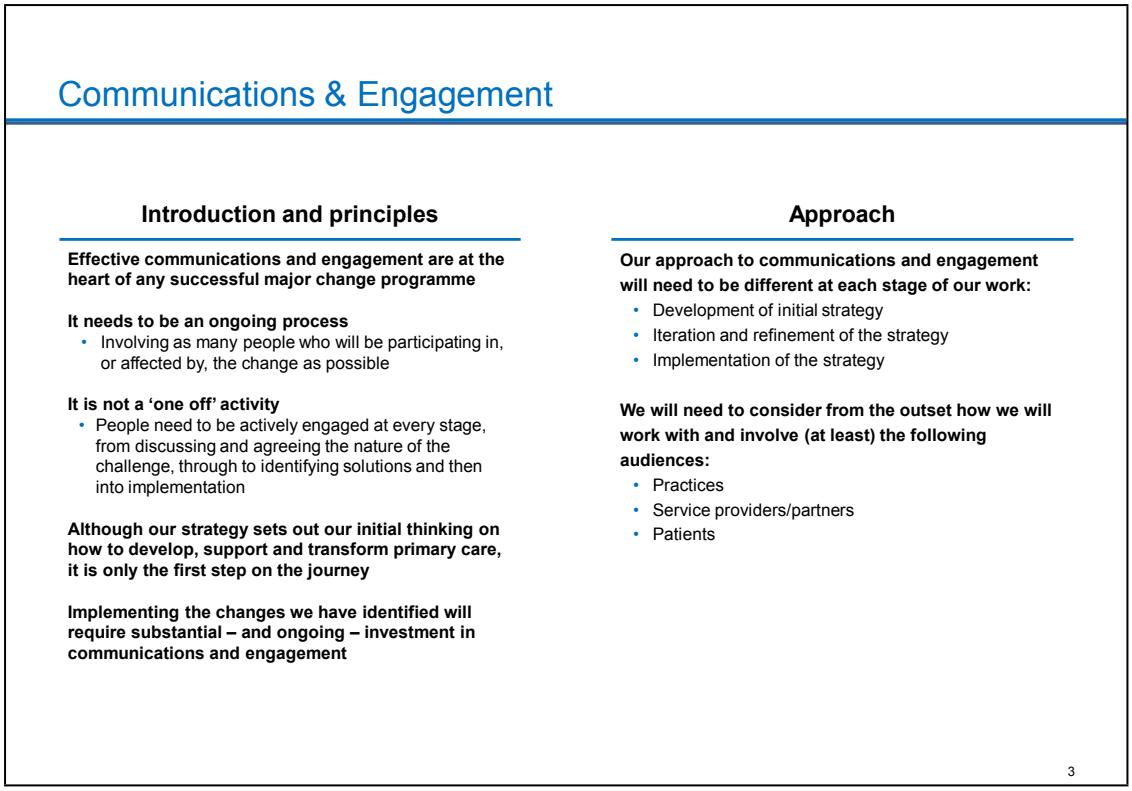
This section sets out the work we have already done to engage local practices and other partners in agreeing the case for change and developing the solutions proposed in this strategy. It then outlines how we plan to build on this by continuing to work closely with patients, practices and partners as we finalise our strategy and, crucially, move into implementation.

**Context**

Effective communications and engagement are at the heart of any successful major change programme. It is not a 'one off' activity – people need to be actively engaged at every stage, from discussing and agreeing the nature of the challenge, through to identifying solutions and into implementation.

Although this document sets out our initial thinking on how to develop, support and transform primary care, it is only the first step on our journey. Designing the detail of and then implementing the changes we have identified will require substantial – and ongoing – investment in communications and engagement.

The principles and broad approach we agreed in developing this strategy are set out below:




**Phases**

Our broad approach has been to divide our communication and engagement work into three main phases, and our approach is necessarily different at each stage as more and more people are affected by implementing our new model of care. The main phases are:

- *Development* of initial strategy
- Iteration and *refinement* of the strategy
- *Implementation* of the strategy

**Audiences**

General practice sits at the centre of our health and care system. As a result, because we are seeking to work with practice to make changes to the way it operates, we need to engage not just with practices and their patients but also with the very wide range of other services and partners that they interact with. In fact, many of the opportunities or solutions we have identified in this strategy are entirely dependent on other organisations changing what they do, so their ongoing involvement is vital.

In applying our three phase approach, we have identified three main audiences to focus on in our communications and engagement:

- Practices
- Service providers and system partners
- Patients

**Engaging with Practices**

Effective engagement with practices has been our top priority during the first phase of our work; without practice level buy in, little will change and this strategy will not be delivered. We have worked hard to engage practices in the first phase of developing this strategy, and want to build on this as we move into refinement and implementation:

| Phase | Objective | Activity | Status |
|---|---|---|---|
| **1 - Strategy development** | Raise awareness of programme and its objectives | Updates on progress and emerging thinking to CCG Joint Committee | Complete |
| | Raise awareness of programme and its objectives | Presentations to and discussions with practice 'Time to Learn' events at each CCG | Complete |
| | Discuss and agree main solutions to be developed | Discussion at each CCG Clinical Executive (or equivalent) | Complete |
| | Discuss and agree main solutions to be developed | Presentation to and discussion with CCG senior management team | Complete |
| | Discuss and agree main solutions to be developed | Meetings with CCG Chairs | Complete |
| **2 - Refinement of strategy** | Discussion of draft strategy | Meeting with Joint Committee of the CCGs | April |
| | To share draft strategy, gather feedback and update/finalise plan | Discussion at each CCG Clinical Executive<br>Presentations to and discussions with practice Time to Learn events | Apr/May |
| **3 - Implementation** | To finalise approach to implementation | Discussions at each CCG Governing body, including final sign off of the strategy and local implementation plan | May/June |
| | To share/review progress with implementing agreed priorities and spread learning across the system | CCG executives/Governing Bodies<br>Updates to Practice Time to Learn events in each CCG | Ongoing feedback |

**Providers and system partners**

Successful implementation of this strategy will necessitate some changes to the way our partners organise and deliver services. For example, developing localities as a way of integrating services may require some staff – such as those employed by community providers – to be realigned. This will need the agreement of many organisations, making their involvement in each of the three phases vital.

| Phase | Partner | Objective | Activity | When |
|---|---|---|---|---|
| **1 - Strategy development** | **Acute Trust Group** | Ensure awareness of primary care strategy at strategic level | Discussion with senior staff | Complete |

| | | | | |
|---|---|---|---|---|
| | **Community and MH providers** | Ensure awareness of primary care strategy at strategic level | Meeting with CEOs/lead directors | Complete |
| | **Health and Wellbeing Boards** | Ensure awareness of primary care strategy at strategic level | Briefings for HWBs | Complete |
| | **Healthwatch** | Ensure awareness of primary care strategy at strategic level | Discussion with senior staff | Complete |
| **2 – refinement of strategy** | **Acute Trust Group** | Identity potential joint solutions (e.g. access to consultant expertise to practices, OP clinics in community) | Discussion with trust Medical Directors<br><br>Share draft papers for comment with key staff | Apr/May |
| | **Community and MH providers** | Opportunity to gather/contribute ideas on solutions and implementation | Involvement of senior provider staff in solution design workshops/new models<br><br>Share draft papers for comment with key staff | May |
| | **Health and Wellbeing Boards** | Identify implications of emerging strategy on social care/create opportunities to contribute to solution design | Involvement of senior provider staff in solution design workshops/new models<br><br>Share draft papers for comment with key staff | Apr/May |
| | **Healthwatch** | Involvement in co-ordination of patient awareness | Discussions with senior officers from each of the three Healthwatch organisations | Apr/May |

As we move into implementation, which will be led by the five CCGs across the STP, we anticipate that detailed local arrangements will be put in place (such as implementation or delivery boards) to ensure that all local partners are fully involved in local discussions at all stages. There are already good engagement mechanisms in place in many parts of our STP, but we envisage that delivering this STP-wide strategy will provide renewed focus an impetus.

**Patients**

Involving patients in the development of this strategy and, in particular, in identifying potential solutions in each locality will be important. If we fully implement our new model of care, the service patients receive from general practice will increasingly look and feel different, for example:

- There is likely to be routine triage in place when a patient contacts the practice, rather than 'automatic' access to a GP

- Patients will increasingly see a wider range of professionals at their practice rather than being directed to a GP or a nurse
- Patients may sometimes be asked to travel to a locality hub or a neighbouring practice in order to be seen

These changes will, over time, require some shifts in patient behaviour if our new model of care is to be successful. This is much more likely to happen if patients are involved in discussing solutions at every stage.

Although we will seek to co-ordinate patient engagement in the development and implementation of this strategy at an STP level, including working with partners that represent and advocate for patients such as the three Healthwatch organisations and the STP Service User Advisory Group, we think that in order to be effective most patient engagement work needs to be led locally.

This is because the broad model of care that we have set out in this strategy will look different in each place – no two CCGs or localities are the same. It is therefore vital that the conversation with patients and carers about exactly what the service model should be in a given areas is a local one.

We have strong foundations in place to progress this work. For example, all CCGs have lay members that have a particular role in advocating for patients, and many have well established patient advisory panels. Another key route for involving patients at every stage will be at practice level, through practice patient participation groups (PPGs), which are ideally positioned to discuss very local challenges and proposed solutions.

# 9. IMPLEMENTATION

**About this section**

This section sets out our thinking on how to make this strategy a reality, moving at scale and at pace. It describes an approach where each CCG leads local implementation, but in a co-ordinated way, doing things once across the STP where that makes sense. It sets out our 'offer' to practices, as well as plans to identify a first wave of localities and the support that they can expect to receive.

**Overview of approach to implementation**

This document is an 'umbrella' primary care strategy for our STP, building on and complementing pre-existing plans in each of the five CCGs.

In determining our approach to implementation this strategy, we have considered the best way of balancing several factors, including:

- We are not all starting from the same place – in some of our CCGs, plans to develop general practice and localities are better developed than others
- Implementation will not be at the same pace everywhere – we have been explicit with practices that implementing the new model of care is voluntary; as a consequence, it is natural that some areas will progress faster than others
- The local context is critical – we know that the challenges in each part of our patch are different and, as a result, the approach to implementation will differ also.

As a result of these factors, we have concluded that the right approach is for each CCG to lead implementation in partnership with their local practices and localities, but within a consistent STP wide framework.

**Establishing a 'leading edge' of localities**

We are keen to work with a small number of localities that have the capability and drive to make rapid progress. We believe that this will be the best way of generating momentum, capturing learning and acting as a wider catalyst for change in general practice.

As a first step in implementing this strategy, each of the five CCGs plans to identify practices/localities that could become a 'wave 1' locality. In order to enter the first wave, practices and localities must be able to demonstrate that they meet some essential criteria, including:

- Appropriate population coverage (size and geographically coherent)
- Credible leadership
- Commitment to ongoing development of locality
- Demonstrable practice sign up

**The 'offer' to practices**

We anticipate that there will be a clear incentive or 'offer' for practices to enter wave one. Although the details of the offer will vary CCG by CCG, the core elements are likely to be:

- *Reducing workload* – by accessing additional support including workforce, as well as rolling out support to more effectively triage and manage patient flow
- *Access to recurrent funding* - in order to build the locality model and the extended workforce that is required to increase capacity, as set out in our future model of care
- *Support with estate* – where required, a clear 'route map' for a locality to secure the capital required for new or redeveloped premises, including the non-recurrent revenue needed to develop the case, as well as the on-going revenue costs
- *Access to CCG management support* – depending on the locality's needs the CCG will commit to making relevant management expertise, such as change management, HR, governance or data skills, directly available to support the locality
- *Access to learning networks* – localities in wave one would have prioritised access to both local and national packages of development
- *Support to pilot innovation* – localities in wave one would be encouraged to innovate and actively supported to trail new initiatives, especially digital solutions

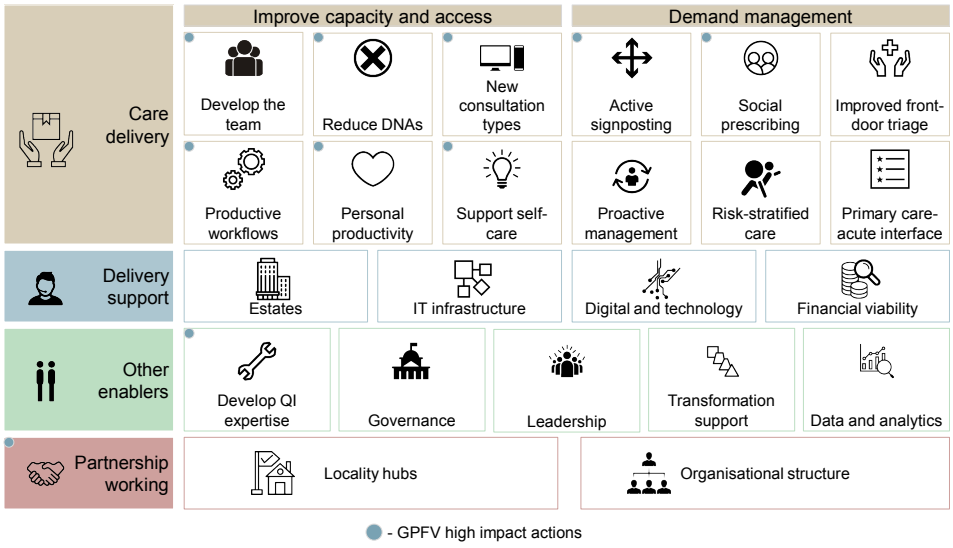
We are also exploring the potential NHSE national funding that may be available to support leading edge localities.

**Locality self-assessment/diagnostic**

Because the starting point and needs of each locality will be different, the first step in supporting localities will be for them to complete, in partnership with their CCG, a simple self-assessment or diagnostic tool that we have developed. This is flexible tool that is designed to structure a series of conversations to determine where a particular locality's development priorities lie. It is *not* intended to be a checklist or an assurance tool.

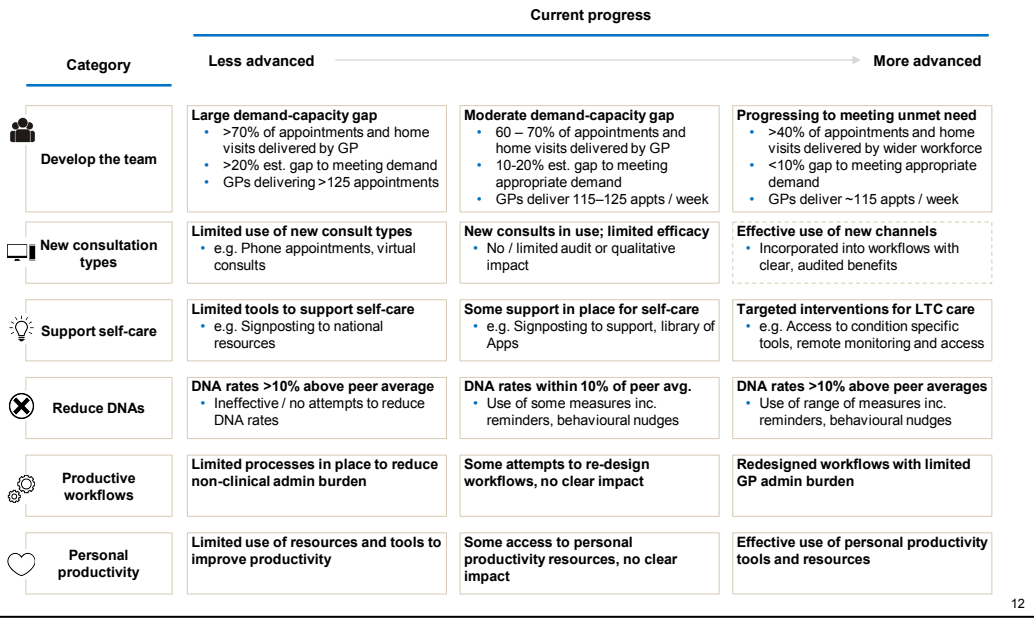
The development tool will consider a range of domains that are relevant to becoming a high performing locality, and also help localities to consider where they are now as well as where they might need to be in future:

## Locality development guide: Key areas




The tool we have developed will also enable localities to assess where they lie on a spectrum of development in each of the domains, against a description of best practice:

## Locality development guide: progress to date




More detail on the tool we have developed is available in the appendix to this document.

**Locality development plans**

The self-assessment will result in an agreed locality development plan. This plan will set out who will do what by when in order to move the locality on to the next stage of their development, and is likely to cover:

- The demand-capacity gap
- The numbers and skill mix of any additional staff required to close this gap
- Any estate or capital implications
- Approach to innovation and digital

Where appropriate, this plan would take the form of a specific commitment between the locality and the CCG, covering, for example:

- Approach to meeting costs of any expansion in the wider workforce
- Prioritisation of any capital development that is required
- Access to and funding for specific tools, such as enabling new types of consultations
- Working with local partner such as councils
- Outcome metrics that will be put in place

**STP wide work streams**

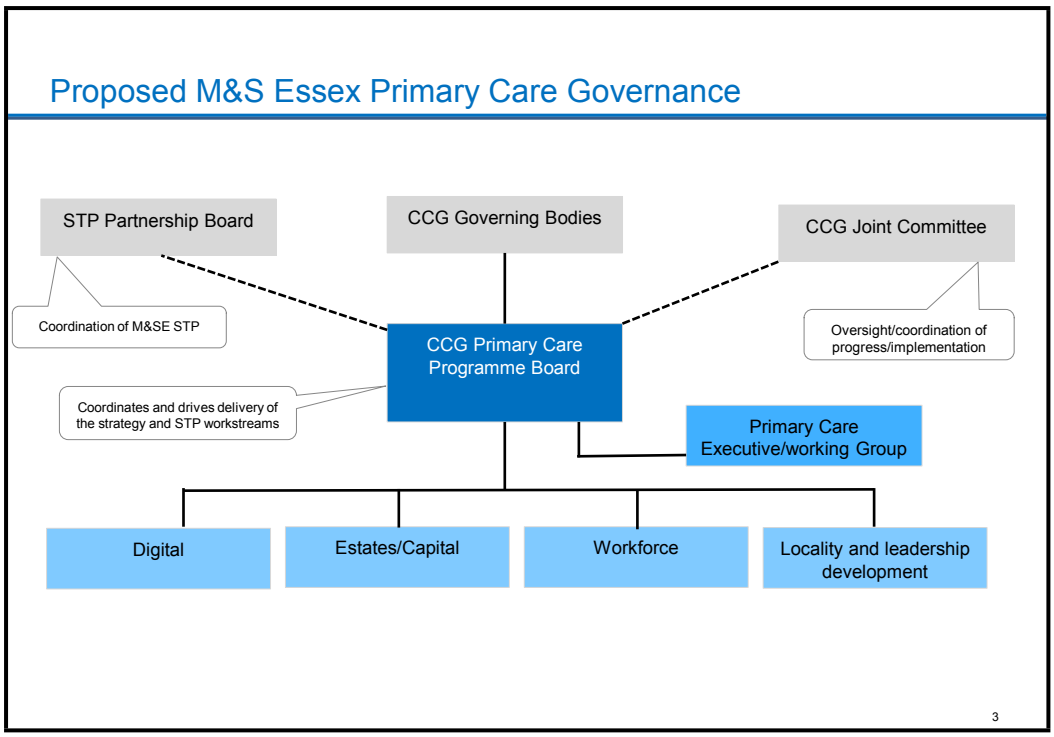
Although implementing this strategy will principally be the responsibility of the five CCGs in our footprint, we know that in some areas is will make sense to coordinate and do things once, adopting an STP wide approach. The key areas we have identified to date, and in which we will develop co-ordinated implementation plans, are:

- Digital
- Development of estates/capital
- Some aspects of workforce, such as work on defining consistent new roles and STP wide recruitment activities
- Practice/locality development offer, which could span legal advice, organisational development expertise and HR support

**Governance**

Work to develop our STP primary care strategy was initiated by the Joint Committee of the five CCGs. Although this Committee does not have delegated authority to take decisions on primary care, it is an invaluable co-ordinating mechanism, and will continue to act in this capacity as we move into the implementation phase.

To support implementation, we are recommending establishing an STP Primary Care Programme Board so that there is appropriate co-ordination and to ensure that pace is maintained. This Programme Board will be supported by workstreams in each of the four areas of STP wide work outlined above, and will report joint to the five CCGs and the Joint Committee:




**Timetable and immediate next steps**

We anticipate the key next steps to implement this strategy are:

| Date | Activity |
|---|---|
| 6 April 2018 | Joint Committee of CCG to discuss this draft strategy and identify areas for further development |
| 4 May 2018 | Joint Committee of CCGs invited to endorse this strategy and recommend that it is considered by each CCG Governing Body |
| June 2018 | CCG Governing Bodies invited to formally approve this strategy and its local implementation and investment plan |
| Late May to August | 'Leading edge' localities identified by CCGs<br>Successful localities selected and diagnostic tool completed<br>First locality development plans agreed and signed off |
| 6 July 2018 | Joint Committee of CCGs notes that the STP Primary care strategy and local implementation/delivery plans have been agreed by all five CCGs |

# APPENDIX

See separate supporting document

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| Friday 20th July 2018 | ITEM: 7 |
|---|---|
| **Health and Well-Being Board** | |
| **Mental Health Peer Review** | |
| **Wards and communities affected:** All | **Key Decision:** Yes |
| **Report of:** Roger Harris : Corporate Director – Adults, Housing and Health | |
| **Accountable Head of Service:** Les Billingham – Assistant Director Adult Social Care and Community Development | |
| **Accountable Director:** Roger Harris : Corporate Director | |
| **This report is** Public | |

**Executive Summary**

Thurrock Council, in conjunction with Thurrock Clinical Commissioning Group (CCG), invited the Local Government Association (LGA) to undertake a Peer Review of the wider mental health provision in Thurrock to see whether it was meeting the needs of Thurrock residents. The scope of the review is attached at Appendix 1.

The review was undertaken between 12th and the 14th June 2018 and attached at Appendix 2 is a copy of the slide presentation received at the end of review feedback session which summarises the findings and recommendations of the review team.

**1. Recommendations :**

**1.1 HWB Board is asked to comment on the findings of the MH Peer review.**

**1.2 HWB Board is asked to agree to receive a detailed response to the findings of the review at its September meeting.**

**2. Introduction and Background**

2.1 Officers for some time have felt that the wider mental health provision in Thurrock needed reviewing. We have had our existing arrangements with the mental health trust – Essex Partnership University NHS Foundation Trust (EPUT) for over 10 years and seconded our social care staff (approx. 20 staff) to EPUT as part of a Section 75 agreement.

2.2. Adult social care has been on a significant transformation journey and recently this has been joined with the CCG transformation plans to become a single programme - under the banner of “For Thurrock in Thurrock”. There

was a view that the service model for mental health had lagged behind the progress being made by FTIT in other parts of health and social care delivery.

2.3 Equally, we were very aware from the discussions with services users, third sector organisations and Thurrock Healthwatch that the demand for mental health support was growing but that people were finding it hard to access services when they wanted them.

2.4 Recent initiatives such as Inclusion Thurrock, the Recovery College and Local Area Co-ordination (although not specifically a mental health focussed offer) were getting very good feedback from service users but it was felt that the whole pathway need an external check and challenge to ensure that it was fit for purpose.

2.5 Adult social care has been under considerable pressure for many years as demand has grown and resources under a lot of pressure. Recent financial support in terms of the adult social care precept and the Better Care Fund had been very welcome but little of this had gone into mental health support as the urgent need was to support the growth in demand for services in domiciliary and residential care.

## 3. Issues, Options and Analysis of Options

3.1 Thurrock invited the LGA to undertake the Peer Review and an expert team was assembled. The Review Team were :

- Ian Winter CBE – Independent consultant.
- Cllr Philip Corthorne – Cabinet member for Social Services, Housing, Health and Wellbeing, London Borough of Hillingdon.
- Carline Taylor – Director of Adult Services and Housing (Torbay Council).
- Helen Maneuf – Assistant Director, Planning and Resources (Adult Care Services) Hertfordshire County Council.
- Bryan Mitchell – Charity Co-ordinator, My Life My Choice – Oxfordshire.
- Katherine Foreman – Independent Nurse, Medway CCG.
- Jonathan Trubshaw – Peer Review Manager, LGA.

3.2 A significant amount of work was undertaken prior to the visit to ensure that the team met as wide a range of people as possible and the views of as many people and organisations as possible could be assembled. The timetable and the list of people seen is attached at Appendix 3. It was also extremely helpful that the Public Health team had just completed the JSNA mental health which provided an excellent overview of the current demands, pressures and service gaps locally.

3.3. We are very grateful to the Thurrock Coalition and to Thurrock Healthwatch who arranged for a series of questionnaires to be completed prior to the visit to give some depth to the interview sessions and get people thinking in advance of the issues they wanted to raise. This meant the interview sessions, especially with users and carers where especially valuable.

3.4 The finding of the review were summarised into 9 “Areas for consideration” :

- Commissioners to develop an improvement plan for EPUT as a provider in Thurrock;
- Develop joint commissioning arrangements between the Council and the CCG;
- Commission for the “middle” of mental health needs;
- Create a Mental Health Programme Group, including children and transition, to ensure the elements of an improvement plan are coordinated to overcome current fragmentation of initiatives, including the JSNA recommendations;
- Develop service user involvement further e.g. in training, remunerated participation in project groups, reviews and inspections;
- Thurrock Council and CCG to agree new operating model which develops referral routes and new pathways whilst managing demand in the system;
- Drive innovation for Thurrock Mental health, which matches Adult Social Care Transformation.
- Capitalise on the “place at the table” to push models of integration in the STP. Recognise risk of NHS changing footprints and requirements in the next 10 years.
- The current model of social work needs urgent revision; social workers need support to practice with support in crisis incidents and bed finding.

3.5 Broadly officers support these set of recommendations and work has already started on most areas :

- Senior meetings are taking place between the Council and EPUT to look at reviewing the current operating model;
- A finance and performance sub-group has been set up to look at reviewing the current KPIs and how the existing system is performing and developing a more outcome based set of indicators;
- A stated above the mental health JSNA has recently been agreed which gives a great deal of useful information about current provision and future demand;
- The Director has asked that a more detailed financial summary is produced to see how much money we are spending on mental health and how this compares with other areas. We have not, as a Council, prioritised this area for growth recently due to other pressures;
- We are urgently seeking to fill the vacant commissioning post.

A more detailed Action Plan will come back to the September HWB Board which will include a recommendation as to whether we should extend the current Section 75 with EPUT or not.

## 4. Reasons for Recommendation

4.1 The recommendations at this stage are only to comment on and note the recommendations of the Peer Review. Generally the view of officers is to

support the findings of the review and a detailed action plan is being produced which will come back to the HWB Board in September.

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

5.1 The Peer Review team undertook extensive consultations with staff, members, users, carers and third sector groups as part of their on-site investigations. Their final report, plus our response, will go to Health Scrutiny Committee.

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

6.1 Mental health and wider support for vulnerable people has been identified as a key corporate priority for the year ahead.

## 7. Implications

### 7.1 Financial

Implications verified by: Jo Freeman – Management Accountant, Thurrock Council

No financial implications have been identified. Recommendations will be made by the Review Team that may have financial implications and these will be considered upon receipt of the final report and development of the subsequent action plan.

### 7.2 Legal

Implications verified by: Roger Harris, Corporate Director, Adults Housing and Health

No legal implications have been identified. The review will help to ensure that the Council is continuing to meet its statutory requirements for Adult Social Care.

### 7.3 Diversity and Equality

Implications verified by: Becky Price, Community Development and Equalities Team I Adults, Housing and Health Directorate

One of the aims of the peer review is to help ensure that our Mental Health offer is fully accessible to those who need it and that it responds effectively to local need. This has been tested as part of the review – including through the involvement of service users and carers feeding in to the review process - and a report will detail the extent to which we meet this aim. An action plan will address any areas that require improvement.

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

- N/A

**9. Appendices to the report**

- Appendix 1 : Scope of the MH Peer Review agreed with the LGA
- Appendix 2 : Slide pack summary of review findings and recommendations
- Appendix 3 : Timetable of the on-site meetings and people interviewed

**Report Author:**

Roger Harris

Corporate Director

Adults, Housing and Health

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## Thurrock Council Adult Social Care scoping email
## Onsite dates: March 2018 tbc

Dear Roger

It was very useful to discuss your requirements for an Adult Social Care Peer Review with a focus on Mental Health and delivered by the Local Government Association (LGA) as part of the East of England ADASS Regional Peer Review Programme. The LGA would be delighted to deliver this **3 day peer review** for you and the dates that you indicated most likely would be in March 2018.

**Scope**: as you have outlined in previous communications
The focus of the proposed peer review will be your mental health provision and to what extent it is meeting local need and delivering a community focussed service.
Your secondary care provision is primarily delivered through a section 75 agreement with Essex Partnership University Foundation Trust (EPUT).

**Focus:**
There are a number of areas of concern with the current model that you want a peer review to investigate and provide recommendations on:

- The extent that current arrangements and organisational culture delivers a person-centred approach – including a focus on delivering outcomes and a move away from a 'one size fits all' approach;
- To what extent the 'offer' needs to expand – both to respond to the recent Mental Health JSNA and the extent to which the market is robust enough to deliver against this;
- The extent to which the current offer is holistic – e.g. not just reactive, but also preventative;
- Does the current service "gatekeep" and so thresholds are set so high that there are a group of people who can't access the current service;
- The interface between other key partners – e.g. housing and primary care
- The extent that the Section 75 (including robustness of governance, decision making arrangements and the delivery of delegated statutory duties) is fit for purpose and possible areas of change;
- To what extent current partnership arrangements are working effectively – both in terms of provider (EPUT/Council) and commissioner (CCG/Council).

**Outputs:**
You want to ensure the review features and responds to the views of service users and considers the recommendations and findings contained within the recent Mental Health JSNA.
You want to ensure the peer review team had a good understanding of Mental Health arrangements.
Expected outputs of the peer review would be a report with clear recommendations that would enable you to review current arrangements and provide options for the future.

**You have indicated that the best timing for the peer review would be the first half of 2018, probably in w/c 13th or w/c 19th March 2018. I will be in touch in the very near future to confirm which date works best.**

**Benchmark**

The peer review will use the Adult Social Care Key Questions as the benchmark which has the following headline themes. As there are eight of these I suggest the team use these as guidelines only and focus on your questions rather than feel obliged to cover every area of these headings.

| | |
|---|---|
| 1. Outcomes for people who use services | 5. Resource and Workforce Management |
| 2. Participation | 6. Service Delivery and Effective Practice |
| 3. Vision, Strategy and Leadership | 7. Commissioning |
| 4. Working Together | 8. Improvement and Innovation |

The peer review team will consider your scope in the light of your Self-Assessment and Key Questions and give you feedback on your work as they see it. The team will work on the basis of there being 'no surprises' during the process and as 'critical friends', seeking to add value to your improvement journey. Each interview will be conducted as non-attributable to encourage participants to be as open and honest as they can. You will also receive feedback on what the team see as notable practice and signpost you to other good or useful practice they are aware of.

**Peer Review Team** you would like the team to consist of:

1. Lead Peer – DASS (with experience of mental health and personalised services)
2. Member Peer – Leader or Portfolio Holder, Conservative
3. Health Peer – CCG Senior Officer
4. Senior Officer Peer1 – Assistant Director/Head of Social Care
5. Senior Officer Peer2 – **From the Eastern Region** with experience of MH services
6. LGA Peer Review Manager

**Timetable**

There is an example timetable included in the Guidance Manual and I can forward other recent Adult Social Care peer review timetables in due course. Your review manager will be happy to see draft versions and give further guidance as you progress the preparations to the on-site work.

**Feedback and Action Planning**

On the last day there is the option of concluding the peer review with a presentation and an action planning session with an audience of your choice with the team present to add some detail. This approach has been found to enable clients to actively own the findings amongst a number of stakeholders. Please indicate which type of feedback works best for you.

**Self-Assessment**

The self-assessment example in the Guidance Manual tends towards creating a detailed self-assessment. A successful one has a narrative with links to documents for further information embedded.

**Cost**

**The cost of a 3 day review will be £9,000 plus expenses.**

**Other contacts:**

Natasha Burberry from East of England ADASS is experienced in peer review and can offer advice and guidance. Email: natasha.eastsli@gmail.com

**I attach:**

1. LGA Adult Social Care Peer Challenge Guidance Manual
2. Link to Adult Social Care Peer Review Reports on the LGA website: http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/7375659/ARTICLE

**Next steps:**

a. Agree of dates for the peer review
b. Agree the proposed peer team
c. Begin to write your Self-Assessment

Please do get in touch if there are any questions and queries and I look forward to working with you.

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Local Government Association

# Thurrock Council
# Adults Peer Review – Mental Health

Feedback from the peer review team

June 2018

www.local.gov.uk

# This peer review feedback

- The peer team
- The process
- Feedback in key questions format
  - Strengths
  - Areas for further consideration
- Your reflections and questions
- Next steps

# The Team

- Ian Winter CBE – Independent Consultant
- Cllr Philip Corthorne – Cabinet Member for Social Services, Housing, Health and Wellbeing London Borough of Hillingdon
- Caroline Taylor – Director of Adult Services and Housing, Torbay Council
- Helen Maneuf – Assistant Director – Planning and Resources (Adult Care Services) Hertfordshire County Council
- Bryan Michell – Charity Coordinator, My Life My Choice, Oxfordshire
- Katherine Foreman – Independent Nurse, Medway CCG
- Jonathan Trubshaw – Peer Review Manager, Local Government Association

# The peer review process

- The peer challenge is based on the Adult Social Care Framework, tailored to Thurrock's requirements
- Not an inspection – invited in as 'critical friends'
- Information collection is non-attributable basis
- Document and data analysis, interviews, focus groups and meetings
- People have been open and honest
- Feedback is based on the triangulation of what we've read, heard and seen.

# The team has:

Spent 3 days onsite at Thurrock Council, during which we:

- Spoke to more than 100 people including a range of council staff together with councillors, external partners and service users
- Gathered information and views from more than 35 meetings, visits and additional research and reading
- Collectively spent more than 280 hours to determine our findings – the equivalent of one person spending 8 weeks in Thurrock Council

# You asked us to look at:

- The extent to which the current service ‘gate keeps’ with thresholds set
- The extent that current arrangements and organisational culture delivers a person-centred, strength based approach – including a focus on delivering outcomes and a move away from ‘one size fits all’
- To what extent the current ‘offer’ needs to expand and the extent to which the market is robust enough to deliver against this
- The extent to which the current offer is holistic
- The extent to which the service is preventative
- The interface between other key partners – e.g. housing and primary care
- The extent that the Section 75 is fit for purpose and possible areas of change
- To what extent current partnership arrangements are working effectively – both in terms of provider (Essex Partnership University Foundation Trust – EPUT, and commissioning (Thurrock CCG/Thurrock Council)

# Council leadership

- Vision to leave no-one behind by members and chief executive
- Strong financial management and commitment to vulnerable people
- Cross-party commitment to Health and Social Care
- Strong pride in community
- Health and Wellbeing Board have the right people at the table
- Healthwatch are strong with standing item on Scrutiny
- Committed leadership of Adult Social Care Public Health and Housing

# Thresholds

**Strengths**

- Thresholds are set and applied
- Open referral for Local Area Coordinators
- When high-level need identified the Grays Hall service received is perceived as good

# Thresholds

## Areas for consideration

- Crisis team perceived as gatekeepers and maintain high thresholds
- GP referral system is seen as building in delays; medical model
- Opportunity to open up other referral routes but only as part of an holistic system change
- Difference in perception of what “crisis” is and understanding of Threshold criteria; for individual and service
- Performance information not seen to evidence intervention impact on improvements in Mental Health

# Person-centred, Outcome Focussed

**Strengths**

- Local Area Coordinators person-centred aspect widely acknowledged
- Mind, Inclusion Thurrock (IAPT) and Recovery College services are well regarded
- Once diagnosed, services seen to be good
- Cross-party agreement for service improvement
- Housing services reported that they worked well with Grays Hall on individual cases
- Low numbers of rough sleepers

# Person-centred, Outcome Focussed

**Areas for consideration**

- Variable provision when thresholds are not met
- Lack of specialist housing plan for people with mental health issues
- Ensure social workers focus on the complex and less complex are met through other arrangements
- Ensure that social work practice/values as a profession are asserted and owned within EPUT arrangements, including Grays Hall team
- Stretched but effective preventative provision for border-line homeless not consistent across the area and rising demand from inner-London movements

# Market Capacity and Development

**Strengths**

- Existing Market Position Statement and JSNA
- Housing Investment and Regeneration Group recognising vulnerable people
- Proactive in-house housing team dealing with difficult supply issues
- Innovation in terms of fragile social care market i.e. Domiciliary Care could be applied to Mental Health
- Community Hubs and Strength Based conversations in Adult Social Care and voluntary sector; needs to be aligned and planned with service model in nascent four integrated medical centres

# Market Capacity and Development

**Areas for consideration**

- Detailed analysis of Mental Health market needs and specialist accommodation
- Opportunity to Invest to Save to deliver accommodation, looking at external placements with CCG
- Build on personalisation approach and values in Adult Social Care into Housing

# Holistic Offer

**Strengths**

- Thurrock First is seen as responsive and innovative
- Local Area Coordinators development is seen as positive and well regarded
- Joint commitment to development of Integrated Medical Centres
- Joint funding of Integrated Care Director
- Opportunity to resolve operational housing issues through local housing group
- Social prescribing in Primary Care

# Holistic Offer

## Areas for consideration

- Opportunity exists for EPUT to work jointly with NELFT building on pilots in Tilbury and Chadwell
- Secondary Mental Health care needs to benefit from a wider multi-disciplinary approach
- IT incompatibilities between council and EPUT
- High staff turn-over at Grays Hall
- Ensure full engagement of seconded staff in all council initiatives
- Grays Hall Crisis Line not responsive
- Local Area Coordinators some inconsistency in approach and skill variations

# Prevention

**Strengths**

- Local Area Coordinators responsive and can prevent crisis
- Recovery College
- Thurrock First
- Improving out-reach reported in Purfleet and South Ockendon
- Mind recognised as an asset
- Healthwatch providing useful feedback to prevent direct interventions

# Prevention

## Areas for consideration

- Consider funding of prevention in Mental Health with CCG as an invest to save
- Older People's Mental Health service workload does not allow focus on prevention
- Thurrock First to consider interim measures to fill gap in Mental Health expertise and housing
- Opportunities to agree housing strategy and policy for people with Mental Health issues – "Same people float around the system"
- Care Act not well understood across partners

# Working with Other Community Partners

**Strengths**

- Recent evidence of EPUT and local authority wanting to improve relationship
- Robust evidence of good practice in the community e.g. Community Hubs, Social Prescribing, Micro-enterprises, Housing First, Shared Lives
- Shared care protocol
- Positive relationships across partners with a ‘can-do’ attitude
- Strong and valuable partnership with Thurrock Coalition

# Working with Other Community Partners

**Areas for consideration**

- Recalibrate the relationship with EPUT and local authority moving on from legacy issues and past working
- Making better use of resources across Health and Social Care economy
- Work in communities disparate and disjointed
- Independent sector expressed uncertainty about future funding, risking further integration

# Section 75

**Strengths**

- Southend-on-Sea open to working more closely on Performance Information
- Working more positively with EPUT post-reorganisation
- Operations group ready to take on a more engaged role; including provider and service user representation
- Better Care Fund perceived as positive

# Section 75

## Areas for consideration

- No single reporting and outcomes framework
- Assurance that social care values and approaches are part of EPUT ways of working, including executive board level representation
- Social work practice needs to be valued, including availability of crisis team to support AMHPs and being responsible for bed-finding, championed by Principle Social Work, for example
- No single point of contact within Thurrock for Southend-on-Sea for developing commissioning issues
- S75 staffing arrangements have a Health led culture that shapes practice

# Commissioning Arrangements

**Strengths**

- Public Health an asset; has driven “Case for Change” and through JSNA e.g. Stretch Quality and Outcomes Frameworks for GPs
- Opportunities to work together with other commissioners
- Recognised difficulties with EPUT and started to grip situation
- Reputation for innovation and ability to deliver transformation – well regarded by partners

# Commissioning Arrangements

**Areas for consideration**

- Consolidate new approach to management of EPUT; plan required to be set out and monitored
- Need to deal with ”Missing Middle” e.g. with 24/7 crisis support, Step-down, dual diagnosis – absence seen as clear gap by stake-holders
- How to manage development of four Integrated Medical Centres within context of NHS/STP and consideration of realistic timetable and service model
- Agree joint commissioning with CCG - CCG currently focussed too narrowly on commissioning primary and secondary care

# Quotes

- “Do I have to get better or worse to get treatment?”
- “If you are not already registered (for Mental Health) go to A&E or get arrested to get a service”
- “Once there was a diagnosis, everything was fantastic”
- “Grays Hall sometimes seems to be under siege”
- “If we change eligibility we will be over-whelmed”
- “No-one was listening to me”
- “I walked along side him and listened to his story”
- “You can check out but you can never leave”

# Action areas for consideration

- Commissioners to develop an improvement plan for EPUT as a provider in Thurrock
- Develop joint commissioning arrangements between council and CCG
- Commission for ‘the Middle’ of Mental Health needs
- Create a Mental Health programme group, including Children and Transition, to ensure the elements of an improvement plan are coordinated to overcome current fragmentation of initiatives, including the JSNA recommendations
- Develop service user involvement further e.g. in training, remunerated participation in project groups, reviews and inspections

# Action areas for consideration

- Thurrock Council and CCG to agree new operating model which develops referral routes and new pathways whilst managing demand in the system
- Drive innovation for Thurrock Mental Health, which matches Adult Social Care transformation. Capitalise on the ‘place at the table’ to push models of integration in STP.  Recognise risk of NHS changing footprints and requirements in the next ten years
- The current model of social work needs urgent revision; social workers need support to practice with support in crisis incidents and bed finding

# Next steps

- Discussion
- Report provided soon
- You will want to take the time to reflect on the report and consider how to take things forward
- Agree final report
- Evaluation – how was it for you?

Thank You

Any Questions

# Thurrock Council ASC Peer Challenge – Tuesday 12th June

| TIME | A<br>ROOM 9, 2nd Flr 9:30-1<br>ROOM 4, 4th Flr 1-5:30 | B<br>ROOM 3, 4TH FLOOR | C<br>ROOM 6, 4TH FLOOR |
|---|---|---|---|
| **08.30-09.30** | **Team arrival, domestic arrangements, room set up, capturing of main issues etc.** | | |
| **09.30-10.30** | **Presentation by council and partners on main issues/ achievements/ areas for consideration**.<br>Roger Harris, Les Billingham, Ibrahim Bakarr, Catherine Wilson, Maria Payne, Richard Birchett, Mandy Ansell<br>*(Room 9 , 2nd Flr)* | | |
| **10.30-11.00** | Team preparation/ discussion | | |
| **11.00-12.00** | **ASC Commissioning Lead**<br>○ Catherine Wilson | Integrated Care Director (NELFT/Thurrock Council)<br>○ Tania Sitch | **FREE** |
| **12.00-13.00** | **Corporate Director of Adults, Housing and Health**<br>○ Roger Harris | **Portfolio Holder for Health and Education**<br>○ Cllr Halden – *by telephone Call him on 07785 517011* | **Older People's Mental Health Team**<br>○ Adeyemi, Adewale,<br>○ Blessing Asanya,<br>○ Frank Holloway<br>○ Nicole Harrington<br>○ Kenneth Ngobele<br>○ Dominic Okonji<br>○ Debi Thomas |
| **13.00-14.00** | **Lunch & Team Meeting** | | |
| **14.00-15.00** | **Interim Service Manager Adult Social Care**<br>○ Ibrahim Bakarr<br>**Assistant Director of Adult Social Care and Community Development**<br>○ Les Billingham | **Portfolio Holder for Adult Social Care**<br>○ Cllr S Little | **Adult MH Team Social Workers**<br>○ Janet Foroma<br>○ Carolyn Trenwith<br>○ Chris Lucas<br>○ Adriana Ricci<br>○ Maxine Southgate<br>○ Ann Kerin |

| | | | |
|---|---|---|---|
| **15.00-15.30** | **Break**<br><br>***15:00-16:00*** **Lyn Carpenter, Chief Executive,** *(1st Floor Room 3)* | | |
| **15.30-16.30** | **Focus Group – Front Line Staff**<br><br>○ Corrine Williams CPN<br>○ Patricia Chesco CPN<br>○ Janet Foroma SW<br>○ Sipo Mabena<br>○ Mary Phiri<br>○ Mark Gillett<br>○ Carolyn Trenwith | **Healthwatch**<br><br>○ *Kristina Jackson*, Chief Executive Thurrock Community and Voluntary Sector (CVS)<br>○ *Andrea Valentine,* Deputy Chief Operating Officer Thurrock Healthwatch | **Voluntary Sector Providers (MIND, IAPT, Recovery College)**<br><br>○ Lynne Morgan – Chief Executive Thurrock Mind |
| **16.30-17.30** | **Team meeting** | | |

# Thurrock Council ASC Peer Challenge – Wednesday 13th June

| TIME | A<br>ROOM 6, 4TH FLOOR | B<br>BEEHIVE – TRAINING RM 1ST Flr | | C<br>ROOM 1, 2ND FLOOR |
|---|---|---|---|---|
| **08.30-09.00** | Team gathers in on-site room | | | |
| **09.00-10.00** | **FREE** | **Local Area Coordinators**<br>○ Francis Allie – LAC Manager<br>○ Kate Williams – Senior LAC<br>○ Karen Dobson – Senior LAC<br>○ Martin Trevillion – LAC<br>○ Lynn Carr (mum)<br>○ Michael Carr (son) | | **Housing Focus Group**<br>○ Lorrita Johnson<br>○ Nicolas Dean<br>○ Joanne Davies<br>○ Richard Birchett |
| **10.00-11.00** | **AMHPs**<br>○ Ibrahim Bakarr<br>○ Vivette Akintokun<br>○ Marie-Line Bannis<br>○ Cheryl McCabe<br>○ Christine Lucas<br>○ Caroline Spray | **Stronger Together Thurrock**<br>○ Francis Allie<br>○ Les Billingham, Sue Bradish<br>○ Kristina Jackson – Thurrock CVS<br>○ Sue Wellard | **Chair of HOSC/Shadow Portfolio Holder**<br>*Room 10, 2nd Floor*<br>○ Cllr Victoria Holloway | **Supported Housing Providers**<br>○ Barbara Horne - Peabody<br>○ Lynne Morgan – Thurrock Mind<br>○ Helen Leavy - Peabody |
| **11.00-11.30** | **Break/ Team Meeting** | | | |
| **11.30-12.30** | **MH Operational Delivery Group**<br>○ Carla Fourie<br>○ Lynnbritt Brown<br>○ Stefka Andreeva<br>○ Vivette Akintokun | **Clinicians' Group**<br>○ Via Jane Itangata<br>*Port Room -, CCG Offices*<br>*(2nd Floor CO-1, Civic Offices)* | | **Homeless into accommodation**<br>○ Jake Hogg (St. Mungos)<br>○ Shel Cribben (St. Mungos)<br>○ Linda Benson (Open Door) |
| **12.30-13.30** | **Lunch** | | | |
| **13.30-14.30** | **EPUT Senior Management Group**<br>○ Sue Waterhouse<br>○ Malcolm McCann | **Service User Focus Group**<br>Via MIND, HW, Thurrock Coalition<br>*The Beehive – 1st Flr Training Rm* | | **Public Health**<br>○ Maria Payne |

| | | | | |
|---|---|---|---|---|
| **14.30-15.30** | **Community Safety and Adult Safeguarding**<br><br>○ Les Billingham<br>○ Graham Carey<br>○ Emer Connolly<br>○ Phillipa Ladd – Changing Pathways<br>○ Fiona Kell - Thurrock<br>○ Paul Ballard – Essex Police<br>○ Joanne Davies - Thurrock<br>○ Luis Degoniparks – Essex Fire<br>○ Natalie Warren (tent)<br>○ Linda Smart - CCG | **Carers' Group**<br>*Beehive 1st Flr Training rm* | **Chief Exec - EPUT**<br>Sally Morris<br>*By telephone – call SM on 07771676417*<br>*14:30-15:00*<br>*(30mins only)* | **Grays Hall – Meet with Team Therapy Room**<br><br>Stefka to escort to GH from Civic<br>*07583019369 – Stefka's mobile*<br><br>○ Stefka Andreeva<br>○ Corrine Williams<br>○ Irena Kurbale<br>○ Carolyn Trenwith |
| **15.30-16.00** | **Break/ Team Meeting** | | | |
| **16.00-17.00** | **Placements**<br><br>○ Catherine Wilson<br>○ Louise Brosnan<br>○ Marie Stepney | **Director of Children's Svs**<br><br>○ Rory Patterson | ***CCG Commissioning***<br><br>○ Jane Itangata<br>○ Mark Tebbs Director of Commissioning Thurrock CCG | **Grays Hall – Meet w. team cont'd..** |
| **17.00-18.00** | **Team Meeting** | | | **Informal Feedback** |

# Thurrock Council ASC Peer Challenge – Thursday 14th June

| TIME | Room 4, 4th Floor |
|---|---|
| 08.30-12.00 | **Team Session** |
| 12.00-12.30 | **Informal Feedback Session**<br>○ Catherine Wilson<br>○ Les Billingham<br>○ Roger Harris<br>○ Ibrahim Bakarr |
| 12:30-13:30 | **Lunch and Final Preparation** |
| 13:30-15:00 | **Final Presentation & Feedback**<br>○ Roger Harris<br>○ Les Billingham<br>○ Catherine Wilson<br>○ Sue Waterhouse<br>○ Mandy Ansell<br>○ Lynnbritt Brown<br>○ Ibrahim Bakarr<br>○ Stefka Andreeva<br>○ Vivette Akintokun<br>○ Maria Payne |
| 15.00-16.00 | **Presentation to Service User Group by Lead Peer** – *The Beehive, Main Hall* |

| 20 July 2018 | ITEM:8 |
|---|---|
| **Health and Wellbeing Board** | |
| **Essex Southend and Thurrock Dementia Strategy 2017-2021 – Thurrock Implementation Plan** | |
| **Wards and communities affected:** All | **Key Decision:** Non Key |
| **Report of:** Catherine Wilson Strategic Lead Commissioning and Procurement and Irene Lewsey Head of Transformation Thurrock CCG | |
| **Accountable Assistant Director:** Les Billingham Assistant Director Adult Social Care and Community Development | |
| **Accountable Director:** Roger Harris Corporate Director Adults Health and Housing | |
| **This report is** Public | |

**Executive Summary**

The purpose of this report is to present to the Health and Wellbeing Board the Thurrock Dementia Implementation Plan for the Southend, Essex and Thurrock Dementia Strategy 2017 – 2021

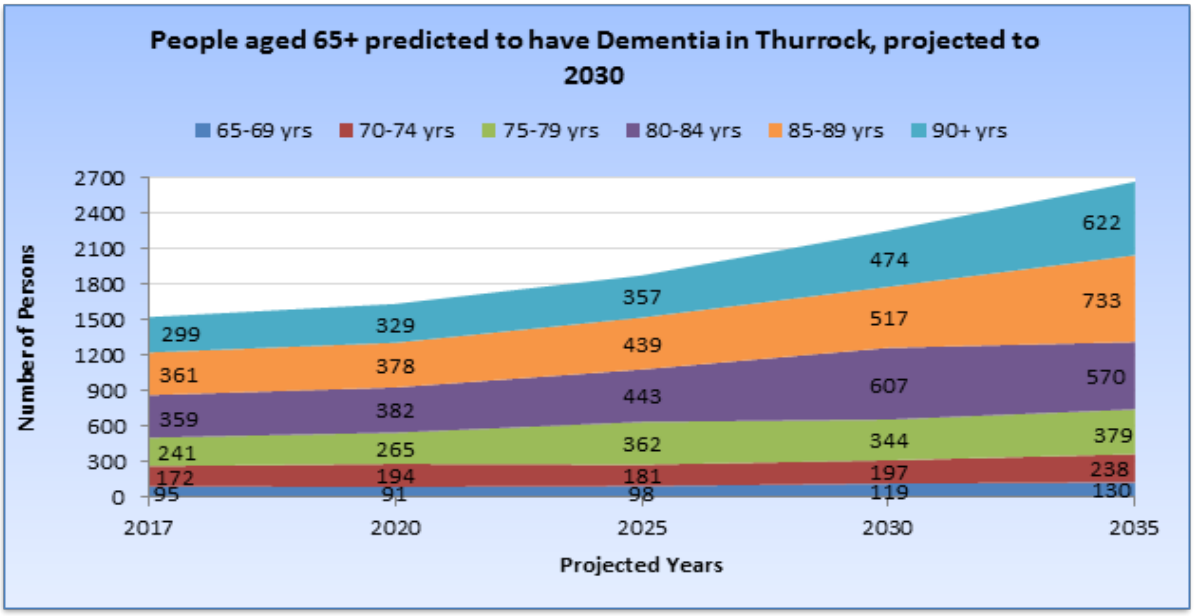
## 1. Recommendation(s)

**1.1 For the Health and Wellbeing Board to note and agree the Thurrock Implementation Plan for the Southend, Essex and Thurrock Dementia Strategy 2017 to 2021.**

## 2. Introduction and Background

2.1 This strategy is for everyone in Southend, Essex and Thurrock who is living with dementia or supporting someone who is. It describes what we want support for people with dementia to look like in the future and it describes nine priorities for action to make this happen.

2.2 It is estimated that the number of people within Thurrock aged 65+ with dementia could increase by 75% between 2017 and 2030. The 85+ age group have the greatest prevalence of dementia. People in this age group with dementia more than doubles during this period from 660 to 1355




Timely diagnosis enables people living with dementia, their careers and support networks to plan accordingly and improve health and care outcomes. It is therefore important to ensure the correct diagnosis in made in an appropriate timescale. It is estimated that the diagnosis rates in Thurrock are similar to national average.

| Indicator | Period | England | East of England region | Thurrock | Suffolk | Southend-on-Sea | Peterborough | Norfolk | Luton | Hertfordshire | Essex | Central Bedfordshire | Cambridgeshire | Bedford |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Estimated dementia diagnosis rate (aged 65+)<br>≥ 66.7% (significantly)<br>similar to 66.7%<br>< 66.7% (significantly) | 2017 | 67.9 | 63.2 | 63.1 | 63.3 | 72.1 | 78.4 | 62.8 | 66.2 | 64.7 | 60.5 | 58.8 | 62.7 | 62.1 |
| Dementia: Recorded prevalence (aged 65+) | Sep 2017 | 4.33 | 4.09 | 3.96 | 4.07 | 4.98 | 5.12 | 4.04 | 4.22 | 4.41 | 3.92 | 3.41 | 3.94 | 3.93 |
| People receiving an NHS Health Check per year | 2016/17 | 8.5 | 9.7* | 11.3 | 12.7 | 9.5 | 10.4 | 8.9 | 9.0 | 7.5 | 10.7 | 9.2 | 9.6 | 6.6 |
| Smoking Prevalence in adults - current smokers (APS) | 2016 | 15.5 | 14.4 | 20.8 | 14.7 | 17.2 | 17.6 | 13.5 | 16.3 | 13.5 | 14.0 | 10.3 | 15.2 | 15.1 |
| Hypertension: Recorded prevalence (all ages) | 2016/17 | 13.8 | 14.1 | 13.9 | 15.3 | 15.1 | 11.7 | 15.5 | 12.1 | 12.9 | 15.0 | 13.8 | 12.7 | 13.5 |
| Percentage of physically active and inactive adults - inactive adults | 2015 | 28.7 | 27.6 | 29.6 | 28.3 | 29.5 | 34.3 | 29.0 | 30.9 | 25.9 | 28.0 | 22.7 | 25.3 | 27.2 |
| Dementia: Ratio of inpatient service use to recorded diagnoses | 2016/17 | 55.1 | 56.5 | 59.2 | 55.3 | 65.7 | 59.6 | 48.6 | 63.0 | 55.3 | 61.4 | 53.9 | 55.4 | 63.1 |
| Dementia: DSR of emergency admissions (aged 65+) | 2016/17 | 3482 | 3219 | 3678 | 3152 | 4334 | 4240 | 2601 | 3929 | 3307 | 3298 | 3008 | 3195 | 3674 |
| Directly Age Standardised Rate of Mortality: People with dementia (aged 65+) | 2016 | 868 | 805 | 960 | 763 | 1050 | 961 | 827 | 905 | 754 | 801 | 721 | 820 | 712 |
| Deaths in Usual Place of Residence: People with dementia (aged 65+) | 2016 | 67.9 | 68.4 | 58.3 | 73.2 | 70.8 | 68.5 | 69.6 | 70.4 | 68.6 | 63.7 | 69.0 | 70.8 | 71.8 |

2.3 The purpose of the new strategy is to reduce fragmentation in service delivery creating a robust pathway through diagnosis and support and increase accessibility to information and advice across Greater Essex for people with lived experience of dementia and for organisations offering support. The strategy aspires to deliver its vision that:

"People living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain physically and emotionally healthy for as long as possible".

In Thurrock we want to deliver this vision and the priorities within the strategy to ensure a fully developed pathway supporting individuals with lived experience of dementia their families and carers to remain within their local communities for as long as possible with appropriate and timely support.

We want to also ensure that the offer of specialist provision is robust, there is a specific need to ensure that we are able to provide specialist dementia domiciliary care support together with specialist day care provision these are currently being developed. Based on the prevalence data and our Market Position Statement we will develop a strategic approach to accommodation and support to ensure that extra care housing, residential and nursing care is appropriate to identified need.

Thurrock will ensure that the programme of Dementia Friends training continues across the borough and that dementia friendly environments are created across a range of services, organisations community spaces and businesses. The Dementia Action Alliance will be crucial in supporting and ensuring that awareness is continuously raised as it is formed from local businesses, the voluntary sector, local communities, health partners, the local authority and those with lived experience of dementia.

Within the strategy there are nine priorities these are:

**Prevention** – to ensure that people in Thurrock have good health and wellbeing enabling them to live full and independent lives for longer.

**Finding Information and advice** – Everyone with dementia will have access to the right information at the right time.

**Diagnosis and support** – all people with dementia will receive appropriate and timely diagnosis and integrated support.

**Living well with dementia in the community** – all people with dementia are supported by their communities to remain independent for as long as possible.

**Supporting Carers** – carers are supported to enable people with dementia to remain as independent as possible.

**Reducing risk of crisis** – all people with dementia receive support to reduce the risks and manage crisis.

**Living well in long term care** – all people with dementia live well when they are supported in long term care.

**End of life** – people with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their own wishes.

**To have a knowledgeable and skilled workforce** – all people with dementia receive support from knowledgeable and skilled professionals where needed.

**2.4** Living Well with Dementia: A National Dementia Strategy published by the Department of Health on the 3rd February 2009 laid the foundation for significant changes across Health and Social Care for the support of people living with dementia.

Dementia continues to be a growing challenge. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. In England it is estimated that around 676,000 people have dementia. In the whole of the UK, the number of people with dementia is estimated at 850,000.

Dementia is a key priority for both NHS England and the Government. In February 2015 the Challenge on Dementia 2020, was launched. It sets out NHS England's aim that by 2020 we are:

- the best country in the world for dementia care and support for individuals with dementia, their carers and families to live; and
- the best place in the world to undertake research into dementia and other neurodegenerative diseases.

Some of the key aspirations of this vision are:

- Equal access to diagnosis for everyone
- GPs playing a lead role in ensuring coordination and continuity of care for people with dementia
- Every person diagnosed with dementia having meaningful care following their diagnosis
- All NHS staff having received training on dementia appropriate to their role.

One of the priorities identified by NHS England as part of the Five Year Forward View is to improve the quality of care and access to mental health and dementia services.

**2.5** In order to deliver the Southend, Essex and Thurrock Dementia Strategy 2017 to 2021 it was agreed at the Essex wide implementation group that locality implementation plans should be developed. The Strategy itself set out a 5 year plan for implementation, the first year to undertake an analysis of current provision and identify the gaps in services and support, the second year for local implementation plans to be developed to ensure delivery and link to the Essex wide group and to then agree timeframes for the changes to be implemented. In the third to fifth years of the strategy to develop a clearly defined single pathway that joins up health and social care services to support those with lived experience of dementia and their carers and families.

**2.6** The implementation plan attached to this report identifies each priority area noted above; the outcome to be achieved against that priority and the success measures that will evidence the priority has been met. Within the Thurrock Implementation plan we have identified some positive areas of working including:

- The Alzheimer's Society development of our local Dementia Action Alliance. .
- The implementation of the Older Adult Wellbeing Service provided by North East London Foundation Trust (NELFT). This is a multi-disciplinary integrated approach to the care and support of older age adults including people living with dementia. The aim of the service is to support people to remain as independent as possible for as long as possible in their local communities and at home. This has proved to be very successful. The nurses within the team deliver Dementia Nursing support within our residential care homes and within the community.
- Diagnostic services provided by Essex Partnership Trust (EPUT) and a clear pathway for referral post diagnosis to the Older Adult Well Being Service.
- The Dementia Crisis Support Team has been extended so that the team can support individuals for longer at home in their own communities.
- Further funding has been agreed through the Better Care Fund for the Alzheimer's Society to deliver information, advice and community support together with their memory service.
- St. Luke's are working with care homes regarding end of life planning to support people living with dementia to remain within the care home wherever possible.
- The Alzheimer's Society has undertaken a programme of Dementia Friends training across the Council and in local communities which has been well attended.

- Adult Social Care and EPUT's Older People Mental Health Team provide specialist support for people living with dementia and their carers together with a duty response to urgent situations. This integrated team provides services in the community to people who are over 65 years old and experiencing functional or organic mental health problems. The team consists of social workers, nurse practitioners and therapists

The details of further services provided within Thurrock are:

**RAID (Rapid Assessment Interface and Discharge)**
The Team specialises in understanding the links between people's physical and mental health. The Team supports the assessment, diagnosis and management of people aged over 16 years, who attend A&E, or are admitted to hospital, who might be suffering with mental health issues.

**Mayfield Unit**
The Mayfield Unit has 24 beds providing intermediate reablement within Thurrock Community Hospital. The Mayfield Unit's purpose is to support people with dementia to reduce the length of stay in an acute hospital and support them to return home or to local care provision.

**Meadowview Ward**
Meadowview Ward is an assessment and treatment inpatient service provided for people over the age of 65 with functional or organic mental illness. Referrals are made by GP's; Community Mental Health Teams or A&E. Meadowview Ward is based at Thurrock Community Hospital.

**2.7** Within the Implementation Plan a series of actions have been identified against each outcome these include:

- Establishing an Implementation Group which will include people with lived experience and their families, to monitor the implementation of the Strategy.
- Developing the end to end pathway for dementia services and support in Thurrock
- Ensuring that the Dementia Action Alliance is supported to grow and develop
- That the Alzheimer's Society is supported to deliver a full range of services and information and advice.
- GP's have training and are aware of the available support for those with dementia
- BME groups are fully engaged in the dementia agenda and information advice and support available
- Base line data regarding diagnosis rates is established and monitored regularly to ensure that Thurrock has above the national average of diagnosis

- The revised Thurrock Carers Strategy incorporates all carers issues identified in the Dementia Strategy
- All Care Homes achieve the Dementia Care Home standards by 2020
- The Market Position Statement identifies the gaps in Dementia provision and what is required within the health and social care market to be part of the dementia pathway.
- Good links to the new Learning Disability Specialist Health Care contract are made to support people with learning disability who have dementia
- Work with St Luke's continues to deliver positive end of life care in accordance with individual's wishes
- The development of a detailed whole system workforce training plan for dementia

## 3. Issues, Options and Analysis of Options

3.1 It is key that we retain the local focus to the delivery of the wider strategy to ensure good quality service and community responses in Thurrock. The implementation plan gives a positive local Thurrock focus and identifies all key areas to be consolidated, improved and developed.

## 4. Reasons for Recommendation

4.1 For the Health and Wellbeing Board to be fully informed regarding the work being undertaken and planned to implement the Southend, Essex and Thurrock Dementia Strategy 2017 to 2021 to support people with lived experience of dementia and their carers living in Thurrock.

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

5.1 As the detailed work progresses we plan to hold a series of consultation and engagement events in partnership with the voluntary sector and local communities to listen to the experience of those receiving services and to help shape and develop further community and care supports. The Implementation Group will include those with lived experience of dementia and their families and carers.

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

6.1 Dementia services and the programme of work the Dementia Action Alliance will deliver will support and enhance the well-being of individuals with lived experience of dementia and their carers and this will benefit our wider communities. The work will also ensure that we adhere to the Council's Charter for Older People which echoes many of the priorities within the Strategy to support independence, choice and ensure that people are treated with dignity and respect. The strategic approach is to highlight and ensure that

support and care is fair and equitable and that people living with dementia have a voice in shaping their own services and support networks.

## 7. Implications

### 7.1 Financial

Implications verified by: **Joanne Freeman,** Management Accountant Social Care & Commissioning

There are no current financial implications to the delivery of the strategy however there may need to be consideration of further investment. This will be done in collaboration with our Health colleagues and with the intention of allocation of funds through the Better Care Fund. Detailed business cases would need to be presented to the Integrated Commissioning Executives committee and adhere to the usual governance arrangements.

### 7.2 Legal

Implications verified by: **Courage Emovon**, Senior Contracts Lawyer

There are no direct legal implications at this stage but as the strategy continues to be implemented Legal Services is available to provide any necessary legal advice by officers and members.

### 7.3 Diversity and Equality

Implications verified by: **Natalie Warren**, Community Development and Equalities Manager

The delivery of the strategy will support wider communities within Thurrock to embrace and support people with lived experience of dementia to live well in their local community.

### 7.4 Other implications (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

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

- N/A

## 9. Appendices to the report

- Southend, Essex and Thurrock Dementia Strategy 2017-2021
- Thurrock Dementia Implementation Plan 2018

**Report Author:**

Catherine Wilson strategic Lead Commissioning and Procurement Adult Social Care

Irene Lewsey Head of Transformation Thurrock CCG

# Southend, Essex and Thurrock Dementia Strategy 2017 to 2021

Thurrock Implementation Plan June 2018

Southend, Essex and Thurrock Dementia Strategy 2017 – 2021

Thurrock CCG and Adult Social Care Implementation and Action Plan

**Aim: A single dementia pathway that joins up health and social care services is the aspiration of this strategy**

An implementation group is being established across all partners including those with lived experience of dementia and their families. This will link into the Dementia Action Alliance in Thurrock and into the Essex wide monitoring and implementation of the overall strategy. The group will monitor progress reporting to the Health and Wellbeing Board and Health Overview and Scrutiny Committee.

The implementation plan is a 5 year plan, the first year is to identify what is currently being provided and where the gaps are, the second year is to develop an action and implementation plan and start that implementation across the final 3 years of the strategy.



The analysis of current support has been completed and a significant number of gaps have been identified (there will be more gaps identified as the pathway is developed), the actions now require oversight from the soon to be established Dementia Implementation Group with at its centre those with lived experience of dementia and their family, carers and friends.

There are detailed in the plan some indicative timescales which will be revised and refined as the work progresses to achieve a single dementia pathway by 2021

| Priority | Outcome | Success Measures | Thurrock's Progress to date | Actions | Timescales |
|---|---|---|---|---|---|
| 1. Prevention | People in Greater Essex will have good health and wellbeing, enabling then to live full and | ❖ Using the Making Every Contract Count approach, people understand the link between healthy and active lifestyles and are able to make positive changes in their lives. | The Public Health strategy is population wide focusing on early intervention and prevention and healthy lifestyles. | Regular review of the prevention agenda across health, public health and social care.<br><br>Training for GP's regarding support | April 2019 and then ongoing<br><br>April 2019 and |

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| Page 118 | independent lives for longer. | ❖ People have an increased awareness of Mild Cognitive Impairment.<br>❖ People are aware of how to access information and support should they be concerned about dementia.<br>❖ Increased percentage of people diagnosed with dementia receive an annual face to face view of their health needs, including medication, and whose vital health indicators are checked.<br>❖ People in Black, Asian and Minority Ethic (BAME) Greater Essex Communities have increased awareness of dementia and the warring signs.<br>❖ Carers have access to annual health check and have access to Improved Access to Psychological Therapies. | Thurrock First established to offer information support and advice.<br>Thurrock First Staff have had dementia training.<br><br>Library services have received dementia friends training. Libraries across Thurrock have books and information about dementia together with the reading for Mental Health scheme.<br><br>. | available and dementia friends<br><br>Continue to ensure that Libraries and Community Hubs remain a centre for information and advice about dementia<br><br>Clear pathway and information to be available to ensure individuals know how to gain support from the GP or to make self-referral to the Alzheimers society in Thurrock<br><br>Those diagnosed with dementia should have 12 month review the CCG to work with GP's to monitor progress.<br><br>BAME groups awareness of dementia to be raised through the grant programme across health and social care | then ongoing<br><br>April 2019 and then ongoing<br><br>September 2018<br><br>April 2019<br><br>April 2019 |

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| Page 119 | | | | drawing on the expertise of already existing groups<br><br>Improving Access to Psychological Therapies (IAPT) Services provided by Inclusion to provide data regarding how many people with dementia and their carers are being supported and what outcomes are being achieved.<br><br>Thurrock's current Carers Strategy will be refreshed and rewritten through 2018, all the carers aspects of the dementia strategy will be cross referenced and incorporated in both The dementia implementation plan and the Carers Strategy | September 2018 and then ongoing<br><br>April 2019 |
| 2. Finding information and advice | Everyone with dementia will have access to the right | ❖ A comprehensive whole system and guidance offer is available.<br>❖ People living with | There have been some very positive steps to raise awareness and develop a clear | A comprehensive pathway will be developed across the whole system to ensure | Within the first year although .Timetable for the work to be |

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| | information at the right time. | dementia will feel supported to navigate the system and access information and support that is relevant to them. | accessible pathway.<br><br>Essex Partnership University Trust has developed an Information pack.<br><br>Alzheimer's Society undertakes a follow up contact after diagnosis to ensure that families and individuals have information and advice.<br><br>The Dementia Action Alliance is starting to form across a range of businesses, services and support for example in Grays Precinct dementia friendly shopping times have been arranged and Greggs Bakers ensures that their staff are Dementia friendly.<br><br>Local Area Coordinators have received training to signpost people to the right information and to a referral point if required | that the system is accessible. The Thurrock Implementation Group will develop and deliver this outcome.<br><br>Information requires regular updating the Alzheimers Society, CCG and Adult Social Care will be responsible for ensuring all information is updated on an annual basis<br><br>The Dementia Action Alliance will audit and ensure that training is available to support the community.<br><br>The Dementia Friends Training to continue across Thurrock. This is provided by the Alzheimers Society | developed by the Implementation Group. Must be achieved by 2021<br><br>September 2018 then quarterly updates<br><br>December 2018<br><br>April 2020 - There is a fully developed ongoing programme across Thurrock this will be monitored through |

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| | | | | | the implementation group |
| 3. Diagnosis and Support | All people with dementia will receive appropriate and timely diagnosis and integrated support. | ❖ GP's across Greater Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe.<br>❖ Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process.<br>❖ There is a clear pathway to diagnosis with appropriate information and support offered.<br>❖ BAME Greater Essex Communities are accessing assessment and diagnostic services.<br>❖ There is appropriate screening for people who are considered to be at high risk of dementia. | Diagnosis is almost at the national level in Thurrock at 65% of people with dementia having been diagnosed.<br><br>For those diagnosed the service is very positive: The Alzheimers society Memory clinic has a six week follow up for everyone referred to them (this can be self-referral) to ensure the person an family have all the information they need. For those with server dementia the follow up is a visit at home.<br><br>There is a positive working relationship between North East London Foundation Trust (NELFT) community support and Essex | To have a clear and accurate baseline of how many people are diagnosed with dementia in Thurrock – the CCG are monitoring and developing this data to give an accurate figure.<br><br>Data is also required to understand the level of referral from BME communities to diagnostic services – the CCG will include this is monitoring reports.<br><br>The whole end to end pathway requires further development to include: Comprehensive screening for at risk groups<br>Post diagnosis support – the CCG and Adult | A timeframe will be developed for all aspects of the actions identified and this will be a phased approach to be in place by 2021 |

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| | | ❖ People with dementia have access to post diagnostic support that is relevant and personalised.<br>❖ People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia and plan for the future.<br>❖ People are offered a direct payment upon diagnosis of dementia where appropriate. | Partnership University Trust (EPUT) diagnostic service with good pathways of referral from EPUT to NELFT.<br><br>Direct Payments are available and a new direct payment policy is being written in full consultation with people who use services. | Social Care will lead the development of the full pathway.<br><br>As the new policy is launched dementia will be a key priority to increase take up and Adult Social Care personal budget lead will report on progress.<br><br>Adhere to NICE guidelines for Dementia | September 2020 |
| 4. Living well with dementia in the community | All people with Dementia are supported by their Greater Essex communities to remain independent for as long as possible. | ❖ There is a whole community response to living well with dementia.<br>❖ Environments and physical settings in the community are dementia friendly.<br>❖ People living with dementia are able to take advantage of open space and nature.<br>❖ The voice of lived experience helps to shape how Greater Essex Communities respond to dementia. | Dementia Action Alliance is being developed and will focus on community presence<br><br>Dementia Friends training by the Alzheimers Society is ongoing and needs to be extended.<br><br>The Thurrock Mind Garden project supports people with mental health challenges and dementia | New builds to be dementia friendly – simple things make a huge difference. Integrated Medical Centres – Dementia friendly.<br><br>Dementia friendly outdoor spaces audit required throughout Council Directorates of what is available in the community | This will be linked to the timelines for each IMC through the Programme Board<br><br>Audit through 2019 |

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| Page 123 | | ❖ People living with dementia are encouraged to access information and support that helps them to live well and independently.<br>❖ The lives of people living with dementia in the community are transformed through the Dementia Action Alliance activity.<br>❖ Young people are part of the community support for people living with dementia.<br>❖ The market is able to respond to people living with dementia and support them to live well.<br>❖ People with dementia have awareness of alternative accommodation options. | Support within residential homes has increased the Dementia crisis team has 2 nurses and geriatrician to prevent admission to hospital and support with crisis. | Dementia care home standards to be achieved by 2020. These will ensure the environment within the residential home is dementia friendly for example have a red toilet seats, doors painted specific colours. Capital funding and winter pressures money to be used to support this wherever possible. Adult Social Care Contracts and Compliance Team will embed and deliver the monitoring of the providers as they implement the dementia are standards<br><br>It will be clear in the Market Position Statement what the levels of need are in Thurrock and the type and amount of provision required to support | The Contracts and Compliance Team will draw up a programme of support for care homes to achieve this and will undertake monitoring to ensure in place by 2020<br><br>The Market Position Statement will be in place by October 2018 |

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| | | | | dementia. | |
| 5. Supporting Carers | Carers are supported to enable people with dementia to remain as independent as possible. | ❖ Cares are a driving force behind shaping the response to dementia in Greater Essex.<br>❖ Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia.<br>❖ Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy.<br>❖ Careers feel informed and equipped to care for someone living with dementia and able to plan or flex to increased needs of challenges.<br>❖ Carers are able to access a range of opportunities to take a break from their role as Carer. | We are supporting Carers within the framework of the current Carers Strategy, however this will be revised this year and the new strategy will be coproduced with carers and Cariads.<br><br>Respite, day care and sitting services are available to support carers.<br><br>The dementia crisis team mainly supports carers to continue to care for relatives and friends who have dementia. | The new provider for Carers Information Advice and Support Services, Cariads, has been appointed. Cariads will now support a co-produced cares strategy<br><br>Cariads will now within the new contract undertake carers assessment rather than individuals always needing to access adult social care. Carers will also be able to self-refer for assessments. Contract monitoring of the service will give an understanding of the levels of need and where additional support is required. Cariads services will need to be widely publicised through GP surgeries.<br><br>The Carers survey this year indicated that | The Carers Strategy will be revised and coproduced with support from Cariads this will be finalised by 2019 |

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| | | | | considerable improvement is required within carers support and as such across all carers this will have a detailed focus and this will include dementia.<br><br>Admiral nurses to support carers process | September 2019 |
| 6. Reducing the risk of crisis | All people with dementia receive support to reduce the risk and manage crisis. | ❖ All hospitals to aspire to being dementia friendly care settings.<br>❖ People living with dementia, with complex needs such as co-morbidities are offered specialist information and support.<br>❖ Crisis situations are avoided or managed appropriately – Crisis situations are planned for and responded to effectively. Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments.<br>❖ The Community and | Basildon & Thurrock University Hospital (BTUH) is a dementia friendly hospital, the hospital has its own internal dementia strategy<br><br>All BTUH staff have dementia training and 2 sessions of training are available each week for all staff.<br><br>BTUH has dementia friendly wards<br><br>Rapid Assessment Interface and Discharge (RAID) Service ensures that patients are seen | The services available to reduce risk of crisis will be monitored and evaluated and become part of the single dementia pathway for health and social care | The single Pathway will be developed in full by 2021 |

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| | | Primary Care are able to respond to episodes of crisis in care homes appropriately. | within 2 hours.<br><br>Mayfield / Meadowview / Collins House all offer Dementia Support<br><br>The dementia crisis team offers support within care homes to prevent admission to hospital. | | |
| 7. Living well in long term care | All people with dementia live well when in long term care | ❖ All care homes for people with dementia in Greater Essex will be supported to be dementia friendly by 2020.<br>❖ People living with dementia, their families and carers understand what high quality care looks like and where to find it.<br>❖ People with learning disabilities who have dementia, (or at risk of), are fully supported in long terms care settings through linking Dementia in to Learning Disability health checks.<br>❖ People with dementia in long term care are | Care home teams are currently undertaking training and anecdotally attendances to A&E from care homes are reducing.<br><br>Care homes to be Dementia friendly by 2020.<br><br>Learning disability health checks are progressing well in Thurrock and numbers are steadily increasing. | Detailed work to be undertaken to monitor the impact of training, dementia friendly environments and the work of the crisis team in reducing A&E attendance and hospital admission – the CCG to lead<br><br>Learning Disability specialist health care contract under Transforming Care to be linked in the local Learning Disability implementation plan to the dementia strategy and implementation plan. Link also to be | Training and Care homes standards to be achieved by 2020<br><br>The specialist Learning Disability Health contract will guide the time frame. Thurrock will have an implementation plan for the |

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| | | encouraged to build and maintain networks both in and out of the care setting.<br>❖ People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate. | | made to Learning disability health checks to include dementia. CCG and Adult Social Care to jointly lead<br><br>Mental Capacity Assessment referral should be standard and record how many people with dementia. Adult Social Care to lead to ensure the data is collated. | Learning disability specialist health care contract and dementia will form part of this.<br><br>April 2019 |
| 8. End of life | People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes. | ❖ People with dementia, their families and carers complete advance care plans that are recorded and held by the GP.<br>❖ People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate.<br>❖ People are not delayed in being discharged from hospital.<br>❖ People are informed of options about end of life | Working with St. Luke's around support for people with dementia.<br><br>Dementia bereavement counselling for 6 months prior to the person dying to help prepare and support the loss already experienced when someone is in the later stages of dementia | Work with St Luke's to continue to expand regarding dementia this will include:<br><br>• Advanced care plans<br>• Action to look at support in the community<br>• Positive use of Mental Capacity Assessment<br>• Different options regarding end of life for those with | September 2019 |

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| | | and are given appropriate support, respect and dignity to die in the place they choose.<br>❖ Carers and families receive bereavement support at a time that is right for the individual or family. | | Dementia and how St Luke's can support those options to be developed | |
| 9. A knowledgeable and skilled workforce | All people with dementia receive support from knowledgeable and skilled professionals where needed. | ❖ There is a framework for dementia training across Greater Essex to ensure all people receive training relevant to their role.<br>❖ To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so.<br>❖ To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to love well. | Sustainability and Transformation Partnership(STP) have workforce development where does dementia feature<br><br>Wider workforce across health and social care receive dementia friends training and this needs to be further developed.<br><br>Dementia Action Alliance to ensure that a wide range of organisations and businesses are trained to support individuals with dementia. | STP workforce plan does not include dementia at present this needs to be developed CCG to make links and lead<br><br>A detailed local workforce training plan requires development for dementia CCG, Adult Social Care, Voluntary sector, providers and wider business community to lead. | A local plan will be required and the Thurrock Dementia Implementation Group will set a time line to achieve this by 2021 |

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NHS Basildon and Brentwood CCG
NHS Castle Point and Rochford CCG
NHS Mid Essex CCG
NHS North-East Essex CCG
NHS Southend CCG
NHS Thurrock CCG
NHS West Essex CCG

Essex County Council

ESSEX POLICE
Protecting and serving Essex

NHS

southend on sea
BOROUGH COUNCIL

THURROCK COUNCIL



# "Let's Talk" ...about dementia

## Southend, Essex and Thurrock

# Dementia Strategy 2017-2021



# Table of contents



# Living well with dementia

## ...in Southend, Essex and Thurrock

This strategy is for everybody in Southend, Essex and Thurrock, (Greater Essex), who is living with dementia or supporting someone who is. It describes what we want support for people with dementia to look like in the future and identifies 9 priorities for action to make this happen.

The strategy has been developed in partnership between Essex County Council, Southend on sea Borough Council, Thurrock District Council, and Clinical Commissioning Groups across Greater Essex. It sits alongside Greater Essex's Mental Health and Wellbeing strategy, to form a new and comprehensive, all–age ambition for mental health and emotional well-being in our county.

There are real opportunities for change and innovation across Greater Essex to ensure that people have the best support available to live well with dementia. We want to make Greater Essex more inclusive for everyone living with dementia and empower people to live the life they want in the community for as long as possible.

Over the past year Essex County Council has worked with partners to talk extensively to people who live with dementia and worked to develop the understanding of people's current experience of dementia in Greater Essex. The Public Office also produced a report following a range of engagement activity in Greater Essex and this insight was used to inform this strategy.

Southend Borough Council also conducted a wide range of public and stakeholder consultation activities. The key themes identified reflected similar challenges and needs to those across Essex, with some local differences.

These engagement activities highlighted some challenging truths about existing systems, which involve all of the partners above who commission dementia services in their specific geographical areas:

- Systems are fragmented and bureaucratic. The "battle" to find what they need wears carers down and professionals find it difficult to navigate too
- Services do not consider people as part of a family – or even in partnership with their carer
- Support is not personalised – and doesn't enable people to maintain their capabilities, interests or relationships
- Systems rely heavily on the carer, but don't support them very well. Carers carry on until they can no longer cope, and then health or care services often need to intervene in the midst of a crisis
- Carers are often unable to access services when they are available and have few options available over night and at weekends
- Current avenues of support don't help people and families to withstand the emotional pressures they face – stress, relationship breakdown, loneliness
- Existing systems push people towards residential care because they can't find the support they need in the community.

These are stark revelations, but ones that emphasise the need and opportunity for change and innovation to ensure that people have the best support available to live well with dementia.

# Rethinking dementia

## ...a collaborative enquiry

**Together we built a 'case for change':**

| | |
|---|---|
| Current experience of services is poor: quality, inconsistency. Services are fragmented and access is difficult. | Demand is increasing, money is being wasted, and we can't afford to keep doing things the way we currently are. |
| There is stigma and a lack of awareness understanding of dementia in communities, which can be a barrier to diagnosis. | Existing arrangements do not support whole families or the needs of carers. |
| Individual needs are not currently sufficiently understood or met. | The world has changed (technology, expectations and nature of families) but services haven't. |
| Professionals' values, knowledge and skills do not always support good outcomes for people with dementia and their families. | Lack of timeliness is a major issue: diagnosis, availability of quality information & support, planning for the future. |

**Critical conclusions we draw included:**

| | |
|---|---|
| • We need family-led solutions<br>• Carers lack support and respect: we should be celebrating their role<br>• Current services are women-centric: more balance required<br>• Residential care is the default solution, but is outdated<br>• This needs to be about supporting active citizenship for people with dementia<br>• We have to move away from a professional-driven approach, and think about new roles and networked solutions<br>• There is challenge and complexity in providing information that is, timely relevant and meaningful to individuals.<br><br>• Where is the positive risk-taking?<br>• There are waiting lists for current services<br>• We are not commissioning for flexibility or personalised approaches | • We don't know how good current provision is, or not the impact it's having<br>• No one organisations is taking responsibility for monitoring and coordinating current provision<br>• We are spending huge resources responding to crisis rather than preventing them.<br><br>• There are BIG implications for the way we commission: it needs to change<br>• This will require culture change that we need to own<br>• Significant number of staff lack basic training<br>• It's not just about training and skills: it's values. Staff need to tackle attitudes towards older people more generally<br>• What is 'good enough' evidence? We need to understand what we don't know and feel confident to take considered risks on the new. |





# Vision

Our vision for the future is one in which: People living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain as physically and emotionally healthy for as long as possible.

# Dementia ...a shared strategy

Our strategy to achieve this is organised around nine priorities that reflect specific aspects of people's life with dementia. However there are five key elements to our approach that underpin the whole strategy:

## Features of the new system

**We will...**

| | |
|---|---|
| **Listen to citizens' voices and focus on their strengths & abilities:** take time to understand individual desires & needs, as well as their capabilities and respond appropriately as these change over time. | **Take a holistic approach:** work with whole families to build a picture of what support is needed, support independent living as much as possible/appropriate and do all we can to meet the needs of family carers. |
| **Work together across the whole system:** align resources to best help citizens & families and 'do what needs to be done when it needs. | **Focus on timely intervention:** ensure early diagnosis, support future planning (including for end of life) and offer flexible, responsive help when and where it's needed. |
| **Build citizens' and communities' understanding of dementia:** reduce stigma and increase opportunities and capacity for people to support one other. | **Be clear and consistent about outcomes:** be ambitious about what should count as 'success', looking to help people live rich, meaningful, independent lives for as long as possible |

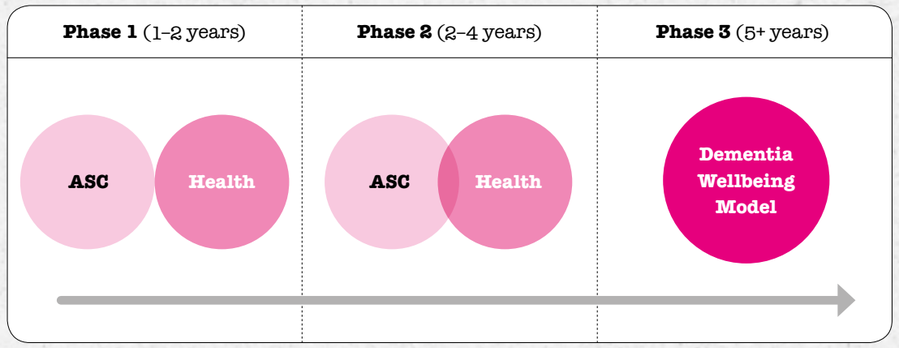
**We will know our system is good if it delivers these outcomes:**

| | |
|---|---|
| **Citizens with dementia**<br>• Can access help and advice when and where they need it<br>• Remain as physical and emotionally healthy as possible for as long as possible<br>• Are actively shaping their lives and their care<br>• Are supported by their families, their communities and professionals to live active and enriching lives as long as possible. | **Communities**<br>• Understand the signs of dementia and how to reduce the risk of developing it by living active and healthy lives<br>• Demand and build a way of life that responds positively to the needs of those living with dementia<br>• Are involved in supporting those living with dementia<br>• Know where to go for advice or help. |
| **Family carers**<br>• Feel supported and informed in their role<br>• Can access help and advice when and where they need it<br>• Are able to plan ahead with confidence<br>• Remain physically and emotionally healthy themselves. | **Practitioners**<br>• Have a shared vision and understanding of outcomes and success<br>• Seek to provide integrated care which supports independence, reducing hand-offs and increasing simplicity for citizens<br>• Are skilled, knowledgeable and are co-creating and co-delivering approaches that work<br>• Are confident about diagnosing dementia and build trusted relationships with citizens. |

**ThePublicOffice** Dementia in Essex








**Five Year Forward View**

## A joint strategic approach to dementia in Greater Essex

The range of support for people with dementia is fragmented; people often get lost trying to navigate an intricate web of information and services. We know people living with dementia face a spectrum of challenges and have a range of needs; so to achieve our vision it is vital that organisations work together to collectively transform the approach to dementia in Greater Essex.

Our vision aspires to create systems where organisations work towards the same goal; All localities are addressing challenges in both health and social care, and developing Sustainability and Transformation Plans setting the future direction for health and mental health services (including as part of the NHS Success Regime in Mid and South Essex). Supporting people living safely with dementia to remain as physically and emotionally healthy for as long as possible is key to this.

We aim to design systems that reflect the unique local and demographic needs of communities across Greater Essex but are able to:

- Support people to receive a timely diagnosis
- Intervene earlier to inform and support people to adapt to a life with dementia
- Develop communities that are inclusive to people living with dementia.

We want our systems to help families develop support networks to manage, or avoid times of crisis, explore independent living situations and not have to turn to hospital or long term care settings to manage. Collectively, our systems need to be structured to promote solutions that build upon people's strengths and support networks to achieve the outcomes they want, rather than impose service-based solutions.

A single dementia pathway that joins up health and social care services is the aspiration of this strategy; as we recognise the benefits this will bring to people living with dementia and the wider health and social care system. In an agreed locality, we aspire to having a single assessment, a single care plan and clear route to information and support that works around a person, their family and wider network

We recognise the vital role Primary Care play and strive to work with their skills, knowledge and expertise to develop a model that enables closer working between General Practitioners and the wider dementia care system. We recognise these aspirations are transformational changes and plan to approach these changes in phases, to achieve the aspiration of fully integrated models of dementia care within 5 years, across Greater Essex. Equally we recognise these changes should not happen in isolation to the wider health and social care system, and should align with the local priorities set out in Sustainable Transformation Plans as part of the Five Year Forward View.

## A new model of specialist support

People with more complex needs or challenging behaviours cannot always find specialist advice or support when they need it. The lack of specialist advice can also lead to hospital or residential care admission when this might be avoided. Expertise on dementia tends to be concentrated in services for older people, which is not always appropriate for younger people with dementia or people with learning disability.

An integrated all-age dementia service for those with the most complex needs that will provide specialist advice and support across the Health and social care system in Essex, and possibly Southend , will support those that can sometimes be overlooked by the current system of support.

## Support that is personalised and empowers people within an inclusive community

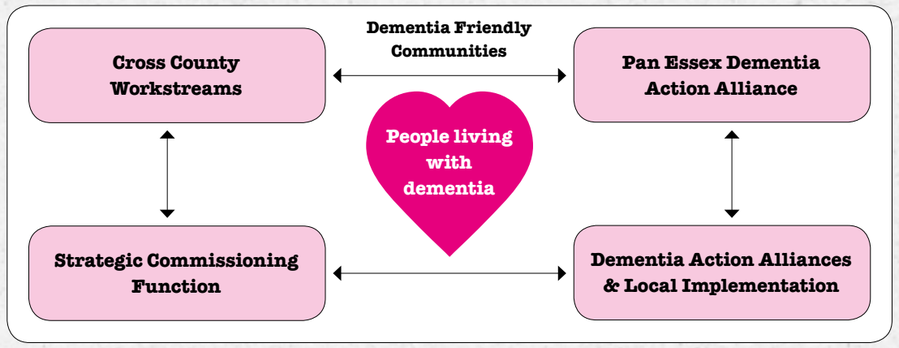
People living with dementia want information and support that enables them to adapt, but keep living the life they led prior to their diagnosis. They often feel isolated from the wider community and many feel scared to go out of their home. We think that a community-wide response is needed to address this problem.

Support should build upon a person's strengths, their skills, their qualities and their own resources. We want to empower people to embrace outdoor space, be physically active and take positive risks that enable them to live they life they want to lead. We recognise early intervention is a key part in achieving this; and strive to ensure people have access to timely intervention that enables it to happen. We need to change the culture of assessment, support planning and care, through the "Good Lives" approach (or Live Well, the approach used In Thurrock) to ensure that the person, and their family, are kept at the heart of what we do and enable them to live independently in the community for as long as possible. All people with dementia should be offered a personal budget, where applicable under the Care Act to give them maximum control over the kind of help they receive.

We have established a Pan-Essex Dementia Action Alliance to shape and influence a county wide response to dementia in Greater Essex; and worked with District Councils to form local alliances that can drive change in local towns, villages and Greater Essex Communities. We will continue to grow these alliances and aspire to engage a breadth of organisations across the private, public, community, third, health and social care sectors to commit to ways they will transform the lives of people living with dementia.

In Southend people living with dementia and their carers along with 44 businesses, services and community groups are working in partnership with Southend Borough Council to maintain the 'Working towards becoming Dementia Friendly' status awarded in March 2016. Southend is very fortunate to have a variety of members within the Southend Dementia Action Alliance (SDAA), including the UK's first dementia friendly airport, a committed community support approach from Essex Police Southend and Essex Fire & Rescue Southend.






**Future Partnership Model**

There are examples of dementia friendly support within Health, with a local GP Surgery working towards becoming a dementia friendly practice and a dedicated team of professionals within Southend Hospital creating dementia friendly wards through changing policies and cultures. Building on this work we feel confident that Southend will be a place where people affected by dementia can live their lives with access to the services and support they need to fully participate in community life.

We want Carers to feel supported in their own right and to be respected as partners in care. We will work with Carers to develop a network that enables their loved one but ensures they remain connected to information and support should they need it.

## Maximise the use of technology

There are a growing number of ways that technology can be used to support people to remain independent, give Carers more freedom and peace of mind and reduce dependence on formal services all of which are outlined in the Dementia Technology. We will work with people to raise their awareness of technology as an enabler to independent living and we will create environments that enable the use of technology. We are working with partners to find and promote new tools that address some of the obstacles to independence faced by people with dementia and their Carers and will align with wider programmes of work taking place across Essex focused on developing digital response to health and social care needs.

## The voice of lived experience

We know to really meet the needs of people living with dementia, it's vital we listen to the voice of those living with the condition, not only to better understand the challenges they face but identify solutions to overcoming these challenges. We want to facilitate activity in the community that responds to need, and recognise the only way of doing so is to speak to those that are living with dementia day in, day out. We will involve those living with dementia in helping us achieve the aspirations set out in this strategy and continue to re-visit our vision to ensure the voice of lived experience not only remains central to the transformation within the system, but helps to measure the impact of the new system. To underpin this strategy a sustainable way of engaging with people, in a relevant and meaningful way, will be developed. This, along with the community response, will be supported through the ongoing delivery of local Dementia Action Alliances and specific user groups to support engagement and to change the messaging around dementia in Greater Essex Communities.

To achieve our vision; and drive forward the actions set out in this strategy we recognise the need to bring together the five key elements listed above, to form a whole systems partnership function. A function that is responsible for mobilising activity, and implementing change but one that is accountable to the wider health and social care infrastructure that it works within.

# Priorities

We have worked with our partners and through the Public Office engagement, to identify nine priorities that reflect key aspects of the lives of people living with dementia:

We want to intervene earlier to prevent needs from increasing and help people to continue to live independent lives, building on their strengths and the resources available to them within their personal network and the wider community.

For those who need ongoing support, we want to make sure this responds to the needs of individuals and supports the wider family network, with the offer of a personal budget to give them maximum control over their care and support.

- **Prevention**
- **Finding Information & Advice**
- **Diagnosis & Support**
- **Living well with Dementia in the Community**
- **Supporting Carers**
- **Reducing the Risk of Crisis**
- **Living well In Long Term Care**
- **End of Life**
- **A Knowledgeable and Skilled Workforce**

| Priority | Outcome | Success Measures |
|---|---|---|
| **Prevention** | People in Greater Essex will have good health and wellbeing, enabling them to live full and independent lives for longer. | • Using the Making Every Contract Count approach, people understand the link between healthy and active lifestyles and are able to make positive changes in their lives<br>• People have an increased awareness of Mild Cognitive Impairment<br>• People are aware of how to access information and support should they be concerned about dementia<br>• Increased percentage of people diagnosed with dementia receive an annual face to face review of their health needs, including medication, and whose vital health indicators are checked<br>• People in BAME Greater Essex Communities have increased awareness of dementia and the warning signs<br>• Carers have access to annual health check and have access to Improved Access to Psychological Therapies. |
| **Finding information and advice** | Everyone with dementia will have access to the right information at the right time. | • A comprehensive whole system Information and guidance offer is available.<br>• People living with dementia will feel supported to navigate the system and access information and support that is relevant to them. |



| Priority | Outcome | Success Measures |
|---|---|---|
| **Diagnosis and support** | All people with dementia will receive appropriate and timely diagnosis and integrated support. | • GP's across Greater Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe<br>• Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process<br>• There is a clear referral pathway to diagnosis with appropriate information and support offered<br>• BAME Greater Essex Communities are accessing assessment and diagnostic services<br>• There is appropriate screening for people who are considered to be at high risk of dementia<br>• People with dementia have access to post diagnostic support that is relevant and personalised<br>• People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia, and plan for the future<br>• People are offered a direct payment upon diagnosis of dementia where appropriate. |
| **Living well with dementia in the community** | All people with Dementia are supported by their Greater Essex communities to remain independent for as long as possible. | • There is a whole community response to living well with dementia<br>• Environments and physical settings in the community are dementia friendly<br>• People living with dementia are able to take advantage of open space and nature<br>• The voice of lived experience helps to shape how Greater Essex Communities respond to dementia<br>• People living with dementia are encouraged to access information and support that helps themselves to live well and independently<br>• The lives of people living with dementia in the community are transformed through the DAA activity<br>• Young people are part of the community support for people living with dementia<br>• The market is able to respond to people living with dementia and support them to live well<br>• People with dementia have awareness of alternative accommodation options. |

| Priority | Outcome | Success Measures |
|---|---|---|
| **Supporting carers** | Carers are supported to enable people with dementia to remain as independent as possible. | • Carers are a driving force behind shaping the response to dementia in Greater Essex<br>• Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia<br>• Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy<br>• Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges<br>• Carers are able to access a range of opportunities to take a break from their role as a Carer. |
| **Reducing the risk of crisis** | All people with dementia receive support to reduce the risk and manage crisis. | • All hospitals to aspire to being dementia friendly care settings<br>• People living with dementia, with complex needs such as co-morbidities are offered specialist information and support<br>• Crisis situations are avoided or managed appropriately – Crisis situations are planned for and responded to effectively<br>• Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments<br>• The Community and Primary Care are able to respond to episodes of crisis in care homes appropriately |
| **Living well in long term care** | All people with dementia live well when in long term care. | • All care homes for people with dementia in Greater Essex will be supported to be dementia friendly by 2020<br>• People living with dementia, their families and carers understand what high quality care looks like and where to find it<br>• People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings through linking Dementia in to LD health checks<br>• People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting<br>• People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate. |



| Priority | Outcome | Success Measures |
|---|---|---|
| **End of life** | People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes. | • People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP<br>• People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate<br>• People are not delayed in being discharged from hospital<br>• People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose<br>• Carers and families receive bereavement support at a time that is right for the individual or family. |
| **A knowledgeable and skilled workforce** | All people with dementia receive support from knowledgeable and skilled professionals where needed. | • There is a framework for dementia training across Greater Essex to ensure all people receive training relevant to their role<br>• To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so<br>• To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well. |



# The stages of dementia

"Dementia" is a term that covers a range of symptoms that result from damage to the brain that can affect memory, attention, communication, problem-solving and behaviour. Every individual's "dementia journey" is very different. Some people may live for years without any obvious decline, while others experience rapid deterioration. However there are similarities in the challenges and pressures people experience as symptoms develop.

In the early stage, people may dismiss forgetfulness or difficulty concentrating as normal signs of ageing or attribute disorientation and mood swings to stress. Once symptoms begin to impact on normal life, diagnosis can be a relief but also lead to fear and denial about the future. People may feel a sense of loss, a loss of their identity and the person they believe they once were.

People with dementia say that it is important to feel that their life still has meaning. Some achieve this by maintaining relationships with important people in their lives or by keeping up interests. Others struggle through lack of opportunity, lack of confidence or other barriers. In the Alzheimer's Society Dementia 2014 survey, only 60% said that they left the house every day and 40% said that they felt lonely.

Dementia is a progressive condition which means that the symptoms will become worse over time. People's ability to make decisions about their lives or even day-to-day situations will decline. To compound these problems, a large proportion of people with dementia will also have other medical conditions or disabilities, such as arthritis, hearing problems, heart disease or mobility problems. The Alzheimer's Society found that 72% of respondents to their Dementia 2014 survey were living with another medical condition or disability – some were living with up to twelve conditions.

As the disease progresses, people gradually find normal activities challenging and may fear losing control as they become increasingly dependent on others. People may become depressed and anxious when diagnosed as well as when they begin lose their ability to do everyday things for themselves. In the late stage, people can become totally dependent on others for basic life tasks and this is often when they consider moving into a care home.

## Ethnicity

Dementia among black, Asian and minority ethnic (BAME) Greater Essex Communities is significantly under-diagnosed and research by the Social Care Institute for Excellence has found that these groups are less likely to use dementia services. There are low levels of awareness, late diagnosis and a lack of culturally sensitive services. All of which makes it more difficult for people from these Greater Essex Communities to get the support they need. Greater Essex has a relatively small BAME population (5.7% in Essex and 13% in Southend) but the proportion of people receiving services is even smaller (1.2%) suggesting they are under-represented.

## Early onset dementia

Care for younger people (ie. under 65) with dementia is a challenge. Younger people with dementia face different issues, not least that they are more likely still to be working or have a young family. Support designed for older people with dementia is often not suitable for younger adults. This means that people with early onset dementia can find themselves isolated within the community. Those with more challenging needs can find it difficult to find suitable long term care options with the majority of solutions aimed either at older people or people with learning disability. The majority of people with dementia in Greater Essex are over 70 but 7.5% are younger than this and there are a few are under 30. In Southend 98% of people living with dementia are over 65 and just 38 people are registered under the age of 65.

## Learning disability and dementia

People with learning disabilities have a higher risk of developing dementia than other people and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s. Symptoms of dementia can present differently so that people often don't recognise changes as being dementia related. Because of this, opportunities for early intervention are lost. In Greater Essex we have found that mainstream diagnostic services are not geared up to assess people with learning disability, are not making reasonable adjustments and often refer people back to learning disability services. Likewise, mainstream dementia services are not geared to support people with learning disability or their carers.

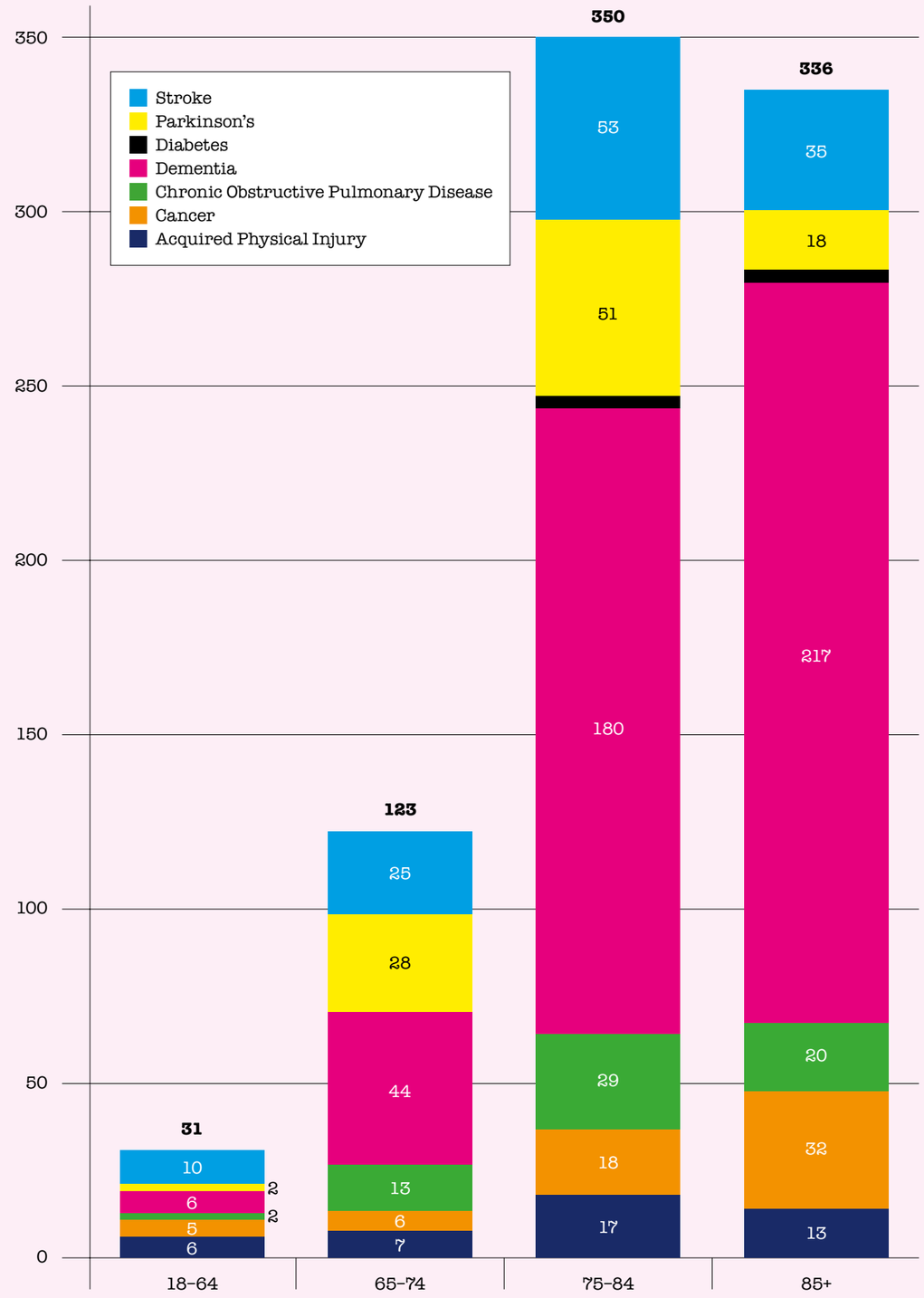
## Carers

Over 21 million people in the UK know close friends or family affected by dementia and it is estimated that one in three people will care for a person with dementia in their lifetime (Prime Minister's Challenge on Dementia). Approximately one third receive no support from either social services or the voluntary sector. In Southend, Thurrock and Essex an estimated 145,000 provide care and support for someone who needs help (not specific to Dementia) with their day to day life of which about 32,000 are estimated to provide care for more than 50 hours per week. We know that over half of people who have approached ECC for a social care assessment have an unpaid family carer and there will be even more in the community who have not yet sought support from us (ECC Dementia Specialist Topic Needs Assessment (2015)). The support of family carers is often crucial to enabling people with dementia to remain in their community. They are often the first to spot changes in the person's health or behaviour and can support communication and sharing of information.

However carers of people with dementia can face a particularly challenging range of symptoms and behaviours that can persist over several years. Research shows that carers of older people with dementia experience greater strain and distress than carers of other older people (Carers Trust: The Triangle of Care: A guide to best practice in dementia care). In addition, many carers are themselves older people with physical frailty and health conditions of their own. The graph on the next page has been taken from data provided at assessment.



**Types of health conditions that affect older (65+) cared-for**





# Our priorities for action 2015-2020

## Priority 1: Prevention

**The issue**

The risk of developing dementia increases with age. Currently we estimate there are 19,000 people in Greater Essex with dementia but predicted to rise to over 25,000 in the next ten years, (based on Office for National Statistics Population 2014 and is higher than the national average). The highest increase is predicted in those over 85, so likely to present with more complex needs suggesting huge implications for the Health and Social Care System.

According to Alzheimer's Society research (Dementia UK Update 2014), as many as 70% of people with dementia will also have other medical conditions or disabilities, such as arthritis, hearing problems, heart disease or mobility problems. Many will have one or two conditions, some will have far more. This emphasises the importance for people to receive advice and support that is tailored to their needs. The ability to measure awareness around cardio vascular risk factors, and general health and wellbeing will be key in supporting people to think in a preventative way.

The Blackfriars Consensus Statement (2014) made clear that the risk of some types of dementia can be reduced but it cannot be eliminated. There is growing evidence that cardiovascular factors, physical fitness, and diet have a major part to play in keeping the brain healthy and thus reduce the risk of developing dementia in later life. Other lifestyle choices such as not smoking, keeping low cholesterol and blood sugar can also help.

The economic impact of dementia is enormous. The Alzheimer's Society calculate the average annual cost per person with dementia as about £30,000 for those living in the community versus c. £37,000 for those in residential care. For people living in the community, three quarters of the cost relates to the indirect costs associated with the contribution of unpaid family carers. For those people in residential care, £32,700 relates to social care, this is £26.5bn a year, enough to pay for every household's energy bills in the UK. (Source Dementia 2015) Alzheimer's Society.

To maintain independence and quality of life as long as possible, it is essential we prioritise the health and wellbeing of people with dementia and that of their carers and support them to self-manage any co-existing health problems. Social isolation and loneliness can be a significant problem and can lead to anxiety and depression. However in Greater Essex the percentage of those diagnosed with dementia receiving an annual review from their GP or recording of vital health indicators is currently among the lowest in the country.

**Outcome**
People in Greater Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.

**Success measures**
- Using the Making Every Contract Count approach, people understand the link between healthy and active lifestyles and are able to make positive changes in their lives
- People have an increased awareness of Mild Cognitive Impairment
- People are aware how to access information and support should they be concerned about dementia
- Increase percentage of people diagnosed with dementia receive an annual face to face review of their health needs, including medication, and whose vital health indicators are checked
- People in BAME Greater Essex Communities have increased awareness
- Carers have access to annual health check and have access to Improved Access to Psychological Therapies.

> “We estimate there are 19,000 people in Greater Essex with dementia but predicted to rise to over 25,000 in the next ten years.”

Based on Office for National Statistics Population 2014



## Priority 2: Finding information and advice

**The issue**
Information and advice is fundamental to enabling people, carers and families to take control of their care and make well-informed decisions about the support they need. We need to help people find and connect to resources and support that will help them get on with their life and develop technological solutions that make it easier for them to do this. However people tell us that they struggle to navigate the large amount of information available about dementia and identify the right support in their area. This can be really distressing when people are at a vulnerable point, such as when they have just received a diagnosis or when they have an immediate need for help. The offer of information and advice needs to be personalised because people will have different preferences for how they want to receive information.

GP’s and their surgeries can be key sources of information but the quality and availability of information available is variable. From April 2015, everyone with dementia should have access to a named GP with overall responsibility for their care.

**Outcome**
Everyone living dementia will have access to the right information at the right time.

**Success measures**
- A comprehensive whole system Information and guidance offer is available
- People living with dementia will feel supported to navigate the system and access information and support that is relevant to them.

> “There’s so much information, where am I supposed to start?”

Carer

> “I have been given a lot of information, cannot make head nor tail of it and not sure what it all means.”

Carer

> “It is difficult for carers to find out what help is out there and how to access it.”

Counsellor

## Priority 3: Diagnosis and assessment

**The issue**

Early diagnosis of dementia is vital because it helps people to understand what is happening to them, make plans and gain access to the most appropriate support and treatment. Some professionals can be reluctant to refer people for diagnosis because of a perceived lack of post-diagnostic support, amongst other reasons. In Essex, 52% of the estimated dementia population have a diagnosis. In Southend the diagnosis rate at December 2016 was 72.6%. The national target is 67%.

Some groups are at higher risk of not being diagnosed. Greater Essex has a relatively low BAME population (5.7%) but the proportion of people of BAME origin receiving services generally, is even lower (1.2%), suggesting they are underrepresented. In Southend the BAME population in the 2011 census was 13%.

Early onset dementia can be harder to recognise and diagnose and people may still be working and have young children. In Greater Essex 7.5% of those with dementia are under 70 and a few are under 30. Finally, people with learning disabilities are at significantly higher risk of developing dementia and at a younger age. There are no specialist services for people with both LD and dementia in Greater Essex.

Following diagnosis, people need personalised ongoing support and advice both to understand their condition; the support available (including for their carers) and the importance of planning in advance. They should have an assessment of their needs and a personalised care plan covering both health and social care.

**Outcome**

All people with dementia will receive appropriate and timely diagnosis and integrated support.

**Success measures**

- GP's across Greater Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe
- Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process
- There is a clear referral pathway to diagnosis with appropriate information and support offered
- BAME Greater Essex Communities are accessing assessment and diagnostic services
- There is appropriate screening for people who are considered to be at high risk of dementia
- People with dementia have access to post diagnostic support that is relevant and personalised
- People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia, and plan for the future
- People are offered a direct payment upon diagnosis of dementia.



> "Getting a diagnosis took so long. It was a huge relief when it finally came. I knew then I wasn't imagining it. We could start to make plans."
>
> Carer

> "I was given this devastating news, given a folder of stuff and left to get on with it in the darkness."
>
> Carer

> "At the point of diagnosis we need someone who is there for the family. Not just bits of paper and a crisis line. We need practical, real advice from someone who knows what we're experiencing."
>
> Carer

## Priority 4: Living well with dementia in the community

**The issue**

Especially in the early stages, people with dementia tell us that they want to continue to live their life as normally as possible. This means staying in their own home, being included in their local community, maintaining friendships and interests. As people's symptoms worsen they become more dependent on others for transport and general help to be able to do this. Fear about becoming confused or getting lost also leads to people going out less and restricting themselves to less demanding activities, which can lead to them becoming more isolated from the community. Loneliness is an increasing problem and can lead to depression or anxiety – over half of those we support who have dementia are widowed and about 4% live alone.

We know that there are gaps in the support available for people with dementia in Greater Essex. Greater Essex is above average in providing equipment or adaptations to help people stay in their own homes but below average in its provision of home care. Services are also not personalised. They often group people together without taking account of their individual capability or their personal preferences, experiences or personality. There is a limited range of activity to choose from in some areas and few services at evenings or weekends. Transport is a problem, particularly in more rural parts of the county. There is little support to help people maintain friendships or relationships or make new ones.

The traditional approach to assessing people's needs can be too focused on assessing for services. In fact formal services are just part of a wider network of community support which encompasses other public services, voluntary and commercial services, local amenities and the informal help and support that Greater Essex residents give to each other.

We want to promote a more inclusive approach to help people live independently in their community, maintaining the relationships and activities that matter to them. We will do this by helping people and their families to use their existing strengths and resources and connect to things that will help them get on with their lives. Where people need more intensive support we will make sure this is tailored to their individual needs and preferences, with the option of a personal budget to give them maximum control over the kind of help they receive.

In a Dementia Friendly Community people are empowered to have aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them. But we know that there is still stigma and misunderstanding in our Greater Essex Communities and that people are not knowledgeable about dementia or how to help someone with the disease live well. Key services including blue light services, supermarkets, banks, etc. do not always have staff able to recognise and support people with dementia.



**Outcome**

People living with dementia feel able to access and contribute to their community, undertaking day to day tasks that supports them to remain as independent for as long as possible.

**Success measures**

- There is a whole community response to living well with dementia
- Environments and physical settings in the community are dementia friendly
- People living with dementia are able to take advantage of open space and nature
- The voice of lived experience helps to shape how Greater Essex Communities respond to dementia
- People living with dementia are encouraged to access information and support that helps themselves to live well and independently
- The lives of people living with dementia in the community are transformed through the DAA activity
- Young people are part of the community support for people living with dementia
- The market is able to respond to people living with dementia and support them to live well
- People with dementia have awareness of alternative accommodation options.

> "At first I didn't think 'activity centres' were really for people like him. Who else is a grown up and goes to an 'activity centre'?"

Carer

> "People don't know what to say or do, your world gets very small all of a sudden."

Carer

## Priority 5: Supporting carers

**The issue**

The impact on the family of a person diagnosed with dementia is significant, especially on family members who take on the responsibility of caring for the person. Diagnosis can be a difficult time for the carer as much as for the person with dementia. The condition can have a major impact on their relationship as the person becomes more dependent on their family for day to day support. Carers tell us they need help to understand the condition and how it is likely to affect their family member and may need help to find support for them both.

People with dementia become increasingly dependent on others and in the later stages may develop behaviours and psychological symptoms that make them among the most challenging to care for. Many carers gain personal satisfaction from caring and want to continue but caring comes at great personal cost. 40% of carers experience psychological distress or depression with those caring for people with behavioural problems experiencing the highest levels of distress (Carers Trust: Triangle of Care: Best practice for dementia care). Yet their ability to continue caring may be essential to the person being able to remain in the community. Carers tell us that they need practical support and reassurance in caring and someone to turn to when things get tough.

Carers find it difficult to take time for themselves, whether to take a break or for essential activities such as their own health appointments, because it can be hard to find others they trust who are willing or able to look after someone with dementia. Services are not always the best answer. They are often at the wrong time or place and may not offer things that people really want. But carers of people with dementia often end up relying on a narrow range of day services and dementia cafés for lack of alternative forms of support.

When it comes to longer breaks, carers evidently find it hard to find suitable options and gain access to them. In addition there are limited options for people with more complex needs or who are more challenging to care for. We need to work with people with dementia and their carers to understand what they need and examine the full range of options within their own network and the wider community that would allow them to take a break, whether on their own or with the person they care for.

It is also important that health and care professionals listen to the carer and work with them to support the person with dementia. As well as giving the carer peace of mind, working in partnership with the carer can achieve better outcomes for the person with dementia and ensure services have a fuller picture of the person's needs. Yet carers report feeling disconnected from the process and frustrated that they are not listened to.



**Outcome**

People caring for someone living with dementia feel informed and able to support their loved one, whilst able to maintain their own health and wellbeing

**Success Measures**

- Carers are a driving force behind shaping the response to dementia in Greater Essex
- Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia
- Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy
- Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges
- Carers are able to access a range of opportunities to take a break from their role as a Carer.

> "I have to stop myself from thinking about more than one day ahead because if you try, it overwhelms you. It destroys you."

Carer

> "The diagnosis was a difficult experience. I walked in a daughter and walked out a carer."

Carer

## Priority 6: Reducing the risk of crisis

**The issue**

Dementia is not a generic condition. People with dementia can develop a wide range of symptoms that are particularly challenging for carers and put unprecedented demand on services. These can include aggression, agitation, delusions, wandering, night time waking, hoarding, loss of inhibition and shouting. Behavioural and Psychological Symptoms of Dementia (BPSD) can lead to crisis and care breakdown resulting in admission to acute services or residential care. Some people with dementia also have other conditions, such as learning disability or long term health problems, that can make their condition even more complex.

Other crises can occur as a result of the carer themselves becoming injured, ill or unable to continue caring, leaving the person with dementia unsupported. Carers can be at increased risk of becoming ill as a result of caring. Studies have shown that providing carers with breaks from caring, emotional support and access to training can significantly delay the need for the person receiving care to go into residential care. It may also prevent emergency hospital admission.

Finally, people with dementia can experience other physical or mental health problems which, if not identified and addressed, can lead to admission to acute hospital or mental health services. Nationally, 25% of hospital beds are thought to be occupied by someone with dementia (Fix Dementia Care; Hospitals Report 2016 (Alzheimer's society), and in Greater Essex we know that people living with dementia stay in hospital 50% longer than those without. Care Managers say that it can take days or even weeks for mental health services to respond to a referral. Social workers told us that mental health teams are focused on preventing escalation to residential and acute services but that we need to identify and support people earlier and look at the role of community psychiatric support to keep people out of hospital.

**Outcome**

All people with dementia receive support to reduce the risk and manage crisis

**Success Measures**

- All hospitals to aspire to being dementia friendly care settings
- People living with dementia, with complex needs such as co-morbidities are offered specialist information and support
- Crisis situations are avoided or managed appropriately – Crisis situations are planned for and responded to effectively
- Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments
- Primary Care are able to respond to episodes of crisis in care homes appropriately.



> "I was so exhausted by it all I almost gave in and said "do what you want" but I managed to make it in the end."

Carer

> "She called us because she wanted someone to talk to. As her condition was progressing she felt scared. She had gone into her local town shopping as she always had but had got lost and was found walking round the roundabout."

Carer

> "People don't contact us until they're in crisis. And when they do contact us, there are often two people in crisis, the individual with dementia and their carer. We wait for people to come to us and by then the dementia has progressed quite far, we have to be more proactive."

Paid carer

## Priority 7: Living well in long term care

**The issue**

In 2014 the Care Quality Commission found that whilst many hospitals and care homes deliver excellent care, the quality of care for people with dementia varied greatly. A key issue was that some hospitals and care homes did not comprehensively identify all of a person's care needs and there was variable or poor staff understanding and knowledge of dementia care.

The government wants to avoid people with dementia requiring long term care by improving the provision of local community services, education and training. The majority (85%) of people with dementia say that they would prefer to remain in their own home. In Greater Essex over 80% of people with dementia live in the community but the proportion of people with dementia supported in residential care is still higher in this county than in similar local authorities.

There are currently 252 care homes and 81 nursing homes for people with dementia across the county. There is a lack of data about the quality of residential care in the market and carers and families tell us that they struggle to find appropriate care for the person they care for.

The government wants all hospitals and care homes to meet agreed criteria to become dementia friendly by 2020.

**Outcome**

All people with dementia live well when in long term care and able to access their community as appropriate

**Success Measures**

- All care homes for people with dementia in Greater Essex to be dementia friendly by 2020
- People living with dementia, their families and carers understand what high quality care looks like and where to find it
- People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings through linking Dementia in to LD health checks
- People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting
- People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate.



> "I can't trust that they're going to follow his care plan. I can't switch off."
>
> Carer

> "I had to place someone four times due to his dementia. His behaviour wasn't difficult – he just needed personalised support. His behaviour deteriorated due to the transfers but this should have been anticipated."
>
> Carer

> "Care homes need to be enabled to provide outings, passionate about taking people outside, but I accept care homes are not staffed to provide regular outings for people in their care. We need to find another way to ensure people have a life."
>
> Carer

## Priority 8: End of life

**The issue**
It is important to have early conversations with people with dementia about advance planning and end of life care so that people can plan ahead and ensure that their wishes are known and acted upon. The government has said that all people with a diagnosis of dementia should be given the opportunity for advance care planning early on to ensure the person and their carer are fully involved in decisions on care at end of life.

The aim should be to maximise the person's quality of life and support carers. All people with dementia and their carers should receive coordinated, compassionate and person-centred care towards the end of their life. This includes palliative care for the person with dementia and bereavement support for carers.

**Outcome**
People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes

**Success Measures**
- People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP
- People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate
- People are not delayed in being discharged from hospital
- People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose
- Carers and families receive bereavement support at a time that is right for the individual or family.

> "People's wishes are not known. We need to get this information earlier."

Social worker

> "People don't plan. We need to help people plan for the inevitable whilst they've still got the capability."

Social worker



## Priority 9: A knowledgeable and skilled workforce

**The issue**
If health and care professionals and all other care workers understand the complexity of dementia; its impact upon the person and their family and know how to provide effective help and support, this will improve the quality of information, advice and care that people receive in all areas. Poor quality care has a major, negative impact on the quality of life of the person with dementia and causes stress and anxiety for their carer. It can also lead to higher care costs when health and social care professionals do not know how to support people to maintain their independence and quality of life in the community.

Across health and social care there is a lack of consistency or a clear pathway around dementia training. Training is provided at different levels and there is no clear picture of what the training is meant to deliver.

**Outcome**
All people with dementia receive support from knowledgeable and skilled professionals where needed

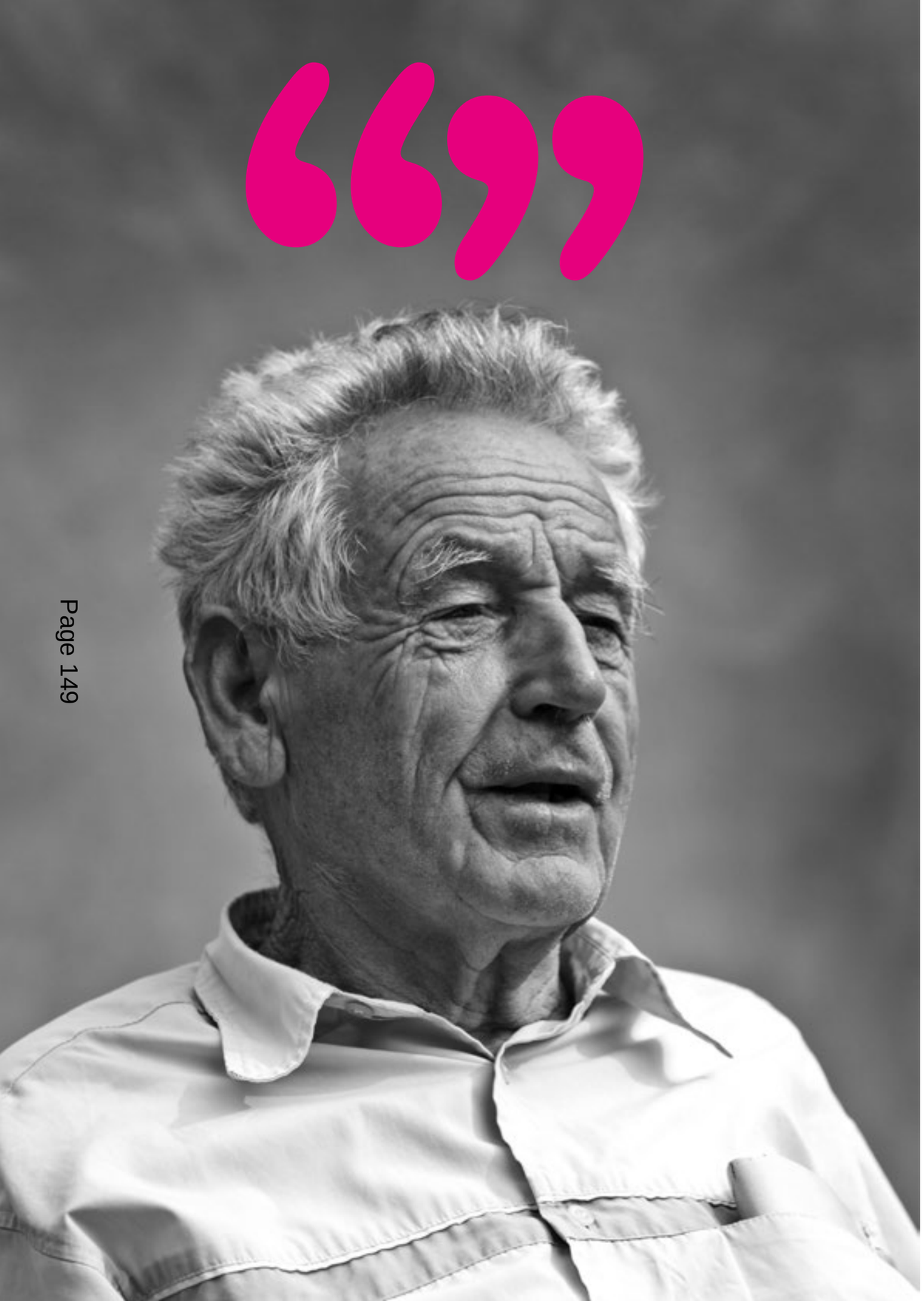
**Success Measures**
- There is a framework for dementia training across Greater Essex to ensure all people receive training relevant to their role
- To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so
- To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well.

> "People think you can't communicate with people with dementia; there is a general lack of awareness."

Support worker

> "The biggest impact that could happen to assist those living with dementia is education. To educate people and eradicate the stigma."

Care home manager





# key documents


Alzheimer's Society (2010). My name is not dementia

Alzheimer's Society (2013). Building dementia-friendly Greater Essex

Greater Essex Communities: a priority for everyone

Alzheimer's Society (2014). Dementia 2014: Opportunity for Change

Carers Trust & Royal College of Nursing (2013). The Triangle of Care: Carers Included: a Guide to Best Practice for Dementia Care

Department of Health (February 2015): Prime Minister's Challenge on dementia 2020

Greater Essex County Council (April 2015). Carers count in Greater Essex: Greater Essex Carers Strategy 2015-2020

Greater Essex County Council (June 2015). Dementia specialist topic needs assessment.

Greater Essex County Council (June 2015): Literature review of interventions to support the dementia needs assessment

ESRO and ThePublicOffice (2015). Living well with dementia in Greater Essex: ethnographic research findings

Joint Commissioning Panel for Mental Health (2013). Guidance for commissioners of dementia services

National Institute for Health and Care Excellence (2006, modified March 2015). Clinical Guideline 42: Dementia: supporting people with dementia and their carers in health and social care

National Institute for Health and Care Excellence (April 2013). Quality Standard 30: Supporting people to live well with dementia

The Princess Royal Trust for Carers and the Royal College of General Practitioners (2011). Supporting carers: an action guide for general practitioners and their teams

Public Health England and UK Health Forum (2014). Blackfriars Consensus on promoting brain health: reducing risks for dementia in the population.

Royal College of General Practitioners (2013). Commissioning for Carers

Southend on sea borough Council (Jan 2016) Themes From the Consultation Workshops

Southend on sea Borough Council (December 2016) Dementia JSNA (draft)

Technology Charter https://www.alzheimers.org.uk/technologycharter

# Glossary and appendix

## Glossary

| | |
|---|---|
| **ASC** | Adult Social Care |
| **BAME** | Black and minority ethnic groups |
| **BPSB** | Behavioural and psychological symptoms of dementia |
| **DAA** | Dementia Action Alliance |
| **GP** | General Practitioner |
| **LD** | Learning Disability |
| **MCI** | Mild Cognitive Impairment |
| **Good Lives** | ECC approach to Social Care |

## Appendix – Implementation Plan

The following activity will help us delivery our aspirations and vision set out in the strategy but will required addition investment to deliver. It is expected that an Outline Business Case (OBC) will be developed to request the level of investment needed to improve the lives of people living with dementia, the families and carers. Again, you can see from the table how the activity links in to the priorities and outcomes outlined in the strategy as well as how we propose we will measure whether or not we are successful. At this time the level of investment/cost is not given as a financial figure as this will be part of the OBC.





| 20 July 2018 | ITEM: 9 |
|---|---|
| **Thurrock Health and Wellbeing Board** | |
| **Thurrock Health and Wellbeing Strategy Annual Report 2017-2018** | |
| **Wards and communities affected:**<br>All | **Key Decision:**<br>To approve the contents and publication of Thurrock's Health and Wellbeing Strategy Annual Report. |
| **Report of:** Councillor James Halden, Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board | |
| **Accountable Head of Service:** N/A | |
| **Accountable Director:** Roger Harris, Corporate Director of Adult Housing and Health | |
| **This report is** Public | |

**Executive Summary**

The Health and Wellbeing Strategy 2016-2021 was approved by the Health and Wellbeing Board in February 2016 and the CCG Board and Council in March 2016. At its meeting in July 2017, the Health and Wellbeing Board approved the first annual report and agreed that a further report that sets out progress being made with achieving the Strategy's Goals to improve the health and well-being of the population of Thurrock will be published on an annual basis.

This paper provides the second annual report on Thurrock's Health and Wellbeing Strategy for the Health and Wellbeing Board's consideration. The annual report is a stand-alone document that:

- Explains the Health and Wellbeing Board's function, membership and how it drives forward the development and implementation of the Health and Wellbeing Strategy;
- Describes Thurrock's Health and Wellbeing Strategy and reports year two key achievements; and
- Sets out progress made against Key Performance Indicators, approved by the Health and Wellbeing Board in November 2018

Subject to the Health and Wellbeing Board's approval the annual report will be published on Thurrock Council's website.

## 1. Recommendation(s)

**1.1 The Board is asked to approve the structure and contents of the annual report and agrees that it should be published on the council's website.**

## 2. Introduction and Background

2.1. Thurrock's Health and Wellbeing Strategy comprises five strategic goals which make the most difference to the health and wellbeing of the people of Thurrock. Each of the Goals is defined by four objectives.

| GOALS → | 1 OPPORTUNITY FOR ALL | 2 HEALTHIER FOR LONGER | 3 BETTER EMOTIONAL HEALTH AND WELLBEING | 4 QUALITY CARE CENTRED AROUND THE PERSON | 5 HEALTHIER FOR LONGER |
|---|---|---|---|---|---|
| Objectives | 1A All children in Thurrock making good educational progress | 2A. Create Spaces that make it easy to exercise and be active. Amended from: Create outdoor places that make it easy to exercise and to be active | 3A. Give parents the support they need | 4A. Create four integrated healthy living centres | 5A. Reduce obesity |
| | 1B More Thurrock residents in employment, education or training | 2B. Develop homes that keep people well and independent | 3B. Improve children's emotional health and wellbeing | 4B. When services are required, they are organised around the individual | 5B. Reduce the proportion of people who smoke |
| | 1C Fewer teenage pregnancies | 2C. Build strong, well-connected communities | 3C. Reduce social isolation and loneliness | 4C. Put people in control of their own care | 5C. Significantly improve the identification and management of long term conditions |
| | 1D Fewer children and adults in poverty | 2D. Improve air quality in Thurrock | 3D: Improve the Identification and treatment of mental ill-health, particularly in high risk groups. Amended from: Improve the identification and treatment of depression, particularly in high risk groups | 4D. Provide high quality GP and hospital care to Thurrock | 5D. Prevent and treat cancer better |

2.2 Following the Health and Wellbeing Strategy being launched in July 2016 impressive progress has been made. Year 1 annual report (2016/17) set out actions that had been taken to achieve Strategy outcomes. The 2017/18 Annual Report also includes a comprehensive Outcomes Framework and provides a progress report against individual KPIs, where practicable.

2.3 We previously reported that lead officials had been identified across partner organisations to drive forward the development of action plans for all of the Strategy's objectives. Following a review of the way in which we monitor progress of actions required to support the achievement of Strategy outcomes we recognised that much of the information contained in action plans was recorded elsewhere. The current review processes identifies key strategies, programmes and actions being taken to improve health and wellbeing outcomes for the population of Thurrock, avoiding unnecessary duplication. These are described throughout the report.

2.4 The commitment to publish an annual report and set out progress made against agreed KPIs ensures that progress being made is scrutinised and approved by the Health and Wellbeing Board. This provides continued accountability and ensures momentum is sustained over the five year lifespan of the Strategy.

## 3. Issues, Options and Analysis of Options

3.1 The public and partners were actively involved in the development of Thurrock's Health and Wellbeing Strategy and subsequent action plans that had been developed to support the achievement of the Strategy's outcomes. Publishing an annual report will help to ensure that engagement is sustained and that the council and partners can be held to account on progress that has been made.

## 4. Reasons for Recommendation

4.1 Health and Wellbeing Board members are responsible for driving forward Thurrock's Health and Wellbeing Strategy. Board members previously agreed that a report showing progress made with achieving the Strategy's Goals will be published annually.

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

5.1 Partner and community engagement is a key part of the development of action focussed plans to support the achievement of Thurrock's Health and Wellbeing Strategy. Publishing the annual report that explains how action plans have been developed to reflect feedback received from stakeholders reinforces Thurrock's continued commitment to genuine engagement.

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

6.1 The Health and Wellbeing Strategy is the means through which the priorities for improving the health and wellbeing of Thurrock's population are identified.

## 7. Implications

### 7.1 Financial

Implications verified by: **Roger Harris, Corporate Director, Adults Housing and Health**

There are no financial implications. The priorities of the Health and Wellbeing Strategy will be delivered through the existing resources of Health and Wellbeing Board partners.

### 7.2 Legal

Implications verified by: **Roger Harris, Corporate Director, Adults Housing and Health**

There are no legal implications. The Council and Clinical Commissioning Group have a duty to develop a Health and Wellbeing Strategy as part of the Health and Social Care Act 2012.

### 7.3 Diversity and Equality

Implications verified by: **Roger Harris, Corporate Director, Adults Housing and Health**

Action will need to be taken to improve the health and wellbeing of Thurrock's population and reduce inequalities in the health and wellbeing of Thurrock's population. Being successful will include identifying sections of the population whose health and wellbeing outcomes are significantly worse, and taking action that helps to ensure the outcomes of those people can improve. This will be supported by information contained within the Joint Strategic Needs Assessment. Thurrock Health and Wellbeing Strategy aims to reduce health inequalities.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None identified

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

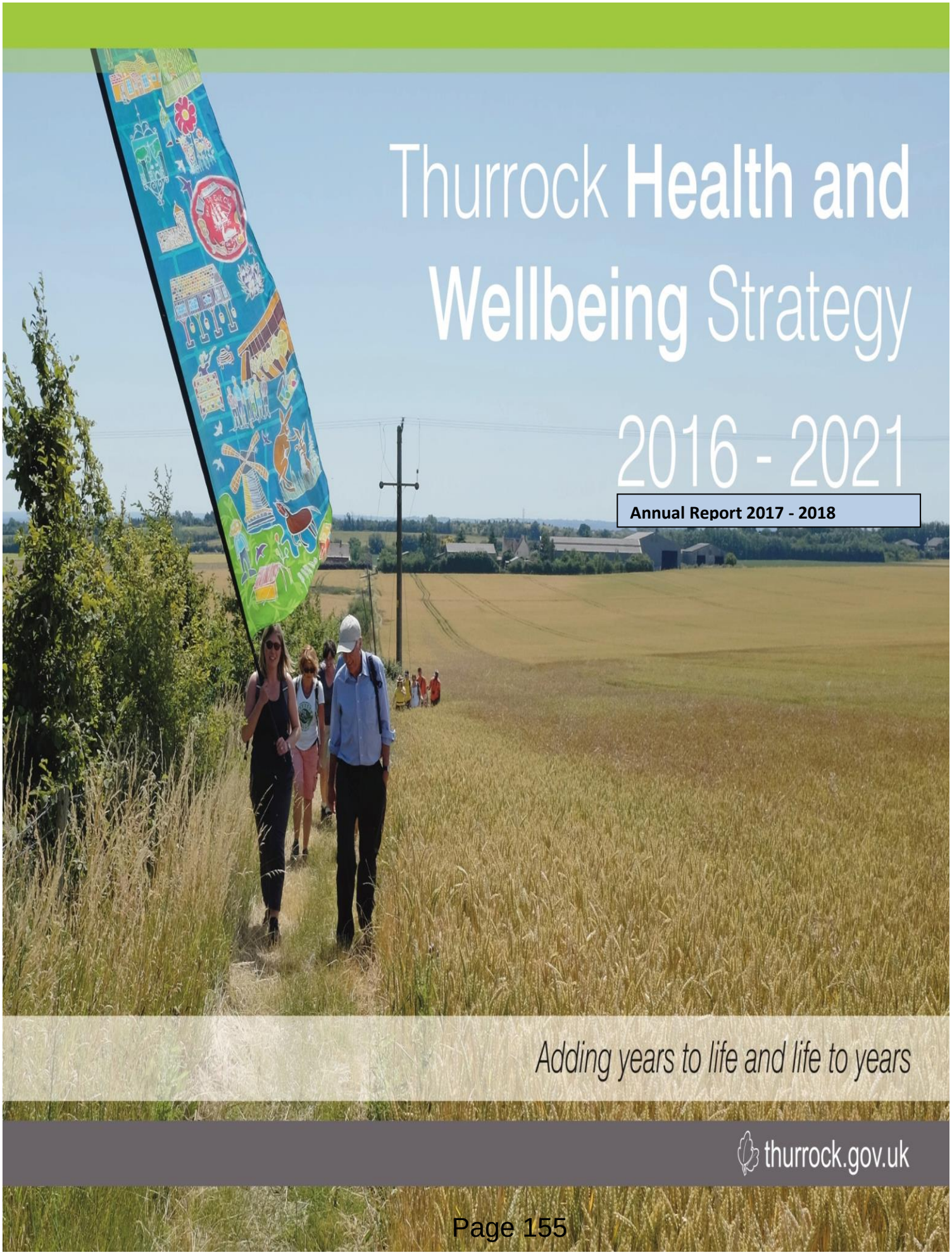
- Thurrock Health and Wellbeing Strategy https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy

## 9. Appendices to the report

- Thurrock Health and Wellbeing Strategy Annual Report

**Report Author:**

Darren Kristiansen, Business Manager, Adults Housing and Health Directorate, Thurrock Council


Thurrock Health and Wellbeing Strategy
2016 - 2021
Annual Report 2017 - 2018
Adding years to life and life to years
thurrock.gov.uk

# Contents

**Contents continued**

# Foreword

**Cllr James Halden**
**Chair of Thurrock Health and Wellbeing Board**

I am pleased to welcome you to Thurrock Health and Wellbeing Board's 2017-18 annual report. The five year Health and Wellbeing Strategy was launched in July 2016 and is the result of a genuine partnership approach, driven forward by the Health and Wellbeing Board.

I have been Chair of Thurrock's Health and Wellbeing Board since 2016 and it's my strong belief that the Board and Health and Wellbeing Strategy's primary purpose is to improve health and wellbeing outcomes for the people of Thurrock.

The Health and Wellbeing Strategy is informed by evidence and ensures action is taken on the wider determinants of health and wellbeing including housing, employment and the local environment. That is why our Strategy identifies five strategic goals that focus on the areas within which we can make the most difference to the health and wellbeing of Thurrock's people.

We remain committed to striving towards our goal of making sure that people remain healthier for longer, can remain in their own homes and in their own communities for as long as possible.

The Health and Wellbeing Strategy demonstrates that our joined up, coordinated approach for designing and delivering services is making a difference to people's lives, as shown throughout this report, which:

- Summarises some of the wider work of the Health and Wellbeing Board, holding partners to account and overseeing the development of new ways of working;
- Describes the range of strategic partners who are members of the Health and Wellbeing Board;
- Sets out our jointly agreed vision and key principles for improving health and wellbeing;
- Provides a snapshot of the Strategy's five strategic goals and explains why they have been prioritised;
- Explains some of the key strategies and programmes that support the Strategy
- Outlines key achievements for the second year of the Strategy; and
- Demonstrates performance against our targets.

Cllr James Halden
**Portfolio Holder Education and Health**
**Health and Wellbeing Board Chair**

Health and Social Care Act 2012

# Thurrock Health and Wellbeing Board
# Who we are and what we do

## Background and why Thurrock established its Health and Wellbeing Board

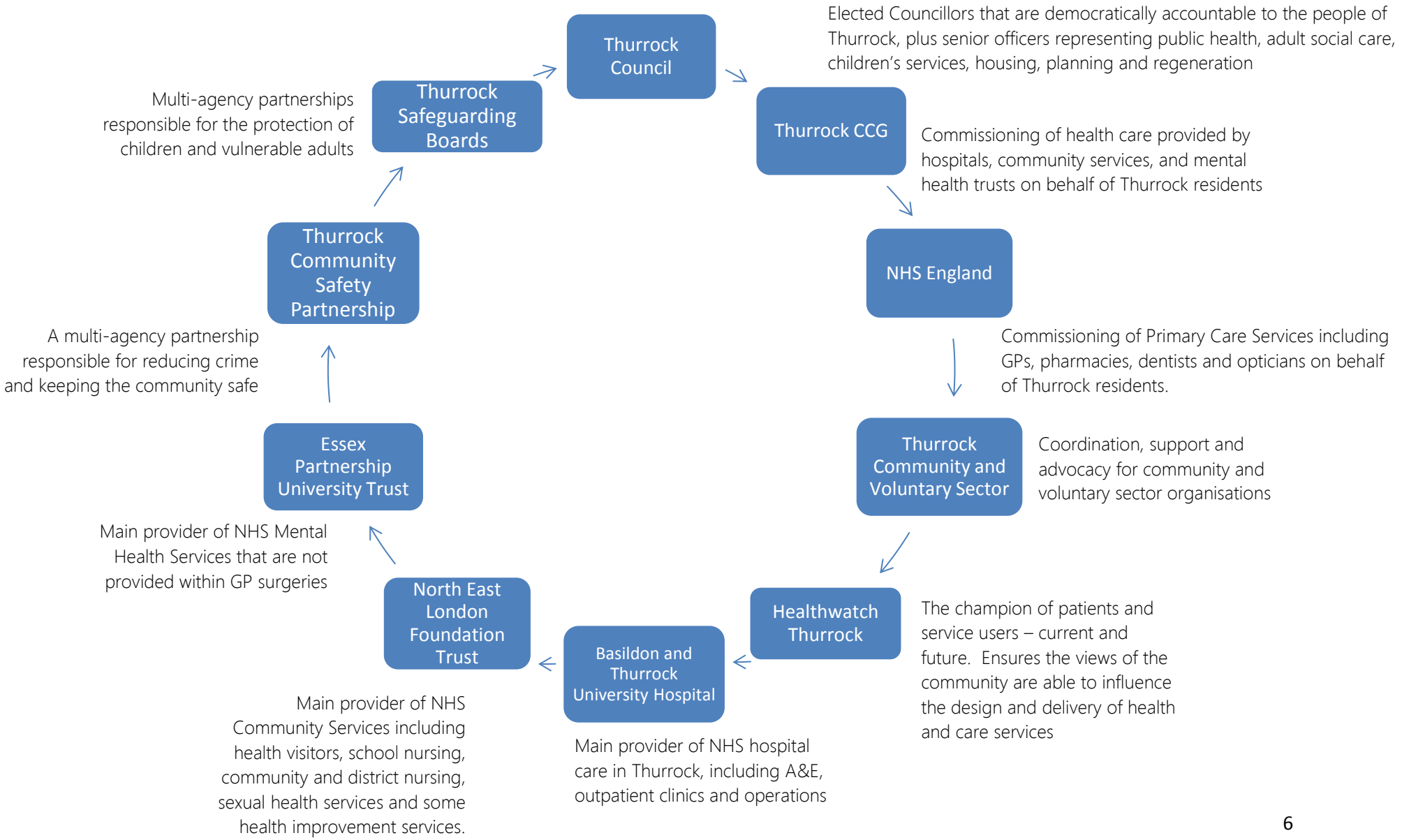
1. Section 194 of the Health and Social Care Act 2012 requires Thurrock Council to establish a Health and Wellbeing Board. The Health and Wellbeing Board is the primary partnership body in Thurrock responsible for informing policies and programmes established to improve health and wellbeing outcomes for the people of Thurrock. The Board's membership comprises Elected Councillors and key strategic partners, as described on page 6.

2. The Health and Wellbeing Board identifies and joins up areas of commissioning across the NHS, Social Care, Public Health and other services directly related to health and wellbeing; signs off key commissioning plans, strategy and policy related to health and wellbeing; and oversees the ongoing development and refresh of the Joint Strategic Needs Assessment.

3. Thurrock's Health and Wellbeing Board are also responsible for developing and overseeing the implementation of Thurrock Health and Wellbeing Strategy, upon which this annual report is focussed.

4. The Health and Wellbeing Board is supported by a **Health and Wellbeing Board Executive Committee** comprising senior officers representing the council and key partners. The Health and Wellbeing Board has four sub-groups:
    - **The Housing and Planning Advisory Group** (HPAG). As a sub-group of the Board HPAG influences plans for the built environment and the potential impact of those plans on health and wellbeing of the population of Thurrock. It does this by looking at significant development plans (major) at the earliest possible stage to enable full consideration to be provided to the potential impact of new developments on people's health and wellbeing.
    - The **Integrated Commissioning Executive (ICE)** is a decision making body responsible overseeing the delivery of the Better Care Fund Plan, and the wider health and wellbeing transformation agenda in Thurrock. The ICE meets monthly and minutes are a standing item at Health and Wellbeing Board meetings.
    - **Thurrock Integrated Care Alliance** comprises different organisations from the health and care system who work together to improve the health of their local population by integrating services and tackling the causes of ill health.
    - The **Health and Wellbeing Engagement Advisory Group.** Aims to ensure that the health and care system is responsive to meeting the needs of Thurrock's population and that that residents have the opportunity to engage with, influence and shape that system.

# Thurrock Health and Wellbeing Board – Our members



# Thurrock's Health and Wellbeing Board
# Vision and Principles

**Thurrock Health and Wellbeing Board Vision**

***Add years to life and life to years***

5. The Health and Wellbeing Board's vision and the work of the Board is guided by a set of key principles:

**Reducing inequality in health and wellbeing**
We want things to get better for everyone but we are also committed to ensuring that the poorest communities enjoy the same levels of opportunity, health and wellbeing as the most affluent.

**Prevention is better than cure**
Rather than waiting for people to need help, we want Thurrock to be a place where people stay well for as long as possible.

**Empowering people and communities**
We don't just want to do things to people, but give people the opportunity to find their own solutions and make healthy choices.

**Connected services**
Good health and care services should be organised around the needs of people, not around the needs of organisations.

**Our commitments will be delivered**
We will ensure that commitments are delivered and all partners are accountable.

**Continually improving service delivery**
We will not settle for poor levels of service, continually striving to improve the planning and delivery of local services, ensuring that they meet the needs of the people of Thurrock.

**Continuing to establish clear links between health and education services, improving accessibility for all**
We will make sure that clear links continue to be established between health and education services, improving accessibility.


# Thurrock Health and Wellbeing Board
## Work over the year

6. The Board meets bi-monthly. The Health and Wellbeing Board has considered more than 37 separate agenda items between the periods of July 2017 and June 2018. This has involved members of the Board reading over 1000 sheets of paper.

7. In addition to considering specific Health and Wellbeing Strategy programmes and policies over the last year the Health and Wellbeing Board has also informed, approved or noted:

   **Thurrock's Better Care Fund for 2017-19** which comprises almost £40million of pooled resources from Thurrock Council and Clinical Commissioning Group. The Better Care Fund is overseen by the Integrated Commissioning Executive, a sub group of the Health and Wellbeing Board.

   **Annual Public Health Report** which is a report by the Director of Public Health on people's health in Thurrock.

   **Mid and South Essex Sustainability and Transformation Partnership (STP)** which has developed plans setting out practical ways to improve NHS services and health outcomes. This is a standing item on the Health and Wellbeing Board's agenda, which has enabled the Board to help ensure that the STP consultation exercise was meaningful and accessible, providing Thurrock residents with opportunities to engage and provide their views on STP proposals.

   The **Creation of the Thurrock Integrated Care Alliance** which comprises different organisations from the health and care system work together to improve the health of their local population by integrating services and tackling the causes of ill health. It marks a shift away from policies that have encouraged competition towards an approach that relies on collaboration between the different organisations delivering care – such as hospitals, GPs, community services, mental health services and social care – and the organisations paying for it.

   **Transforming Care Programme** which sets out how the national service model for people with learning disabilities and/or autism that display challenging behaviours will be implemented locally.

**Joint Strategic Needs Assessments (JSNA) on**

- **Whole systems obesity** which included recommendations to shift from treating the individual to promoting small lifestyle changes at population level; considering options around restricting the proliferation of fast food outlets in Thurrock; ensuring the nutritional quality of food in early years settings and schools remains high; improving the quality and quantity of local transport and leisure, green spaces and pitch and play provision and; giving greater strategic focus to physical activity.
- **Adult mental health and children's mental health** which provide evidence based studies of common mental health disorders in adults and children

**Pharmaceutical Needs Assessment** which provides a comprehensive report on the needs for and provision of pharmaceutical services (as defined by legislation) in Thurrock. It will be used by NHS England to decide upon applications to open new pharmacies, change hours, relocate existing pharmacies or merge pharmacies, and will inform commissioners regarding the commissioning of pharmaceutical services. As part of ensuring that the Health and Wellbeing Board adheres to legislative requirements it will now make representations to NHS England when an application to consolidate local pharmacies is received.

**Southend, Essex and Thurrock Dementia Strategy 2017 – 2021** which identifies nine priorities that are focused on improving the lived experience of those with dementia and their families and carers by addressing the fragmentation of response and the lack of understanding of dementia. Health and Wellbeing Board members agreed to the development of a local Thurrock implementation plan to deliver the Dementia Strategy in Thurrock which was presented to the Board and approved in June.


# Thurrock Health and Wellbeing Strategy Summary

8. We want Thurrock to be a place where people live long lives which are full of opportunity, allowing everyone to achieve their potential. To achieve this, we have developed a Health and Wellbeing Strategy, which we launched in July 2016.

9. The Strategy comprises five strategic goals, which we are all committed to achieving. The goals are ambitious and require a lot of hard work from Thurrock Council, the NHS, voluntary organisations and communities themselves. We believe that by working together we can achieve these goals and make a real difference with and for the people of Thurrock.

10. To clearly define each of the Health and Wellbeing strategic goals and to ensure that action taken by the Council and partners focusses on the right areas, each of them are supported by four key objectives as set out on page 12.

11. The Strategy is a live document that is organic and regularly refreshed, ensuring it focusses on the areas that matter most. This is the second annual report that sets out progress made against delivering Strategy's Goals.

## Delivering the Strategy

12. We previously reported that lead officials had been identified across partner organisations to drive forward the development of action plans for all of the Strategy's objectives. Following a review of the way in which we monitor progress of actions required to support the achievement of Strategy outcomes we recognised that much of the information contained in action plans was recorded elsewhere.

13. The new review processes aim to capture key strategies, programmes and actions being taken to improve health and wellbeing outcomes for the population of Thurrock, avoiding unnecessary duplication. Links to further information about strategies and programmes highlighted throughout this report are provided at **Appendix B**.

## How we will know if the Health and Wellbeing Strategy is working

14. We want to be clear about whether or not our Strategy is working and to hold each other to account for achieving its goals. That's why we have developed an Outcomes Framework which comprises a suite of Key Performance Indicators (KPIs), providing measurable, stretching but achievable targets and trajectories for what we expect to achieve over the next three years. When considering the KPIs it is helpful to note that

some have a time lag due to different data collection arrangements. This means that on some occasions reporting against the target for a specific year will be using data from previous years – i.e. 2017 targets may utilise data from earlier years such as 2015. This is because action taken today will not always deliver immediate outcomes. For example, if gym equipment is provided in a community environment it will be some time before health improvements for the local population can be seen or measured.

15. Over the course of the Strategy some of the KPI's have been amended to reflect national policy changes and amendments made to the Health and Wellbeing Strategy Objectives. In some cases KPIs did not measure improved outcomes, so they have been abolished. The full list of KPIs is provided at **Appendix A**. How we have delivered against them is reported throughout this document.

# Thurrock Health and Wellbeing Strategy – Goals and Objectives

| GOALS → | 1 OPPORTUNITY FOR ALL | 2 HEALTHIER FOR LONGER | 3 BETTER EMOTIONAL HEALTH AND WELLBEING | 4 QUALITY CARE CENTRED AROUND THE PERSON | 5 HEALTHIER FOR LONGER |
|---|---|---|---|---|---|
| Objectives | 1A All children in Thurrock making good educational progress | 2A. Create Spaces that make it easy to exercise and be active. Amended from: Create outdoor places that make it easy to exercise and to be active | 3A. Give parents the support they need | 4A. Create four integrated healthy living centres | 5A. Reduce obesity |
| | 1B More Thurrock residents in employment, education or training | 2B. Develop homes that keep people well and independent | 3B. Improve children's emotional health and wellbeing | 4B. When services are required, they are organised around the individual | 5B. Reduce the proportion of people who smoke |
| | 1C Fewer teenage pregnancies | 2C. Build strong, well-connected communities | 3C. Reduce social isolation and loneliness | 4C. Put people in control of their own care | 5C. Significantly improve the identification and management of long term conditions |
| | 1D Fewer children and adults in poverty | 2D. Improve air quality in Thurrock | 3D: Improve the Identification and treatment of mental ill-health, particularly in high risk groups. Amended from: Improve the identification and treatment of depression, particularly in high risk groups | 4D. Provide high quality GP and hospital care to Thurrock | 5D. Prevent and treat cancer better |

# The Health and Wellbeing Strategy
# Goals in Focus

16. The remainder of this document describes each of the Health and Wellbeing Strategy Goals, sets out some of the key policies and actions that help to achieve them and demonstrates progress we have made with improving health and wellbeing outcomes for the population of Thurrock.

## GOAL ONE – OPPORTUNITY FOR ALL

**We want to achieve better educated children and residents who can access employment opportunities**

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- Objective 1A. All children in Thurrock making good educational progress
- Objective 1B. More Thurrock residents in employment, education and training
- Objective 1C. There will be fewer teenage pregnancies
- Objective 1D. Fewer children and adults will live in poverty

**Why this goal is a key element of the Health and Wellbeing Strategy**
'*Disadvantage starts before birth and accumulates throughout life*'

The best way to break the cycle of disadvantage and poor health is to take action early. Ensuring that children have a good start in life can lead to life-long improvements in health and wellbeing.

We know that more than one in five Thurrock children live in poverty. That makes it much harder for them to achieve their full potential in life. Our target is to halve this by 2020.

Thurrock is a place of opportunity. The ambitious programme of regeneration in the borough means new jobs are being created – for example through London Gateway (DP World) in the east of the borough. Thurrock people must be able to access these jobs. That means people must leave school with good qualifications and go on to get the skills they need to secure good jobs.

# Objective1A - All Children in Thurrock making good educational progress

Key Strategies and actions for achieving this objective

17. To make sure there are enough school places available in the borough the council uses school admissions information to make pupil forecasts, and align pupil places with demand. Where more capacity is needed, it is provided by either adding places to existing schools or opening new schools. Further information is available in our **Pupil Place Plan 2017-2021.**

18. Another key strategic document for ensuring that children in Thurrock are making good educational progress is the **Plan on a Page,** which has 5 main priorities:
    I. **Improve pupil attainment and progress** so that all Thurrock educational provision is good to outstanding. Differences between disadvantaged pupils and all other pupils nationally are diminished. Ensure that every child, including the most able, receive the support they need to reach their full potential.
    II. As part of the **Recruitment & Retention Strategy**, ensure high quality leadership, teaching and learning in all schools, colleges and settings, including the six planned new free schools and new Alternative Provision (AP) for primary pupils across the borough.
    III. As part of the Health & Wellbeing Strategy **ensure Safeguarding, Personal Development, Health & Wellbeing, including mental health services, are improved** in order to better meet the needs of all children and young people in Thurrock.
    IV. Produce a meaningful **SEND strategy and action plan**; ensuring value for money and improved outcomes for some of our most vulnerable and disadvantaged pupils. Developing appropriate alternative provision, where possible, in the borough.
    V. Working with a range of partners, continue to develop our **cultural entitlement** within a high quality curriculum - to include culture, music, sport and work experience

19. To achieve the plan on a page priorities all schools and the council will:
    - Increase the pace of improvement and accelerate progress especially in English, mathematics and science whilst maximising the unique benefits of working in partnership with the Royal Opera House and other outstanding external cultural partners to ensure our pupils have a rich and varied curriculum that meets the needs of all pupils
    - Reduce exclusions; improve attendance; reduce differences in progress and attainment in pupils with the same starting points
    - Develop the primary hub and Alternative Provision with the hub at East Tilbury Primary and satellite centres across the borough, and implement the new primary Fair Access procedures

- Work with the three teaching schools to develop more effective use of best practice within the borough, promoting school to school support and building on the good practice.
- Develop a range of high quality employment, apprenticeships and training opportunities supported by settings, schools, academies, higher educational establishments and local business to ensure no one is NEET.
- Recruit high quality teaching staff through the 'Teaching in Thurrock' website, attend university recruitment fairs, develop a key worker scheme, seek to reduce workforce workload with clear focus on CYP and staff being at the heart of all that we do.
- In partnership with colleagues from health, deliver the new Health & Wellbeing Strategy with a specific focus on CYP mental health.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

20. The Plan on a Page was developed with Head Teachers, Principals and Governors to ensure all schools and stakeholders were working towards the same vision and outcomes. All schools are committed to ensuring children achieve the best outcomes and the **majority of our schools (94%) are judged by Ofsted to be good or outstanding**.

21. For the second year in a row, **94% of primary children in Thurrock have been offered a place at their preferred primary school**. This evidences that our Pupil Place Planning strategy is delivering school places where they are most wanted and needed.

22. Recruitment of teaching staff is a national challenge. Thurrock's proximity to London increases the difficulties we have in the recruitment of teaching staff. To address the council has worked with the Teaching School Alliance and established a **website to support teacher recruitment.** *Teaching in Thurrock* recruits and trains excellent teachers at all levels to continue our ambitious education plans and ensure future success for our schools and children. It sets out why Thurrock is an exciting place to build a teaching career and contains details of all current teaching jobs and vacancies. The aim of the website is to recruit and develop high quality teachers to ensure our schools continue to improve and to ensure the best possible outcomes for the children in our care.

23. In May 2016, the Careers and Enterprise Company was introduced to Thurrock secondary schools. An Enterprise Advisor Network comprising local business leaders has been recruited, trained and maintained to **support schools to develop a whole school enterprise strategy (year 7-13), share their network of business contacts to improve students' readiness for employment** and support schools to select careers activities that provide significant, positive impact. To date, **10 of 13 schools have joined the network** and are actively working with their business leader to implement improvements.

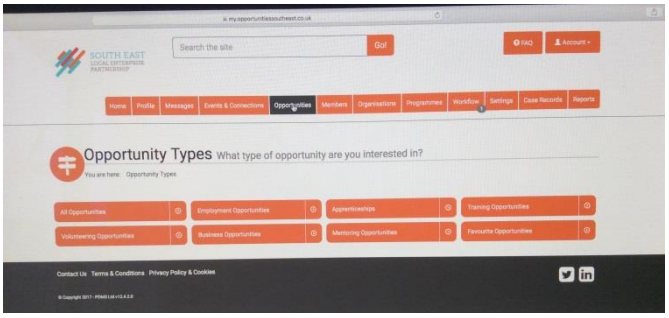
**24.** A **children's mental health summit took place in May 2018**. Stakeholders began mapping dynamic services and preparing a vision for residents. School staff were pleased to be able to meet a range of professionals and to discover what other services are available locally to support children and young people's mental health and wellbeing, as well as discovering more about what they could do in school.

Progress against our targets

25. 2017 validated data shows that;
    - **76% of children achieved a good level of development at the end of the Early Years Foundation Stage**, exceeding the trajectory target of 73% and the national average of 71%.
    - **62% of children are achieved the national standard in Reading, Writing and Maths at the end of Key Stage 2**, exceeding the trajectory target of 57%, consistent with the national average of 61%.
    - **Progress in reading, writing and maths was broadly in line or better than the national average** for children at the end of Key Stage 2.
    - There is a **17 percentage point gap between pupil premium children achieving a Good Level of Development and others at end of Early Years Foundation Stage.** While we did not meet our target of 11.76% for 2017. However, our performance is in line with the national average of 18%.

26. The Health and Wellbeing Board agreed two new KPI's in November 2017:
    - **Latest results show that 38% of Thurrock pupils at KS4 achieved combined level 5 in English and Maths –** combined level 4 was not reported on nationally or locally in 2017. This compares to 43% of pupils achieving the combined level 4 nationally. The target should therefore be set for pupils in Thurrock to achieve in line with national percentages.
    - **The average Progress 8 score in 2017 was +0.03, compared to -0.03 nationally**. Targets need to be set that are challenging and aspirational and based on prior attainment.


*Jobs@Opportunity Thurrock Facebook page*




*Opportunities South East website*

# Objective 1B – More Thurrock residents in employment education or training

Key Strategies and actions for achieving this objective

27. Inspire is working alongside an extensive range of partners and agencies to collaboratively and coherently reduce unemployment. The Council's **local skills strategy** is aligned with other relevant local, regional and national strategies to enable residents to develop the right skills for the rapidly changing world of work.
    - The Council has introduced **Jobs@OpportunityThurrock** to raise the visibility of live vacancies within local communities. Members of the Economic Development and Skills Partnership are developing plans to increase take up.
    - The **Youth Employment Initiative, OnTrack Thurrock**, provides targeted support to young people and adults on how to access employment opportunities.

28. Local community, voluntary and faith sector organisations are currently in receipt of grant funding that is jointly provided by Thurrock Council and Thurrock Clinical Commissioning Group to give **education, volunteering and training opportunities for people with a learning disability**.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

29. **Opportunities South East** has been introduced providing a platform designed to de-clutter the vast range of offers and services available to residents in Thurrock. Jobs that are advertised on Jobs@OpportunityThurrock are automatically shared to this website too.

30. The council's **joint housing pilot**, **created to reduce unstable accommodation for young people already in employment or education, has benefited 9 people so far**. The programme is working towards the modification of 2-4 further properties 2018-2019. This will provide accommodation for up to 12 more young people.

31. The council has **increased the wages, paid to our apprentices**, to National Minimum Wage from day one of employment, making the council an employer of choice whilst improving the income of new staff working in public services.

Progress against our targets

32. Validated data for March 2018 shows:
    - **2.1% of 16/17 year olds are not in employment, education or training, achieving the trajectory target of 5%.** This data is based on 16/17 year olds and therefore considerably exceeds the trajectory target that was set for 16-19 year olds.
    - The **number of residents claiming Universal Credit is 2185 (2.1%), which is identical to UK percentage.** Under Universal Credit a broader span of claimants are required to look for work than under Jobseeker's Allowance. As Universal Credit Full Service is rolled out in particular areas, the number of people recorded as being on the Claimant Count is therefore likely to rise.

**More Thurrock residents in employment education or training**

**People Stories - Thurrock OnTrack**

When Ed joined OnTrack he was unemployed and living at home. He found his situation very hard, he wanted a regular income and to move out from home and poverty. He realized he needed help. "I was at a point in my life when I didn't know how to move forward – I had no plan. My confidence was low and this really does prevent you from achieving what you want to do. It's a massive barrier."

He started the OnTrack programme to get the support he needed. He had an idea of what he wanted to do as he had previously worked with young carers and loved it. "I wanted to get a full-time job doing something I loved which is working with families and young people. I needed more experience."

The programme offered him lots of advice and guidance and he was offered a volunteering role supporting other learners at the Inspire Hub. "I helped to support unemployed young people in lessons to ensure they understood the information on the programme. OnTrack really helped him as it gave him experience; he developed his communication skills which was essential to his career goals. He worked with learners and improved his skills at supporting them. He has since gone on to support OnTrack clients with their own employability skills and he is starting his own career as an Employability Tutor.

"I am working with families with low incomes in Grays where I started, so I have come full circle. I have a new group and I'm delivering the support to young people helping them to achieve their work goals and to get on in life." Ed has ambition and he wants to continue to develop himself and teach other subjects and gain more qualifications. "The programme has given me the tools to achieve some of my dreams. It has inspired me to continue to develop and never give up. Because if it I have my own place and a job I love

*Awards at Thurrock Next Top Boss*

# Objective 1C – There will be fewer teenage pregnancies

Key Strategies and actions for achieving this objective

33. There is a comprehensive Teenage Pregnancy Strategy in place and includes a variety of actions which aim to support the reduction of teenage pregnancies:
    - Public Health commission a Sexual Health Service provider (Provide, formerly NELFT) who **support the delivery of Relationships and Sex Education (RSE) in schools.** They do this by offering a comprehensive training programme for school staff. Provide also deliver a variety of assemblies, drop-ins and outreach sessions for students in schools and colleges.
    - Public Health has **increased accessibility of sexual health and contraception clinics through a dedicated young person's clinic** with options for both booked appointments and drop-in sessions.
    - Teenage pregnancy reduction cannot be achieved by the sexual health service alone and requires partnership working. A **sexual health stakeholder group meets quarterly to discuss sexual health in Thurrock**, of which teenage pregnancy plays a key part.
    - Thurrock Careers **deliver individualised and targeted career support to increase participation in employment, education and training** in partnership with the Family Information Service (FIS), WISHES, School Nurses, Children's Centres and youth hostels. They also **deliver the Inspirational Agenda programme to secondary school students, which aim to raise aspirations of girls to progress into a rewarding career**. There is a particular focus on harder to reach areas with generation issues of teenage pregnancies.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

34. Public Health participated in the **Thurrock's Next Top Boss programme** and set Gable Hall students the challenge of designing and producing a video that aims to raise awareness of sexual health services in Thurrock, reduce associated stigma and raise awareness of issues such as pornography, sexting and consent. The entry was awarded runner up in the programme, as demonstrated in the photograph. The video was rolled out and launched at an event held at Gable Hall School in May. An evaluation plan for the video is currently being developed.

35. A successful procurement process was undertaken with **a new provider, Provide Community Interest Company, which started on 1st April 2018.** There are key requirements for Provide to deliver RSE in schools and/or train up the workforce who will be delivering RSE. The new service will also provide greater accessibility to contraception e.g. running the C-Card condom distribution scheme and clinics that

are accessible to young people. The website can be viewed at https://www.thurrocksexualhealthservice.org.uk/. Provide will also be working with their specialist sexual health charitable partner Brook in order to integrate their expertise in delivering targeted services to under 25 year olds. The service will implement Brook's RSE training and support professionals to deliver this. RSE will be integrated into the service to support reduction in teenage pregnancy, STI rates and increase resilience in response to Child Sexual Exploitation (CSE) for those in and out of mainstream education. This offer will be rolled out to schools in autumn 2018.

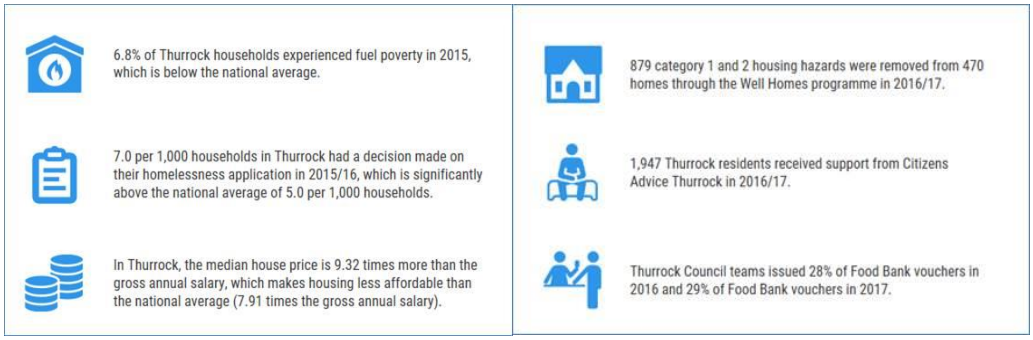
36. Public Health attended the Headteachers Forum in September 2017 to communicate and discuss the upcoming changes to the RSE legislation. The responses were positive and **schools are keen to receive support from the Sexual Health Service in order to deliver high quality RSE to students**. Schools agreed in principle and were keen to receive sexual health training from Provide.

37. Public Health also delivered against a previous commitment and **established a sexual health stakeholder group.** Over the past 12 months three stakeholder meetings have been held. The meetings bring together key stakeholders that work together to improve sexual health and wellbeing outcomes in Thurrock. The group meets quarterly and shares best practice, knowledge and intelligence.

38. In November 2017 Public Health wrote to all Thurrock secondary schools in conjunction with Children's Services with an offer of a **programme developed specifically for teenage boys aimed at reducing teenage pregnancies**. This programme was developed as a result of engagement with young people where they identified difficulties relating to sexual health information as they felt it was tailored more to females. Unfortunately no schools accepted this offer, mainly due to lack of time and competing priorities. It is hoped that schools will take up the offer of support from the sexual health service in 2018/19 with the upcoming legislation whereby RSE will be mandatory in all secondary schools from September 2019.

Progress against our targets

- Conception data is provided by the Office of National Statistics (ONS). The Thurrock Council Teenage Pregnancy Strategy set an ambition to reduce the number of under 18 conceptions year on year with the aim to achieve fewer than 20 conceptions per 1,000 females by 2021.
- The **under 18 conception rate in Thurrock continues to decline year on year and 2018 target for 2016 conceptions (23.2 per 1,000) was achieved**. The 2016 under 18 conception rate in Thurrock was 18.4 per 1,000 females aged 15-17 years, lower than the 2016 England rate of 18.8. **This rate is equivalent to 54 conceptions locally, of which 64.8% resulted in abortions.** This is **higher than the England abortion rate** of 51.8%, indicating there is **more work to be done** in preventing unwanted conceptions. It is to be noted that the significant reduction in conception rates between 2015 and 2016 was also partially attributable to the recent publication of ONS revised population statistics. This will be reviewed further in the upcoming refresh of the Teenage Pregnancy Strategy.




## Objective 1D – Fewer children and adults will live in poverty

Key Strategies and actions for achieving this objective

39. Tackling poverty across the Borough requires multi-faced action that impacts on different elements of people's lives. Some of the action being taken to reduce poverty within Thurrock is set out within Objective 1B, more Thurrock residents in employment, education or training, at page 17 of this report

40. Children Centres are **creating opportunities for families and expectant parents** to ensure they have the skills to increase household income and move out of poverty.

41. **Pathways into employment** provides retired skilled workers acting as volunteers for development clubs and as mentors.

42. Use of **Pupil Premium** to provide family learning and other home-based support for children's learning. The pupil premium is additional funding given to schools so that they can support their disadvantaged pupils and close the attainment gap between them and their peers.

43. **OnTrack** is a programme to help young people in Thurrock who are unemployed and not in education or training. You can benefit from OnTrack if you are:
    - aged 16 to 29 years-old
    - living in Thurrock
    - unemployed

44. Since 2012, the council has worked with local communities and Thurrock CVS to develop **six community hubs** in South Ockendon, Purfleet, Aveley, Tilbury, Chadwell St Mary and Stifford Clays. Hubs provide a local community anchor to residents on a wide range of issues. They are friendly and informal places where residents can access free Wi-Fi and access to PCs, information on local activities and support, and link with a wide range of partners from across many services that arrange local promotion or appointments as necessary. Hubs host the Department of Work and Pensions (DWP) at South Ockendon and Tilbury hub for a targeted cohort of clients. One hub hosts a self-serve library and four hubs are co-located in libraries where a number of services and events seek to engage families and young children in learning and reading through baby rhyme time, Treasure packs for 0 – 3 years and the annual Reading Challenge over the summer period. The sixth hub has supported a youth club to be explored in the area with support from youth services.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

45. OnTrack has **engaged more than 750 young people to receive personalised training and skills**. Of these, more than half have received accredited training and a large proportion have secured employment (sustained for more than 6 months).

46. A **new Brighter Futures service has been commissioned** (https://www.nelft.nhs.uk/brighterfutures) which unites services for families in need of help and support. Within this structure there will be key strands of service delivery; primarily 'Healthy Families' (0-19 public health services), Children's Centres and a newly formed team within Children's Services that is known as the 'Prevention and Support Service'. This team brings together the existing Early Offer of Help Team and the Troubled Families Team and incorporates key partners across services to support families at an earlier point through a model of direct work, supported by commissioned services. One of their key outcomes is to support a reduction in the gap between the most and least deprived groups by supporting child development and school readiness.

47. In 2017/18, **over 7,000 DWP appointments were provided at community hubs**, saving clients time and money, by not travelling into Grays. Of these appointments **163 individuals were signed off back into work.** Hubs play a vital role in helping to support all families but especially those who may be experiencing child poverty. https://www.thurrock.gov.uk/community-hubs-and-community-centres/supporting-local-people

48. The Well Homes programme has been targeted towards older people with long term conditions who are in receipt of low incomes. Last year the **Well Homes programme completed over 400 assessments in Thurrock, supporting these residents to access relevant grants** to further improve their homes.

49. In March 2016, **Children's Services and Housing developed a strategic partnership to pilot a council owned House of Multiple Occupation**. The purpose of the pilot was to address some of the key barriers young people face in finding suitable accommodation, at an affordable rate, whilst receiving support to enable sustainable employment and independent living. At full occupancy, from day one, the first HMO generated income to Thurrock Council that was reinvested in another property to create a second HMO for the pilot. **To date, nine people all employed or in full time education who had had unstable living arrangements have benefitted from the accommodation.** We are working on Headstart Housing to identify/modify four additional properties to provide HMO accommodation for a further 12-16 young people. In doing so, we anticipate generating further income to Thurrock Council and making significant savings on accommodation costs. We will seek to increase LA HMO stock by a further 2 properties per annum, providing accommodation for a further 6-12 tenants per annum, providing accommodation for between 18-36 tenants, by 2021.

50. The Fairness Commission made a number of recommendations following consultation and engagement with local residents, businesses and public agencies. Some of these have since developed, for example, the introduction of **Give it For Thurrock** – a local giving initiative to support groups and projects across Thurrock to improve the health and wellbeing of residents and communities. The Residents Survey was also introduced with the results used to inform the key performance indicators (KPIs) for the council helping to ensure we reflect the issues of most concern to residents as well as providing evidence to help with policy direction and decision making. Priorities identified by the Fairness Commission further inform the

objectives of the council's current draft Single Equality Scheme and Corporate Equality Framework (2018-2022).

Progress against our targets

- In 2015, **17.4 % of children are living in poverty (0-19 years) - exceeding our target of 19.28%**. This has decreased since 2006 from 20.1% however this is above both the East of England average (13.6%) and England (16.6%).

- 2016 saw a **reduction of 1200 households, with dependent children in workless homes**, compared to 2015.

# GOAL TWO – A HEALTHIER ENVIRONMENT

**We want to achieve places and communities that keep people well and independent**

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- Objective 2A. Create spaces that make it easy to exercise and be active
- Amended from Create outdoor spaces that make it easy to exercise and to be active
- Objective 2B. More homes will be built that keep people well and independent
- Objective 2C. Communities will be stronger and better connected
- Objective 2D. Air quality will be improved

- **Why this goal is a key part of the** Health **and Wellbeing Strategy**

We want to keep people well for as long as possible. For this to happen, we need communities that are strong and inclusive. We also need the way Thurrock's neighbourhoods are designed and built to make it easy for people to lead active and healthy lives.

If children and adults are to be more active we need to create environments that encourage them to be more active – either at school or where they live. We also need to ensure that public space is attractive and that people feel safe when they use it.

Much has already been done to empower local communities to be strong and inclusive. The Stronger Together partnership is a ground-breaking initiative which promotes community activities that strengthen connections between people. It also encourages people to have a greater say in what happens in their neighbourhood, taking control over the decisions that affect them. We want to build on that work to build strong, well-connected communities.

## Objective 2A – Create spaces that make it easier to exercise and be active

Key Strategies and actions for achieving this objective

51. It should be noted that action being taken to create spaces that make it easier to exercise and be active is also included as part of reducing obesity and increasing the number of people in Thurrock who are a healthy weight, objective 5A of the Health and Wellbeing Strategy, set out in more detail at page 45.

52. The following strategies and supporting action plans have been developed to ensure that the physical infrastructure, aligned to the growth of the borough, is planned and in place to create the spaces that make it easier for residents to exercise and be active:
    - **Active Places Strategy** (Indoor Sports and Leisure Facilities / Playing Pitches / Open Spaces and Play Facilities / Active Travel Routes)
    - **Parks and Play Improvement Programme**
    - **Local consultation on Local Green Spaces** as part of Local Plan

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

53. Strong **relationships have been developed with Sport England** and other key partners with regard to supporting and resourcing elements of strategy implementation.

54. The **Active Travel strategy** has been finalised. All Active Place Strategy components are ready for formal approval linked to the Local Plan.

55. The **assessment of open space and play has been used to develop a prioritised parks improvement programing** which factors in: supply; demand; and health and deprivation indicators.

Progress against our targets

56. Increasing local population physical activity levels over relatively short time period is incredibly difficult as this is affected by a whole range of interrelated lifestyle, cultural and societal factors that take many years to change. These indicators therefore are unlikely to show significant increases year on year. However, a baseline has been established for both adult and children's participation for 2017/18 which will show a general direction of travel. The children's indicator is comes from the percentage of children in Years 6, 8 and 10 who state they take part in 1 hour of physical activity 6-7 times per week and it's self-reported on an annual bases

57. Improvements to the physical infrastructure are more easily measured however these will take some time to completion.

58. The resident survey has been used to set a baseline for establishing how easy resident think that the Council make it to exercise in parks and open spaces. The timing of the next survey has yet to be decided and therefore future reporting will occur as this information becomes available.

59. A parks improvement programme has been implemented with progress being made with three parks during 2017/18.
    - There were **3 Parks and Play sites improvement projects** to encourage greater use during 2017/18.
    - **52 % of adults aged 19+ are physical active** achieving our target of 52%.
    - Latest information shows that **39% of residents are fairly or very happy with council owned sports and leisure facilities**, as reported in the Thurrock Residents Survey in 2016.
    - The residents survey also showed that **69% of residents think that the Council make it easy to exercise in parks and open spaces** , achieving our trajectory target
    - **20.2% of children reported that they take part in 1 hour physical activity, 6-7 times per week** in response to the Brighter Futures Survey. This is a new indicator approved by the Health and Wellbeing Board in November 2017


# Objective 2B – More homes will be built that keep people well and independent

Key Strategies and actions for achieving this objective

60. There is a well evidenced link between the quality of housing and the occupant's health. The location, design, tenure mix and requirement for supporting infrastructure are key elements in achieving well balanced communities that support health communities, and provide the opportunity for the development of specialist accommodation to meet the defined health and social care needs of some of the most vulnerable in our community. The following actions are our response to meeting that agenda.
    - Development of Thurrock's Local Plan
    - **HAPPI Scheme Tilbury** providing greater choice of council owned accommodation for people aged 65+
    - Development of **Specialist Housing Schemes**
    - Development of a **21st Century Residential Care Facility**
    - Development of a **Right Size scheme** enabling older occupiers to downsize into sheltered accommodation while leasing their property to the Council
    - Expansion of the **Housing Support Scheme** to support a total of 9 people at any one time
    - Ensure **all Major Planning Applications are considered by the Housing and Planning Advisory Group** and feedback is provided on the Planning Consultation Portal

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

61. Use of **grant money to refurbish and re-let 8 ex-sheltered housing flats** as supported housing accommodation for learning disabled adults.

**62.** Plans to develop Approval by Cabinet to **develop a 21st Century residential care facility** were approved by Cabinet

63. Development of and consultation on Thurrock's Local Plan.

Progress against our targets

- One person has expressed an interest in joining the Right Size scheme and they will be assessed for suitability. This is a new KPI, agreed by the Health and Wellbeing Board in November 2017
- The number of people who are **supported by the Housing First Scheme for the period of 2017-18 is 6**. This is a new KPI, agreed by the Health and Wellbeing Board in November 2017.


Stronger Together logo

# Objective 2C – Build strong, well connected communities

Key Strategies and actions for achieving this objective

64. Thurrock's **Stronger Together Partnership** promotes local, community activities that strengthen the connections between people. The Partnership also encourages local people to have a greater say in what happens in their neighbourhood and to take control over where they live and the decisions that affect them. Strong and resilient communities are key to achieving wellbeing.

65. Continued **development and implementation of initiatives that strengthen communities** including: Timebanking, supporting volunteering, community hubs. Support the Partnership's Small Sparks Grant enabling local communities to undertake small projects of no more than £250 monetary value. To date £15,362 has been awarded through the grant programme.

66. Expansion of the **Social Prescribing** initiative for members of the public who do not require medical support and can be signposted to other activities to support them. The Service is open to all patients aged 18+ who present to their GP with issues that have a non-clinical underlying cause.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

67. Successful bid for the National Lottery and DCMS Place-Based Social Action Funding Programme

68. Expansion of the Social Prescribing initiative to **21** practices in Thurrock

69. In 2017/18 27,242 Timebanking hours were banked, with over 4,679 hours donated.

70. Community **Hubs expanded with a new sixth Hub** developing in Aveley

71. **Local Area Coordination service expanded to 14** LACs

72. The **number of micro enterprises established has increased** and the confirmation of a post to continue the ongoing development and establishment of micro enterprises

Progress against our targets

- The number of **micro enterprises operating in Thurrock is** 55, exceeding the trajectory target of 25.
- The **quarterly target of volunteering hours** banked through the time bank was set at 3,000 hours; this has been vastly exceeded with an average of 6,000 hours per quarter.

# Objective 2D – Improve Air Quality in Thurrock

Key Strategies and actions for achieving this objective

73. Thurrock Council **developed and published its Air Quality and Health Strategy** in December 2017 following approval by Council. The Strategy builds on a range of preparatory work to identify actions and measures which can be undertaken to improve air quality either across the Borough or within specific Air Quality Management Areas. Thurrock has declared 18 AQMA's, which have been declared on annual average exceedance of Nitrogen Dioxide, and four which have been declared for exceedance of the Daily Mean Objective for Particulate Matter, specifically PM10. Each AQMA is tightly defined, based on existing data, and detailed modelling and simulation. While a significant proportion of the contributing source of poor air quality within AQMA's is due to external sources, approximately 50% is in many cases attributed to Transport emissions.

74. The Air Quality and Health Strategy sets out four key policies in addressing poor air quality, including the **reduction in transport emissions, tackling health inequalities, the opportunity to develop a clean air zone, and influencing future development and planning to reduce emissions**. The strategy also sets out an action plan to prioritise the revocation of the AQMA's most easily influenced by the measures. Each measure is attributed a target level with which to reduce the source emissions.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

75. Increased **awareness of the impact of idling vehicles on the health of children outside of schools** – Woodside Academy and Purfleet Primary;

76. Establishment of an **Air Quality Officers Group** to help implement actions;

77. Installation of **additional air quality monitoring stations**, by use of passive NO2 diffusion tubes across the Borough to review baseline AQ levels along and in the vicinity of the proposed Lower Thames Crossing route

Progress against our targets

78. Thurrock Council is continually monitoring and reviewing our 18 Air Quality Management Areas to identify improvements and opportunities for revocations. Overall, **there is a continuing trend that air quality in Thurrock is improving**, however in order to declare the revocation of an AQMA, there is a need to ensure the data across multiple years shows levels significantly below the recognised UK and EU threshold levels. This is especially true where new and additional monitoring diffusion tubes have been added at existing AQMA's.

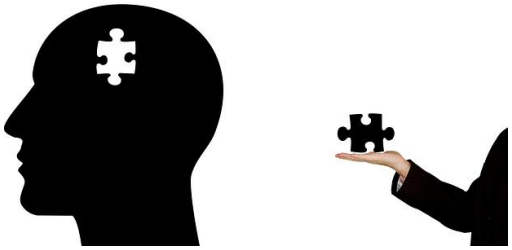
79. Thurrock Council will continue to monitor AQMA's and deliver actions to reduce poor air quality in defined areas, and implement revocations where possible. Where AQMA's are close to or just below threshold levels, Thurrock Council may choose to not revoke an AQMA, despite it being in compliance, in order to maintain actions to improve air quality further. However the Council will consider reducing the size of the AQMA, enabling challenging actions to be undertaken in a targeted approach.

80. The revocation of an AQMA is not necessarily a simple process, and requires a large evidence base and agreement from DEFRA, and therefore the Council will seek to make its application closer to the 2021 deadline. This will likely see a significant reduction in AQMA's at one time, rather than a gradual reduction. However, the Council submits annually to Defra the level of air quality within its AQMA's against threshold levels, which can be found in the Thurrock 2017 Air Quality Annual Status Report[1].

81. There **were 18 Air Quality Management Areas in 2016.** The agreed 2021 target is 8. Currently it is projected applications to Defra for revocation will take place in 2020/2021.

[1]Thurrock 2017 Air Quality Annual Status Report - https://www.thurrock.gov.uk/sites/default/files/assets/documents/air-quality-report-2017.pdf

# GOAL THREE
# BETTER EMOTIONAL HEALTH AND WELLBEING



**We want to strengthen mental health and emotional wellbeing**

The following four objectives have been identified as part of defining this goal and describing what achieving it looks like:

- Objective 3A. Parents will be given the support they need when they need it
- Objective 3B. Children will have good emotional health and wellbeing
- Objective 3C. Fewer people will feel socially isolated or lonely
- Objective 3D. Identification and treatment of mental ill-health will be improved, particularly for those at greatest risk. Amended from identification and treatment of depression will be improved, particularly for those at greatest risk

**Why this goal is an important part of the Health and Wellbeing Strategy**

We know that at least one in four people will experience a mental health problem at some point in their life and that one in six adults will have a mental health problem at any one time. We also know that half of those with lifetime mental health problems first experience symptoms by the age of 14. Depression is the most common mental health problem making it a priority for us.

There are a number of things we can do to lessen the chance of poor mental health from occurring, or to prevent it from worsening. This includes ensuring that parents receive good support when they need it and identifying problems as early as possible. Tackling bullying is also important because it not only affects the mental health of children but can have long-term effects stretching into adulthood.

For people who do require long term medical care, we want to ensure that people are identified before they reach crisis point and that the service they receive is of high quality and tailored to the individual. People with poor mental health often have poor physical health too, and we must ensure that we consider mental, physical and emotional wellbeing together. We know that within our communities, particularly with Thurrock's older population and those with caring duties, many people will be suffering due to social isolation. Social isolation can have a significant impact on physical health as well as mental and emotional wellbeing. We must give people opportunities to connect.


*Brighter Futures logo*

# Objective 3A – Give parents the support they need

Key Strategies and actions for achieving this objective

82. The **Prevention and Support Service (PASS)** provides early intervention to families to ensure that they receive the right service at the right time to achieve effective outcomes and reduce the demand on statutory Social Work Intervention.

83. The team has now been formed for approximately 1 year and has brought 2 teams together with staff from multiple disciplines, with wide ranging skills and knowledge bases, along with additional staffing and resources from other parts of the council, whose primary roles are that of prevention. This will ensure that children and families will receive the right support at the right time, by professionals with the right skills, knowledge and experience to effect change and prevent the escalation of needBrighter Futures which incorporates and reflects:
    - **0-19 Brighter Futures Healthy Families Service** is an integrated service encompassing Health Visiting, School Health (historically School Nursing), targeted support and a range of health interventions for children, young people and their families.
    - Prevention and support services (PASS, Formerly Early offer of help and troubled families )

84. The Short Breaks Policy makes provision for parents/carers of children and young people who are looked after and/or have a disability, to have respite and support to enable them to continue to care and support their children. The Disabled Children's Short break and Outreach Service is located at both the Sunshine centre, Tilbury and Hannah's Place at Treetops School.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

85. PASS have been **successful in securing funding for 2018/2019 from the Department of Work and Pensions for 2 x Community Support Employment Officers** whose role would be to work with a mixture of residents that are economically inactive or suffering entrenched worklessness.

86. The council has successfully **tendered our Carer's Information Advice and Support Service** which commenced in June 2018. The needs of parent carer's were included within the tender.

87. The Disabled Children's Short break and Outreach Service is currently **accessed by 220 children and their parents and carers.** High levels of satisfaction are reported by children, young people and their families for both aspects of the service.

88. Anecdotal evidence suggests that during the year referred 200 parents to structured parenting programmes,150 victims of domestic abuse and violence to a structured eight week programme, 590 had telephone or face-to-face focused contact and

support, and 35 victims/survivors of sexual violence been referred for support. Many of the service users referred for support for domestic violence and abuse and sexual violence and abuse have been referred onto specialist counselling within those services, enhancing the recovery of their emotional wellbeing and mental health. All programmes work on improving parental capacity with a focus on parents own emotional wellbeing.

89. Over the last year our five main Children's Centres and a number of outreach sites have offered a wide range of support to parents, ensuring the right support is given where needed.

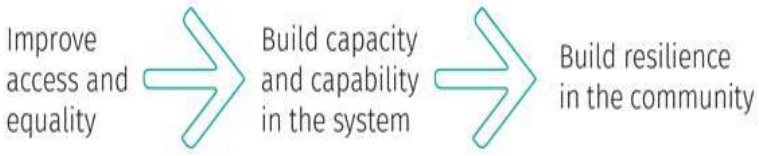
Progress against our targets

90. Future success will be directly measured against outcomes experienced by children, young people and their families. Over the next 3 years we will expect to see that more families are empowered and supported to take control of their lives, and that they are supported in their local communities avoiding the need for statutory intervention. We will measure the outcomes detailed in the Early Help strategy as proxy indicators of success, and we have agreed performance indicators to measure the impact. The figures below demonstrate increased engagement of Thurrock families leading to positive outcomes.
    - **61.6 % of parents achieving successful outcomes from early intervention prevention parenting programmes**.
    - At the of June **2018 there have been 1050 families attached to the Troubled Families Programme** with the target of 2525 families supported by the TF programme when it ceases in March 2020. It is anticipated that 50% of the families will have achieved their outcomes at the end of the programme.
    - Increasing the proportion of children who achieve a 'Good Level of development'1 (GLD was at 75% in 2016) and reducing the gap between the most and least deprived groups by supporting child development and school readiness. Data of September 2017 shows that **the trajectory target of 76% has been achieved and as of April 2018 is at 77%**.

**People Stories – PASS**

Parents (family not open to PASS) attended their son's school stating that they were being evicted for rent arrears on Tuesday 13th March and that they had nowhere to go. School Pastoral Lead contacted PASS for some advice. PASS Team Manager spoke to their housing contact and they advised that eviction will be going ahead unless full amount of arrears is paid in full (£1160.55). Team Manager then spoke to Strategic Lead, who advised that Children's Social Care may be able to pay the arrears to stop the eviction and to prevent the children then becoming involved with the department. It was agreed that the arrears would be paid; parents were invited to Civic offices and informed of the decision. They were advised that arrears would be paid in this instance only and that they would now be required to work with PASS so that they do not find themselves in this situation again. Parents are engaging with PASS and are now making weekly rent payments. The outcomes of this piece of work are:-

- Family did not become homeless (intentionally)
- Children did not have to move schools
- Children were able to remain in their safe and familiar environment
- Limited cost to Children's Social Care
- Parent are now learning to budget and cope with finances




# Objective 3B – Improve children's emotional health and wellbeing

Key Strategies and actions for achieving this objective

91. Partners have been working closely together to transform local services and improve children's emotional health and wellbeing. This is being approached on a Thurrock basis whilst the local transformation of mental health services also includes Essex and Southend. This is reflected in the following key strategies and actions:
    - Open Up; Reach Out our Transformation Plan for the Emotional Wellbeing and Mental Health of Children and Young People 2015-2020.
    - Develop resources for educational settings.
    - Development of school support for anti-bullying.
    - Mental Health Conference and Resource Launch Thurrock, Essex and Southend (November 2017).

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

92. **Mental Health Conference and Resource Launch November 2017**. This event focused on learning and sharing best practice both from a national and local perspective. New resources were launched including "let's Talk"… about self-harm (a management toolkit for educational settings) and new service developments in the Emotional Wellbeing and mental health Service including outreach for schools and an e-portal for mental health resources for schools.

93. Commissioned an **online Counselling Service (Kooth)** which provides a free, safe and anonymous online support for young people. Improved the **planning for young people who are moving from children's to adult mental health services**.

94. **Published Open Up, Reach Out** in year 3 which outlines the achievements so far and plans for the next 2 years. Exchange of best practice via the safeguarding leads forum regarding anti-bullying practice.

Progress against our targets

95. The key performance indicators were approved by the Health and Wellbeing Board in November 2018. Each of the KPIs are linked to outcomes of responses submitted by **children completing the Brighter Futures Survey which was undertaken by 8 primary schools and 4 secondary schools in 2017.** The measures below provide baseline information and enable us to consider targets for future improvement.
    - **57.7% of children and young people report that they are able to cope with the emotional difficulties they experience**.
    - **53.5% of children and young people reporting that they know how to seek help when experiencing difficulties** with emotional health and wellbeing.
    - **17.6% of children reporting being bullied** in the last 12 months**.**

Local Area Coordination Team

## Objective 3C – Reduce social isolation and loneliness

Key Strategies and actions for achieving this objective

96. There is a proven link between loneliness and poor health. Our **Health and Care Transformation Programme** aims to ensure that we focus on developing a system that supports people to achieve the outcomes that are most important to them – regardless of their condition. The Programme also aims to shift the system towards prevention and early intervention. The **Stronger Together Thurrock programme** is a key element of this work (See Objective 2C, page 28 of this report).

    - Further development of the Stronger Together Programme – including expansion of Local Area Coordination, Timebanking, Social Prescribing, Community Hubs
    - Development of **service pilots** that enable a community-led approach – Wellbeing Teams and Care and Assessment Team
    - Development of the **New Models of Care system redesign Programme** – reimagining health and care around 'place'

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

97. Time banking levels at over **27000 hours of support, contributed by volunteers**

98. **Expansion of Local Area Coordination** with 14 LACs now in place

99. Establishment of a **New Models of Care Programme** to redesign the health and social care system around 'place' – initially focusing on Tilbury and Chadwell.

Progress against our targets

- The number of **people who are supported by a Local Area Coordinator is 841** exceeding the trajectory target of 576.
- **9.3 % of people have self-reported that their wellbeing happiness score is low,** as evidenced from for 2015/16. This has exceeded the 2017 trajectory target of 10.16% has been exceeded
- **29.67% of carers reported that they had as much social connection as they would like** when responding to the personal social services survey of adult carers (SAC). This is a new KPI agreed by the Health and Wellbeing Board in November 2017.

**People Stories – an example of practice, Local Area Coordination**

I was introduced to H by a local elected councillor, who was concerned about H's situation. H had been evicted from a flat, and was sofa surfing and sleeping on the streets. H had been diagnosed with Mental Health conditions, and had a drug and alcohol addiction. Over a number of months I built a good trusting relationship with H. H engaging with me, which H had not done previously.

H identified that what was most important to them was to get a secure home that they could then focus on their Mental Health, and moving forward with their life. I worked with H to support in challenging the eviction due to being a vulnerable adult, and H was placed in a hostel. H then started to engage with Inclusion Thurrock about the impact of the drugs and alcohol on their life.

H also engaged with the Prince's Trust programme, and was successful in bidding on a flat. H had no furniture, so working with the Housing department, H was provided with basic furniture. H then said that the next step could now be taken in their life.

H recently said **"thank you for everything honestly I wouldn't of done anything of it if it wasn't for you motivating me so thank you".**


# Objective 3D – Improve the identification and treatment of mental ill-health, particularly in high risk groups

Key Strategies and actions for achieving this objective

100. The **development of a Mental Health JSNA** has given a positive opportunity to have a much clearer view of mental health challenges in Thurrock.

- **Adult Mental Health Joint Strategic Needs Assessment**
- **Southend, Essex and Thurrock Mental Health Strategy** - local plan
- **Southend Essex and Thurrock Dementia Strategy** - local plan
- **Inclusion Thurrock** providing the IAPT Services
- The **development of the Recovery College**
- Continued **funding for the world of work with a focus on mental health**
- **Thurrock Mind remain a strong voice delivering support information and advice**
- The **Alzheimer's Society receives financial support to provide emotional & practical support to people diagnosed with Dementia,** ensure independence and Living Well with Dementia.
- **Depression screening by social workers** in adult social care
- Development of a **working group to address the development of a pathway for people experiencing personality disorder**

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

101. Significant milestones and developments have been achieved and delivered in year 2 of the Strategy.

- The **IAPT service has continued to perform well on the national targets** and supported people by improving access to treatment, increased choice and user satisfaction, promoted recovery and resilience building.
- **The launch of the Integrated IAPT service after a successful bid for national Transformation funding** has seen the service extend dedicated support for people with LTCs to complement a previously commissioned community service.
- The **service was also successful in a RightCare funding bid to develop and implement a dependency reducing service offering a menu of interventions to support people to reduce or wean off altogether** the dosage and types of high end pain management medications e.g. opioids, they may be addicted to without any therapeutic value.
- The **Recovery College continues to expand its' portfolio of courses** delivered with extraordinary outcomes as more people are supported to maintain recovery, achieve independence and build their resilience.

- The **Recovery College is engaged in the delivery of Family Interventions** and Carer Focused Education for the Early Intervention in Psychosis (EIP) service, supporting the development of the Individual Placement Support (IPS) employment service offer and has developed a Recovery Coaching network and training programme with Visions Inclusion
- The Early Intervention in Psychosis (EIP) service has been redesigned to ensure full delivery of the new Standard so that people identified with a First Episode of Psychosis have access to a NICE Concordat treatment pathway within 2 weeks of referral. The new service will have a multi-provider delivery approach via a MOU between EPUT and SSSFT-Inclusion, a national first.
- The **Shared Care Protocol (a collaborative arrangement between consultants and GPs) has seen more than 190 people transfer their care safely from secondary care into primary care**. The Protocol is currently being revised to formalise the arrangement between consultants and GPs to ensure increased uptake of physical health checks and subsequent interventions for people on SMI registers.
- **Investment has been increased by the CCG to continue the development and attaining of the IPS fidelity standard**. IPS is an evidence-based approach to providing employment support for people experiencing serious mental health problems, shown to be twice as effective as vocational rehabilitation, and associated with reduced utilisation of other services, including use of inpatient admissions.
- A **commissioner led multi-agency project group has been set up** to develop an appropriate service offer for people presenting with complex needs particularly Personality Disorders to ensure a joined up approach to providing holistic support.

<u>Progress against our targets</u>

102. The CCG needs to provide assurance on a number of national constitutional standards and in 2017-18:
    - The **IAPT access target was set at 16.8% and the service delivered 16.6%** based on local data
    - The Recovery Target was set at 50% and the service delivered 52.2%
    - The Waiting Times Standard is 75% at 6 weeks and 95% at 18 weeks with the service delivering 99.4% and 100% respectively.

- The % of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool. This is a new tool and key performance indicator and was approved by the Health and Wellbeing Board in November 2017. Baselines for indicators within the LTC will be established in 2018 and will inform future targets.

# GOAL FOUR
# QUALITY CARE CENTRED AROUND THE PERSON

**We want to remodel health and care services so they are more joined up and focus on preventing, reducing and delaying the need for care and support.**

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- Objective 4A. Four new Integrated medical centres will be built with GPs, nurses, mental health services, wellbeing programmes, community hubs and outpatient clinics under one roof
- Objective 4B. Care will be organised around the individual
- Objective 4C. People will feel in control of their care
- Objective 4D. High quality GP and hospital care will be available to Thurrock residents when they need it

**Why this goal is an important part of the Health and Wellbeing Strategy**

There will always be times when people need treatment or care from GPs, hospitals, social care or other services. When they do, we want to ensure that services in Thurrock are joined up and organised around people's needs rather than the needs of organisations. When people are passed from one organisation to another to receive different services they often don't get the best package of care and valuable resources are wasted. That's why we have a vision to create four Integrated Healthy Living Centres in Thurrock which will provide a whole range of health and care services under one roof. This is part of providing holistic solutions, which go beyond treating conditions to supporting people.

Hospitals are under huge pressure but much of that could be avoided if we get better at providing support at an early stage, to stop things progressing. So, instead of waiting for people to develop serious illnesses before we treat them, we want services to act at an early stage to prevent, reduce and delay the need for care and support. When people use health and care services in Thurrock we want to make sure that healthcare is easy to access and that they get the best possible treatment.

As far as possible, people should be in control of their own care. That is especially important for people who have long term conditions and we have already begun to develop some of these approaches, but we must work together and with communities to take this further.

# Objective 4A – Create four integrated medical centres (IMCs)

Key Strategies and actions for achieving this objective

103. All partners have agreed, subject to the consultation and decision on the future location of clinical services currently provided within Orsett Hospital:
    - To develop a clinical specification and integrated workforce model, based on the principles contained in **'For Thurrock in Thurrock', and the Mid and South Essex STP,** including a clear service aim that specifies which services would be provided from each IMC
    - That the **clinical specification and workforce model will have a clear aim of making care more local and of better quality**, as outlined in the primary care strategy, and of reducing avoidable demand on hospital and residential care services.
    - That services provided across the four proposed IMCs would include (although may not be limited to nor include on every site) an enhanced GP and other primary care service offer; hospital services including diagnostics and outpatient clinics; community and mental health care services; social care services; health improvement services, and: services that address the wider determinants of health such as employment and housing advice
    - That any new IMCs will be constructed to a size that is "future proof" and that takes into account the predicted population growth within Thurrock and the increased demand for health and care services that will result from this, as defined by the Thurrock Public Health Team.

- In January**, oversight of the IMC programme was assumed by the Thurrock Integrated Care Alliance**, representing all partners and the programme is reviewed at its monthly meeting

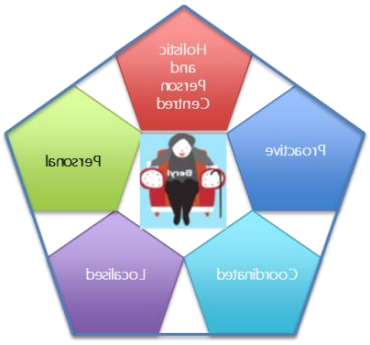
Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

104. During this period, **schedules of accommodation for the IMCs at Tilbury and Purfleet have been agreed, with advanced design work completed for the Tilbury site**, and agreement reached with PCRL for the design for Purfleet to commence in the near future.

105. Amended **planning consent for the Corringham IMC is awaited** to allow it to operate 7 days per week and for extended hours and plans are also being made for the investment in Thurrock Hospital in Grays which will be the site of the 4th IMC.

Progress against our targets

- **Four localities have been identified for Integrated Medical Centres**, achieving the key performance indicator of identifying all four localities in 2017.
- Our target is to develop business cases for all four IMCs during 2018
- Our target is for 4 IMCs to be operational in 2020




# Objective 4B – When services are required they are organised around the individual

Key Strategies and actions for achieving this objective

106. **Better Care Together Thurrock is a product of the wider Strategy - For Thurrock in Thurrock** – which, following consultation provided feedback on the principles behind the strategy of working together, helping people to stay well and take responsibility for their health. This began in 2016, and a further consultation was undertaken in 2017, thousands fed back with support for the principles.

107. **Better Care Together Thurrock is an Alliance of health, social care and voluntary sector agencies** that working together as one will provide a solution for health and care needs. Using the electronic frailty index (eFI) to identify need along with face-to-face assessment through multidisciplinary teams (MDTs) a comprehensive care and escalation plan is coordinated by a dedicated member of the team.

108. Better Care Together Thurrock is overseen by the **Thurrock Integrated Care Alliance.** The principles behind this alliance of agencies and healthcare professionals are to design an integrated way of working to provide services and solutions that wrap around the person. By working more closely together we will improve communication between agencies and be able to offer a multidisciplinary package of support.

Key achievements

109. We have been working across partnership agencies to design and create the Better Care Together Thurrock programme, set out above.

110. We have **successfully developed social prescribers**, which empower patients whose ill health is caused by other problems such as abuse, debt or housing. Once a social issue has been resolved often the person makes fewer visits to their GP. Over 3,900 patients have benefited from a new way of working where a walk-in, book on the day GP has been made available in the minor injuries unit in Thurrock (data from 21 Dec 17-29 May 18).

111. The number of **Learning Disability (LD) health checks undertaken has increased considerably**. In 2015 44% of LD healthchecks were undertaken. This has increased to 77% in 2018, barriers to take up were identified and a novel solution was found with Thurrock's extended access health hubs and GPs.

Progress against our targets

- A contract is in place with a third party organisation (Mede Analytics) intending to link primary care, secondary care, community, social care and mental health records together on NHS number.

- Adult Social Care data and an extract of inpatient data were successfully linked via this system in phase 1 of the programme late in 2017, and work is now underway to include the wider datasets. It is envisaged that this summer will see some GP practice data, Adult Social Care data, hospital data and IAPT data linked together, enabling commissioners to see where patients are known to different services and understand flows through the wider health and care system.


# Objective 4C – Put people in control of their own care

Key Strategies and actions for achieving this objective

112. The focus of this objective is to support individuals to have increased choice and control over their own lives. Supporting the social care market to become more diverse in turn supports an increase in options for people who require support. New and innovate ways of delivering support continue to be at the fore front of the transformation of adult social care. The support options and services listed below are increasing choice:

- **Living Well @ Home**
- **Advocacy Service**
- **Personal Budgets including Direct Payments and Individual Service Funds**
- **Transforming Care for people with learning disabilities**
- **Shared Lives Service**
- **Well Being Teams**
- **Micro Enterprises**
- **Local Area Co-ordinators**

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

113. Since the last annual report the **Living Well @ Home contract has been awarded supporting care in people's own homes to be delivered more locally**, a successful pilot of individual services funds has been concluded and this has supported the development of an accredited list of providers delivering day opportunities for people with learning disabilities and Shared Lives has been introduced as an option for people to be supported within a family home.

114. **Micro Enterprises have grown extensively in Thurrock** offering small individual providers supporting people locally with everything from meals, reducing social isolation to gardening and handy person services. Local Area Co-ordinations continues to thrive and be the first point of contact for communities offering information support and advice which supports greater choice for individuals. Currently we are planning the introduction of Well Being Teams, a focused team ensuring that the person is far more in control of their own support.

Progress against our targets

- **74% of people have reported receiving self-directed support**, not achieving our target of 76.24%. While not achieving our target an increase of self-directed support is being seen when current performance is compared against our baseline of 70.3%.


# Objective 4D – Provide high quality hospital and GP care to Thurrock

Key Strategies and actions for achieving this objective

115. GP **practices are supported to improve CQC inspection ratings** by way of regular practice visits and support with development of policies processes and governance arrangements. **4 Hubs have been extended over the weekend** to support out of hours provision

116. The **Primary Care Strategy** which includes workforce planning and development has been published.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

117. **Weekend hubs have now been extended to provide 7 day out of hours access** for primary care appointments (GP, nurse, pharmacists, physiotherapists and mental health therapists) covering 100% of Thurrock population.

118. **None of the GP practices in Thurrock are now in special measures**.

Progress against our targets

- **71% of GP practices have a CQC rating of at least "good''** exceeding the trajectory target of 40%. Overall **CQC Rating of good achieved for BTUH**.
- **77% of patients report having a good experience of GP services**, not achieving the trajectory target of 81%. Part of the reason could be due to various primary care procurements that are ongoing which may have compromised on the satisfaction rate.
- As of February 2018, **83.3% patients attending A&E spent four hours or less in A&E from arrival to transfer, admission or discharge**. The trajectory target of 91.88% has not been achieved. There has been a decline in 4 hour wait targets since August 2017 which can to some degree be explained by the monthly increase in activity during the same period. The system is also recovering from significant winter pressures experienced by A&E.
- The overall CQC rating – **NELFT of good or working towards good has not been achieved with a rating of requires improvement being provided**.
- The overall CQC Rating - East of England Ambulance Service of good or working towards good has not been achieved with a rating of requires improvement being provided.
- The number of GPs per 1,000 patients in all four CCG localities and the number of nurses per 1,000 patients in all four localities. This has been a national challenge and in Thurrock this is being addressed by piloting an enhanced primary care model within Chadwell and Tilbury locality. **The model is expected to be compliant by Oct 2018 and is expected to improve GP to patient ratio significantly.** Based on the outcome, this model will be rolled out in the other 3 localities.

# GOAL FIVE – HEALTHIER FOR LONGER

**We want to reduce avoidable ill-health and death**

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- A greater proportion of our population will be a healthy weight
- Fewer people in Thurrock will smoke
- The identification and early treatment of long term conditions such as diabetes or high blood pressure will be significantly improved
- More cancers will be prevented, identified early and treated better

**Why this goal is a key element of the Health and Wellbeing Strategy**

Thousands of us will be ill or die each year from diseases which are preventable. Promoting healthy lifestyle choices is vital. Smoking is still by far the most common cause of preventable ill health and death, and obesity is a growing problem which is particularly acute in Thurrock.
These issues affect physical and mental health, they result in shortened lives and poorer quality of life, and they put huge strain on families and health services. Tackling these issues is vital, therefore, if we are to improve health and wellbeing in Thurrock.

To do this, we want to help people make healthy choices. For example, help people maintain a healthy weight we want to make it easy to be active, have a healthy diet and provide people with good information on how to live a healthy life.

Cancer is one common reason for ill health and death. Many cancers are avoidable through lifestyle changes but when people do have cancer we want to ensure that it is identified early through screening programmes and treated effectively when it does happen.



# Objective 5A – Reduce obesity / increase the number of people in Thurrock who are a healthy weight

Key Strategies and actions for achieving this objective

119. The activities that have been focused on below, some of which were identified as recommendations within the Thurrock Whole Systems Obesity Joint Strategic Needs Assessment (2017), have been chosen to support the achievement of this objective. They include preventative measures in childhood as a priority, in accordance with the National Child Obesity Strategy published in August 2016, and activities that can help to address inactivity and long term conditions within adults. Making an investment in intervention at an earlier age or stage of obesity has the potential to decrease long-term costs associated with overweight and obesity. Schools were identified as a critical setting for making a positive impact on reducing or preventing obesity, particularly for schools situated in neighbourhoods of high childhood obesity.

- **Whole Systems Obesity JSNA**. Obesity is a complex problem with a large number of different but often interlinked causes. No single measure is likely to be effective on its own in tackling obesity To have any significant impact on obesity levels a collaborative approach is required. The Whole System Obesity JSNA sets out in detail the scale of the problem in Thurrock with some of the contributing factors identified. Recommendations that will help to address the problem and achieve the indicator are suggested within the document.
- **Whole Systems Obesity Strategy**. Utilising the information and recommendation from the Whole System Obesity JSNA the strategy will set out Thurrock's intentions going forward to address this issue. A high level strategic document it will identify key elements to focus on and appendices a delivery framework which will identify stakeholder involvement. Once completed this will be a vital instrument in the achievement of this objective.
- **Active Places Strategy**. The Active Thurrock strategy contains four main strands, these are
    - Indoor Sports and Leisure Facilities Assessment and Strategy
    - Playing Pitch Assessment and Strategy
    - Open Space and Play Areas Assessment and Standards
    - Active Travel Strategy

  Aligned to the local growth agenda the strategy looks at existing provision measuring against quality and type of resource markers and models this against existing and future population requirements. Recommendations are then given in relation to this information. The recommendation within this strategy will enable the development of high quality accessible facilities to meet future needs that will remove barriers and encourage the inactive to become active and assist in achieving this objective

- **National Childhood Obesity Action Plan - Development of Local Plan**. Following on from a previous comprehensive literature review to assess what interventions and prevention activities impact upon healthy weight and physical activity in children and young people in particular and the exploration of any innovative interventions with an emerging evidence base that we could pilot in Thurrock. A Whole Systems Obesity Strategy across the life course will be developed where a local plan will feature elements for Children, Young People and their families.
- **Daily mile implementation across primary schools in Thurrock**. From year 2015 to 2017, we have been promoting the uptake of the Daily Mile in schools. It is likely that fewer schools have been able to participate in the winter months where there has been bad weather and probable this has impacted on the drop in the percentage of schools taking part. The current strategy will be to continue to promote the uptake of the Daily Mile with schools alongside commissioned providers. It will also be important to continue to explore evaluation of the programme to be clear on the impacts of participation for Children's Health and Wellbeing.
- **Revision and review of children's weight management and support as part of Brighter Futures - Healthy Families Service re-procurement**. A project group has been established to look at the development of this part of the Brighter Futures Service. A strategy paper was written to examine the children's recommendations from the Whole Systems Obesity JSNA. The paper scopes opportunities for change in the approach to commissioning; to impact on population child obesity outcomes. A new approach is being piloted with a small number of schools initially. The service will be measured on outcomes at school level, including increasing physical activity, healthy eating and increasing the proportion of children taking up healthy school meals. There will also be an increased focus on active travel to school.
- **Obesity and overweight management incorporated into Long Term Condition Profile Card**. The % of people referred into lifestyle services now incorporated into the GP long term condition profile card. This is updated 3 times per year.

<u>Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)</u>

120. **Successful Developers Event** around healthy developments, active by design which fed into the Town and Country Planning Association (TCPA), Developers and Wellbeing parliamentary report.

121. **Second Health, Wellbeing and planning event building on the learning from the initial event the previous year**. Another good opportunity for building links and partnerships between planning and health colleagues and understanding the complexities around building healthier developments.

122. Completion of a robust and informative **Whole Systems Obesity JSNA** and a series of presentations at various meetings including the Health and Wellbeing board.

123. New **resource around walking and cycling has been identified within Active Travel.** A network of walking and cycling opportunities will be developed aimed initially at our most inactive populations and including the Exercise on Referral service around people with long term conditions.

124. **Re-commissioning of the Exercise on Referral service**. Impulse leisure has been awarded the contract to deliver the Exercise on Referral programme 2018-2020 with an optional 1 year extension. The programme continues to work with patients with identified long term conditions known to improve with physical activity and who are sedentary. The programme is now delivered from the 3 leisure centres across the Borough.

125. Two new **weight management pilots, a community weight management programme and a community physical activity programme have been commissioned** with the aim to improve people's health through adoption of a healthier lifestyle and reduction in weight.

126. A **strategy paper has been developed to follow up on recommendations within the Whole Systems Obesity JSNA** and a change of approach within the Healthy Families service is being piloted. Work will continue with the Place Environment and Communities team in Public Health to impact on a wider Whole Systems Obesity Strategy across the life course where a local plan will feature elements for Children, Young People and their families.

127. As of May 2017**, 50% of primary schools were signed up to and delivering the Daily Mile**. The latest refresh of this data shows that currently (Feb-March 2018) 37% of primary schools are actively taking part in the Daily Mile.

Progress against our targets

128. The targets that were originally set for the adult's overweight or obese and physical activity have been altered due to changes to the indicator methodology. The change occurred due to the use of a new survey method entitled Active Lives and the change in the age denominator from 16+ to 18+ and also now combining obesity and overweight data, which was previously reported against separately. Therefore the original target and trajectory data is not comparable to the current ones so new targets have been set for the upcoming year and remainder of the HWB Strategy.

129. The latest data is showing that the **percentage of Thurrock adults who are overweight or obese is 65.8%** and the percentage of inactive adults is 28.5%. Remaining targets include:

- % of children overweight or obese in year 6. T**he percentage of children in year 6 that are measured as being overweight or obese in year 6 at school was 36.9% for school year 2016/17**. The target for 2017 was to achieve 37% and for 2018 to achieve 36.5%. The next available data for school year 2017/18 will be available in December 2018.
- % of adults who are overweight or obese in Thurrock. Due to new collection methods the data is not comparable to report progress. New targets for a reduction will be 65.3% (reduction of 0.5%) for 2018/19.
- % of adults who are physically inactive in Thurrock. Due to new collection methods the data is not comparable to report progress. New targets for a reduction will be 28% (reduction of 0.5%) for 2018/19

## Objective 5B – Reduce the proportion of people who smoke

Key Strategies and actions for achieving this objective

130. Public Health England (PHE) wants to see a tobacco-free generation by 2025. Despite a continuing decline in smoking rates, nearly 1 in 5 adults still smoke. Smoking causes 17% of all deaths in people aged 35 and over. This is why reducing the proportion of people who smoke is a key priority within Thurrock's Health and Wellbeing Strategy.

131. We have a **multi-faceted approach for reducing the proportion of people who smoke in Thurrock** which includes:

- A **Tobacco Control Strategy** and delivery plan
- A **Tobacco Control Alliance (TCA)** which is a multi-agency group that includes Health, Mental Health, Licensing and Trading Standards. The TCA monitors progress against reducing the prevalence of smoking in Thurrock and progress made against the Tobacco Control Strategy Delivery Plan.
- Work with Essex Partnership University Trust (EPUT) to support them to **implement a smoke free status across residential mental health settings**. We will be working in partnership with BTUH during 2018/19 to support them with achieving smoke free status as set out in the Tobacco control plan for England.
- Working with **Trading Standards to tackle illicit tobacco** across Thurrock
- Targeted delivery of **treatment services to those residents with Long Term Conditions and pregnant women** who smoke
- Working with **VAPE shops to support smokers to quit** tobacco.
- **Thurrock Healthy Lifestyle Service**.
- Preventing young people from becoming smokers via **school based interventions and programmes**. Surveying the number of young people who smoke in Thurrock through the Brighter Futures Survey.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

132. A **reduction in smoking prevalence in Thurrock for Adults**

133. Over **30,000 illicit cigarettes have been seized off the streets** of Thurrock.

134. Supporting **EPUT to achieve a smoke free status in residential settings**

135. The **first VAPE shop has signed up to supporting smokers to quit** tobacco.

136. We reinforced our commitment to this objective by **bringing the smoking cessation service in house**.

Knowing when to stop

137. We commissioned A Stop Smoking in Schools Trial (ASSIST) for 2016-17, intended to be a 3-year cluster controlled programme involving 6 secondary schools and increasing to all 10 secondary schools by year 3 of the programme. ASSIST identifies and trains influential pupils to become peer mentors who promote and record brief interventions designed to deter young people from initiating smoking. However, in early 2017-18 we evaluated the programme's year-1 cost-effectiveness, factored in the dramatic drop in young people's smoking prevalence and concluded that prevention was now more expensive than cure. We therefore decommissioned the programme and diverted attention into testing the reliability of the low young person's smoking prevalence via our Brighter Future's survey. We can then compare these results with the official statistics to inform future commissioning.

Progress against our targets

138. We have seen a reduction of smoking prevalence across all target groups with a small reduction in adult smoking prevalence and have exceeded the target set for pregnant women who smoke.

- There is **currently a 20.8% rate of smoking prevalence in those aged 18+,** which does not achieve the trajectory target of 19.3%. However, the data source for this key performance indicator has changed from the Integrated Household Survey to the Annual Population Survey. This has increased initial smoking prevalence data from 20.3% to 21.3%. While the estimated trajectory target has not been achieved Thurrock has seen a reduction in smoking prevalence in those 18+ from 21.3% to 20.8%.
- **9.0% of mothers are recorded as smoking at the time of delivery**, exceeding the trajectory target of 9.45%.
- **7.4% of Year 10 students that completed the Brighter Futures Survey reported that they had smoked once a month or more**. This is a new indicator approved by the Health and Wellbeing Board in November 2017.

# Objective 5C – Significantly improve the identification and management of long term conditions

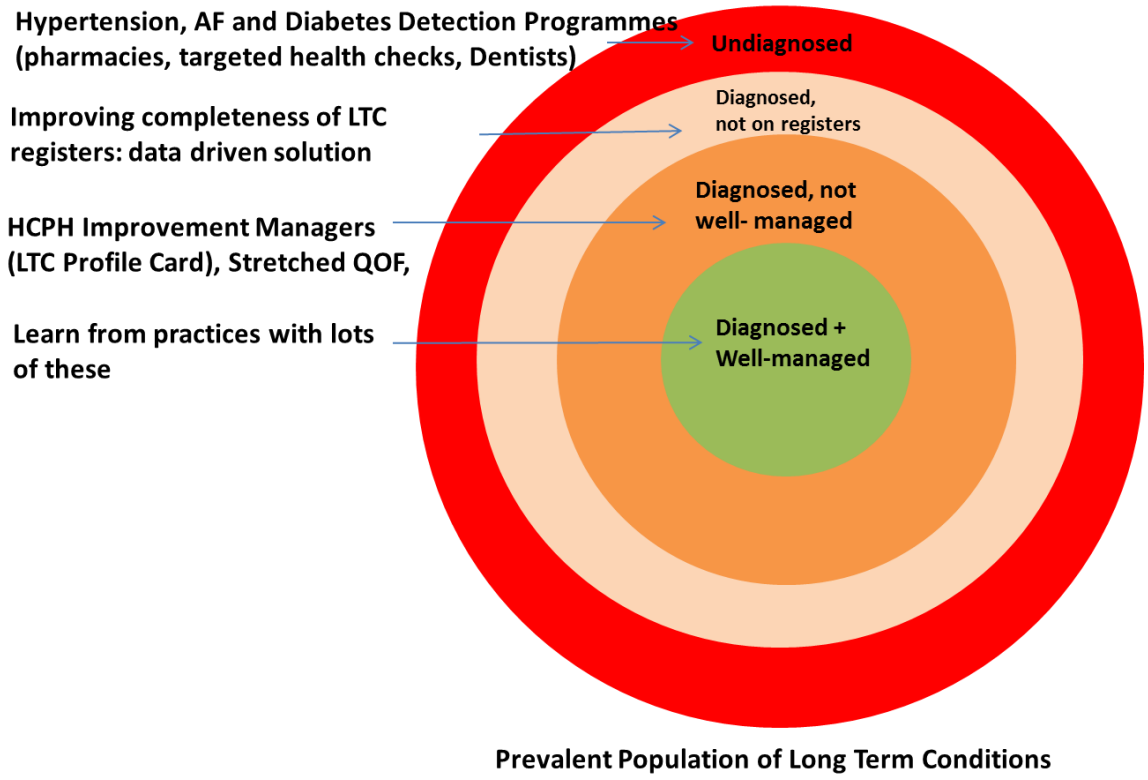
Key Strategies and actions for achieving this objective

139. The purpose of this Objective is to find and ensure effective treatment and management of patients with Long Term Conditions with a view of reducing risks of major health events.

140. Effective management of long term conditions is absolutely vital in order to prevent patients' health, wellbeing and independence from deteriorating and to prevent/delay them being admitted to hospital or requiring social care packages.

141. The management of Long Term Conditions should be done by patients with support from primary and community care services. QOF records contain quality of care information on how patients who are diagnosed with diseases are treated in primary care. It was set up as an incentive system and GP practices get paid for the percentage of their "diseased population" that they offer certain tests, medication reviews and treatments for. The indicators are based on evidence of good quality care for the conditions.

142. However to be able to be supported to manage their conditions they first need a diagnosis. Unfortunately evidence suggests that there are 1,000's of people in the Thurrock population with one or multiple long term conditions who are not currently diagnosed and so are not receiving effective treatment and management.



143. The prevalent population of any given Long Term condition can be split into 4 cohorts:

1) **Those who are diagnosed and their condition is well managed.** This is shown in green on the diagram above. We want to increase the size of this cohort relative to all other cohorts.
2) **Those who are diagnosed but their condition is not well managed.** This is shown in dark orange on the diagram. This group of patients are either exception reported under QOF or are not being managed for other reasons. They are likely to be a more difficult group of patients to engage with and/or get to attend appointments. Practices are likely to have attempted contact but do not have the resources to follow up further.
3) **Those who are diagnosed, or almost diagnosed, are known to the practice but have not been coded correctly.** This is shown in lighter orange on the diagram. Alerts that are active for patients who are on practices disease register will not necessarily be in place for these patients meaning that they are unlikely to be reviewed under QOF guidelines.
4) **Those with no knowledge that they (may) have a condition.** This is our most at risk cohort as if a patient or their GP does not know that they have a condition then no steps, by either will have been taken to reduce the risks of major health events.

144. Our activities support all 4 cohorts by identifying currently non-diagnosed patients and ensuring both existing and newly identified patients are supported to be effectively managed, as well as a systematic clinical coding cleaning programme.

<u>Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)</u>

**Stretched QOF**

- Under QOF practices only get paid to a certain threshold, this is usually around 70-80%, meaning that they are only incentivised to offer evidence based interventions to this % of the diseased cohort.
- Generally practices usually achieve very close to this threshold.
- Our new stretched QOF programme is due to go live in July 2018 and will incentivise practices to achieve higher percentages for specific indicators.
- This programme offers incentives for both diagnoses and management.
- Many of our other programmes will support practices to achieve these stretched thresholds and will result in more funding in Primary Care for this purpose.

**Hypertension and AF screening and detection programmes**

- 180 people received an initial test for hypertension in our Pharmacy detection programme. Unfortunately very few people returned for follow up tests. This will be addressed in the evaluation to identify whether there is anything we could do differently to improve this.
- All 6 community hubs in Thurrock will start to offer free blood pressure and AF checks (self-testing) which began in July 2018.
- GP surgery: 6 surgeries in Tilbury and Chadwell were equipped with self-test BP machines in the waiting area and supported to develop a personalized pathway for both detection and management of hypertension. 134 people were tested in the first two months of the programme of which 29 were known to be hypertensive and used the machine for self-management; After the success seen in the first 2 months, 4 other practices in Thurrock received a BP machine in May and will start testing;

- The healthy lifestyle team are embedding hypertension and AF screening in their smoking cessation pathways as smoking is a high risk factor for cardiovascular disease;
- Due to the continuous promotion of hypertension detection as a priority in Thurrock, the hypertension registers have seen a higher increase than usual with 730 new diagnoses in the first 3 quarters of 2017/18.
- In addition funding has been agreed and arrangements made for practices across Thurrock to be offered a CVD up-skilling course which will support them to effectively diagnose and support patients to manage CVD long term conditions.

**Diabetes Screening and Detection programmes**

- 3 Dental practices totalling 4 dentists are piloting a screening programme where patients who indicate moderate to high risk on a risk score questionnaire or coupled with periodontal disease (gum disease) are tested, using HbA1c chair side point of care testing. Those who are in the Diabetic range are referred to their GP for formal diagnosis and those who are in the pre-diabetic range are referred directly to the National Diabetes Prevention Programme.

145. The **dentistry pilot whilst still in its infancy is so far showing signs of being successful.** Public Health England has shown interest for this to potentially be rolled out nationally. A full evaluation and case study will be conducted on completion and shared to assess potential for roll out or inclusion within the NDPP pathway.

146. **Approval and funding has been granted to develop screening programmes** in the following settings:

- GP extended hours Hubs
- Primary care using Clinical Pharmacists and/or Health Care Assistants
- Testing during Phlebotomy clinics
- Extension of NHS Health Checks programme (see below for more details)
- Targeted community detection – e.g. In Faith groups and other high risk population groups. We have conducted initial screening within a small scale event attended by carers of which out of 18 tested 1 had a reactive screen as positive for diabetes and 3 were within the pre-diabetic range.

**People Story– Diabetes Screening in Dentistry**

The pilot began on the 1st February 2018 and to date 5 diabetic patients and 14 pre-diabetic patients have been identified. The objective of the pilot is to have minimal individuals screened whilst obtaining high positivity rates to eliminate randomised screening. Due to the success of such a small sample, dental nurses have recently been trained to expand their capacity to screen. Therefore we fully anticipate the figure to rise in the final stages of the pilot.

The most predominant outcome to date has been within the Community Dental Service for transient patients who despite having minimal screens have yielded a positivity rate of 57% against general dental practice of 33% which is still high.

*"We are very excited to be taking part in this project as we believe that patient care goes beyond healthy teeth and gums."*
*Lead Dentist*

Progress against our targets

147. These Key Performance Indicators were approved by the Health and Wellbeing Board in November 2017 and the performance measures provide baselines against which future performance can be measured.

- 25% of GP practices meet the recommended parameters for diagnosis and treatment of Hypertension.
- 26% GP practices meet the recommended parameters for diagnosis and treatment of Stroke.
- 26% GP practices meet the recommended parameters for diagnosis and treatment of Coronary Heart Disease.
- 26% of GP practices meet the recommended parameters for diagnosis and treatment of Peripheral Arterial Disease.
- 25% of GP practices meet the recommended parameters for diagnosis and treatment of Depression.
- 26% of GP practices meet the recommended parameters for diagnosis and treatment of COPD.

# Objective 5D – Prevent and treat cancer better

Key Strategies and actions for achieving this objective

148. The CCG continue to work closely with public health colleagues to improve the care and treatment of people with cancer in Thurrock. The Thurrock cancer steering group regularly meets to implement the Thurrock cancer action plan. The plan is focussed on three key strands of work:
    - Improving the early diagnosis of cancer
    - Reducing emergency presentations of cancer
    - Raising awareness of cancer screening and cancer symptoms in the population

149. The hospital treatment pathways are now led by the Mid and South Essex STP. We are extremely disappointed that we have not achieved 62 days recovery and continue to work closely with the trusts in relation to improvements in pathway mapping at STP for 4 cancer pathways ( lung, skin, colorectal and upper GI) to optimise each of these pathways and ensure inter-provider transfers has been undertaken as per the EoE Cancer Alliance guidance. All hospitals in the STP have signed up to implementing the new guidance and are recording and reporting inter hospital transfers against the standard for specific pathways. STP providers are working closely with NHSI to revise their 62 days cancer trajectories with BTUH and SUHFT forecasting delivery by March 2018 and MEHT forecasting recovery by September 2018.

Key Achievements for Year 2 of the Health and Wellbeing Strategy (July 2017 – June 2018)

150. Improving the early diagnosis of cancer - **we have implemented NG-12, NICE guidance on "urgent referrals for suspected cancer" covering all practices by way of practice visits.** We have rolled out new NICE compliant 2WW referral forms and we have conducted educational sessions to GPs (TTL sessions) on early diagnosis of cancer and feedback on completion of practice visits.

151. Reducing emergency presentations of cancer - **we have conducted an audit of emergency presentation of cancers in TCCG and audit results have been presented to GPs in TTL session**. We have focussed on safety netting and use of risk assessment tools to reduce emergency presentations during our practice visits.

152. Raising awareness of cancer screening and cancer symptoms in the population - **we have participated in the BCOC (Be Clear on Cancer) campaign on bowel cancer screening in association with CRUK**.

Progress against our targets

- **58.8% of patients were treated within 62 days of receipt of urgent GP referral** for suspected cancer to first treatment during the 2017/18 period. This target has been difficult to achieve historically pan Essex and it is a focus of various other work streams, particularly the Mid and South Essex STP Cancer Board. It should be noted that performance against this target fluctuates from month to month.
- 2015 data shows **95.3% of patients achieve 1 year survivorship of breast cancer** and that the direction of travel is positive and progress continues to be made.
- Data from 2016/17 shows that **55.2% of people aged 60-69 years who were eligible for bowel screening and had a screening test result recorded** in the last 2.5 years.
- The ratio of people per 100,000 being diagnosed for cancer the first time via emergency presentation **86 people per 100,000**. In England the ratio is 88 people per 100k population. This has been decreasing consistently for the past five years. Over the next five years we would like to aim for 2021 we have set an ambition target 78 per 100k population.

**Appendix A**

# Health and Wellbeing Strategy
## Outcomes Framework

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 1. Opportunity for All | Objective 1A. All children in Thurrock making good educational progress | EYFS Attainment - % of children achieving a Good Level of Development (GLD) at the end of Early Years Foundation Stage | **72.5%** (2015) | **73%** Achieved 76% | **73.50%** | **74%** | **74.50%** | **75%** | Target Exceeded |
| | | EYFS Attainment - Percentage point gap between pupil premium children achieving GLD and others at end of Early Years Foundation Stage | **12.20%** | **11.76%** Achieved 17% | **11.32%** | **10.88%** | **10.44%** | **10%** | Target not achieved |
| | | KS2 Attainment – % Achieving the National Standard in Reading, Writing & Maths | 51% | **57%** Achieved 61%, | **67%** | **73%** | **79%** | **85% National Target** | Target Exceeded |
| | | % of children achieving combined level 4 in English and Maths at GCSE | | **38%** Baseline | **TBC** | **TBC** | **TBC** | **TBC** | This KPI will be amended to % of children achieving combined level 5 in English and Maths due to combined level 4 not being reported on nationally or locally. Targets will be established. |
| | | New progress 8 scores | | Current data **+0.03** aligned with national progress of -0.03 | **TBC** | **TBC** | **TBC** | **TBC** | This is a new indicator targets will now be established. |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 1 Opportunity for All | Objective 1B. More Thurrock residents in employment, education or training | % of people claiming universal credit | N/A indicator developed in 2017 | | **2.1%** | TBC | TBC | TBC | This is a new KPI and Universal Credit is currently being rolled out across Thurrock. The % of people claiming Universal Credit is expected to increase during the roll out period. |
| | | % of 16 – 17 year olds not in Employment, Education or Training (See column T for suggested amendments). *Amended age group from previously 16-19 year olds* | **5.2%** (2014) | **5%** Achieved 3.8% | **2%** | **2%** | **2%** | **2%** | Target Exceeded |
| | Objective 1C. Fewer Teenage Pregnancies in Thurrock | Under 18 conception crude rate per 1,000 | **25.5** (2014) | **24.5** Achieved 24.5 | **23.2** Achieved 23.2 | **22.2** | **21.1** | **20** | Target Achieved |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 1. Opportunity for All | Objective 1D. Fewer children and adults in poverty | % of children in poverty (all dependent children). | **19.6% (2013)** | **19.28%** Achieved 17.4% | **18.96%** | **18.64%** | **18.32%** | **18.0% (Draft Target)** | Target exceeded |
| | | Number of homeless households supported by Thurrock Council. | **472 (2015)** | | | | | | This KPI will be removed because measuring the number of homelessness applications received or processed does not provide an outcome |
| | | Increase in number of HMOs available for young people across Thurrock | **0** | | | | | | This KPI will be removed because measuring whether a young person is living in a HMO will not determine whether they are living in poverty. |
| 2. Healthy Environments | Objective 2A. Create places that make it easier to exercise and be active<br><br>Amended from: Create Outdoor Spaces that make is easier to exercise and be active: | % of physical active adults 19+ amended from % Physical Active adults 16+ (150 mins per week). | | **52.00%** Achieved 52% | **52.50%** | **53.00%** | **53.50%** | **54%** | Target Achieved |
| | | % of children who take part in 1 hour physical activity 6-7 times per week | **N/A** | **20.2%** Baseline | | | | | This KPI will be further developed once the Brighter Future's Survey is further defined and the cohort of schools and year students that are going to be subject to the survey is determined |
| | | Residents very or fairly satisfied with council owned sports and leisure facilities. | **39%** Achieved 39% | **NA** | **45%** | **NA** | **50%** | | These KPIs have not been measured as part of reporting against outcomes for Year 2 of the Health and Wellbeing Strategy. Details provided within this annual report are reiterating previous performance statements. |
| | | Residents who think that the Council make it easy to exercise in parks and open spaces (Bi yearly survey) | **69%** Achieved 69% | **NA** | **71%** | **NA** | **73%** | | |
| | | Based on needs assessment, the number of Parks and Play sites improvement projects to encourage greater use | | **3** Achieved 3 | **3** | **3** | **3** | **14** | Target Achieved |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 4. Healthy Environments | Objective 2B. Develop homes that keep people well and independent | % of all major housing developments that have an approved Health Impact Assessment. | | | | | | | This KPI is to be removed as systems are not in place to measure progress against the target. The KPI does not measure the outcome of a HIA on specific planning applications |
| | | Number of Right Size Schemes developed in Thurrock | | **0** Achieved 1 | **5** | **5** | **5** | **20** | Target Exceeded |
| | | Number of people who are supported by the Housing First Scheme | | **0** | **5** Achieved 6 | **5** | **5** | **20** | Target Exceeded |
| | Objective 2C. Build strong, well connected communities | Number of quarterly hours of volunteering time in Thurrock. | | **3000 hours per quarter** Achieved 6,000 hours per quarter | **10% increase** | **10% increase** | **10% increase** | | Target Exceeded |
| | | Number of micro-enterprises operating in the area. | **0** | **25** Achieved 55 | **An increase on 2017** | **An increase on 2018** | **An increase on 2019** | **An increase on 2020** | Target Exceeded This KPI was initially part of a pilot exercise and due to its success has now been embedded in the council as part of the Local Area Coordination Team. Our ambition is to continue to increase Micro Enterprises while supporting those already established. |
| | | Corporate Volunteering. Number of businesses across Thurrock that facilitate volunteering for staff | | | | | | | This indicator is to be removed as there are not currently systems in place to measure corporate volunteering |
| | Objective 2D. Improve air quality in Thurrock | Number of AQMAs declared in Thurrock. | **18 (2016)** | | | | | **8** | |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 3. Better Emotional Health and Wellbeing | Objective 3A. Give parents the support they need | % of parents achieving successful outcomes from early intervention prevention parenting programmes. | **72% (2015/16)** | **61.6%** Achieved 61.6% | **73.20%** | **73.80%** | **74.40%** | **75%** | Target Achieved |
| | | Number of families known to Troubled Families Service | **370 (2016/17)** | **567** Achieved 1050 | **1500** | **1900** | **2525** | NA as TF programme concludes in March 2020 | Target Exceeded |
| | | Increasing the proportion of children who achieve a 'Good Level of Development'1 (GLD is at 75% in 2016) and reducing the gap between the most and least deprived groups by supporting child development and school readiness | **75%** | **76%** Achieved 76% | **77%** | **78%** | **79%** | **80%** | Target Achieved |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 3 Better emotional health and wellbeing | Objective 3B. Improve children's emotional health and wellbeing | % of children and young people reporting that they are able to cope with the emotional difficulties they experience. | **N/A** | **57.7%** Baseline | | | | | This KPI will be further developed once the Brighter Future's Survey is further defined and the cohort of schools and year students that are going to be subject to the survey is determined |
| | | % of children and young people reporting that would be happy to seek help when experiencing emotional difficulties that they might face | **N/A** | **53.5%** Baseline | | | | | This KPI will be further developed once the Brighter Future's Survey is further defined and the cohort of schools and year students that are going to be subject to the survey is determined |
| | | % of children reporting being bullied in the last 12 months | **N/A** | **17.6%** Baseline | | | | | This KPI will be further developed once the Brighter Future's Survey is further defined and the cohort of schools and year students that are going to be subject to the survey is determined |
| | Objective 3C. Reduce isolation and loneliness | Number of people who are supported by a Local Area Coordinator. | **558 (Jan-Dec 15)** | **576 -** Achieved 841 | **595** | **613** | **632** | **650** | Target Exceeded |
| | | % of people whose self-reported wellbeing happiness score is low | **10.7% (2014/15)** | **10.16%** Achieved 9.3% | **9.62%** | **9.08%** | **8.54%** | **8.00%** | Target Exceeded |
| | | Proportion of carers who reported that they had as much social connection as they would like (Sarah Turner) | | **29.67%** (16/17 survey results) Baseline | | | | | This is a new KPI. Annual targets to be established |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 3. Better Emotional Health and Wellbeing | Objective 3D. Improve the identification and treatment of mental ill-health, particularly in high-risk groups.<br><br>Amended from Improve the identification and treatment of depression, particularly in high risk groups | People entering IAPT as a % of those estimated to have anxiety / depression. | **15% (Sept 15)** | **16.8%** Achieved 16.6% | **19.00%** | **21.00%** | **23.00%** | **25%** | Target not achieved |
| | | % of people who have completed IAPT treatment who are "moving to recovery". | **39.00%** | **41%** Achieved 52.2% | **44.00%** | **46.00%** | **48.00%** | **50.0% (Current national target)** | Target Exceeded |
| | | % of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool. | | | | | | **95%** | This is a new tool and baselines and trajectories will be established during 2018. See page 39 for further information |
| | | % of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff | | | | | | | This KPI is to be removed as the %of ASC clients over 65 screened for depression by frontline staff does not provide an outcome measure or indication of what happens to those that have been screened and are suspected of experiencing mental ill health. |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 4. Quality Care Centred Around the Person | Objective 4A Create four Integrated Medical Centres. Amended from Create four healthy living centres | Identify localities for IMCs | **N/A** | **4** Achieved 4 | **N/A** | **N/A** | **N/A** | **N/A** | Target achieved. This KPI will be closed. |
| | | Develop business case for IMCs | **N/A** | **N/A** | **4** | **N/A** | **N/A** | **N/A** | Progress against this target will be reported in next year's Health and Wellbeing Strategy annual report (year 3) |
| | | Number of IMCs that are operational | **0** | **0** | | **2** | **2** | **4** | |
| | | % of A&E attendances that are coded as no investigation with no significant treatment. | **40.93%** | | | | | **38.8% (draft target)** | Progress on target will partly depend on other system changes happening later (i.e. IMCs). IMCs will be being developed during this period |
| 4. Quality Care Centred Around the Person | Objective 4B. When services are required they are organised around the individual | % of the 2% highest risk frail elderly in Thurrock with a care plan and named accountable professional. | | | | | | | This KPI is to removed and will be replaced with new KPIs once the Mede Analytics data sharing project has been developed and launched as set out on page 42 |
| | | Establish a data system linking records from primary, secondary, community, mental health and adult social care | | | **System in place and roll out commences** | | | | Target achieved – it is envisaged that Mede Analytics will be rolled out during 2018 |
| | | % of Early Offer of Help episodes completed within 6 months. | | | | | | | This KPI is to removed and will be replaced with new KPIs once the Mede Analytics data sharing project has been developed and launched as set out on page 42 |
| | Objective 4C. Put people in control of their own care | % of people who have control over their daily life. | **74.2% (2014/15)** | **76.36%** Achieved 79.9% | **78.52%** | **80.68%** | **82.84%** | **85%** | Target exceeded |
| | | % of people receiving self-directed support. | **70.3% (2014/15)** | **76.24%** Achieved 74% | **83%** Achieved 78.45% | | | | Target not achieved. Targets against this KPI are set on an annual basis. |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 4. Quality Care Centred Around the Person | Objective 4D. Provide high quality GP and hospital care to Thurrock | The number of GPs per 1,000 patients in all four CCG localities. Amended was previously the number of GPs per 1,000 patients | **0.47 (2015)** | | **1 locality** | **1 locality** | **2 localities** | **0.27 (National Average in 2015) in all 4 localities** | A report against target is scheduled for the next annual report to be published in July 2019 |
| | | The number of nurses per 1,000 patients in all four localities. Amended was previously the number of nurses per 1,000 patients | **0.22** | | **1 locality** | **1 locality** | **2 localities** | **England average was 0.27 in 2015 to be achieved in all 4 localities** | A report against target is scheduled for the next annual report to be published in July 2019 |
| | | % of GP practices with a CQC rating of at least "good". | **2 practice rated as good from 32 practices** | **40%** Achieved 71% | **90%** | **100%** | **All practices rated as good and 2 practices rated as outstanding** | **50%** | Target exceeded |
| | | % of patients who had a good experience of GP services. | **80% (2015/16)** | **81%** Achieved 77% | **82%** | **83%** | **84%** | **England average was 85% in 2015/16** | Target not achieved. |
| | | % of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge. | **91.11% (2015/16)** | **91.88%** Achieved 88.3% | **92.67%** | **93.44%** | **94.22%** | **95%** | Target not achieved |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 4. Quality Care Centred Around the Person | Objective 4D. Provide high quality GP and hospital care to Thurrock | Overall CQC Rating – BTUH | **Good (Maternity Dept rated as outstanding)** | **Will not be subject to inspection** | **Will not be subject to inspection** | **Will not be subject to inspection** | **Retain good overall rating** | **Retain good overall rating** | |
| | | Overall CQC Rating - NELFT | | **Requires Improvement** | | | | **Good or be working towards good** | |
| | | Overall CQC Rating - SEPT | **Good (** | **Will not be subject to inspection** | **Will not be subject to inspection** | **Will not be subject to inspection** | **Retain good overall rating** | **Retain good overall rating** | |
| | | Overall CQC Rating - East of England Ambulance Service | | **Requires Improvement** | | | | **Good or be working towards good** | |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 5. Healthier for Longer | Objective 5A. Reduce Obesity / Increase the number of people in Thurrock who are a healthy weight | % of children overweight or obese in year 6 | 36.7% 2014/15 37.8% 2015/16 | 37% Latest data will be available in December 2017 | 36.50% | 36% | 35.50% | 35% of statistically similar to national average | |
| | | % of physically inactive adults | N/A | 31% or 37,890 adults (new reporting method in place 28.5%) | 28% Reduction of 0.5% | 27.5% Reduction of 0.5% | 27% Reduction of 0.5% | 26.5% Reduction of 0.5% | |
| | | % of adults overweight or obese | 70.4% (2012/14) 70.3% (2013-2015) | 70.30% (new reporting method in place 65.8%) | 65.3% Reduction of 0.5% | 64.8% Reduction of 0.5% | 64.3% Reduction of 0.5% | 63.8% Reduction of 0.5% | |
| | Objective 5B. Reduce the proportion of people who smoke | Smoking prevalence in those aged 18+. | **20.3%** | **19.3%** Achieved 20.8% | **18.30%** | **17.30%** | **16.30%** | **Below 16%** | Target not achieved |
| | | % of children reporting that they smoke once a month or more | **N/A** | **7.4 % (Baseline)** | | | | | This KPI will be further developed once the Brighter Future's Survey is further defined and the cohort of schools and year students that are going to be subject to the survey is determined |
| | | % of mothers smoking at time of delivery. | **9.9% (2015)** | **9.45%** Achieved 9% | **9.00%** | **8.54%** | **8.09%** | **Trajectory suggests 7.64% should be achievable** | Target exceeded |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 5: Healthier for Longer | Objective 5C. Significantly improve the identification and management of long term conditions | Indicators:<br>a) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Hypertension.<br>b) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Stroke.<br>c) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Coronary Heart Disease.<br>d) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Peripheral Arterial Disease.<br>e) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Depression.<br>f) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of COPD. | **A) 25%**<br>**B)26%**<br>**C) 26%**<br>**D)26%**<br>**E)25%**<br>**F) 26%** | **A) 28%**<br>**B) 27%**<br>**C) 29%**<br>**D) 29%**<br>**E)25%**<br>**F) 39%** | **A) 31%**<br>**B) 29%**<br>**C) 33%**<br>**D) 33%**<br>**E) 25%**<br>**F) 48%** | **A) 35%**<br>**B) 31%**<br>**C) 36%**<br>**D) 36%**<br>**E) 28%**<br>**F) 56%** | **A) 40%**<br>**B) 35%**<br>**C) 40%**<br>**D) 40%**<br>**E) 30%**<br>**F) 65%** | | This is a new programme and first reports against KPIs will be provided in the next Health and Wellbeing Strategy Annual Report 2019. |

| Goal | Objective | Key Performance Indicators | Baseline (2016) | 2017 Target | 2018 Target | 2019 Target | 2020 Target | 2021 Target | Narrative |
|---|---|---|---|---|---|---|---|---|---|
| 5. Healthier for Longer | Objective 5D. Prevent and treat cancer better | % of cancer admissions diagnosed for the first time via emergency presentation. | | **86 per 1000k population** Achieved 86 per 1000 population | **84 per 100k population** | **82 per 100k population** | **80 per 100k population** | **78 per 100k population** | Target achieved |
| | | % of patients treated within 62 days of receipt of urgent GP referral for suspected cancer to first treatment | **56% (February 2016)** | **62%** Achieved 58.8% | **68.00%** | **73.00%** | **79.00%** | **Working toward national standard of 85%** | Target not achieved |
| | | 1 year survivorship after breast cancer. | **95% (2013)** | **96%** Achieved 95.3% | **96.25%** | **96.50%** | **96.75%** | **Working towards 97%** | Target not achieved |
| | | Bowel cancer screening coverage | **54% (2015)** | **55.00%** Achieved 55.2% | **56.00%** | **57.00%** | **58.00%** | **60% (Current national target)** | Target Exceeded |

**Appendix B**

# Links to key strategies and programmes

| Strategies/Programmes | Further information | Location in this report | |
|---|---|---|---|
| | | | |
| Mid and South Essex Sustainability and Transformation Partnership | http://www.nhsmidandsouthessex.co.uk/ | A Summary of the Board's work (page 8) | Strategy / Programme |
| Thurrock Better Care Fund for 2017-2019 | https://www.thurrock.gov.uk/how-care-is-changing/better-care-fund-plan | A Summary of the Board's work and objective 3D (page 8) | Strategy |
| Southend, Essex and Thurrock Dementia Strategy | http://democracy.thurrock.gov.uk/Data/Health%20and%20Wellbeing%20Overview%20and%20Scrutiny%20Committee/20110906 1900/Agenda/$7275%20-%2015702.ppt.pdf | A Summary of the Board's work and objective 3D (page 9) | Strategy |
| Joint Strategic Needs Assessments | https://www.thurrock.gov.uk/healthy-living/joint-strategic-needs-assessment | A Summary of the Board's work (page 9) | Evidence report |
| Annual Public Health Report | https://www.thurrock.gov.uk/healthy-living/other-public-health-reports | A Summary of the Board's work (page 9) | Evidence report |
| Pharmaceutical Needs Assessment | https://www.thurrock.gov.uk/healthy-living/pharmaceutical-needs-assessment | A Summary of the Board's work (page 9) | Evidence report |
| School place planning strategy | https://www.thurrock.gov.uk/pupil-place-planning/overview | Objective 1A (page 14) | Strategy |
| Teacher recruitment website for Thurrock | www.teachinginthurrock.co.uk/ | Objective 1A (page 15) | Recruitment of teachers |

| Strategies/Programmes | Further information | Location in this report | |
|---|---|---|---|
| Jobs at Opportunity Thurrock | https://www.thurrock.gov.uk/news/jobs-and-careers/opportunity-thurrock-jobs-network-launched | Objective 1B(page 17) | Vacancy website |
| On Track Thurrock | https://www.thurrock.gov.uk/careers-advice/ontrack-opportunities | Objective 1B (page 17) | Job Opportunities for young people |
| Sexual health clinics and support for young people | https://www.thurrock.gov.uk/sexual-and-reproductive-health/sexual-health | Objective 1C (page 19) | Sexual Health Service |
| Community Hubs in Thurrock | https://www.thurrock.gov.uk/community-hubs-and-community-centres/supporting-local-people | Objective 1D (page 21) | Community Hubs |
| Stronger Together Partnership | https://www.thurrockcvs.org/stronger-together | Objectives 2C and 3C (page 28) | Information providing local community activities |
| Thurrock Time Banking | http://www.timebanking.org/location/time-bank-thurrock/ | Objectives 2C and 3C (page 28) | Volunteering Service |
| Small Sparks Grant | https://www.thurrockcvs.org/small-sparks | Objective 2C (page 28) | Funding for small community projects |
| Social Prescribing | https://www.thurrockcvs.org/social-prescribing | Objectives 2C and 3C (pages 28) | Service is open to all patients aged 18+ who present to their GP with issues that have a non-clinical underlying cause |
| Thurrock Air Quality and Health Strategy | https://www.thurrock.gov.uk/sites/default/files/assets/documents/strategy-airqualityhealth-201612-v01.pdf | Objective 2D (page 29) | |

| Strategies/Programmes | Further information | Location in this report | |
|---|---|---|---|
| | | | |
| 0-19 Brighter Futures Healthy Families Service | https://www.nelft.nhs.uk/services-thurrock-brighter-futures-healthy-families | Objective 3A (page 32) | |
| Thurrock Anti-Bullying Strategy | https://www.thurrock.gov.uk/bullying-and-anti-bullying/bullying | Objective 3B (page 34) | Anti-bulling Strategy, Advice and Guidance |
| Open Up Reach Out | http://www.essex.gov.uk/Health-Social-Care/Families-and-childrens-social-care/Documents/Open-up-reach-out-year3.pdf | Objective 3B (page 34) | Transformation Plan for Children's emotional health and wellbeing |
| Local Area Coordinators | https://www.thurrock.gov.uk/local-area-coordinators-help-in-community/overview | Objective 3C (page 35) | Service - Local area coordinators (LACs) help vulnerable people find ways to make a better life |
| Thurrock Recovery College / Inclusion Thurrock | https://inclusionthurrock.org/recovery-college/ | Objective 3D (page 37) | Mental ill health support |
| Shared Lives Thurrock | https://www.thurrock.gov.uk/shared-lives-adults-living-with-carers/overview | Objective 4C (page 42) | |
| Micro Enterprises Thurrock | https://www.thurrock.gov.uk/community-enterprises-for-care-and-support/supporting-local-people | Objective 4C (page 42) | |
| Thurrock Healthy Lifestyle Service | https://www.thurrock.gov.uk/improving-your-health/thurrock-healthy-lifestyle-service | Objective 5B (page 48) | Smoking Cessation Service |
| Thurrock Tobacco Control Strategy | https://www.thurrock.gov.uk/sites/default/files/assets/documents/tobacco-strategy-2016-v03.pdf | Objective 5B (page 48) | |

| 20 July, 2018 | ITEM: 10 |
|---|---|
| **Thurrock Health and Wellbeing Board** | |
| **Consequential amendments to the Health and Wellbeing Board's Terms of Reference and membership** | |
| **Wards and communities affected:** None | **Key Decision:** Non-key |
| **Report of:** Councillor James Halden, Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board | |
| **Accountable Head of Service:** n/a | |
| **Accountable Director:** Roger Harris, Corporate Director for Adults, Housing and Health | |
| **This report is** Public | |

**Executive Summary**

The Health and Wellbeing Board is a committee of the Council. As such, its terms of reference are agreed by Council and are contained within the Council's Constitution.

Statutory provisions for Health and Wellbeing Boards are contained within the Health and Social Care Act 2012. This includes provisions about changes to Board membership which require Council approval, following approval from the Health and Wellbeing Board. The Monitoring Officer has the authority pursuant to Article 15 Paragraph 3.4 of the Constitution to make consequential amendments to the Constitution including the current clarifications to the Board's Terms of Reference and changes in legislation to ensure that the Constitution is up-to-date...

Once Health and Wellbeing Board members have considered recommendations in this report the Monitoring Officer will be requested pursuant to Article 15 to incorporate these consequential amendments into the Constitution.

This paper asks the Health and Wellbeing Board to agree to the following consequential amendments to its Terms of Reference. Key changes proposed are:

- Minor amendments to the Board's membership to ensure that the TOR reflects the current membership
- Inclusion within the TOR of the Board's sub-groups, bolstering governance and reporting arrangements
- Inclusion of new legislative requirements placed upon the Board

## 1. Recommendation(s)

1.1 That the Health and Wellbeing Board agrees to:

- The changes to the Terms of Reference as outlined within the report.
- Delegating authority for representations to be made on behalf of the Board to NHS England on Pharmaceutical Consolidation Applications

## 2. Introduction and Background

2.1 The Health and Wellbeing Board is a statutory partnership board governed by s194 of the Health and Social Care Act 2012 (the Act). The Act specifies who must be a member of the Board and specifies how additional Board members are to be appointed. The Act states that at any time after a Health and Wellbeing Board is established, the Local Authority must, before appointing another member of the Board or amending the Terms of Reference, consult the Health and Wellbeing Board.

2.2 A commitment provided in the Board's Terms of Reference is that it will be reviewed and refreshed on an annual basis. The purpose of this report is to ask the Health and Wellbeing Board to agree the recommended amendments prior to them being considered by the Council's Monitoring Officer for inclusion in the Council's Constitution as consequential changes pursuant to Article 15 Paragraph 3.4.

## 3. Issues, Options and Analysis of Options

3.1 The inclusion of the Health and Wellbeing Board's sub groups will ensure governance arrangements are accurately presented in the TOR and that the aims, objective and reporting arrangements for each sub group is clearly defined.

3.2 Amending the functions and job titles for Board membership will ensure that the Terms of Reference continues to accurately reflect the roles of existing members of the Health and Wellbeing Board. Positions amended are as follows:

- Cllr Barbara Rice and Cllr Tony Fish are members of the Board. Cllr Leslie Gamester and Cllr Steve Liddiard are no longer members of the Board
- Andrew Pike is now Chief Executive of BTUH and will be invited to future Board meetings as the Director level executive on behalf of BTUH.
- Adrian Marr will be invited to future Board meetings as a Director level executive representing NHS England, Midlands and East of England Region, replacing Andrew Pike.
- Gillian Ross will be invited to future Board meetings as lay member, patient participation, Thurrock NHS CCG.

3.3 Including new legislation that places a requirement on the Board to submit representations to NHS England on pharmaceutical consolidation applications

that are received ensures that the TOR continues to accurately reflect functions determined by statute. It is proposed that authority to submit representations on behalf of the Board to NHS England is delegated to Public Health. This is because Public Health already lead on Pharmaceutical Needs Assessments and will ensure that statutory deadlines for responding to NHS England can be met.

## 4. Reasons for Recommendation

4.1 As set out in section 3, the recommendations aim to ensure that the Terms of Reference for the Health and Wellbeing Board accurately reflect members' roles and functions and ensures appropriate representation.

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

5.1 The report is being provided to Health and Wellbeing Board as part of consulting members about proposed changes.

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

6.1 The Health and Wellbeing Board leads on the community and corporate priority 'improve health and wellbeing'. It is important that its membership is appropriate to influencing and setting that agenda and allows health and wellbeing in Thurrock to be improved and inequalities in health and wellbeing to be reduced.

## 7. Implications

7.1 **Financial**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

There are no financial implications.

7.2 **Legal**

Implications verified by: David Lawson, Assistant Director of Law & Governance & Monitoring Officer

The membership of the Board is in keeping with the requirements of the Health and Social Care Act 2012. The process for amending the Board's membership also complies with the Health and Social Care Act 2012 and Article 15 of the Council Constitution.

7.3 **Diversity and Equality**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

The Board's membership ensures representation is able to identify and respond to diversity and equality implications for Thurrock to ensure that all Thurrock citizens can achieve good health and wellbeing outcomes.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)
None

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

- Not applicable

**9. Appendices to the report**

- Health and Wellbeing Board Terms of Reference

**Report Author:**
Darren Kristiansen, Business Manager, Thurrock Health and Wellbeing Board

**Appendix A**

## Thurrock Health and Wellbeing Board
## Revised Terms of Reference

| | THURROCK HEALTH AND WELL-BEING BOARD |
|---|---|
| **Appointed by:**<br>The Council under section 102 of the Local Government Act 1972 | **Number of Elected Members:**<br>Five |
| **Chair and Vice-Chair appointed by:**<br>The Chair will be the Portfolio Holder for Education and Health and shall be appointed by the Council | **Political Proportionality:**<br>There is no requirement for elected Members to be appointed in accordance with Political Proportionality |
| **Quorum:**<br>One quarter of the whole number of Board Members, provided that in no case shall the quorum of a Committee be less than three | **Co-opted Members to be appointed by Council:**<br>None |

**Membership:**

- Leader of the Council* (Cllr Robert Gledhill)
- Portfolio Holder for Education and Health (Chair) (Cllr James Halden)
- Portfolio Holder for Children's and Adult Social Care (Cllr Sue Little)
- Cllr Barbara Rice
- Cllr Tony Fish
- Corporate Director of Adults, Housing and Health * (Roger Harris)
- Corporate Director of Children's Services * (Rory Patterson)
- Director of Public Health* (Ian Wake)
- Accountable Officer: Thurrock NHS Clinical Commissioning Group* (Mandy Ansell)
- Chief Operating Officer HealthWatch Thurrock * (Kim James)
- Clinical Representative: Thurrock NHS Clinical Commissioning Group (Dr Anjan Bose)
- Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board (Dr Deshpande)
- Executive Nurse: Thurrock NHS Clinical Commissioning Group (Jane Foster-Taylor)
- Lay Member Patient Participation: Thurrock NHS Clinical Commissioning Group (Gillian Ross)
- Corporate Director – Place (Steve Cox)
- Director level Executive, NHS England Midlands and East of England Region (Adrian Marr)
- Chair Thurrock Community Safety Partnership Board / Director – Environment and Highways (Julie Rogers)
- Chair of the Adult Safeguarding Board or their senior representative (Graham Carey, Independent Chair or Jane Foster-Taylor, Thurrock CCG)
- Chair Thurrock Local Safeguarding Children's Board or their senior representative (David Archibald)
- Integrated Care Director Thurrock, North East London Foundation Trust (NELFT) (Tania Sitch)
- Executive member, Basildon and Thurrock Hospitals University Foundation Trust (Andrew Pike)
- Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Malcolm McCann)
- Chief Executive Thurrock CVS (Kristina Jackson)

* denotes mandatory organisational representation

**Our Vision**

- Adding Years to Life and Life to Years:

**Our Principles**

- Reducing inequality in health and wellbeing
- Prevention is better than cure
- Empowering people and communities
- Connected services
- Our commitments will be delivered
- Continually improving service delivery
- Continuing to establish clear links between health and education services, improving accessibility for all

**Our Goals**

- Opportunity for All
- Healthier Environments
- Better Emotional Health and Wellbeing
- Quality Care Centred Around the Person
- Healthier for Longer

**1. Purpose**

1.1 To improve health and wellbeing and reduce inequalities in health and wellbeing;

1.2 To develop and facilitate the delivery of transitional arrangements to meet statutory requirements within the emerging health agenda; and

1.3 To determine the health improvement priorities in Thurrock.

**2. Functions**

2.1 Identify and join up areas of commissioning across the NHS, social care, public health, and other services directly related to health and well-being and reducing health inequalities;

2.2 Encourage and develop integrated working – for the purpose of advancing the health and well-being of and reducing health inequalities amongst Thurrock people;

2.3 Oversee the on-going development and refresh of the Joint Strategic Needs Assessment (JSNA);

2.4 Oversee the on-going development, refresh, and implementation of Thurrock's Health and Well-Being Strategy (HWS) – ensuring that it provides an overarching framework for commissioning plans related to Health and Well-Being and Health Inequalities;

2.5 Sign-off key commissioning plans, strategy, and policy related to Health and Well-Being;

2.6 Oversee the development of the pharmaceutical needs assessment; and

2.7 Performance manages the achievement of and progress against key outcomes

identified within the JHWS and against key commissioning plans.

**3. Meeting Frequency**

3.1 The Board will meet a minimum of six times a year as far as practicable

**4. Governance and Approach**

4.1 The Board will function at a strategic level, with priorities being delivered and key issues taken forward through existing partnership arrangements – which may at times include the establishment of task and finish groups

4.2 Only a small number of permanent sub-groups will exist to support the work of the Board:

- **Health and Wellbeing Executive Committee**, a strategic group that supports the Health and Wellbeing Board
- **Integrated Commissioning Executive** (ICE). ICE is a decision making body responsible overseeing the delivery of the Better Care Fund Plan, and the wider health and wellbeing transformation agenda in Thurrock. The ICE meets monthly and minutes are a standing item at Health and Wellbeing Board meetings.
- **Housing and Planning Advisory Group** (HPAG). HPAG supports the Board with influencing plans for the built environment and the potential impact of those plans on health and wellbeing of the population of Thurrock. It does this by looking at significant development plans (major) at the earliest possible stage to enable full consideration to be provided to the potential impact of new developments on people's health and wellbeing. HPAG reports to the HWB on an annual basis.
- **Thurrock Integrated Care Alliance** comprises different organisations from the health and care system who work together to improve the health of their local population by integrating services and tackling the causes of ill health.
- The **Health and Wellbeing Engagement Advisory Group.** Aims to ensure that the health and care system is responsive to meeting the needs of Thurrock's population and that that residents have the opportunity to engage with, influence and shape that system.

4.3 Decisions taken and work progressed will be subject to scrutiny by the Health and Well-Being Overview and Scrutiny Committee – and other Overview and Scrutiny Committees as appropriate (note: HealthWatch has a scrutiny function)

4.4 The development of the Health and Wellbeing Board and its agenda is a dynamic process. As a result, the Board's Terms of Reference will be reviewed at least annually and altered to reflect changes as appropriate.

4.5 Elected members will be nominated by the Leader of the Council

4.6 The Local Authority may nominate additional Board members in consultation with the Health and Wellbeing Board

4.7 The Board may appoint additional members as it thinks appropriate

**5. Wider Engagement**

5.1 The Board will ensure that the decisions it makes and the priorities it sets take

account of the needs of all of Thurrock's communities and groups – particularly those most in need

5.2 The Board will ensure that stakeholders including providers are engaged, with a Health and Well-Being Stakeholder Network established to assist with this purpose

**Functions determined by Statute**

The Health and Wellbeing Board will operate in accordance with the provisions of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The Health and Wellbeing Board may appoint one or more sub-committees of the Board to advise it with respect of any matter relating to the discharge of functions by the Board. Functions of the Health and Wellbeing Board may also be discharged by a sub-committee of the Board or by an officer of the authority.

Schedule 2, paragraph 19(5) of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended) require the Health and Wellbeing Board to make representations to NHS England on the effect of the proposed removal of premises from the pharmaceutical list, usually provided through an application to consolidate pharmacies. The Health and Wellbeing Board have delegated authority to respond on its behalf to Public Health.

| 20 July 2018 | ITEM: 11 |
|---|---|
| **Health and Wellbeing Board** | |
| **A report of the work of the Housing & Planning Advisory Group (HPAG)** | |
| **Wards and Communities affected**<br>All | **Key decisions**<br>None |
| **Report of:** Les Billingham Assistant Director Adult Social Care & Leigh Nicholson, Strategic Lead, Development Services, Place Directorate (Co-Chairs of HPAG) | |
| **Accountable Head of Service:** Les Billingham Assistant Director Adult Social Care and Andy Millard, Assistant Director – Planning, Transport and Public Protection, Place Directorate | |
| **Accountable Director:** Steve Cox, Corporate Director, Place<br>Roger Harris, Corporate Director Adults Housing and Health | |
| **This report is public** | |

**Executive Summary**

The purpose of this report is to brief the Health and Wellbeing Board on the work of the Housing and Planning Advisory Group. The report describes the on-going work of the Advisory Group and the main areas of focus for the Group in the next 12 months.

The Advisory Group was established in 2014 following a report to the Health and Wellbeing Board in January 2014. The Terms of Reference for the Group is attached at Appendix 1.

## 1. Recommendation(s)

**1.1** The Health and Wellbeing Board are asked to note the work of the Housing and Planning Advisory Group undertaken in the past year and the proposed work plan for 2018/19.

**1.2** The Health and Wellbeing Board approve Terms of Reference of the Advisory Group.

## 2. Introduction and Background

2.1 The Health and Wellbeing Board's Housing & Planning Advisory Group is a multi-agency group which considers the health and well-being implications of major planning applications, and provides advice and guidance on the health, social care and community impacts of proposed new developments.

2.2 The Advisory group comprises representatives from Thurrock Clinical Commissioning Group (CCG), NHS England (Essex Area Team), the Community and Voluntary Sector (Thurrock CVS), as well as Planning, Housing, Adults, Health and Commissioning, Public Health, Regeneration, Children's Services and Essex Police. It has a significant role in articulating the Health and Wellbeing Board's vision and priorities in relation to housing and the built environment.

2.3 The Group also aims to influence planning policy and thereby developers so that planning applications when received, have already taken into consideration the impact of the proposed development on health and wellbeing. The Group plays a role in promoting good design and sustainable communities as well as influencing the provision of good quality housing for older people and people with disabilities. Incorporating crime prevention through environmental design provides a focus on quality and sustainable places, primarily through the application of Crime Prevention Through Environmental Design, and the national Secured by Design initiative incorporating the National Planning Policy Framework and Guidance.

2.4 The purpose of the HWB Housing and Planning Advisory Group is to:

- Review emerging development plans,
- Identify how Section 106 monies might best be used to enhance Health and Wellbeing;
- Input into emerging planning policy and strategy and;
- Provide an opinion on plans as part of the formal consultation process on major developments;
- To incorporate and maximise at every available opportunity the principles of crime prevention through environmental design.

2.5 The Advisory Group is consulted on all planning applications and pre applications for housing developments of 10 units or more, and residential care homes. The Advisory Group also acts as a conduit for consultations with NHS Property Services. Responses from members of the Advisory Group are collated to provide a co-ordinated response to planning applications and therefore to reflect a very broad perspective on health and well-being issues. This co-ordinated response, plus the detailed reports from NHS Property Services are submitted to the Planning Service within agreed timeframes.

2.6 The Group's multi-disciplinary focus corresponds with a number of statutory requirements of The Care Act 2014. The Care Act established a duty on local authorities to promote wellbeing as well as preventing, reducing or delaying the need for care. Care Act guidance specifies that the wellbeing principle

should inform the delivery of universal services not just services related to adult social care, and that the principle should be considered by the local authority 'when it undertakes broader, strategic functions such as planning, which are not in relation to one individual'. In addition the Care Act introduces a duty of integration of services and cooperation between services in relation to promoting wellbeing, and preventing, reducing or delaying the need for care. The Care Act guidance states that 'suitability of living accommodation is one of the matters local authorities must take into account as part of their duty to promote an individual's wellbeing'.

2.7 Since its establishment in May 2014, the meetings of the Group have led to closer partnership working between diverse professional groups within the Council, and with other local stakeholders, as well as a much better understanding of the respective legislative drivers that need to be managed effectively to ensure that health and wellbeing is at the heart of decision-making. Examples of the partnership approach between Council services and different professional groups include:

- the Well Homes programme;
- the HAPPI Housing schemes developed by the Council at Derry Avenue, South Ockendon and Calcutta Road, Tilbury;
- The proposed Integrated Medical centre in Civic Square, Tilbury; and
- the current development by Family Mosaic of 6 units of specialist housing for young adults with autism.

2.8 The Advisory Group meets monthly, with regular liaison between meetings in relation to consultation requests to review pre-applications and planning applications. Areas which have been addressed by the Group include:

- The Local Plan has been considered by the Group at a number of meetings, providing valuable inputs on both the plan itself and also the wider issues of public consultation and engagement. The development of the Local Plan will continue to feature in future meetings;
- Substantive comments on the proposed major new developments in Aveley, Lakeside and Corringham;
- Advice on an application to build a large care home;
- A meeting with a developer to provide guidance on HAPPI housing design in relation to a pre-application;
- Involvement with the Air Quality Working Group;
- Advising on ways to improve the administration of the Infrastructure Requirements List so as to maximise the opportunity to secure investment of Section 106 monies in health, education and community facilities.

## 3. Issues, Options and Analysis of Options

3.1 In terms of the work of the Advisory Group going forward, as well as responding to new pre-applications and planning applications, the Group will continue to be involved in the development of the Local Plan, the large scale regeneration programmes at Purfleet and Lakeside, and major applications.

3.2 One area that has been identified by the Group as a priority in the coming year is the development of a housing strategy for older people (65+). The benefits of the multi-disciplinary approach to developing the strategy will be the shared understanding of Thurrock's health profile and future projections of health and social care needs which can be translated into the Local Plan and discussions with developers. Work on the housing strategy will be informed by the forthcoming Annual Public Health Report on the housing needs of older people

3.3 It is anticipated that in order to progress the housing strategy, task and finish groups will need to be convened to undertake the coordination and analysis of data, review of current provision, analysis of gaps in provision and the identification of potential locations for specialist housing. The task and finish groups could comprise officers from the range of disciplines and would report to the Housing& Planning Advisory Group. Once completed it is envisaged the housing strategy would be adopted by the Health and Wellbeing Board.

3.4 A focus on the wider determinants of health will continue to be embedded in planning practice, and the Advisory Group will continue to influence the shaping of healthier environments. Two key events delivered in 2017/18 by Public Health and Planning in conjunction with Housing and Adult Social Care demonstrate what can be achieved:

- A Developer Forum in September 2017, with a focus on health and wellbeing formed a part of the Town and Country Planning Association's (TCPA) Developers and Wellbeing project. This event focussed on engaging with developers to achieve a business perspective on building healthier places; considered the Purfleet Centre model of development; introduced Public Health England's (PHE) Spatial Planning for Health and offered a skill-building session on Sport England's Active Design Principles;
- The 2nd South Essex Health and Well-being Summit in November 2017, aimed to continue the conversation with a focus on health infrastructure – new models of care, sustainability, garden cities, planning for an ageing population – dementia, food access, and designing safer places.

3.7 Following on from these key events, local plan guidance and policy is being further shaped to promote and encourage healthier and safer environments. The Advisory Group, as a key stakeholder, will continue to ensure the wider determinants of health are considered in both the pre-application and application process, in future as part of a systematic Health Impact Assessment.

3.8 In summary, the Advisory Group has been consulted on a significant number of planning pre-applications and applications, it has developed a role in relation to strategic policy development and has been pro-active in relation to large-scale regeneration plans. The Group has also raised the profile of creating healthier and safer environments and HAPPI housing both across the council and with developers. The Group has broken down the professional barriers that can often exist between services, where there is no regular channel for communication and the sharing of information and views. This approach is clearly aligned to the Care Act's requirements for collaboration between services.

## 4. Reasons for Recommendation

4.1 The Housing and Planning Advisory Group continually try to strike a balance between providing oversight to pre-applications and planning applications with fulfilling a strategic role in relation to promoting Health and Wellbeing in housing and the built environment.

4.2 Recognising the time constraints of Advisory Group members, there is nonetheless, a commitment to articulate more clearly, the housing needs of older people. The development of the housing strategy will provide a policy framework for the planning service and will provide much needed evidence to developers of the range of housing needs and aspirations in Thurrock and how best to meet them.

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

5.1 The Advisory Group is an effective mechanism for co-ordinating contributions to formal consultations on major developments. It also provides a means to ensure consultations concerning the built environment take account of the potential implications for health and well-being.

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

6.1 The Advisory Group aims to improve health and well-being by influencing planning policies and development in Thurrock to:

- make sure people stay healthy longer, adding years to life and life to years;
- reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home;
- enhance quality of life through improved housing.

## 7. Implications

### 7.1 Financial

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

This report is for the Health and Wellbeing Board's information. Financial implications will be considered as the Housing and Planning Advisory Group's programme develops further

7.2 **Legal**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

This report is for the Health and Wellbeing Board's information. Legal implications will be considered as the Housing and Planning Advisory Group's programme develops further.

7.3 **Diversity and Equality**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

This report is for the Health and Wellbeing Board's information. Diversity implications will be considered as the Housing and Planning Advisory Group's programme develops further

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

- There are none.

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

- The report of the Housing Our Ageing Population Panel for Innovation: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/378171/happi_final_report_-_031209.pdf
- The Housing LIN Case Study on Building Positive Futures in Thurrock http://www.housinglin.org.uk/_library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy72_Thurrock.pdf
- Planning Practice Guidance Methodology: assessing housing need http://planningguidance.planningportal.gov.uk/blog/guidance/housing-and-economic-development-needs-assessments/methodology-assessing-housing-need/

**9. Appendices to the report**

- Housing and Planning Advisory Group Terms of Reference.

**Report Author:**

Christopher Smith, Programme Manager, Adults, Housing and Health

# Appendix 1

**Health and Wellbeing Housing and Planning Advisory Group**
**Terms of Reference[1]**

## Background and Purpose

Major planning decisions will have a significant impact on the health and wellbeing of individuals and communities. The implications can be both positive and negative. The negative implications can be minimised or mitigated and the positive implications enhanced with early input from the right individuals, and if plans are then developed accordingly.

The Health and Wellbeing Board recognise, in terms of the wider determinants of health and wellbeing, the significance of good planning and development. . The purpose of the Advisory Group is to look at significant development plans (major) at the earliest possible stage (pre-application where possible) to enable full consideration of the health and wellbeing impact. The functions of the Advisory Group are set out below.

## Functions

- To review emerging development plans (those classified as 'major'[2]) – at an early stage – e.g. either at pre-application if applicable, or post-application;
- Identify health and wellbeing implications of the plans being considered;
- Identify how the proposed developments might mitigate or minimise any negative implications and emphasis any positive implications;
- Consider the impact of planning proposals on existing local infrastructure including the availability of pupil places;
- Provide initial input on how developments can consider preventative measures to support the reduction of crime on new developments (Design Out Crime)
- Provide an opinion on plans that can be considered by planners, as part of the formal consultation process on major plans;
- Provide an option on plans that can be considered by developers and planners on major plans submitted pre-application;
- Link with developers to influence thinking – e.g. via Council-sponsored meetings and forums;
- To make recommendations for supported housing provision;

[1] Terms of Reference agreed and approved by the HWB Housing and Planning Advisory Group on 15th May 2014

[2] A major planning application is defined as the creation of at least 10 residential units; Work on a residential development on a site of 0.5 hectares or more; Work on a non-residential development on a site of 1 hectare or more; The creation or change of use of 1000m2 or more of gross floor space (does not include housing). Major planning applications are given 13 weeks in which to be determined as they are more complex and will usually require a greater level of consultation and negotiation.

- Inform and engage in the development of Thurrock's Local Plan; and
- Input in to emerging policy and strategy.
- Identify how section 106 monies might best be spent to enhance health and wellbeing and make recommendations;

**Membership**

Membership will consist of representatives of the following:

- Planning Department
- Housing Department
- NHS Thurrock Clinical Commissioning Group
- Public Health
- NHS England (Essex Local Area Team)
- Adult Social Care
- Essex Police
- Community Health Partnership
- Children's Services

Membership will alter as appropriate and be reviewed annually. Depending upon the nature of the application and its impact, individual members may also wish to submit a separate response – e.g. Public Health or CCG. Substantial members are set out at Appendix B.

**Frequency of Meetings**

- The Advisory Group will meet monthly to consider major applications

**Chair Arrangements**

- Les Billingham - Assistant Director, Adult Social Care and Community Development
- Leigh Nicholson - Development Management Team Leader Planning

**Governance**

- The Advisory Group has accountability to the Health and Wellbeing Board and sits within the Board's structure.
- The Advisory Group will report its work to the Health and Wellbeing Board on an annual basis, usually of July of each year.
- Comments made by the Group will be submitted to the Planning Department as part of the formal consultation process for major applications or the informal consultation process if commenting on a proposal pre-application

**Operation**

- Received applications will be circulated to Advisory Group members for comment alongside papers for the next meeting;

- Minutes of meetings will be circulated to HPAG members within one week following the meeting. Amendments or revisions should be suggested by members within 3 working days otherwise the minutes will be deemed approved in advance of the next meeting.
- Once approved key points made by HPAG members about planning applications, as captured in the minutes, will be submitted to the formal planning portal by HPAG Business Management
- Records of applications considered by HPAG and responses provided to the Planning Portal will be recorded centrally by HPAG Business Management

**Review**

The Terms of Reference will be reviewed on an annual basis. Minor changes to the Terms of Reference will be approved by the Chair and Planning Department representative. Major changes to the Terms of Reference will be approved by the Health and Wellbeing Board – after consultation with the Planning Department to ensure consistency with the Planning process.

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NHS
Thurrock
Clinical Commissioning Group

# MINUTES
## Integrated Commissioning Executive (ICE)
26 April 2018

**Attendees**

Roger Harris – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Jeanette Hucey – Director of Transformation, NHS Thurrock CCG
Iqbal Vaza – Strategic Lead for Performance, Quality and Information, Thurrock Council
Ian Wake – Director of Public Health, Thurrock Council
Jane Foster-Taylor – Chief Nurse, NHS Thurrock CCG
Catherine Wilson – Strategic Lead for Commissioning and Procurement, Thurrock Council
Jo Freeman – Management Accountant, Thurrock Council
Tendai Mnangagwa - Head of Finance, NHS Thurrock CCG
Maria Wheeler, Acting Chief Finance Officer, NHS Thurrock CCG
Christopher Smith – Programme Manager Health and Social Care Transformation, Thurrock Council
Darren Kristiansen – Business Manager Health and Wellbeing Board, Thurrock Council

**Apologies**

Mandy Ansell – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Mark Tebbs – Director of Commissioning, NHS Thurrock CCG
Les Billingham – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Mike Jones – Strategic Resources Accountant, Thurrock Council
Allison Hall – Commissioning Officer, Thurrock Council
Philip Clark – Continuing Health Care Transformation Lead
Ceri Armstrong - Senior Health and Social Care Development Manager, Thurrock Council

1. **Minutes of the last meeting**

   The minutes of 29 March were approved as an accurate record. Members considered the action log and agreed which actions could now be closed. These are reflected in the updated action log, circulated with these minutes

2. **BCF Plan 2017-19 – Performance DTOC Report and the BCF scorecard**

   Iqbal Vaza introduced the item. Key points included:

   Total non-elective admissions in to hospital (general & acute), all age

   - There have been 15,839 non-elective admissions in the YTD. The monthly figures have been amended to the new figures provided by the CCG. The target of 12,351 equates to a year-to-date target of 11,322 which means the indicator is currently 4,507 over target (Red). The year-end projection is 17,279 which will be 4,928 over target.
   - Members were asked to note that there has been a change as to what is included as non-elective admissions. Previously admissions in the Ambulatory Care and CDU were recorded as outpatients but now they are recorded as non- elective.

- Due to this change the CCG has agreed a new target trajectory with NHS England; however the BCF target cannot be changed at this stage to make it reflect the new target.
- The new target agreed with NHS England is 16,374 which is 4,023 higher than the BCF target. The year-to-date target is 14,962 which would make the indicator only 877 over target. The year-end projection would be 905 over target.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation

- In Quarter 4, 50 out of 58 service users that were discharged from hospital into reablement/rehabilitation were still at home 91 days later, which equates to 86.2%. This is 4.8% under target but is an increase from the Quarter 3 outturn. As this indicator is a snapshot the Quarter 4 figure is the official outturn used in the national ASCOF indicator. However, members were asked to note that due to data lags in updating the system, the year-end/Q4 figure is provisional and may change.
- Of the 8 individuals who were not at home 91 days later, 5 had passed away, 1 was in hospital and 2 were in residential care. With 5 individuals deceased the maximum percentage that could have been attained (if everyone else was at home) would be 91.4%

During discussions the following points were made:

- Members noted that 24 DTOC days were attributed to Adult Social Care in January 2018, providing the best performance in the FY to date. Members were interested to learn more about the cause of the improvement and welcomed further exploration and an update at the next ICE meeting

  **Action Iqbal Vaza**
- Members agreed that in future information about the total non-elective admissions to hospital will provide an update on performance against the new target which incorporates ambulatory care and CDU as non-elective and performance against the previous target which did not consider ambulatory care and CDU as non-elective.

  **Action Abdul Ahad** to provide figures under the old definition as well as the new definition so a comparison can be made. This should be provided to Ann Laing on a monthly basis

  **Action Ann Laing** to incorporate into reports provided to ICE

- Members were keen to learn about provision targets that had previously been set for 2018/19. Christopher Smith agreed to circulate provisions targets for 2018/19 based on the previous BCF submission

  **Action Christopher Smith**

**3. BCF Plan 2017 – 2019 Finance Report**

Jo Freeman updated members. Key points included:

- The value of the 18-19 pool will be confirmed at May's ICE following the LA's pay award and increment allocation. Members were being asked to approve provisional budgets at this stage
- There is 300k non-recurrent money to be allocated in 18-19 and a separate winter pressures allocation to be utilised later in the year
- All identified CCG & LA pressures have been met with the additional iBCF funding, 17-18 underspend and reallocation of funds from on-off projects in 17-18.

During discussions the following points were made:

- ICE members approved provisional budgets for 2018/19.
- Members were advised that a meeting will be arranged between ASC and CCG Commissioners to consider GP provision at Collins House and will report back at the next ICE meeting.

**Action Mark Tebbs and Catherine Wilson**

- Members requested an update on the Thurrock First System Integration project at the next meeting.

**Action Emma Sanford**

- It was agreed that provisional figures for 2018/19 will be circulated with these minutes

**Action Secretariat (complete)**

**4. Integrated Commissioning Contracting Plan and revising ICE Terms of Reference**

Catherine Wilson provided members with an update which included:

- Reminding members that the purpose is to develop the Commissioning and Contracting Model for Thurrock CCG and Thurrock Council Adult Social Care to deliver integrated commissioning within the remit of an 'Integrated Care Alliance'.
- Advising members that a draft project plan has now been created.
- There are plans to hold three workshops:
  - Workshop one will target commissioners and consider how Alliance Contracting might work in Thurrock
  - Workshop two will be a mapping workshop with all stakeholders, including providers to discuss and agree aims for an Alliance approach in Thurrock
  - Workshop three will be arranged to consider and agree next steps

During discussions the following points were made:

- It will be important to ensure that Children's Directorate and Corporate Procurement Team (Sharon Bayliss or Stephanie Seft) are engaged in this process

**Action Catherine Wilson**

- It was agreed that the project should learn from effective practice demonstrated elsewhere and that consideration should be given to how Alliance Agreements are established elsewhere. Jeanette Hucey advised members about information available about London Borough of Croydon's approach and agreed to provide copies of relevant documentation for circulating to members.

**Action Jeanette Hucey (Completed)**

**5. IBCF and BCF Quarterly returns (quarter 4)**

Christopher Smith advised members that iBCF and BCF quarter 4 returns had been circulated to ICE members electronically and are approved by the group

**6. Using BCF in future to pool budgets within Thurrock for placement costs / LD Transformation paper**

It was agreed that this item would be deferred until the next meeting.

**Action Catherine Wilson and Mark Tebbs**

**7.AOB**

No other business was raised or considered by members.

The meeting concluded at 10.18am

# Meeting Planner

## Health and Wellbeing Board

### Health and Wellbeing Board Executive Committee

| Meeting | Meeting date and time | | Meeting | Meeting date and time |
|---|---|---|---|---|
| Exec Committee | 24/5/18 (2-3:30pm) | | Exec Committee | 29/11/18 (2:30-4pm) |
| HWB | 8/6/18 (10:30-1pm) | | Exec Committee | Dec 18 To be arranged |
| Exec Committee (Cancelled) | 19/6/18 (3-4:30pm) | | HWB | 25/1/18 (10:30-1pm) |
| Exec Committee | 19/7/18 (3-3:30pm) | | | |
| HWB | 20/7/18 (1:30-4pm) | | | |
| Exec Committee | 16/8/18 (2-3:30pm) | | | |
| HWB | 21/9/18 (10:30-1pm) | | | |
| Exec Committee | 27/9/18 (2-3:30) | | | |
| Exec Committee | 18/10/18 (2-3:30) | | | |
| HWB | 23/11/18 (10:30-1pm) | | | |

| Meeting | Date | Agenda | Key Deadlines | Secretariat Notes |
|---|---|---|---|---|
| | | | | |
| **Health and Wellbeing Board meeting** | Friday 13 July 2018 10.30 – 1.00<br><br>Amended to **Friday 20 July 1:30-4:00pm following request from Cllr Halden** | 1. STP Update<br>2. Primary Care Strategy<br>3. Mental Health Peer Review Findings<br>4. Thurrock Dementia Action Plan (Catherine Wilson / Irene Lewsey)<br>5. Health and Wellbeing Strategy Annual Report – Year 2 (to include update on Outcomes Framework)<br>6. HWB Terms of Reference<br>7. HPAG Annual Report and HPAG TOR<br>8. HWB Exec Committee (5 April, 24 May and 14 June) and ICE minutes (May) | Implications and papers ready to brief Cllr Halden: Friday 29 June<br><br>Publishing date: Thurs 12 July | Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September<br><br>Invitations sent to members |

| Meeting | Date | Agenda | Key Deadlines | Secretariat Notes |
|---|---|---|---|---|
| Exec Meeting | Thurs 19 July 2018<br>2.00 – 3.30<br>3rd floor room 4 | 1. How to address concerns about ASB / Possible drug dealing in HWB Strategy under Goal Healthier Environments | | |
| Exec Meeting | Thurs 16 August 2018. 2:00pm-3:30pm<br>3rd floor room 4 | | | |
| **Health and Wellbeing Board meeting** | **Fri 21 September 2018**<br>**10.30 – 1pm** | 1. Adult Mental Health Peer Review findings Local Action Plan<br>2. SEND Disabilities local area self-assessment (Malcom Taylor)<br>3. Emotional wellbeing in schools (building on Mental Health Summit)<br>4. BTUH Performance and operational update and update on visit (Deferred as visit being arranged for mid-August)<br>5. Cancer care<br>6. Air Quality and<br>7. The East of England Ambulance Service | Implications and papers ready to brief Cllr Halden: Friday 31 Aug<br><br>Publishing date Thurs 13 Sept | Room reserved from 10.00-1.30 CR1<br>Invitations sent to members<br><br>Item 1 Mandy asked to be deferred from July HWB meeting<br><br>Item 4 Emotional health and wellbeing in schools suggested by Michele Lucas<br><br>Items 5-7 agreed at 8 June HWB |
| Exec Meeting | Thurs 27 September<br>2.00 – 3.30<br><br>3rd floor room 4 | | | |

| Meeting | Date | Agenda | Key Deadlines | Secretariat Notes |
|---|---|---|---|---|
| Exec Meeting | Thurs 18 October 2018<br>2.00-3.30<br><br>3rd floor room 4 | | | |
| **Health and Wellbeing Board meeting** | **Friday 23 November 2018**<br>**10.30 – 1.00pm**<br><br>**Committee Room 1** | Plan on a page and Education attainment results (Michele Lucas)<br>Reflects agenda item being included on Nov 17 HWB<br><br>Open Up Reach Out Year Four Sign Off emotional wellbeing and mental health services for young people. Paula McCullough | Implications and papers ready to brief Cllr Halden: Fri 2 Nov<br><br>Publishing date Thurs 15 Nov | Request sent to room hire on Mon 26 March – Invitations sent to members |
| Exec Meeting | Thursday 29 November 2018<br>2.30-4.00pm.<br>3rd floor room 5 | | | Room reserved, invitations sent to members |
| Exec Meeting | December 2018 | | | |
| **Health and Wellbeing Board meeting** | **Friday 25 January 2019**<br><br>**10.30 – 1:00pm CR1** | | Implications Fri 4 Jan<br>Final papers to me: Monday 14 Jan<br>Publishing date 18/1/19 | Request sent to room hire on Mon 26 March – Invitations to be sent to members<br><br>Papers to be sent to Ceri as I will be on AL |
| Exec Meeting | January 2019 | | | |
| Exec Meeting | February 2019 | | | |
| **Health and Wellbeing Board meeting** | March 2019 | | Implications and papers ready to brief Cllr Halden:<br>Publishing date | |
| Exec Meeting | March 2019 | | | |