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

# Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **6.30 pm** on **11 January 2024**

**Committee Room 2, Civic Offices, New Road, Grays, Essex, RM17 6SL.**

**Membership:**

Councillors Mark Hooper (Chair), Georgette Polley (Vice-Chair), Tony Fish, Terry Piccolo, Neil Speight and James Thandi

Georgina Bonsu (Thurrock Lifestyle Solutions) and Kim James (Healthwatch Thurrock Representative)

**Substitutes:**

Councillors John Cecil, James Halden, Mark Hurrell, Augustine Ononaji and Joycelyn Redsell

**Agenda**

Open to Public and Press

**Page**

**1. Minutes** **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 2 November 2023.

**2. Apologies for Absence**

**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. To agree any relevant briefing notes submitted to the Committee.

**4. Declarations of Interests**

| | | |
|---|---|---|
| **5.** | **HealthWatch** | |
| **6.** | **Updates from Mid and South Essex Trust** | **13 - 30** |
| **7.** | **EPUT Update - Powerpoint Presentation** | |
| **8.** | **Integrated Health and Wellbeing Centres (IMWCs) and co-location opportunities across Thurrock** | **31 - 38** |
| **9.** | **The Mid and South Essex Primary Care Access Recovery Plan** | **39 - 46** |
| **10.** | **Commissioning Report - Domiciliary Care** | **47 - 82** |
| **11.** | **Work Programme** | **83 - 86** |


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

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **3 January 2024**

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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?**

**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

**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 Overview and Scrutiny Committee held on 2 November 2023 at 7.00 pm**

| | |
|---|---|
| **Present:** | Councillors Mark Hooper (Chair), Georgette Polley (Vice-Chair), Terry Piccolo, Neil Speight and James Thandi<br><br>Georgina Bonsu – Thurrock Lifestyle Solutions |
| **Apologies:** | Councillor Tony Fish<br>Kim James (Healthwatch)<br>Diane Sarkar – Chief Nurse and Quality Officer Mid and South Essex NHS Foundation Trust |
| **In attendance:** | William Guy, Director of Primary Care in Mid and South Essex<br>Aleksandra Mecan, NHS MID AND SOUTH ESSEX IC<br>Jim Nicholson, Independent Chair – Thurrock Safeguarding Adults Board<br>Fiona Ryan, Mid and South Essex NHS Foundation Trust<br>Mark Tebbs, Thurrock CVS<br>Ian Wake, Corporate Director of Adults, Housing and Health<br>Rhiannon Whiteley, Senior Democratic Services Officer |

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

**21. Minutes**

The minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 31 August 2023 were approved as a correct record.

**22. Urgent Items**

The Chair provided an update to the Committee in relation to the Obesity and Mental Health Working Groups. He confirmed it has been a challenge to get officers to facilitate these groups, he has however been assured that by January officers will be available to support these groups. The updates expected in March from the working groups will therefore not be available.

The Chair also confirmed in relation to the Integrated Medical Centres (IMC's), it was decided in 2017 the Orsett hospital will close but not before the IMC's were in place. To date only one IMC is up and running and that is the one in Corringham. It looks like the Grays IMC will be on the Thurrock Hospital site which is good. The Tilbury IMC business case was rejected due to cost, Tilbury has a high level of need as the life expectancy there is 12

years shorter than any other part of Thurrock. Purfleet has the largest growing population in the Thurrock area.

At the 19 July 2023 Health and Wellbeing Overview and Scrutiny Committee meeting members were informed that a Plan B would be developed and presented at this meeting. I have received a request that this was deferred. I reluctantly agreed as I wanted to receive a plan that is going to work.

The Chair proposed that he and Councillor Coxshall will write a joint letter to NHS England requesting the reasons why the business case was rejected for Tilbury and Purfleet and what they will be doing to ensure there is adequate funding to develop the IMC's for Tilbury and Purfleet. The Chair sought the Committee's agreement to this. The Committee members agreed.

Councillor Thandi queried what the outcome of Orsett Hospital is.

Alex Mecan confirmed the Tilbury and Purfleet Business cases have not been formally rejected. The regional office has identified a number of queries regarding affordability and they will be working through these as part of preparing plan B. This will be brought back to the Health and Wellbeing Overview and Scrutiny Committee in January. The Orsett hospital has not yet formally closed, the site is still being used although certain services are being moved to the Thurrock Hospital site.

Councillor Speight raised concerns about the terminology being used, Committee Members were told Orsett Hospital would not close until every facility is replicated across the borough.

Councillor Polley echoed Councillor Speights comments and stated that she understood Thurrock would get increased services in the Borough not just a replicate of what is at Orsett Hospital. Councillor Polley stated that she agrees with the Chair's recommendation and highlighted that it needs to be taken to the highest level.

Councillor Piccolo sought assurance that if they do find somewhere to relocate Orsett Hospital's services that it will be able to cope with the same level of usage.

Alex Mecan responded that she could provide the assurance that is the intention and she would seek the Council's help to maintain transport links to those sites. Bus Services are vital for the elderly.

The Chair expressed concern that Orsett Hospital is being allowed to run down without sufficient funding to keep it in good condition which is criminal when Thurrock hasn't got the IMC's it was promised. Every party is behind getting these 4 IMC's up and running.

**23. Declarations of Interests**

Councillor Polley declared a non-pecuniary interest as in her role as a councillor she had been appointed by the Council to the Council of Governors for MSE for the non-executive directors.

Councillor Polley also declared a non-pecuniary interest in relation to her employment with the NSH Ambulance service.

## 24. Healthwatch

Kim James has given her apologies and there is therefore no report from Healthwatch today.

## 25. Thurrock Safeguarding Adults Board Annual Report 2022/23

The Independent Chair of the Thurrock Safeguarding Adults Board provided a Powerpoint presentation of the slides included in the agenda.

- Members thanked the Independent Chair of the Thurrock Safeguarding Adults Board for a detailed report which as a result members had few questions.
- Members were assured that the Adult Safeguarding Board work closely with Housing and a representative from the Housing team sits on the Board.
- Members asked about any future engagement events coming up. The Independent Chair of the Thurrock Safeguarding Adults Board stated that events do slow down in the winter due to the weather. They do receive cases from talking to people in the street.
- Members queried if they were aware of an event, could they invite the Adult Safeguarding Board to attend. The Independent Chair of the Thurrock Safeguarding Adults Board they would be grateful to receive invites.
- Members queried the financial situation and if the Adult Safeguarding Board would be affected. The Independent Chair of the Thurrock Safeguarding Adults Board responded that they receive funding from the Police and Health and currently due to the pandemic they have a significant underspend. A cost/ benefit analysis is completed nationally which confirms the work of the Board does save money.

## 26. General Practice Patient Survey 2023

The Executive Director of Adults, Housing and Health presented the report. He confirmed every year NHS England commission a GP Patient Survey. Overall satisfaction with Thurrock GP practices varies considerably, ranging from 30% to 90%. Satisfaction with general practice is multifactorial. It was clear that what is contributing to satisfaction mostly is access, when patients received the services they were largely satisfied with the care they received.

The Executive Director of Adults, Housing and Health confirmed that data should be the starting point for further questions to be asked and a much more detailed analysis is required. The Dell Medical Centre scores significantly better than England as a whole. It should be considered if we can spread better practices.

- Members queried why Thurrock is finding it hard to get Doctors to come to the area. The Executive Director of Adults, Housing and Health responded that due to being under-doctored the Doctors that are working in Thurrock may be become more stressed or retire early or go elsewhere. Newly qualified Doctors do not want to come to Thurrock. Integrated care will use all Health sources such as social care staff, addiction staff, Housing staff and Community Nurses in a more integrated way. One Doctor has provided feedback that integrated care has revolutionised the way he practised.
- William Guy, the Director of Primary Care in Mid and South Essex stated that they are trying to attract the right workforce. The national trend is alarming and there has been a reduction in GP's since the pandemic. Access is where dissatisfaction is the major issue. Everyone has been encouraged to access primary care at 8am in the morning regardless of need. There isn't enough GP's in the country if the default is if you go into primary care that you see a GP. Pharmacies and other community assets can provide the solution.
- Members raised the pressure, stress and abuse that is put on to GP Receptionists and support staff and called for them to be supported as well as GP's. Receptionists are now required to do more and are called 'Care Navigators'. The Director of Primary Care in Mid and South Essex stated that they are investing in new training for staff.
- Members highlighted that Thurrock's GP's need to be looked after and asked how they think things can be better. The Director of Primary Care in Mid and South Essex responded that they will complete a visit to every GP Practice.
- Members queried if there is scope for a Thurrock Health Awards to spotlight what is good and raise expectations.
- Members queried helping nurses with key worker housing and whether the Planning Committee could assist with this. The Chair suggested that this could be looked at in the Local Plan and stated that housing for Healthcare professionals should be encouraged.
- The Chair queried how many GP practices take on trainees. This may encourage newly qualified Doctors to stay in Thurrock.
- Councillor Hooper made an additional recommendation that a report is brought back to the January 2024 meeting as a response to the report. Councillor Hooper's recommendation was seconded by Councillor Speight.

**RESOLVED:**

**1.1 The Committee considered the findings of the GP Patient Survey 2023 summarised in the attached report and evidence pack and the implications for local NHS priorities.**

1.2 **The Chair requested a response is provided in response to the report and brought back to the January 2024 meeting.**

## 27. Update from Mid and South Essex NHS Foundation Trust

Fiona Ryan from the Mid and South Essex NHS Foundation Trust presented the briefing note included in the agenda.

- Members queried why they had not been provided any feedback in relation to the case of a gentleman who died which was raised at the last meeting. Fiona Ryan stated that she was unable to comment on individual cases and will look into this and respond to the Chair with some further information on this.
- Fiona Ryan clarified that they look at ambulance waiting time for Accident and Emergency around 6 times a day and meet about them face-to-face 4 times a day. All three hospitals are looked at to ensure they are supporting each other and the population. The target is to get 80% seen within 4 hours.
- Councillor Polley complimented Basildon Hospital on the urgent mental health care department.
- The Chair commented in relation to the Industrial action that he hoped the Government and Unions can come to an agreement soon as it is having a negative effect on the people of South Essex.
- Fiona Ryan stated in relation to maternity services it had been some years since they had been inspected, neo-natal death rates are being monitored closely and there is no concern in the MSE data. Staff members are being given additional opportunities to raise any concerns. Maternity colleagues will provide a report for the next meeting.
- Members raised concerns about the fabric of the building at Basildon and water getting into building. Fiona Ryan confirmed there is a backlog with maintenance of the building. The patch and repair approach has not been the most cost effective. Fiona Ryan will liaise with Jonathan and provide an update.
- The CDC at Pitsea should increase availability of diagnostic services and help residents to get diagnosed more quickly and hopefully bring some activity away from the Hospitals and into communities.

## 28. Phlebotomy update from Mid and South Essex NHS Foundation Trust

Fiona Ryan from the Mid and South Essex NHS Foundation Trust presented the briefing note included in the agenda. She confirmed that demand for phlebotomy had increased from 30,000 per month in 2020 to 45,000 per month in 2022. Thurrock clinic has one of the highest levels of patients who do not attend their appointments.

- Members raised that some of the patients who did not attend their appointments may have in the interim whilst waiting for their appointment been admitted to Hospital
- Members raised concerns regarding patients who require blood tests before treatment and if anything can be done to ensure they get access to a blood test in time
- Members raised that you cannot get a same day blood test appointment in Thurrock on Swift Queue but you could get same day appointments in Kent, Southend, Basildon, Wickford and Billericay. Members noted that if you have a vehicle, can work flexibly and do not have dependants you may be able to get an appointment earlier at some distance away but that is not fair on those who do not have this option. It is also not fair on those using the walk-in option who have a long wait as some are not able to do this if they have dependants. The Chair noted that the walk-in services has become a race like getting GP appointments.
- Fiona Ryan stated that she will take back to the team the points raised about the walk-in service.
- The Vice-Chair raised concern that questions are not being answered in relation to the issues of blood test appointment issues from the Committee or in her capacity as a Governor. Members raised that those in the west of the Borough get offered Queens hospital as an option but there can be a delay in the test results getting back to their GP.
- The Chair highlighted that it is not cost effective to Health for residents to be waiting 8 weeks for a blood test. 18 months ago the service was fairly responsive and is not now. The Chair urged the Trust to deal with this as a matter of urgency.

**29. Work Programme**

The Chair asked the Committee to agree to the next meeting on 11 January 2024 starting at 6.30pm. The Committee members agreed.

Councillor Speight requested a report on the LGBT Community services. He stated that it may fit under the EPUT update. Councillor Speight raised that lots of distressed families are concerned that support services for the LGBT Community are not being well-run. The Chair suggested this could be brought to the March meeting. The Executive Director of Adults, Housing and Health stated that someone from the NHS specialist provision team would probably be the right person to bring this back.

Councillor Polley raised that the waiting times for neurodivergent children diagnoses is two years plus. The Executive Director of Adults, Housing and Health suggested this may be for the Children’s Services Overview and Scrutiny Committee to look at and he suggested Councillor Polley discusses this with Councillor Carter.

**The meeting finished at 9.13 pm**

Approved as a true and correct record

**CHAIR**

**DATE**

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

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## Health Overview and Scrutiny Committee

# Briefing Note: An update from Mid and South Essex NHS Foundation Trust

| **Purpose of the briefing note:** | To answer previous questions from members and provide updates on operational data from Mid and South Essex NHS Foundation Trust |
|---|---|

**1.1** This briefing provides an update on topics of questioning from members at the previous HOSC meeting on 2 November 2023

**1.2** Update on maternity action plan for CQC:

**Background**
In June 2022, the CQC inspected the three maternity services across Mid and South Essex NHS Foundation Trust's acute sites. In December 2022 the CQC rated the services as 'requires improvement'.

The Trust went through all the actions, which were 'must do' and 'should do' and prioritised those could be quickly improved. There are also weekly Maternity Improvement Programme meetings to keep the Trust on track with making the improvements.

The Maternity Improvement Programme (MIP) focuses on *32 of the outstanding CQC actions and continues to drive towards the Trust Evidence Assurance Group process to sign off these actions when they are completed. Weekly site CQC meetings are in place to discuss with the heads of Midwifery, matrons, and Governance lead plans and progress, which is further overseen in workstream meetings.

**CQC Maternity Should Do's: 38 initially; 20 complete with evidence, 5 complete, 13 in progress. This covers Basildon, Broomfield and Southend sites.**

| Domain | Blue (Complete with Evidence) | Green (Complete) | Yellow (in progress) | Total outstanding | Total of all CQC actions |
|---|---|---|---|---|---|
| SAFE | 6 | 1 (*CQC 7.3) | 11 | 12 | 18 |
| EFFECTIVE * | | | | | |
| RESPONSIVE | | | 3 | 3 | 3 |
| WELL LED | 12 | 1 | 4 | 5 | 17 |
| Total | 20 | 5 | 13 | 18 | 38 |

*The previously listed Effective has been corrected and counted within Well Led.

A summary of the Must do actions is below. Actions have only been included for Basildon Hospital, as that is where most women and birthing people attend from Thurrock.

**Completed actions**

- The report picked up on staff culture and working together effectively, this has been addressed now and the action is complete
- Levels of harm and incidents are now graded accurately. Staffing is reviewed regularly and any safety concerns raised at daily safety meetings
- All equipment is now checked and logged, and medicines are stored safely.

**In progress**

- Mandatory training, appraisals, recording of medicines, staffing and record keeping are all in progress and are being improved
- The Trust's target is 85% for completion of mandatory training, and maternity teams are meeting this target. Record keeping is included in this mandatory training as is recording of medicines
- Appraisals are also improving with over 69% of appraisals now completed, and a plan for us to reach target by the end of March 2024.
- There has been successful recruitment of international midwives while the Trust waits for a pipeline of newly qualified midwives to join from Anglia Ruskin University, and are the Trust is almost up to its full establishment of staff
- The Trust will aim to improve continuously, and certainly to have addressed all the issues in full by the end of this financial year.

### 1.3 Estates and capital works

This paper will report on:

- Overview of Trust estate
- Backlog maintenance
- Estates strategy and planning
- Capital resources

**1.31 Mid and South Essex NHS Foundation Trust overview**

The Trust formed in April 2020 following the merger of Mid Essex, Southend and Basildon Hospital trusts. It is one of the largest trusts in the country, with an annual turnover of £1.4 billion and which employs 16,000 staff. The Trust delivers services to a population of around 1.2 million across mid and south Essex, through over 1,700 in-patient beds and 64 theatres across the three main acute hospital sites. There are capacity issues across all acute sites, and mixed quality community premises.

The Trust estate covers:

- Broomfield Hospital 128,000 $m^2$
- Basildon Hospital 137,000 $m^2$
- Southend Hospital 93,000 $m^2$
- St Peter's Hospital 9,000 $m^2$
- Orsett Hospital 10,000 $m^2$
- St Andrew's centre 500 $m^2$
- + other community estate
- Total Trust estate = 397,000 $m^2$

**1.32 The Trust's approach to estates strategy development**

The Trust estates strategy addresses the three key questions set out in the NHS estate's guidance 'Developing an Estate Strategy':

- Where are we now?
- Where do we want to be?
- How do we get there?

The Trust's response to these questions is framed by a number of specific challenges and considerations:

- Addressing the significant levels of critical backlog maintenance
- The significant impact on urgent and elective care pathways, cancer services, diagnostics arising from the growth and changing population demographic

- The impact in acute care of constraints in access to primary care and adult social care
- Intensified financial challenge - impact of inflation, constraints on capital funding, and achieving efficiencies in running costs
- Exploring opportunities to Section 106 and Community Infrastructure Levy (CIL) contributions for acute care
- COVID-19 – short-term impact on waiting lists and service delivery and the longer-term impact on the future development and design of the estate
- Digital technology – a challenge and an enabler. The pace of change outstripping the cultural change necessary to realise the benefits fully
- Increasing sustainability and reducing the environmental impact.

While there are risks identified for the purposes of audit and safety, the Trust works hard to maintain all of its estates to a standard that keeps our patients and visitors safe.

**1.33 Current status of the Trust's estates**

There is a wide variation in the age and condition of Trust-owned estate. The Trust has significant levels of critical backlog maintenance, creating risk and impacting on functionality, service continuity and safety. There are also elements of poor statutory compliance and end-of-life and aged engineering systems.

Patients, visitors and staff can experience long waits to park, which has a knock-on impact to service delivery that is compounded by a lack of sustainable transport options. Across the estate there are examples of poor external circulation, signage, and public spaces, with improvements needed in energy performance. Alongside constrained sites and capacity issues, the Trust has a plethora of leases and freehold properties that need to be rationalised.

**A) Acute sites**

**Basildon Hospital** was built in 1973, covering residents of Basildon, Thurrock, and parts of Brentwood and Castle Point. It serves as a specialist site for cardiothoracic services through the world-renowned Essex Cardiothoracic Centre.

Key Issues

- Significant backlog maintenance
- End of life and aged engineering systems
- Poor energy compliance and resilience
- Lack of parking
- Poor external circulation and signage
- Number of temporary buildings
- Dispersed teams, creating barriers to effective working.

**Broomfield Hospital** was built in the late 1930s, with significant additions made in the 1970s, 1990s and 2000s. It covers residents of Chelmsford, Maldon, and Braintree (including Witham), serving as a specialist site for plastics and burns across Essex.

Key Issues

- Backlog maintenance issues
- RAAC - present in the roof of an area (3,562 $m^2$) used for medical records storage and facilities management services
- Parking congestion.

**Southend Hospital** was built in the 1930s, with the addition of the tower block in 1971 and the Cardigan Wing in the 1990s. It covers residents of Southend-on-Sea, Rayleigh and Castle Point, and serves as specialist site for cancer services.

Key Issues

- Significant space constraints
- Significant backlog maintenance
- Failures in the heating system, external cladding, and routine lift failures
- Fire compartmentation breaches and poor fire dampers
- Degraded gas pipework
- High-risk asbestos removal
- Poor electrical resilience.

**B) Non-acute sites**

**St Peter's Hospital, Maldon**

- Built in the 1870s, the building has grown incrementally over the years with a variety of extensions having a wide range of building styles and ages
- Significant backlog maintenance - the six-facet survey completed in January 2022 graded the overall condition of the site as poor with 76% of the internal area exhibiting defects, 52% of which is high-risk when viewing condition backlog costs by risk.

**Brentwood and Braintree PFIs**

- **Brentwood Community Hospital**: PFI built in 2007-8. It is managed by NHS Property Services. There is a 30-year lease, providing inpatient, outpatient and diagnostic services.
- **Braintree Community Hospital**: PFI lease that expires in January 2040. The premises return to the Trust in its entirety on expiry of the lease. It provides inpatient, outpatient and diagnostic services.

**C) Other community sites**

Freehold:

- St. Andrew's, Billericay

Leased:

- Eastgate Shopping Centre
- Victoria Shopping Centre
- Britannia Park, Southend
- Fairfields, Chelmsford
- Canvey Primary Care Centre
- Tyrells, Southend
- Lighthouse Centre, Southend
- Balmoral Road, Southend
- Castle Road, Rayleigh
- Wren House, Chelmsford
- Greenbury House, Chelmsford

**1.34 Orsett Hospital**

- Developed circa 1960 and has since decreased in overall size. Some extensions and refurbishment in the 1970s and 1980s
- Significant backlog maintenance – the six-facet survey completed in January 2022 graded the overall condition of the site as poor with 76% of the internal area exhibiting defects, 56% of which is high-risk when viewing condition backlog costs by risk
- Identified for disposal in Sustainability and Transformation Programme – the NHS in mid and south Essex has committed to maintaining the site until services can be decanted locally.

**Strategic considerations**

We acknowledge the challenges around affordability of the Tilbury and Purfleet Integrated Medical and Wellbeing Centres (IMWCs) and this will inevitably impact our plans to some extent for re-location of services from Orsett Hospital. However, the majority of services at Orsett Hospital have always been planned to be re-provided at Grays and we remain committed to developing proposals for this site.

The benefits of co-location of services remains clear, with the new Thurrock Community Diagnostic Centre (CDC) opening on the Grays IMWC site in late 2024; and providing improved buildings for our patients is also hugely important to us. The Thurrock CDC is not an alternative to the IMWC at Grays. Any activity that can no longer be provided at the Tilbury and Purfleet sites will remain within Thurrock and we will seek to explore alternative options to deliver this. Clearly each service move is likely to require capital funding and until this funding is available, services will remain where they are currently based at Orsett Hospital.

Mid and South Essex NHS Foundation Trust and Mid and South Essex Integrated Care Board remain committed to retaining local services in Thurrock and until suitable alternative provision can be realised, Orsett Hospital will remain open to facilitate this.

### 1.35 Backlog maintenance

A detailed six-facet survey was undertaken in 2021-22 to evaluate the estate. The results demonstrate that the physical condition and statutory compliance standards of the estate present a significant risk of deterioration. There are currently insufficient local capital funds available for backlog maintenance to bring the estate portfolio up to required standard or fully mitigate all risks, and the physical condition and statutory compliance standards continue to deteriorate further year by year due to lack of resource to fully support necessary capital and lifecycle maintenance.

The Trust works hard to maintain services and estate and ensure they are safe for patients to attend and use. However, below is the total cost of tackling the backlog maintenance issues at each site, as identified in the six-facet survey completed in January 2022:

| Backlog overall risk summary costs | | | | | | |
|---|---|---|---|---|---|---|
| **Risk Category** | **Basildon** | **Broomfield** | **Southend** | **Orsett** | **St Peters** | **All Sites** |
| Low | 2,062,800 | 300,000 | 1,553,200 | 180,445 | 172,140 | **4,268,585** |
| Moderate | 14,219,930 | 5,580,700 | 20,585,537 | 1,716,665 | 727,103 | **42,829,935** |
| Significant | 10,489,893 | 4,989,200 | 13,214,353 | 1,385,005 | 2,962,333 | **33,040,784** |
| High | 3,313,000 | 452,000 | 2,250,000 | 4,118,154 | 4,127,028 | **14,260,182** |
| **Total** | **30,085,623** | **11,321,900** | **37,603,090** | **7,400,269** | **7,988,604** | **94,399,486** |
| | | | | | | |
| **Condition backlog maintenance works costs by area** | | | | | | |
| | **Basildon** | **Broomfield** | **Southend** | **Orsett** | **St Peters** | **All Sites** |
| Building | 14,280,450 | 2,806,950 | 19,745,750 | 3,386,385 | 7,092,982 | 47,312,517 |
| M&E | 3,256,050 | 1,335,150 | 4,640,350 | 893,860 | 725,120 | 10,850,530 |
| Statutory compliance | 9,850,680 | 5,397,650 | 10,436,487 | 2,728,900 | 138,620 | 28,552,337 |
| Fire Safety | 2,698,443 | 1,782,150 | 2,780,503 | 391,124 | 31,883 | 7,684,103 |
| **Total** | **30,085,623** | **11,321,900** | **37,603,090** | **7,400,269** | **7,988,604** | **94,399,487** |
| | | | | | | |
| **Condition future planned costs for future maintenance works (5 years)** | | | | | | |
| | **Basildon** | **Broomfield** | **Southend** | **Orsett** | **St Peters** | **All Sites** |
| Building | 6,000,900 | 5,068,000 | 6,875,625 | 741,378 | 2,017,376 | 20,703,279 |
| M&E | 4,738,950 | 9,814,850 | 5,581,700 | 1,107,346 | 2,494,228 | 23,737,074 |
| Statutory compliance | 0 | 0 | 0 | 0 | 0 | 0 |
| Fire Safety | 0 | 0 | 0 | 0 | 284,052 | 284,052 |
| **Total** | **10,739,850** | **14,882,850** | **12,457,325** | **1,848,724** | **4,795,656** | **44,724,405** |
| | | | | | | |
| **Combined total costs** | **40,825,473** | **26,204,750** | **50,060,415** | **9,248,993** | **12,784,260** | **139,123,892** |
| **Combined inc. on costs** | **64,095,993** | **41,141,458** | **78,594,851** | **14,520,918** | **20,071,288** | **218,424,508** |

### 1.36 Where does the Trust want to be?

The Trust's estates objectives include:

- Generic, fit-for-purpose estate, capable of supporting diverse activity and being sustainable and digitally enabled
- Reduce the critical backlog maintenance
- Improve efficiency and effectiveness by maximising the benefits of digital technology and fully using all clinical and non-clinical space.
- Dispose of assets that do not meet the criteria of modern standards for clinical service delivery
- Estate that complies with performance and quality standards and adheres to net-zero carbon principles
- One Public Estate – optimising opportunities to support new models of care as part of a coordinated approach to deliver care closer to home.

The following have been considered when working towards achieving these objectives:

- System allocated funding – Capital constraints and affordability
- Service and clinical priorities – the impact on the estate of any proposed changes
- Activity – key activity and capacity planning metrics, including population growth and demographic changes
- Bed occupancy, average length of stay, theatre use and how many sessions take place
- Outpatient department use – the impact of virtual clinics
- Space occupancy – including the needs of an agile workforce
- Levels of critical backlog maintenance.

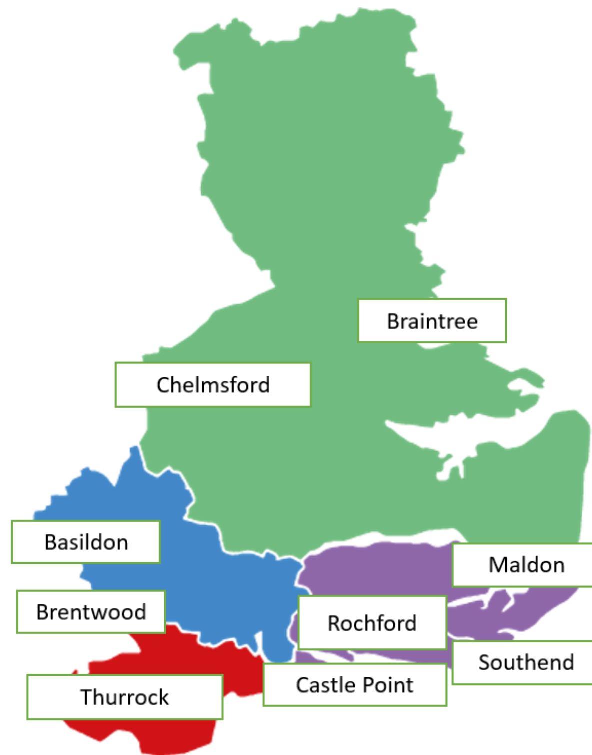
**1.37 Local planning – impact on acute services**

- It is important to understand the consequential impact of population growth and demographic changes as planning policy has a direct impact on health service demand
- The Government's standard methodology, adopted in 2018, calculates an annual housing requirement for each local authority. If met in full, 6,827 houses would be built across mid and south Essex per year, or 34,135 over five years. When multiplied by the average household size in each district this equates to a potential population increase of 81,926 across mid and south Essex
- Recognising that this may be an over-estimate, as the housing requirements are often not met in full, a comparative projection using ONS household data reflects a population increase of 46,000 across mid and south Essex between 2024-2029
- Therefore, the growth in the local population is anticipated to fall between the two projections.

Five year growth projections

| Local Authority | Based on housing requirement Five year projection | ONS Projection Population change 2024-2029 |
|---|---|---|
| Basildon | 12,492 | 8,000 |
| Braintree | 10,224 | 5,000 |
| Brentwood | 7,248 | 4,000 |
| Castlepoint | 4,224 | 2,000 |
| Chelmsford | 11,340 | 6,000 |
| Maldon | 3,780 | 2,000 |
| Rochford | 4,320 | 3,000 |
| Southend | 13,536 | 7,000 |
| **Thurrock** | 14,763 | 9,000 |
| **Total** | **81,926** | **46,000** |

In addition to the impact on services, key worker accommodation and acute healthcare, provider access to Section 106/CIL contributions are key considerations.




**1.38 How do we get there – delivery across four key areas**

- Mid and South Essex NHS Foundation Trust local and national strategic objectives
- Mid and South Essex Integrated Care System objectives
- A programme of work funded through capital investment, commercial opportunities and alternative funding sources
- Ongoing planned preventative maintenance works

**Delivering mid and south Essex local and national strategic objectives**

The core principles of estates development and the clinical principles set out in the Trust's Merger Business Case, which formed the basis of the public consultation, remain.

- Principle 1 – Emergency Departments will remain at each acute site, and Emergency Care Hubs will be established
- Principle 2 – Consolidation of certain specialist inpatient services
- Principle 3 – Consolidation of specialist emergency services, for example, stroke
- Principle 4 – Separation of emergency and elective care
- Principle 5 – Care moved closer to the patient's home.

**Clinical principles**

- Reorganise acute hospital services to provide high-quality, safe care, focused on consolidating more specialised services in one place,

separating emergency and elective care where appropriate and enabling the provision of some services to be provided more locally, closer to where people live
- Build capacity outside the hospital organised around natural communities (Localities).
- Manage demand across primary, community and acute settings via a step-change in prevention, developing integrated pathways and strengthening capacity in the urgent and emergency care pathway.

**1.39 Capital investments**

**A) Acute clinical reconfiguration investment - £118 million**

- The Trust has received confirmation from the Department of Health and Social Care (DHSC) of the provision of £110 million of capital funding. This is the money needed to enable the Trust to progress the clinical reconfiguration, detailed in the 2018 Your Care in the Best Place public consultation.
- The formal agreement will see approximately £40 million of funding released to the Trust over the period until March 2025, allowing all remaining schemes in the programme to progress to Full Business Case stage. It will enable the Trust to deliver critical preparation works and then fully complete some elements of the build programme.
- This funding follows the earlier funding announcement of £8 million in January 2023, to improve and expand the emergency department at Southend Hospital. This £8 million was the first release of the previously agreed £118 million envelope.
- To deliver these positive changes, and to account of the inflationary impact of the affordability of the original capital schemes, there are now four distinct priority areas in the revised capital programme. These have been decided by clinical leaders, working closely with Integrated Care System partners, and are:

  Emergency Department schemes at all three sites:
  - Includes phase 1 and 2 for Southend ED
  - Works at Basildon and Broomfield to support modernisation of the departments and appropriate capacity

  Elective schemes – Basildon and Southend:
  - Modernisation of theatres and development of a day unit/23-hour facility at Basildon
  - Modernisation of the endoscopy suite to support JAG accreditation* and theatre refurbishment at Southend Hospital

  Bed capacity:
  - Renal ward reconfiguration and infrastructure at Basildon Hospital

- Ward capacity and shell space at Southend Hospital
- Improvement of environment and refocusing wards to enable additional ward capacity at Broomfield Hospital.

Enabling works and infrastructure:
- £6.1m for early enabling works to include infrastructure, decant and demolitions
- Estimated £7.8m further infrastructure work across schemes.

**B) Community diagnostic centres (CDCs)**
- There is further capital investment through CDCs in Thurrock, Braintree, Pitsea and Southend.

**C) Targeted Infrastructure Funding for a new 23-hour surgical unit in Southend**
- The Trust has been allocated £23 million of national capital funding to deliver this facility on the Southend Hospital site, allowing us to meet future elective activity demands and repatriate local activity that the system is currently unable to deliver.

**D) Capital departmental expenditure limit (CDEL) funded capital programme asks**
- Board Assurance Framework risk
- Critical risk priorities remain unfunded
- Critical risk backlog maintenance
- Medical equipment replacement
- Orsett Hospital

**2.0 Operational update from the Trust**

**2.1 Industrial action**
- Staff continue to work hard to provide patients with the best possible care during the ongoing industrial action
- Wherever possible, elective activity (both outpatients and inpatient) continues – especially in high-priority services for example, cancer treatments. Where cancellations happen, most patients are given another appointment close to their original date

**Cancelled activity**
- We have faced a year of industrial action and the Trust has had to cancel around 31,000 outpatient appointments since industrial action began in April, including new and follow-up outpatient appointments, as well as approximately 4,450 inpatient and day case surgeries
- As a result of the latest December industrial action (as at 20/12/23) around 120 inpatient and day case surgeries and 830 outpatient appointments have had to

be cancelled. But we will also have not booked patients in knowing that we can't fulfil the appointments during strike periods so the impact is likely to be higher. The full impact of the January industrial action is yet to be determined.

- This has had a negative impact on the Trust's ability to reduce waiting times for treatment in some areas, particularly in general surgery, ear, nose and throat, urology, gynaecology and trauma and orthopaedics.

**Impact on cancer care**

- A very small number of cancer treatments have sadly had to be delayed, affecting 458 inpatient and day-case surgeries since April
- Cancer-related appointments made up 10% of all cancelled appointments. These appointments and surgeries are prioritised for rebooking at the earliest opportunity. This decision has not been made lightly and clinicians will review the patient's level of clinical need before making any decision to postpone.

**2.2 Urgent and emergency care**

- The Trust is working to a national target to have as a minimum 76% of patients seen and treated within four hours in the emergency department (ED) from March 2024. The Trust will strive to better this number, with the ambition to treat patients quickly, recognising that faster emergency care supports improved patient outcomes.
- Performance was 65.8% in November, down slightly from 66.3% in October. While performance has been improving up until July 2023, from August to October there were challenges from frequent rounds of industrial action and a growing number of attendances at the EDs.
- The Trust has in place an urgent and emergency care improvement programme that is seeking to improve performance and governance across its EDs, along with winter resilience plans that are making sure that rotas and staffing levels are appropriate for patterns of demand
- New streaming processes are in place for when patients arrive, making sure they are treated in the right place first time. At Basildon Hospital frail patients are assessed to avoid admission where appropriate
- The Trust is making the best use of same-day emergency care services, with a focus on frailty. This will improve their outcomes and increase the flow of patients
- There has been a focus on improving rapid assessment and treatment processes, sharing best practice across the Trust, and decreasing the length of stay of patients in the department, to improve the flow of patients out of hospitals and reduce handover times
- A decision has been made to increase the medical establishment (the number of substantive medical staff) by 101 doctors in medicine across the Trust, to meet the demand and reduce reliance on short-term agency staffing.

**2.3 Ambulance handovers**

- Having entered the winter period, the priority has been to prevent delays in handing over patients brought to the ED by ambulance, which releases crews to the community.
- A very high number of patients are arriving at the Trust's EDs, and ambulance arrivals have increased from 4,642 in November 2022 to 6,815 in November 2023, a rise of 46.8%. Despite this, the time it takes an ambulance to hand a

patient over to the ED has fallen from an average of 77 minutes in November 2022 to 26 minutes in November 2023. However, in December this had worsened to 38 minutes.
- In November 2023, 79% of ambulances handed over in under 30 minutes, up from 75.7% in October, and 39.5% handed over in under 15 minutes, up from 38% in October. The plan is to achieve and maintain 90% of patients handed over within 30 minutes. Ahead of the Christmas period the Trust took extra steps to improve length of stay and ensure there was capacity in the EDs for offloading ambulances, so performance can be restored and the public reassured.
- The Trust has worked with partners across the Integrated Care System to set up Unplanned Care Coordination Hubs (UCCH), which community responders contact for advice ahead of any admission to the ED. This is helping to save patients being admitted to hospital and receive alternative treatment.

**2.4 Cancer performance**

- The Trust has a target that 75% of people are seen within the 28-day faster diagnosis standard by March 2024. Performance was 60.3% in October, which has been affected by industrial action and higher demand, as it was nationally
- The Trust plans to have no more than 475 patients waiting over 62 days to be told that they do not have cancer or to receive treatment by the end of March 2024. At the end of November there were 699 patients waiting over 62 days, which is 189 patients above the original 2023/24 plan. The Trust aims to return to its agreed plan by February 2024
- The top cancers contributing to the backlog are colorectal, urology, skin, and gynaecology. Measures that have been taken include:

    - Skin cancer: the rollout of tele-dermatology, which has helped to reduce waiting times for outpatient appointments and brought waits for minor operations to under two weeks. The Trust continues to bring in staff from external providers and run weekend clinics to reduce waiting lists further
    - Colorectal: patients are now seen more quickly, with an improvement in the faster diagnosis standard of 6% from August-October 2023
    - Urology: a second robot has been installed at Southend Hospital to deliver additional treatment capacity, while the multidisciplinary team is working to streamline pathways across all three hospitals.

**2.5 Elective care and referral to treatment**

- Nationally, there is a commitment to have no patients waiting over 65 weeks for their routine elective treatments by the end of March 2024, and to have none waiting more than 52 weeks by March 2025
- Performance has been affected in part by industrial action. The Trust is closely managing all patients on the waiting list whose wait for treatment would be over 65 weeks by March 2024. This cohort number fell from 90,000 patients in April 2023 to 13,000 patients in November
- Nationally, the total NHS waiting list for elective treatments has been growing since the pandemic.
- The total waiting list at the Trust is 162,000, down from 191,000 in September. The Trust has been validating its waiting list, meaning some patients have been discharged, which releases appointments for those in need of care.

- Specific specialties with risks are plastics and breast reconstruction surgery, allergy, oral surgery, and ear, nose and throat (ENT). Breast reconstruction is a highly specialist area where there is no further capacity elsewhere. For allergy, the Trust has access to the capacity to run more clinics, and for ENT the mid and south Essex health system has been working with a number of independent sector providers to support waiting list reduction efforts
- Where patients do not attend appointments (DNA), this has a large impact on waiting lists. The Trust is expanding the use of text reminders and booking systems to more specialties to identify where DNA may be expected, so that clinics can be booked more efficiently to reduce the impact
- New models of care are being developed in a range of specialties through the Trust's outpatient transformation programme. These include referring patients directly for a test; triaging more patients before they are seen at an appointment; and expanding the use of patient-initiated follow up, where patients can ask for further care if they need and avoid unnecessary appointments, if it is clinically appropriate. The Trust is also aligning itself with 'Getting it Right First Time' principles, to ensure patients are given the right care at the right time.

**2.6 Diagnostics**

- Delivering quick diagnostics is key to shortening waiting times for cancer or routine care. The Trust has a target to ensure patients receive tests within six weeks. In November this was achieved for 70.9% of patients, down slightly from 71.2% in October
- The biggest reduction has been in imaging – CT, MRI, non-obstetric ultrasound – after a new Radiology Information System made it easier to gather and validate data. Challenges remain in radiology through increased demand, sickness and vacancies
- There has been successful recruitment of radiographers and sonographers. Further work is planned on general anaesthetic endoscopy and cystoscopy, and funding was agreed to bring in additional external staff and resources into the organisation for endoscopy
- The opening of community diagnostic centres (CDCs) and temporary mobile facilities in mid and south Essex will mean that beginning from 2024/25, there will be additional capacity available to carry out tests faster and closer to home
- Recognising the need to reduce the backlog of ophthalmology appointments, the Trust is planning to open a one-stop shop diagnostics hub for ophthalmology, temporarily based at Orsett Hospital which will focus on supporting glaucoma and medical retina checks. Once diagnostics have taken place, patients will be reviewed virtually, reducing the need for them to come to the hospital and freeing up consultant capacity. The Trust expects this to begin in the spring.

**2.7 News and developments**

- Florence Hammond, a Basildon Hospital Gastrointestinal (GI) Advanced Practitioner with over 25 years' experience, was named Radiography Professional of the Year for the Eastern region at the Radiography Awards because of her outstanding work leading the GI Fluoroscopy service
- Professional musicians playing for patients at Basildon have been helping to improve their experience in critical care. String instruments like the lute and violin have been played to over 100 patients to see if they help reduce stress levels

and inspire calm through the power of music. A relative of a patient said: “This had a very calming effect for me and my mother. Keep the music coming.”
- The Critical Care Outreach team at Basildon Hospital have received three Oxygen Venturi Airvo devices that are being used for patients needing extra warmed and humidified oxygen for respiratory support. This was made possible thanks to the League of Friends voluntary group, that run a tea bar at Basildon Hospital and raised £9,000.

**3.0 Phlebotomy**

**3.1 Service overview**

Pathology First, a joint venture between Synlab and Mid and South Essex NHS Foundation Trust, has been providing a community phlebotomy service across Basildon, Thurrock and Southend since the contract was awarded in 2014.

Pathology First phlebotomy services are delivered from the following locations in Thurrock:

- Corringham Integrated Medical and Wellbeing Centre, The Sorrells, Corringham, SS17 7ES – Monday - Wednesday, 8:30am-3:30pm with 62 pre-booked appointments
- Thurrock Community Hospital, RM16 2PX- Tuesday to Thursday 7.10am-3.45pm
- South Ockendon Health Centre, Darenth Lane, South Ockendon, Essex RM15 5LP – 8.10am-12pm and 12.30pm-3.45pm
- Orsett Hospital – three chairs, five days a week, with a new oncology phlebotomy service that is a same-day queue service open five days per week from 8am-3pm.

NELFT also provide phlebotomy services to the Thurrock community at the following locations:

- Thurrock Community Hospital – two chairs, daily from 9am-12pm, walk-in service, averaging 150-200 patients seen a week
- Brentwood Community Hospital – appointment-only 8am-4pm. 70 booked appointments a day and recently introduced 10 same-day bookable slots per day to allow for those with urgent blood forms
 Corringham Integrated Medical and Wellbeing Centre, The Sorrells, Corringham, SS17 7ES – Thursdays 9am-12pm and 12.30-3.30pm walk-in service.

There are also several GP surgeries in Thurrock that provide in-house phlebotomy services through a locally enhanced service agreement with the Integrated Care Board (ICB).

**3.2 Service delays and improvements**

Delays in appointments have been due to a mixture of a rise in demand and a high number of ‘do not attends’ (DNAs) to appointments booked. In 2020 there were 30,000 phlebotomy appointments per month, which rose to 45,000 in 2022, a rise of

66%. In November 2023, there were 2,955 appointments lost to patients not attending their appointment, of which Thurrock accounted for 10.2%, which was the second highest of all locations where community phlebotomy is delivered within mid and south Essex.

To help reduce the times that patients are waiting for their blood tests, the Trust is working with Pathology First to review and improve the service. Pathology First now has a dedicated improvement team to oversee and take actions and have already made several improvements. The Trust continues to work closely with Pathology First to oversee these improvements, which are monitored through formal contract meetings.

Improvements include:

- The Thurrock Community Hospital clinic run by Pathology First has had its opening hours to patients extended from 7am-1pm to 7am-3.45pm, from Tuesdays to Thursdays. This has provided an extra 45 appointments per week
- The service at Orsett Hospital is provided on both an appointment and same-day queue basis. There has been a recent service review and a new oncology phlebotomy service started running from December 2023. This service is a same-day queue service and is open five days a week, from 8am-3pm, which is providing an extra 40 appointment slots per day
- Capacity at the clinic in Corringham Integrated Medical and Wellbeing Centre has been reviewed and increased
- Pathology First are continuing to offer additional clinic hours as staffing allows in Basildon and Orsett hospitals
- The laboratory staff at Basildon Hospital have also been trained in phlebotomy to allow clinic phlebotomists to be released to provide services on hospital wards.

**3.3 Responses to questions at November 2023 HOSC meeting**

**How phlebotomy services in Thurrock compare to elsewhere**

- The Trust is working to meet the growing demand for phlebotomy appointments in Thurrock, with approximately 2000-2500 non-urgent phlebotomy appointments offered each day through Pathology First. There are different types of appointments, including:
    - Non-urgent appointments: booked online via SwiftQueue or over the phone
    - Urgent blood tests requested by a GP
    - Same-day queue or walk-in appointments: these are for hospital-based patients, but a few appointments are provided for patients with urgent GP referrals. These are available at either the Basildon Hospital or Orsett Hospital Outpatients departments.

- At Thurrock Community Hospital phlebotomy services are also provided by North East London NHS Foundation Trust (NELFT). Pathology First do not provide a domiciliary phlebotomy service in Thurrock as this service is provided by NELFT.

- Overall, services are comparable across mid and south Essex with minimal variation.

**Availability of same-day or walk-in appointments**

- These are available at either Basildon Hospital or Orsett Hospital Outpatient departments. Ten additional appointments have been added each day at both sites which are already available to patients to increase capacity. This is also available in the Southend Victoria Shopping Centre and waits in both centres are similar.

**Do Not Attend (DNAs)**

- A variety of causes can be recognised as the contributors to the high numbers of no-shows. Higher DNAs are mostly occurring on Saturday evenings. Multiple bookings made by same patients and GPs requesting tests sooner than the minimum test interval are also adding to the DNA numbers. This is being investigated further, on which the Trust will provide a further update
- Pathology First continues to produce communication materials to inform patients to reduce the prevalence of DNAs. Regular newsletters are also being sent to GPs to encourage them to raise awareness among patients about DNAs.

**For any questions regarding this briefing note, please contact:**

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## Health and Wellbeing Overview and Scrutiny Committee

## 11 January 2024

# Briefing Note: Integrated Health and Wellbeing Centres (IMWCs) and co-location opportunities across Thurrock.

**Purpose of the briefing note:** The purpose of this briefing is to provide HOSC Members with an update on Integrated Health and Wellbeing Centres (IMWCs) Programme (1)
and opportunities for co-location in Thurrock (2).

**PART 1: Summary of progress of IMWC Programme**

In May 2017, a Memorandum of Understanding (MoU) was signed between the council and NHS organisations in Thurrock. This anticipated the planned closure of Orsett hospital and represented a joint commitment to re-provide displaced services, at four locations: Corringham, Grays, Tilbury, Purfleet on Thames. The new buildings envisaged were subsequently named Integrated Medical Wellbeing Centres (IMWCs). This paper considers how to progress these shared objectives captured in the MoU against the backdrop of the local current health and care environment. The agreed outcomes partners committed to work towards can be summarised as follows:

- An enhanced and more resilient Primary Care that attracts the best clinicians to Thurrock.
- Bringing outpatient, diagnostic and other hospital services closer to the communities they serve, supporting centres of excellence where there is a clear evidence base and community support.
- An integrated care model that encompasses primary, secondary, community and mental health care together with social care and community and third sector organisations.
- A reduction in avoidable demand for hospital and residential care services.
- Improving the health and wellbeing of the people of Thurrock by working collectively to tackling the causes of ill health.

Ultimately, these represent a lasting commitment to delivering services that are both integrated, effective and preventative. This is rooted in close partnership working, the very thing the Integrated Care System (ICS) was created to enhance. A second MoU in September 2018 paved the way for this by setting out specific commitments to underpin integrated working locally.

Since 2017, the NHS commissioning landscape has changed significantly. MSE Integrated Care Board (ICB) has replaced the five local CCGs. But neither the NHSs continuing commitment to integrated care as reflected in both MoUs, nor its commitment to delivering the Better Care Together Thurrock strategy, have diminished. The ICB remains committed to integrating care as the best path to delivering better outcomes for people in Thurrock. We must nonetheless recognise the limits of our respective roles and the financial reality that all partners in Thurrock face. For healthcare, NHSE is ultimately in charge of capital deployments for new Primary Care estate, and the financial pressure on revenue budgets has increased significantly. Indeed, the ICS incurred a significant deficit last year and we expect similar challenges in the future financial years. Whilst a huge amount of work is underway to address matters, these two factors have a significant impact on our ability to create and fund new buildings.

There are several enablers set out in Better Care Together Thurrock strategy. The replacement of services currently provided on the Orsett Hospital is central to this. Not only because it would make a contribution to capital costs, but also because it will free up staff and other resources that can be re-invested in the local economy. Indeed, these planned changes now represent a higher priority for stakeholders in terms of patient safety and experience; Orsett Hospital currently has a significant backlog maintenance requirement. Progress has however been made to improve other aspects of the estate in Thurrock, such as through the opening of the Corringham IMWC. The development of the other sites will inevitably face serious constraints, including:

1. Limited revenue and capital available to support a range of schemes in the pipeline system wide.
2. Lack of OBC approval for Tilbury and Purfleet on Thames from NHS England (now formally confirmed in Nov 2023).
3. Lack of capital available for the Grays scheme.
4. Lack of NHSE approval to spend more revenue per m2 than district valuer valuation.

These factors represent significant challenges to progressing the remaining three schemes. However, there are also several opportunities that have accompanied the advent of the MSE ICB. For instance:

1. **Corringham IMWC**. The centre is open, active, but currently underutilised, and we are therefore not seeing all the benefits anticipated in relation to more integrated, cross-organisational working. In part, this is no-doubt a reflection of the way that working practices have changed post-pandemic. We have an opportunity to significantly increase the value to the system of this asset and realise the potential of co-location of a range of services if the planned model for the centre is adapted accordingly. This in turn would further strengthen future business cases for any other integrated health and care sites.
2. **Void primary care space in Thurrock**. We currently have void space (both clinical and collaborative working space) across a number of buildings in Thurrock, including Stifford Clays Health Centre and South Ockenden Health Centre. These present an immediate opportunity to develop our integrated

ways of working, in Grays and the Purfleet areas, with co-located services as appropriate.

3. **Integrated Neighbourhood Teams (INTs)/Integrated Locality Teams**. In Autumn 2023 Integrated Neighbourhood Teams began to bring together statutory and non-statutory services and assets that reflect the strength of the community where residents identify and serve to keep people well physically, mentally, socially and economically. This aligns entirely with the principles set out in Better Care Together Thurrock. A shared commitment to progressing this important initiative will therefore be required to maximise the benefits of the Transfers of Care Hubs (TOCHs) being established to ensure that people leaving hospital benefit from all partners in Thurrock working together to organise their ongoing care and support.
4. **Community Diagnostic Centre (CDC)**. Mid & South Essex has been successful in securing capital for new CDCs, one of which will be situated in Grays. This creates scope to shift some of the diagnostic services current accommodated on the Orsett Hospital site and expand upon this range of services significantly. The CDC, which has ready received planning permission and building is due to commence in January 2024, and will over time integrate with the four INTs that must be developed across Thurrock. The CDC could thus quickly substantiate and become the first phase of Grays IMWC.
5. **Additional Roles Reimbursement Scheme (ARRS):** Recruitment via the ARRS has continued to increase in Thurrock. As of November 2023, 80 FTE staff are now employed via the scheme in Thurrock, with a further 10 FTE staff planned to be recruited by the end of the 2023/24 financial year.
6. **Core General Practice Workforce:** Over the last three months, the general practice workforce has remained stable, except for admin and non-clinical staff group which has grown by 10 headcounts over the last 12 months.
7. **GP Fellowships:** In 2022/23, a fellowship programme for Thurrock GPs was created. The aim of the programme was to retain and provide enhanced opportunities for newly qualified GPs working in Thurrock. The programme provides GPs with 50% clinical practice, 25% personal and professional development, and 25% specialist interest training over a two-year period. It is envisaged that GPs who enrol on the programme will be supported to develop specialist skills that will enhance patient care once they complete the fellowship. The programme was launched system wide in 2023/24, with some small amendments to help scale the opportunity, and has been received well by GPs across the system. In Q4 MSE ICB advertised the opportunity for a final time in 2023/24 and our focus is attracting GP trainees in Thurrock to take up the scheme post-qualification. To date 7 GP trainees, have either commenced, or are due to commence, the programme early this year.
8. **Education Capacity and GP Recruitment & Retention:** The long-term plan for recruitment and retention of GPs in Thurrock is orientated around Educator and Learning Organisation expansion. Three of the four PCNs in Thurrock were awarded funding in March 2023 to develop PCN training teams (ASOP, SLH and Tilbury and Chadwell). The aim of this programme is to grow the number of multi-professional educators within PCNs, expand multi-professional placement capacity, create rich training environments to grow and retain a skilled primary care workforce, expand clinical and non-clinical training capacity, and develop action plans on how the PCNs will retain

learners post-training. In addition, with ICB's increasing focus on growing the number of GP educators and learning organisations at a practice level in Thurrock, we hope this will result in an increase in GP trainee and clinical placements – which will lead to an increased inflow of newly qualified GPs and other staff in Thurrock PCNs / practices. Thurrock has also seen an increase in the number of GPs working in the alliance. 80 FTE GPs are currently working in Thurrock, the highest number recorded since March 2016.

To realise these opportunities to deliver the greatest value to Thurrock residents, and in accordance with the MoU that was agreed upon, the following actions were proposed by IMWC Programme Board and endorsed on 19th December 2023 by Thurrock Integrated Care Alliance (TICA) which is a place-based sub-committee of MSE ICB.

1. **Agreed the design and implementation of a refreshed model of care / joint working for Corringham IMWC** through the Thurrock Locality Board and Thurrock Integrated Care Alliance Board, to maximise the value from the site, reduce void space and create a powerful case study of co-located joint working. This must factor in changes to working practices and clinical methods that have changed since the pandemic.
2. **Agreed to accelerate the development of four Thurrock integrated neighbourhood teams** through the Thurrock Locality Board and Thurrock Integrated Care Alliance Board and continue to channel ICB resource towards supporting INTs as a way of achieving the Better Care Together Thurrock vision. This will bring together all relevant providers around a shared mission on a geographic footprint that communities recognise.
3. **Agreed to repurpose void primary care space** in Thurrock to contribute towards the objectives of the IMWC programme and to plan such refurbishment of the estate as required. This should align with emerging INT principles and priorities and be fit for purpose for collaborative working. (Note part 2 of this report).
4. **Establish a detailed programme plan for Grays IMWC** building on the imminent development of the CDC as the first phase of work, with clear milestones and timeframes to proceed with further development as soon as the requisite capital is identified.
5. **For Orsett Hospital:** The system partners acknowledge the challenges around affordability of the Tilbury and Purfleet centres, and this will inevitably impact our plans to some extent for re-location of services from Orsett Community Hospital. However, the majority of services at Orsett Community Hospital have always been planned to be re-provided at Grays IMWC, and Mid and South Foundation Trust, who own the site, remain committed to developing proposals for this location. The benefits of co-location of services remains clear, with the new Thurrock Community Diagnostic Centre opening on the Grays IMWC site in providing improved buildings for our patients is also hugely important to all system partners. Any activity that can no longer be provided at the previously planned Tilbury and Purfleet sites will remain within Thurrock, and the Trust and system partners will seek to explore alternative options to deliver this. Clearly each service move is likely to require capital funding and, until this funding is available, services will remain where they are

currently based at Orsett Community Hospital. Mid and South Foundation Trust and MSE Integrated Care Board remain committed to retaining local services in Thurrock. Until suitable alterative provision can be realised, Orsett Hospital will remain open to facilitate this.

6. Based on the above, both the programme team and the IMWCs Programme Management Board were stood down in the current form, with a recommendation from TICA that overall coordination of building programmes are led through existing system-wide Estates Board.

**PART 2A: Co-location opportunities across Thurrock**

In order to progress with principles underpinning integrated health and wellbeing centres health and care teams across Thurrock Alliance undertook analysis of co-location sites across Thurrock and identification of potential sites to support Integrated Neighbourhood/Locality Teams (INTs/ILTs).

The ambition of Thurrock Council and Mid and South Essex Integrated Care Board (MSE ICB) under the Better Care Together Thurrock (BCTT) programme is to transform, improve and integrate health, care and third sector services for adults and older people to improve their wellbeing. The strategy is to redesign, implement and evaluate a new model of integrated care, delivering blended health and care roles that improve access to services for the communities they serve. This means focussing on how community resources are supported and utilised to address the needs of the population.

This part of the briefing sets out the current distribution of community health and wellbeing services, specifically Community Led Support (CLS), Housing Surgeries, Local Area Coordinators (LAC) and Integrated Locality Teams (ILTs). It also seeks to identify further potential sites for the co-location of services such as the Integrated Neighbourhood Teams (INTs) utilising void space in the borough. This work will further allow MSE ICB to explore improvements that will contribute to diagnostic capacity in the borough which will be detailed in a separate report.

**Community Led Support (CLS)** are social work teams able to provide a coordinated response to the community utilising a network of allied professionals. They provide drop-in sessions – 'Talking Shops'- across the borough in local shops, church halls, cafes and libraries. They are split into four teams:

- Team 1 - Tilbury, Chadwell, East Tilbury, West Tilbury & Linford
- Team 2 - Aveley, South Ockendon and Purfleet
- Team 3 - Grays, Chafford Hundred, Stifford Clays, West Thurrock & Riverside
- Team 4 - Stanford-le-Hope, Corringham, Horndon and Bulphan.

A full list of locations of the CLS 'Talking Shops' can be found here:

https://www.thurrock.gov.uk/adult-care-and-support-drop-in-sessions/talking-shop-session

**Housing Surgeries** are delivered by Thurrock Council Estate Officers supported by other council departments and agencies offering advice to residents on housing issues. Residents can access this service online at the following link:

https://www.thurrock.gov.uk/estate-staff-and-tenant-surgeries/housing-surgeries

Housing Surgery locations

| Place | Day | Times |
|---|---|---|
| South Ockendon Centre, Derry Avenue, South Ockendon, RM15 5DX | Monday | 10am to midday |
| Chadwell Community Room, George Tilbury House, Chadwell St Mary, RM16 4TF | Tuesday | 10am to 11am |
| South Ockendon Centre, Derry Avenue, South Ockendon, RM15 5DX | Tuesday | 10am to midday |
| Aveley Community Hub, New Maltings, High Street, Aveley, RM15 4BY | Tuesday, fortnightly | 10:30am to 11:30am |
| Hardie Park Café, Hardie Road, Stanford-le-Hope, SS17 0PB | Thursday | 9:30am to 11am |
| Corringham library, St Johns Way, Corringham, SS17 7LJ | Thursday | 2pm to 4pm |
| Purfleet Community Hub, 53-54 River Court, Centurion Way, Purfleet-on-Thames, RM19 1ZY | Thursday | 2pm to 4pm |

Figure 1 Housing Surgeries Thurrock

The Local Authority Housing Department also conducted a mapping exercise in 2023 which explored customer interaction with the service.

Appendix 1.xlsx

Local Area Coordinators (LACs) host weekly drop-in sessions in each PCN, though these are not advertised on the Thurrock website. There are currently fourteen Local Area Coordinators covering the four PCNs. The LACs role is primarily to develop a detailed understanding of all community assets, networks, services and groups and work with residents to find pragmatic solutions to problems. Residents are encouraged to contact the LAC team via a generic email: localareacoordination@thurrock.go.uk Posters and leaflets are used to advertise the service in the local communities.

Integrated Locality Teams (ILTs) referred to in the Fuller Stocktake as Integrated Neighbourhood Teams (INTs), will operate across the four PCNs and are representative of all health and care service providers. There are two that are operational currently (Stanford Le Hope and Grays) and ASOP and Tilbury and Chadwell will be operational by the end of January 2024. The strategic aim is to embed multiple services capable of addressing all aspects of health and social care, allowing professionals to build relationships with each other and residents to co-design integrated solutions rather than simply relying on assessments and referrals. The INTs will bring together statutory and non-statutory services and assets that reflect the strength of the community where residents identify and serve to keep people well physically, mentally, socially and economically. This aligns entirely with the principles set out in Better Care Together Thurrock. A shared commitment to progressing this important initiative will therefore be required in order to maximise the benefits of the Transfers of Care Hubs being established to ensure that people leaving hospital benefit from all partners in Thurrock working together to organise their ongoing care and support.

The INT Incentive Scheme improves the foundations for more integrated working. Related PCN initiatives are as follows:

- Cardio-Vascular Disease Case Finding for Hypertension in partnership with Community Pharmacy
- Learning Disability & Autism– Increasing Awareness & Uptake of LD Health Checks
- Tackling Health Inequalities - Anticipatory Care for Complex Patients & Preventative Care - Patient Identification and Segmentation
- Quality Improvement – Directory of Services
- High Intensity User Project – Reducing System Pressures
- Obesity and Weight Management Project in collaboration with TICA & PCN Colleagues, Thurrock Council and Public Health - Increasing Referrals and Impacting Longer Term Outcomes
- Population Health Management – ‘Reducing the Odds’ Project
- Complex Care and Frailty

- Screening and Immunisation in Underserved Groups
- Access and Urgent and Episodic Care.

**Part 2B: Maximising void space to accommodate INTs**

The development of the INTs has been challenged by a lack of suitable estate to house the teams and facilitate true integration of Multi-Disciplinary Teams (MDTs). Stanford-Le-Hope INT holds weekly MDT meetings at the Corringham Integrated Medical & Wellbeing Centre (IMWC) and being in the same building has already resulted in excellent examples of cross organisational working, providing timely interventions to individuals in need.

Part two of this report highlights potential spaces which supports the ambition of MSE ICB in achieving 75% utilisation of NHSPS void space as part of the revised Estates Strategy.

***(THIS PART OF THE REPORT IS COMMERCIALLY SENSITIVE THEREOFRE NOT AVAILABLE IN PUBLIC DOMAIN)***

**Summary**

The NHSs commitment to integrated working for the benefit of the people of Thurrock remains undiminished. However, the context we find ourselves in has changed dramatically over the recent years. The financial constraints faced by all statutory organisations in Thurrock have deepened, the pandemic has left a last legacy on all health and care services, and models of care and ways of working have also transformed accordingly.

NHS and Local Authority along with all Thurrock Alliance Partners remain committed to improving the health and care estate in Thurrock.

Corringham IMWC is already live and we continue to optimise the way that its used, to demonstrate the value of collaborative working hubs in practice. It is the way we work together, rather than where we work together that has the greatest bearing on outcomes for residents, so we are continuing to develop integrated neighbourhood teams together, and channelling improvements to workforce, estate and digital enablers to these INTs accordingly will support this.

**For any questions regarding this briefing note, please contact:**

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# Health and Wellbeing Overview and Scrutiny Committee

## Briefing Note: The Mid and South Essex Primary Care Access Recovery Plan

**Purpose of the briefing note:** The purpose of this briefing note is to provide members with an overview of the Mid and South Essex ICB Primary Care Access Recovery Plan and specific developments that are being progressed within Thurrock. This paper is for noting only.

1.1 The briefing provides the national and local context of the Primary Care Access Recovery Plan.

1.2 The briefing describes the approach being adopted by NHS Mid and South Essex ICB to improve access to primary care services.

1.3 The briefing reflects upon the previous analysis undertaken by the Thurrock Public Health team (An analysis of survey results describing patient satisfaction with GP access and quality in Thurrock and the factors which may influence this). The briefing identifies specific measures being undertaken in Thurrock to address some of the findings of this report.

**For any questions regarding this briefing note, please contact:**

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# Primary Care Access Recovery Programme

## 1.0 Introduction

Every weekday in Mid and South Essex (MSE), primary medical services undertake 25,000 consultations for our population. Beyond core consultations, primary medical care is responsible for significant amounts of unrecorded interactions with the population. National estimates suggest that somewhere between 70%-90% of all patient interactions with NHS services occur in primary care. Good access to primary care services is therefore fundamental to the delivery of NHS services as a whole.

In May 2023, NHS England published "Delivery Plan for Primary Care Access Recovery". This report focusses on two key commitments:

- Tackling the 8.00am rush and reducing the number of people struggling to contact their practice.
- For patients to know on the day they contact their practice how their requests will be managed.

The Plan emphasises that multiple actions are required to deliver these commitments. This includes the need for the delivery of the models of care outlined in the Fuller Stocktake. The Plan challenges Integrated Care Boards (ICBs) to be at the forefront of creating the environment for change and leading system partners to adapt their service models to support new approaches.

The Plan indicates that practices will need to implement a "Modern General Practice Access Model" where patient need is consistently triaged and navigated to the most appropriate solution for the presenting need.

Integrated Care Boards have been required to develop their local Access Recovery Plan to deliver upon these national objectives and local objectives.

## 2.0 Case For Change

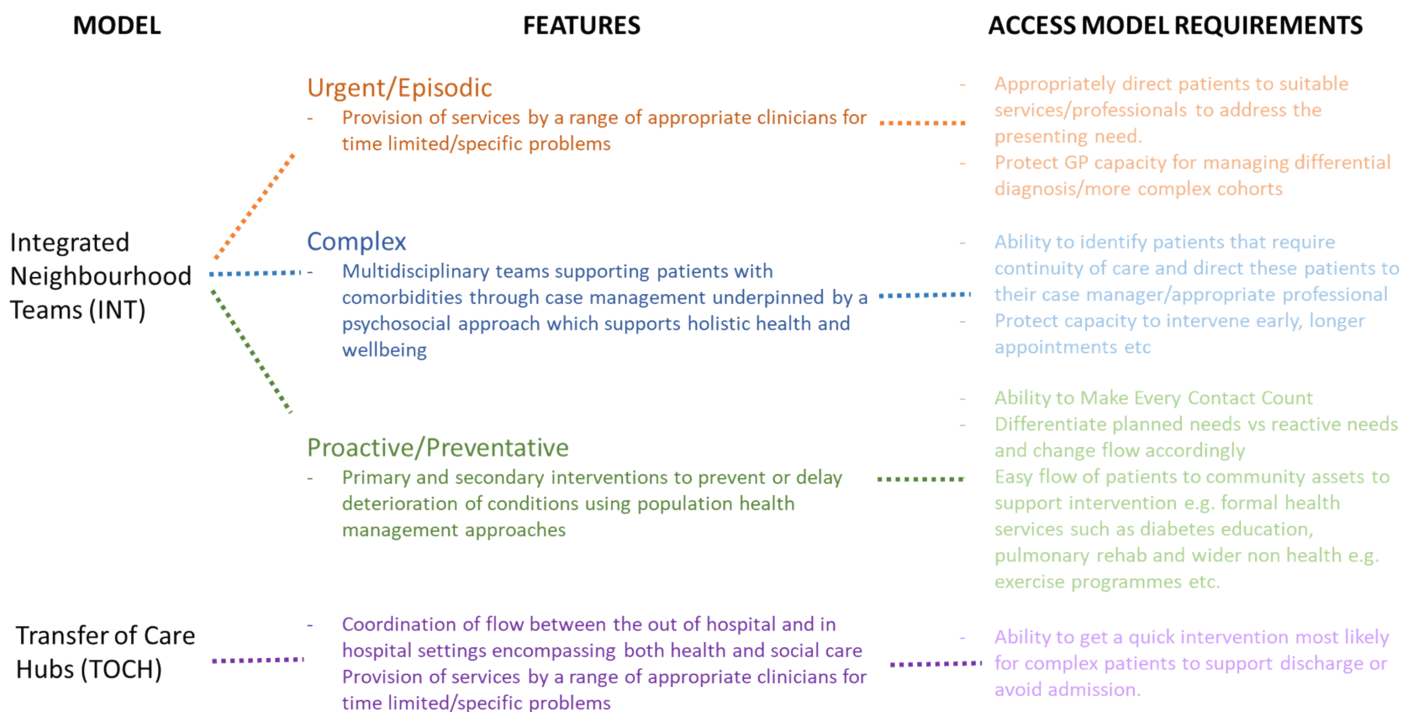
The need for change to access models is not solely driven by the need to respond to the national plan. Locally, through the GP patient survey, our population is feeding back two broad themes:

- When patients receive care from their practice, satisfaction is high e.g. 90% saying their needs were met, 88% saying they have been appropriately involved in their care and decisions and 91% having confidence in the professional they saw.
- However, access to services results in a poor overall experience e.g. only 38% of survey respondents describe getting through on the phone as easy, 66% describing their last experience as positive.

Primary care providers are also feeding back that historic models of access are no longer fit for purpose due to the change in demand and growth in demand for primary care services. There is an increasing desire to adapt models, work with other stakeholders and implement more effective pathways.

Our target operating model for out of hospital care in Mid and South Essex is based on the establishment of Integrated Care Teams with tailored approaches for Urgent and Episodic Care, Complex Care and Preventative Care. In order for this target operating model to be delivered, demand on primary care services must be differentiated and then navigated to a range of appropriate solutions, some of these will be core general practice but an increasing number will be alternative providers of statutory and non-statutory provision e.g. PCN services, community pharmacy, voluntary sector providers. The current "8.00am rush" model described by the national plan and experienced by a large part of our population is largely managed on a first come first served basis where general practices attempt to triage as best they can but are limited by capacity, technology and outdated pathways.

We need to move to a model where demand is differentiated based on the Fuller principles of Integrated Neighbourhood Teams:



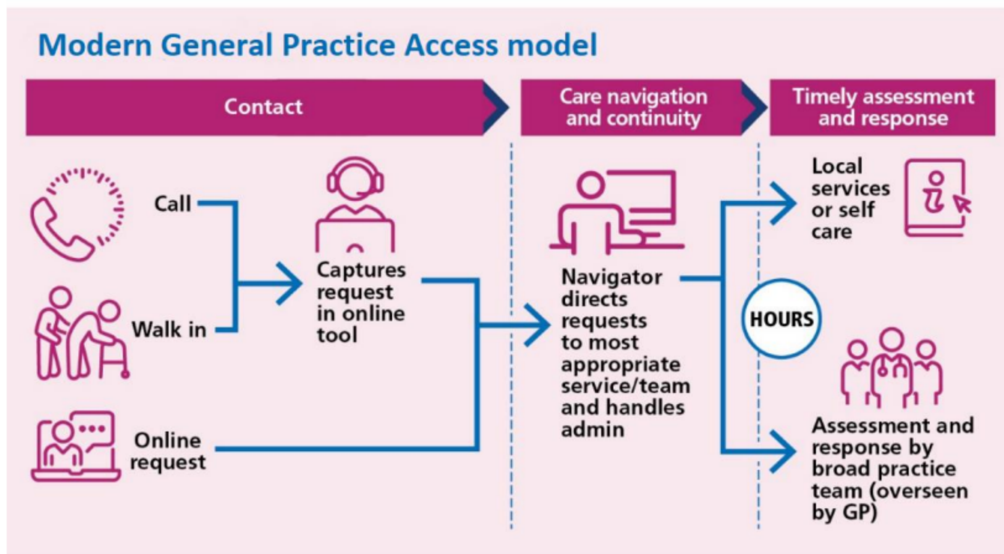

## 3.0 Proposed Change

We are seeking to address the challenges of Access through four programmes of work each delivering a specific but complimentary aim:

- "Connected Pathways" which through a series of interventions, will enable the implementation of a Total Triage model in line with Modern General Practice.
- Improving the Primary/Secondary Care Interface through a clinical leadership led approach that fundamentally seeks to improve relationships between primary and secondary care (clinical and administrative) in order to reduce unnecessary bureaucracy, improvements safety, quality and efficiency grounded in the principle of doing the best for our patients.

- Optimisation of the workforce through an established programme that seeks to recruit, retain and enable staff to act at the top of their license.
- Integrated Neighbourhood Teams – through an established programme, offer appropriate care pathways across the episodic, complex and preventative models that best meet patient need.

The identified interventions will support the delivery of the nationally specified "Modern General Practice Model.




This model:

- Empowers patients by rolling out tools so that people can manage their own health.
- Builds capacity so practices can offer more appointments than ever before.
- Cuts bureaucracy to give practice teams more time to focus on their patient's clinical needs.

- In conjunction with the ICB and Primary Care Networks, practices are working through plans on how to implement this new model.
- Part of the implementation process includes reviewing demand and capacity and maximising opportunities for offering patients alternative support.
- Modern General Practice requires a "total triage" approach to managing demand regardless of how patients/providers contact in order to best serve clinical need.
- Modern General Practice requires multiple changes to implement across workforce, digital, pathway, communications, clinical management etc.

Through these programmes and the delivery of a number of specific schemes they cover, we aim to achieve improvements in the following outputs and outcomes:

*Outputs*

- All practices to be operating a Cloud Based Telephony system by March 25.
- All patients to be able to access a minimum of 10 self-referral pathways by March 24.
- Implementation of Total Triage model in a minimum of 8 practices by March 24 and 50 practices by March 25.
- Increase in number of consultations undertaken in a primary care setting from 6.27m in 2022/23 to 6.4m in 2024/25.
- Increase in Additional Roles Reimbursement Scheme (ARRS) workforce of 195 by March 24 from 495 (October 23 baseline).

*Outcomes (targets and baselines will be determined by March 24)*

- By 2025, increase in overall % of patient satisfaction from 66% in 2023 baseline (National GP Survey).
- By 2025, increase in ease of getting through to your practice on the phone from 38% in 2023 baseline (National GP Survey).
- By 2025, increase in proportion of patients saying practice websites are easy to use from 61% in 2023 baseline (National GP Survey).
- By 2026, improvement in staff satisfaction for staff working within primary care (baseline and tool to be determined).

**4.0 Delivery of the Plan**

Whilst the core work programme is identified within our Access Recovery Plan, its implementation will be an iterative process and be refined based on experience of delivery.

To support the implementation, we will establish a primary care clinically led forum of representatives from early adopter practices who will use their experience and ambition to support the delivery of the plan. Through this process we will better influence the wider primary care system.

Practices, PCNs, Alliances and the wider ICB will work with patient forums, Healthwatch and other organisations to continuously gain patient insight to inform and refine models that are established.

**5.0 "An analysis of survey results describing patient satisfaction with GP access and quality in Thurrock and the factors which may influence this."**

Comprehensive analysis of the GP Patient Survey was presented to the Thurrock Health and Overview Scrutiny Committee by the Thurrock Council Public Health Team in November 2023. This report looked that the variation

between the GP Patient Survey results locally compared to local and national benchmarks and considered whether a number of other factors such as deprivation had a statistically significant impact on the survey results.

This report identified a number of key findings which have and will continue to inform the Mid and South Essex ICB/Thurrock Alliance response to improving access to primary care services. This includes:

- *The percentage responding 'good' to "Overall, how would you describe your experience of your GP practice?" ranged widely among Thurrock practices from 30% to 90% (evidence 2a). On average, patients in Thurrock reported lower satisfaction with their practice (62%) than the England average (71%) and MSE average (66%) and that this has been consistently repeated over a number of years.*
- *Reported ease of contacting a practice on the phone varied among practices from 11% to 93%, with an average of 42% (evidence 3a). On average Thurrock practices performed below the England average (50%) but above the MSE average (38%).*
- *Satisfaction with the experience of making an appointment ranged among practices from 15% to 84%, with an average of 46% (evidence 3c). The Thurrock average was below the England average (54%) but similar to MSE (47%).*
- *The percentage of patients who were satisfied their needs were met at their last appointment was consistently high, ranging from 80% to 99% with an average of 87% (evidence 4b). The Thurrock average was below the national average (91%) and MSE average (90%).*
- *That only a small proportion of variation in satisfaction between practices can be explained by differences in deprivation, appointment availability or health need.*

In order to address the issues that this analysis identifies, the ICB will ensure that alongside the overarching Primary Care Access Recovery Plan it is delivering, specific initiatives are undertaken within Thurrock to address the relatively lower levels of satisfaction with primary care access in comparison to the wider Mid and South Essex ICB population.

Examples of where this has been undertaken include:

- The piloting of a specific GP Fellowship Scheme in Thurrock. This scheme funded attractive Fellowship roles for newly qualified GPs but only where they applied for roles within Thurrock practices. This scheme has seen the successful recruitment of a number of GPs who are establishing their careers in Thurrock.
- Thurrock's highest area of deprivation, Tilbury & Chadwell PCN, are working with MSE Community Collaborative to implement a Diabetes Innovation Project aiming at improving the diabetes outcomes of the Tilbury & Chadwell population. The data shows that for the initial 8 weeks of the project over 180 priority 1 patients have been reviewed so far and work is continuing with patients considered to be priority 1 and starting on patients in priority 2 groups.

- Through the implementation of Stretched Quality and Outcome Framework (QOF) scheme and Cardio Vascular Disease (CVD) Local Enhanced Service by Thurrock's Public Health Team there has been increased patient capacity for case finding and screening of CVD conditions by GPs working closely with community pharmacies and providing ad-hoc Advanced Nurse Practitioner clinics. This has led to improved patient access and treatment for CVD conditions alongside improved awareness for patients of CVD services offered in community pharmacies. This scheme has shown a substantial improvement in uptake of primary prevention which is the current aim of NHS England/Public Health England and a substantial improvement of optimising CVD for patients post CVD/Cardio Vascular Accident event through meds optimisation. The data shows that Thurrock has some of the best CVD data nationally and Thurrock was showcased recently at a national CVD conference attended by Thurrock Public Health colleague and Thurrock Alliance Clinical Lead to do a joint presentation.

- With MSE ICB Health Inequality funding, additional clinics are being conducted by GP practices in deprived areas to focus on CVD, especially lipid management. Alliance is supporting this work by trying to source extra phlebotomy clinics whilst this project is running. This work is currently ongoing so no data is available yet.

Critically, NHS England and Mid and South Essex Integrated Care Board recognise that the requirements and challenges facing practices as they seek to implement the Modern General Practice model vary. Practices are not homogenous and GP Patient Survey results demonstrate variation in the patient view on various aspects of how their practice is delivering parts of the service. As a result of this variation, the ICB is required to undertake "Support Level Framework" visits to each practice to enable the development of a practice specific plan to implement the "Modern General Practice" model. This will look at a number of factors currently impacting on Access to services within the practice and then identify a series of interventions to support the implementation of new ways of working. There is a limited amount of additional funding available to each practice to support change e.g. backfilling of staff for training, additional capacity for locums when implementing service changing.

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| 11 January 2024 | ITEM: 10 |
|---|---|
| **Health and Wellbeing Overview and Scrutiny Committee** | |
| **Commissioning Report – Domiciliary Care** | |
| **Wards and communities affected:** All | **Key Decision:** Key |
| **Report of:** Cllr. George Coxshall – Portfolio Holder for Health, Adult's Health, Community and Public Protection | |
| **Accountable Assistant Director:** Les Billingham - Assistant Director of Adult Social Care and Community Development | |
| **Accountable Director:** Ian Wake - Executive Director Adults, Housing and Health | |
| **This report is** public | |

**Executive Summary**

The Council has a statutory duty under the Care Act (2014) to provide care and support to people whose needs meet the eligibility criteria detailed in this legislation.

Domiciliary care is commonly referred to as home care and the terms are used interchangeably. Domiciliary care services are regulated by the Care Quality Commission (CQC) and cover a wide range of activities, including (but not limited to) the provision of personal care such as assistance with washing/bathing, getting dressed, going to the toilet as well as support with nutrition and hydration. These services are delivered in the person's home and seek to support people to remain in the community.

Domiciliary care can also extend to reablement services (help to regain or retain skills and confidence) for people leaving hospital or seeking care and support for the first time. Reablement services seek to delay or reduce the need for ongoing care and support.

Current contracting arrangements for domiciliary care come to an end on 31 March 2025. This report seeks the view of the Health and Wellbeing Overview and Scrutiny Committee and then subsequently Cabinet, on the proposed recommendation that the procurement of these services commences in February 2024 for a contract start date of 01 April 2025.

**1. Recommendation(s)**

**1.1 That HOSC support the tender of domiciliary care services to meet our statutory requirements under the Care Act (2014). This includes both the core domiciliary care service, reablement and the Out of Hours service.**

**1.2 That HOSC support the recommendation to delegate the award of the contract to the Executive Director for Adults, Housing and Health in consultation with the Portfolio Holder for Health, Adult's Health, Community and Public Protection.**

**2. Introduction and Background**

2.1 We have a statutory responsibility to meet eligible need (Care Act 2014). Although other types of community-based support such as supported living, extra care and shared lives schemes are also regulated under CQC's domiciliary care regime, these services are not included in this tender as they are commissioned separately. This tender only relates to the provision of domiciliary care in people's own homes (regardless of tenure).

2.2 Current contract arrangements for domiciliary care finish on 31 March 2025. The tender is scheduled to start in April 2024 and the proposed procurement timetable is attached as Appendix 1.

2.3 As domiciliary care provision is based on assessed need, the amount of care commissioned is variable. However, in the first quarter of 2023 approximately 8900 hours of domiciliary care was provided per week for 690 people (an average of 1.8 hours per person per day). 900 hours per week is delivered by internal services (Caring for Thurrock) and the remainder is externally commissioned.

2.4 Currently 89% of directly provided or commissioned domiciliary care services in Thurrock are rated by CQC to be of 'good' quality. This is in line with CQC's 2022 reported national average of 87% of domiciliary care services being rated as 'good' or above.

2.5 Thurrock currently pays £20.58 per hour for externally commissioned domiciliary care.

2.6 Our spend on externally commissioned home care per year is approximately £8.6million.

2.7 In addition to externally commissioned domiciliary care services, Thurrock retains in-house provision (Caring for Thurrock). As well as providing both domiciliary care (both traditional and wellbeing models) and reablement, Caring for Thurrock acts as the 'Provider of Last Resort' (PoLR).

2.8 A PoLR is in place should there be a provider failure, insufficient capacity in the market as a whole or geographical area, a client for whom all other care options have been exhausted or in a support or management role for providers who require additional assistance. A PoLR is essential to managing and controlling risk levels in externally provided care.

2.9 The Care Act places a responsibility on local authorities to ensure continuity of care for vulnerable adults should there be a service disruption such as those detailed above. Caring for Thurrock's current hours and location of care delivery has largely been shaped by a previous failure of a provider who supplied services to people utilising direct payments or their own funds to buy care. As such, internal services have grown larger than intended. Thurrock must ensure that the correct balance is achieved between what it commissions externally and what level of provision we retain in-house to manage the risk of any potential provider failure.

2.10 Although reablement is currently provided by both internal and external providers, the specialist support and advice of therapy and nursing staff given to external agencies to enable people to regain skills sits within the Thurrock Council run joint health and social care reablement team. The council will continue to test and review our approach to the delivery of reablement, but as we try to minimise the amount of duplication of services/people going into clients, it is likely that reablement will remain an activity of all providers going forward. However, the specialist advice and support function provided by nursing and therapy staff would remain in-house.

2.11 Thurrock's in-house domiciliary care and reablement services also support with hospital discharge. External providers who supported an individual prior to admission also enable discharge by 'restarting' their package of care. In addition to this, Mid and South Essex NHS Foundation Trust also run a 'bridging' service from Basildon Hospital to enable people who are medically optimised to experience a timely discharge whilst long term care provisions are arranged.

2.12 The bridging service is funded through the Better Care Fund - BCF (a pooled budget and integrated spending plan between the health and social care system to aid integration). The Council contributes £0.216m per annum towards this service for approximately 200 hours per week. Health partners then meet the cost of any provision that exceeds this number of hours (i.e. they meet the cost at periods of higher demand).

2.13 Improving the transfer of care between the hospital and the community is a priority for the government and health and social care systems. In line with guidance, a Transfer of Care Hub (TOCH) is currently in development. A TOCH is the local health and social care systems co-ordinating centre. It is based around an Alliance (an Alliance is a strategic partnership between health, care, housing and third sector services that is responsible for the transformation of the system and developing and overseeing the deployment of the BCF in a geographical area i.e. Thurrock Integrated Care Alliance -

TICA) and seeks to prevent demand for hospital services.. How the TOCH develops will guide whether we need to reshape the market and how we currently operate to deliver a ‘home first’ approach.

2.14 Any changes to our existing hospital discharge pathways will be tested with the successful providers once they are fully embedded.

2.15 In addition to the statutory responsibility to meet eligible need and ensure continuity of care, the local authority also has a duty under the Care Act (2014) to ‘shape’ the market. This includes ensuring that services can meet current and future needs of people who use them and their unpaid carers.

2.16 Thurrock has seen a significant increase in the amount of domiciliary care commissioned, and it is very likely with demographic growth that this will continue.

2.17 In 2013 Thurrock commissioned 5100 hours of care per week. Today Thurrock commissions 8,900. This is partially due to the commitment to support people to remain in their own homes/communities. For example, even though Thurrock has experienced a significant increase in the number of older people with support needs over the last decade, the amount of residential based care within the Borough has not increased. Instead, resources have been redirected wherever possible away from residential care to a community setting.

2.18 Thurrock’s 2021 Census data suggests that residents aged 65 years old or more have increased by almost 4000 people in the last ten years and it is estimated that one in four/five residents in Thurrock will be 65 years old or more within the next ten years. Census 2021 predicts an increase of 16,000 people aged 65 or older living in Thurrock by 2031.

Based on available data[1], the impact of these demographic changes on demand and contract value have been modelled. This is attached as a separate table in Appendix 5.

2.19 In addition to demographic pressures, the change in hospital discharge criterion during the pandemic from people being medically ‘fit’ to ‘optimised’ has created an increase in both the complexity of those requiring services and the level of care that needs to be delivered to support people effectively and safely i.e. people are coming out of hospital earlier and with more complex care needs/larger packages.

This change in criterion to medically optimised has affected all areas of provision. However, the largest impact is on the delivery of domiciliary care and accounts for a significant amount of the growth in care hours

[1] We are still awaiting census 2021 population estimate data. As such, the modelling was based on ONS Population projections – local authorities: SNPP Z1 data release March 2020.

commissioned since March 2020. For example, between April 2020 to March 2022 an additional 2,700 hours per week of home care was commissioned.

2.20 Although the Council has continued to secure safe and good quality care to meet current need, doing so has been a significant challenge. With the demographic changes detailed in 2.18, the demand for this service is likely to grow over the life of the new contract. However, the domiciliary care market is fragile and faces many challenges. As such, Thurrock intends to shape the market to enable it at first to stabilise before ensuring it is sustainable long term.

2.21 Feedback shows that consistency of staff and timely visits are commonly the most important elements of a service to the client. However, retention of staff remains a fundamental challenge in Thurrock. Care work is often viewed as low status and attracts low pay. This coupled with the extremely competitive labour market in Thurrock (both in care and the wider economy) makes it difficult to achieve continuity of care for clients - this will only ever be achieved with a valued and retained workforce.

2.22 Skills for Care estimates that nearly half (46%) of Thurrock's adult social care workforce are on a '0' hour contract compared to a regional average of 24% i.e. we have double the number. Thurrock also has an older workforce - with nearly one third (30%) of people working in the local adult social care sector expected to retire within the next 10 years.

2.23 In addition to workforce, the Kings Fund has also identified rurality as a problem when securing supply of domiciliary care. This is due to the travel time and cost involved in a low number of visits over a large geographical area. Thurrock has similarly experienced difficulty in securing care in its villages (Orsett, Horndon and Bulphan) and in areas where demand is low, and travel can be affected e.g. East Tilbury (past the railway crossing).

2.24 If Thurrock is to secure care over the next ten years, some things need to be done differently. For example, addressing how unattractive a career in care is, moving away from the role being low status, low pay and with low job security. There is also a need to commission differently. Short term contracts focusing on time and task activities do not assist with the challenges faced both now or in the future, nor do they assist in helping Thurrock to meet its aspirations.

2.25 To address this, in Thurrock we have adopted a Human Learning System (HLS) approach as a framework for delivering the change required. HLS is about "*building relationships with real people – the people we're trying to help…….and responding to the complex reality of people's lives - their strengths and needs*"[2].

2.26 Utilising an HLS approach, the council will move away from fixed ideas on how we support people and will instead accept that the model of care will continuously adapt and change over time in response to need. The council will

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[2] https://realworld.report/

‘experiment’ in partnership with providers and those that use services to shape support and care to better meet outcomes.

2.27 The council accepts that not all experiments will be successful. However, it will use the learning and if something doesn’t work or stops meeting need, change it. In essence, the council will commission for learning. As such, the specification has been designed to evolve and change in response to learning. An example of how learning may change what is delivered is the Wellbeing Teams (please see 2.30 and 2.31)

2.28 Better Care Together Thurrock – The Case for Further Change, Thurrock’s integrated care strategy, details the (HLS) approach being used to transform, integrate and improve care. Chapter 8 details how the approach is being used to transform care delivered in the home.

2.29 Engagement work with residents has demonstrated that those in receipt of homecare want a service that is flexible, treats them as a whole person, is based on long-term relationships and is joined up, minimising the number of people coming into their home.

2.30 How Thurrock currently commissions, organises and provides care does not support service user aspirations. In response to this, Thurrock has developed Wellbeing Teams to test delivering home care differently. These teams are based on the Dutch Buurtzorg model which are small neighbourhood-based teams who are able to respond to the needs of the whole person and can link with other professionals to provide a joined-up response. Because they work on a neighbourhood level, they can have a detailed knowledge of the community assets and networks available to them and connect service users to these.

2.31 The Buurtzorg model was proven to be efficient and to deliver much better outcomes for people. However, it was based around health interventions (community nursing) and not social care. As such, Thurrock has been piloting Wellbeing Teams based on the same principles as Buurtzorg but applying them to people in receipt of social care. This pilot and its evaluation are ongoing and will be used to support the future development of the model of care provided in the Borough.

2.32 Although initial results are positive, the pilot is currently too small to be able to draw wider conclusions. It is currently unclear whether this approach inspired by the Buurtzorg model will have the same positive outcomes as experienced in the Netherlands when limited to social care needs. As such, when more robust evidence becomes available, in line with a HLS approach, Thurrock will adapt its external model to take account of that learning (see section 3. Options).

2.33 As part of this pilot, work has been taking place to explore blended roles for Wellbeing Workers. This means upskilling existing staff to be able to undertake certain health tasks (e.g. diabetes management) to improve continuity of care and reduce duplication. It is hoped that this will also

improve the status of care workers, resulting in higher retention. This is at an early stage, but again the results of this work will support the development of the external model.

2.34 In addition to Thurrock's core domiciliary care service, the Authority also commissions an Out of Hours (OOH) service which operates between 11pm and 7am. Prior to this service being put in place over a decade ago, there was no option for people with this level of need to remain in their own home. This service has enabled people to remain independent for longer, avoiding residential care and hospital admissions.

2.35 The service consists of three 'runs' which incorporates planned activity and an emergency component (i.e. able to respond to issues that arise such as a fall or continence issue – this part of the service is usually accessed via a 'lifeline' pendant alarm). Planned care activities are largely concerned with continence and skin integrity including repositioning/turning for those who are cared for in bed.

2.36 Due to the complexity of service users, the need to respond to emergencies and to keep staff safe during unsociable hours, each 'run' is staffed by two workers. The cost of each 'run' is currently £97,368 per annum. One of the three 'runs' is funded by Continuing Healthcare (CHC) partners i.e. the NHS. The OOH service is in addition to the 8,000 externally commissioned core domiciliary care hours detailed in 2.3. This will be a separate contract opportunity in the tender and will operate on a Thurrock wide basis. Unlike the core offer, there is insufficient demand in some localities to operate this service on a place/locality basis. The two 'runs' commissioned by the council are built into existing budgetary commitments.

## 3. Issues, Options and Analysis of Options

There are three main options. The preferred option is 2.

3.1 **Option 1 – Re-commission on the same basis as has been done historically i.e. time and task, priced per hour over a short contract period**.

3.1.1 Although it could be viewed as a low-risk option to go out to tender on the same basis as before, by doing so the council would not address the significant risk it faces in attracting a sufficient workforce to secure enough high-quality care to meet projected demand.

3.1.2 Due to the nature of the support required, people who use these services have an intimate relationship with the person supporting them and as such they want consistency in their care worker.

3.1.3 Current commissioning activity does not address long term recruitment and retention issues. As already explained, Thurrock has experienced difficulty in securing supply and is expecting both significant demographic growth and for

30% of its workforce to retire over the next 10 years. Recommissioning on the same basis – short term contracts, time and task etc will not address these issues.

3.1.4 As part of the Integrated Care Strategy (The Case for Further Change), Thurrock has organised its health and social care systems into localities to enable greater integration and to take advantage of community resources and natural networks of support that exist in each area. Continuing to commission in a traditional way does not support locality working. What is proposed will see care delivered on the same geographical 'footprint' as primary and social care, moving the relationship away from commissioner/provider to one of a partner who works jointly and equally alongside health and social care services.

3.1.5 This 'zoning' of care delivery cuts down on travel between visits and reduces the frequency of visits starting late.

3.1.6 As stated in 2.18, demographic pressures have been modelled alongside assumed levels of inflation – please see Appendix 5. These pressures result in an inflated cost, for the 10-year life of the contract of £114m.

3.2 **Option 2 – Preferred Option – Work with providers as partners to test, learn and shape services over the life of the contract.**

3.2.1 This option provides the opportunity to move towards a sustainable model, co-produced with service users and providers.

3.2.2 The recommendation is that the tender is at first for a traditional home care service albeit with some alterations to the current model. During the life of the contract, Thurrock's Adult Social Care Commissioning Team will experiment with providers, testing new models of delivery. Based on this learning, users views and the outcome of financial modelling/cost benefit analysis the service will be adapted over time.

3.2.3 Appendix 2 shows the locality boundaries and current delivery of care.

3.2.4 To allow providers to really embed in each locality, understanding the assets and networks unique to each area, care in this contract will be arranged around the existing Social Care Locality Team/Primary Care Network footprints. One provider will be sought for each of the four localities. The expectation is that potential providers must have the capability and capacity to meet all arising need for domiciliary care within their locality.

3.2.5 To mitigate the risk of any future quality or contract failure in the external market, potential providers cannot bid for more than one area (although they can also bid for the Out of Hours contract in addition to one locality contract). Should the designated provider for the locality be unable to meet demand, the package of care will be offered to the providers operating in other localities.

Should we still be unable to secure care, need will be met by the use of spot provision. Ultimately, we retain Caring for Thurrock as a PoLR.

3.2.6 However, prior to contract commencement the council will work with one village (Bulphan) and one difficult to access area (East Tilbury beyond the railway crossing) to grow an alternative response. Thurrock has experience in developing community-based solutions and has grown a vibrant and diverse Micro Enterprise market (a Micro Enterprise is small social business providing support in a bespoke way – most commonly as a sole trader). Since 2015 Thurrock has supported the development of over 100 micro providers to operate in the area to support people.

3.2.7 As part of this model, to enable all partners to build strong relationships and to give greater assurance, allowing providers in turn to give more security and to invest in those they employ, it is proposed that the contract is for a period of 10 years. However, to minimise risk there will be a break clause at 5 years in addition to the usual termination clauses. A significant change in the relationship with providers or a reduction in the reliance on '0' hour employment contracts will not be achieved by continuing to issue short term contract agreements. Recurrent tenders are time consuming, costly and do not foster joint working between providers but instead puts them in competition with each other. As Thurrock declares the rate for care, this frequent procurement activity adds little benefit or value for money for either the Authority or the user of commissioned services.

3.2.8 Based on the current hourly rate and demand levels for home care a 10-year contract would be approximately £89 million. The table in Appendix 5 models the estimated cost of the contract on a year-by-year basis incorporating both demographic and inflationary growth.

3.2.9 Legal and procurement advice has been obtained on the ability to change the model during the life of the contract without attracting challenge. Based on this advice, Adult Social Care Commissioners will set out within the specification the areas of service delivery that could alter over time e.g. introducing the principles of the wellbeing model externally, blended roles, reablement and hospital discharge etc. This allows for incremental change to occur over the life of the contract.

3.2.10 As providers move to the role of partner, the commissioning approach will also adapt to reflect this. The possibility of moving the commissioning of services from an hourly basis to allocating a set amount of core hours per area will be explored – allowing the provider to operate as a trusted assessor, staffing with some security and having inherent flexibility to adapt and deliver care to people whose needs may fluctuate/change over time e.g. reductions as people re-able/recover, increases in response to an episode of illness.

3.2.11 An implementation timetable of this option is attached as Appendix 4. As service developments will be shaped by learning, this is subject to change. However, the timeframes show when the learning outcomes should be

available and how and when we will work alongside the successful providers. As stated in 3.3.4, the current provider market is currently not at the point that it could deliver our aspirations and services in a different way. The tender will be used to test and secure future partners who understand what the Alliance plans to achieve and have the capability to adapt over time.

3.2.12 As can be seen from Appendix 4, the implementation of domiciliary care contracts is complex. As such, it is recommended that delegated authority to award the contract is given to the Executive Director of Adults, Housing and Health, in consultation with the Portfolio Holder for Health, Adult's Health, Community and Public Protection. This will allow a sufficient window of time between contract award and contract commencement, during which the necessary handover and onboarding activity can take place to ensure a smooth and effective transition of care to the new service model and possibly new providers (depending on outcome of the tender). Risk in the delivery of care is at its highest during a period of change, as such delegated authority will allow a longer handover period, which in turn will mitigate some risk.

3.3 **Option 3 – Go out to the market with a new but untested model of care.**

3.3.1 Although the existing model of care is flawed and early results from the Wellbeing Team experiment are positive, going to the market with a largely untested model poses significant risk for the local authority.

3.3.2 The wellbeing model appears to deliver better outcomes for individuals and the system as a whole (i.e. less g.p. and hospital visits) but due to the additional costs involved with delivering this model (although again there is some evidence that these additional costs are recouped elsewhere in the system), the benefits need to be replicated with a much wider cohort of people before the reshaping of all externally commissioned services should be considered.

3.3.3 There is also uncertainty about what the delivery of wellbeing principles in externally commissioned home care would look like and this will need to be robustly tested in partnership with providers.

3.3.4 In addition, there is a significant risk that the market would not be able to respond to this new way of working without support. As such, this option is not seen as viable.

The preferred Option 2 allows the Council to make the incremental change required.

## 4. Reasons for Recommendation

4.1 It is a statutory requirement to meet eligible care and support needs.

4.2 It is a statutory requirement to shape the market to meet current and future demand.

4.3 The preferred option (option 2) minimises risk, seeks immediate improvements but secures long term flexibility to shape services in response to learning/user feedback.

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

5.1 As part of Adult Social Care's quality improvement work and its commitment to co-production by ensuring people who use domiciliary care can also shape the services they receive; a survey was sent to all existing users seeking their views of the current service and its impact on their life. As part of this, people who use home care were asked to come forward to be part of an independently run focus group so that more in-depth discussions could be conducted.

5.2 During September and October 2023, Thurrock's User Led Organisation (ULO) ran focus groups with those people who have volunteered to participate.

5.3 In addition, Public Health colleagues continue to assess the impact of the wellbeing model on service user outcomes.

5.4 Also, to make use of existing contacts with domiciliary care service users, between August and October 2023 Contract Officers as part of their quality monitoring visits asked anybody in receipt of home care 3 additional questions.

5.5 A provider engagement event for existing and potential providers was held on 27 November 2023. This event allows the Council to have early discussions with providers about the HLS approach and the proposed model of care including the expectation that the successful partners will adapt and shape their service over the life of the contract based on evidence from learning and user engagement.

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

6.1 The domiciliary care contract impacts on the following Council Priority;

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

Specifically, the delivery of 'high quality, consistent and accessible public services which are right first time'.

## 7. Implications

### 7.1 Financial

Implications verified by: **Michael Jones**

**Head of Corporate Finance**

An assessment of the annual costs, for the duration of the contract, are detailed in **Appendix 5**. This has been used as the basis to demonstrate an indicative value, which incorporates predicted demographic and inflationary impacts.

This is based on indices and assumptions consistent with the Councils medium term financial strategy.

Actual annual fee uplifts to providers are subject to consultation, and external market and economic factors which could alter that value of the annual contract totals.

The annual estimated expenditure of £8.6m, used as the starting point for external homecare services is consistent with the 2023/24 base budget.

Budget provision of £0.216m, to finance the Councils contribution to the Bridging service (para 2.212) is included in the base budget. This is in addition to the £8.6m for external homecare services.

### 7.2 Legal

Implications verified by: **Kevin Molloy**

**Team Leader Contracts Team**

Following issue by the Council of a s114 notice, the Council must ensure that its resources are not used for non-essential spending. The contract at issue here is essential and the provision of it a statutory duty under the Care Act. In procuring the services outlined, the Council must observe the obligations upon it outlined in national legislation and in its internal procurement rules. Officers should ensure Legal Services are kept informed as they progress through the procurement.

### 7.3 Diversity and Equality

Implications verified by: **Roxanne Scanlon**

**Community Engagement and Project Monitoring Officer**

Due to the nature of the services under discussion in the report, older people will be disproportionately impacted by any change/activity in this area.

However, the approach detailed in the report seeks to address the key risks to the long-term sustainability of domiciliary care and details how we as a council (working in partnership with providers and people who use this service) will mitigate these risks.

As such, the development of the domiciliary care service model and the application of the HLS approach in commissioning, should have a positive impact on older people (and all service users) in that it should secure sufficient services to meet needs both now and in the future. It is also hoped that it will improve workforce retention and improve service users' outcomes.

There have been no adverse outcomes identified, however as the service evolves ongoing evaluations of the impact of these changes will be undertaken through the completion of a Community Equality Impact Assessment (CEIA).

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

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):

- ***Better Care Together Thurrock – The Case for Further Change,*** https://democracy.thurrock.gov.uk/documents/s34501/Appendix%20B%20-%20Better%20Care%20Together%20Thurrock%20-%20Further%20Case%20for%20Change%20-%20Full%20Version.pdf

- ***Market Sustainability Plan 2023***, https://www.thurrock.gov.uk/adult-care-strategies-and-plans/adult-social-care-local-account

- ***Skills for Care - Thurrock Summary***, https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/Local-authority-area-summary-reports/Eastern/2022/Thurrock-Summary.pdf

**9. Appendices to the report**

- Appendix 1 – Procurement Timeline
- Appendix 2 – Heat Maps of care delivery with locality boundaries identified.
- Appendix 3 – Community Equality Impact Assessment
- Appendix 4 – Option 2 (Preferred Option) Implementation Timetable
- Appendix 5 – Predicted Inflationary and Demand Pressures on contract value.

**Report Author:**

Sarah Turner
Commissioning Manager
Adult Social Care

**Appendix 1 – Procurement Timetable**

| Activity | Start Date | End Date |
|---|---|---|
| Market Engagement Event | Nov 23 | - |
| Cabinet approval to tender | 07 Feb 24 | - |
| Selection Stage (SQ) | 19 Feb 24 | 22 Mar 24 |
| SQ Evaluation | 25 Mar 24 | 19 Apr 24 |
| Tender Stage (ITT) | 22 Apr 24 | 07 Jun 24 |
| Evaluation of written tenders | 10 Jun 24 | 28 Jun 24 |
| Tender Interviews | 01 Jul 24 | 19 Jul 24 |
| Service User Visits | 22 Jul 24 | 16 Aug 24 |
| Notification of Outcome | 19 Aug 24 | - |
| Standstill | 20 Aug 24 | 29 Aug 24 |
| Award | 30 Aug 24 | - |
| Handover/TUPE | 02 Sep 24 | 31 Mar 25 |
| Contract Start | 01 Apr 25 | - |

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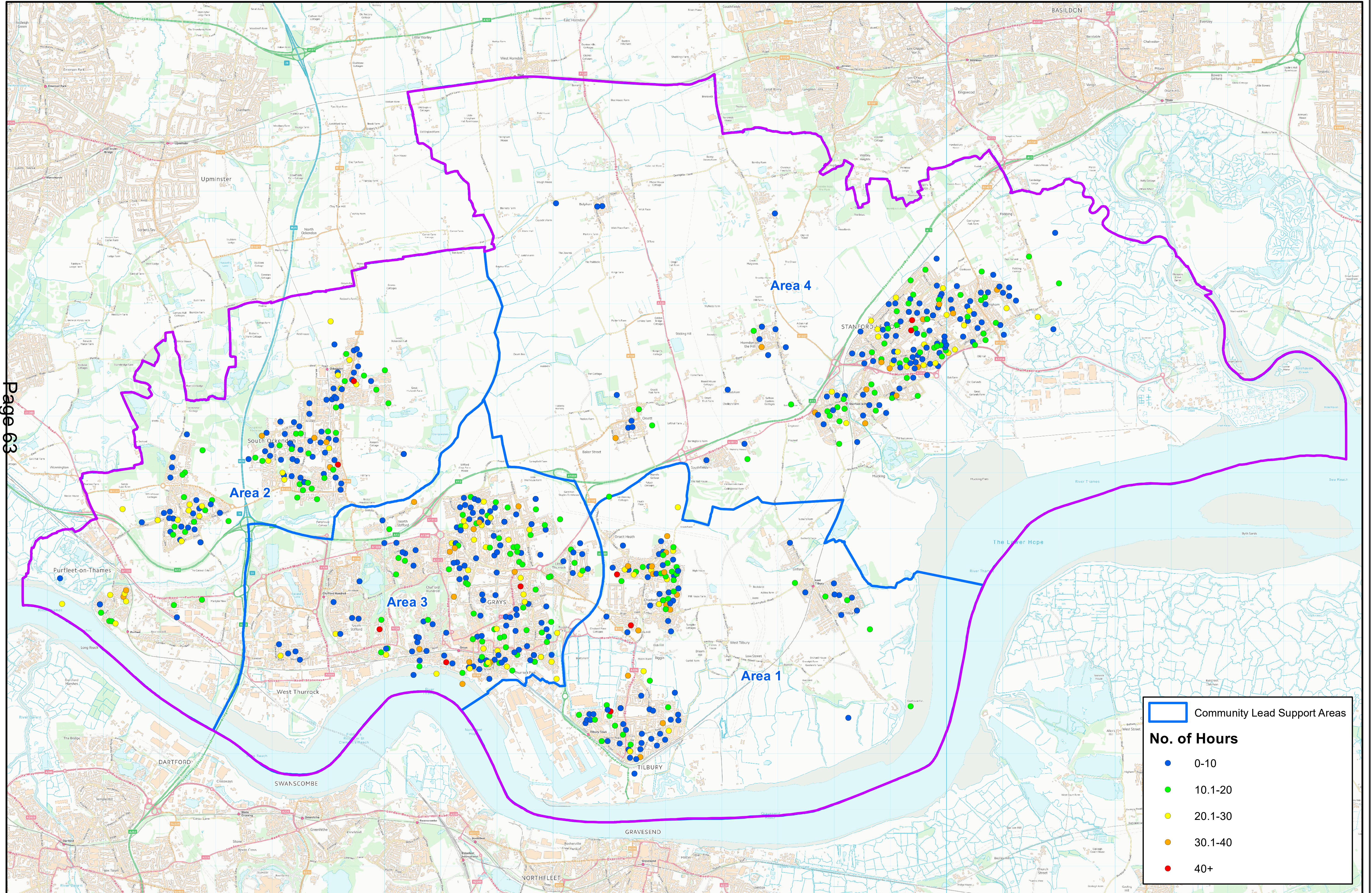
# Homecare provision across the borough by total of weekly hours

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# Thurrock Council

## Community Equality Impact Assessment

### Service area and lead officer

| **Name of service** | Adult Social Care |
|---|---|
| **CEIA Lead Officer** | Sarah Turner |
| **CEIA Lead Officer job title** | Commissioning Manager |
| **CEIA Lead Officer email address** | SAturner@thurrock.gov.uk |

### Subject of this assessment

| **What specific policy, strategy, function or service is the subject of this assessment?** |
|---|
| **Commissioning of domiciliary care (aka home care) services.** |
| **Borough-wide or location-specific?** |
| ☒ Borough-wide ☐ Location-specific – please state locations below.<br><br>Click or tap here to enter text. |
| **Why is this policy, strategy, function or service development or review needed?** |

**This is a large-scale procurement affecting the most vulnerable people in our community. As such a review is required to ensure we do not adversely affect service users or their unpaid carers.**

**Little change will occur to the service at contract commencement. Instead, the service will evolve in line with a Human Learning Systems (HLS) approach. As such, there will be multiple iterations of this document over the life of the contract as we decide to test and implement modifications to the existing service design in response to learning.**

**We are moving the service to operate on a locality basis as 'place' is the organising principle for health and social care in Thurrock. It is hoped that by moving the service onto the same locality footprint as G.P.s, district nursing and social work teams that service users will experience a more integrated and joined up approach to support, reducing duplication and the number of people coming into their home.**

**Should an 'experiment' (pilot) prove to be successful we hope to enhance the role of care workers. This in turn should lead to greater renumeration and status of these workers, hopefully addressing the recruitment and retention challenges facing us (care as a career is unattractive, often viewed as low status and low pay with little progression) as one third of our workforce is due to retire in the next 10 years, yet we attract few young entrants to the sector.**

**We have proposed a 10 year contract, to move away from the endless short term cycle of tenders which have historically added little value whilst being time consuming and costly. Thurrock has an over reliance on '0' hour employment contracts within the adult care sector compared to national and regional averages and it is expected that by offering greater security of contracts, providers can in turn offer more security in their employment.**

## 1. Engagement, consultation and supporting information

1.1. What steps you have taken, or do you plan to take, to engage or consult (where applicable) the whole community or specific groups affected by this development or review? **This is a vital step.**

| Steps you have taken, or plan to take, to engage or consult |
|---|

| We have carried out a baseline survey with all users of the service and have commissioned Thurrock Coalition (our User Led Organisation) to undertake focus groups on our behalf. We have also utilised the contract officers existing contact with service users as part of their quality monitoring activity to ensure we understand what is working well and what areas we need to improve i.e. what is important to people who use the service both now and in the future. |
| --- |

1.2. What data or intelligence sources have you used to inform your assessment of the impact? How have these helped you understand who will be affected by the development or review?

| **Sources of data or intelligence, and how they have been used** |
| --- |
| We have undertaken a review of the protected characteristics of the people who use the service and compared this to survey respondents and the census data. |

## 2. Community and workforce impact

2.1. What impacts will this development or review have on communities, workforce and the health and wellbeing of local residents?

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Local communities in general** | ☒ | ☐ | ☐ | We are moving to an area based (locality) delivery of care to ensure greater joined up working between health and social care. This should reduce duplication, reduce travel and increase timeliness of calls and consistency of carers.<br><br>We have not identified any negative impacts in this approach. | It is hoped that users of the service will experience an improved service – especially in the two areas that they have identified as important to them, namely timeliness of visits/calls and consistency of carers. |
| **Age** | ☒ | ☐ | ☐ | 85% of users of domiciliary care users are older people – with the majority being aged 80+. Any change in service will impact on this group of people more than anyone else. The initial change to place based working should have no adverse impact on older people and support the service improvements identified by users as being of importance e.g. timeliness of calls and consistency of carers.<br><br>Other impacts will be assessed as the service is shaped. | No negative impacts have been identified. We are introducing electronic monitoring so that we can monitor timelines of calls/consistency of staff. Should we see improvements in these areas of delivery, we will have higher satisfaction amongst users. |

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Disability** | ☒ | ☐ | ☐ | The majority of users will have some form of disability and require help and assistance with aspects of daily living e.g. washing, dressing etc. As such, improvements in services should lead to greater satisfaction with their support. | No negative impacts have been identified. Improved service quality and satisfaction should lead to improved outcomes for people with a disability. We will be testing over time how to connect people who use this service with the community they live in thereby reducing the high levels of self-reported loneliness. |
| **Gender reassignment** | ☐ | ☒ | ☐ | Neither positive or negative impacts identified. We do not have enough data to draw any meaningful conclusions. | Neither positive or negative impacts identified |
| **Marriage and civil partnership** | ☐ | ☒ | ☐ | Neither positive or negative impacts identified. We do not have enough data to draw any meaningful conclusions. | Neither positive or negative impacts identified |
| **Pregnancy and maternity** | ☐ | ☒ | ☐ | Neither positive or negative impacts identified due to the age of most service users (80+). | Neither positive or negative impacts identified |

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Race** | ☐ | ☒ | ☐ | Race was considered as part of evaluation of users of the service. User profile matched census data for these age groups and there was no evidence that access to services was a concern. There was also no evidence that race impacted on satisfaction levels in the survey results. However, please note that the user group was too small to draw any more meaningful conclusions. | Please see explanation. |
| **Religion or belief** | ☐ | ☒ | ☐ | Neither positive or negative impacts identified. Please note that it is a requirement of providers registrations to not discriminate against people for their religion or beliefs so this is checked by CQC in addition to our own contract monitoring. | Neither positive or negative impacts identified. |
| **Sex** | ☐ | ☒ | ☐ | As women live longer than men, we have more women who use domiciliary care. As such any change in service delivery would impact women more. However, no adverse impact has been identified. | Neither positive or negative impacts identified. |

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Sexual orientation** | ☐ | ☒ | ☐ | Neither positive or negative impacts identified. We do not have enough data at this time. However, we are aware that nationally (although still awaiting local analysis) that people from the LGBTQ+ community are more likely to be an unpaid carer than the general population. As such, this is considered in that section. | Please see implications. |
| **Location-specific impact, if any** | ☒ | ☐ | ☐ | The service will operate on a locality basis. This should ensure greater integration with other social care, health and voluntary sector services reducing duplication and confusion for service users. It should also reduce travel and improve timeliness of visits and carer consistency. | Apart from the reduction in duplication and improvement in timeliness of visits/carer consistency, it is expected that by working on a locality basis that the successful provider can draw on local assets and natural circles of support within the community. We have issues with reported loneliness amongst home care service users and we see place based working as an opportunity to increase service users connections to the community they live in. |

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Workforce** | ☒ | ☐ | ☐ | Recruitment occurs within this sector on a hyper local basis. By operating on a place basis recruitment should be positively impacted.<br><br>In addition, we are proposing a 10 year contract to give providers more stability. We expect this stability to result in a reduction in the use of ‘0’ hour contracts. We will also explore the possibility of paying differently during the life of the contract to again support this. | We know we are heading for a significant issue in the recruitment and retention of care workers. We have an over reliance on ‘0’ hour workers and are expecting one third of our workforce to retire within the next 10 years. Due to the low status and pay of workers we are not attracting younger recruits.<br><br>As such, we have highlighted recruitment and retention as our main priority in our Market Sustainability Plan. This has helped shape procurement decisions – most obviously the move away from insecure short-term contracts which foster the use of ‘0’ hour contracts in the sector.<br><br>An increase in more secure employment contracts will be evidence of an improved approach. A more secure workforce will support greater consistency of carers – which is a priority for service users. |

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Health and wellbeing of residents** | ☒ | ☐ | ☐ | The purpose of the service is to support the health and wellbeing of residents who meet the eligibility criteria of the Care Act 2014. We are trying to take forward greater integration to support improved outcomes for service users. | We are currently piloting a wellbeing teams approach internally – initial evidence suggests that this change to how we deliver care results in far less hospital admissions and g.p. visits. When we pilot this wider, should these outcomes be replicated, we will be able to maximise this positive aspect throughout Thurrocks communities. |

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Socio-economic outcomes** | ☒ | ☐ | ☐ | More people work in social care than the NHS and it accounts for about 5% of the economy. Therefore, this tender can have a significant impact on the local economy and employment.<br><br>We will be requiring providers to invest in the local area and seeking social value commitments through this process. Due to the hyper local recruitment of care workers we are aware that by changing the way we commission we could positively impact on both of the socio-economic outcomes identified.<br><br>If the proposed 10 year contract period is agreed, then we expect more people to be offered greater security of employment. | We are attempting to maximise the investment of successful providers into the local area and will be seeking social value commitments. The contract is worth an estimated £114million over the 10 year period. |
| **Veterans and serving members of the armed forces** | ☐ | ☒ | ☐ | Neither positive or negative impacts have been identified. | Neither positive or negative impacts have been identified. |

| Communities and groups | Positive | Neutral | Negative | Summary of positive and negative impacts | How will positives be maximised, and negatives minimised or eliminated? |
|---|---|---|---|---|---|
| **Unpaid carers** | ☒ | ☐ | ☐ | We are making the support of unpaid carers a priority within the specification including. | We will be seeking social value commitments that support unpaid carers. It is an expectation of the specification that the successful providers will support unpaid carers to access information, advice and support and to signpost them to local resources that can help eliminate loneliness and stress of their caring role. |

## 3. Monitoring and review

3.1. How will you review community and equality impact once the policy, strategy, function or service has been implemented? These actions should be developed using the information gathered in sections 1 and 2 and included in your service area's business plans.

| Action | By when | By who |
|---|---|---|
| We have committed to review the CEIA as part of our 'experiment' (pilot) process over the course of the contract. This will be an ever-evolving CEIA and not a one of process. | Various – as part of the HLS approach we will review the CEIA at the start and finish of each experiment before making any modifications to the operating model. Co-production is a core element of the HLS approach. | Commissioning Team – Adult Social Care |
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## 4. Next steps

4.1. The information gathered must be used to inform reports presented to Cabinet or overview and scrutiny committees. This will give members a necessary understanding of the impact their decisions will have on different groups and the whole community.

Summarise the implications and customer impact below. This summary should be added to the committee reports template in the Diversity and Equality Implications section for review and sign-off at the consultation stage of the report preparation cycle.

| Summary of implications and customer impact |
|---|
| For this tender we are undertaking an HLS approach to the service. As such, the specification will evolve and change in line with learning. Initially there are no changes to the service (except for operating on a locality rather than borough wide footprint) and no adverse impact has been identified. However, we have committed within the HOSC and Cabinet report to update the CEIA as each change is proposed to the model. As such, this will be an evolving CEIA with multiple versions by the end of the contract period (10 years). |

## 5. Sign off

5.1. This Community Equality Impact Assessment must be authorised by the relevant project sponsor, strategic lead, or assistant director. This should not be the CEIA Lead Officer. Officers authorising this assessment are responsible for:

- the accuracy of the information
- making sure actions are undertaken

| Name | Role | Date |
|---|---|---|
| Ceri Armstrong | Head of ASC Transformation and Commissioning | 12/12/23 |
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Summary/Outline of Key Activities and Dates

| Theme 1 - Provider Development / Market Readiness | | | |
|---|---|---|---|
| **No.** | **Action** | **Timeline** | **Lead** |
| 1. | **Initial engagement with current providers –** individual meetings held at the beginning of the process (with providers over a certain size) to understand the current challenges they face and to seek their expertise in shaping the model. Opportunity also used to have early discussions about Thurrock's aspirations/HLS/Wellbeing Teams etc. | June 2023 | Commissioning |
| 2. | **Additional engagement with current providers –** Second conversation with above providers to discuss the potential model whilst it is being shaped. Opportunity for providers to highlight any concerns with the proposed model at this early stage. Meeting also used to identify what support partners would need at the beginning of the contract (should they be successful in the tender) to meet our aspirations/plans regarding change in service model. | October 2023 | Commissioning |
| 3. | **Support potential providers to understand Thurrock strategic direction –** Prior to tender commencement, a Provider Engagement Event to be held with current and potential providers to enable them to understand HLS, Thurrock's integrated health and social care strategy (Better Care Together - The Case for Further Change, specifically chapter 8) and the details of the contract opportunity e.g. length of contract, handover, model etc. | November 2023 | Commissioning and Procurement Teams |
| 4. | **Rural outliners and difficult to access areas -** work undertaken in Bulphan and in East Tilbury (pass the crossing) to develop a community/micro response to need in these areas. | When post is recruited to. | Micro Enterprise Officer (when vacant post is recruited to) |
| 5. | **Shape specification and tender process** – ensure the specification has built in flexibility that enables the service to adapt to learning over the life of the contract. Ensure tender process seeks adaptable providers who can evidence innovation and working in partnership (with users of services and health, care, housing and third sector partners). | By March 2023 | Commissioning |
| ***Please note: Based on legal advice, Commissioning is unable to have further conversations with current or potential providers regarding the tender or the development of the model of care/support after the Provider Engagement Event in November. This 'ethical wall' ensures a fair and transparent tender process.*** | | | |
| Theme 2 – Learning and its application (Interdependency between 'experiments' and the model of care and support) | | | |
| 1. | **Wellbeing Pilot Evaluation –** | September 2024 onwards | Public Health (evaluation results). |

| | | | |
|---|---|---|---|
| | The wellbeing evaluation will report once the procurement of domiciliary care service is underway. As such, the results will feed into and shape the model from contract award onwards. | | Commissioning (interpreting the learning for the external market) |
| 2. | **ToCH/Hospital discharge and avoidance pathway –**<br>Model will be developed, tested and then established during 2023/24. The specification will either capture how the ToCH operates and the role that successful providers will undertake or be flexible enough to allow changes to occur. If it is the latter, any alterations to published existing practices will be embedded with providers between contract award and contract commencement. | September 2024 to March 2025 | Contracting and Commissioning |
| 3. | **Blended Roles –**<br>A large amount of progress has already been made in this area and recruitment is agreed for a specialist nurse role who will oversee the training and assessment of competences in health-related tasks being undertaken by adult social care staff i.e. the Wellbeing Team. Once in place, we will be able to see how blended roles progresses (e.g. the number of different tasks/conditions they can support) and then assess both the likely demand that could be delegated to adult social care and the extent of crossover between health and adult social care service users (to stop duplication of effort/visits).<br><br>The current pilot is centred around health and social care working together as partners. As statutory partners we already have a strong platform for integration and risk sharing that this project has built upon. If the above 'experiment' proves successful, both the risk to health of delegating tasks wider to non-statutory partners and the accountability framework will need to be explored before progressing. | End of March 2025 - there should be a robust evaluation of the success and cost/benefit of this model. Its wider application can then be considered. | Commissioning (adapting the learning to the external market) |
| Theme 3 – Post award implementation and Human Learning Systems (HLS) 'experiments' | | | |
| 1. | **Award to contract commencement** –<br>Work with the successful providers to ensure their submitted mobilisation plan is on track. Ensure TUPE takes place (if applicable). Revise risk and contingency plans based on outcome of tender (number of new and existing providers increases or decreases risk, outgoing providers willingness to TUPE, staff retention rates of outgoing providers, new providers recruitment and onboarding etc). | September 2024 to March 2025 | Contracting and Commissioning Teams. |

| | | | |
|---|---|---|---|
| 2. | **Contract commencement - 0 to 6 months/12 months** – The timeframe is variable as it is dependent on the number of contracts awarded to existing and new providers. For example, if all four contract opportunities were awarded to new providers, this period could be 12 months. Equally, if they were awarded to existing providers this period would be minimal. Delivery of care is complex, and a significant amount of resource is always required at contract commencement to ensure the safe delivery of services to vulnerable people and to embed good working relationships and Thurrock practices. | Between April 2025 and March 2026 (timeframes variable as dependent on profile of successful providers) | Contracting Team with support from the Commissioning Team. |
| 3. | **Test model in different localities/with different partners –** As part of the tender, potential partners will be asked to submit plans regarding how they would develop the service. We will use this submission in conjunction with the learning from Theme 2 and service user engagement to test the future model of care in different localities. | Year 1 to 2 of the contract (see above – dependent on contract commencement). | Commissioning |
| 4. | **Finalise Model –** Based on learning, finalise a model that works at either a Thurrock wide or locality level (i.e. the model may need to look different in Corringham compared to Grays depending on the strengths and assets in that community).<br><br>This model to continue to adapt and respond to learning. | Year 2 to 3 (dependent on contract commencement) | Commissioning |

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## Appendix 5 – Predicted Inflationary and Demand Pressures on contract value.

| | | Per Client | | Total | | Inflation | | | | | Annual Budget Impact | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Financial Year - Stating 2024/25 | Number of Clients | Average Weekly Home Care Package (Hours) | Average Annual Home Care Package (Hours) | Total Home Care Hours per week (Hours) | Prior Year Hourly Rate £ | Staffing Element - 70% of Contract %'age | Staffing Element - 70% of Contract £ | Non Staffing Element - 30% of Contract %'age | Non Staffing Element - 30% of Contract £ | Uplifted Hourly Rate £ | Annual Hours (Hours) | Annual Growth Requirement £m's | Annual Cost - Budget Requirement £m's |
| **Base Year 2023/24** | 690 | 11.59 | 605 | 8,000 | | | | | | **£ 20.58** | 417,143 | | 8,585 |
| Year 1 | 695 | 11.59 | 605 | 8,058 | £ 20.58 | 5% | £0.72 | 7% | £0.43 | £ 21.73 | 420,166 | 546 | 9,131 |
| Year 2 | 700 | 11.59 | 605 | 8,116 | £ 21.73 | 5% | £0.76 | 3% | £0.20 | £ 22.69 | 423,189 | 470 | 9,602 |
| Year 3 | 705 | 11.59 | 605 | 8,174 | £ 22.69 | 5% | £0.79 | 2% | £0.14 | £ 23.62 | 426,212 | 465 | 10,067 |
| Year 4 | 710 | 11.59 | 605 | 8,232 | £ 23.62 | 5% | £0.83 | 2% | £0.14 | £ 24.59 | 429,234 | 487 | 10,554 |
| Year 5 | 715 | 11.59 | 605 | 8,290 | £ 24.59 | 5% | £0.86 | 2% | £0.15 | £ 25.60 | 432,257 | 510 | 11,064 |
| Year 6 | 720 | 11.59 | 605 | 8,348 | £ 25.60 | 5% | £0.90 | 2% | £0.15 | £ 26.64 | 435,280 | 534 | 11,598 |
| Year 7 | 725 | 11.59 | 605 | 8,406 | £ 26.64 | 5% | £0.93 | 2% | £0.16 | £ 27.74 | 438,303 | 559 | 12,157 |
| Year 8 | 730 | 11.59 | 605 | 8,464 | £ 27.74 | 5% | £0.97 | 2% | £0.17 | £ 28.87 | 441,325 | 586 | 12,743 |
| Year 9 | 735 | 11.59 | 605 | 8,522 | £ 28.87 | 5% | £1.01 | 2% | £0.17 | £ 30.06 | 444,348 | 613 | 13,356 |
| Year 10 | 740 | 11.59 | 605 | 8,580 | £ 30.06 | 5% | £1.05 | 2% | £0.18 | £ 31.29 | 447,371 | 642 | 13,999 |

**10 Yr Contract Value** **114,270**

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**Health and Wellbeing Overview & Scrutiny Committee**
**Work Programme**
**2023/2024**

Dates of Meetings: 19 July 2023, 31 August 2023, 2 November 2023, 11 January 2024, 7 March 2024

| Topic | Lead Officer | Requested by Officer/Member |
|---|---|---|
| **19 July 2023** | | |
| Integrated Medical Centres Update (PowerPoint) | Aleksandra Mecan | Members |
| Terms of Reference | Democratic Services | Officers |
| ICB Community MSK and Pain Service | Tina Starling (NHS Report) | Officers |
| Direct Payment Support Services | Ian Kennard | Officers |
| Verbal CQC report on Basildon Hospital | NHS | Members |
| Work Programme | Democratic Services | Officers |
| **31 August 2023** | | |
| 2022/23 Annual Complaints and Representations Report – Adult Social Care | Lee Henley | Officers |
| Safeguarding Adult Board – Three Year Strategic Plan | Jim Nicolson | Officers |
| Tobacco Control Strategy | Jo Broadbent | Officers |
| Agree Working Group Terms of Reference | Democratic Services | Members |
| Updates from Mid and South Essex Trust | Fiona Ryan | Members |
| Healthwatch | Kim James | Members |
| Work Programme | Democratic Services | Officers |

| 2 November 2023 | | |
|---|---|---|
| Thurrock Safeguarding Adults Board Annual Report 2022/23 | Jim Nicolson | Officers |
| General Practice Patient Survey 2023 | Jo Broadbent | Members |
| HealthWatch | Kim James | Members |
| Updates from Mid and South Essex NHS Foundation Trust | NHS Report | Members |
| Phlebotomy Update | NHS Report | Officers |
| Work Programme | Democratic Services | Officers |
| **11 January 2024** | | |
| Integrated Medical Centres Update Report | Aleksandra Mecan (NHS Report) | Members |
| The Mid and South Essex Primary Care Access Recovery Plan | NHS Report | Officers |
| EPUT Update | Paul Scott and Alex Green (NHS Report) | Members |
| Commissioning Report - Domiciliary Care | Sarah Turner | Officers |
| Updates from Mid and South Essex Trust | Fiona Ryan (NHS Report) | Members |
| HealthWatch | Kim James | Members |
| Work Programme | Democratic Services | Officers |
| **7 March 2024** | | |
| Integrated Medical Centres Update Report | Aleksandra Mecan | Members |
| Report of the Cabinet Member for Health, Adult Social Care, Community and Public Protection | Cllr Coxshall | Members |
| Updates from Mid and South Essex Trust | Fiona Ryan | Members |

| | | |
|---|---|---|
| SERICC | Rebekah Brant / Sheila Coates | Members |
| Dentistry | Tbc | Members |
| Advocacy to include Healthwatch | Tbc | Members |
| Co-Production | Ceri Armstrong | Members |
| LGBT Community Services | Tbc | Members |
| HealthWatch | Kim James | Members |
| Work Programme | Democratic Services | Officers |
| Briefing Notes | | |
| | | |



Working Groups

1. Mental Health Services
2. Healthy Living

Items to be included or plans for 2024/25 Work Programme:

1. Community Musculoskeletal (MSK) and Pain service Community Musculoskeletal (MSK)

Clerk: Jenny Shade
Last Updated: August 2023

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