Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **23 July 2015**

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

Membership:

Councillors Graham Snell (Chair), Jane Pothecary (Vice-Chair), Russell Cherry, Yash Gupta (MBE), Charlie Key and Tunde Ojetola

Substitutes:

Councillors Leslie Gamester, James Halden, Martin Kerin, Susan Little and Steve Liddiard

Agenda

Open to Public and Press

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: **15 July 2015**

Information for members of the public and councillors

Access to Information and Meetings

Members of the public can attend all meetings of the council and its committees and have the right to see the agenda, which will be published no later than 5 working days before the meeting, and minutes once they are published.

Recording of meetings

This meeting may be recorded for transmission and publication on the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is to be recorded.

Members of the public not wishing any speech or address to be recorded for publication to the Internet should contact Democratic Services to discuss any concerns.

If you have any queries regarding this, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

Guidelines on filming, photography, recording and use of social media at council and committee meetings

The council welcomes the filming, photography, recording and use of social media at council and committee meetings as a means of reporting on its proceedings because it helps to make the council more transparent and accountable to its local communities.

If you wish to film or photograph the proceedings of a meeting and have any special requirements or are intending to bring in large equipment please contact the Communications Team at CommunicationsTeam@thurrock.gov.uk before the meeting. The Chair of the meeting will then be consulted and their agreement sought to any specific request made.

Where members of the public use a laptop, tablet device, smart phone or similar devices to use social media, make recordings or take photographs these devices must be set to ‘silent’ mode to avoid interrupting proceedings of the council or committee.

The use of flash photography or additional lighting may be allowed provided it has been discussed prior to the meeting and agreement reached to ensure that it will not disrupt proceedings.

The Chair of the meeting may terminate or suspend filming, photography, recording and use of social media if any of these activities, in their opinion, are disrupting proceedings at the meeting.

Thurrock Council Wi-Fi

Wi-Fi is available throughout the Civic Offices. You can access Wi-Fi on your device by simply turning on the Wi-Fi on your laptop, Smartphone or tablet.

- You should connect to TBC-CIVIC
- Enter the password **Thurrock** to connect to/join the Wi-Fi network.
- A Terms & Conditions page should appear and you have to accept these before you can begin using Wi-Fi. Some devices require you to access your browser to bring up the Terms & Conditions page, which you must accept.

The ICT department can offer support for council owned devices only.

Evacuation Procedures

In the case of an emergency, you should evacuate the building using the nearest available exit and congregate at the assembly point at Kings Walk.

How to view this agenda on a tablet device

You can view the agenda on your iPad, Android Device or Blackberry Playbook with the free modern.gov app.

Members of the Council should ensure that their device is sufficiently charged, although a limited number of charging points will be available in Members Services.

To view any “exempt” information that may be included on the agenda for this meeting, Councillors should:

- Access the modern.gov app
- Enter your username and password

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.

Vision: Thurrock: A place of **opportunity**, **enterprise** and **excellence**, where **individuals**, **communities** and **businesses** flourish.

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 17 February 2015 at 7.00 pm

Present:	Councillors Charles Curtis (Chair), Charlie Key (Vice-Chair), Yash Gupta (MBE), Terry Brookes and Graham Snell Kim James, Healthwatch Thurrock
Apologies:	Ian Evans, Thurrock Coalition Representative
In attendance:	Roger Harris, Director of Adults, Health and Commissioning Dr Andrea Atherton, Director of Public Health Cate Edwynn, Interim Consultant for Public Health Stephanie Cox, 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.

33. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee, held on 13 January 2015, were approved as a correct record.

34. Urgent Items

There were no urgent items of business.

35. Declarations of Interests

Councillor Gupta declared a non-pecuniary interest in respect of Agenda Item 6, Adult Social Care Local Account 2014, as he was a carer.

Councillor Curtis declared a non-pecuniary interest in respect of Agenda Item 6, Adult Social Care Local Account 2014, as his daughter was employed in Adult Social Care.

36. Items raised by HealthWatch

The Chief Operating Officer of Healthwatch Thurrock provided an update to the Committee on the following key points:

- That there had recently been a number of changes to the HealthWatch project in Thurrock, and the board was now overseen by Thurrock CVS with a new advisory Committee to be created to support the CVS Board.

- That a number of concerns had been raised from a recent preliminarily information gathering exercise by the Care Quality Commission (CQC) in preparation of its inspection of GP's surgeries. It was explained that the findings had been misreported in the press and clarified that this had been an information gathering exercise and not the inspection itself.
- In response an event was scheduled for 23 February 2015, and the CQC Area Inspector for Primary Care invited to attend, to explain how the inspection will take place, what the findings could be, how this would be reported and what this meant for individual GP's and patients of the surgeries. NHS England were also due to attend the event to explain what would happen if there were any difficult findings.
- That concerns had also been raised about the proposed changes to the Walk-In centre, and a petition was currently underway, however this was not being led by HealthWatch.

Councillor Gupta questioned how many GP's surgeries would be inspected, to which the Chief Operating Officer of Healthwatch explained that approximately 25% of Thurrock surgeries would be inspected which was due to start in July 2015. Members were advised that preliminarily work had begun and patient participation groups had been contacted.

The Chair proposed that item 7, 'Air Quality, Regeneration and Health' be brought forward on the agenda for discussion, to which Members agreed.

37. Air Quality, Regeneration and Health

The Interim Consultant for Public Health provided a detailed introduction and presentation of the report, which provided an overview of the multiple sources and types of air pollution, in addition to the associated acute and chronic health effects from exposure.

A Member observed that air pollution had been an issue for some time and felt that it was difficult to implement a solution. He felt that schools had improved numbers of children walking or cycling to school, but that it was difficult to measure any significant impact of Public Health or Local Authority initiatives.

In response it was explained that air pollution had been prioritised in recent years and the Public Health Framework and Indicators had improved, however it was thought further work was required to join up action undertaken across Local Authorities.

Councillor Key questioned the Interim Consultant for Public Health and received responses on the following matters:

- Whether the type of particulate matter was more important that the mass or level of matter.

It was explained a number of variables affected health of individuals and communities, and that length and the volume of exposure were particularly important.

- In reference to the opportunities to increase impact for health, he observed that Thurrock had high levels of exposure due to the fact that the Borough had the biggest economy in East Anglia and Essex. However he recognised that most of the opportunities identified targeted individual people rather than businesses and questioned whether these were aimed at the wrong target audience.

  Officers agreed that a balance needed to be achieved with Thurrock's growing economy. The Director of Adults, Health and Commissioning explained that a link needed to be established with the planning process, business board and local employers to both attract businesses and control emissions in the Borough.

- He asked whether any schools were located within Air Quality Management Areas (AQMA).

  The Committee were advised that there were a number of Air Quality Management Areas in Thurrock, which did encompass some schools.

- If particulate matter pollution was easily measurable as a Key Performance Indicator (KPI).

  Members were advised that there was an indicator for particulate matter and so it was easily measurable.

Councillor Snell questioned whether it was counter-productive to slow traffic down in attempt to reduce pollution, as it would make journeys slower and longer. In response it was explained that slow and steady journeys through traffic calming measures were better in order to reduce pollution levels.

Councillor Brookes asked whether it was possible to measure and compare pollution in different parts of the Borough, to which it was explained that officers continued to monitor pollution across the Borough.

A brief discussion took place in response to Members concerns about health inequalities between different wards in the Borough due to varying pollution exposure levels. Officers explained that Thurrock was doing good work but it was proposed an officer working group be established to examine where the local authority should concentrate its efforts in order to achieve the greatest impact.

The Director of Adults, Health and Commissioning further reported that air pollution was an issue both regionally and nationally, and that Thurrock benefitted from its work with Public Health to examine where it impacted on other parts of the Local Authority.

The Chair read the new proposed recommendation to the Committee, which was agreed.

RESOLVED:

1. **That the contents of the report be noted.**
2. **That an officer working group be established to consider how air quality objectives can be improved in Thurrock.**

38. Adult Social Care Local Account 2014

The Director of Adults, Health and Commissioning introduced the report which outlined the performance of Adult Social Care and the progress that had been made in delivering the key priorities and actions from the 2012/13 local account. The following key facts and figures were highlighted:

- The net budget of Adult Social Care was £43.7 million but the gross was in excess of £50 million. The difference was accounted for by fees and charges and NHS contributions to Adult Social Care.
- That over 2000 adults and older people received Adult Social Care services.
- Over 1030 people received a personal budget or direct payment.
- The service was focussed on prevention and supporting communities, through the work of Local Area Coordinators, Extra Care Housing and the Telecare Service over 250 people had been enabled to live independently.
- That the £43.7 million Adult Social Care budget was approximately 20% of the overall total budget of the Council, which meant that Thurrock was a low spend authority as the National Average was 26%.
- That the legislation had changed, with the introduction of the Care Act 2014, Duty to Promote Wellbeing, and further changes to Adult Social Care funding were expected for April 2016.

The Director of Adults, Health and Commissioning explained that a new system called Quickheart had been introduced, and it was expected that a demonstration would be provided to the Committee in the new municipal year.

Members asked how recent budget cuts had impacted on the service, in recognition of the fact that Thurrock's budget was smaller every year and was already less than that of the national average. In response the Director of Adults, Health and Commissioning advised that:

- Income had been increased and full-cost recovery obtained to maintain services, such as the increase in the cost of homecare from £10.50 a day to full cost-recovery of £13.00 per hour.
- The service had been successful in securing money from the NHS so that service levels did not have to be reduced.
- Eligibility Criteria had been re-examined so that care was now delivered to only those with substantial or critical care needs.

In addition, the Director of Adults, Health and Commissioning advised some packages of care were no longer affordable, and although there was no easy answer, the service examined every opportunity for external funding sources. He proposed that a further report be referred back to the Committee to examine how this could be improved in future.

There was a brief discussion on the importance of intervention to prevent cases from escalating, which in turn saved the service considerable money. The Director of Public Health added that the Public Health Report would detail further information about primary prevention.

Councillor Snell observed that the Key Performance Indicator (KPI) for the percentage of people who used the service who had control over their daily life had been interchangeable over the reporting period, and question why this was. In response the Director of Adults, Health and Commissioning explained that a third of service users were sampled and asked to summarise their experiences, which could vary due to a multitude of factors.

Members commended the work of all those involved in preparing the report, which was both informative and well presented.

RESOLVED: That the Committee praise and note the contents of the report.

39. Work Programme

The Director of Adults, Health and Commissioning informed Members that the Annual Public Health Report should be referred to Committee in March. He advised that he would liaise with Democratic Services and the Chair and Vice-Chair of the Committee regarding other items for inclusion on the agenda.

RESOLVED: That the Annual Public Health Report be added to the work programme for 31 March 2015.

The meeting finished at 8.15 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

This page is intentionally left blank

Terms of Reference of Health and Wellbeing Overview and Scrutiny Committee

HEALTH AND WELL-BEING OVERVIEW AND SCRUTINY COMMITTEE	
Appointed by: The Council under section 21, Local Government Act 2000	**Number of Elected Members:** Six, of whom none may be Cabinet Members or Members of the Health and Wellbeing Board
Chair and Vice-Chair appointed by: The Council	**Political Proportionality:** The elected Members shall be appointed in accordance with Political Proportionality
Quorum: Three elected Members	**Co-opted Members to be appointed by Council:** Two, non-voting

Functions determined by Council:

1 Provision, planning, management and performance of adult social services;

2 Libraries, museums and community facilities;

3 Arts and sports development;

4 To review and scrutinise the planning, provision and operation of the health service in Thurrock;

5 Diversity and equality issues (other than the Authority's human resources policies);

6 Work in partnership and act as a member of regional, sub-regional and local health scrutiny networks;

7 Adult training and skills;

8 Scrutiny of the Health and WellBeing Board

Functions determined by Statute

All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000, Local Government and Public Involvement in Health Act 2007, Social Care Act 2001, the Health and Social Care Act 2012 and any subsequent regulations.

This page is intentionally left blank

23 July 2015	ITEM: 6
Health and Well-being Overview and Scrutiny Committee	
Adult Social Care – Budget Review and Service Reductions	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Roger Harris – Director of Adults, Health and Commissioning	
Accountable Head of Service: Les Billingham – Head of Adult Social Care	
Accountable Director: Roger Harris	
This report is Public	

Executive Summary

Cabinet at its meeting on 11th June 2015 received a report from the Head of Corporate Finance on the 2015/16 budget and an updated Medium Term Financial Statement (MTFS). That report highlighted that there were a series of budget savings which were no longer deliverable and, therefore, further savings from within Directorates were required. In addition we have looked at pressures within the Directorate which means we need to identify further in year savings – these two areas combined mean we need to find £ 500k additional savings this year. This paper looks at how that figure will be realised and those areas that will require consultation.

1. Recommendation(s)

1.1 Members are asked to comment on the proposed budget reductions as part of the wider consultation exercise.

2. Introduction and Background

2.1 The Council set its 2015/16 budget in February at the full Council meeting. Various reports had been presented to Cabinet and Council detailing a list of savings proposals to deliver a balanced budget.

2.2 Further reductions are still required because savings that had been planned from the SERCO contract and changes to staff terms and conditions have not materialised. In addition the proposed saving on the Meals on Wheels contract and some savings proposed in voluntary sector budgets have not been delivered. The combined total of all these pressures means that this Directorate has to find a further £ 500k savings this year.

3. Issues, Options and Analysis of Options

3.1 Officers have reviewed the budget for the whole Directorate. It should be noted that Public Health is having to find a further £ 600k savings as part of the late government announcement of £ 200m cuts nationally – that is the subject of a separate report at HOSC tonight.

3.2 It should also be noted that as part of the initial budget setting exercise for 2015/16 this Directorate has already identified, and is delivering, £ 3m of reductions – this £ 500k and the £ 600k public health reductions are both on top of that figure.

3.3 The review officers have undertaken has taken the following approach :

- Maintain front line services as far as possible.
- Ensure the Council fulfils its statutory duties.
- Identify efficiencies and service transformation in the first instance.

3.4 The list of proposals to deliver the £ 500k is summarised in the table below. The first block is the subject of formal consultation which will commence on 1st August and will run for 8 weeks, the results of which will come back to Cabinet and HOSC in October. The second block are savings that officers have implemented immediately to ensure we deliver the figure required this year :

Proposal for consultation	**Saving Target 2015/16 (Part year)**	**Savings Target 2016/17 (Full year)**
Review of Older People's Day Services	£ 100k	£ 200k
Review of Charging	£ 50k	£ 100k
To stop paying for small items of equipment up to a value of £50.	£ 30k	£ 60k
Review of Extra Care	£ 50k	£ 100k
Management Action		
Hospital Social Worker Team – stop Saturday and Sunday specific service	£ 20k	£ 20k
Cut 5 social worker posts	£ 150k	£ 150k
Review of contracts due to expire in 2015/16	£ 30k	£ 100k
Deleting further vacant posts, internal efficiency measures	£ 75k	£ 90k
Total	**£ 500k**	**£ 820k**

4. Reasons for Recommendation

4.1 These additional reductions will be very challenging for Adult Social Care services. We are delivering a range of new responsibilities from April 2015 under the Care Act (2014). We are also facing up to increased demand due to people living longer and also people having more complex health and social care needs. These service reviews and reductions we will be consulting over, will be difficult and we do want to have a genuine consultation with people over how these reductions are made and their impact.

4.2 The formal proposals are contained in more detail at :

- Appendix 1 : Older People's Day Services.
- Appendix 2 : Review of charging.
- Appendix 3 : Small Items of equipment under £ 50.
- Appendix 4 : Extra Care Review.

4.3 In the table summary above there are a number of reductions that are listed as management actions. In discussion with the portfolio holder we have implemented these as they do not require formal external consultation and urgent implementation is need to ensure that we get the full benefit of the savings in this financial year. However, they still require some difficult decisions to be taken. The decision to delete five social worker posts in particular is likely to mean that assessments and reviews will take longer, caseloads for the rest of the teams will increase and we will have to focus even more on our core statutory duties.

4.4 There will also need be a full Equality Impact Assessment (EIA) undertaken as part of the consultation process and reported back to HOSC / Cabinet when the final savings proposals are confirmed. Our User Lead Organisation (ULO) Thurrock Coalition will be assisting the Council to facilitate the production of the EIA.

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

5.1 These proposals are to be issued for wider consultation which will commence on 1st August and last for 8 weeks.

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

6.1 These savings are required to ensure that the Council has a balanced budget for 2015/16. Their impact on performance will be closely monitored by the Directorate Management Team.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Resources Accountant

The savings proposed in this report are required in order to ensure that the overall savings target within the MTFS is delivered. The final proposals that are out for consultation will need to be reported back to HOSC and Cabinet to ensure that they meet the Council's statutory responsibilities.

7.2 Legal

Implications verified by: **Dawn Pelle**

Adult Care Lawyer

The legal implications are dealt within the body of the report and the relevant appendices. A full consultation exercise is being undertaken which will include an Equality Impact Assessment.

7.3 Diversity and Equality

Implications verified by: **Catherine Wilson**

Strategic Lead – Commissioning and Procurement

There will be a full Equality Impact Assessment (EIA) undertaken on these proposals. Thurrock coalition has agreed to help facilitate this. The results of the EIA will be reported back to HOSC and Cabinet when the final proposals are submitted.

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

N/A

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

- Thurrock Council MTFS

9. Appendices to the report

- See Appendices 1 – 4 with more details on the actual savings proposals.

Report Author:

Roger Harris
Director
Adults, Health and Commissioning

This page is intentionally left blank

Appendix 1

Review of Older People's Day Service Provision

Saving Proposal 2015/16 £100K

Adult social care currently provides day service to older people at five sites across Thurrock. The day services are delivered from:

- **Harty Close** (Stifford Clays) **and Arthur Barnes Court** (Chadwell), this is one service delivered across the two sites on alternate days by the same staff team.
- **The Lodge at Piggs Corner** (Grays) offers dementia support.
- **Kynoch Court** (Stanford) offers dementia support on certain days**.**
- **Bell House** (South Ockendon).
- **Cromwell Road** (Grays) offers support to carers where cared for people can attend for a few hours to support their relative.

Arthur Barnes court offers 12 places a day and the other 4 sites 15 places a day. The service offers 5 days a week Monday to Friday with the alternative days at Harty Close and Arthur Barnes Court. Cromwell Road offers weekend services in addition to week day services.

Approximately 60 people a day access day services which deliver services on a whole day basis to service users.

Eligibility criteria – In order to be eligible to attend day services the person will have an eligible need as defined under the Care Act 2014 and the main purpose of meeting those needs is to reduce social isolation, supporting people to remain in their own homes rather than an admission to residential care, ensure that the person's wellbeing is monitored and offer support to carers.

In order to deliver savings for the Council, we need to review how the services are operating and ensure that we are delivering services to those who need it most, it will also be important to include day care for carers delivered at Cromwell Road.

The review of day care will include consideration of the following **options**:

- Reduce the number of buildings and/or sites from which the service is currently delivered.
- Keep the number of sites but reduce the opening hours.
- A combination of 1 and 2 and increase the sitting service.
- Offer day services on a sessional basis half days and whole days to increase the numbers who can attend but reduce the level of service to individual.

- Keep the existing service and increase the charge.
- Review the number of staff and that they are deployed correctly across the service.

The day services and carer's services currently offer:

- Respite for carers of older people offering support to families to continue in there caring role by giving them a break for a few hours, carers will use this time for practical activities that it is difficult to do when caring full time, such as shopping, but it is also intended to give carers a break to alleviate the recognised stresses of caring so that they are then able to continue in there caring role.
- The promotion of wellbeing, which means supporting people to stay at home for longer. Attending day services and carer's services reduces the need for domiciliary care and residential care which cost more and creates an additional strain on the adult social care budget.
- An integral part of a person's support package reducing isolation and reducing the risks of falls, the need for primary and secondary health care at crisis point and the need for higher levels of social care intervention.

The proposal is to explore all options to support the required saving. Adult Social Care wants to fully involve people who access services those who might access them in the future and representative organisations for service users in Thurrock. This will be a consultation that will recommend options and explain the impact of those options on older people and their families in Thurrock.

As part of this process, Thurrock Coalition has agreed to help facilitate the production of a detailed Equality Impact Assessment. This will highlight the implications, risks and impact of the subsequent decisions that Health and Well Being Overview and Scrutiny Committee and Cabinet will be required to make.

Appendix 2

Review of Charging for Adult Social Care

Saving Proposal 2015/16 £50K

Adult Social Care reviewed charges for Non Residential services in 2010 and 2013.

Thurrock Council has a duty to provide services to those people deemed eligible under the **Care Act 2014**. The Council has the discretion to charge for those services. If the Council decides to exercise that discretion and impose or increase a charge then those charges must be reasonable and fair. Changes to the Council's **Non-Residential Adult Social Care Charging Policy** must be subject to full consultation and take into account the Council's duty under the **Equality Act 2010**.

Thurrock Council's **Non-Residential Adult Social Care Charging Policy** must accord with the guidance of the Secretary of State, **Fairer Charging Policies for Home Care and Other Non-Residential Social Services**; this is Guidance for Councils with Social Services responsibilities, the Guidance was updated on the 26th June 2014 to reflect the **Care Act.**

The areas that the consultation will focus on will be increasing or introducing a charge for the following options:

Services	Thurrock Charges	Proposal
Carers Centre Cromwell Road	No Charge	To charge for this service on a sessional basis currently delivering one session a day and this could be increased to two sessions a day. The proposal will need to consider if we charge a flat rate or look to a charge which would be subject to financial assessment. Considering other local authorities charges range for £8 an hour, £29.99 a session (half day) to £40 a session
Day Services Older People	£9.70 per day	To consult on increasing to an hourly charge or daily charge, comparative

		data from other Local Authorities show charges that range from £8 an hour, £29.99 a session (half day) to £40 a session
Sitting Services	No Charge	To consult on charging an hourly rate or a flat rate per session (Half a day) This could range from £8 an hour to £40 a session.
Assistive technology and pendent alarms	The current charges are based on the type of tenancy and level of need. There is no charge for Council tenants, for those in private accommodation meeting wellbeing criteria the charge is 93p a week and private accommodate where there is no wellbeing need the charge is £4.13 per week. This is the monitoring charge as the council cannot charge for equipment up to the value of £1000	To consult on increasing the weekly cost.
Residential Respite Adults	£20 per night	To consult on increasing this charge to cover the cost of the service this charge would be subject to financial assessment.
Blue Badges	£10 a badge coving a 3 year period	This is currently the legal maximum charge
Extra Care Housing Charge Elisabeth Gardens	Currently people who own their property at Elisabeth gardens do not pay the additional charge for on-site support however they are able to benefit from and access this support	Explore the options available to gain a contribution to the care and support charge at Elisabeth gardens.

Legal Position

Fees and charges are described in three ways, Statutory, Regulatory and Discretionary.

Statutory charges are set in Statute and cannot be altered by law as the charge has been determined by Central Government and all Local Authorities will be applying the same charge or the same formula for calculating the charge under a financial assessment.

Regulatory Charges relate to services where if the Council provides the service it is obliged to set a fee which the Council can determine itself in accordance with a regulatory framework. Charges have to be reasonable and fairly applied.

Discretionary charges relate to services the Council can provide if they choose to do so. This is a local policy decision. The Local Government Act 2003 gives the Council the power to charge for discretionary services, with some limited exceptions.

Decisions on setting charges are subject to the Council's decision making structure and most charging decisions are the responsibility of the Cabinet.

Risks

- People may refuse to have services; this will mean that Adult Social Care will face challenges in delivering preventative services
- As a result of not accessing lower level preventative services people may reach crisis point sooner and require higher levels of service which will cost more and put a greater strain on the budget.

The consultation process will identify the risks associated with increased charges highlighting the consequences and mitigation.

Consultation

The proposal is to undertake a full public consultation to support the required saving. Adult social care wants to fully involve people who access services those who might access them in the future and representative organisations for service users in Thurrock. This will be a consultation that will recommend options regarding increasing charges for a range of services. The consultation will highlight and explain the impact of increasing charges for services on those people who access the services.

As part of this process Thurrock Coalition have agreed to produce a detailed Equality Impact Assessment of the proposals made which will highlight the implications, risks and impact of the subsequent decisions that Health and Well Being Overview and Scrutiny Committee and Cabinet will be required to make.

Appendix 3

Small Items of Equipment under £50

Savings proposal 2015/16 £30K

Adult Social Care currently provides Occupational Therapy, Sensory and Telecare equipment to vulnerable people who meet the Care Act 2014 well-being principles. This equipment includes aids and minor adaptions to support independence and resilience.

Occupational Therapy, sensory and Telecare equipment can be used to support service users to remain within the community prevent hospital and residential admission and delayed discharge.

Small items of equipment under £50 assist service user with activities of daily living including but not exclusively toileting, bathing, moving and handling, accessing the community and alerting emergency support. Items of equipment can include – white canes, toilet frames, grab rails, shower boards, slide sheets and personal triggers.

The proposal to no longer provide equipment under £50 is clearly supported by a number of points:

- Most of the equipment under the value of £50 is usually generic items which are widely available from a number of retailers at a cost to the individual of far less than the cost to the Council from the approved equipment services.

- People who require small items of equipment will have a much wider choice if they are not limited to approved providers

- A number of Local Authorities have already stopped providing small items of equipment, Barking and Dagenham being one example. Also other Local Authorities have revised their equipment catalogues and identified small items of equipment that are available in the open market and so removed from the catalogues.

- This will enable Adult Social Care to focus on those with high level needs

The proposal is to realise a saving of £30K within this financial year on the issuing of small items of equipment. Detailed work analysis is still to be completed however based on last financial year the budget for small equipment under £50 is approximately £66K per annum.

Small items of equipment are used by service users to support their identified needs. Consideration should be given to the possible risks of removing this provision.

There are a number of clear risks including;

- Likelihood of increase of care and support packages
- Reduction in service users independence
- Likelihood of an increase in hospital admissions
- Likelihood of an increase in admission to residential placements
- Service users may be unable to self-fund the equipment
- Increase risk of falls
- Delay hospital discharges
- Increase demands on carers and break down of care
- If self-funding is agreed there is limited market provision for people to purchase equipment locally in Thurrock.

There is a risk that if Thurrock Council does not supply the item of equipment the service user will not self-purchase a more detailed risk analysis considering each item of equipment and its potential benefit to a service user will be carried out within the consultation process.

Legal Position

The Care Act 2014 and the statutory guidance for the Care Act do not prescribe how specific needs are to be met. Equipment, including smaller pieces of equipment, can be provided under section 2 of the Act which relates to the prevention of care needs developing or sections 18 to20 which relate to meeting care and support needs. Regulations require that Local Authorities must not charge for aids or minor adaptations up to the value of £1,000.

Where a Local Authority is under a duty or decides to meet an individual's care and support needs Under the Care Act 2014 Sections 18 to 20, the Local Authority will develop a care and support plan with the involvement of the person and take reasonable steps to agree with them as to how to meet their needs. The question of whether to provide small equipment would need to be decided on a case-by-case basis, and as part of overall care and support planning.

Prevention is a key responsibility under the Care Act 2014 under Section 2, Local Authorities must provide or arrange for the provision of services, facilities or resources that contribute towards preventing or delaying the development of care and support needs. The guidance clarifies that this can be achieved through a range of measures such as providing information and advice (which may for example include advice to the person about equipment that would support them) or providing interventions such as community equipment. In the case of prevention, a general policy of not providing small equipment may be justifiable in some circumstances, but would need to be kept under review with a view to changing the policy if the situation changes. Local Authorities do have a degree of discretion in how they

discharge their prevention duties but their policies must meet the requirements of section 2 and be lawful.

It is also important to note that small items of equipment under £50 are currently installed to support Children and Adults.
A decision will be required concerning people who already have equipment and who need to replace that equipment.

It will be important to identify clearly the mitigation of risk associated with this proposal. One key development that may support the proposal is that Adult Social Care has introduced a new Information and Advice service and Resource Allocation System. People can access this to establish information and choose the right piece of equipment. if the proposal is agreed then a clear process will be developed to address exceptional circumstances where equipment may need to be purchased by the Council for an individual.

The Care Act 2014 states that Local Authorities must promote well-being when carrying out any of their care and support functions in respect of a person. Well-being is described as relating to the following areas:

- Personal dignity
- Physical and mental health and emotional wellbeing
- Protection from abuse and neglect
- Control by the individual over day to day life
- Participation in work, education, training or recreation
- Social and economic wellbeing
- Domestic, family and personal
- Suitability of living accommodation
- The individual contribution to society

As part of Thurrock's Better Care Fund future planning has included increasing the number of service users using Telecare to support

- Reduction in acute admission avoidance
- Living well with Long Term Conditions
- Living well with complex co-morbidities, dementia and frailty

The proposal is to explore all options to support the required saving. Adult social care wants to fully involve people who access services those who might access them in the future and representative organisations for service users in Thurrock. This will be a consultation that will recommend options and explain the impact of those options.

As part of this process Thurrock Coalition have agreed to produce a detailed Equality Impact Assessment of the proposals which will highlight the implications, risks and

impact of the subsequent decisions that Health and Well Being Overview and Scrutiny Committee and Cabinet will be required to make.

Appendix 4

Extra Care Review

Saving Proposal 2015/16 £50K

Thurrock Council directly runs two extra care schemes, Kynoch Court and Piggs Corner and commissions a third service via Hannover Housing Association at Elisabeth Gardens. There are a number of different ways extra care can be provided however the usual components are:

- Adapted property/building to assist with independence e.g. wet rooms, wider doorframes to accommodate wheelchairs/mobility scooters, adjustable work surfaces.
- Availability of care and/or support staff
- Certain facilities such as a restaurant, lounges or a specially equipped bathroom

The decision was taken just over 10 years ago to convert Kynoch Court and Piggs Corner (specifically the 'hotel' component which is a set block of flats) sheltered housing schemes to extra care housing services as vacancies arose.

It was agreed as each sheltered housing tenancy became available in the 'hotel' that adaptations would take place to each property. Currently 14 flats at Kynoch Court (of the potential 20 flats) and 39 flats at Piggs Corner (of the potential 55 flats) have been converted to extra care.

The Housing Learning and Improvement Network (LIN) suggest that a minimum of 50 units is appropriate for an older people/people with dementia scheme to be financially viable. As such Kynoch Court, with the maximum 20 units converted would not be a viable extra care scheme.

To test viability, a review has been undertaken of the service. These findings show that it is not financially viable for the Council to continue delivering extra care on such a small scale. As such, the service at Kynoch Court will be de-commissioned as Extra Care. Each person will be reviewed to determine the level of care and support that is required from the outcome of the assessment services will be commissioned as appropriate for each person. The Piggs Corner scheme was also reviewed. This scheme is much larger (potentially 55 flats) and as such it is viable to remain as a designated extra care scheme.

However since the removal of Sheltered Housing Support Officer from Extra Care schemes care staff have been performing some housing related tasks which have constrained their capacity to deliver care.

Kynoch Court
As such Adult Social Care want to consult on the proposal to redefine the service delivered at Kynoch Court. This would mean removing the extra care registration. The proposal would be to:

Externalise the delivery of care by tendering for the amount of assessed care hours as a discrete service.

It is not thought this would result in any compulsory redundancies as staff currently working at Kynoch will be offered vacant shifts at Piggs Corner.

There is also a restaurant on site. This operates 3 days per week. Although the cost of food is met by the service users, the cost of food preparation is met by adult social care an alternative model of delivery will also be reviewed for this service.

Piggs Corner the proposal is to consult on the changes outlined below:

To introduce a concierge service and 1full time equivalent sheltered housing officer
The concierge service and sheltered housing officer will cost £75 per service user per week.

This will be chargeable against housing benefit.

Currently there are:

- 62% of service users receiving full housing benefit
- 13% of service users receiving part housing benefit
- 26% of service users do not receive housing benefit

The methods of payment for this will be explored.

The proposal is to explore the options described to support the required saving.

Adult social care wants to fully involve people who access services those who might access them in the future and representative organisations for service users in Thurrock. This will be a consultation that will recommend options and explain the impact of those options. As part of this process Thurrock Coalition have agreed to produce a detailed Equality Impact Assessment of the proposals which will highlight the implications, risks and impact of the subsequent decisions that Health and Well Being Overview and Scrutiny Committee and Cabinet will be required to make.

23 July 2015	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Health and Social Care Transformation Update	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Roger Harris, Director of Adults, Health and Commissioning	
Accountable Head of Service: Les Billingham, Head of Adult Social Care	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

The purpose of this report is to provide the Committee with an update on the Health and Social Care Transformation Programme, focusing in particular on:

- Implementation of the Care Act 2014, and preparation for part 2 of the Act (cap on care charges); and
- Arrangements for and implementation of the Better Care Fund Plan.

1. Recommendation

1.1 That the Committee note the update report.

2. Introduction and Background

2.1 The Health and Social Care Transformation Programme was established by Thurrock Council (the Council) and Thurrock Clinical Commissioning Group (the CCG) in early 2014 to bring together a number of projects linked to the transformation of adult social care and health. This included:

- Preparation for and implementation of the Care Act 2014 (the Act);
- Development of the Better Care Fund Plan and related Section 75 agreement; and
- Whole System Transformation.

2.2 The focus of the Programme is not only the integration of health and social care, but also the development and transformation of the health and care 'system' – ensuring that collectively, resources across that system are used to best effect and that the system encourages and enables prevention and early intervention rather than a focus on responding to people at crisis point.

2.3 The health landscape has changed radically since the introduction of the Health and Social Care Act 2012. Changes included the introduction of Health and Wellbeing Boards, Clinical Commissioning Groups responsible for the commissioning of health services in the local area, and the introduction of NHS England whose responsibilities included the commissioning of primary care. The complexities of that landscape coupled with growing demands and pressures on health and care resources make a local programme focused on shaping a sustainable health and care system for the future key.

2.4 Since the Programme's inception, the part 1 of the Care Act has been implemented, and Thurrock's Better Care Fund Plan has been signed off. The focus of the Programme is now the development and delivery of the Better Care Fund Plan – including shaping and influencing the redesign of the local health and care system; and the development and implementation of part 2 of the Care Act (cap on care costs).

2.5 This report focuses on updating the Committee on those two areas of the Health and Social Care Programme.

3. Issues, Options and Analysis of Options

Implementation and Preparation for the Care Act

Care Act 2014 Implementation – Part 1

3.1 The Care Act 2014 represents the greatest legislative change to Adult Social Care since the introduction of the National Assistance Act in 1948. Prior to the Care Act, the legislative framework for Adult Social Care was made up of a number of different acts, regulations, and guidance. The Care Act brings the legislative framework for Adult Social Care together under one Act.

3.2 The Care Act 2014 (the Act) is divided in to two parts, with part 1 becoming operational as of April 2015. This included changes such as:

- The introduction of a national minimum eligibility standard – focused on the delivery of outcomes rather than needs;
- The delivery of equality of access to assessments and services for carers in their own right – independent of the person they care for;
- The introduction of a duty of wellbeing and also of a duty to prevent, reduce and delay the need for care and support;
- Adult Safeguarding Boards becoming a statutory requirement; and
- The introduction of a duty to provide information and advice.

3.3 Whilst the Council is confident that it has met the requirements of part 1 of the Act, there are a number of risk areas which include:

- Uncertainty about additional demands from carers;
- Managing additional assessments;

- Impact of the new national eligibility threshold;
- Impact on the provider market;
- Public expectation;
- Available resource for preventative services; and
- Implementation costs.

3.4 Whilst the Council is confident that it has made the changes necessary to be compliant with the Act, it recognises that some changes will take time to embed – for example a shift in practice. As a result, the Council – through the Care Act Implementation Group – has agreed to undertake activity to measure how well embedded certain elements of the Act are. This includes the following:

- Audits of assessments carried out since April – a new Care Act compliant assessment has been introduced;
- Secret shopper activity;
- Action learning sets for practitioners; and
- Formal practice reviews – e.g. follow-up workshops to refresh and develop practice based on staff feedback.

Sufficient time for changes to embed will be allowed prior to measurement activity taking place.

3.5 Any elements of the Act which are not as embedded as they should be, or as we would want them to be, will be accompanied by development actions. These will be overseen by the Care Act Implementation Group.

3.6 The changes that have taken place in Thurrock from April 2015 as a result of the Act's implementation include:

Mycare Information and Advice Portal – to comply with its information and advice duty, the Council has developed a comprehensive on-line information and advice portal. The Portal allows individuals to find out how their care and support needs can be met – including formal services as well as what might be available within their own community. The Portal can be accessed via https://mycare.thurrock.gov.uk Work is now being carried out to include NHS information and advice.

Improved access to advocacy – the Council contracts external provider Powher to undertake its independent advocacy function. The Care Act makes clear that subject to certain conditions being met, independent advocacy services must be available at any part of the care and support process.

Implementation of the wellbeing principle – the Act introduces a duty of wellbeing which means that local authorities must promote wellbeing when carrying out any of their care and support functions. The Council is doing several things to meet this duty, including changing the way it carries out assessments so that they focus on strengths and outcomes rather than just needs.

Carers assessments – the Act for the first time gives carers rights equal to the individuals they care for. This means that carers can have an assessment in their own right. The Council works with local provider Cariads to provide and promote information and advice to carers. The change in legislation is likely to lead to an increase in demand for assessments from carers, and Thurrock is already beginning to see an increase.

Prevent, reduce and delay – the Act gives local authorities responsibilities for preventing, reducing and delaying the need for care and support. In Thurrock, we already have a number of initiatives that meet those responsibilities. These range from public health initiatives, and our borough-wide Local Area Coordination scheme, to our Rapid Response and Assessment Team who aim to prevent people at or near to crisis point ending up in hospital or a residential setting.

Care Act 2014 Preparation – Part 2

3.7 Part 2 of the Act relates to the cap on care costs and will be introduced in April 2016. There may also be, subject to the outcome of consultation, the introduction of a new appeals system for Adult Social Care.

3.8 With the final guidance and regulations related to part 2 expected at the end of October, the Council has already started to prepare for the changes. This has included the refresh of the Care Act Implementation Group, the establishment of themed working groups, the recruitment of a project manager, and the development of an accompanying project plan.

3.9 Key elements of implementing part 2 of the Act are as follows:

- Identification and assessment of current self-funders (people who currently arrange and pay for their care independently of the Council and who are therefore not known to the Council) – and application of new Independent Personal Budgets (every person eligible for care and support services will be given a personal budget stating the cost of meeting those care and support needs);
- Development and implementation of Care Accounts (Care Accounts allow people to identify how far away or near to reaching the care cap of £72k they are);
- Implementation of the 'Care Cap' – and related system changes; and
- Implementation of the new Appeals System for Care and Support.

3.10 Accompanying the changes will be communication and engagement activity, policy development and also workforce development.

3.11 Key risks associated with the introduction of part 2 are:

- Financial impact on the Council of the changes – in particular the extension of means testing support (upper threshold, above which

individuals pay the full cost of their care, will increase to £118k where it is currently £23,500k), the cap on care (£72k cap), and the introduction of a lower or zero cap for working age adults;
- Capacity required to identify and assess current self-funders prior to April 2016;
- Potential impact on market sustainability and provider failure; and
- Ensuring that our IT systems and the providers of those systems are able to implement the changes associated with the Act – e.g. so we can monitor how near the £72k cap individuals are etc.

3.12 The most significant risk to the Council is the potential cost associated with implementing the changes. The extent to which these additional cost pressures will be met by central government is very uncertain – we have assumed that they will be met by government but this is unlikely to be known until the end of the year. Whilst detailed cost modelling is being undertaken in preparation for part 2, we currently estimate that the cost to Thurrock of implementing part 2 is £1.5 – £2 million.

Care Act Implementation Governance

3.13 The Council's preparation for and implementation of arrangements for the Act are overseen by a Care Act Implementation Group. The Group is chaired by the Director of Adults, Health and Commissioning. Regular update and assurance reports are taken to both the Health and Wellbeing Board and Cabinet.

Better Care Fund Implementation

3.14 The Better Care Fund is a Government initiative focused on the pooling of funds across health and social care. Every local authority area is required to have a Better Care Fund Plan and Better Care Fund which must exceed a minimum amount (set per area) and must meet a number of certain national conditions. This includes a requirement to deliver a 3.5% reduction in the total number of emergency admissions. The terms and conditions for how the pooled fund in Thurrock is to be used are contained within a jointly agreed section 75 agreement.

3.15 Thurrock's Better Care Fund is just over £18m and focuses on people aged 65 and over and consists of the following schemes:

- Locality Service Integration;
- Frailty Model;
- Intermediate Care Review;
- Prevention and Early Intervention;
- Disabled Facilities Grant and Social Care Capital Grant;
- Care Act Implementation;
- Payment for Performance (related to achievement of the 3.5% reduction in emergency admissions).

3.16 Governance arrangements include the establishment of an Integrated Commissioning Executive and the appointment of a Better Care Fund Manager (within an existing role – Strategic Lead for Commissioning and Procurement). The Integrated Commissioning Executive's membership includes officers from both Thurrock Council and Thurrock CCG, including the Director of Adults, Health and Commissioning, the CCG's Acting Interim Accountable Officer, the Head of Corporate Finance, CCG's Chief Finance Officer and Head of Integrated Commissioning, and the Strategic Lead for Commissioning and Procurement (also acting as the Better Care Fund Manager).

3.17 The remit of the Integrated Commissioning Executive (ICE) extends beyond that of overseeing the implementation of the section 75 agreement. The Group will also ensure the development of and provide strategic direction to the whole health and care system redesign agenda. Whilst the development of the inaugural BCF was separate to the development of the broader redesign programme, it is hoped that any future iteration of the BCF will incorporate a far broader redesign agenda. At its last meeting, the ICE agreed to the development of a strategic document setting out the direction of travel for the whole system. This document will influence all redesign work.

3.18 As part of ensuring the schedules contained within the section 75 agreement are implemented, the ICE has agreed an implementation plan. The plan consists of a number of separate projects spanning the health and social care spectrum. The strategic document mentioned in paragraph 3.15 will help to ensure the projects developed contribute to system change. For example, a greater emphasis on prevention and early intervention (prevent, reduce, delay), a focus on ensuring that when people do develop a long-term condition they are able to manage it well, and a greater focus on community-based and non-service solutions rather than a reliance on traditional service route. The ICE will oversee the development and implementation of the implementation projects, with further reporting to the Health and Wellbeing Board.

4. Reasons for Recommendation

4.1 To enable the Committee to receive an update on progress made with the Health and Social Care Transformation Programme.

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

5.1 Consultation and engagement on the development of the projects contained within the implementation plan will be undertaken via the steer provided by the Health and Social Care Transformation Engagement Group.

5.2 A series of workshops for the public, service users, carers and providers will be organised later in the year to communicate the changes brought by the implementation of part 2 of the Care Act 2014. The workshops for the public

will be organised in conjunction with Thurrock Coalition as per part 1 of the Act.

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

6.1 The development and delivery of the Health and Social Care Transformation Programme supports the delivery of the Community and Corporate priority – Improve Health and Wellbeing.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**
Management Accountant

The development and delivery of the programme is being managed within existing budgets, including as part of the Better Care Fund.

7.2 Legal

Implications verified by: **Dawn Pelle**
Adult Social Care Lawyer

The Better Care Fund Section 75 agreement is a legal agreement between the Council and Thurrock CCG.

The Council is required to meet the legal requirements set out within the Care Act 2014, its guidance, and its requirements.

7.3 Diversity and Equality

Implications verified by: **Rebecca Price**
Community Development Officer

The implementation of the Care Act 2014 and Better Care Fund provides a framework and means to support vulnerable adults with a focus on safeguarding, producing better outcomes and wellbeing at the core of all adult social care activity.

Workshops for the public, service users, carers, and providers will be organised later in the year to communicate the changes brought by the implementation of part 2 of the Care Act 2014. The workshops for the public will be organised in conjunction with Thurrock Coalition as per part 1 of the Act.

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

None

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

None

9. Appendices to the report

None

Report Author:

Ceri Armstrong

Strategy Officer

Adults, Health and Commissioning

23 July 2015	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
The future of the Thurrock walk-in service	
Wards and communities affected: All	**Key Decision:** Key
Report of: Beata Malinowska, Senior Consultant, NEL CSU – Walk in service project lead for Thurrock CCG Presented by Don Neame, Director of Communications, NEL CSU	
Accountable Head of Service: Mandy Ansell, Acting (Interim) Accountable Officer, Thurrock CCG	
Accountable Director: Mandy Ansell, Acting (Interim) Accountable Officer, Thurrock CCG	
This report is Public	

Executive Summary

This report provides a summary of the findings and feedback from both pre-consultation and public consultation processes which informed the Thurrock CCG's decision to close the walk-in service from April 2016 and reinvest the funds in four GP hubs across Thurrock.

The report includes evidence of the completion of the public consultation plan as presented to HOSC on 13 January 2015 which is included in Appendix A.

1. Recommendation(s)

1.1 To note the decision of the Thurrock CCG Board to decommission the Thurrock walk-in service from 1 April 2016 and reinvest the funds in the four GP hubs across Thurrock.

1.2 To note the full completion of the communications and engagement plan which was implemented during the public consultation process.

2. Introduction and Background

2.1 Thurrock CCG currently commissions one walk-in service based in Thurrock Health Centre, Grays, to serve its population of 161,000. The contractual arrangements for this walk-in service are tied with the provision of services for the GP practice registered list which is commissioned by NHS England. Thurrock Health Centre opened in March 2010 as part of the then national programme which required each Primary Care Trust (PCT) area to open a GP-led Health Centre (GPLHC).

2.2 Following changes to the NHS set out in the Health and Social Care Act 2012, the CCG is now responsible for the walk-in element of the contract with Thurrock Health Centre, whilst NHS England retains responsibility for the GP practice registered list.

2.3 The approaching end of the contract provided Thurrock CCG with an opportunity to review the model of care provided by the walk-in service, as well as its overall alignment with the CCG's and national strategies for both urgent and primary care.

2.4 To capitalise on this opportunity, in 2014 Thurrock CCG conducted a robust analysis of the current use of, cost of, and patient satisfaction with, the Thurrock walk-in service. In addition, local access to primary care and attendance rates at the A&E at Basildon and Thurrock University Hospitals FT were also examined to set some context to the landscape in which the walk-in service operates.

2.5 In advance of the public consultation process which started on 2nd February 2015, Thurrock CCG presented to the HOSC at its meeting on 13th January 2015 for comment and noted the following:

- A summary of the pre-consultation engagement which included clinicians and patients and patient representatives.

- Analysis of the effectiveness and impact of the current services provided by the walk-in service in Thurrock Health Centre in Grays.

- Three options for the future of the walk-in service which were developed on the basis of the data analysis as well as the engagement process that the Thurrock CCG conducted in 2014:

- Option 1: Re-tender the service on the current specification
- Option 2: Re-tender with a new specification for the service
- Option 3: Decommission the walk-in service and reinvest in four local GP hubs (preferred option, selected by a scoring panel in November 2014)

- Whilst the change was assessed not to be significant, Thurrock CCG proposed an eight week consultation period under section 14Z2, Health and Social Care Act 2012 which was noted by the HOSC.

2.6 HOSC members were also asked to comment and note the public consultation communications and engagement plan which was supported and agreed with no changes.

2.7 From 2 February to 24 March 2015, Thurrock CCG conducted a robust and transparent public consultation process in line with section 14Z2, Health and Social Care Act 2012.

2.8 At its governing body meeting held in public on 27 May 2015, the Governing Body members of Thurrock CCG received an independent analysis and report (Appendix D) and considered the findings and feedback from the public consultation process, together with the findings from the walk-in service data analysis and pre-consultation engagement. It made a unilateral decision to support Option 3 which is to decommission the walk-in service and reinvest in four local GP hubs.

3. Issues, Options and Analysis of Options

3.1 Pre-consultation

In 2014, Thurrock CCG conducted an open and transparent pre-consultation engagement process to develop and appraise the options available for the future of the Thurrock walk-in service and the wider primary care services across the area. This included:

- A review of the available data on the existing walk-in service
- Engagement with local people and organisations
- Developing the proposals for the future of the walk-in service

The feedback received at that stage of the pre-consultation engagement shaped the three options that the CCG consulted on during its public consultation process.

3.2 In advance of the public consultation, the CCG engaged with the following local people and organisations:

- Thurrock Council Health and Wellbeing Overview and Scrutiny Committee
- Thurrock MPs and councillors
- Basildon and Brentwood CCG
- Basildon and Thurrock University Hospitals NHS Foundation Trust
- Healthwatch Thurrock
- Members of the public
- North East London NHS Foundation Trust
- South Essex Emergency Doctors Surgeries
- South Essex Local Medical Committee
- South West Essex System Resilience Group
- Thurrock CCG's Commissioning Reference Group
- Thurrock CCG's Primary Care Development Working Group
- Thurrock CCG's Annual General Meeting
- Thurrock Council for Voluntary Service
- Thurrock GPs through the the CCG's Clinical Engagement Group and visits to GPs in their practices.

3.3 Key themes that emerged from the pre-consultation stage:

- The review found that 90 per cent of people who went to the walk-in service were already registered with a GP in Thurrock and many used the service for reassurance (to check what they had already been told by their own GP). People also went to the walk-in service to save them from waiting to see their own GP or because they didn't know where else to go.

- The analysis of the attendances at the walk-in service showed that most of the people who went there came from Grays and Tilbury (72.5%).

- A survey of the use of the walk-in service showed that the majority of people attended for minor injuries and ailments. This evidence shows that people who use the walk-in service go mainly for primary care problems; in fact many of the people turn up at the walk-in service with conditions which would be better seen by a GP.

- A breakdown of people who attend the walk-in service showed that most are aged between 19 and 40; older adults and young children make up a much smaller proportion of attendances at the walk-in service.

- The analysis of the available data was not conclusive whether the walk-in service prevented or reduced the number of A&E attendances at BTUH.

Findings from the pre-consultation phase along with the options for the future of the walk-in service and a recommendation to proceed with the public consultation were presented at the HOSC meeting on 13 January 2015. In addition, the CCG presented a communications and engagement plan for the public consultation which was supported and agreed with no changes.

3.4 **Public consultation**

Feedback on the identified options was gained through a range of focused activities and events aimed at gathering opinions and views of local people from all sections of the community. The process was run in line with the communications and engagement plan presented to the HOSC members on 13 January 2015 (Appendix A provides evidence of completion of the public consultation communications and engagement plan).

1,800 printed consultation documents were distributed to key stakeholders including local MPs, Thurrock councillors, health partners, and patients' and community groups. Local GP surgeries and libraries were asked to have copies of the document available for the public. The public consultation document, along with the feedback questionnaire, was also available on the CCG's website.

The CCG actively encouraged feedback through publicising the information via its newsletter, website, twitter account, as well as attending a range of meetings and events across Thurrock. A leaflet door drop was completed by

an independent company to all Thurrock households between 2 and 14 February 2015. To encourage participation in the consultation, three public engagement events were held where people could speak to clinicians, ask questions, find out more about the proposals, and share their opinions. These events were held on:

- 11 February – Orsett Hall, Orsett (2-4 pm)
- 4 March, Civic Centre, Grays (7-9 pm)
- 18 March, Spring House, Corringham (7-9 pm).

The events aimed to capture views of residents from all sections of Thurrock communities and therefore the events were held in various locations and during different times of the day to allow people in full time employment to participate in the process. A presentation was developed for CCG clinicians and representatives to outline the proposals to members of the public at each of the three public events.

Appendix B includes Thurrock CCG's communications and engagement log which lists the events and meetings initiated and attended by the Thurrock CCG team during the consultation period and the approximate number of people in attendance.

3.5 In addition to the communications and engagement activities conducted by the CCG, Healthwatch Thurrock also contributed to spreading the information about the public consultation. It is part of Healthwatch Thurrock's work to engage with Thurrock communities regarding their experiences of using health and social care services, and it also encourages residents to take part in any relevant consultations.

During the consultation period, Healthwatch Thurrock had posters and leaflets on their stand at all drop-in sessions, along with hard copies of the consultation document which were handed out, encouraging people to complete the feedback questionnaire. In some instances the Healthwatch Thurrock team assisted people to complete the questionnaires (e.g for those with literacy or learning difficulties). The team also raised awareness of the consultation at all meetings/presentations they attended, by handing out leaflets with the online information or hard copies.

In addition, Healthwatch Thurrock advertised the link to the public consultation on its website and Facebook board and tweeted about it regularly, particularly

during the final two weeks of the consultation, releasing tweets daily with a countdown.

Appendix B lists the events and meetings attended by the Healthwatch Thurrock team during the consultation period and the approximate number of people in attendance.

Healthwatch Thurrock also alerted the CCG team to any venues they attended which had no copies of the leaflets or posters and ensured there was a good supply in the reception of the Beehive Resource Centre, the voluntary organisations within the Beehive and in the Citizen's Advice Bureau reception.

In total Healthwatch Thurrock informed more than 730 Thurrock residents about the public consultation.

3.4 A total of 251 written responses, including 242 questionnaire responses and nine emails, containing feedback on the future of the walk-in service were received. In addition, 102 local residents attended three separate public events in different parts of Thurrock to discuss the proposals with GPs and CCG staff. CCG representatives also attended 24 separate meetings to present the options for the future of the service and gain feedback from a variety of community groups and stakeholders.

3.4 **Key findings from the consultation phase**

- Analysis of the feedback received at the public events showed that the majority of local residents who attended the events indicated that Option 3 was the most supported option for the future of the walk-in service.
- Analysis of the quantitative data from the questionnaires was not conclusive overall but indicated that the least preferred option is Option 2 – to retender the service on a different specification. The preferred option for the future was Option 1 – to retender for the service on the current specification (no change), followed by Option 3 – to close the walk-in service and invest in four local GP 'hubs'.
- Option 3 was strongly supported by local clinicians through the feedback received during Clinical Engagement Group's meetings as well as the written response explicitly supporting Option 3 submitted by the Local Medical Council (LMC).

- Other key stakeholders such as Basildon and Brentwood CCG as well as the Commissioning Reference Group indicated their support for Option 3 for the future of the walk-in service.
- The MP for Thurrock (since re-elected in the 2015 General Election) supported Option 3 and two parliamentary candidates supported Option 1 in their submissions to the public consultation process.
- Analysis of the qualitative data from the completed questionnaires highlighted a range of key themes of which **access** was the greatest concern. The feedback focussed on the following areas:
  - Difficulty of getting routine and urgent GP appointments
  - A desire to see GP opening hours extended to evenings and weekends,
  - The length of waiting times, with many respondents saying they felt that the walk-in service was an assured means of accessing a healthcare professional when they needed it
  - Mixed views about location – some felt the central position of the walk-in service made it very accessible, while others were concerned that it did not support equal access for people who lived further out, relied on public transport (difficult in evenings and weekends), or were too unwell/had a disability that made travelling difficult.
- There was some mixed feedback on the **quality of the service** received at the walk-in service. There were many positive comments about the reliability and speed of being seen at the walk-in service, and some comments that pain relief and diagnosis was of better quality than at the user's GP surgery. There were also some comments that the walk-in service had long waiting times and was less personal.
- Respondents felt that there needed to be **better use of resources**. There were differing views about how resources could be used more effectively e.g. closing the walk-in service and utilising GPs, or creating more walk-in services to reduce burden on local hospitals. There were some suggestions of adding diagnostics e.g. x-ray/blood tests, to local GP practices or the walk-in service
- **Communication and education** emerged as key suggested actions for CCG that would enable better understanding of services available to local residents and better use of those services.

3.5 Additional considerations

In advance of making the final decision, and in addition to pre-consultation and consultation feedback and findings, the CCG Governing Body considered the

following:

- An Equality Impact Assessment for different options for the future of the walk-in service
- Travel that would be required of the members of the public to access services if they are changed
- Level of clinical engagement throughout the process
- Wider financial landscape for the CCG both now and in the future
- Strategic alignment of different options with the CCG and national strategies as well as those of the Thurrock Council.

4. Reasons for recommendation

4.1 Given the wide ranging and comprehensive engagement and analysis process that has been adhered to on an ongoing basis by the Thurrock CCG, both before and during public consultation process, the HOSC is asked to **note the decision of the Thurrock CCG.**

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

5.1 The HOSC members were consulted on 13 January 2015 when Thurrock CCG presented a summary of its data analysis and pre-consultation engagement. The CCG also presented three options for the future of the walk-in service and its approach to conducting a public consultation process.

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

6.1 The process of deciding on the future of the walk-in service conducted by Thurrock CCG aligns with the Council's priority of improving the health and well-being of the population.

7. Implications

7.1 Financial

Implications verified by: N/A

No impact on the Thurrock Council

7.2 **Legal**

Implications verified by: N/A

No impact on the Thurrock Council

7.3 **Diversity and Equality**

A separate Equality Impact Assessment was developed in advance of the launch of the public consultation.

Implications verified by: Thurrock CCG

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

None for the Thurrock Council

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):

None

9. Appendices to the report

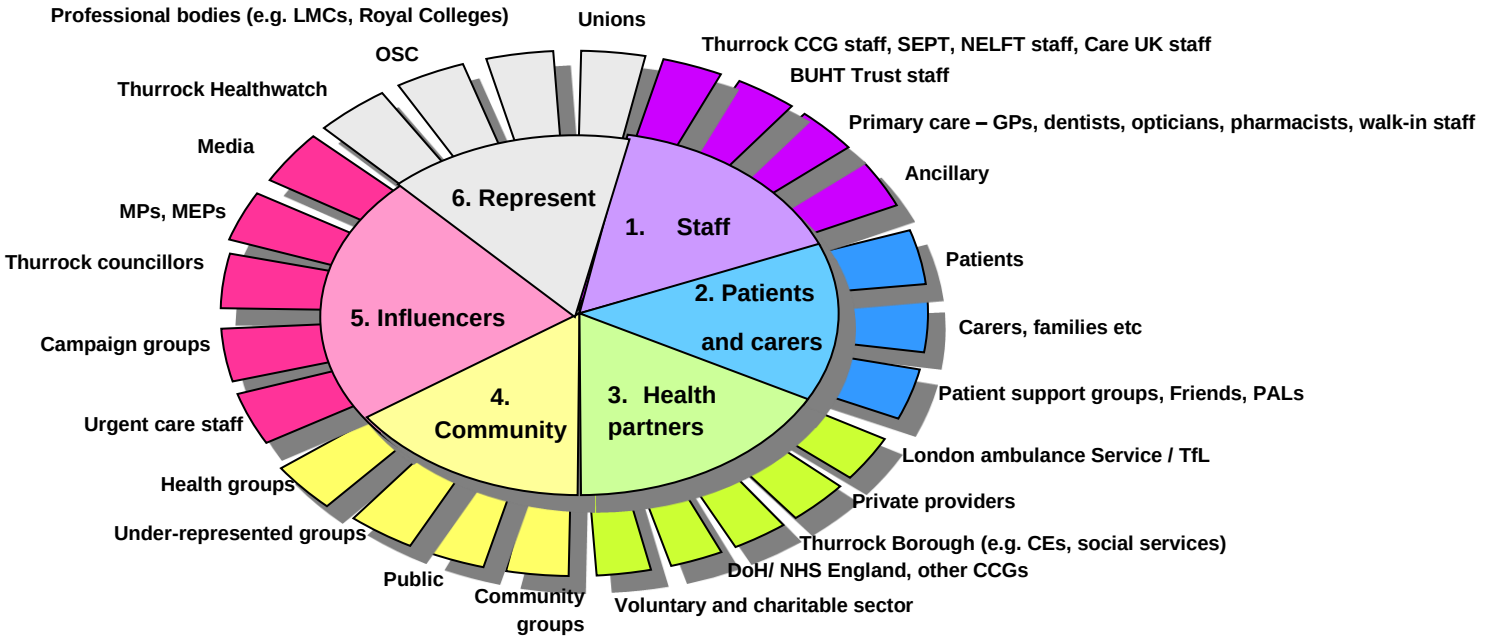
Appendix A:	Evidence of completion of the public consultation communications and engagement plan
Appendix B:	Thurrock CCG communications and engagement log
Appendix C:	Healthwatch Thurrock meetings and events attended
Appendix D:	Report on the outcomes of the public consultation on the future of the walk-in service at Thurrock Health Centre, Grays

Report Author:

Beata Malinowska, NEL CSU, walk-in service project lead for Thurrock CCG

Appendix A – Evidence of completion of the public consultation plan

This stakeholder framework details the communications and engagement responsibilities of Thurrock CCG as presented to the Health Overview and Scrutiny Committee on 13 January 2013.



Stakeholder engagement plan

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
1. NHS staff, internal stakeholders e.g: Includes: • College Health group • Thurrock walk-in Centre • Thurrock CCG • North East London Foundation Trust staff • SEPT staff • BUHT staff • EEAST staff • Care UK staff • GPs • GP practice managers and staff • SEEDs • Other Clinical Commissioning Groups • Community pharmacists • Other staff working at the same location • NEL CSU	• to develop NHS staff as potential ambassadors and drivers for change • to ensure awareness of the aims of the consultation • to ask staff their views in order to inform our understanding and to improve and develop the proposals • to enable staff to understand the impact of any proposals on their roles or professional groups, and what it means for them – and help allay any fears about their jobs and future careers	• Develop proposals in partnership • Draft letters/emails to keep informed • Emails and links to consultation website • Make formal proposal document available • Produce information for staff briefings and articles in stakeholders newsletters • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above As above End of consultation	Y Y Y Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
2. Patients/carers Includes: • patients/carers with experience of walk-in services • patients using the location to access other services (e.g. GP patients) • people with a long-term conditions • people with mental health problems or dementia • PALS and Friends • patient groups • carers of patients	• to ensure awareness of the aims of the consultation and ask people to respond to the consultation • to explain the benefits and issues around quality, equalities, travel, patient pathways • to be open and create understanding • to provide reassurance of the NHS commitment to clinical quality and patient care • to encourage informed debate • to understand the needs of patients • to help prevent ill health and improve the health of	• Develop proposals in partnership • Draft letters/emails to keep informed • Emails and links to consultation website • make formal proposal document available • Public drop-in event for Thurrock-based patients and carers • Media releases • Leaflet door drop • Newspaper advertising • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above As above As above As above	Y Y Y Y Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
	residents		As above As above End consultation	Y Y Y
3. Health and related partners Includes: • Dept of Health; NHS England; other CCGs – in particular Basildon and Brentwood • Health and Wellbeing Board • Thurrock Council • London Ambulance Service • local partnerships; groups/boards • private providers • Voluntary groups – especially associated with the locations	• as section 2, plus: • to ensure any impacts on health partners are fully explored • to utilise specialist knowledge of issues and opportunities • to ensure synergy with partners' developments and announcements	• Develop proposals in partnership • Draft letters/emails to keep informed • produce information for staff briefings and articles in stakeholders newsletters • emails and links to consultation website • encourage local organisations to create and publicise a link from their website home page to website and include information in their publications • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above End consultation	Y Y Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
4. Community • public • community groups e.g. schools, faith communities and leaders, residents associations, • traditionally excluded groups • health groups	• as section 2, plus: • to build trust in the Trust and the NHS as effective caretakers of the health of local population • for the community to understand how the NHS works and the services on offer • to understand the needs of residents	• develop proposals in partnership • Draft letters/emails to keep informed • emails and links to consultation website • make formal proposal document availablemedia releases • Leaflet door drop • Newspaper advertising • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above Throughout consultation Start and end of consultation End of consultation	Y Y Y Y Y Y
5. Influencers • MPs • Media • Councillors	• as section 2, plus: • to listen to their views • to facilitate influencers in providing reliable information to constituents	• develop proposals in partnership • Draft letters/emails to keep informed • distribute copies of proposals, but face-to-face meetings are key for this audience: one-to-one meetings or roundtable	Ongoing Start of consultation and throughout consultation Start and end of consultation	Y Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
		discussions • media releases • press advertisements • Communicate to all following decision	Start and end of consultation End of consultation	Y Y
6. Representatives • HOSCs • Local Medical Committees • Thurrock Healthwatch • Unions • professional bodies / royal colleges	• as section 2, plus: • to provide information as required under the NHS Act (OSCs) • receive independent endorsement for proposals and thereby reassure relevant audiences • to receive critical challenge and objective examination	• develop proposals in partnership where appropriate • distribute proposals, but face-to-face meetings are key for this audience • presentations • respond to OSC/ submission • Communicate to all following decision	Ongoing Start of consultation and throughout consultation Ongoing TBA Start and end of consultation	Y Y Y Y Y

Appendix B – Thurrock CCG communications and engagement log

Date	Type of activity	Audience	Number of people reached
02.02.15	Launch of the public consultation process of the Thurrock CCG website by uploading the public consultation document and questionnaire Launch of a dedicated email address for the queries relating to the public consultation (thurrockwicconsultation@nhs.net)	Thurrock residents	500+ clicks to the questionnaire link
02.02.15	Letters and emails sent to inform about the start of the public consultation to all key stakeholders as per communication and engagement plan supported and agreed by HOSC members on 13 January 2015. These stakeholders included influencers such as: • local MPs, • Thurrock Council members, • health partners such as Healthwatch, • Basildon and Brentwood CCG, • Basildon and Thurrock University Hospitals NHS Foundation Trust, • North East London NHS Foundation Trust, • South Essex Partnership University NHS Foundation Trust, • Royal College of Nursing, • Nursing and Midwifery Council, • patient and voluntary groups, • and other stakeholders such as GPs	Key stakeholders	Difficult to assess the total number of people reached
02.02.15	Community, CVS and CCG newsletters	Key stakeholders and Thurrock residents	Difficult to assess the total number of people reached

02.02.15	Local media releases	Key media stakeholders	Residents reading 3 local newspapers and portals (Thurrock Gazette, Thurrock Enquirer and Your Thurrock)
02.02.15	Thurrock CCG's twitter account updated with the information and link to the public consultation document and questionnaire	Thurrock residents	1291 followers+
02.02.15	Set up an information stand at the Healthwatch Dignity in Care event	Thurrock residents	45
Between 2.02.15 and 14.02.15	A leaflet door drop was completed by an independent company to all Thurrock households.	Thurrock households	The leaflets were sent out to all Thurrock households.
Between 2.02.15 and 9.02.15	Posters informing about the public consultation along with copies of the public consultation documents were sent out to all Thurrock GP practices, GP Patient Participation Groups, pharmacies, dentists, opticians, libraries, Children's Centres as well as key community organisations: Healthwatch, Thurrock Centre for Independent Living, Thurrock Coalition and TOFFs (Thurrock Over Fifties Forum)	Thurrock residents	1,800 copies of the public consultation document and questionnaires distributed; Difficult to assess the total number of people reached
5.02.15	Local newspaper advertising (Thurrock Enquirer)	Thurrock residents	Difficult to assess the total number of people reached
9.02.15	Presentation at the Thurrock Over Fifties Forum (TOFFs)	TOFF members	36 present at the meeting
9.02.15	Health and Wellbeing Board	Health and Wellbeing Board members	10 present at the meeting
09.02.15	Following a press release by Cllr John Kent, the team contacted Cllr Kent and offered clarification around the planned locations of hubs and offered to meet to address any concerns	Cllr Kent	1
11.02.15	Live BBC Essex interview about the public consultation and the future of the walk-in service	Thurrock residents	Difficult to assess the total number of people reached
11.02.15	Public event at Orsett Hall	Thurrock	83 attendees

		residents and community organisations	
18.02.15	Meeting with Healthwatch Thurrock	Healthwatch	1
18.02.15	NHS England area team	NHSE	3
20.02.15	South Essex College – asking for access to set up a stand at the College to engage with the students	South Essex College	1
20.02.15	Thurrock Coalition and Thurrock Centre for Independent Living	Community organisations	Difficult to assess the total number of people reached
20.02.15	Your Thurrock	Media	1 editor
23.02.15	Stand at the CQC/Thurrock Healthwatch event	Thurrock residents	60+ attendees
23.02.15	Thurrock GP practices	Practice managers	30+
23.02.15	Pat Kielty, Young Thurrock	Young Thurrock	526 Twitter followers
26.02.15	Members of the public – emails with queries sent to the dedicated email address	Thurrock residents	2
26.02.15	Letter to Cllr Tim Aker clarifying Thurrock CCG's position on the public consultation	Cllr Tim Aker	1
27.02.15	South Essex LMC	Clinicians	20+
04.03.15	Letter to Polly Billington, MP candidate for Thurrock clarifying queries relating to the public consultation process	Polly Billington	1
04.03.15	Students at South Essex College – information stand at the premises	Students	20+
04.03.15	Public event in Grays – Civic Centre	Thurrock residents	11
10.03.15	All attendees of public events who shared their contact details with us – encouraging them to engage their families, friends, neighbours and community organisations to respond to the questionnaire	Thurrock residents	52
18.03.15	Public event in Corringham	Thurrock residents	8

18.03.15	Tony Coughlin, one of the BTUH governors – clarifying issues related to the public consultation and the proposals	BTUH governors	1
18.03.15 – 24.03.15	Emails and letter sent out to all key stakeholders encouraging them and their staff or members to complete the questionnaire; Tweets about the approaching deadline for the consultation on CCG's Twitter account and its wesbsite	Thurrock residents	Difficult to assess the total number of people reached

Appendix C - Healthwatch Thurrock meetings and events attended

DATE	EVENT	NUMBER OF PEOPLE
2nd February 2015	Healthwatch Dignity in Care Event	45
3rd February 2015	LAC Meeting	12
10th February 2015	WI Corringham	60 +
12th February 2015	Ngage Recruitment Fair	30 - 40
16th February 2015	Stanford Library Drop In	Numbers vary
17th February 2015	South Ockendon Hub Drop In	Numbers vary
19th February 2015	Dementia Awareness Event Tilbury	50 +
19th February 2015	Chadwell Drop In	Numbers vary
19th February 2015	East Tilbury Drop In	Numbers vary
19th February 2015	West Tilbury Forum	20
20th February 2015	Aveley Community Drop In	Numbers vary
23rd February 2015	CQC/Healthwatch Event	60+
25th February 2015	Bulphan WI	40+
26th February 2015	Diabetes UK Thurrock Branch	38
27th February 2015	Together S U Meeting /(MH Services)	12
3rd March 2015	C2C Commuters Meeting	40+
3rd March 2015	South Ockendon Drop in	Numbers vary
3rd March 2015	Eastern European Support Group	28
4th March 2015	Afternoon Tea for Dementia Stifford Clays	30+
4th March 2015	Horndon on Hill WI	30
6th March 2015	Tilbury One Community Drop In	Numbers vary
6th March 2015	Tilbury Drop In Sure Start Children's Centre	Numbers vary
10th March 2015	Faith Matters Meeting	14
13th March 2015	East Tilbury Library Drop in	Numbers vary
16th March 2015	Stanford Library Drop In	Numbers vary
17th March 2015	Modern Day Slavery Conference	90 - 100
19th March 2015	Chadwell Drop In	Numbers vary
20th March 2015	Aveley Drop In	Numbers vary

20th March 2015	Corringham Older People Group	65+
23rd March 2015	Multi Ethnic Counselling Service Drop In (Thameside Children Service)	Numbers vary
23rd March 2015	Coffee Morning @ TAA (Thurrock Asian Assoc.)	18
24th March 2015	Clip Café Aveley Drop In	Numbers vary
24th March 2015	Family Coffee Morning Marisco Hall	12
25th March 2015	CAPPA AGM (Children & Parents Association)	28 - 30

Report on the outcomes of the public consultation on the future of the walk-in service at Thurrock Health Centre, Grays.

Prepared for
Thurrock Clinical Commissioning Group

Document revision history

Date	Version	Revision	Comment	Author / Editor
19.05.15	1.0	Exec meeting		BM
22.05.15	2.0	Finance & Performance Committee		BM
27.05.15	2.0	CCG Board		BM

Document approval

Date	Version	Revision	Role of approver	Approver

Contents

Executive summary

Thurrock Clinical Commissioning Group (CCG) is responsible for the walk-in service element of the contract for the Thurrock Health Centre which is due to expire in March 2016. This has provided the CCG with an opportunity to review the effectiveness and patient satisfaction with the contracted service.

Following extensive data analysis, as well as engagement with service users and residents of Thurrock, three options for the future of the walk-in service were developed:

- Re-tender for the service on the current specification (do nothing)
- Re-tender with a new specification for the service
- Decommission the walk-in service and invest in four local health 'hubs' (preferred option).

The CCG believes that the service currently provided by the walk-in service does not meet its ambition of supporting residents across the whole of Thurrock; pointing to the fact that the service is being utilised mainly by residents local to the Thurrock Health Centre in Grays.

The options were consulted on with a number of key stakeholders and, with Thurrock Council's Health Overview and Scrutiny's support, the CCG conducted an eight week public consultation under section 14Z2 of the Health and Social Care Act 2012. The consultation ran between 2 February and 24 March 2015.

The feedback on the identified options was gained through a range of focussed activities and events which aimed at gathering opinions and views of local people from all sections of the community.

1,800 printed consultation documents were distributed to key stakeholders including local MPs, Thurrock councillors, health partners, and patient and community groups. Local GP surgeries and libraries were asked to have copies of the document available to the public. The public consultation document, along with the feedback questionnaire, was also available on the CCG's website.

The CCG actively encouraged feedback through publicising the information via its newsletter, website, Twitter account and attending a range of meetings and events across Thurrock. In addition, a leaflet door drop was completed by an independent company to all Thurrock households between 2 February and 14 February 2015.

A total of 251 written responses, including 242 questionnaire responses and nine emails, containing feedback on the future of the walk-in service were received. In addition, 102 local residents attended three different public events to discuss the proposals with GPs and CCG staff. CCG representatives also attended 24 separate meetings to present the options for the future of the service and gain feedback from a variety of community groups and stakeholders.

Key findings include:

- Analysis of the quantitative data from the questionnaires indicates that the preferred option is Option 1 – to retender for the service on the current specification (no change), followed by Option 3 – to close the walk-in service and invest in four local GP 'hubs' (preferred option)
- Analysis of the feedback received at the public events shows that the majority of local residents who attended the events indicated that Option 3 is the most supported option for the future of the walk-in service

- Feedback and written responses from key stakeholders including the Local Medical Council (LMC), Basildon and Brentwood CCG and the Commissioning Reference Group indicated their support for Option 3 for the future of the walk-in service
- The MP for Thurrock (since re-elected in the 2015 General Election) supported Option 3 and two parliamentary candidates supported Option 1 in their submissions to the public consultation process
- Analysis of the qualitative data from the completed questionnaires has highlighted a range of key themes of which **access** has been by far the greatest concern. The feedback was focussed on the following areas:
    - Difficulty of getting routine and urgent GP appointments
    - A desire to see GP opening hours extended to evenings and weekends,
    - Concern about the length of waiting times, with many respondents saying they felt that the walk-in service was an assured means of accessing a healthcare professional when they needed it
    - Mixed views about location – some felt the central position of the walk-in service made it very accessible, while others were concerned that it did not support equal access for people who lived further out, relied on public transport (difficult in evenings and weekends) or were too unwell/had a disability that made travelling difficult.
- Mixed feedback on the **quality of the service** received at the walk-in service. There were many positive comments about the reliability and speed of being seen at the walk-in service, and some comments that pain relief and diagnosis was of better quality than at the user's GP surgery. There were also some comments that the walk-in service had long waiting times and was less personal
- Respondents felt that there needed to be **better use of resources**. There were differing views about how resources can be used more effectively e.g. closing the walk-in service and utilising GPs, or creating more walk-in services to reduce burden on local hospitals. There were some suggestions of adding diagnostics e.g. x-ray/blood tests, to local GP practices or the walk-in service
- **Communication and education** emerged as key suggested actions for CCG that would enable better understanding of services available to local residents and better use of those services.

Next steps

The CCG Governing Body will consider the feedback contained in this report to support members in the decision-making process in relation to the future of the Thurrock walk-in service. The decision is expected to be made in its Board meeting in public on 27 May 2015.

1. Background

Following changes to the NHS set out in the Health and Social Care Act 2012, Thurrock CCG became responsible for the 'walk-in service' element of the contract at Thurrock Health Centre whilst NHS England retains responsibility for the patients' list at the registered GP surgery on the same sites.

As the joint contract expires in March 2016, this has provided the CCG with an opportunity to review how the walk-in service is provided, as well as its overall alignment with the CCG's and national strategies for both urgent and primary care. To capitalise on this opportunity, Thurrock CCG conducted a robust analysis in 2014 of the available data on the use, cost and patient satisfaction with the walk-in service.

People in Thurrock face major challenges, with significant levels of unemployment and low levels of health and wellbeing, compared to neighbouring areas. Thurrock is also an under-doctored area (not enough GPs for the population of Thurrock), nearly a third of GPs are over 60, and there is difficulty recruiting clinical staff to the area.

Additionally, in common with other NHS and public sector organisations, Thurrock CCG has limited resources. In spite of this, we must still make savings every year. NHS walk-in services – where people simply walk in off the street and ask for medical help – have been increasingly in the spotlight. Doctors and nurses have become concerned that, rather than easing pressure on other services, walk-in services are simply creating extra demand and patients are by-passing GPs, pharmacists, out of hours' services and sensible self-care.

During 2014, Thurrock CCG worked closely with patients, carers, service users, local residents and a range of key organisations, including Healthwatch Thurrock to develop possible options for the future of the walk-in service. These options were also informed by the available data of the existing walk-in service and the wider primary care services.

In line with the CCG's responsibilities to consult with the public outlined in the Health and Social Care Act 2012, the three options were put out to public consultation from 2nd February to 24th March 2015. The feedback received during this consultation period is outlined in this report.

The aim of the report is to provide an in-depth analysis of the feedback received through the public consultation process for the future of the Thurrock walk-in service based at Thurrock Health Centre in Grays. As such, the report will play a role of enabling an informed and transparent decision making process for the CCG Board in deciding on the future of the walk-in service.

1.1 Case for change

In 2014, in advance of the public consultation, and as part of the Transforming Primary Care in Essex agenda led by NHS England, the CCG engaged with many residents, clinicians, and organisations across Thurrock about the thoughts and plans to improve local NHS services in the borough and build resourceful and resilient communities. The CCG sought their opinion on the proposals for the future shape of primary care in Thurrock, including the future of the walk-in service.

When the CCG was discussing possible changes to the walk-in service, people said that the three things they are most concerned about are:

- The need for greater access to primary care in Thurrock,
- That the walk-in service does not provide a borough-wide service, and
- That while the four GP 'hubs' would provide more access to GPs across Thurrock, they would be open for fewer hours than the walk-in service.

Alongside this, local GPs stated that the walk-in service did not provide a streamlined service for patients, for example there was poor communication from the walk-in service back to patients' registered practices with implications for continuity of care. The feedback also included comments that the whole NHS system is perceived to be complicated which prevents patients and carers from accessing right services at the right time. GPs highlighted that should the walk-in service be closed, there would need to be more information provided for Thurrock residents as to where they could go for treatment. GPs and nurses tell us there are too many people visiting walk-in centres who are not managing (or being helped to manage) their long-term condition.

During these discussions with Thurrock's residents and organisations over the past few months, people have stated that they use the current walk-in service because they don't want to wait for an appointment with their GP, or that they don't know where else to go. It is clear that the current range of services is not meeting the needs of all Thurrock residents. **A simpler, better system is required so that local people can get the best health care they need.**

1.2 Developing primary care services for Thurrock

The vision and objective for primary care services in Thurrock advocates that everyone should know how to, and be able to, register with a GP so they can access high quality primary care when they need it. Making sure this happens is a priority for the CCG.

A GP surgery should be the first port of call for people needing care that is not an emergency. People should be able to:

- Phone before they go – to get good information from their GP surgery before having to travel to see a clinician, make an appointment or go to another health care service.
- Get all their primary care at a GP surgery close to where they live during weekdays as a minimum – ideally at their own GP practice but if not, another practice nearby.

In the evenings and at weekends people should be able to access health care just as easily as during the day. People should be able to:

- Phone NHS 111 for advice or to make an urgent appointment with their GP.

- Get an urgent appointment at their GP practice.
- Outside GP practice hours, where appropriate, be referred to the GP out of hours' service.

GP Health hubs

Last year, the CCG was successful in gaining extra funding from the government which means that GP practices (health hubs) in four areas across the borough will be open at the weekend from 9:00am to 12:30pm until 2021. These hubs are staffed by local practice staff or out-of-hours clinicians on a rota basis, providing continuity of care for patients, as well as increasing local knowledge of the area and its health care services. Through offering a mixture of pre-bookable and urgent appointments without the need to refer back to the patients' own GP, the CCG believes this service will improve access to primary care closer to Thurrock residents' homes.

The urgent care system (A&Es, GP urgent appointments, GP out-of-hours' service, walk-in services centres and urgent care centres) is expensive to manage and run. If a patient goes to two or three places to seek advice or care for the same reason, the NHS can pay from two to five times the cost compared with simply booking an urgent appointment with a GP.

The CCG's preferred option of decommissioning the walk-in service in its current form and reinvesting the funding into four health hubs would allow the CCG to enhance the health hub services outlined above and improve access to routine and urgent appointments.

2. Pre-consultation engagement and review process

In 2014, Thurrock CCG conducted an open and transparent pre-consultation engagement process to develop and appraise the options available for the future of the Thurrock walk-in service and the wider primary care services across the area. This included:

- A review of the available data on the existing walk-in service
- Engagement with local people and organisations
- Developing the proposals.

The feedback received at that stage of the pre-consultation engagement shaped the three options that the CCG consulted on between 2nd February and 24th March 2015.

2.1 A review of available data on the existing services

To help decide if the CCG should invest in this service in the future, a review[1] was carried out of how people had been using the Thurrock walk-in service, why they were using it, and the current cost of, and patient satisfaction with, the service. Access to local primary care and attendance at the A&E department at Basildon Hospital was also examined.

The review found that 90 per cent of people who went to the walk-in service were already registered with a GP in Thurrock and many used the service for reassurance (to check what they had already been told by their own GP). People also went to the walk-in service to save them from waiting to see their own GP or because they didn't know where else to go.

The analysis of the attendances at the walk-in service showed that most of the people who went there came from Grays and Tilbury (72.5%).

[1] The review was based on a one-month snapshot view of patients attending the Walk in Centre in May 2014.

A survey of the use of the walk-in service showed that the majority of people attended for minor injuries and ailments. This evidence shows that people who use the walk-in service go mainly for primary care problems; in fact many of the people turn up at the walk-in service with conditions which would be better seen by a GP.

A breakdown of who goes to the walk-in service showed that most are aged between 19 and 40; older adults and young children make up a much smaller proportion of attendances at the walk-in service.

The CCG conducted a robust analysis of the available data on the current use, cost and patient satisfaction with the walk-in service at the Thurrock Health Centre. In addition, existing local access to primary care and attendance rates at A&E in Thurrock were examined to set some context to the landscape in which the walk-in centre service operates.

2.2 Pre-consultation engagement with local people and organisations

In advance of the public consultation, we engaged with the following local people and organisations:

- Basildon and Brentwood CCG
- Basildon and Thurrock University Hospitals NHS Foundation Trust
- Healthwatch Thurrock
- Members of the public
- MPs, councillors
- North East London NHS Foundation Trust
- South Essex Emergency Doctors Surgeries
- South Essex Local Medical Committee
- South West Essex System Resilience Group
- Thurrock CCG's Commissioning Reference Group
- Thurrock CCG's Primary Care Development Working Group
- Thurrock CCG's Annual General Meeting
- Thurrock Council Health Overview and Scrutiny Committee
- Thurrock Council for Voluntary Service
- Thurrock GPs through the CCG Clinical Engagement Group and visits to GPs in their practices
- Thurrock Health and Care: working together for a better future (a public engagement event)

2.3 The proposals

After reviewing the available data and discussing the issues identified in the case for change with local people and organisations, Thurrock CCG identified three options for the future of the Thurrock walk-in service:

Option 1	Re-tender for the service on the current specification (do nothing)
Option 2	Re-tender with a new specification for the service
Option 3	Close the walk-in service and invest in four local GP 'hubs' (preferred option).

These options were considered and appraised by a selected scoring panel of local clinicians, GPs, commissioners, patients and representatives from the public, at a meeting in November 2014 where, based on a strict set of criteria, the panel unanimously agreed to select closure of the service and invest in four local GP hubs as the preferred option. A fourth option to close the walk-in service and do nothing further was considered and dismissed. The proposed changes only apply to the walk-in service at the Thurrock Health Centre, not the GP practice based at the same location.

Option 1 – Re-tender for the service on the current specification (do nothing)

This option would keep the service 'as is', where people would have access to health care needs weekdays and weekends, 365 days a year. While we know that patients who attend the walk-in service value the service, this option would not address the issues highlighted by residents, patients and partners across Thurrock.

Access to primary care across the borough would not improve under this option as it is mainly Grays and Tilbury patients that use the walk-in service. Nor does the option address continuity of care (seeing the same GP or a GP with a ready access to their patient record, for example) which patients consider to be of high importance.

This option would also not address the issue of duplication where we know that 90 per cent of the people who attend the walk-in service are already registered with a GP, which means that the NHS is paying twice. Nor would it encourage resilience through self-management of care or increase the number of people registering with a GP.

Option 2 – Re-tender with a new specification for the service

This option would mean that the walk-in service remains at Thurrock Health Centre, but would be open less than it is now.

This service would partially address the duplication that is taking place with already paid-for primary care services, but is also subject to similar cost pressures as in option 1 (although not quite as much pressure as the service would be open for fewer hours). And resilience through self-management of care would not be encouraged.

Access would not be improved across the rest of the borough as it is mainly Grays and Tilbury patients that use the walk-in service.

Option 3 – Close the walk-in service and invest in four local GP 'hubs' (preferred option)

This option supports both the Essex primary care strategy and Thurrock Council's strategy for health care services to improve health and wellbeing across the borough. It would also help us to achieve the savings we know we will need to protect and improve other health services.

There would still be a GP practice at the Thurrock Health Centre, and people outside Grays would get better access to health care services across the borough, closer to their own homes, seven days a week. People would be encouraged to use their own GP practice as their first point of contact, which is essential if we are to help patients keep healthier and better manage long-term conditions.

This option would make the system more efficient by removing duplication and improve the likelihood of residents registering with a GP practice, encouraging resilience through self-management of care. The funds that are currently used for running the Walk-in service will be used for enhancing services across four hubs making access to health care more equal across Thurrock and responsive to local patients' needs.

We expect that, if there is no walk-in service, patients would go to their own GP practice and we believe that there is capacity in the system to absorb any extra in-hours attendances.

3. Governance and responsibilities

3.1 Governance

Thurrock CCG holds the responsibility for the walk-in element of the service in Thurrock Health Centre[2]. It is responsible for ensuring that the walk-in service meets the needs of the local population in a way that provides a high quality service for patients and the best value for taxpayers. It also needs to fit in with the wider regional and national strategy for primary care services.

Thurrock CCG's Governing Body has been overseeing the process for determining the future of the walk-in service. The Governing Body has been kept up to date at each stage of the consultation process and has worked to ensure that the engagement and consultation process has been open and transparent.

The report of the public consultation will be presented to Thurrock CCG Governing Body on 27 May 2015. The review of the report will enable the Board to consider the outcomes of the public consultation and make decisions about the way forward for the walk-in service and the wider primary care service in Thurrock.

[2] The CCG's responsibilities do not include the contract for the GP practice based in the Thurrock Health Centre. This is the responsibility of NHS England).

3.2 Responsibilities

The Health and Social Care Act 2012 states that, when NHS organisations (such as Clinical Commissioning Groups) are considering changing the way a service is provided, they must ensure that individuals to whom services are being or may be provided are involved (by being consulted or provided with information or in other ways) in:

- Planning commissioning arrangements,
- The development of changes that would impact on the manner in which services are delivered or the range of health services, or
- Decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The CCG has complied with this guidance as part of its comprehensive communications and engagement strategy and plan, details of which are outlined in Appendix A.

4. Structure of the consultation

The consultation started on Monday 2 February 2015 with the CCG uploading its public consultation document and feedback questionnaire. The process ended at 5pm on Tuesday 24 March 2015. Online responses received between 5pm and midnight on 24 March and postal responses received on the morning of Wednesday 25 March were included in the analysis to allow for any IT-related issues with submitting the feedback that some may have experienced as well as any delayed post issues.

4.1 Consultation document, questionnaire and materials

Information on the consultation was made available through the Thurrock CCG website www.thurrockccg.nhs.uk. A questionnaire was also made available for people to share their views.

Consultation feedback could be submitted through completing the consultation questionnaire (paper or online) or by emailing thurrockwicconsultation@nhs.net.

The information about the public consultation was publicised through a variety of channels:

- Community and CCG newsletters
- Existing CCG-led meetings
- Healthwatch Thurrock website
- Information stand at South Essex College (Grays site)
- Leaflet door drop to all Thurrock households between 2 and 14 February 2015
- Local media releases on 2 February
- Local newspaper advertising (Thurrock Enquirer on 5 February 2015)
- Posters, public consultation documents and questionnaires distributed to all Thurrock-based GP practices, GP Patient Participation Groups, pharmacies, dentists, opticians, libraries and Children's Centres
- Thurrock CCG's Twitter account
- Letters and emails to key stakeholder organisations.

A total of 1,800 printed consultation documents were distributed throughout the consultation period. The consultation document along with an online copy of the questionnaire were available on the CCG website throughout the consultation period, easily accessed from a link on the homepage. In addition hard copies in English and any foreign language were available on request. Regular updates and publicity were included in the CCG's Twitter account (nearly 50 tweets over the consultation period) along with the publicity for the public events.

Printed consultation documents with questionnaires were sent to Thurrock MPs, GP surgeries and libraries in the first week of February. The distribution was followed up by a phone call to each of the GP practices to check they had received the documents and posters and that they were displayed and available to the patients. Key community and voluntary organisations such as Healthwatch, Thurrock Centre for Independent Living, Thurrock Coalition, TOFFs (Thurrock Over Fifties Forum) also received a set of consultation documents for distribution to their members early in the consultation period. Thurrock councillors received emails and letters informing them of the start of the consultation with a link to the consultation document and questionnaire, early in the consultation period.

A door drop of leaflets about the public consultation to all Thurrock residents was commissioned and started in the first week of February 2015. It was completed on 14 February 2015. Consultation documents were also distributed at public events held at Orsett Hall, Civic Centre in Grays and Spring House in Corringham.

The consultation document was written in collaboration with patient representatives to ensure that it was easily understood, jargon-free and in plain English. . Patients also had the opportunity to request the documents in other formats, such as different languages, Braille or 'easy-read'. No requests for supplying the document in other formats were made during the consultation period.

4.2 Consultation activities

To encourage participation in the consultation, three public engagement events were held where people could speak to clinicians, ask questions, find out more about the proposals, and share their opinions. These events were held on:

- 11 February – Orsett Hall, Orsett (2-4 pm)
- 4 March, Civic Centre, Grays (7-9 pm)
- 18 March, Spring House, Corringham (7-9 pm).

The events aimed to capture views of residents from all sections of Thurrock communities and therefore the events were held in various locations and during different times of the day to allow people in full time employment to participate in the process. A presentation was developed for CCG clinicians and representatives to outline the proposals to members of the public at each of the three public events.

The CCG actively promoted the public consultation at a number of events and meetings run by local community and voluntary groups, which included the following:

- An information stand at the Dignity event on 2 February (attended by approximately 80 people)
- A presentation followed by distribution of the public consultation documents, questionnaire and discussion at TOFFs (Thurrock Over Fifties Forum) on 9 February.

The CCG was pro-active in following up any additional information requests and created a targeted Q&A document following the first public event held at Orsett Hall which contained more detailed answers to questions raised at the event that were not fully answered on the day.

The public consultation generated a considerable interest from the media and local politicians, particularly prospective parliamentary candidates. This included a live interview on BBC Radio Essex which was broadcast on 11 February 2015. In addition, the CCG officially responded to the allegations and concerns related to the process of conducting the public consultation raised by prospective parliamentary candidates Polly Billington (Labour) and Cllr Tim Aker (UKIP).

On the consultation launch date, emails and letters were sent to key stakeholders with a link to the consultation page on the CCG website and information on how to respond. These stakeholders included influencers such as local MPs, Thurrock Council members, health partners such as Healthwatch, Basildon and Brentwood CCG, Basildon and Thurrock University Hospitals NHS Foundation Trust, North East London NHS Foundation Trust, South Essex Partnership University NHS Foundation Trust, Royal College of Nursing, Nursing and Midwifery Council, patient and voluntary

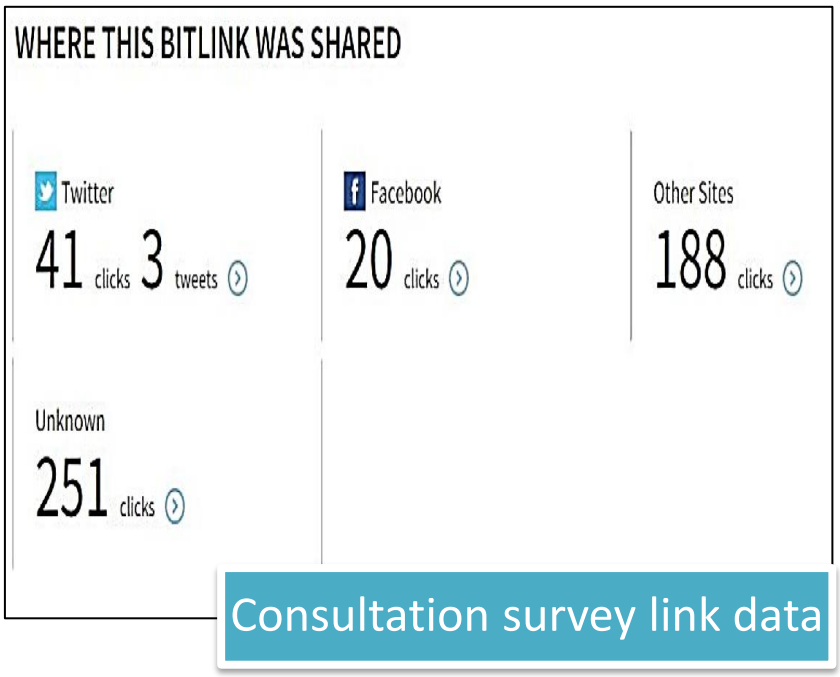
groups, and other stakeholders such as GPs. A further email was sent to key stakeholders in advance of the public events as well as before the close of the public consultation process.

A whole page advertisement was placed in the local press (Thurrock Enquirer) at the beginning of the consultation (on 5 February 2015) to publicise the consultation and to direct readers' attention to the website and included contact details for more information.

A media release was sent to local media when the consultation launched to publicise the consultation and public event sessions, as well as directing people to the website and other sources of information.

A further media release was issued in March 2015, which aimed to remind people of the closing date of the public consultation. The consultation launch, drop-in sessions and the information on public meetings were covered in the local newspapers, the Thurrock Enquirer, Thurrock Gazette (also in their online version) and Your Thurrock.

Thurrock CCG posted nearly 50 tweets on its account about the public consultation encouraging its followers (over 1,200 Twitter users follow Thurrock CCG) to share their feedback. The data received through our bit.ly account indicates that the questionnaire link received 500 clicks (41 of them from Twitter) and the consultation page on the CCG website received 46 clicks (23 of them from Twitter).



In addition, the CCG followed up the nine emails that were received through the thurrockwicconsultation@nhs.net email account, answering any consultation-related queries and incorporating the feedback into the overall consultation analysis.

Following the feedback received at the first public event, the CCG engaged with Thurrock Youth Cabinet and South Essex College to design effective ways of engaging with younger people. An information stand on-site at South East College was organised and two CCG staff members provided information and distributed consultation documents along with the questionnaires for two hours during lunch time on 4 March 2015. Thurrock Youth Cabinet members were encouraged to attend the public event held at the Civic Centre and they re-tweeted the information about the consultation on their account.

To provide the evidence of completing the communications and engagement plan that was approved by the Health Overview and Scrutiny Committee on 13 January 2015, a comprehensive overview is provided in Appendix A.

5 Responses to the consultation

5.1 The consultation in numbers

Number of responses	Questionnaires (printed and online):	242
	Letter/email responses:	9
	Total responses:	**251**
People who engaged and fed back at public meetings	11 February – Orsett Hall, Orsett (2-4 pm):	83
	4 March, Civic Centre, Grays (7-9 pm)):	11
	18 March, Spring House, Corringham (7-9 pm):	8
	Total attendees:	**102**

The groups or organisations which responded were:	Basildon and Brentwood CCG –	letter submission
	Local Medical Committee –	email submission
	Thurrock Over Fifties Forum (TOFF) –	questionnaire
	Hassengate Medical Centre –	questionnaire
	Chafford Hundred Local Authority –	questionnaire
	Thurrock Health Centre –	questionnaire
	Two parliamentary candidates –	email submission
	Commissioning Reference Group –	verbal feedback

5.2 Who responded to the consultation questionnaire?

Respondents were asked to provide additional information about themselves, for example their gender, age, ethnicity and whether they were responding individually or on behalf of a group. A full summary of this data can be found in Appendix B. Where possible, the profile of respondents was compared to the known profile of users of the walk-in service. This comparison showed **that whilst the gender of respondents appears to reflect the users of the walk-in service, the age and ethnic background of respondents does not appear to fully resemble that of the users of the service.** It is also worth noting that only just over half (51.9%) of respondents declared themselves to be service users although 74.8% of respondents stated that they were local residents.

5.3 Qualitative data

Respondents were invited to leave a comment to clarify or explain the answer which they had given to the question. These comments have been examined in some detail as they provide valuable additional information about the views of patients and public. Common themes which have been identified are highlighted within the report for each section where qualitative data was collected. A sample selection of quotes from respondents has also been included in order to give some indication of the range and diversity of views.

5.4 Limitations of the data

A consultation process is a very valuable way of gathering opinions about a wide-ranging topic but it is important to consider limitations of the feedback collected through this method. When interpreting the responses, it is important to note that whilst the consultation was open to everyone, the respondents were self-selecting. Moreover, the number of people who took part in the consultation was not sufficient for the sample to be considered representative.

Typically with consultations, there can be a tendency for responses to come from those more likely to consider themselves affected and particularly from anyone who believes they will be negatively impacted upon by the implementation of proposals. In case of the consultation on the future of the walk-in service in Thurrock, it could be assumed that Grays residents could perceive themselves as more affected by the change than residents in other parts of Thurrock. Only a small number of respondents (18) provided information on their location which made it difficult to ascertain whether the responses could be skewed. **The responses therefore cannot be assumed to be representative of the population as a whole.**

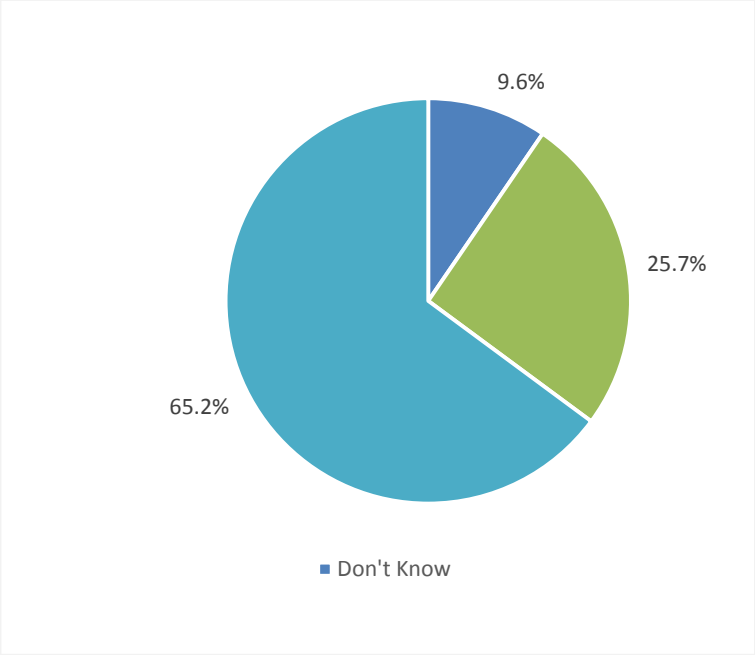
It should also be noted that respondents had the option not to complete some of these questions by either choosing the ‘don’t know’ or ‘prefer not to say’ categories, or by skipping the question completely. A count of how many respondents answered each question has therefore been included alongside each graph as there are variations in the number of responses to each question.

5.5 What were the views of those who responded to the consultation questionnaire?

Answered Question: 230
Skipped Question: 12
Additional Comments: 150

Changing urgent primary care services

Question: Do you think we need to change the current way of providing urgent primary care services? (Primary care covers GP practices, dental practices, community pharmacies and high street optometrists)



Nearly two thirds (65.2%) of respondents agreed that change is needed to the current way of providing urgent primary care services. Of the remaining respondents, 25.7% did not think that any change was needed and 9.6% did not know if change was needed.

An overwhelming number of comments submitted by respondents alongside this question indicated that having **better access** to GP services is an area where it is felt change is needed. Other areas for change included the **quality** of the services provided, how **finance and resources** are allocated and how primary care teams and other health and social care teams work together. There were also comments around the role of patients and the public voicing the need for more pro-active self-management by patients.

Respondents primarily commented on **the difficulties of accessing an urgent or routine GP appointment**, and linked to this were comments around long waiting times within practices and the walk-in service and a feeling that triage and prioritisation systems could be improved to ensure that urgent cases get appointments first. Respondents also expressed a desire to see **GP opening hours extended to evenings and weekends** in order to meet the needs of people who work during the week and to reduce the strain on urgent and emergency care and out of hours services at weekends.

Access

Other concerns included an apparent increase in demand for services which some respondents felt was linked to the area's growing population and new housing developments. Ensuring equal access to services across the whole borough was advocated in terms of where services such as the walk-in service are located, and also with regard to practices having standard opening hours and a standard way of accessing appointments. Comments on the future health hubs suggested that if these are located in multiple locations across the borough, they could support more equal access.

> *"GP appointments can be up to 2 weeks, or you can form a queue at 8.30 in the morning or try to ring the surgery but lines are always busy so by the time you get through, all emergency appointments have been taken."*

There was also a small number of comments around being able to access nurses more easily for minor ailments, and for GP practices to offer diagnostics services such as blood tests or x-rays as well as a suggestion to have an end of life care service based in Thurrock.

> *"Grays walk in centre is a god send for all people needing medical help."*
>
> *"There are far too many locum doctors so patients cannot build a trusting relationship with their GP"*

Quality

There were mixed comments about the quality of local services. Some respondents fed back that they had very positive experiences at the walk-in centre and that it provided a good alternative to A&E. Also that their local GP practice provided an excellent service. However a slightly greater proportion of respondents felt that current services are not meeting the needs of users and that, for example, some patients are going to Basildon Hospital rather than use their local GP service. It was also suggested that more GPs and nurses are needed in Thurrock and that too many locum doctors are being used. One respondent indicated that they also lacked confidence in pharmacy services.

Finance and Resources

Better use of resources was a concern. For example, there were suggestions that there is currently too much duplication of services and that walk-in services are ineffective and a poor use of resources. Some respondents felt that financial resources have not been spread fairly across different primary care and hospital services and that some areas of the borough are not getting enough funding.

Other comments

Other comments were around better collaboration – for example GP practices working with pharmacists, dentists and A&E services was highlighted as an area for improvement; and for better communication and education for service users around which services to use, registering with a GP and not missing appointments.

5.6 Options for changing the current walk-in service

Question: Our preferred option is to close the Thurrock walk-in service and invest in four local GP 'hubs'. With which option do you agree/disagree?

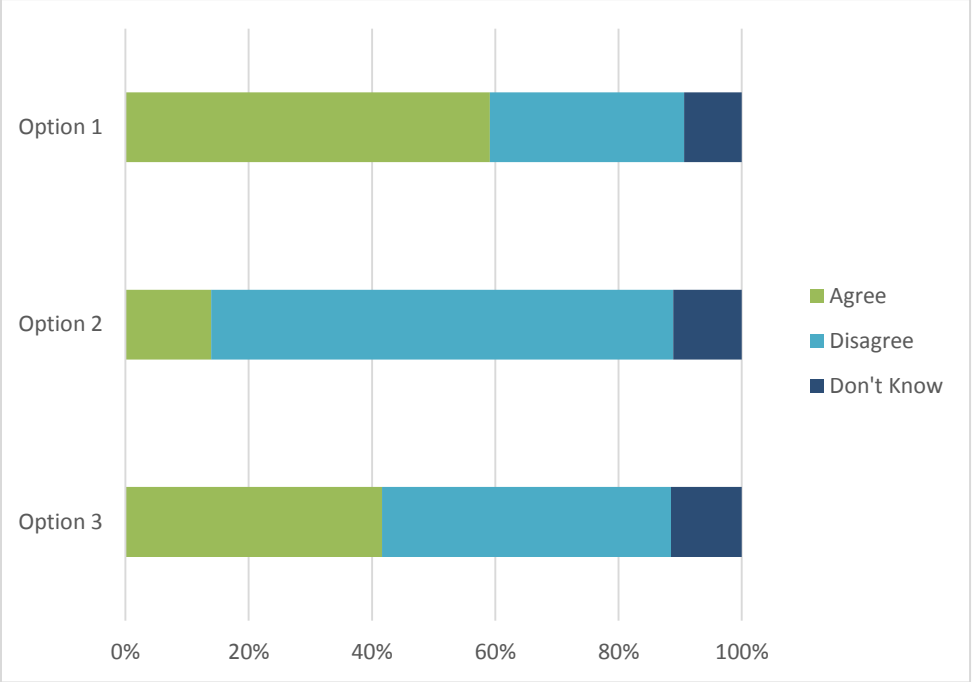
Option 1 – Retender for the service on the current specification (no change)

Option 2 – Retender with a new specification (i.e. with reduced opening hours)

Option 3 – Close the walk-in service and invest in four local GP 'hubs' (preferred option)

Answered Question: 233
Skipped Question: 9
Additional Comments: 180

Table 1: Questionnaire results: breakdown of answers to options for changing the current walk-in service.



These answers and results need to be considered alongside the feedback that was received at public events as the vast majority of participants at these events supported Option 3 with Option 1 being the least popular choice.

Respondents were able to select whether they agreed or disagreed with the proposed options for the Thurrock walk-in service. Some also stated that they did not know. Not all of the respondents selected a view about each option. It is therefore valuable to look at the data shown in **Table 1** which provides greater detail as to how many respondents replied to each option.

Option 1 had the greatest number of respondents (59.11%) agreeing with the suggestion of retendering for the service on the current specification (no change). 31.53% disagreed with this suggestions, and another 9.36% did not know.

Option 2 had the greatest number of respondents (75.00%) disagreeing with the suggestion of retendering with a new specification (i.e. with reduced opening hours). 13.89% agreed with this suggestion and another 11.11% did not know.

Option 3 had fairly equal split of opinions between those who agreed and disagreed with this option. 46.89% of respondents disagreeing with the suggestions of closing the walk in service and investing in four local GP 'hubs' (preferred option). 41.63% respondents agreed with this suggestion and another 11.48% did not know.

It can be therefore concluded that the most supported option by those who responded through online or paper questionnaires is Option 1 – to retender for the service on the current specification (no change), followed by Option 3 – to close the walk-in service and invest in four local GP 'hubs' (preferred option). Option 2 was rejected by 75% of the respondents.

By far the majority of comments submitted by respondents alongside this question were on the subject of access to services – for example on issues such as booking appointments, opening hours, equal access, access to urgent care and location of services. Respondents also commented on the future health hubs, quality of services, finance and resources, patient and public involvement, and collaboration. The key themes are outlined in more detail below.

Access

Comments from respondents given alongside answers to this question indicated that many felt they don't have timely access to a GP appointment when they need it and that they felt the walk-in service provides this for routine or urgent appointments and during evenings and weekends. Others felt that the walk-in service is already unable to meet patient demand at times and that reduced opening hours as suggestion in option 2, would lead to much longer waiting times. Multiple respondents felt that GP opening hours should be extended to evenings and weekends. This would be to provide easier access to urgent and out of hours care for patients and reduce use of local A & E services.

"The walk-in service is an essential refuge from harsh GP appointment regulations."

"If the walk-in service is closed, ALL GPs must be accessible."

"Option 3 would make the service more 'district wide' and therefore of greater benefit to the wider community."

Ensuring **equal access to services** was a concern for respondents. There were mixed views about the location of the current walk-in service. For example, some respondents felt that the current location was helpful because it is centrally located, offers good parking, is accessible by train and bus, and is located next to a pharmacy. One respondent also felt that keeping a central **location** was a cost-effective way of providing an evening or weekend service. Contrary to this, some respondents felt that people outside of town cannot easily access the walk-in service and that access needs to be for all, not just those living nearby. For example, one respondent felt that service users with restricted mobility such as the elderly or disabled, and who live outside of Grays and Tilbury, cannot easily access the current service. A small number of respondents were concerned about current levels of **demand** and felt that the walk-in service relieves the burden on A&E services and on GP services.

Health Hubs

Respondents felt they **needed more information** about the services that will be offered by the health hubs. For example, what will be the opening hours, where will they be located, how can patients register and whether there will be a walk-in option. The **location** and **opening hours** of the health hubs were felt to be key factors, with a preference being shown for evening and weekend opening – especially if the walk-in service was to close or offer reduced opening hours. It was also suggested that both the health hubs and the walk-in service be kept open.

It was felt that the health hubs would need to be **accessible by public transport** especially for disabled service users or people who cannot afford or are otherwise unable to travel. A number of respondents suggested that the current walk-in service should become one of the health hubs because of its current location, its spacious layout and because money has already been spent on it.

There were mixed views as to whether the health hubs would improve **access and quality** of services with some feeling that it may not be any easier to get a GP appointment and that they may lose the personal care provided by a registered GP, whilst others felt they would save travel time and costs and, unlike the walk-in service, it would provide personal care from a local clinician. One respondent suggested that the new hubs will need a triage process to filter urgent and non-urgent cases and to prevent unnecessary appointments.

Quality

With regard to the quality of existing services, comments from respondents generally stated that their experience of the walk-in service has been very good, for example with regard to pain relief and diagnosis, as well as being convenient and accessible, and for these reasons would prefer that it remained open. There were a smaller number of comments about how services could improve, and from these it was felt that care from GPs is variable, that GPs are not always approachable and that there seemed to be a high turnover of doctors. However it was not clear whether these comments specifically related to the users' own GPs or to walk-in service GPs. At least one respondent felt that their experience of the walk-in service had not been helpful as they had been turned away on more than one occasion, and another respondent felt that patients would receive better care from their own GP.

"I have used the walk in centre and think it works very well as it is."

"I think patients would receive a better value of continued care from their own GP."

There were some suggestions that more GPs are needed as there are currently not enough to support local GP surgeries, and that more staff should be added to the walk-in service. Also there were concerns that the current system is not currently being used correctly and that the town centre location of the walk-in service invites people to congregate in the health centre which makes it uninviting for other users.

Finance & Resources

Comments suggested that respondents were concerned about making better use of resources, for instance by reducing duplication. The opinions were split as to whether the walk-in service was more cost effective (by having everything in one place) or a waste of money (because people can attend their own GP or out of hours GP). Concern was expressed about the amount of money that has already

been invested in the walk-in centre and a suggestion that letting out rooms in the walk-in centre to pharmacies or other organisations could raise additional funding.

"But services available should be made very clear."

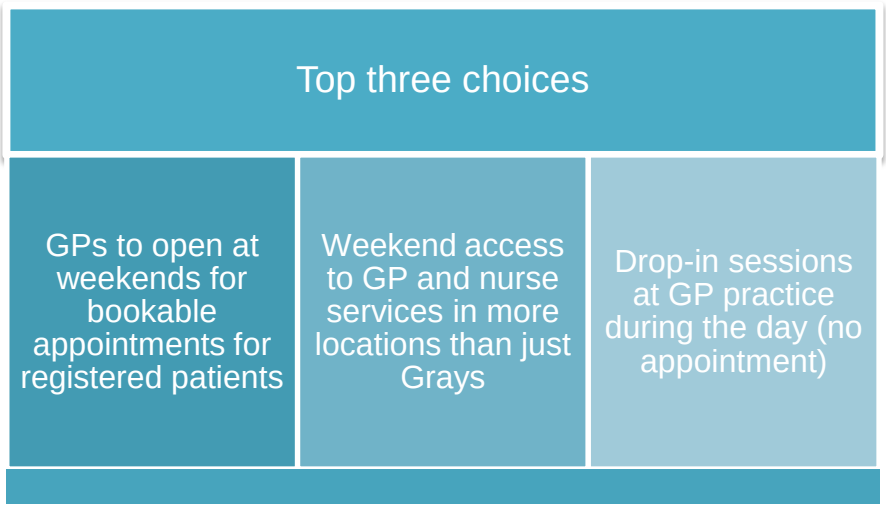
Other comments

Some respondents felt that they themselves or other service users do not have enough knowledge about which services to use when and where, to be able to use them effectively. Two respondents felt that patients and the public did not have real influence as to how the services were to be changed, whilst one comment indicated that developing local services would allow the community to be involved.

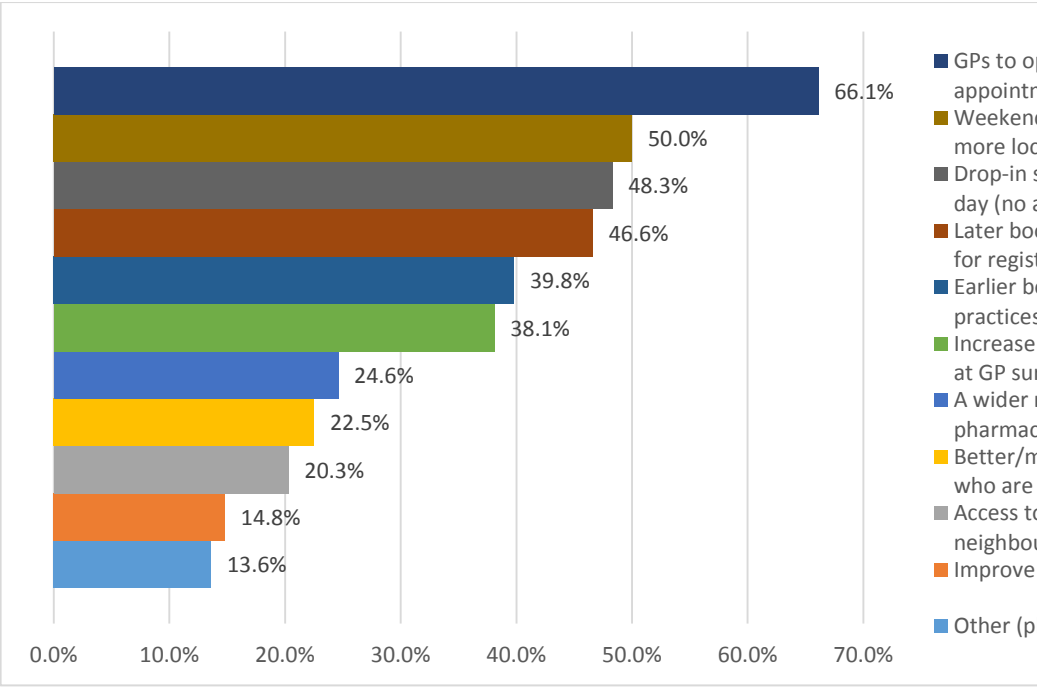
Services that would most improve care in the borough

Question: To continue helping us develop health care in Thurrock, please tick the three services shown below that you think would most improve care in the borough.

The data shows that it was felt that being able to book GP appointments at weekends for registered patients, being able to access a GP or nurse in a variety of locations at weekends, and also being able to access a drop in session at a GP practice during the day were felt to be the top three choices for improving care in Thurrock.



In addition to these three, accessing later and earlier bookable appointments at GP practices for registered patients and increasing the number of urgent appointments at GP surgeries were deemed to be additional services that would improve care in the borough.



Answered Question: 236
Skipped Question: 6
Additional Comments:32

Fewer comments accompanied respondents' answers to this question. The majority of these comments related to access. Other observations focused on collaboration, finance and resources, patient and public involvement, and workforce. These key themes are outlined in more detail below.

Access

Introducing **drop in sessions at GPs surgeries** was suggested by some respondents. Others suggested that GP practices could be replaced by more walk-in services. This was because it was felt, for example, that the service would be faster and that even pre-booked GP appointments still mean waiting a long time in the practice to see the GP. Another suggested reason was that GP surgeries do not have the staff to be able to offer appointments.

"Have a 24 hour NHS walk in service in Grays High Street as there is too much pressure on Basildon A&E at the moment."

Respondents indicated that they would like to see **GP opening times extended to evening and weekend appointments**.

"Close walking centre and spread out this service through-out borough evenly to be fair."

There were comments about the **location** of services and provision of **equal access**. For instance, it was suggested that each locality could have a walk-in service, or that more drop-in centres could be provided using existing surgeries. Having a service that could be closer for people in places such as Tilbury, who are too unwell, are elderly, or have no transport to access the existing walk-in service. Other suggestions included **utilising technology** to improve services, for example through offering online consultations and using telephone triage; expanding existing facilities to be a minor injury unit with 7 day opening and x-ray provision; offering more mental health services for children, a proposal for the walk-in service to

become a mini-hospital and for more GP surgeries with better facilities to meet the needs of the growing population.

Other comments

It was felt by some respondents that more **collaboration** between primary care teams was needed, for instance through better communications between pharmacies and GPs, Pharmacy access to GP IT systems, for GP practice based pharmacists and for GPs to work together in larger practices.

"Better comms between pharmacies and GPs."

There were a range of comments on the issue of **finance and resources**. For instance there was a comment about the cost of implementing options 2 and 3 and whether this would provide the anticipated outcomes; a concern was raised as to whether the money which had been invested to date into the walk-in service might be wasted if it were to close; one respondent suggested there should be more investment to build capacity to meet demands, and there was a suggestion that practices which do not provide adequate access should be penalised.

Comments on **patient and public involvement** included introducing a proposal to introduce fines for missed appointments and increase service user knowledge around missed appointments and expectations of what services are available.

"Fines for missed appointments."

"some of the above are not workable. GPs have paperwork to do and home visits. They can't work 24/7. They have to eat. Saturday opening just brought in the same people every week,"

There were a small number of **workforce** comments around increasing the number of doctors and one respondent felt that GPs already have a large workload and that Saturday opening is creating more demand.

Other suggestions for improving urgent primary care in the borough

Question: Are there other any suggestions you have to improve urgent primary care in the borough?

Answered Question: 109
Skipped Question: 133

The key themes identified in answers to this question were access, quality of services, finance and resources, patient and public involvement, collaboration and the proposed health hubs. More detail from this analysis is outlined below.

Access

A whole range of comments were given as to how services could be changed in order to improve access. **Extending GP opening hours** to evenings and weekends was felt to be important in order to meet the needs of service users who work during the day. There was also a suggestion that a GP service should be permanently based at Orsett Hospital as an out-of-hours service. A number of respondents felt the current **walk-in service** should remain open or even that new ones should be opened because GP surgeries are oversubscribed and it prevents the over loading of A&E services. Other respondents felt that the walk-in service had become too busy and that more staff should be brought in to alleviate this.

"I think service could improve by providing more services or appointments outside office hours for patient who find it difficult to access services due to work commitments."

Improving access to **GP appointments** and reducing **waiting times** were a common suggestion alongside recommendations that **phone triage** or other systems are put in place to ensure urgent cases are seen first, and to direct patients to pharmacy or other primary care services.

"Online engagement (e.g. web chats) as many residents now use smart phones, tablets and computers to engage with services."

Some respondents felt that **existing services should be expanded** to include blood testing, x-rays, minor surgeries and mental health services for children. This could be done through the development of 'cottage' or 'mini-hospitals' or through the development of a 'super surgery' in main towns.

It was felt access could be improved by **using technology** to provide online appointment booking, telephone or video consultations, an online interface for patients to update their symptoms or offer web chats as a means of triaging patients and providing general advice or prescription updates. **Location** of services, with easy and affordable transport links was another factor put forward for consideration.

Quality

The GP and primary care **workforce** received a mixture of comments such as improving GP and practice nurse recruitment and retention in order to meet the growing patient numbers and reduce the use of locum doctors; better training for reception staff and better training for GPs and nurses on issues such as mental health.

"I feel that reception staff should be better trained. They are the 'gate keepers' to the GP and without them listening to you, it can have a negative impact on your GP experience."

One comment

"Use nurse practitioners more giving GPs the time to deal with the patients who have serious illnesses"

suggested that patients should have a designated doctor at their local surgery. Respondents felt that the care currently provided by GPs in the borough is variable with some reporting poor **patient experience** and requesting better services for disabled patients, better involvement of patient participation groups and better communication by healthcare professionals where English was not a first language. The walk-in service received several positive comments around the care provided, although one respondent felt that language needs of patients could be met more effectively as it was felt that a lack of translation support for completing paperwork currently creates a backlog.

Finance & Resources

Respondents felt there could be **better use of resources** through using existing services more effectively, reducing wastage of medicines, utilising pharmacy services and reducing some A&E services because patients have been using the walk-in service instead. Greater i**nvestment in primary care** was proposed as necessary to improve access and GP premises, and there was a suggestion for the walk-in service to screen for overseas patients who should be paying for services.

"Publicise the full range of NHS services available to the public and ensure they know where to go to access the right services"

Patient and& Public Involvement

Comments on patient and public involvement focused on building **service user knowledge** through better communication of the services that are available and when to use them; supporting **self-management** for minor ailments; fining patients who miss appointments, and working with patients and the public with regard to improving services.

Collaboration

Improved **collaborative working** was proposed. For example GPs working together in groups in order to provide existing services more effectively, share running costs and run specialist services; better utilisation of pharmacies and closer working together of primary care teams, community teams and social services.

"Empower the PPG; work collaboratively."

"They should have good transport links, public and private, disabled access, ample parking."

Health Hubs

It was suggested that the **location** of the new health hubs be in central geographical areas e.g. Aveley, have good transport links, disabled access and parking and possibly incorporate other facilities such as food outlets an hairdressers in order to act as a social focal point for the community. **24-hour opening** alternating across the four hubs was suggested by one respondent and a view was expressed to see any savings (should the walk-in service be closed) reinvested in the health hubs so they can offer evening and weekend opening.

5.7 What were the views of those who participated in the public events?

Thurrock CCG held three public events to give Thurrock residents an opportunity to meet with the clinicians, ask questions relating to the proposals for the future of the Walk-in service and familiarise themselves with the data and findings that underpinned them.

The events were held during different times of the day, two of them in the evenings, to allow people with different working patterns the opportunity to attend at least one of them. The events were held in venues that were easily accessible for local people and were suitable for disabled residents.

All three events attracted 102 people in total, with the first event held in Orsett Hall attracting 83 people (for detailed statistics please see 5.1 in this report). Due to the large number of attendees, the format of the first event included table discussions and feedback whilst the last two events allowed around 1.5 hours for Questions & Answers session with the clinicians presenting the proposals and the rationale for them.

Feedback from the public event on 11 February 2015

The feedback gained from the participants at this event is split into two distinct areas relating to the primary care services provided by GPs and the options for the future of the Walk-in service. Both strands of feedback are described below.

Please describe how you would want your GP to provide services for you and your family. How does this compare to GP services that you receive now?

The key themes identified in answers, comments and table discussions to this question were access, communication with patients, continuity of care, educating patients and public and collaboration between different health professionals. More detail from this analysis is outlined below.

Access

Participants from all eight tables commented on the access issues currently experienced in primary care in Thurrock. The feedback reflected the frustration of some participants and their relatives of not being able to get GP appointments when they needed them. Majority of table discussions supported the idea of extended evening and weekend working hours to accommodate patients' working patterns and ensure equal access to GP services. Some participants voiced their concerns that current health services and overall provision does not keep up with the population growth in Thurrock which makes accessing GP care even more challenging. Key improvement recommendations included utilising modern technology and introducing online appointments booking system as well as more effective triage systems to ensure that those with the most pressing need are seen by their GP in a timely fashion.

Communication with patients

Improving the communication with patients was widely discussed on each of the eight tables. There were specific issues that the event participants wanted to see addressed:

- Succinct, clear and easily accessible information about the services available for all patients as well as those with specific conditions

- Better utilisation of the social media and internet to inform, educate and engage with patients
- Support staff to display greater compassion in their interactions with patients, particularly when they want to book an urgent appointment with a nurse or a GP

Participants perceived improved communication as key to reducing the number of appointments that patients did not attend and did not cancel. The participants felt that better communication systems would also ensure that patients access the right service first time improving their experience of using health services.

Educating patients and public

Majority of the table discussions reflected participants' concern about the DNAs statistics (Did Not Attend, this is a term used to describe unused appointments when patients booked an appointment but did not cancel it making it impossible for someone else to use it). The discussions revolved around better communication and building awareness among patients on the impacts of not cancelling the appointments.

Other tables discussed various roles that other health professionals, particularly pharmacist could take in educating the patients and thus reducing their need for accessing a GP. One of the tables indicated that better utilisation of pharmacies could be particularly helpful for improving sexual education among younger population.

The need for more preventative work by all health professionals was discussed by majority of the participants and it was felt that more effort and resources need to be directed to public health issues.

Collaboration between different health professionals

Majority of the participants raised their concerns that GP appointments are not used appropriately and both patients and health professionals need to take responsibility for ensuring that the right service or health professional is accessed each time. Some of these discussions linked with the education and communication themes indicating a close link between these enablers of more effective patient care.

Participants on more than half of the discussion tables would like to see more health professionals working closely together with patient at the centre of their services. This could include sharing GP services and premises to ensure that they are maximised for the patient benefit. Majority of the participants would like to see more diagnostic tests available closer to home, either at their own GP practice or in a shared 'GP hub' facility locally. In addition, participants on one of the tables put forward an idea of creating community hubs that would also include a meeting place for local residents and easy access to charities such as Age UK.

Continuity of care

Participants on two tables raised issues related to the continuity of care offered by GPs. They expressed their preference for being seen and treated by the same GP or a GP from the same practice with easy access to their records. This would improve levels of trust between GPs and patients and enable more preventative work.

The Q&A session was followed by more detailed table discussions among participants and feedback was shared with everyone at the end of the discussions. The key themes of the feedback on each of the options are presented below.

Option 1	Option 2	Option 3
• The Walk-in service does not offer anything different than a GP practice other than longer hours • Perceived as an inefficient service and a duplication • Only utilised by those living in Grays and Tilbury	•Perceived as a 'waste of money' •No advantage of choosing this option	• Emerged as the most supported option through all table discussions • The participants wanted to see opening hours in hubs extended • There is a need to open hubs during the times that services are most needed and used, beyond the weekends • Best option for those who live outside of Grays and offer equal access for all Thurrock residents • 'Only logical option'

In addition to the comments related to specific options for the future of the Walk-in service, some of the participants also pointed out that:

- Transport links need to be carefully considered when choosing specific locations for hubs
- Clear and easily accessible information on services available needs to be provided so those who are not registered with GPs have equal access to health services across Thurrock
- A consideration should be given whether Thurrock Health Centre where the current walk-in service is located could be one of the health hubs

There was a small number of questions that remained unanswered due to the time limitations of the session. Thererofore, the CCG encouraged everyone to share their email addresses to send responses to the unanswered questions after the event. The Q&A sheet was created after the event and sent out to everyone who provided their contact details on 10 March 2015.

Feedback from the public events on 4 and 18 March 2015

Both evening events attracted 19 participants in total and therefore their format was adjusted to a smaller audience. Instead of providing feedback on the future of the walk-in service following table discussions among the participants, an extensive Q&A session was conducted.

Due to the similarity of feedback themes at both events, they have been collated and presented below:

- Access was raised as a key issue and a source of concern for a vast majority of participants; a number of questions and concerns were raised with relation to the equality of access across Thurrock with the current Walk-in service being underutilised by residents not local to it
- The second most talked about topic was around the communication issues and knowing when and where patients can access appropriate services which made them anxious about potentially removing a service that is available seven days a week
- There was a number of questions clarifying the planned locations for hubs, the way the appointments would be organised and whether they will provide some drop in appointments
- There was a wide acknowledgement that the limited funds available need to be utilised in the best possible way and some services are currently duplicated
- There were mixed opinions on the effectiveness and service provided at the current walk-in service with some participants highly valuing it being available whilst others criticised the waiting time and some of the treatment or advice they received there.
- Overall, participants at the event held in Corringham supported Option 3 as their preferred option whilst participants at the event held in Grays were more divided in their opinions; some preferred the option of the walk-in service remaining unchanged whilst others recognised the advantages of moving into the health hubs model.

5.8 Other feedback received

In addition to the feedback received through the questionnaire, the CCG received the following submissions:

- Basildon and Brentwood CCG supported Option 3 to close the walk-in service and invest in four local GP health hubs
- South Essex Local Medical Council (LMC) indicated its support by confirming that after considering the matter the Committee unanimously supported Option 3 on the understanding that the geographical fit of the four “hubs” would increase accessibility for patients of all GP practices in Thurrock
- Commissioning Reference Group verbally expressed their support for Option 3
- Jackie Doyle-Price, MP for Thurrock publicly expressed her support for Option 3
- Email submission from Polly Billington, Labour parliamentary candidate expressing her opposition to the option 3 of closing the walk-in service
- Email submission on behalf of Cllr Tim Aker, MEP and UKiP parliamentary candidate expressing his opposition to the option of closing the walk-in service

5.9 Summary of key feedback themes

In summary, the feedback on the proposed three options for the future of the walk-in service indicates that:

- The majority of those who took part in the consultation through participating in the events, completing the questionnaire and submitting their views, did not support Option 2 for the future of the walk-in service

- Those who provided their opinion through the questionnaire and email submissions (251) were more supportive of Option 1 than Option 3
- A vast majority of those who attended events organised by the CCG (102) were supportive of Option 3.

Analysis of the qualitative data from the completed questionnaires has highlighted a range of key themes of which **access** has been by far the greatest concern. Many respondents expressed frustration with the difficulties of getting routine and urgent GP appointments and some concerns were raised about the length of waiting times at local GP practices.

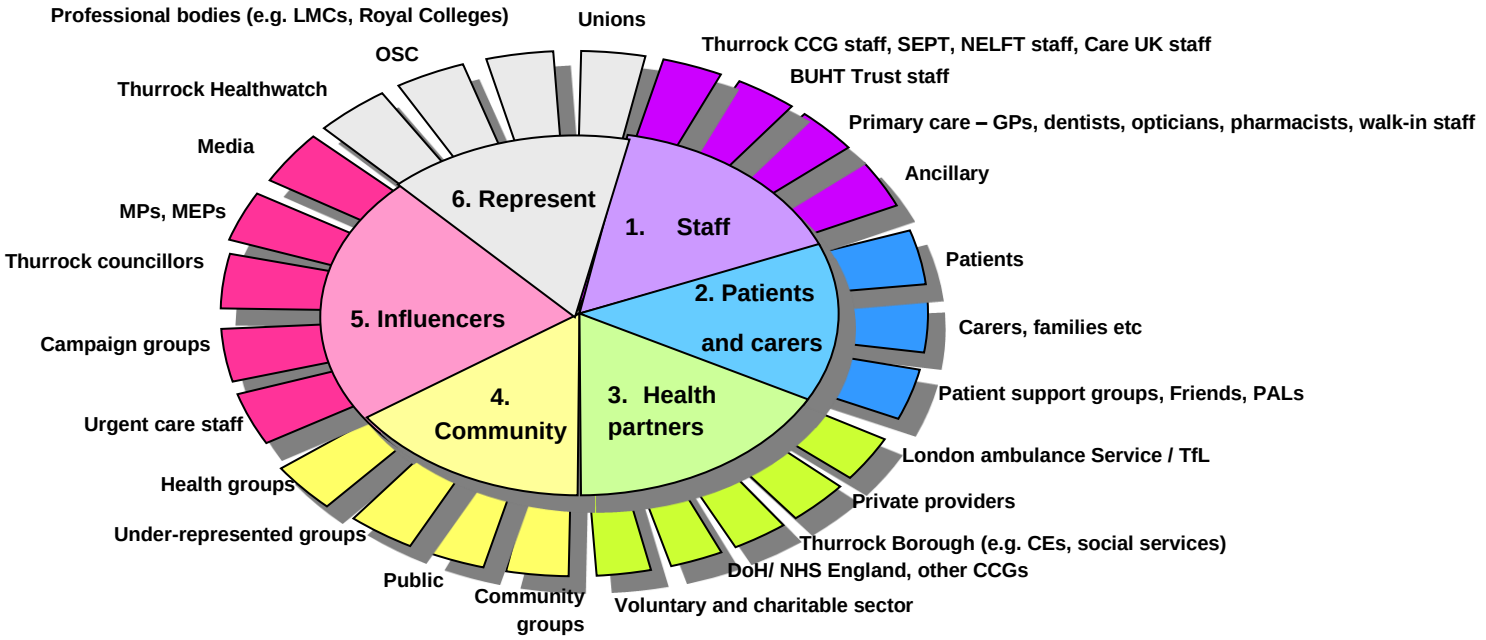
Multiple comments encapsulated a desire to see GP opening hours extended to evenings and weekends in order to accommodate service users who work during the week and to reduce the need to access other urgent care services as an alternative point of contact. Respondents indicated that they felt that the current walk-in service was an assured means of accessing a healthcare professional when they needed it.

Having equal access to services, in terms of where services are located, the distance that needs to be travelled and the availability of public transport generated comments from respondents. Having a consistent approach to booking appointments was also advocated along with an interest in seeing better utilisation of technology.

Appendix A

Stakeholder framework

This stakeholder framework details the communications and engagement responsibilities of Thurrock CCG as presented to the Health Overview and Scrutiny Committee on 13 January 2013.



Stakeholder engagement plan

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
1. NHS staff, internal stakeholders e.g: Includes: • College Health group • Thurrock Walk-in Centre • Thurrock CCG • North East London Foundation Trust staff • SEPT staff • BUHT staff • EEAST staff • Care UK staff • GPs • GP practice managers and staff • SEEDs • Other Clinical Commissioning Groups • Community pharmacists • Other staff working at the same location • NEL CSU	• to develop NHS staff as potential ambassadors and drivers for change • to ensure awareness of the aims of the consultation • to ask staff their views in order to inform our understanding and to improve and develop the proposals • to enable staff to understand the impact of any proposals on their roles or professional groups, and what it means for them – and help allay any fears about their jobs and future careers	• Develop proposals in partnership • Draft letters/emails to keep informed • Emails and links to consultation website • Make formal proposal document available • Produce information for staff briefings and articles in stakeholders newsletters • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above As above End of consultation	Y Y Y Y Y
2. Patients/carers Includes: • patients/carers with experience of walk-in	• to ensure awareness of the aims of the consultation and ask people to respond to the consultation • to explain the benefits and issues around quality,	• Develop proposals in partnership • Draft letters/emails to keep informed • Emails and links to consultation website	Ongoing Start of consultation and throughout	Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
services • patients using the location to access other services (e.g. GP patients) • people with a long-term conditions • people with mental health problems or dementia • PALS and Friends • patient groups • carers of patients	equalities, travel, patient pathways • to be open and create understanding • to provide reassurance of the NHS commitment to clinical quality and patient care • to encourage informed debate • to understand the needs of patients • to help prevent ill health and improve the health of residents	• make formal proposal document available • Public drop-in event for Thurrock-based patients and carers • Media releases • Leaflet door drop • Newspaper advertising • Communicate to all following decision	consultation As above As above As above As above As above As above End consultation	 Y Y Y Y Y Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
3. Health and related partners Includes: • Dept of Health; NHS England; other CCGs – in particular Basildon and Brentwood • Health and Wellbeing Board • Thurrock Council • London Ambulance Service • local partnerships; groups/boards • private providers • Voluntary groups – especially associated with the locations	• as section 2, plus: • to ensure any impacts on health partners are fully explored • to utilise specialist knowledge of issues and opportunities • to ensure synergy with partners' developments and announcements	• Develop proposals in partnership • Draft letters/emails to keep informed • produce information for staff briefings and articles in stakeholders newsletters • emails and links to consultation website • encourage local organisations to create and publicise a link from their website home page to website and include information in their publications • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above End consultation	Y Y Y Y
4. Community • public • community groups e.g. schools, faith communities and leaders, residents associations, • traditionally excluded groups • health groups	• as section 2, plus: • to build trust in the Trust and the NHS as effective caretakers of the health of local population • for the community to understand how the NHS works and the services on offer • to understand the needs of residents	• develop proposals in partnership • Draft letters/emails to keep informed • emails and links to consultation website • make formal proposal document availablemedia releases • Leaflet door drop • Newspaper advertising	Ongoing Start of consultation and throughout consultation As above Throughout consultation	Y Y Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
		• Communicate to all following decision	Start and end of consultation End of consultation	Y Y
5. Influencers • MPs Media Councillors	• as section 2, plus: • to listen to their views • to facilitate influencers in providing reliable information to constituents	• develop proposals in partnership • Draft letters/emails to keep informed • distribute copies of proposals, but face-to-face meetings are key for this audience: one-to-one meetings or roundtable discussions • media releases • press advertisements • Communicate to all following decision	Ongoing Start of consultation and throughout consultation Start and end of consultation Start and end of consultation End of consultation	Y Y Y Y Y

Audience	Communication objectives	Communication activities	Timescale	Completed Y/N
6. Representatives • HOSCs • Local Medical Committees • Thurrock Healthwatch • Unions • professional bodies / royal colleges	• as section 2, plus: • to provide information as required under the NHS Act (OSCs) • receive independent endorsement for proposals and thereby reassure relevant audiences • to receive critical challenge and objective examination	• develop proposals in partnership where appropriate • distribute proposals, but face-to-face meetings are key for this audience • presentations • respond to OSC/ submission • Communicate to all following decision	Ongoing Start of consultation and throughout consultation Ongoing TBA Start and end of consultation	Y Y Y Y Y

Appendix B

Profile of Respondents

The consultation questionnaire asked respondents about their:

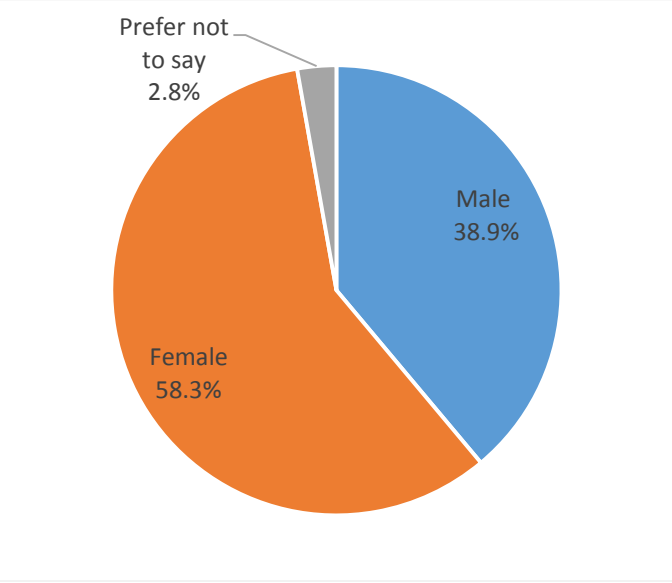
- gender
- age
- ethnic background
- whether they considered themselves to have disability
- whether they are employed by the NHS
- which religion or belief they most identified with
- whether they were responding in a group or personal capacity
- and whether they are a service user, carer or local resident.

Where possible, the profile of respondents was compared to the known profile of users of the walk-in service. This comparison showed that **whilst the gender of respondents does appear to reflect the users of the walk-in service, the age and ethnic background of respondents does not appear to fully resemble that of the users of the service**.

Answered Question: 216
Skipped Question: 26

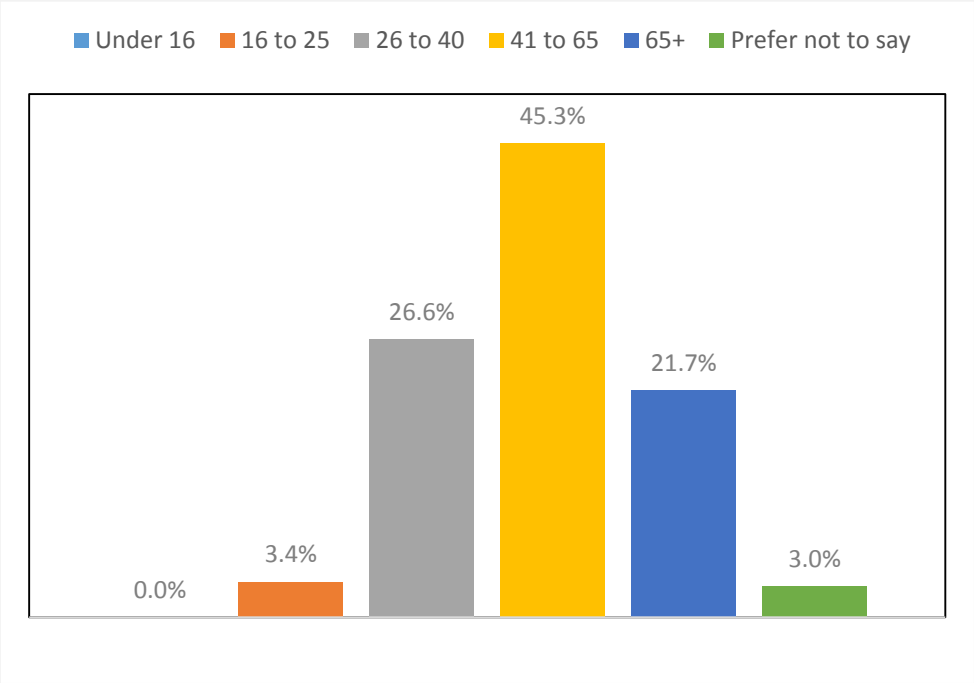
Gender of respondents

The respondents of the questionnaire were primarily female (58.3%), a further 38.9% were male with the remaining 2.8% of the respondents preferring not to specify a gender. A one month snap shot view of patients attending the walk-in centre in May 2014 indicated that 58% of the patients were female. Therefore the gender of respondents to the questionnaire appears to reflect the users of the walk-in service.



Age of respondents

Nearly half of the respondents (45.3%) fell into the 41-65 age group. The next largest age group was 26-40 (26.6%) followed by the over-65s (21.7%). It is worth noting that a snapshot analysis of the age of users of the walk-in service has indicated that, whilst most users of the service fall into the 19-50 age group, only 14% of users are aged 41-60, and only 5% of users are over 61[3]. This would therefore suggest that the age of the respondents may not reflect the age of the users of the walk-in service.



Answered Question: 203
Skipped Question: 39

Ethnic background of respondents

The ethnic background of respondents was principally given as White British (80.2%) with Black British (2.5%) and Indian (2.5%) as the next largest groups. Any other White background was 2.0% with Asian British (1.5%) and Pakistani (1.5%) both having the same number of respondents. White Irish and Black African respondents each reached 1.0% of the total number. There were 0.5% of respondents each from Any other Asian background, Any other ethnic group, Black Caribbean, White and Black African and White and Black Caribbean. A number of ethnic groups had no respondents, and 5.4% of respondents preferred not to say.

Ethnic data of the users of the walk-in service[4] indicated that 39% of respondents gave their ethnicity as White British with Mixed British as the next most common ethnicity (6%). This would indicate that the ethnic breakdown of respondents does not reflect the ethnic breakdown of users of the walk-in service.

Answered Question: 202
Skipped Question: 40

Answer Options	Response %	Response Count

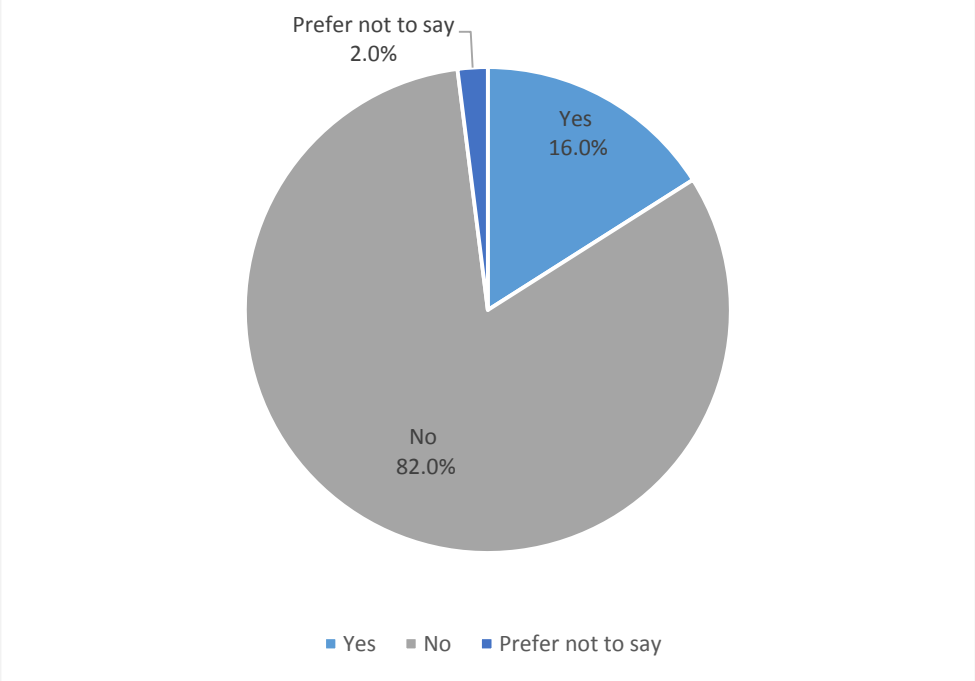
[3] Based on a one-month snapshot view of patients attending the walk-in service in May 2014. Different age group categories were used in the snapshot audit which limits the level of direct comparison.
[4] Based on a one-month snapshot view of patients attending the walk-in service in May 2014.

White British	80.2%	162
Prefer not to say	5.4%	11
Black British	2.5%	5
Indian	2.5%	5
Any other White background	2.0%	4
Asian British	1.5%	3
Pakistani	1.5%	3
Black African	1.0%	2
White Irish	1.0%	2
Any other Asian background	0.5%	1
Any other ethnic group	0.5%	1
Black Caribbean	0.5%	1
White and Black African	0.5%	1
White and Black Caribbean	0.5%	1
Any other Black background	0.0%	0
Bangladeshi	0.0%	0
Chinese	0.0%	0
White and Asian	0.0%	0

Answered Question: 200
Skipped Question: 42

Respondents with a disability

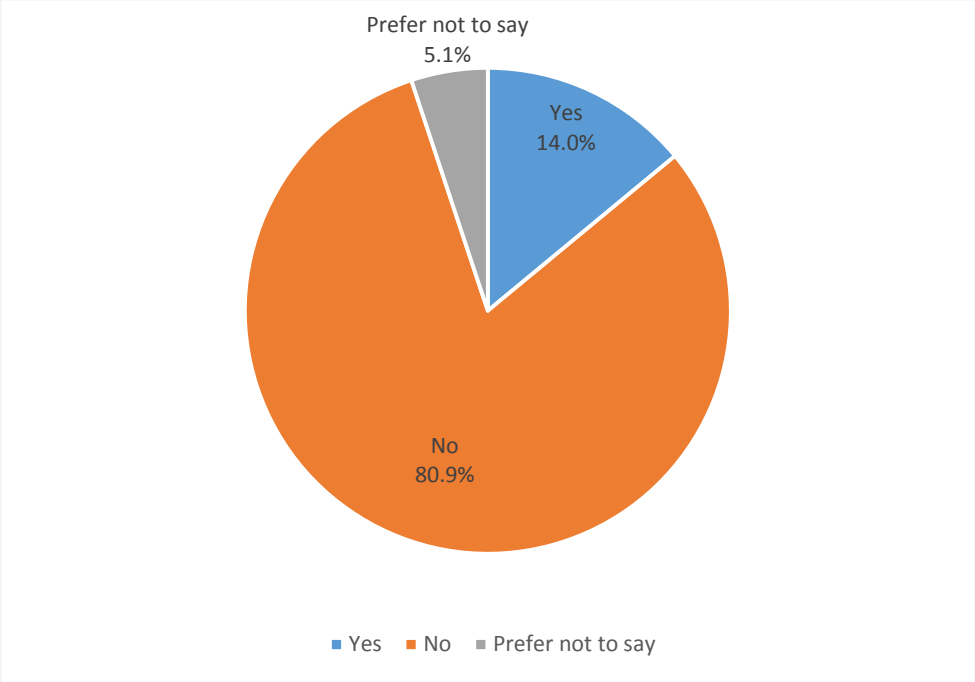
The number of respondents who confirmed that they consider themselves to have a disability was 16.0%; while 82.0% respondents did not have a disability, and 2% of respondents preferred not to say.



Respondents Employed by the NHS

Answered Question: 215
Skipped Question: 27

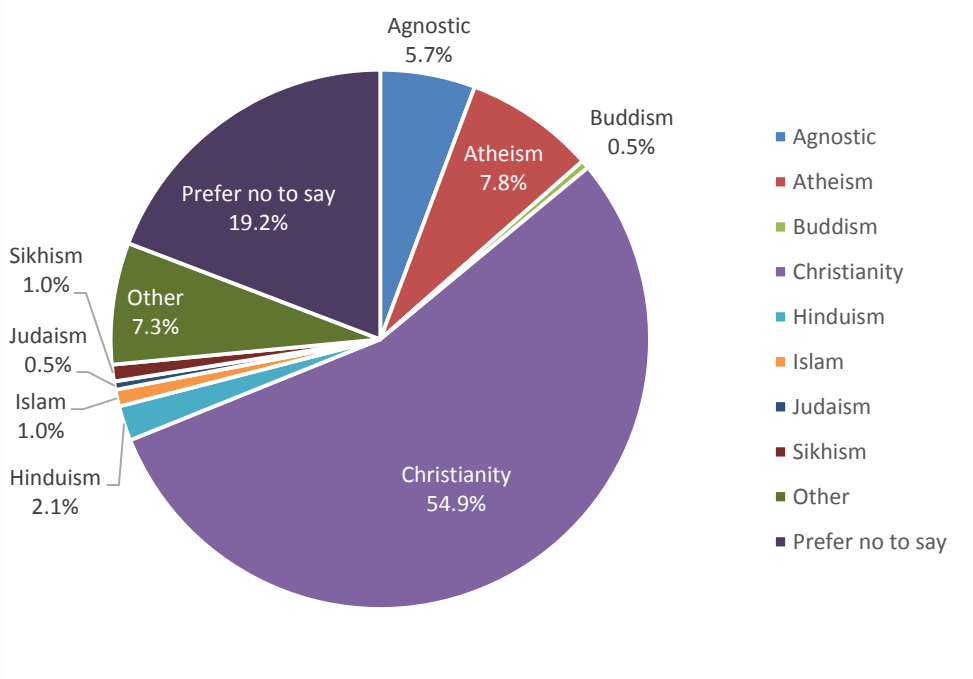
Of the members of the public who completed the consultation questionnaire, 80.9% of respondents were not employed by the NHS; there were 14% who confirmed that they were, and 5.1% preferred not to say.



Religion or Belief of Respondents

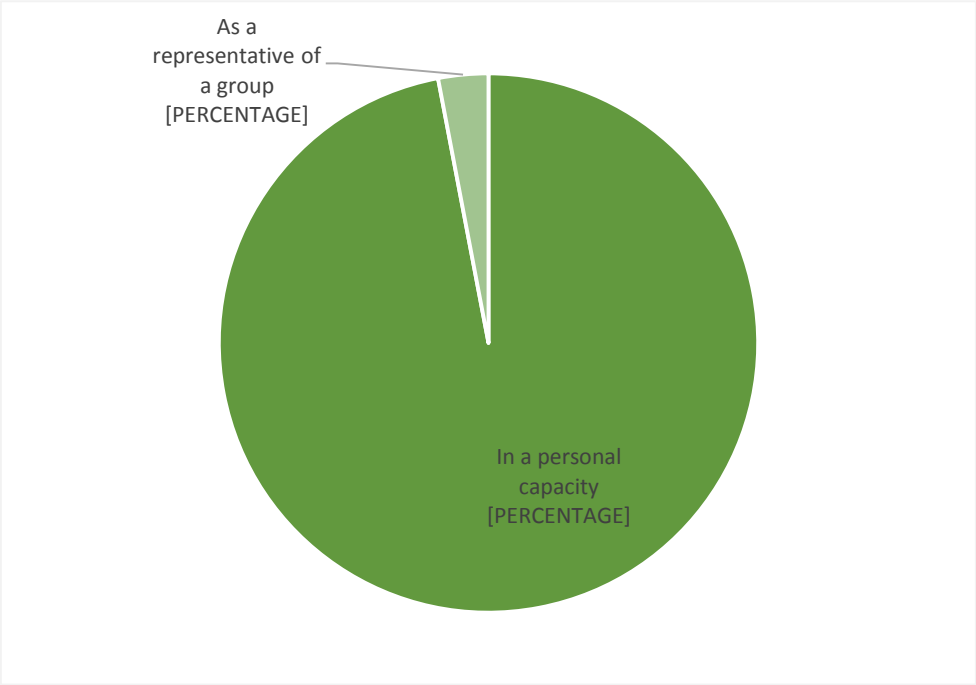
Answered Question: 193
Skipped Question: 49

The religion or belief which respondents most identified themselves with was just over half Christian (54.9%) followed by Atheism (7.8%) and Other (7.3%). The remaining religions represented 10.8% of respondents. Nearly a fifth of people preferred not to say.



Responding in a personal or group capacity

Answered Question: 236
Skipped Question: 6



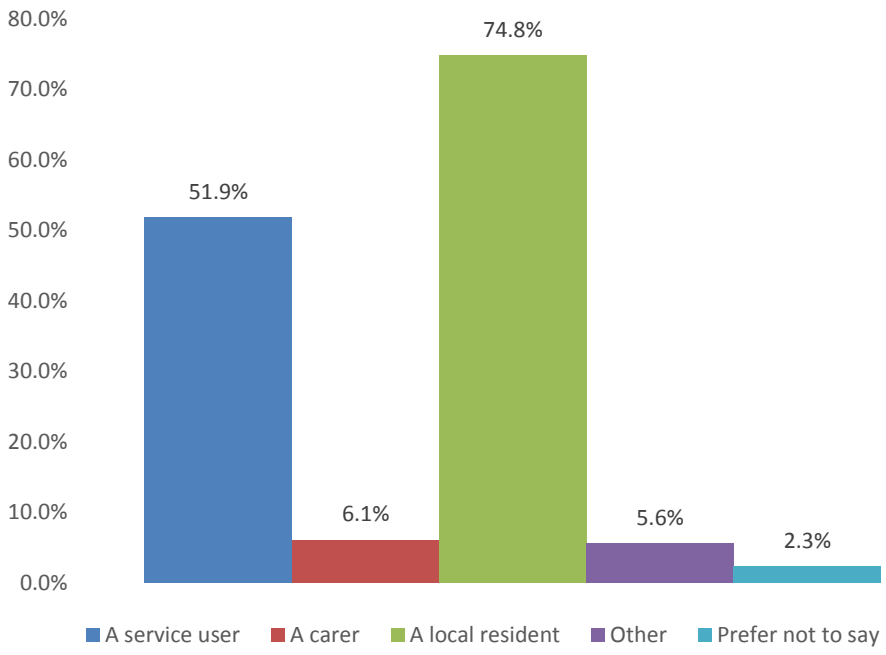
Respondents were asked to confirm whether they were responding to the questionnaire in a personal capacity or as part of a group. The majority of respondents (97%) answered the questions in a personal capacity. 3% of respondents stated that they were representing a group, however two of these group respondents suggested that they were responding on behalf of patients or people they have spoken to without clarifying whether they were members of a recognised patient organisation.

The other group respondents indicated that the respective organisations they represented were the Thurrock Over Fifties Forum (TOFF), the Hassengate Medical Centre, the Thurrock Health Centre and the Chafford Hundred Local Authority.

Service user, carer, or local resident

Answered Question: 214
Skipped Question: 28

Respondents were invited to tick all of the options that applied to them. Therefore more than one answer may have been selected. The data shows that 74.8% or respondents were local residents but **only just over half (51.9%) were also service users**. 6.1% were carers, 5.6% were other, and 2.3% preferred not to say.



28 July 2015	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
Success Regime	
Wards and communities affected: All	**Key Decision:** Note the introduction of the regime
Report of: Mandy Ansell (Acting) Interim Accountable Officer – NHS Thurrock Clinical Commissioning Group	
Accountable Head of Service: Mandy Ansell (Acting) Interim Accountable Officer – NHS Thurrock Clinical Commissioning Group	
Accountable Director: Mandy Ansell (Acting) Interim Accountable Officer – NHS Thurrock Clinical Commissioning Group	
This report is Public	

Executive Summary

The Essex health and care economy has been selected for the first wave of the newly announced *Success Regime for the* following reasons:

- The operational and quality challenges which present risks to clinical sustainability;
- The financial sustainability challenges across the local health economy;
- The limited success with previous strategic interventions to improve services;
- The workforce challenges across primary and secondary care in the local health economy; and
- The benefit to be gained from using new models of care to deliver services.

The intention is to create a new regime for the most challenged local health and care economies was first set out in the *NHS Five Year Forward View* and is explained further in the joint planning guidance for 2015/16. The aim is to change the way that the system provides challenge and support to local leaders in order to address long-standing and often deep-rooted issues which are affecting the quality and sustainability of services for patients and the public. Unlike previous interventions, this regime will be jointly overseen by our three organisations, NHS England, Monitor and the NHS Trust Development Authority (TDA) at both a regional and a national level. It will focus on whole health and care systems and systemic issues as opposed to individual organisations, and the intention is to continue to work with the selected localities until the solutions to the challenges that we are all facing can be successfully implemented by local leaders.

In doing so, we will build on work carried out as part of the Challenged Local Health Economies (note Mid Essex has been part of this programme) initiative last year. There will also be close links to the Vanguards programme, and thought should be given as to whether any of the new care models set out in the Forward View might be part of the solution to the particular challenges in Essex.

Whilst the regime represents an opportunity to transform the way in which the health economy operates, the process will inevitably be challenging for colleagues. Essex has been working hard to improve the quality and sustainability of the health and care economy, but the necessary scale of improvement has not been made which is why we all need to do something different. The system needs to be clear up-front that, as well as support, we will also be offering considerable challenge and, if necessary, direction. But throughout the process the aim is to support the development of local leaders so that the Essex health and care economy is stronger as a result of having been in the regime, and able to sustain the improvements made for local people.

The regional directors will be in touch shortly to take forward next steps, an important part of which will be the appointment of a Programme Director who will oversee the Success Regime in the Essex local health economy. Initial work will determine the work programme within the Essex local health economy, and the degree of involvement of Thurrock in the regime. It is important to note that Thurrock CCG's regulatory status is not changed as a result of this regime and it is still the CCG's responsibility to deliver the regulatory requirements.

1. Recommendation(s)

1.1 The Health Overview and Scrutiny Committee is asked to note the introduction of the regime and any implications that emerge for Thurrock.

2. Introduction and Background

2.1 Work with some of the most challenged health and care economies will start now. The first sites to enter the regime have been chosen by the regional directors from NHS England, Monitor and NHS Trust Development Authority (TDA), and approved by the Board of the seven Chief Executives of the national bodies. Selection decisions have been informed by quantitative – for example, quality metrics and financial performance – and qualitative information.

The attached documents set out the framework for the Success Regimes, these being:

FIVE YEAR FORWARD VIEW
The Success Regime:
A whole systems intervention and

FIVE YEAR
FORWARD VIEW
The Success Regime: A whole systems intervention
The First Health and Care Economies (Annex)

At the time of writing this paper the system is waiting for the announcement of the lead organisation and the appointment of the Project Director. It is expected that once these have been announced a diagnostic phase will commence.

3. Issues, Options and Analysis of Options

3.1 It should be noted that organisations are expected to continue with "business as usual" and therefore the work of the CCG and that which is undertaken through our collaborative arrangements with the Council, including the Better Care Fund, will continue as planned.

4. Reasons for Recommendation

4.1 This is a national directive.

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

5.1 None as a direct result of this intuitive at the time of writing. Consultation events including routine patient participation and engagement will continue as currently embedded in the CCG's constitution.

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

6.1 N/A

7. Implications

7.1 Financial

The implications for the Thurrock Health and Social Care economy will emerge following the diagnostic phase it is anticipated.

7.2 Legal

NA

7.3 Diversity and Equality

No adverse implications anticipated

8. Background papers used in preparing the report

NA

9. Appendices to the report

FIVE YEAR FORWARD VIEW
The Success Regime:

A whole systems intervention and

FIVE YEAR
FORWARD VIEW
The Success Regime: A whole systems intervention
The First Health and Care Economies (Annex)

FIVE YEAR FORWARD VIEW

The Success Regime: A whole systems intervention

3 June 2015

Background

The *NHS Five Year Forward View*[1] sets out the challenges facing the health and care system over the next 5 years, characterised by three gaps which must be closed if the health and care system is to continue to meet the expectations of patients and the public in a sustainable way:

- **The health and wellbeing gap:** if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.
- **The care and quality gap:** unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- **The funding and efficiency gap:** if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

But the Forward View also sets out a vision for how the health and care systems can rise to this challenge, through working differently with patients and the public; through a greater focus on health and prevention; working to clear national quality standards; and changing the way in which services are commissioned and delivered to patients. The scale of this challenge should not be underestimated, and in order to succeed large parts of the health and care system will have to change the way in which they work.

In some health and care economies, the conditions necessary to allow these new ways of working already exist, and the Vanguards programme is working with such localities which are able to forge ahead and start to implement new care models. But there are a number of challenged local health and care systems in which these conditions do not exist, where the quality of care commissioned and provided to patients requires improvement; where services do not meet the expectations of the public, as enshrined in the NHS Constitution; or where the cost of providing services is greater than the financial resources available, meaning that there are sustainability risks in the medium and long-term.

The problems in these health and care economies are often deep-rooted, long-standing, and spread across the whole system as opposed to individual organisations. Local and national organisations may have worked hard for some time to improve services for patients and the public, but not made the required progress. Transformation is therefore now required, and this will only be achieved if national and local leaders take

[1] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

a different approach to those taken previously, which have not yet delivered the expected improvements for patients and the public.

The Forward View signalled the intention by the national bodies to introduce a new regime to address these issues, and create the conditions for success in the most challenged health and care economies: the 'Success Regime'. This new regime will represent a change in approach to providing support and challenge to local systems. The Success Regime:

- Will be overseen jointly by NHS England, Monitor and the NHS Trust Development Authority, working closely with the Care Quality Commission;
- Will **work across whole health and care economies** – with providers, commissioners and local authorities – **and address systemic issues** as opposed to merely focusing on individual organisations;
- Will provide the necessary support and challenge to health and care economies through from **diagnosing** the problems, identifying the changes required and **implementing** these changes;
- Will seek to strengthen **local leadership capacity and capability**, with a particular focus supporting transformation and developing collaborative system leadership;
- Has a direct link to the **new care models** work of the Five Year Forward View, and will consider whether the application of the new care models may form part of the solution for the selected health and care economies.

The regime will require the national bodies to ensure that any interventions in the selected health and care economies are aligned and contributing to improvement and sustainability of the whole system. It will involve a different way of working amongst local leaders but also for the national bodies in order to address the deep-rooted, often long-standing issues which are affecting the health and care of patients and the public in certain health economies.

How the Success Regime will work

The aim of the Success Regime is to provide increased support and direction to the most challenged systems in order to secure improvement in three main areas:

- **Short-term improvement** against agreed quality, performance or financial metrics;
- **Medium and longer-term transformation**, including the application of new care models where applicable;
- **Developing leadership** capacity and capability across the health system.

In particular, the regime will seek to create the conditions for the successful transformation of the health and care economy as set out in the 2015/16 planning

guidance. These conditions include: stable, ambitious collective leadership; collaborative working across partners; strong patient, community and clinical engagement; strong or improving operational and financial performance, and a strong out of hospital system.

In order to achieve this, the regime will work to a consistent nationally-defined approach which can be tailored to each set of local circumstances. This will include:

- **Collective governance arrangements** for oversight of the regime locally, led by regional directors from NHS England, Monitor and the NHS TDA. Where necessary and appropriate, this may include changing the relationship between oversight bodies and their respective local organisations, for example by increasing levels of escalation. Existing intervention and change processes will continue and be aligned with the Success Regime as appropriate. The Success Regime in itself will not alter the regulatory status of organisations, and accountability for statutory duties will remain with their boards.
- **The deployment of a senior leader to the role of Programme Director** to oversee action by the local health and care economy, managing the implementation of the regime locally on the collective behalf of the three regional directors, working closely with local leaders to agree responsibilities and accountabilities for agreed actions.
- The undertaking as the first stage of the regime of **a single, holistic diagnosis** of the performance, strategy and leadership issues facing the health and care economy, leading to the development of a specific plan for improvement during the regime and clear 'exit criteria' for the local health and care economy. This will be developed with the local health and care economy and build on existing work where this has previously been undertaken;
- The development in light of the diagnostic process of **a set of interventions and support** for the local health and care economy to secure the delivery of the transformation plan. This is likely to include both stronger direction and access to a range of support for the health and care economy. As part of this process, the potential application of the new care models outlined in the Five Year Forward View will be considered as a way to enable improvement.
- Consideration by the three national bodies as to whether **an alternative approach to the way in which they oversee individual organisations** and health and care economies would aid transformation. For example, setting a multi-year financial control total for a locality as opposed to purely managing the finances of individual organisations across a single financial year.
- The progression of the regime to a clear and agreed timeline for each phase of work. As local health and care economies demonstrate the capacity and capability to successfully deliver the transformation plans, the levels of challenge, support and oversight of the national bodies may be tapered

culminating in a decision that the health and care economy should exit the regime.

The operation of the regime will always require action from:

- NHS England, through its relationship with Clinical Commissioning Groups, and where relevant as the direct commissioner of services;
- Monitor, as the regulator of NHS Foundation Trusts, unless there are no FTs in the relevant health and care economy; and
- The NHS Trust Development Authority, as the overseer of NHS trusts, unless there are no NHS trusts in the relevant health and care economy.

The regime will be overseen by the relevant regional directors of Monitor, the NHS TDA and NHS England, acting in concert and drawing in partner organisations as required. While the regime will operate to a consistent national framework (as outlined above), detailed decisions on the scope and objectives of the regime and the specific interventions and support deployed in each health and care economy will be taken at regional level. The day-to-day oversight of the regime will also sit at regional level. As part of the Forward View, the regime will ultimately report to the Board of the seven Chief Executives.

In addition, the operation of the regime will normally involve the Local Government Association, the Care Quality Commission, Health Education England, Public Health England and NICE given their important links with local systems. Other bodies such as professional regulators and membership bodies may be drawn into the regime depending on the local circumstances. The involvement of more successful local organisations may also be required, and whilst they may not experience the same level of intervention as other organisations, their contribution to any local solutions will be key.

Most importantly, the regime will require and support leaders within the selected areas to think differently about the challenges they face in order to tackle the issues which have characterised the selected health economies. The national bodies commit to supporting and enabling transformational change because we believe that in these areas such challenges have been left unaddressed for too long. The new care models offer one important set of opportunities to improve care, but whatever the changes required in local health economies, we are determined to seek them out and make them happen through this regime. The engagement of patients, staff and stakeholders in each local health and care economy will be vital.

As with the broader work of the Five Year Forward View, it is important that we engage with the wider health and care system in order to meet the challenges that we face. To support the national bodies with this work, NHS Providers, the NHS Confederation and NHS Clinical Commissioners will lead a design workshop with providers and

commissioners in order to ensure that their ideas help to shape the way in which the regime is implemented.

Relationship with previous and existing interventions

The design and operation of the regime seeks to draw on previous and existing interventions to address challenges at both organisational and system level. There is much to be learnt from these other interventions and a clear need to ensure alignment between different approaches. However, the approach taken through this regime needs to be very different to those taken previously, in order for the result to be different. The table below summarises the ways in which the Success Regime builds on previous interventions, as well as clarifying how the new regime is distinct.

	How it is relevant to the Success Regime	**How it is distinct from the Success Regime**
Planning support for 11 challenged health economies	The planning support provided to 11 systems in early 2014/15 was overseen by the tripartite bodies acting collectively and focused on whole health economies, providing clear parallels with the approach envisaged for the Success Regime. Where the selected sites for the regime were also involved with the Challenged Local Health Economies work, the regime will be able to build on any resulting analysis and plans.	The challenged LHE process provided support rather than intervention, whereas the Success Regime combines support and intervention. The challenged LHE process focused on strategic plans for local health systems, whereas the focus of the Success Regime is more holistic.
Special Measures for NHS trusts and NHS Foundation Trusts	The special measures process combines increased scrutiny and increased support for organisations in order to secure improvement against an agreed quality improvement plan. This mirrors the approach intended for whole health economies as part of the Success Regime.	Special measures is a time-limited process that applies to individual provider organisations, focuses in particular on improvement in the quality of services. The Success Regime which will focus on whole health and care economies and will seek more holistic improvement, focusing explicitly on local leadership development.

	How it is relevant to the Success Regime	How it is distinct from the Success Regime
Trust Special Administration	The TSA process seeks to create a sustainable future for currently challenged organisations and systems, appraising options and making recommendations for future direction in consultation with key local partners. Similar processes are likely to be required for successful strategic planning as part of the Success Regime.	Unlike the TSA process, the Success Regime is not statutorily defined and can therefore be tailored to local circumstances more flexibly. In addition, the Success Regime will work across health economies whereas the TSA process seeks specifically to address the challenges at a single provider organisation.
Contingency Planning process	The contingency planning process, and related approaches to reviewing the sustainability of particular health systems, have many of the same objectives of the TSA regime, but operate without statutory constraints. Like the TSA regime, there are many parallels between the contingency planning process and elements of the Success Regime.	The contingency planning process has tended to focus on individual organisations within the context of their health systems, whereas the focus of the Success Regime is more holistic. Contingency planning and similar processes have tended to be overseen by one of the national bodies, whereas the Success Regime will be collectively overseen by all relevant national bodies working collectively.
CCG Assurance	NHS England provides different levels of support and intervention to CCGs informed by an assessment of the capacity and capability of a CCG to carry out its functions. Where there is insufficient assurance regarding a CCG, NHS England works with it to make the necessary improvements within an agreed timeframe.	The CCG assurance process and associated interventions relate to individual CCGs. It is overseen by NHS England and involves the use of NHS England's statutory powers. The Success Regime will be jointly overseen by the national bodies and will focus on commissioners, providers and other stakeholders in a defined area. Whilst the statutory powers of the national bodies may be used during the course of the regime, the regime itself is not statutorily defined.

In addition to the areas outlined above, there are a range of other potential processes that may be underway in particular health economies, including support for Better Care Fund planning, support or intervention on particular performance issues, and reviews of individual organisations or services. It is possible for the Success Regime to be

implemented in areas where a range of interventions are already in place, but it will be important in such cases to align these processes with the Success Regime. The range and nature of interventions already taking place in particular health economies will be one of the factors considered in determining the best areas for operating the Success Regime.

One of the most important links that the Success Regime will have is with the Vanguards programme as part of the Five Year Forward View. Whilst the starting point for the health and care economies selected for each of these programmes may be different, the ultimate aim is the same: to improve the quality and sustainability of services for patients and the public. The two programmes will therefore work closely together, for example, joint support may be commissioned for both Success Regime and Vanguard sites, and peer support arrangements established to ensure that any relevant learning is shared.

In summary, the Success Regime is distinct from the current processes available for providing support and direction in the following areas:

- It provides the first nationally consistent approaching to intervention at the health economy level since the new system arrangement came into effect in 2012;
- It focuses on the full range of systemic problems addressing whole health economies rather than focusing on particular issues or particular organisations;
- It seeks to strengthen local leadership and create the conditions for future change, with a particular focus on developing collaborative system leadership and delivering transformational change; and
- It has an explicit focus on testing the potential application of the new care models set out in the Five Year Forward View to the most challenged systems.

This page is intentionally left blank

FIVE YEAR FORWARD VIEW

The Success Regime: A whole systems intervention

3 June 2015

Background

The *NHS Five Year Forward View*[1] sets out the challenges facing the health and care system over the next 5 years, characterised by three gaps which must be closed if the health and care system is to continue to meet the expectations of patients and the public in a sustainable way:

- **The health and wellbeing gap:** if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.
- **The care and quality gap:** unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- **The funding and efficiency gap:** if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

But the Forward View also sets out a vision for how the health and care systems can rise to this challenge, through working differently with patients and the public; through a greater focus on health and prevention; working to clear national quality standards; and changing the way in which services are commissioned and delivered to patients. The scale of this challenge should not be underestimated, and in order to succeed large parts of the health and care system will have to change the way in which they work.

In some health and care economies, the conditions necessary to allow these new ways of working already exist, and the Vanguards programme is working with such localities which are able to forge ahead and start to implement new care models. But there are a number of challenged local health and care systems in which these conditions do not exist, where the quality of care commissioned and provided to patients requires improvement; where services do not meet the expectations of the public, as enshrined in the NHS Constitution; or where the cost of providing services is greater than the financial resources available, meaning that there are sustainability risks in the medium and long-term.

The problems in these health and care economies are often deep-rooted, long-standing, and spread across the whole system as opposed to individual organisations. Local and national organisations may have worked hard for some time to improve services for patients and the public, but not made the required progress. Transformation is therefore now required, and this will only be achieved if national and local leaders take

[1] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

a different approach to those taken previously, which have not yet delivered the expected improvements for patients and the public.

The Forward View signalled the intention by the national bodies to introduce a new regime to address these issues, and create the conditions for success in the most challenged health and care economies: the 'Success Regime'. This new regime will represent a change in approach to providing support and challenge to local systems. The Success Regime:

- Will be overseen jointly by NHS England, Monitor and the NHS Trust Development Authority, working closely with the Care Quality Commission;
- Will **work across whole health and care economies** – with providers, commissioners and local authorities – **and address systemic issues** as opposed to merely focusing on individual organisations;
- Will provide the necessary support and challenge to health and care economies through from **diagnosing** the problems, identifying the changes required and **implementing** these changes;
- Will seek to strengthen **local leadership capacity and capability**, with a particular focus supporting transformation and developing collaborative system leadership;
- Has a direct link to the **new care models** work of the Five Year Forward View, and will consider whether the application of the new care models may form part of the solution for the selected health and care economies.

The regime will require the national bodies to ensure that any interventions in the selected health and care economies are aligned and contributing to improvement and sustainability of the whole system. It will involve a different way of working amongst local leaders but also for the national bodies in order to address the deep-rooted, often long-standing issues which are affecting the health and care of patients and the public in certain health economies.

How the Success Regime will work

The aim of the Success Regime is to provide increased support and direction to the most challenged systems in order to secure improvement in three main areas:

- **Short-term improvement** against agreed quality, performance or financial metrics;
- **Medium and longer-term transformation**, including the application of new care models where applicable;
- **Developing leadership** capacity and capability across the health system.

In particular, the regime will seek to create the conditions for the successful transformation of the health and care economy as set out in the 2015/16 planning

guidance. These conditions include: stable, ambitious collective leadership; collaborative working across partners; strong patient, community and clinical engagement; strong or improving operational and financial performance, and a strong out of hospital system.

In order to achieve this, the regime will work to a consistent nationally-defined approach which can be tailored to each set of local circumstances. This will include:

- **Collective governance arrangements** for oversight of the regime locally, led by regional directors from NHS England, Monitor and the NHS TDA. Where necessary and appropriate, this may include changing the relationship between oversight bodies and their respective local organisations, for example by increasing levels of escalation. Existing intervention and change processes will continue and be aligned with the Success Regime as appropriate. The Success Regime in itself will not alter the regulatory status of organisations, and accountability for statutory duties will remain with their boards.
- **The deployment of a senior leader to the role of Programme Director** to oversee action by the local health and care economy, managing the implementation of the regime locally on the collective behalf of the three regional directors, working closely with local leaders to agree responsibilities and accountabilities for agreed actions.
- The undertaking as the first stage of the regime of **a single, holistic diagnosis** of the performance, strategy and leadership issues facing the health and care economy, leading to the development of a specific plan for improvement during the regime and clear 'exit criteria' for the local health and care economy. This will be developed with the local health and care economy and build on existing work where this has previously been undertaken;
- The development in light of the diagnostic process of **a set of interventions and support** for the local health and care economy to secure the delivery of the transformation plan. This is likely to include both stronger direction and access to a range of support for the health and care economy. As part of this process, the potential application of the new care models outlined in the Five Year Forward View will be considered as a way to enable improvement.
- Consideration by the three national bodies as to whether **an alternative approach to the way in which they oversee individual organisations** and health and care economies would aid transformation. For example, setting a multi-year financial control total for a locality as opposed to purely managing the finances of individual organisations across a single financial year.
- The progression of the regime to a clear and agreed timeline for each phase of work. As local health and care economies demonstrate the capacity and capability to successfully deliver the transformation plans, the levels of challenge, support and oversight of the national bodies may be tapered

culminating in a decision that the health and care economy should exit the regime.

The operation of the regime will always require action from:

- NHS England, through its relationship with Clinical Commissioning Groups, and where relevant as the direct commissioner of services;
- Monitor, as the regulator of NHS Foundation Trusts, unless there are no FTs in the relevant health and care economy; and
- The NHS Trust Development Authority, as the overseer of NHS trusts, unless there are no NHS trusts in the relevant health and care economy.

The regime will be overseen by the relevant regional directors of Monitor, the NHS TDA and NHS England, acting in concert and drawing in partner organisations as required. While the regime will operate to a consistent national framework (as outlined above), detailed decisions on the scope and objectives of the regime and the specific interventions and support deployed in each health and care economy will be taken at regional level. The day-to-day oversight of the regime will also sit at regional level. As part of the Forward View, the regime will ultimately report to the Board of the seven Chief Executives.

In addition, the operation of the regime will normally involve the Local Government Association, the Care Quality Commission, Health Education England, Public Health England and NICE given their important links with local systems. Other bodies such as professional regulators and membership bodies may be drawn into the regime depending on the local circumstances. The involvement of more successful local organisations may also be required, and whilst they may not experience the same level of intervention as other organisations, their contribution to any local solutions will be key.

Most importantly, the regime will require and support leaders within the selected areas to think differently about the challenges they face in order to tackle the issues which have characterised the selected health economies. The national bodies commit to supporting and enabling transformational change because we believe that in these areas such challenges have been left unaddressed for too long. The new care models offer one important set of opportunities to improve care, but whatever the changes required in local health economies, we are determined to seek them out and make them happen through this regime. The engagement of patients, staff and stakeholders in each local health and care economy will be vital.

As with the broader work of the Five Year Forward View, it is important that we engage with the wider health and care system in order to meet the challenges that we face. To support the national bodies with this work, NHS Providers, the NHS Confederation and NHS Clinical Commissioners will lead a design workshop with providers and

commissioners in order to ensure that their ideas help to shape the way in which the regime is implemented.

Relationship with previous and existing interventions

The design and operation of the regime seeks to draw on previous and existing interventions to address challenges at both organisational and system level. There is much to be learnt from these other interventions and a clear need to ensure alignment between different approaches. However, the approach taken through this regime needs to be very different to those taken previously, in order for the result to be different. The table below summarises the ways in which the Success Regime builds on previous interventions, as well as clarifying how the new regime is distinct.

	How it is relevant to the Success Regime	**How it is distinct from the Success Regime**
Planning support for 11 challenged health economies	The planning support provided to 11 systems in early 2014/15 was overseen by the tripartite bodies acting collectively and focused on whole health economies, providing clear parallels with the approach envisaged for the Success Regime. Where the selected sites for the regime were also involved with the Challenged Local Health Economies work, the regime will be able to build on any resulting analysis and plans.	The challenged LHE process provided support rather than intervention, whereas the Success Regime combines support and intervention. The challenged LHE process focused on strategic plans for local health systems, whereas the focus of the Success Regime is more holistic.
Special Measures for NHS trusts and NHS Foundation Trusts	The special measures process combines increased scrutiny and increased support for organisations in order to secure improvement against an agreed quality improvement plan. This mirrors the approach intended for whole health economies as part of the Success Regime.	Special measures is a time-limited process that applies to individual provider organisations, focuses in particular on improvement in the quality of services. The Success Regime which will focus on whole health and care economies and will seek more holistic improvement, focusing explicitly on local leadership development.

	How it is relevant to the Success Regime	How it is distinct from the Success Regime
Trust Special Administration	The TSA process seeks to create a sustainable future for currently challenged organisations and systems, appraising options and making recommendations for future direction in consultation with key local partners. Similar processes are likely to be required for successful strategic planning as part of the Success Regime.	Unlike the TSA process, the Success Regime is not statutorily defined and can therefore be tailored to local circumstances more flexibly. In addition, the Success Regime will work across health economies whereas the TSA process seeks specifically to address the challenges at a single provider organisation.
Contingency Planning process	The contingency planning process, and related approaches to reviewing the sustainability of particular health systems, have many of the same objectives of the TSA regime, but operate without statutory constraints. Like the TSA regime, there are many parallels between the contingency planning process and elements of the Success Regime.	The contingency planning process has tended to focus on individual organisations within the context of their health systems, whereas the focus of the Success Regime is more holistic. Contingency planning and similar processes have tended to be overseen by one of the national bodies, whereas the Success Regime will be collectively overseen by all relevant national bodies working collectively.
CCG Assurance	NHS England provides different levels of support and intervention to CCGs informed by an assessment of the capacity and capability of a CCG to carry out its functions. Where there is insufficient assurance regarding a CCG, NHS England works with it to make the necessary improvements within an agreed timeframe.	The CCG assurance process and associated interventions relate to individual CCGs. It is overseen by NHS England and involves the use of NHS England's statutory powers. The Success Regime will be jointly overseen by the national bodies and will focus on commissioners, providers and other stakeholders in a defined area. Whilst the statutory powers of the national bodies may be used during the course of the regime, the regime itself is not statutorily defined.

In addition to the areas outlined above, there are a range of other potential processes that may be underway in particular health economies, including support for Better Care Fund planning, support or intervention on particular performance issues, and reviews of individual organisations or services. It is possible for the Success Regime to be

implemented in areas where a range of interventions are already in place, but it will be important in such cases to align these processes with the Success Regime. The range and nature of interventions already taking place in particular health economies will be one of the factors considered in determining the best areas for operating the Success Regime.

One of the most important links that the Success Regime will have is with the Vanguards programme as part of the Five Year Forward View. Whilst the starting point for the health and care economies selected for each of these programmes may be different, the ultimate aim is the same: to improve the quality and sustainability of services for patients and the public. The two programmes will therefore work closely together, for example, joint support may be commissioned for both Success Regime and Vanguard sites, and peer support arrangements established to ensure that any relevant learning is shared.

In summary, the Success Regime is distinct from the current processes available for providing support and direction in the following areas:

- It provides the first nationally consistent approaching to intervention at the health economy level since the new system arrangement came into effect in 2012;
- It focuses on the full range of systemic problems addressing whole health economies rather than focusing on particular issues or particular organisations;
- It seeks to strengthen local leadership and create the conditions for future change, with a particular focus on developing collaborative system leadership and delivering transformational change; and
- It has an explicit focus on testing the potential application of the new care models set out in the Five Year Forward View to the most challenged systems.

This page is intentionally left blank

FIVE YEAR FORWARD VIEW

The Success Regime: A whole systems intervention

The First Health and Care Economies (Annex)

3 June 2015

Introduction

The Five Year Forward View signalled the intention by the national bodies to introduce a new regime to create the conditions for success in the most challenged health and care economies: the 'Success Regime'. This new regime will represent a change in approach to providing support and challenge to local systems. The regime:

- Will be overseen jointly by NHS England, Monitor and the NHS Trust Development Authority, working closely with the Care Quality Commission;
- Will **work across whole health and care economies** – with providers, commissioners and local authorities – **and address systemic issues** as opposed to merely focusing on individual organisations;
- Will provide the necessary support and challenge to health and care economies through from **diagnosing** the problems, identifying the changes required and **implementing** these changes;
- Will seek to strengthen **local leadership capacity and capability**, with a particular focus supporting transformation and developing collaborative system leadership;
- Has a direct link to the **new care models** work of the Five Year Forward View, and will consider whether the application of the new care models may form part of the solution for the selected health and care economies.

The First Health and Care Economies to enter the Success Regime

Work with some of the most challenged health and care economies will start now. The first sites to enter the regime have been chosen by the regional directors from NHS England, Monitor and NHS Trust Development Authority (TDA), and approved by the Board of the seven Chief Executives of the national bodies. Selection decisions have been informed by quantitative – for example, quality metrics and financial performance – and qualitative information.

Three health and care economies will enter the regime from today, and further localities may enter the regime in the future. Below is a brief introduction to the first health and care economies to enter, and a description of the challenges that the regime will seek to address. The size of the health and care economies with which we work may change during the course of the regime, and the required geographical scope will be finalised as part of the diagnostic phase.

North Cumbria

- North Cumbria was one of the 11 challenged health economies which received support with their strategic planning from the national bodies in 2014/15. There is therefore existing work regarding the future of the locality on which the regime will be able to build.
- There are quality and governance issues with local providers. The causes of and power to address all the quality issues does not sit exclusively with the trust but also across the whole health and care economy.
- There is a need for a single strategic plan for the local health and care economy shared by all local stakeholders, and the proposed transaction between North Cumbria University Hospitals NHS Trust and Northumbria Healthcare Foundation Trust is on hold as a result of North Cumbria entering special measures.

- The financial situation across the whole health economy is unsustainable in the long-term, and there are significant issues regarding workforce, recruitment and retention.

Essex

- There are operational and quality challenges which present risks to clinical sustainability.
- There are financial sustainability challenges across the local health economy.
- There is a recognition that additional levers and regulatory mechanisms may be required, in order to introduce new ways of working and new models of care.
- There are workforce challenges across primary and secondary care in the local health economy.
- Mid Essex was one of the 11 challenged health economies which received support with its strategic planning from national bodies in 2014/15. The Success Regime will build on this work.

Northern, Eastern and Western Devon

- In 2014/15 the Local Health Community was identified as part of the Challenged Health Community Work, and from that significant and increasing Health Community deficits were forecast if action is not taken.
- All partners in the system need to work more closely together to develop a service and financial strategy that delivers National Operational Performance Standards and financial balance.
- The Success Regime will ensure leadership across the community is aligned to a clear strategy; will support the local leaders to deliver change across organisational boundaries; and build on the potential for new models of care to support change.

This page is intentionally left blank

23 July 2015	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Primary Care	
Wards and communities affected: All	**Key Decision:** To note the contents of this report.
Report of: NHS England Midlands and East (East) - Alison Cowie, Head of Commissioning/Alastair McIntyre, Locality Director Presented by Andrew Pike, Director of Commissioning Operations, NHS Midlands and East (East)	
Accountable Head of Service: n/a	
Accountable Director: n/a	
This report is Public	

Executive Summary

This report provides a summary of key issues for NHS England with regards to primary care strategy, particularly in respect of primary medical services and reflects on local primary care developments within Thurrock.

1. Recommendation(s)

1.1 To note this update report on Primary Care in Thurrock.

2. Introduction and Background

2.1 NHS England is responsible for planning, securing and monitoring an agreed set of primary care services for the population that it serves:

1. Primary Medical Services (GP services) of which there are 33 GP practices in Thurrock;
2. Primary Dental Services (Dentists) of which there are 23 NHS Dental Contract holders in Thurrock;
3. Community Pharmaceutical services (Chemists) of which there are 36 Community Pharmacies in Thurrock;

4. Primary Ophthalmic services (Opticians) of which there are 17 contract holders in Thurrock.

2.2 In carrying out this role, NHS England needs to ensure that it:

1. **Plans** the optimum services which meet national standards and local ambitions, ensuring that patients, carers and the public are involved in the process alongside other key stakeholders and the range of health professionals who contribute to patient care;
2. **Secures** services, using the contracting route that will deliver the best quality and outcomes and promote shared decision-making, patient choice and integration; and
3. **Monitors**, assesses and, where necessary, challenges the quality of services; and using this intelligence to design and plan continuously improving services for the future.

2.3 In October 2014, NHS England launched its Five Year Forward View, which sets out a clear direction for the NHS. Within this a commitment was given to invest more in primary care. Steps we will take include:

- Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.
- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

2.4 In January 2015 NHS England and Health Education England (HEE) launched the New deal for General Practice. It is a 10 point action plan and NHS England has responsibility for the implementation of 4 of the 10 work streams:

- Targeted Support – the incentive scheme for targeted support to GP trainees who take up posts for 3 years

- Investment in retainer schemes – NHS England will review existing schemes and invest in new ones
- Incentives to remain in practice - a detailed review to explore how partners can be encouraged to stay in practice, i.e. a funded mentorship scheme, or portfolio careers
- Targeted investment in returners – NHS England will make additional resources available to attract GPs back into practice, undertaking a review of performers lists

3. Local Strategy and Issues in Primary Care Medical Services

3.1 **Care Quality Commission** (CQC) – From 1 October 2014, CQC changed the way that it inspected General Practices. Practices are now rated as being outstanding, good, requires improvement or inadequate. At the time of writing this report, the following publically available ratings are available. Should more be made available by the HOSC meeting, a verbal update will be given. NHS England has a role to both support practices deemed inadequate but to also consider patient safety risk and contractual action following inspection by CQC.

Practice	**Rating**
Drs Masson & Masson, Grays	Good
Dr Cheung, Corringham	Good
Dr S Yasin, South Ockendon	Good
Dr Ramachandran, Tilbury	Requires Improvement
Dr Shehadeh, Tilbury	Inadequate

3.2 CQC are carrying out checks at the following practices and reports will be published in the near future:

- Dr R Suntharalingam, Tilbury
- Aveley Medical Centre
- The Orsett Surgery
- Thurrock Health Centre
- Dr B B Roy, Stansford Le Hope

3.3 **Dr Suntharalingam, Tilbury -** Following an inspection by the Care Quality Commission (CQC) and NHS England, the General Medical Council (GMC) has temporarily suspended Dr Suntharalingam from clinical practice. Dr Suntharalingam has decided to retire and remains the contract holder until 31 August 2015. Tilbury Medical Centre remains open but care is provided by locum doctors as Dr Suntharalingam cannot see or treat patients whilst he is suspended. NHS England has also been supporting this practice with additional practice management and clinical leadership. NHS England is now seeking an alternative provider who will take over the running and management of the practice from 1 September 2015.

3.4 **East Tilbury Medical Centre** – This practice is not yet registered with the CQC. NHS England, along with the practice, CQC and Thurrock CCG are developing a plan and an update will be given at the HOSC meeting on the 23rd July 2015.

3.5 **Dr Shehadeh, Tilbury** – NHS England is working with this practice following the inadequate rating by the CQC which placed this practice into special measures. An action plan to improve services is required and discussions are ongoing with Dr Shehadeh regarding this and the future of the practice.

3.6 **Sai Medical Practice, Tilbury** – this practice recently took on the patient list following Dr P K Mukhopadhyay's retirement. NHS England has funded additional locum cover in order that patient reviews and records are updated on these patients. We are also working with the practice, Health Education England and Thurrock CCG to support the development of this practice with an increased patient list size.

3.7 **Estates review** – this is being led by Thurrock CCG who will have a draft outline by the end of 2015. NHS England and Thurrock Council are supporting this piece of work.

3.8 **Transformation Funding** - A seven year contract was signed between NHS England and the Neera Medical Centre to provide weekend surgeries across 4 hubs in Thurrock. The hubs are situated in Corringham, Tilbury, Grays and South Ockendon. The first hub went live at the Neera Medical Centre on the 25th April 2015 with a doctor and nurse being available to see patients between 9am – 12.30pm. By the end of June 720 extra appointments were available for Corringham GP practice patients to see a doctor or nurse. The Tilbury hub opened on the 20th June 2015 at the Health Centre, London Road. The hubs in Grays and South Ockendon are close to being finalised and hope to be open in July/ August 2015. At present all appointments are only bookable through GP practices.

3.9 There has been significant clinical engagement with this project with Dr Deshpande, contract holder, chairing a monthly group with clinical leads representing each of the hubs. This group reviews the operational policy and ensures that the hubs are delivering excellent patient care to the patients in Thurrock. All GP practices have been kept informed of developments and training provided for practices prior to the hub being launched.

3.10 Patients are being made aware of the opening of hubs with posters in practices advertising the hubs once the hubs are open. Practices in Grays and South Ockendon will receive posters once the details are confirmed. In addition there has been engagement with local community groups at a recent

meeting of Healthwatch. There has been communication to local pharmacists to ensure they are aware of the hub's opening at the weekend.

3.11 The hubs operations are being continuously reviewed and plans are being made to use 111 to book a number of urgent appointments for patients. In addition the hubs may be open for longer or extra staff working at the same demand dependent on demand. The range of services being offered is being reviewed in the light of patient's needs.

3.12 On a separate issue the redevelopment of Purfleet continues with the Council planning to conclude negotiations with the developer in the next few months prior to a formal planning application being submitted around September 2016. There has been extensive engagement between key partners in health and local authority to identify the future needs of the new health facility. At a minimum it will include a GP surgery to meet the planned future growth in the area. This will be further discussions at to what other facilities can be included in the health facility.

4. Reasons for recommendation

4.1 Responsibilities for the commissioning of primary care services rests with NHS England and this is a developing area of work, therefore, the HOSC is asked to **note this update.**

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

5.1 Not applicable.

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

6.1 The provision of good quality primary care in Thurrock aligns with the Council's priority of improving the health and well-being of the population.

7. Implications

7.1 Financial

Implications verified by: N/A
No impact on the Thurrock Council

7.2 Legal

Implications verified by: N/A
No impact on Thurrock Council

7.3 **Diversity and Equality**

Implications verified by: N/A

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)
None for Thurrock Council

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):

None

9. Appendices to the report

None

Report Author:

Alison Cowie, Head of Commissioning, NHS England Midlands and East (East)

Alastair McIntyre, Locality Director, NHS England Midlands and East (East)

23 July 2015	ITEM: 11
Health and Wellbeing Overview and Scrutiny Committee	
Public Health Grant 2015/16 – Proposed Reductions	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Roger Harris – Director of Adults, Health and Commissioning / Ian Wake – Director of Public Health	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris / Ian Wake	
This report is Public	

Executive Summary

Thurrock received notification on Monday 8th June that the Public Health Grant was to be cut nationally by £ 200m in 2015/16 following the Chancellor's pre-budget statement the previous week.

It is not fully clear yet how this figure was arrived at nor the rationale for the decision. It amounts to a 7.4% cut to the total PHG across England.
If this is applied pro-rata to all local authorities it will amount to a cut of £614k to the Thurrock's allocation.

Public Health England are going to have a short consultation on the methodology for applying the cut (not whether the cut will happen or not). This is likely to be based on two options:

a. same percentage cut for all local authorities; or

b. weighted cut based on each local authorities "distance from target" ie how far they are above or below their needs formula.

It is particularly difficult to make this cut because it comes part way through the year, there was no advance notice and the majority of contracts have already been agreed.

1. Recommendation

1.1 Members are asked to consider and comment on the proposed reductions to the Public Health Grant for 2015/16.

2. Introduction and Background

2.1 The Public Health Grant is provided to local authorities to give them the funding needed to discharge their public health responsibilities. Broadly these responsibilities include:

- Improve significantly the health and wellbeing of local populations;
- Carry out health protection and health improvement functions delegated from the Secretary of State;
- Reduce health inequalities for all ages, including within hard to reach groups;
- Ensure the provision of population wide healthcare advice.

Under the DoH guidance it remains essential that funds are only spent on activities whose main or primary purpose is to improve the public health of local populations.

The grant is made under Section 31 of the Local Government Act 2003 the Secretary of State has set down conditions to govern its use. The primary purpose of the conditions is to ensure that the grant is used to assist the local authority to comply with its Public Health duties and mandatory functions, that it is spent appropriately, and accounted for properly.

2.2 **Prescribed and Non Prescribed functions**

Prescribed Functions:

- Sexual Health Services- STI testing and treatment
- Sexual Health Services- Contraception
- NHS Health Check Programme
- Local Authority role in health protection
- Public Health Advice
- National Child Measurement Programme
- Prescribed Children 0-5 Services

Non- Prescribed Functions commonly funded from the Public Health Grant:

- Sexual Health Services- Advice, prevention and promotion
- Obesity – Adults
- Obesity- Children
- Physical Activity- Adults
- Physical Activity- Children
- Drug Misuse- Adults

- Alcohol Misuse- Adults
- Substance Misuse (drugs and alcohol)- Youth Service
- Stop Smoking services and interventions
- Wider Tobacco Control
- Children 5-19 Public Health Programmes
- Non-prescribed Children 0-5 services

3. Issues, Options and Analysis of Options

3.1 Detailed below is a summary of the 2015/16 planned PHG allocation within Thurrock

Table 1

Budget Heading	Original 2015/16 Allocation £000s	Notes
Drug and alcohol contracts	1,310	Contract committed to March 31st 2017
Nutrition, Obesity, Physical Activity	250	Includes mandated National Childhood Measurement Programme
Tier II Weight Management adults	122	Contract committed until 31 March 2016.
Community Weight Management and other community development initiatives	250	150K of grants already awarded in 2015-16.
Smoking cessation and tobacco control programmes	475	Range of services commissioned through GPs, pharmacies and through NELFT. Contract committed until 31 March 2016
Children 5-19	1,300	School nursing service via NELFT Significant savings negotiated this year. Contract committed until 31 March 2016
Adult Health Checks	329	Mandated Service. Have already negotiated significant savings in year. Contract in place until March 2016
Breast feeding and parenting support programmes	432	Contract ends 31 August 2015. Procurement programme currently under-way.
Sexual Health, contraceptive advice, Genito-Urinary Medical Services, chlamydia screening	1,573	Contracts in place with NELFT, BTUH, SHUFT, GPs until March 2016. Significant savings already made on contracts.

Library and other Evidence Based Services	12	Contract in place with ECC until March 2016.
Occupational Health	160	Core service – under review to see if savings possible.
Placements (adults)	250	Support for placements / re-ablement contracts. Resource committed.
Prevention programme – LACs; Early Offer; reablement; independent support, Community Champions	1,490	These services have been reviewed recently and were re-prioritised as part of the £ 1.49m cuts taken out of the PHG in 2015/16 already.
Core team including new full time Director post and strengthened capacity to deliver the NHS Core Offer and Health Protection functions.	955	NHS core offer and health protection functions are mandated. Vacancies have been held and temporary (9 month) 'free' PH Consultant capacity obtained as a result of placing a final year PH Senior Registrar from the Eastern Deanary.
Misc. department running costs	21	Committed
Thurrock 100	20	Committed
Community Builders	30	Committed
Corporate Recharges	200	Committed
Total Planned Spend	9079	
Original 2015/16 PH Grant	**(8631)**	
Carry forward from 2014/15	**(557)**	This was to take into account those projects that had not yet commenced by 1st April or ran across financial years
(Surplus) Deficit	**(109)**	

3.2 £557K has been carried forward from 2014/15. This has arisen for two main reasons – first of all a number of contracts do not run from 1st April and start mid-way through the year and secondly it has taken the PH team some time to get on top of the contracts passed over from the PCT and understand exactly what the spend and activity levels were for Thurrock.

3.3 If the DH were to demand the full £614K of Public Health grant to be returned in year, and PH planned spend were to remain constant, this would leave a deficit of £505K in 2015/16 and an on-going deficit of £1.053M from 2016/17. (see Table 2).

Table 2

	2015/16 £000s	2016/17 £000s
Original PH grant	(8631)	(8631)
Carry forward from 2014/15	(557)	0
Planned spend	9079	9070
Return of 7.4% of PH grant	614	614
(Surplus) Deficit	**505**	**1053**

3.4 Contracts with the current breast feeding and parenting support providers ended on 31 May 2015. A re-procurement exercise has failed to attract any new providers, largely as a result of news of the proposed PH grant reductions. Freezing re-procurement of this service would deliver £266K savings in 2015/16 and £322K in 2016/17 but is not without implications in terms of the health of the population of Thurrock. These include:

- **A reduction in breast-feeding prevalence.** Thurrock currently has a breast-feeding prevalence below the national average. Breastfeeding has been shown to be highly health protective for both mother and child, and a key factor in reducing child and adult obesity, a very significant public health issue in Thurrock where rates are significantly greater than the UK average.
- **An increase in health inequalities.** The programme is designed to target hard to reach and deprived communities where breast-feeding rates are traditionally lower. Removing this support may ultimately increase health inequalities across Thurrock.
- **A loss of community capacity and reduction in community cohesion.** The programme works on a community development model and recruits and trains local volunteers from the communities it targets. As such it acts as a positive skills developing initiative for the people delivering as well as receiving the intervention and builds community skills and capacity.

3.5 Table 3 suggests additional savings that could be made in 2015/16 to cover the £505K deficit, with their implications.

Table 3

Programme	2015/16 in year savings £000s	Implications
Halt re-procurement of Community Breast feeding and parenting support programmes	266	As above
Halt further investment in Community Health/weight management initiatives	100	Thurrock is ranked sixth worst in England for levels of adult obesity. Reducing investment in this programme reduces our ability to address this complex PH issue.
Reduce staff costs in PH team	59	The retirement of the Head of Public Health provides an opportunity to refocus capacity and skills in the PH team to strengthen the PH Core offer to the NHS, and Health Protection functions (both of which are currently inadequate). Recruitment to the Consultant in PH post could be delayed until March 2015/16 due to the free temporary resource from the Senior Registrar placement. However this post will need to be filled in 2016/17 if the Council is to have sufficient capacity to full-fill its statutory responsibilities to provide an NHS core offer and health protection functions. As the Senior Registrar does not start until November 2015, it will also place additional short-term increased workload on existing team members.
Reduce funding to in-house Occupational Health service	60	Few as spend on this service in 2014/15 was £60K less than budgeted.
Slippage in Alcohol Detox and Sexual Health Services contracts	20	None.
Total	505	

3.6 If the Public Health grant for 2016/17 remains the same and the 7.4% cut is applied again to Thurrock, this leaves a further £548K deficit, however at present 2016/17 PH grant funding has not been confirmed. There is more flexibility to re-negotiate and re-commission contracts in 2016/17 as a number of current contracts end at the end of the current financial year.

4. Reasons for Recommendation

4.1 The proposed reductions are required in order to deliver the savings required through the cut in the PHG.

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

5.1 HOSC is being consulted as are our partners in the Thurrock Clinical Commissioning Group.

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

6.1 This is dealt with in the body of the report. If the cuts proceed it will impact on some of the key priority areas in our Health and Well-Being strategy.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Resources Accountant

The projected £0.614m reduction in the Public Health grant will require the Council to reduce its level of public health expenditure, as detailed within the report. The Council set its budget in accordance with the grant confirmation given by central government departments, and subsequent alteration to these requires in-year adjustment, which will have a significant impact on the services that can be delivered this year and going forward.

7.2 Legal

Implications verified by: **Daniel Toohey**

Principal Corporate Solicitor

a. Section 31 of the Local Government Act 2003 provides that a Minister of the Crown may pay a grant to a local authority in England towards expenditure incurred or to be incurred by it; the Minister may determine the amount and the manner of its payment, and the conditions upon which it will be paid;
b. A broad description of the conditions and purposes of the Public Health Grant is contained within the body of this report;
c. This report puts forward a number of options in relation to the discontinuance of certain services. Legal services is available to advise and assist in relation to any consultation requirements or processes for contract termination if relevant.

7.3 **Diversity and Equality**

Implications verified by: **Roger Harris**

Director of Adults, health and commissioning

The Directorate will undertake an Equality Impact Assessment on any major reductions that are proposed.

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

None

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

- None

9. Appendices to the report

- None

Report Author:

Roger Harris

Director

Adults, Health and Commissioning

Ian Wake

Director of Public Health

Health Overview & Scrutiny Committee
Work Programme
2015/16

Dates of Meetings: 23 July 2015, 1 September 2015, 13 October 2015, 1 December 2015, 12 January 2016, 16 February 2016

Topic	Lead Officer	Date
Shaping the Council Budget Update – Proposals from Adult Social Care to meet savings target	Roger Harris	23 July 2015
Transforming Adult Social Care	Roger Harris/Ceri Armstrong	23 July 2015
Thurrock Walk-in-Centre	Mandy Ansell	23 July 2015
Success Regime	Mandy Ansell	23 July 2015
Primary Care	NHS England	23 July 2015
Reduction in Public Health Grant	Roger Harris/Ian Wake	23 July 2015
Shaping the Council Budget Update on themed items as and when required	Sean Clark	1 September 2015
Aging well Annual Public Health Report	Ian Wake	13 October 2015
Regeneration, Air Quality and Health	Ian Wake	13 October 2015
Shaping the Council Budget Update on themed items as and when required	Sean Clark	13 October 2015
Shaping the Council Budget Update on themed items as and when required	Sean Clark	1 December 2015

Updated: 9 June 2015

		1 December 2015
		1 December 2015
Shaping the Council Budget Update on themed items as and when required	Sean Clark	12 January 2016
		12 January 2016
		12 January 2016
Shaping the Council Budget Update on themed items as and when required	Sean Clark	16 February 2016
		16 February 2016
		16 February 2016