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

Health and Wellbeing Board

The meeting will be held at **2.00 pm** on **10 March 2016**

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

Membership:

Councillors Barbara Rice (Chair), John Kent, Brian Little, Bukky Okunade and Joycelyn Redsell

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
David Archibald, Interim Corporate Director of Children's Services, Thurrock Council
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Lesley Buckland, Lay Member Thurrock CCG
Graham Carey, Independent Chair, Thurrock Safeguarding Adults Partnership Board
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Roger Harris, Corporate Director of Adults, Housing and Health, Thurrock Council
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Clare Panniker, Chief Executive Basildon and Thurrock Hospitals Foundation Trust
Andrew Pike, Director of Commissioning Operations, NHS England
David Peplow, Chair of Local Safeguarding Children's Board
Malcolm McCann, Executive Director of Community Services and Partnerships
Lucy Magill, Head of Resident Services
Ian Wake, Director of Public Health
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust

Agenda

Open to Public and Press

	To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.	
4	**Declaration of Interests**	
5	**Shared Lives**	**11 - 28**
6	**Health and Wellbeing Board Development Session**	**29 - 40**
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12	**Forward Plan**	

Queries regarding this Agenda or notification of apologies:

Please contact Ceri Armstrong, Strategy Officer, Commissioning by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **2 March 2016**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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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

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

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

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

Non- pecuniary

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

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

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

PUBLIC Minutes of the meeting of the Special Health and Wellbeing Board held 11th February 2016 at 2.00 pm

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Present: Councillors Barbara Rice (Chair), Brian Little and Joy Redsell

Mandy Ansell, Acting Interim Accountable Officer Thurrock CCG
Graham Carey, Chair of Thurrock Adults Safeguarding Board
Roger Harris, Director of Adults, Health and Commissioning
Kim James, Chief Operating Officer, Thurrock Healthwatch
David Archibald, Interim Director of Children's Services
Malcolm McCann, South Essex Partnership Foundation Trust
Kristina Jackson, Chief Executive, Thurrock CVS
Tania Sitch, Integrated Care Director Thurrock, NELFT
Michelle Stapleton, Basildon & Thurrock University Hospital
Ian Wake, Director of Public Health
Dr Anjan Bose, Clinical Representative, Thurrock CCG

Apologies:

Councillor Bukky Okunade
Andrew Pike, Director of Commissioning Operations, NHS England Essex and East Anglia
Councillor John Kent, Leader of the Council
Lesley Buckland, Lay Member, Thurrock CCG
David Peplow, Chair of Local Safeguarding Children's Board
Jane Foster- Taylor, Executive Nurse NHS CCG
Lucy Magill, Head of Residents Services
Clare Panniker, Chief Executive Basildon and Thurrock University Hospitals Foundation Trust
Dr Anand Deshpande, Chair Thurrock CCG
Jane Foster-Taylor, Executive Nurse Thurrock CCG

In attendance:

Ceri Armstrong, Strategy Officer
Tim Elwell- Sutton, Public Health Registrar (Item 5)
Mark Tebbs, Thurrock CCG (Item 6)

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.

2. Minutes

The minutes of the Health and Wellbeing Board, held on 7th January 2016, were approved as a correct record

3. Urgent Items

Public Health Grant

Ian Wake, Director of Public Health, provided an update on the Public Health Grant.

Ian stated that the Department of Health had just published the Public Health Grant allocations for 2016-17. Ian reminded the Board that a 6.2% in-year cut for the 2015-16 financial year had already been applied and would be recurrent. A further cut amounting to £267,000 had been allocated which amounted to a 7.34% total reduction. Board members were made aware that further detailed work was needed to fully understand the ramifications of the budget including its impact on current and future commissioning plans. Ian would be providing a detailed report on the full impact of the cuts to the Grant to a future Board meeting.

Roger Harris stated that in cash terms, the total reduction equated to £924,000 on a £12.5 million Public Health budget. This would have a significant impact.

4. Declaration of Interests

There were no declarations of interests stated.

5. Thurrock Joint Health and Wellbeing Strategy 2016-2021

Tim Elwell-Sutton, Public Health Registrar presented Thurrock's Joint Health and Wellbeing Strategy 2016-2021. Tim stated that the following aspects had been considered when developing the Strategy: that it is co-created through effective engagement with providers and the community; driven using intelligence from the Joint Strategic Needs Assessment (JSNA); adds value to strategic plans to reduce health inequalities; addresses wellbeing and not just health; systematically aligns partner resources with strategic priorities; has clear delivery mechanisms in place; holds partners to account for actions; and that outcomes are presented in an accessible and compelling way.

Tim stated that the Strategy's focus was on prevention and early intervention to ensure that Thurrock people could 'add years to life and life to years'

The goals and objectives set out within the Strategy focused on the areas that would make the most difference to the health and wellbeing of Thurrock people. These had been developed through a period of engagement and in response to detailed needs analysis.

Tim stated that whilst the timeframe for engagement with the community and stakeholders had been limited, it had been very beneficial.

Kim James stated that Healthwatch had managed to canvass and speak face to face with 250 people, with survey responses still being received. Kim stated

that alongside the consultation document, a piece of work had been conducted to ask residents what they thought of the engagement survey. Kim stated that many people had commented that they had not seen the first Strategy and wanted to know what it had achieved. Kim stated that the consultation had been circulated widely across the Borough including to churches, ethnic groups, mums and also residents who commute outside of the Borough. The contact details of those who fed back have been collated and a suggestion was that a focus group be held in the future to plan further work connected to the Strategy – e.g. action plans. Kim stated that once the Strategy was finalised, Healthwatch would be organising to engage with the community on a theme per month. The themes would mirror the Strategy's goals and be used to inform action plans, performance monitoring, and feedback to the Board.

Kristina Jackson stated that part of the engagement process had included attendance at some of the Borough's Community Forums and that this had been welcomed. The chance for the Forums to give feedback on the Strategy and have an input was felt to be beneficial. Kristina stated that this Strategy was looking more like a partnership approach than a top down approach and would welcome involvement in developing the Strategy further.

Tim stated that some of the themes to come from engaging with the community included Air Quality; Access to GPs; Access to open and green space and support for Mental Health. These themes had helped to develop the Strategy and were reflected within it.

Tim gave the Board an overview of the key aspects of the Strategy including the five goals, principles, and also the objectives. Tim stated that one of the intentions of having a goal-based Strategy was to allow the Board and also the community to hold partners to account. Performance indicators have been set and are contained within an Outcomes Framework. The indicators help to define what success looks like. Tim made the Board aware that there was further work to be done to the Outcomes Framework including the modelling of targets.

Tim stated that further work would also be taking place to develop co-produced action plans. The action plans would assign action owners enabling the relevant organisations and individuals to be held to account for their part in delivering the Strategy.

The Chair acknowledged the immense amount of work that officers, members and partner organisations had carried out over the lifespan of the first Strategy. Cllr Rice stated that it was important to highlight the success of the previous Strategy and what had been achieved.

Roger asked the representatives of the three key NHS providers how their respective organisations could ensure that the relevant elements of the Strategy were incorporated into their key plans.

Malcolm comments that one of the ways in which the Strategy could be embedded within provider organisations' plans would be to place the objectives or indicators into their contracts.

Tania stated that she would welcome the chance to be measured against the Strategy's objectives and that partners would also be able to do this via their contribution to actions contained within the Strategy's action plans.

Michelle commented that it was positive that Basildon Hospital being out of 'special measures' had been acknowledged within the report. Michelle stated that whilst in 'special measures', the Hospital had had to be internally focused whilst but that the Hospital was now focusing on being more outward looking – which included the creation of her role. Michelle commented that she was keen to take the Strategy to Hospital's Board.

Roger further commented that Thurrock's regeneration agenda was very strong, and as such in was important to have an equally strong 'People Strategy'. The Health and Wellbeing Strategy would act as that People Strategy.

Ian stated that the buy-in with the community and partners had been influential and that this was something that had not always been achieved in the past.

RESOLVED:

1.1 That the Health and Wellbeing Board agree the draft Thurrock Joint Health & Wellbeing Strategy and Outcomes Framework.

1.2 That the Health and Wellbeing Board delegate authority to approve any further changes to the Strategy and Outcomes Framework to the Board's chair.

6. Thurrock Transformation Plan: Delivering our Vision

Mark Tebbs, Head of Integrated Commissioning at Thurrock CCG stated the Transformation Plan outlined the CCG's vision for providing health and care closer to or at home for the population of Thurrock – For Thurrock in Thurrock. This was in line with the strategic direction set out in the 5 year Strategic Plan 2014-19.

The Plan also aligned with Thurrock's Health and Wellbeing Strategy and would build on the aims of the Better Care Fund.

Mark stated that patients often said they found the health and care system overwhelmingly complex and disjointed. Whilst there had been major improvements in health and care services recently, these improvements had not kept pace with changes in society over the years. If the changes were not addressed, the system would struggle to meet the population's future needs.

NHS England had launched 50 vanguard sites in 2015 to test new models to integrated care and there was lots that could be learnt from their experience.

Mandy stated that the CCG were working against the backdrop of the Essex Success Regime which for the Essex CCGs and Acute Trusts was proving a challenge.

Cllr Rice stated that we need to think about how to communicate this strategy to the community, for example through roadshows or like the meeting that was held in Tilbury regarding Health and Primary Care in the area.

Kim commented that there is a two page document that summarises the Strategy in simple terms for all residents to be able to understand. Healthwatch were currently in the process of distributing the document between now and March for when the consultation starts.

Cllr Redsell asked whether a 47.5% increase in the over 85 population between 2001 and 2011 meant people were living better lives, and Ian replied that whilst people were living longer, they were living with multiple long term conditions.

RESOLVED:

1.1 The Board is asked to note and comment on the contents of the transformation plan and the CCG's Vision for Thurrock.

7. Work Programme

The Chair stated that the meeting on the 10th march will be extended to start at 2.00pm and finish at 5.00pm.

The meeting finished at 3.07 pm.

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact

Democratic Services at

10 March 2016	ITEM: 5
Health and Well Being Board	
Shared Lives	
Wards and communities affected: All	**Key Decision:** Key
Report of: Allison Hall – Commissioning Officer	
Accountable Head of Service: Les Billingham – Head of Adult Services	
Accountable Director: Roger Harris – Director, Adults, Health & Commissioning	
This report is Public	

Executive Summary

Thurrock Council wishes to develop a Shared Lives service within Thurrock, to provide a new form of care for adults with support needs and an alternative to residential care and other forms of service. To support the development of the scheme and the tender process Thurrock Council has engaged an external partner organisation, Community Catalysts, experts in this area of work. This report provides an explanation of Shared Lives, how the scheme will work in Thurrock including benefits and risks and the anticipated savings that can be made by providing this additional care provision.

To ensure the successful and sustainable development and growth of a Shared Lives scheme in Thurrock the Council intend to enter into partnership with the Shared Lives Incubator. The Incubator combines Shared Lives expertise with social investment, and is uniquely placed to both help the Council to secure an appropriate Provider and then support the Provider to be able to deliver and expand Shared Lives care in a way that meets the local context and need.

Shared Lives will support the delivery of Thurrock Council's Market Position Statement, enabling people to be connected and contributing members of their community, to stay well and independent and increase choice and control by adding diversity to the market. It will provide lower cost, higher quality and personalised alternatives to residential care and supported living, enabling the council to make better use of its resources.

1. Recommendation(s)

1. For Health and Well Being Board to approve the implementation of a Shared Lives scheme in Thurrock:

a) **with support from Community Catalysts and the Shared Lives Incubator and**
b) **by finding an external Provider to develop and grow the service over the 5 year contract period.**

2. Introduction and Background

2.1 Shared Lives is the new term for Adult Placement and is a service delivered by individuals and families who provide care or support to people placed with them in their own home by a local authority, after they have been matched for compatibility. Shared Lives can offer highly positive outcomes for individuals, with people reporting feeling settled, valued, and part of their local community. Shared Lives also costs less than alternative forms of care; on average this could be around £26,000 less per year for people with learning disabilities who might be living in residential care.

The key features of Shared Lives schemes are:

- People using Shared Lives services have the opportunity to be at the heart of their community in a supportive family setting, and have the opportunity to be part of the carer's extended family and social networks.
- The relationship between the carer and those they care for is of mutual benefit.
- Arrangements provide committed and consistent relationships.
- Arrangements are made through an organised Shared Lives scheme that approves and trains Shared Lives carers, receives referrals, matches the needs of service users with carers and monitors the arrangements.
- Carers can use their family home as a resource.
- Carers can support up to three people at any one time.
- Carers do not employ staff to provide care to the people placed with them.

A Shared Lives arrangement is an option for a wide range of people, including people with learning disabilities, older people, care leavers, young disabled adults, and people with mental health needs. Nationally the data indicates that currently the majority of placements under Shared Lives arrangements, 82%, support adults with disabilities.

By establishing a Shared Lives scheme in Thurrock we can better support local populations, in line with our strategic plans as well as our responsibilities under the Care Act, in a cost efficient manner.

2.2 Given that Shared Lives is new to Thurrock, the council have engaged an organisation called Community Catalysts to offer support and advice in developing the specification for the proposed scheme. Following on from this it is proposed that the Council enter into partnership with the Shared Lives Incubator which is a not-for-profit organisation with support from the Department of Health to help develop and expand the provision of Shared Lives provision around the country.

With the support of the Shared Lives Incubator, who have experience of establishing and expanding Shared Lives provision, the Council intends to tender for and award a contract to a Provider following a robust tender process to deliver a Shared Lives service in Thurrock.

Based on the experience of the Shared Lives Incubator, Community catalysts and social care good practice, the successful provider would need to demonstrate;

- An absolute focus on a matching process, through the assessment and approval process. This is based on effective UK practice and is central to this model of care. An effective matching process ensures that carers and individuals supported enter an arrangement that meets the needs of both parties.
- The ability and commitment to strongly support and monitor each arrangement.
- High standards of practice, with a strong and creative manager capable of articulating the vision and ability to drive the development of the service.
- Imaginative recruitment strategies to attract potential Shared Lives carers.
- Robust policies, procedures and processes required by Shared Lives Plus which is the UK network for family-based and small scale ways of supporting adults. These are to ensure that approved Shared Lives carers are safe and have the necessary skills, values and attitudes; that matching is done well and carers are supported and monitored.

2.3 While successful and self-sustaining once established, the introduction of a new service in an area can be slow to become established and upfront capital and expertise is required to develop and grow the capacity of the service. Whilst this varies from scheme to scheme the average is likely to be in the region of £250,000 for 75 new arrangements. This upfront capital is paid to the provider by The Shared Lives Incubator and is recouped as part of the management fee – see also 2.6. The trajectory of Shared Lives placements over the 5 year contract period is anticipated as follows;

Year	New Shared Lives placements	Total Shared Lives placements
1	8	8 (11%)
2	12	20 (27%)
3	22	42 (56%)
4	16	58 (77%)
5	17	75 (100%)

The Shared Lives Incubator was established in 2013 to respond directly to these challenges and to help with the development and growth of Shared Lives schemes nationally. The Incubator is a partnership between Community Catalysts, Social Finance, Macintyre Charity and Shared Lives Plus and is the sole organisation dedicated to developing partnerships to expand Shared Lives provision across the country.

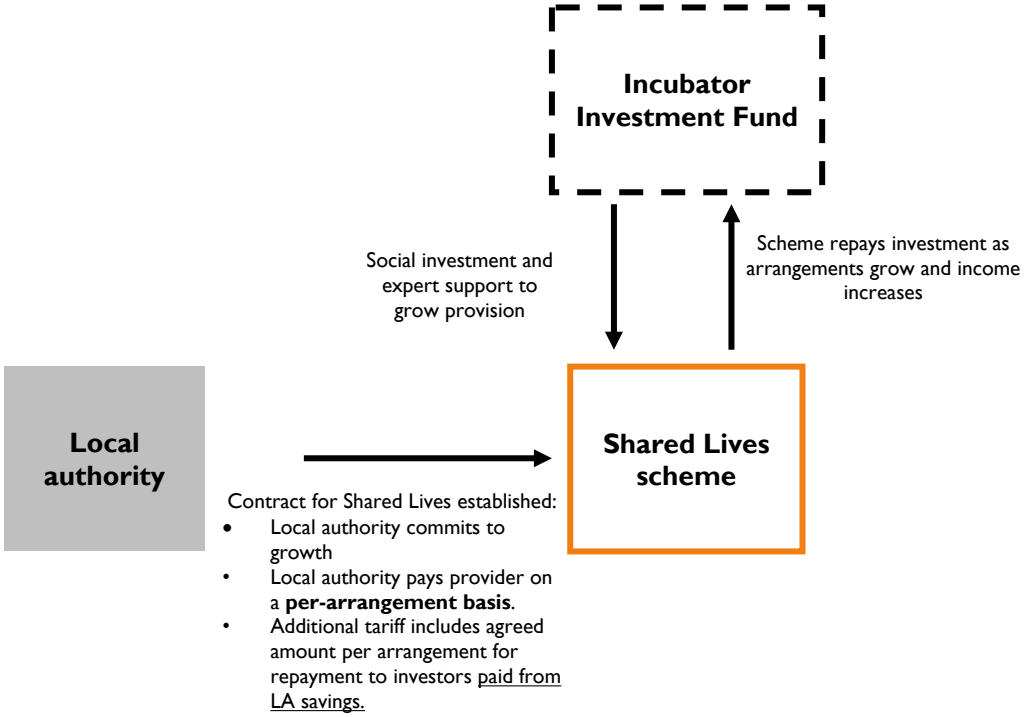
Already working with Councils in London and Manchester to establish new schemes, the Incubator brings a breadth of Shared Lives and social investment expertise to support schemes with capital and organisational support, and local authorities with advice on Shared Lives expansion.

Thurrock Council believes that a partnership with the Incubator will be the most successful approach to establishing a Thurrock scheme, based on their track record of meeting these challenges and successfully establishing new schemes elsewhere.

2.4 The Shared Lives Incubator provides a combination of capital and expertise to enable schemes to grow. Its relationships are with both the chosen Shared Lives Provider and with the Council, providing up-front investment plus bespoke expertise to the former to establish a new scheme, and advice and support to Commissioners to determine how the scheme should look, help develop a service specification and assist in the selection of a Provider to run the scheme.

The Incubator will support the council to appoint a suitable Provider, thereafter, the Council's key relationship is with that Provider, who receives a Management Fee for each Shared Lives arrangement delivered, in place of residential care/supported living placement options.

Having invested in the Provider, the Shared Lives Incubator investment is repaid over time typically a five year period by the Provider who allocates a small proportion of the Management Fee, received from the Council, to pay back the Incubator.



2.6 Indicative modelling carried out by the Shared Lives Incubator with Thurrock Council suggests that the likely number of long-term referrals into a Shared Lives scheme in Thurrock over five years is approximately 75. This is based on demographic information and pressures within social care.

Management fees are paid to the Shared Lives Provider on a payment-per-placement basis, by either the Council or the person using the service via a direct payment or self-funded and are approximately £180 per week. Of this, around £30 per placement per week is then paid on to the Shared Lives Incubator to repay the initial investment into the scheme. In addition, a weekly fee from the Council is paid via the Shared Lives Provider to each Shared Lives carer dependent on the level of need. Typically schemes have low, medium and high bandings; these are yet to be determined for Thurrock however average payments are likely to be approximately £350 per week.

The above costs are indicative amounts and the final numbers of placements, management fee amount to the Provider and weekly fee amount for Shared Lives carers will be determined over the coming months prior to the tender being advertised. However by using the indicative modelling as above it can be determined that the likely full contract value of commissioning a Shared Lives scheme is approximately £5 million for the full 5 years.

2.7 Although the impetus behind Shared Lives is to develop more personalised care which helps people stay integrated into their local community, Shared Lives is also a cost-effective form of care and provides an alternative care option to long-term residential care suggesting that there are potentially significant savings to the Council.

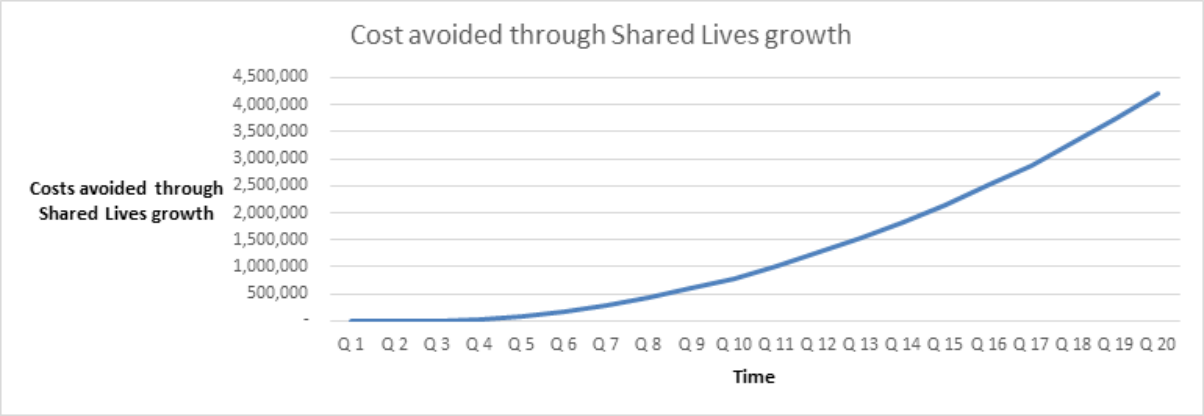
In a previous cost benefit analysis, conducted by Social Finance, they found potential annual savings per arrangement of about£26,000 for adults with learning disabilities and £8,000 per annum for those with mental health needs who access Shared Lives as an alternative to residential or supported living placements.

In Thurrock:

- The current average cost of a long term residential placement for someone with a learning disability in Thurrock is £55,000 per year
- The estimated cost of a long term Shared Lives arrangement for someone with a learning disabled with high support needs is £42,000 per year, therefore **potential savings are at least £13,000 per arrangement per year**
- For an adult with medium needs, the average cost of a shared lives placement would be £27,000 per year, **with savings of at least £28,000 per arrangement per year.**
- If 20% of placements are transferred to Shared Lives, achieving a growth of 75 arrangements over 5 years it can logically be concluded therefore that there would be an anticipated saving of at least £4 million over a five year contract period.

As Shared Lives is more cost-effective than other forms of care, the Council's savings accrue as more people are diverted from more expensive alternate residential care settings into Shared Lives.

The Council only pays if the scheme is successful; the more Shared Lives care that is delivered, the more on-going savings accrue to Thurrock Council.



This has three advantages for Thurrock:

- **Control over contract value**. Thurrock pays only for what it uses.
- **Paying for only what is delivered**. It is challenging to expand Shared Lives. In this model, the Council do not have to risk paying for expansion that does not deliver results. The Council pays only for success.
- **Incentivising growth for the provider**. It is a strategic aim to expand Shared Lives due to the positive care outcomes, savings potential and employment opportunities for local residents. As the Shared Lives provider will be paid more if it grows the scheme, it has an incentive to help the Council meet its strategic goal.

3. Issues, Options and Analysis of Options

There are three main risks, which may impact adversely on the development of the service:

1. Difficulty in recruiting suitable carers
2. Social workers and support planners do not refer enough suitable people to the scheme
3. Families are threatened by the model and resist referrals for Shared Lives arrangements

All three risks are recognised by the Shared Lives Incubator, in particular by Community Catalysts, who have helped to support over 30 schemes in the past seven years and are experienced in addressing these risks and challenges. The following draws on their knowledge and expertise.

3.1. Difficulty in recruiting suitable carers - mitigation

- Demographic profiling of existing Shared Lives carer populations has highlighted some key characteristics of Shared Lives carers. For example: Shared Lives carers are predominantly between the ages of 30 and 64
- the majority are owner-occupiers, although until recently a significant minority were social housing tenants, the ‘bedroom tax’ has reduced the number of people in social housing with a spare bedroom;
- they are settled and crucially have a spare room.
- Shared Lives carers are drawn from a range of backgrounds but the majority are already employed and work in the census category ‘middle managerial, administrative and professions’.
- A significant proportion of Shared Lives carers have been employed as care professionals.
- A ward-by-ward demographic analysis of Thurrock against this Shared Lives carer profile found that ten of the twenty wards in Thurrock had characteristics that suggested they would be likely areas to recruit Shared Lives carers. Of these, three areas Corringham and Fobbing, Orsett and The Homesteads were strongly indicated.

However the demographic makeup of the area is only one of the factors to be taken into account when deciding where to target Shared Lives carer recruitment. A second important factor is the vibrancy and health of the local community. Carer recruitment is most effective through local word-of-mouth which can be generated or amplified by working through community structures and the local people who make that community work well for people. In addition Shared Lives carers tend to be natural volunteers and so an area with lots of volunteers is likely to generate lots of carers. A ward with a favourable demographic analysis but weak community structure is unlikely to generate significant numbers of suitable Shared Lives carers.

Thurrock Council has invested in Local Area Co-ordinators who are embedded in local communities and are the first point of contact for people who need some support and help. The Local Area Co-ordinators concur that all three of the identified wards have positive community structures which will support the good levels of suitable Shared Lives carers. The knowledge and connections of the Local Area Co-ordinators will be a valuable asset to the development of the Shared Lives Scheme

3. 2. Social Workers and Support Planners do not refer enough suitable people to the scheme - mitigation

All Social Workers and Support Planners in Adult Social Care are already aware of Shared Lives and have a high level of enthusiasm for the model and a commitment to refer to the new service. The commissioning team will work with operational teams to ensure they are fully informed of progress and seek support from operational colleagues at different stages of the tender process and service development.

3.3. Families are threatened by the model and resist referrals for Shared Lives arrangements - mitigation

This is a common response nationally to a new Shared Lives service and we have already met with carer advocates. There is work to be done to win over the hearts as well as the minds of family carers and this will be a key element of the tender process and requirement from the successful Provider.

Social workers and Support Planners also recognise that they have a role in supporting families to understand and engage with the model.

4 Reasons for Recommendation

- The Care Act 2014 introduces a duty to the local authority to promote diversity within the market and promote quality in the provision of services to supporting the market to develop affording an increase in choice for those requiring services. Alternatives to residential care are underdeveloped and a Shared Lives Scheme increases options for the local communities of Thurrock.
- Pressures on social care budgets mean that local alternatives to high cost, long term residential care placements are needed.
- Shared Lives compliments our Building Positive Futures programme which is Thurrock Councils response to the national personalisation agenda, it builds upon our community development work and contributes to the development of resilient self-supporting communities

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

5.1 Engagement will be a key part of the development of a Shared Lives Scheme in Thurrock. Through our Engagement Group voluntary sector colleagues are aware of the proposals. As the work progresses commissioners will work with carers groups and service user representatives to ensure that those who may potentially use the scheme are part of the development and tender process. An engagement plan will be developed.

Engagement will also take place with wider communities, across the Council and with the market to raise the profile of the scheme.

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

6.1 As detailed in item 4

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant – Social Care and Commissioning

The financial implications are detailed in the body of the report.

7.2 **Legal**

Implications verified by: **Paul O'Reilly**

Projects Lawyer – Law and Governance

The procurement of the Provider will be undertaken using a competitive Open Procedure. It is anticipated that because of the specialist nature of the services, there is likely to be a limited number of suitable providers who would be available to tender. The final agreement between the Council and the Provider will need to reflect the complexity of the service model and the mutual obligations on the parties. It is recommended that a form of agreement, or memorandum of understanding, should also be entered into between the Council and the Shared Lives Incubator to ensure that funding commitments and other objectives are achieved. The procurement process will take place with full involvement of legal and procurement officers.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The provision of Shared Lives services in Thurrock will ensure that a range of people continue to be supported with dignity and respect, recognising their diversity needs and offered a significant increase in choice.

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):

- http://www.socialfinance.org.uk/wp-content/uploads/2014/04/SF_Shared_Lives_Final.pdf

9. Appendices to the report

- Procurement Report Stage 1

Report Author:

Allison Hall
Commissioning Officer
Adults Health & Commissioning

PROCUREMENT STAGE 1 – APPROVAL TO PROCEED TO TENDER

This form must be completed for all procurements above the tender threshold (£75,000 - Services and Supplies and £500,000 – Works)

If contract value is over Cabinet approval threshold (£750,000) this form shall be attached with the request to tender report to Cabinet. This form will be "Open" for Publication.

Section A: ABOUT THIS PROCUREMENT	
Title	Shared Lives
Directorate	Adults, Health and Commissioning
Procurement Reference Number	PS/2015/103
Contract Cost (Maximum Spend)	£6,000,000
Budget code(s)	SL200/SM200/SP200
Introduction and Background	Thurrock Council wishes to develop a Shared Lives service within Thurrock, to provide a new form of care for adults with support needs and an alternative to residential care and other forms of service. To support the development of the scheme and the tender process Thurrock Council has engaged an external partner organisation, Community Catalysts, experts in this area of work. To ensure the successful and sustainable development and growth of a Shared Lives scheme in Thurrock the Council intend to enter into partnership with the Shared Lives Incubator. The Incubator combines Shared Lives expertise with social investment, and is uniquely placed to both help the Council to secure an appropriate Provider and then support the Provider to be able to deliver and expand Shared Lives care in a way that meets the local context and need. Shared Lives will support the delivery of Thurrock Council's Market Position Statement, enabling people to be connected and contributing members of their community, to stay well and independent and increase choice and control by adding diversity to the market. It will provide lower cost, higher quality and personalised alternatives to residential care and supported living, enabling the council to make better use of its resources.
Proposed Contract Term	5 years
Political Sensitivity	N/A

Section B: COMMISSIONING REPORT	
Business Case	Please see attached Cabinet Report
Key Deliverables (Draft Specification)	Draft specification is currently being written Key deliverables are aimed at meeting Adult Social Care's requirements of the Care Act 2014 & Thurrock Councils Market Position Statement
Quality v Price evaluation	Likely to be set at 80:20
Social Value	The relevance of the Social Value Act for this procurement will be considered and applied throughout the contract as this tender is for Social Care provision and enhancing outcomes for service users and people living in the borough. As part of the quality evaluation, providers will be asked how they aim to meet the requirements of the Social Value Act.
Current / Previous Contract details	N/A

FINANCIAL IMPLICATIONS						
Current / Previous Contract Cost	N/A					
Cost Breakdown	**Breakdown of Estimated Cost**	**15/16 £000's**	**16/17 £000's**	**17/18 £000's**	**Later £000's**	**Total £000's**
	Total Spend	**£**	**£221**	**£551**	**£4823***	**£5595**
Confirm Funding Breakdown Identified	Revenue Budget	£	£221	£551	£4823	£5595
	Capital Budget	£	£	£	£	£
	Other (Please State)	£	£	£	£	£
	Other (Please State)	£	£	£	£	£
	Total Funding	**£**	**£221**	**£551**	**£4823***	**£5595**
Budget Code(s)	SL200/SM200/SP200					
Unsupported borrowing?	N/A					
Other Financial Implications	*Total spend for the later years totalling £4,823m is as follows Financial year: 2019/20 - £1,158m, 2020/21 - £1,598m, 2021/22 - £2,067m					

PROCUREMENT ROUTE ABOVE TENDER THRESHOLD (Choose 1(of A, B, C or D) only)	
A. COMPETITIVE PROCUREMENT (complete B if a Framework)	
Procurement Route	EU Open Tender
Procurement Justification	Due to the specialist nature of this project, there is not an expectation that this will attract a large number of providers, therefore open procedure has been chosen
B. FRAMEWORK (Waiver in accordance with Rule 13.1 (c)	
Framework?	Is this a procurement from a Framework? No
Title & Reference of Framework	N/A
Framework Rationale	N/A
C. REQUEST FOR QUOTE FROM RESTRICTED MARKET (Waiver in accordance with Rule 13.1 (d)	
Restricted Market?	Is this a request for quotes from a restricted market? No
Rationale (only permitted below the EU threshold)	N/A
D. SINGLE SOURCE REASON (Waiver in accordance with Rule 13.1 (a, b or d)	
Single Source	Is this Procurement a Single Source – One Quote/Tender *(Exceptional circumstances only and select reason below)* No
Single Source justification below EU Threshold	*Select reason and explain your rationale* N/A
Single Source justification above EU Threshold	If you are seeking a single tender above the EU threshold – using the "Negotiated Procedure without Call for Competition" route, this is only available in very exceptional circumstances. You must select the reason below and explain your rationale. N/A
Single Source Rationale	N/A

PROCUREMENT TIMETABLE, RISK, CONSULTATION AND MANAGEMENT		
Milestones and target dates *(Draft)*	**Key Event**	**Date**
	Publication of Contract Notice or Advert	11 April 2016
	Return of PQQs (omit if not applicable)	N/A
	Issue of Invitation to Tender	11 April 2016
	Return of Tenders	12 May 2016
	Notification of Results	01 June 2016
	Standstill Period (omit if not applicable)	13 June 2016
	Leaseholder Consultation (omit if not applicable)	N/A
	Expected date of Award	13 June 2016
	Contract Commencement	01 September 2016

Risk Management – Set out Main Risks and Mitigating Actions

Risk	Likelihood (A – E)[1]	Impact (I – IV)[2]	Level of Risk (High to Lower[3]	Potential Negative Impact	Management / Mitigation of Risk
Tender Process Risks					
Non- adherance to procurement timetable	C	III	CIII	Contract does not commence on time	Commissioning Lead will ensure timelines are adhered to. Procurement timetable has been developed to allow for any delays
Non compliance with procurement and legal regulations	D	II	DII	Council is open to challenge	Commissioning Lead will involve colleagues in Legal and Procurement to ensure compliance with Procurement regulations and the Councils Constitution
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Contract Performance Management Risks					
Contract is not appropriately managed	D	III	DIII	Provider fails to deliver against contract	There will be key measurements, outcomes and timescales detailed within the contract, with robust contract management arrangements. There will be designated staff within the Commissioning and Contract management Teams with responsibility for full oversight of this contract.
Financial viability of provider	D	II	DII	Provider is unable to operate	Financial viability of the provider will be tested through the procurement stage including a business plan for the full term of the contract
Enter Risk	L	I	Level	Impact	Mitigation

Contingency Arrangements	As this is a new service there is no requirement to put any contingency arrangements in place, the timetabling however has been set to ensure that this will be delivered as close to the estimated timescales provided . Adult Social Care has robust contract management processes already in place, these will be followed at the start of the contract This contract will also be managed closely by the lead commissioner to ensure that the service is developed and grown.

[1] **Risk Likelihood:** A = Very High, B = High, C = Significant, D = Low, E = Very Low
[2] **Risk Impact:** I = Critical, II = Significant, III = Marginal, IV = Negligible
[3] **Risk Level:** High = AI, BI, AII, BII, CI,CII, all others lower

Consultation	This project has aleady seen a wide range of consultation, including Local Area Co-ordinators, Social Care staff and Carer groups. Soft Market Testing will be taking place for potential and exisiting Shared Lives providers. Engagement will be crucial to the success of this scheme and will be a key priority of the provider once the contract has been awarded.
Project and Contract Management Proposals	There is a lead commissioner for this project, workshops are already timetabled to ensure that operational processes are in place by contract award. Key stakeholders will be invited to further workshops post contract award to meet with the provider to raise awareness and manage barriers.
Procurement Comments	*The value of the contract exceeds the EU tendering threshold for services that fall under the Light Touch Regime (£589,148). It is the Council's intention to run an Open OJEU tender process in compliance with EU regulations and the Council's constitution. As the contract falls within the Light Touch Regime there is flexibility in the how the procurement process can be run, however, it has been decided in this case that the Council will adhere to the timescales set out for standard EU service contracts.*

Section C: LEGAL, FINANCE AND PROCUREMENT APPROVAL		
Procurement Services	**Name**	Kiri Mason
	Signed *(Or obtain email of confirmation)*	KMason
	Date	~~Click here to enter a date.~~ 01/02/2016 .
Legal Services **(Insofar as it relates to Legal implications)**	**Name**	~~Name~~ Paul O'Reilly
	Signed *(Or obtain email of confirmation)*	
	Date	~~Click here to enter a date.~~ 4.2.16
Finance **(Insofar as it relates to Finance implications)**	**Name**	Jo Freeman
	Signed *(Or obtain email of confirmation)*	
	Date	~~Click here to enter a date.~~ 3.2.16

Section D: APPROVAL TO PROCEED VALUE	
The Responsible Officer must sign the form, together with the Head of Service as a minimum. Delegated Authority Limits below.	
Approval Level	Over £750,000 - Cabinet

Section E: SIGN OFF APPROVAL TO PROCEED		
Confirmation by the Responsible Officer of Compliance with Contract Procedure Rules	The Responsible Officer **Allison Hall** confirms that the procurement of **Shared Lives** and **PS/2015/103** has been carried out in accordance with Rule 5 of the Council's Contract Procedure Rules (Chapter 9, Part 2 of the Constitution) and in particular the following duties have been met by the Responsible Officer: • Compliance will occur with all regulatory or statutory provisions and the Council's decision making requirements • The Contract will be included on the Council's Contract Register • Value for Money will be achieved • Advice has or will be sought from the Director of Finance and Corporate governance as to an appropriate security bond or guarantee • Document Retention Policy has and will be complied with • Financial Evaluation will be made of all the proposed tenders including the recommended bidder • Advice has been and will be sought and followed from Procurement, Legal and Finance as necessary	
	Signed	A. Hall
	Date	Click here to enter a date. 1 · 2 · 16
Approval to Proceed	In accordance with the Contract Procedure Rules, I/we confirm the accuracy of the information contained within this form and authorise this request to **Proceed to Tender** including, where relevant, the permitting of a Waiver from the Contract Procedure Rules in accordance with Rule 13	
Head of Service	**Name**	Les Billingham
	Signed *(Or obtain email of confirmation)*	
	Date	Click here to enter a date.
Corporate Director *I confirm that the Portfolio Holder has been consulted as required*	**Name**	Roger Harris
	Signed *(Or obtain email of confirmation)*	
	Date	Click here to enter a date. 4/2/16
Head of Corporate Finance *If waiver required*	**Name**	Click here to enter text.
	Signed *(Or obtain email of confirmation)*	
	Date	Click here to enter a date.
Cabinet	**Approval Minute Number**	Enter minute reference
	Date	Click here to enter a date.
Now send complete form to Procurement Services signed and scanned (with emails if used)		

10 March 2016	ITEM: 6
Health and Wellbeing Board	
Health and Wellbeing Board Development Session	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ceri Armstrong, Directorate Strategy Officer	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

The Health and Wellbeing Board are committed to holding at least one development session per year. This provides the Board with an opportunity to reflect on what it has achieved; identify development opportunities; and plan for the future.

The Board held its most recent Development Session as part of the Local Government Association's facilitated self-assessment offer on the 10th December 2015.

Key themes to arise from the self-assessment and from the facilitated session included:

- Clarity needed over the Board's vision, direction of travel and priorities;
- Ensuring the Board is sufficiently ambitious;
- Ability to hold partners to account;
- Vary the style and structure of Board meetings; and
- Develop approach for communication and engagement.

The report asks the Board to agree key points from the day and note an update on actions from the development session held in January 2015. The report also asked the Board to agree an updated action plan to incorporate key points from the December session and any actions carried forward from the January 2015 session.

1. Recommendation(s)

1.1 That the Board agrees the report; and

1.2 The Board agrees the development action plan.

2. Introduction and Background

2.1 Members of the Health and Wellbeing Board attend at least one development session per year. The aim of the session is to provide the Board with the opportunity to reflect on what has been achieved, but also to identify areas requiring improvement or development.

2.2 The Board held its most recent development session on the 10th December, where it took advantage of the Local Government Association's (LGA) facilitated self-assessment offer. The offer consisted of Board members completing a survey in advance of the development session, the results of which were reviewed and discussed on the day. A facilitator was provided by the LGA to assist the Board with this process.

2.3 This report outlines the results of the self-assessment, key points from the session itself, and recommendations and actions for the Board to agree. The report also reviews the actions agreed from the January 2015 development session.

3. Issues, Options and Analysis of Options

Looking Back – January 2015

3.1 The Health and Wellbeing Board held its last development session on the 12th January 2015. The session grouped development activity in to a number of themes:

- Prioritisation – reviewing HWBB strategic themes and priorities and ensuring the Board's access to the right expertise in order to prioritise effectively and ensure delivery of the priorities;
- Communication and Engagement – developing effective communication and engagement mechanisms;
- Board membership – ensuring the right representation on the Board and making sure members were clear about roles and responsibilities;
- Board performance – having the mechanisms in place to ensure the Board is effective, including having agendas that reflect priorities and interesting and engaging meetings;
- Supporting Individual HWBB member contributions – including clarifying expectations; and
- Data – using and promoting the use of data to support the delivery of priorities and for the Board to be able to measure success.

3.2 Many of the themes and actions to be identified at the January development session have been taken forward as a result of the refresh of the Health and Wellbeing Strategy. This includes:

- Refreshed priorities through the refresh of the Health and Wellbeing Strategy;
- Discussions with Healthwatch, CVS and Thurrock Coalition about effective on-going engagement;

- Board membership that has been expanded to reflect a population-wide whole systems approach to health and wellbeing; and
- Enabling the Board to measure performance through the development of an Outcomes Framework and making meetings engaging through the introduction of 'items in focus' and workshop items as part of Board meetings.

3.3 Further work needs to be carried out concerning:

- Induction of new Board members;
- How best to communicate the work of the Board with the public and with stakeholders; and
- Development a forward plan that reflects the Board's priorities – as contained within the Health and Wellbeing Strategy, and that also enables effective engagement to take place prior to items being discussed.

Self-Assessment

3.4 Prior to the Board's development session on the 10th December, Board members were asked to complete a questionnaire. The questionnaire was designed to gauge opinion against the following themes:

- Vision, ambition and role;
- Fit for purpose;
- System leadership and partnership working;
- Ensuring delivery and impact;
- Communication and engagement; and
- Integration and system redesign.

3.5 15 Board members completed the self-assessment which can be summarised as follows:

Vision, ambition and role

- Most strongly agreed or tended to agree that the Board was ambitious in what could be achieved locally;
- Most people tended to agree that there was a sharp focus on priorities – although 20% of respondents neither agreed or disagreed; and
- There was no consensus over whether the Board had achieved a narrative and road map for change.

Comments included:

- Respondents commented that the Board needed to demonstrate an understanding of wider system issues and drivers, and where Thurrock wished to position itself within the broader agenda; and
- Respondents also commented that an outcomes framework should be agreed where partners could be held to account.

Fit for purpose

- Most people responding felt that the Board was 'fit for purpose' with regard to meeting arrangements – e.g. chairing, agendas, agenda planning, forward planning;
- The vast majority felt that Board membership was right;
- There was no consensus on whether the Board's sub-structures were fit for purpose;

Comments included:

- Inclusion of more professionals – e.g. pharmacists;
- Ensuring that the Executive Committee is scheduled so all can attend;
- Too many people at the meeting making little contribution;
- Agendas too insular;
- Board needs to demonstrate wider system issues;
- Clinical engagement is poor; and
- Agenda too lengthy and the right time is not always given to key issues.

System leadership and partnership working

- Most respondents felt that Board members were able to influence other members, but partner organisations only to a moderate or small extent;
- Most felt that Board members had a clear understanding of the constraints and opportunities facing major organisations in the health and care system, but 27% tended to disagree;
- Most felt that Board members had clarity over partnership roles – but 20% tended to disagree;
- Most tended to agree that the Board were able to influence all key partners to secure action, but 20% tended to disagree; and
- There was no consensus over whether there was alignment to partners' strategies and plans – so that they are focused on delivering shared priorities.

Comments included:

- More clarity required – including future direction and targets;
- The need to be able to hold partners to account;
- Board needing to lead on integration but also be a key player in the wider system;
- Strategy not currently a driving force for change;
- Board members need clear roles and responsibilities; and
- Make sure the Board can influence – e.g. do not agree everything prior to the meeting.

Ensuring delivery and impact

- The majority of people felt that the Joint Strategic Needs Assessment (JSNA) was used by partners to inform strategy, commissioning and delivery; and
- Whilst the majority tended to agree that action plans and performance measures were focused on the delivery of HWB outcomes, 35% disagreed or tended to disagree.

Comments included:

- Make more use of patient stories;
- Feels like a 'tick box' committee;
- Set agenda to enable proactive discussions;
- Look at how the totality of health and social care resources are deployed;
- Ensure the priority for the Board is on delivery; and
- Ensure agendas are managed better to give sufficient time to items.

Communication and engagement

- There was no consensus over the questions relating to communication and engagement which indicates that more needs to be done; and
- The majority of people felt that Healthwatch was building on community networks to increase its engagement with and visibility to the community.

Comments included:

- All Board members have a role to play;
- The Board is isolated from a range of other groups that form a wider partnership framework;
- Residents don't always know where to get the advice they need; and
- There are good links with CVS and Healthwatch.

Integration and system redesign

- The majority tended to agree that the Board was thinking broadly about horizontal and vertical integration of services, but there was no strong consensus;
- There was no consensus on whether the Board was enabling a shift of resources to make prevention and early intervention a priority; and
- Most agreed that the Board was focused on maximising community assets – but there was no overall consensus.

Comments included

- Ensure the Board is well positioned to influence system drivers – e.g. the Success Regime;
- Shifting resource away from the acute sector;
- Need to understand the priorities of the whole system;
- Better involvement of GPs required; and
- The need to have greater vision/ambition – and need to move faster to achieve it.

Development Session

3.6 The Board's development session on the 10th December was facilitated by Andrew Cozens and was attended by fourteen Board members or representatives. Andrew's career had included being a strategic adviser to local and central government on children's services, adult social care and

local government's relationship with NHS for the Improvement & Development Agency for local government and the Local Government Association from 2006-12.

3.7 A number of points were raised by attendees – many reflecting themes to emerge from results the self-assessment exercise. These included:

- **Engagement and communication** – ensuring 'real voices' were heard prior to decisions being made and that the individual was always 'at the centre'; the need to think about how the Board communicates to the public and how best to 'brand' the Board; also about responsibility of the public to improve their own health and wellbeing;
- **Delivery and success** – making sure that the Board was able to move from strategising to making an impact; ability to influence key agendas; the ability to deliver significant change; getting the balance between focusing on priorities and 'hot issues';
- **Contribution of Board members** – recognising the value of providers; using Council and all 49 members to influence and lobby on the Board's behalf; making sure new Board members have an induction – including meeting the chair; need to avoid organisations going back to 'default' positions – Board members should challenge each other when this happens;
- **Fit for purpose** – making sure agendas are concise and timely; ensuring agendas and papers reflect the strategy's priorities; be clear about the role and purpose of the Board; move away from committee-style meetings – e.g. run workshops, bring successful case studies – or even individuals to describe positive change;
- **Vision and direction** – need to identify how the Board can be best used to achieve better health and wellbeing; need to identify what has stopped integration to date; need to be brave enough to take risks; each organisation has to have accountability for delivering the vision; current vision not ambitious enough – need to focus on eliminating health inequalities as quickly as possible
- **Data and intelligence** – the need to have 'one version of the truth'

Additionally, the Chair wishes to ensure that all reports coming to the Board focused on or demonstrated their contribution to reducing health inequalities.

Facilitator Comment

3.8 The session facilitator also provided feedback from the day consisting of areas of strength and areas in need of attention. These are summarised below:

Strengths

- High level of commitment and engagement by all key players;
- Co-terminous CCG and very positive working relationship with NHS partners;
- Political commitment at the highest level;
- Strong sense of Thurrock's identity and needs;

- Dedicated public health leadership bringing obvious benefits;
- Engagement with planning and housing innovative and of national interest; and
- Consensus on the main priority areas for the refreshed Strategy.

Suggested areas for further attention

- Reflect further on self-assessment issues identified;
- Induction for new members;
- Clarifying role of the Executive and sub-groups;
- More focused agendas and different styles of meetings;
- Turning commitment into action – particularly in integrating service offers;
- Promoting the health and wellbeing agenda to the wider membership of the Council; and
- More work needed on public and community engagement.

Recommendations and next steps

3.9 Following on from the 10th December 2015 Development Session, recommended actions that allow the Board to respond to areas requiring further development have been incorporated within an action plan appended to this report. The Board are asked to consider and agree the action plan and to ensure progress against actions are reviewed on a regular basis through the Executive Committee and by exception to the Board.

4. Reasons for Recommendation

4.1 The recommendations ensure that the Board can continue to be effective and in doing so, ensure it can make a difference to the health and wellbeing of Thurrock residents.

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

5.1 Consultation has taken place with members of the Board through the development session and self-assessment questionnaire.

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

6.1 The Health and Wellbeing Board is responsible for delivering the Corporate priority 'Improve health and wellbeing' and needs to be effective to be able to do so.

7. Implications

7.1 **Financial**

Implications verified by: **Kay Goodacre**

Finance Manager

None identified.

7.2 **Legal**

Implications verified by: **Solomon Adeyeni**

Solicitor

None identified.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

None identified.

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

Not applicable.

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):

- January 2015 Development Session Action Plan

9. Appendices to the report

- Development Action Plan 2016

Report Author:

Ceri Armstrong

Strategy Officer

Adults, Housing and Health

THURROCK HEALTH AND WELLBEING BOARD DEVELOPMENT PLAN 2016-17

A) Vision, ambition and role

Area of development	Action	Lead	Timescales
Clarity over vision, direction of travel and priorities	Developed as part of Health and Wellbeing Strategy refresh	Director of Public Health – via the Health and Wellbeing Board	March 2016
Ensure the Board is sufficiently ambitious	Articulate through development of the Strategy, Action Plans, and targets contained within the Outcomes Framework	Director of Public Health – via the Health and Wellbeing Board	Strategy and Outcomes Framework – March 2016 Action Plans – June 2016
Ability to hold partners to account	Through the development of an Outcomes Framework and Strategy action plans with clear leads and action owners	Director of Public Health – via the Health and Wellbeing Board	As above
Clarify the Board's purpose	Review Terms of Reference	Directorate Strategy Officer	June 2016

B) Fit for purpose

Area of development	Action	Lead	Timescales
Agendas to reflect priorities – forward plan	Board workshop to develop forward plan for 16/17 – aligned with priorities in refreshed Health and Wellbeing Strategy	Directorate Strategy Officer	Discussion at March Board Develop Forward Plan for July Board
Board meetings to be more engaging – e.g. move away from 'committee-feel' and 'tick-box' perception	Continue to ensure that agendas and meeting structure are varied and sufficient time allowed for items – e.g. inclusion of workshops, case studies, item of focus	Directorate Strategy Officer via Executive Committee	Consider as part of March Board workshop and on-going via Executive Committee

Sub-structure	Undertake review of Board sub-structure	Directorate Strategy Officer via Executive Committee	June 2016
Induction for new Board members	Ensure induction takes place including meeting with the Chair and updated induction pack	Directorate Strategy Officer	Process in place by July 2016

C) SYSTEM LEADERSHIP AND PARTNERSHIP WORKING

Area of Development	Action	Lead	Timescales
Ensure all Board members have a clear understanding of the constraints and opportunities facing each other's organisations	Incorporate within Board Forward Plan – e.g. spotlight on different organisations represented on the Board	Directorate Strategy Officer via Executive Committee	As part of Forward Plan (July Board)
Ensure alignment to partner organisations strategies and plans	As part of developing the Strategy and Outcomes Framework – organisations need to bring key strategies and plans to the Board for endorsement, and show how those strategies and plans are aligned with the HWB Strategy and the four key principles within the Strategy – consider altering Board Terms of Reference to incorporate this	Representative of each organisation to commit to alignment of strategies and plans via signing off refreshed Health and Wellbeing Strategy	All to sign up to HWB Strategy March 2016 Strategies and plans to clearly demonstrate how the align with HWB Strategy as developed

D) ENSURING DELIVERY AND IMPACT

Area of development	Action	Lead	Timescales
Actions plans and performance measures to be focused on the delivery of HWB outcomes	Development of Outcomes Framework to sit alongside the refreshed Health and Wellbeing Strategy	Director of Public Health – via the Health and Wellbeing Board	March 2016
Effective use of data and evidence to assess delivery or impact	As above – but also development of methodology for involving the public voice in evidence of impact	As above Use of public voice to evidence impact – via Engagement Group	March 2016 Engagement approach – June 2016

E) COMMUNICATION AND ENGAGEMENT

Area of development	Action	Lead	Timescales
Communication with the public and stakeholders	Development of Board communication plan	Directorate Strategy Officer	July 2016
Build engagement in to work of the Board – e.g. to inform decision making and also as measure of success	Develop methodology for engagement via Engagement Group	Director of Public Health/ Directorate Strategy Officer	July 2016

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10 March 2016	ITEM: 7
Health and Wellbeing Board	
Health and Wellbeing Strategy Engagement Report	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ceri Armstrong, Directorate Strategy Officer	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is public	

Executive Summary

Engagement activity was undertaken as part of the development of the 2016-2021 Joint Health and Wellbeing Strategy. This resulted in 539 surveys being completed, mostly through face-to-face facilitation undertaken by Healthwatch Thurrock and Ngage. Additional engagement activity was undertaken through attendance at existing community meetings, and also through key stakeholder meetings.

The results of the engagement exercise have influenced the shape and focus of the final Strategy document. This includes strengthening parts of the Strategy to reflect the key themes to emerge from engagement.

Whilst the period of engagement was relatively short (23rd November 2015 – 22nd January 2016), further dialogue will take place to develop the Strategy's action plans and also as part of ensuring the community voice is part of measuring the Strategy's success.

1. Recommendation(s)

1.1 That the Board agree the Health and Wellbeing Strategy Engagement Report

2. Introduction and Background

2.1 Thurrock's current Joint Health and Wellbeing Strategy will expire at the end of March 2016, and work has taken place to renew the Strategy for 2016 – 2021.

2.2 The work carried out to refresh and renew the Strategy included engagement activity with both stakeholder organisations and with Thurrock people.

2.3 The purpose of the engagement activity was to test draft priority areas and to gain views about the actions people thought would improve the health and wellbeing of Thurrock's residents.

2.4 Throughout the period of engagement which commenced on the 23rd November and ended on the 22nd January, 539 surveys were completed – the majority of which were completed through face-to-face dialogue facilitated by Healthwatch Thurrock and Ngage.

2.5 Additionally, views were also sought via attendance and presentations at both community and stakeholder forums including:

- Community Forums (namely Chadwell and Stifford Clays);
- Thurrock CCG Practice Managers' meeting;
- Thurrock CCG Commissioning Reference Group;
- Stronger Together Board;
- CVS Chief Officer Meeting;
- Clinical Engagement Group;
- Children and Young People's Partnership Board;
- Head Teachers' Forum;
- Corporate Working Group;
- Staff Forum Chairs' Group;
- Youth Cabinet; and
- Children's Services Overview and Scrutiny Committee and Health and Wellbeing Overview and Scrutiny Committee.

2.6 The appended Engagement Report analyses the responses gained from the period of engagement, identifies how views have been used, and also suggests next steps. The Board are asked to agree the Report and in doing so, commit to ongoing engagement as part of developing action plans and measuring success.

2.7 The report was considered by the Health and Wellbeing Engagement Group at its meeting on the 25th February.

3. Issues, Options and Analysis of Options

3.1 The appended Engagement Report analyses feedback received from Thurrock residents and details how this has been used in developing the Strategy. This includes identifying the key themes to emerge through the period of engagement. The Report also commits to involving Thurrock people in future work as it develops.

3.2 One of the areas the Board needs to consider over the coming months is how to best involve Thurrock people on an ongoing basis. This includes considering how to better communicate and publicise what the Board does.

These were areas also flagged for further development at the Board's recent development session.

3.3 Work will take place through the Board and the Engagement Group to develop the best method for engagement with residents and stakeholders, and as part of that, how to best communicate what the Board does.

4. Reasons for Recommendation

4.1 Engagement was carried out to ensure that the refreshed Health and Wellbeing Strategy reflected the views of the community. Through the engagement activity conducted, a number of key themes emerged. These themes have informed the final Strategy – detail of which is included within the Engagement Report. Engagement also led to the Strategy itself being presented in a more accessible way than previous versions.

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

5.1 The Engagement Report and also paragraph 2.5 of this report detail examples of where engagement has been carried out.

5.2 The Engagement Report was considered at the meeting of the Health and Wellbeing Engagement Group on the 25th February, with some amendments to the report being made as a result.

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

6.1 The Health and Wellbeing Strategy outlines how the Community Strategy priority and Corporate priority 'improve health and wellbeing' is defined and will be delivered.

7. Implications

7.1 Financial

Implications verified by: **Roger Harris**

Corporate Director of Adults, Housing and Health

None identified.

7.2 Legal

Implications verified by: **Roger Harris**

Corporate Director of Adults, Housing and Health

None identified.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The Health and Wellbeing Strategy has two key aims – to improve the health and wellbeing of the local population, and to reduce inequalities in the health and wellbeing of the local population. Engaging with the local population is a key part of ensuring that the Strategy is able to achieve its aims. The Health and Wellbeing Board has committed to engaging with Thurrock's communities on an on-going basis, to ensure that their views are reflected in and help to shape how the Strategy is delivered, and also as part of measuring success.

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

- Thurrock Joint Health and Wellbeing Strategy Engagement Report

Report Author:

Ceri Armstrong

Directorate Strategy Officer

Adults, Health and Housing

Reducing air pollution

Being able to visit groups so you can socialise

I could take more exercise

Thurrock Health and Wellbeing Strategy 2016 - 2021

Engagement Report

More information for people about healthy lifestyles

Easier access to my GP surgery

More joined up working

Background

From 2013, all areas have had a Health and Wellbeing Strategy in place. The purpose of the Strategy is to improve the health and wellbeing of the local population and reduce health inequalities. Thurrock's first Health and Wellbeing Strategy expires in March 2016 and work has taken place to develop its replacement.

Why?

As part of developing the new Strategy, we wanted to know what people felt about the proposed priority areas, whether we'd missed anything, and what they felt would improve health and wellbeing in Thurrock. This would help us to identify if our Strategy reflected local views.

How?

We developed a survey which we put on the Council's website. More importantly, facilitated through Thurrock CVS, Healthwatch Thurrock and Ngage, we spoke to people about their views.

We gathered 539 completed surveys between 23rd November 2015 and 22nd January 2016.

What did we ask?

Firstly, we asked people what they thought of our five draft priority areas:

1. Preventing ill-health and taking early action;
2. Ensuring all agencies work together to deliver services that collectively improve the lives of all children and young people, ensuring that every child in Thurrock regardless of their circumstances has access to the best services and outcomes;
3. Building strong and resilient communities;
4. Strengthening the mental health and emotional wellbeing of Thurrock people; and
5. Transforming services and solutions to focus on preventing ill-health and taking early action

What did we ask?

We also asked people:

- If they'd disagreed with any of the priorities, why that was;
- If we'd missed anything as a priority;
- To name one thing they could change that would improve their health and wellbeing;
- One thing that could have the biggest impact on the health and wellbeing of people living in Thurrock; and
- Name up to three actions the Health and Wellbeing Board could take.

Who did we ask?

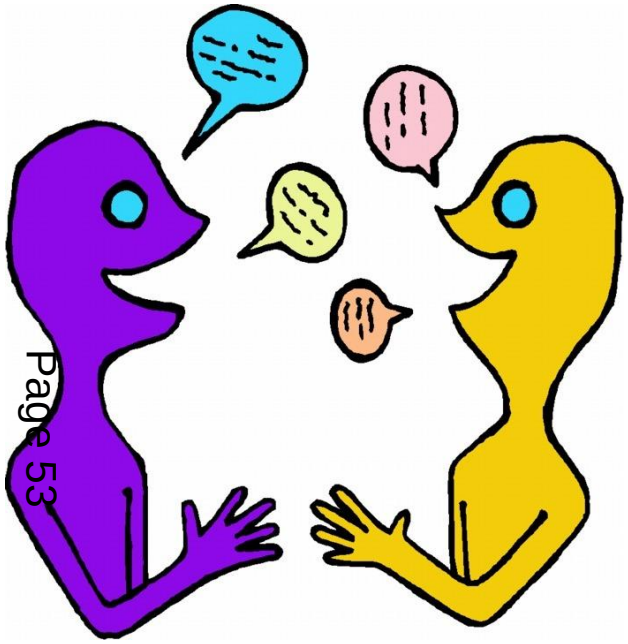
- 52 people completed the survey on-line.
- 487 paper copies were received – mostly from members of the public through Healthwatch and Ngage.
- Written responses were also received from Thurrock Coalition and SERICC.
- We tried to reach as many people as possible in as many areas as possible including the young and old, service users and non-service users.
- A full breakdown is available.

Where did we go to get views?

We tried to reach as many people as possible. This included through:

- Community Forums and Community Groups
- Sheltered Accommodation
- Faith groups
- Youth Cabinet
- Children's Centres
- Supermarkets
- Community Hubs
- Train Stations
- Commissioning Reference Group
- Thurrock Diversity Network meeting
- Advertising in the press
- GP Surgeries

What did people say?



On the draft priority areas….

- Most people agreed with the priority areas
- The most common feedback was that priority 1 and 5 were very similar so were both needed?
- A number of people commented on the length of priority 2 and the need to use plain English
- Some people commented on the need to turn words in to action

Any priority areas missed?

We asked people if they thought we'd missed any priority areas. Common themes were:

- Access to healthcare (mostly GPs, but mental health and hospitals also mentioned) – this included time to get appointments, availability and quality of services;
- Pollutants and air quality;
- Access to good quality (including clean) open space;
- Sufficient provision for older people – including maintaining independence;
- Controlling the impact of new development on health and wellbeing of Thurrock people;
- Too many agencies – the need for better coordination;
- Educating the population – on how to stay healthy but also how and when to use services;
- Support for carers; and
- Good quality housing.

What could you personally change?

We asked people to name one thing they could change to improve their health and wellbeing. Common themes were:

- Access to healthcare – mostly GP appointments;
- Healthy living – diet, weight, healthy eating, smoking, drinking all received numerous mentions;
- Stress and achieving a work/life balance;
- Good information and advice available;
- Affordability – both of exercise facilities and ability to eat well on a low income; and
- Isolation and loneliness.

What could impact on someone's health and wellbeing?

We asked people what they thought could have the biggest health and wellbeing impact on Thurrock people. Common themes were:

- More and accessible health facilities – GPs, hospital, mental health;
- Air quality – including concern about impact of second crossing;
- Ability to take action on factors causing poor health – take-aways, cheap alcohol, sugar;
- Availability of good information on what's available and healthy living;
- Taking exercise and encouraging exercise;
- Coordinated services;
- Creating a welcoming, clean environment – litter mentioned frequently;
- Good quality housing;
- Accessible open space – including cycle paths;
- Ability to access activities and facilities locally

What should the Health and Wellbeing Board do?

We asked people to name three actions that Health and Wellbeing Board should take to improve health and wellbeing in Thurrock. The most common themes were:

- Ensure sufficient health services and that they are accessible and timely – mostly GPs, but also mention of mental health and hospital;
- Coordination of services including close to home;
- Lobbying the Government on key issues;
- Educate the public and ensure they can take ownership of their own health and wellbeing;
- Health activities that are affordable;
- Ensure there is good information and advice it is communicated well;
- Promote civic pride;
- Isolation and loneliness and ability of people to get involved in their communities;
- Prevention;
- Accessible and good quality open space.

Our response

Our Health and Wellbeing Goals for Thurrock:

- Opportunity for all
- Healthy environments
- Better emotional health and wellbeing
- Quality care centred around the person
- Healthier for longer

We have developed five clear goals which are supported by a number of objectives. These goals and objectives make clear what we will focus on to improve the health and wellbeing of Thurrock people.

We are confident that our goals and objectives reflect the themes that emerged from public engagement.

What's changed as a result of engagement?

Engagement has allowed us to check our understanding of what the priorities are for improving health and wellbeing in Thurrock. People told us clearly what those priorities were, as several key themes emerged:

- Accessibility to and quality of health services;
- Air quality;
- Access to good quality open space;
- Loneliness and isolation;
- Good information and advice; and
- Educating people to take care of their own health and wellbeing.

The themes arising from the engagement exercise led us to strengthen and change some of our goals and objectives. This includes:

- An objective on air quality – 'improve air quality in Thurrock'
- An objective on health care – 'provide high quality GP and hospital care in Thurrock
- We have also made the 'priority areas' (now goals) far clearer and removed duplication as a result of feedback received

What about the things we didn't include

Just because we didn't include certain topics in our Strategy, doesn't mean they are not being progressed.

We will continue to review the Strategy, its goals and its objectives, to ensure that it is focused correctly and making an impact.

We will also be developing detailed action plans that support the delivery of each of the five goals.

Whilst we were pleased that many of the themes from the engagement exercise matched what we thought the key areas of focus should be, and have also led to us adding or strengthening parts of the Strategy, we haven't included everything. For example:

- We wanted the goals and objectives to impact on the health and wellbeing of everyone, so we have not included at this level a focus on specific groups;
- We have not included reducing domestic abuse as an objective as discussions are taking place as to where the agenda is best placed to have the greatest impact; and
- Some of the comments made will influence action planning as they were too specific for the strategy, or should be 'business as usual' for key organisations.

There are a number of other strategies and plans that contain activity mentioned in the engagement exercise, but not included within the Health and Wellbeing Strategy.

What's next?

We will be working with Healthwatch Thurrock, Thurrock CVS, and Thurrock Coalition to ensure we design a process that enables Thurrock people to be involved in developing our action plans and also measuring success.

healthwatch

Thurrockcvs

Once the Strategy has been agreed, we will be developing five action plans to support each of the Strategy's five goals.

We want to make sure that the action plans are developed with input from Thurrock people.

We also want to make sure that Thurrock people are involved in helping us to find out if the Strategy is making a difference.

What happened to the last Strategy?

Our first Strategy was agreed in 2013. It has achieved the following:

Adult Health and Wellbeing	Children and Young People's Health and Wellbeing
• Development of Local Area Coordination service; • Development of Derry Avenue (Bruyn's Court) housing scheme for older people; • Four GP hubs with extended opening and walk-in appointments; • Basildon Hospital out of special measures; • Development of Thurrock's first Better Care Fund Plan between the Council and Thurrock Clinical Commissioning Group • Delivery of Elizabeth House Extra Care facility	• Thurrock performing above the national and comparator average for children with good level development (GLD); • Improvement in the number of children achieving grades A-C at GCSE level; • Improved rate of young people achieving at least a level 3 qualification by the age of 19; • Launch of Thurrock's Multi-Agency Safeguarding Hub; • Strong performance on the number of young people not in employment, education or training

Where can I find more information?

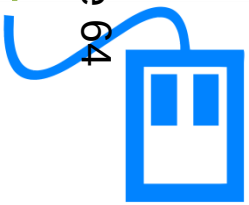
Many people told us that they didn't know where to go to find out information – particularly about health and care services or about how to live a healthy life.

We launched our Information and Advice Portal last year to help people who wanted to know more about health and care services, and also useful references to help groups and resources available in the community.

www.mycare.thurrock.gov.uk

Have any comments or what to get involved?

If you have any comments on the report or would like to be involved in future Health and Wellbeing Strategy work, then please contact us:



ASCpolicy@thurrock.gov.uk

Strategy Officer - Adults, Housing and Health, Thurrock Council, New Road, Grays, RM17 6SL.

10 March 2016	ITEM: 8
Health and Wellbeing Board	
Proposed amendments to Thurrock Health and Wellbeing Board membership	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ceri Armstrong, Directorate Strategy Officer	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is public	

Executive Summary

The purpose of this report is to ask the Board to agree to amend its membership to include the senior Council officer responsible for the Borough's regeneration agenda. Doing so will ensure the links between the people and place agendas are recognised and cemented, and that the Board can influence the regeneration agenda to positively impact on the Health and Wellbeing of Thurrock's population.

1. Recommendation(s)

1.1 That the Board agrees to invite the senior Council officer with responsibility for the Borough's regeneration agenda to become a full member of the Board – subject to agreement by Council.

2. Introduction and Background

2.1 The development of the Health and Wellbeing Strategy for 2016-2021 has highlighted the relationship between the 'people' and 'place' agendas, and the potential impact of the 'place' agenda on the health and wellbeing of Thurrock people.

2.2 Thurrock is the largest regeneration area in the UK, with six growth hubs:

- Purfleet - home of High House Production Park and soon a new town centre;
- Lakeside and West Thurrock - already a major retail and leisure destination and set to expand to become a regional town centre;
- Grays - the administrative hub of Thurrock will build upon the current projects to improve economic growth and enhance the public realm;

- Tilbury - a new vision will build on the strengths of the close community and expansion of the port;
- London Gateway - the largest inward investment project in the UK sees DP World's high tech deep-sea container port open in 2013 and be home to a high tech logistics business park creating thousands of new jobs; and
- Thames Enterprise Park - creating an Environmental Technologies and Energy hub alongside a new import/export and blending facility for oil products on the site of the former Coryton Oil Refinery; it will include the world's first bio jet fuel plant converting landfill waste into jet fuel in a partnership between Solena Fuels and British Airways.

2.3 Failure to recognise both the opportunities and threats the place agenda brings and subsequent failure to maximise or mitigate the impact of those opportunities and threats is a real risk to the Board's ability to improve the health and wellbeing of Thurrock people and reduce related health and wellbeing inequalities.

2.4 This paper recommends a change to the Board's membership to ensure that the necessary links between the 'people' and 'place' agendas are made, that opportunities are maximised, and that threats are controlled. Agreeing a change to the Board's membership will subsequently need to be agreed by Council in accordance with the Council's Constitution.

3. Issues, Options and Analysis of Options

3.1 For the reasons set out in section 2, achieving good health and wellbeing for all is connected to the Board's ability to influence both the people and place agendas and recognise the connections between them. This is recognised within the newly refreshed Health and Wellbeing Strategy 2016-2021 and Outcomes Framework. For example, objectives 'more residents in employment, education or training' and 'develop homes that keep people well and independent' are examples of how the place agenda will influence the health and wellbeing of Thurrock people.

3.2 For the Board to be able to adequately recognise and influence Thurrock's place agenda, it needs to understand what the key issues are and ensure they can be included on the forward plan for discussion and debate. The most effective means of doing this and being able to link in with the place – and in particular the regeneration agenda – is to ensure appropriate representation within the Board's membership. The Director of Housing was previously added as a member of the Board for the same reasons, and the Board also established a Housing and Planning Advisory Group to be able to positively influence the planning and development agenda.

3.3 The Council in preparation for a Corporate Peer Challenge identified the need to strengthen the relationship between the 'people' and the 'place' agendas – including through the Health and Wellbeing Board. Amending the Board's membership as set out in this paper responds to the identified issue.

3.4 The recommendation is for the Board to agree to add the senior Council officer responsible for the regeneration agenda to the Board's membership.

4. Reasons for Recommendation

4.1 For the reasons set out in sections 2 and 3, it is suggested that an addition to the Board's membership of the senior Council officer responsible for regeneration will help to ensure the relationship between the people and place agendas are cemented and that they work to positively influence the health and wellbeing of Thurrock people.

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

5.1 Consultation on the Health and Wellbeing Strategy highlighted the importance of the Board being able to influence the place agenda – including a recommendation from Directors' Board that the Council officer responsible for regeneration should sit on the Health and Wellbeing Board. The recommendation made by Directors' Board is linked to the Council's preparation for its Corporate Peer Challenge which focused on the 'place' agenda.

5.2 Consultation on expanding the membership of the Board will take place via discussion at the Health and Wellbeing Board on the 10th March 2016.

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

6.1 The Health and Wellbeing Board, through the development of the Health and Wellbeing Strategy, is responsible for defining and delivering the priority 'improve health and wellbeing'.

7. Implications

7.1 Financial

Implications verified by: **Roger Harris**

Corporate Director of Adults, Health and Housing

None identified.

7.2 Legal

Implications verified by: **Roger Harris**

Corporate Director of Adults, Health and Housing

None identified.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

Reducing inequalities in the health and wellbeing of Thurrock's population is a key aim of Thurrock's Health and Wellbeing Board and Health and Wellbeing Strategy. Achieving this means being able to influence the factors that contribute to health and wellbeing of the population – including the wider determinants of health and wellbeing. The place agenda has a significant impact on the health and wellbeing of Thurrock people, and the Board's ability to influence that agenda is key to its ability to improve health and wellbeing and reduce inequalities in health and wellbeing.

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

Directorate Strategy Officer

Adults, Housing and Health

10 March 2016	ITEM: 9
Health and Wellbeing Board	
Thurrock Better Care Fund Section 75 Agreement	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Barbara Rice, Portfolio Holder Adult Social Care and Health	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

In March 2015, Cabinet approved Thurrock's Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group. The Agreement allowed the creation of a pooled fund, operated in line with the conditions set within it, to promote the integration of care and support services.

The Council is the 'host' organisation for the pooled fund, which means that once the Section 75 Agreement is agreed, providers of community health care services to be provided under the Better Care Fund can be paid.

The pooled fund is overseen by an Integrated Commissioning Executive made up of officers from the Council and CCG which receive regular reports on expenditure, quality and activity. The Executive reports on the performance of the Fund to the Health and Wellbeing Board, as well as Cabinet and the Board of the CCG.

This report concerns arrangements for 2016/17.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board note the arrangements for entering into a Better Care Fund Section 75 Agreement for 2016/17.

2. Introduction and Background

2.1 The Better Care Fund requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation.

2.2 Section 75 of the NHS Act 2006 gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

2.3 The purpose of the section 75 Agreement is to set out the terms on which the Partners (Thurrock Council and Thurrock NHS Clinical Commissioning Group) have agreed to collaborate and to establish a framework through which the Partners can secure the future provision of health and social care services. It is also the means through which the Partners will pool funds.

2.4 The Agreement to support Thurrock's 2015/16 Better Care Fund was agreed by Cabinet at its meeting in March 2015. Whilst the Agreement supported the 2015/16 Better Care Fund Plan, the intention was that it could be rolled over in to subsequent years with changes made to reflect the updated Better Care Fund for 2016/17.

2.5 Better Care Fund allocations by area have very recently been published. On this basis, Cabinet was asked at its meeting of the 9th March 2016 to agree to the Council entering in to the Section 75 agreement for 2016/17, and to delegate changes and final sign off to the Director of Adults, Housing and Health and Director of Finance and ICT in conjunction with the Portfolio Holder for Adult Social Care and Health.

3. Issues, Options and Analysis of Options

Value of the Better Care Fund

3.1 The value of Thurrock's Better Care Fund for 2015/16 was £18,019,336. This was made up of a £14,766,142 contribution from the CCG and a £3,253,194 contribution from the Council. The Fund consisted of a mandatory amount, and an additional contribution agreed locally by the Council and CCG. The mandated amount for Thurrock's Better Care Fund in 2015/16 was £10,565,000.

3.2 Allocations for 2016/17 were published on the 9th February 2016. For Thurrock, the mandated Better Care Fund amount is £10,770,000. This consists of a contribution from the CCG of £9,871,000 and a contribution from the Council of £899,000. As part of preparations for the 2016/17 Better Care Fund, the Council and CCG will need to agree how much they are adding to the Fund over and above the mandated amount. This is unlikely to be less than the amount added to the Fund in 2015/16.

Focus of the Fund

3.3 The Better Care Fund 2016/17 Policy Framework outlines changes for 2016/17. This includes:

- Increased Fund of £3.9 billion compared to £3.8 billion in 2015/16;
- £1 billion payment for performance element to be removed; and
- The addition of two new national conditions which replace the performance fund – requirement for local areas to fund NHS

commissioned out-of-hospital services; and to develop a clear, focused action plan for managing delayed transfers of care (DTOC).

3.4 The focus of Thurrock's Better Care Fund in 2015/16 was on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes chosen for the Fund reflected this focus. The schemes contained within the 2015/16 Plan will be reviewed to reflect the latest position, but it is likely that the 2016/17 Plan will retain the same focus.

Overspends and Underspends in the Better Care Fund

3.5 The March 2015 Cabinet report and Section 75 Agreement set out arrangements for overspends and underspends to the Fund. The arrangements will continue and consist of any expenditure over and above the value of the Fund falling to the Council or CCG depending on whether the expenditure is incurred on social care functions or health functions. Arrangements for monitoring expenditure and managing any overspend in an individual scheme are set out in detail within the Section 75 Agreement. Underspends will stay within the Pooled Fund unless otherwise agreed by both parties.

Governance

3.6 Similar to the majority of areas, the Council is the host for the pooled Fund. The management of the pooled Fund has regular oversight by both the Council and CCG including through the established Integrated Commissioning Executive. The Executive reports to the Health and Wellbeing Board. A Pooled Fund Manager exists to provide regular reports.

Contracting arrangements

3.7 The Council as host of the Fund enters into contracts with third party providers – namely NHS providers. The standard NHS contact is used for these services with the Council becoming an equal commissioning partner. This arrangement will continue in to 2016/17 with the majority of the Fund relating to existing NHS contracts.

4. Reasons for Recommendation

4.1 To ensure that the Health and Wellbeing Board are aware of the arrangements for entering in to Better Care pooled fund arrangements between the Council and CCG in 2016/17.

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

5.1 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services, as required under the terms of the Health and Social Care Act 2012, was held in September and October 2014.

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

6.1 A key aim of the Better Care Fund is to reduce emergency admissions, which brings with it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services. This will contribute to the priority of 'Improve Health and Wellbeing' and the vision set out within the refreshed Health and Wellbeing Strategy 2016-2021.

6.2 Achieving closer integration and improved outcomes for patients, service users and carers is also seen to being a significant way of managing demand for health and social care services, and so manage financial pressures on both the CCG and the Council.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Management Accountant

The Better Care Fund is made up of contributions from the Council and Thurrock CCG. The mandated amount as published on the 9th February 2016 is £9,871,000 for Thurrock CCG and £899,000 for Thurrock Council. Additional contributions for 2016/17 have not yet been confirmed, but are unlikely to be less than 2015/16 amounts which are £5,046,142 for Thurrock CCG and £2,408,194 for Thurrock Council.

The nature of the expenditure is an agreed ring-fenced fund. Financial risk is therefore minimised and governed by the terms set out in the Agreement. Paragraph 3.5 refers.

The Fund will be accounted for in accordance with the relevant legislation and regulations, and the agreement between the Local Authority and CCG.

Financial monitoring arrangements are in place, ensuring that auditing requirements are met, as well as disclosure in the financial statements.

7.2 Legal

Implications verified by: **Paul O'Reilly**

Projects Lawyer

Legal Services can advise that the entry of the Council into the Better Care Fund Agreement is governed by S75 of the NHS Act 2006. The procurement of specific services by the Council utilising the Better Care Fund is a separate process for consideration and will be the subject of a further report. Legal Services will ensure its continuing availability to support the Corporate

Director of Adult Social Care and appropriate colleagues during the further procurement exercise.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and social care services. The commissioning plans developed to realise this vision will be developed with due regard to the equality and diversity considerations.

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):

- Cabinet Report March 2015

9. Appendices to the report

None

Report Author:

Ceri Armstrong

Directorate Strategy Officer

Adults Housing and Health

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10 March 2016	ITEM: 10
Health and Wellbeing Board	
Reporting Arrangements with Thurrock Integrated Commissioning Executive	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ceri Armstrong, Directorate Strategy Officer	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health; and Mandy Ansell, Acting Interim Accountable Officer Thurrock CCG	
This report is public	

Executive Summary

The Integrated Commissioning Executive is responsible for overseeing the development and delivery of the Better Care Fund Plan. This includes all decisions and oversight relating to the Better Care Pooled Fund.

The Integrated Commissioning Executive is responsible to the Health and Wellbeing Board and the Board are responsible for signing off the Better Care Fund Plan.

This report sets out the reporting arrangements between the Board and the Integrated Commissioning Executive. In doing so, it establishes an increased level of transparency and ensures the Board can gain the appropriate levels of assurance for how the Plan is being both developed and delivered.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board agree reporting arrangements with the Integrated Commissioning Executive.

2. Introduction and Background

2.1 The Integrated Commissioning Executive was established for the purpose of overseeing the development and delivery of the Better Care Fund Plan including agreeing the scope of the related health and care transformation programme.

2.2 Reporting arrangements for the Integrated Commissioning Executive are to the Health and Wellbeing Board and respective partner organisations – Thurrock Council and Thurrock CCG.

2.3 The first Better Care Fund Plan and Better Care Fund Section 75 Agreement commenced in April 2015. Responsibility for the Plan and for adhering to the terms of the Section 75 Agreement fall to the Integrated Commissioning Executive, and the Executive meets on a monthly basis to do this.

2.4 The purpose of this report is to formalise reporting arrangements between the Integrated Commissioning Executive and Health and Wellbeing Board to ensure that the Board has appropriate oversight of the decisions and operation governing the delivery of Thurrock's Better Care Fund Plan.

3. Issues, Options and Analysis of Options

3.1 The Integrated Commissioning Executive meets monthly to oversee the development and delivery of Thurrock's Better Care Plan and Better Care Fund. How the Fund operates is governed by a section 75 agreement between the Council and Thurrock CCG. The Fund is spent in accordance with the Plan which is agreed by the Health and Wellbeing Board. Any changes must be agreed by both parties (Thurrock Council and Thurrock CCG) through the Integrated Commissioning Executive.

3.2 Whilst the Integrated Executive Committee is governed by the Health and Wellbeing Board, formal reporting arrangements have not been established – the section 75 agreement includes the Executive Committee's Terms of Reference which state that an annual governance report should be brought to the Board. In order for the Board to receive the assurance it requires and to have necessary oversight, the recommendation is that the Board receives Integrated Commissioning Executive minutes at each Board meeting – in addition to an annual governance report.

3.3 The minutes from the most recent meeting (January 2016) are attached for the Board's review.

4. Reasons for Recommendation

4.1 Formalising reporting arrangements between the Board and Integrated Commissioning Executive will allow the Board to gain the assurance it needs that the Better Care Plan is being delivered as agreed, and that the Pooled Fund is being spent in accordance with the terms and conditions set out within the Section 75 Agreement.

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

5.1 Discussions have taken place with members of the Integrated Commissioning Executive.

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

6.1 The delivery of the Better Care Fund Plan is linked to the delivery of the Health and Wellbeing Strategy and therefore the corporate priority 'improve health and wellbeing'. The Plan aims to develop the health and care system to prevent, reduce and delay the need for health and care services.

7. Implications

7.1 Financial

Implications verified by: **Roger Harris**

Corporate Director of Adults, Housing and Health

The terms of the Better Care Fund are set out within the section 75 agreement. The Council is the host organisation for the Fund and provides regular reports through the Integrated Commissioning Executive. Reporting of meeting minutes to the Health and Wellbeing Board will provide a greater degree of transparency and oversight.

7.2 Legal

Implications verified by: **Roger Harris**

Corporate Director of Adults, Housing and Health

The governance arrangements for the Better Care Fund are set out within the Better Care Fund Section 75 Agreement (section 19). This includes the establishment of the Integrated Commissioning Executive to meet the roles and obligations set out in schedule 2 of the Agreement.

The Section 75 Agreement sets out that the Integrated Commissioning Executive will prepare an annual governance statement, which will be included to the Health and Wellbeing Board, on an annual basis. Reporting of meeting minutes to the Health and Wellbeing Board will further strengthen the established governance arrangements and increase the level of transparency concerning how the Fund operates and how the Plan is being delivered.

7.3 **Diversity and Equality**

Implications verified by: **Roger Harris**

Corporate Director of Adults, Housing and Health

No diversity and equality implications have been identified in relation to this report, although reporting of meeting minutes from the Integrated Commissioning Executive to the Health and Wellbeing Board will allow further scrutiny of decisions and enable the Board to challenge any decisions – including any challenges related to diversity and equality.

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):

- Better Care Fund Section 75 Agreement 2015-16

9. Appendices to the report

- Integrated Commissioning Executive – January 2016 Meeting Minutes
- Integrated Commissioning Executive Terms of Reference

Report Author:

Ceri Armstrong

Strategy Officer

Adults, Housing and Health

MINUTES

Integrated Commissioning Executive

6th January 2016

Attendees
Roger Harris (RH) – Director of Adults, Health and Commissioning (Joint Chair)
Mandy Ansell (MA) – Acting Interim Accountable Officer (Joint Chair*)
Mark Tebbs (MT) – Head of Integrated Commissioning
Ceri Armstrong (CA) – Directorate Strategy Officer
Ade Olarinde (AO) - Chief Finance Officer
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation

Apologies
Sean Clark (SC) – Head of Corporate Finance
Mike Jones (MJ) – Finance Manager
Ian Wake (IW) – Director of Public Health
Allison Hall (AH) – Commissioning Officer

Item No.	Subject	Action Owner and Deadlines
1.	**Notes of previous meeting (26th November) and matters arising**	
	Notes of the 26th November meeting were agreed.	
2.	**Better Care Fund 2016/17 – Refreshing Thurrock's BCF**	
	The first draft of the Better Care Fund 16/17 was due on the 8th February with a final version requiring submission in April. There was a potential issue with the submission of the Plan taking place during the purdah period. It was agreed that there should be a light refresh of the Plan, including the vision and Direction of Travel. The CCG Transformation Plan should also be reflected within the refreshed BCF. The schemes would need to be reviewed. Ade stated that he was currently rebasing NHS provider contract values based on activity levels. The section 75 should go to the March Cabinet, but delegations would be required due to the number of	

	unknowns.	
3.	**Thurrock CCG Transformation Plan**	
	Mark presented the Transforming Thurrock Vision document. Roger asked whether the intention was that this was a joint document, and Mark replied that he felt it was be stronger if that was the case. It was agreed that MT and CW would meet to discuss and to scope the document. Comment was also made that it was important that the necessary time was taken for engagement to ensure the document was co-produced. Mark stated that consultation was taking place between March and May and that the first stage of transformation was the intermediate care review.	MT, CW, CS, IW and Jeanette Hucey to meet to agree how to take forward
4.	**Delivering the Forward view – NHS Planning Guidance 2016/17**	
	A timetable for planning had been published as part of the Forward View. This included a full submission of operational plans for 16/17 on the 8th February, and a final submission on the 11th April. Local milestones were likely to be earlier. The Group were told that the Estates Strategy Plan was likely to be part of the local Sustainability and Transformation Plan.	
5.	**Success Regime – Commissioning and Geographical Footprint**	
	MA reported on the Success Regime (SR) meeting she had attended on the 5th January. The main focus of the SR was to achieve financial stability by 19/20. Different work streams had been established which included Commissioning, Acute, Emergency Care, and Urgent Care. Each work stream had been allocated a lead. The Local Authority including the role of Public Health appeared to receive little mention with the focus of the SR being achieving financial balance of the three Hospitals and CCGs. The geographical footprint for the SR was split in to West, North and 'Central' Essex. Central Essex was South and Mid-Essex. A meeting had been arranged between Andrew Pike and the Leader of the Council and Chief Executive. A joint meeting was already been arranged between the three HWBBs by Essex HWBB. Concerns were raised about the potential of the SR to	

	dominate all agendas. MA reported that CCG allocations were increasing on average by 3.4% and that Sustainability and Transformation Plans would be written on a local footprint (i.e. Thurrock) and not the Essex SR footprint. MT distributed the 'geographic levels of commissioning' diagram for discussion. It was agreed that social care commissioning projects should be added to the diagram as well as the five HWB Strategy goals.	CW/MT to amend diagram
6.	**Medeanalytics**	
	A task and finish group were to be established to look at the requirements and also to evaluate different systems. A final report would be brought back to the Group with recommendations. Any comments on the paper should be made to Mark with Ian Wake copied in.	Comments on paper to MT
7.	**Any Other Business**	
	AO will send to the Group the final submission for Quarter 2 (BCF). An internal audit report has taken place, and AO will circulate any relevant recommendations. RH stated that it was important that notes of this meeting went to the HWBB for sign off as the Group reported to the Board.	AO to action AO to action CA to ensure on HWBB agenda

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TERMS OF REFERENCE – INTEGRATED COMMISSIONING EXECUTIVE

1 Integrated Commissioning Executive

The membership of the Integrated Commissioning Executive will be as follows:

CCG:

- Mandy Ansell (Chief Operating Officer(CCG)) or her successor
- Ade Olarinde (Chief Finance Officer) or his successor
- Mark Tebbs (Head of Integrated Commissioning) or his successor

or a deputy to be notified to the other members in advance of any meeting;

the Council:

- Roger Harris (Director of Adult Health and Commissioning) or his successor
- Sean Clark (Head of Finance) or his successor
- Catherine Wilson (Strategic Lead for Commissioning) or her successor

or a deputy to be notified in writing to Chair in advance of any meeting;

2 Role of Integrated Commissioning Executive

3 The Integrated Commissioning Executive shall:

Provide strategic direction on the Individual Schemes

receive the financial and activity information;

review the operation of this Agreement, including by way of formal Annual Review, and performance manage the Individual Services;

agree such variations to this Agreement from time to time as it thinks fit;

review risks Quarterly and agree annually a risk assessment and a Performance Payment protocol;

review and agree annually revised Schedules as necessary; and

request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Pooled Fund;

4 Integrated Commissioning Executive Support

The Integrated Commissioning Executive will be supported by officers from the Partners from time to time.

5 Meetings

The Integrated Commissioning Executive will meet at least Quarterly at a time to be agreed within following receipt of each Quarterly report or other reports of the Pooled Fund Manager.

The quorum for meetings of the Integrated Commissioning Executive shall be a minimum of two representatives from each of the Partner organisations. Attendees may attend meetings via telephone or teleconference facility.

Decisions of the Integrated Commissioning Executive shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Integrated Commissioning Executive. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

6 Delegated Authority

The Integrated Commissioning Executive is authorised within the limit of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to authorise an officer of the Host Partner to enter into any contract for services necessary for the provision of Services under an Individual Scheme.

7 Information and Reports

The Pooled Fund Manager shall supply to the Integrated Commissioning Executive on a Quarterly basis the financial and activity information as required under the Agreement.

8 Post-termination

The Integrated Commissioning Executive shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

9 Extra-Ordinary or Urgent Meetings

If there are urgent or extra-ordinary matters to be considered the Integrated Commissioning Executive may choose to meet between the Quarterly interval in order to take decisions on urgent issues.

10. Annual Governance Statement

The Integrated Commissioning Executive will prepare an annual governance statement, which will be included in a report to the Health and Wellbeing Board, on an annual basis.

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10 March 2016	ITEM: 11
Thurrock Health and Well-Being Board	
Essex Success Regime	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Roger Harris – Corporate Director of Adults, Housing and Health. Mandy Ansell – Acting, Interim Accountable Officer – Thurrock Clinical Commissioning Group	
Accountable Head of Service: N/A	
Accountable Director: As Above	
This report is Public	

Executive Summary

This report provides the Thurrock Health and Well-Being Board (HWBB) with an update on the current progress being made with the Essex Success Regime (ESR).

A detailed stakeholder summary has been sent out to all stakeholders across Essex, Southend and Thurrock. A copy of that briefing is attached.

The ESR is a national programme designed to support health and care economies with challenging financial, workforce and service difficulties. Essex is one of three health and care economies within a Success Regime framework.

1. Recommendation(s)

1.1 The HWBB is asked to note and comment on the current developments with the Essex Success regime and in particular their impact on Thurrock.

1.2 The HWBB will receive a more detailed briefing at a further meeting when more information is available on the impact on Thurrock residents.

2. Introduction and Background

2.1 The ESR was launched in June 2015. A diagnostic phase ran from October to November 2015. Out of that initial phase the geography of the ESR was refined and the ESR was focussed only on Mid and South Essex (see map within attached briefing). The goal is to :

- Create an integrated, internally consistent whole system plan for Mid and South Essex;
- Get the system back into financial balance by 2018/19;
- Enable local organisations to deliver high quality care and address local inequalities

3. Issues, Options and Analysis of Options

3.1 It is important that there are clear benefits for the people of Thurrock out of this complicated and top down process. There are clearly urgent, immediate financial and workforce problems that are being faced by the three acute trusts that now form the core element of the ESR boundaries. These do have to be addressed but at the same time it is an opportunity to be radical and tackle some of the root causes of the problems being faced by the acute sector.

3.2 The work that has started around out of hospital care and in particular the focus on primary care is very encouraging and does offer the opportunity to make some significant changes to the current health and care system so that there is a much stronger focus on prevent and early intervention.

4. Reasons for Recommendation

4.1 No formal decision is required at this stage but a more formal consultation report will be produced later this year and that will come back for further consideration.

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

5.1 A similar report will be going to the next meeting of the Health and Well-Being Overview and Scrutiny Committee.

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

6.1 N/A

7. Implications

7.1 Financial

Implications verified by: **Roger Harris**

Corporate Director

N/A as the report is only for information at this stage.

7.2 **Legal**

Implications verified by: **Roger Harris**
Corporate Director

N/A as the report is only for information at this stage.

7.3 **Diversity and Equality**

Implications verified by: **Roger Harris**
Corporate Director

N/A as the report is only for information at this stage.

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):

- Stakeholder Briefing

9. Appendices to the report

- Stakeholder Briefing

Report Author:

Roger Harris
Corporate Director
Adults, Housing and Health

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Mid and South Essex Success Regime

A programme to sustain services and improve care

Progress update

Update no.2 – 1 March 2016

What's in this briefing

This briefing starts the first of several phases of local involvement in the development of plans for potential service change in mid and south Essex.

The document provides a summary of discussions to date, some background on the key issues and the areas where changes may be needed in order to sustain local NHS services and improve care.

How to have your say

1. Send us your views in writing

   Please write to us at england.essexsuccessregime@nhs.net

2. Hold a discussion within your team, group or organisation

   Local trusts, CCGs and other organisations are arranging staff briefings. Check your staff news or ask your line manager for details.

3. Invite us to attend your meeting

   If you would like a representative to attend your meeting, please contact us on england.essexsuccessregime@nhs.net

Contents

Summary

Why change is needed

- We need to keep pace with changes in modern healthcare so that we can do more for patients now and in the future.

- If we do not change, the current NHS deficit in mid and south Essex could rise to over £216 million by 2018/19; and we would not be able to meet year on year growing demands.

- Our aim is to get the system back into balance by 2018/19 and deliver the best joined up and personalised care for patients.

- The kinds of changes we are looking to make have major benefits for patients, such as:

    - More emphasis on helping people to stay well and tackling problems at an earlier stage to avoid crises.

    - Joined up health and care services to provide more care for people at home and in the community, avoiding the need for a visit to hospital.

    - New technologies and treatments to do more for people without the need to be in hospital, even in a crisis.

    - When people do need the specialist care that only a hospital can provide, collaboration between hospitals and other services will ensure the best possible clinical staff and facilities.

    - By redesigning some hospital services, the improvements in staffing levels and capability will mean safer, more effective, more compassionate care for patients.

The plan to date

- The Success Regime gives us the opportunity to realise the full potential of our workforce and provide the best of modern healthcare for local people.

- Change will be led by clinicians. Service users, staff and local people will have a say at every stage.

- The Success Regime provides programme structure and support.

- We have identified six areas for change to sustain local services and improve care. These are listed below:

    1. **Address clinical and financial sustainability of local hospitals by:**

        - Increasing collaboration and service redesign across three sites
        - Sharing back office and clinical support services.

    2. **Accelerate plans for changes in urgent and emergency care, in line with national recommendations e.g.:**

        - Doing more to help people avoid problems and get the right help
        - Developing same day services and urgent care in communities, to reduce unnecessary visits and admissions to hospital
        - Designating hospital sites for specialist emergency care.

    3. **Join up community-based services** – GPs, primary, community, mental heath and social care – around defined localities or hubs.

    4. **Simplify commissioning**, reduce workload and bureaucracy e.g.:

        - Reduce the number of contracts from around 300 to around 50
        - Commission services on a wider scale e.g. with one lead provider where several may be involved
        - Agree a consistent and common offer to focus on priorities and identify limits of NHS funding.

    5. **Develop a flexible workforce** that can work across organisations and geographical boundaries.

    6. **Improve information, IT and shared access to care records**.

Next steps and milestones

1 March 2016	Start of discussions
April	Further detailed planning
End May	Start patient, clinical and staff engagement on potential service changes
Early Sep	Refine options and engage
Sep - Dec	Public consultation on service changes, where required

Background

Area and services involved

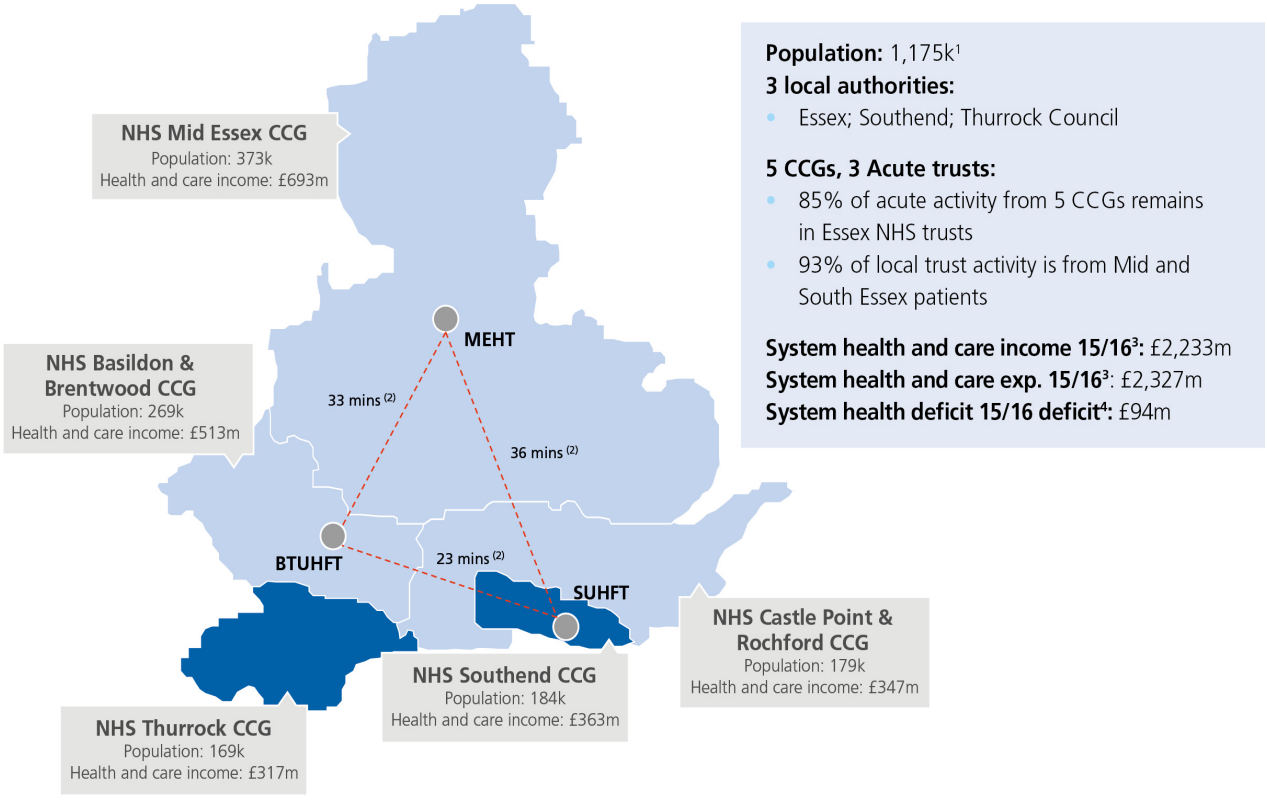
The Mid and South Essex Success Regime involves the following main organisations:

Service providers
Basildon and Thurrock University Hospitals NHS Foundation Trust
East of England Ambulance Service NHS Trust
Mid Essex Hospital Services NHS Trust
NELFT NHS Foundation Trust
North Essex Partnership University NHS Foundation Trust
Provide
Southend University Hospital NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust

Clinical commissioning groups (CCGs)
Basildon and Brentwood
Castle Point and Rochford
Mid Essex
Southend
Thurrock

Local authorities:
Essex County Council
Southend-on-sea Borough Council
Thurrock Council

All health and social care services are involved in the programme, including over 180 GP practices, community services, mental health and social care and hospital services.



Note: all financials are 2015/16 estimates: Version 13, 12th Feb modelling assumptions
1. Population based on 14/15
2. Travel times without traffic from google (Jan 16)
3. Includes estimate of social care expenditure (based on 14/15 report) related to health and CCG mental health expenditure
4. Deficit relates to health only

A programme to sustain services and improve care

All health services are going through major changes. New technologies and ways of working are opening up opportunities that change what is possible – faster scans and treatments, more day surgery, more care for people at home and better ways to manage health and wellbeing.

However, it is also a major challenge to keep pace with developments and at the same time to manage the escalating demands on health services every year. Mid and south Essex has a rapidly growing population and the proportion of older people in the population is also fast increasing. In addition to rising demands from people living with long term-conditions, such as diabetes, heart problems and chest problems, we are seeing more complexity of health issues, and people living with several long-term conditions.

This leads to rising costs and pressures on staffing levels.

- **Current estimates show the total deficit for the NHS in mid and south Essex will be £94 million in 2015/16.**

- **If we made no changes to way in which we provide health services the deficit would rise to an estimated £216 million by 2018/19.**

And yet, we know that there is significant potential to reduce costs and get the system back into balance by doing things differently. This is possible by delivering more personalised, safer, higher quality care.

All organisations in mid and south Essex are already working on transforming services to keep people healthy and well and out of hospital. The Success Regime is a programme designed to build on what is already happening and to speed up the pace of change.

How the Success Regime is supporting change

The Mid and South Essex Success Regime is currently one of three such programmes in the country. It is overseen jointly by three national organisations - NHS England, NHS Trust Development Authority and Monitor, which looks after NHS Foundation Trusts. The other two Success Regimes are in Devon and Cumbria.

Local clinicians, supported by managers, will continue to drive change with the involvement of partners and local people. The Success Regime provides coordination and programme management, plus financial support, and will help to unblock any barriers to change.

The work is assured by the national organisations. This will provide independent challenge, but also ensure Essex is connected to best practice nationally.

Scope of the Success Regime

The Success Regime covers a wide spectrum of change, but not all change that is happening in mid and south Essex.

Other transformational change programmes will continue as planned already. These include, for example, transformation in mental health services, services for people with learning disabilities and services for the emotional wellbeing and mental health of children and young people.

The main areas of change for patients

Local health and care

This area of work builds on and extends existing CCG plans to expand the range of services in GP surgeries and local health centres by bringing together teams of health and care professionals to meet rising demands.

Examples of potential developments include:

- Increasing the number of consultations available locally by involving a wider range of professionals in primary care
- Teams working together to support patients with complex needs, such as frail and older people, or people receiving end of life care
- Shifting some routine hospital outpatient services to GP surgeries or local health centres
- Strengthening links with voluntary sector, housing and other public services in each locality.

Care in hospital

The three main hospitals are seeking to extend their current collaboration in order to improve staffing levels in some specialties, reduce duplication and costs and improve outcomes for patients.

The plan is to take steps towards building single teams in some specialties, clinical support and back office functions.

Clinicians will be looking at which specialties could improve care through sharing expertise across the three sites in order to improve clinical staffing rotas and meet national guidelines.

Some specialised services that are already centralised on one site would continue in the same location, such as cardiothoracic services at Basildon, radiotherapy at Southend and burns and plastics at Broomfield.

Urgent and emergency care

One key element in managing health emergencies is to do everything possible to avoid the emergency arising in the first place.

This could include, for example:

- Proactive care and support for patients who could be at risk of hospital admissions

- Developing frailty assessment units to ensure frail people are seen by staff with specialist skills

- Improving 24/7 mental health crisis support

- Continuing to improve 111 and ambulance services to treat people, both on the phone and in the community

- Consistent health and social care support for older people leaving hospital.

National guidelines recommend that some specialist emergency care should be provided by a designated centre, with the appropriate infrastructure for the delivery of such services. This ensures that services can meet nationally recommended staffing levels for emergency medical and surgical expertise. Over the next few months, clinicians will work together to develop options for designation.

What this means for patients is that most people in need of urgent care could be seen at home, in a local GP surgery or health centre or at the nearest local hospital. Under the options, some very serious emergencies would be taken by ambulance to a designated hospital.

Commissioning – developing a "common offer" of services

CCGs plan and buy healthcare services for their local population by placing contracts with service providers, which set the amount of money spent on services and the quality standards expected from those services.

The five CCGs in the Success Regime will work together to simplify contractual arrangements, and to reduce current variations in access to NHS services.

Support to make change happen

Alongside the clinical work to develop options for service change, we need to increase the pace of development in systems and people to put new models into practice. This includes:

- Improving information and IT to provide real-time access to care records.

- Improving data and analysis to understand patient needs

- Looking at what changes may be required to ensure that new services have the right buildings and facilities, and releasing outdated estate that is no longer required

- Creating new roles, improving education training and career progressions.

Governance for collaboration

The Success Regime offers an opportunity to put new arrangements in place that will support collaboration between local organisations e.g.:

- Exploration and agreement on a group model for the three main hospitals

- A committee for the five CCGs to plan and buy services jointly across mid and south Essex.

Success Regime governance

- As a programme, the Mid and South Essex Success Regime is accountable to the Regional Directors of the national organisations.

- Locally, the Success Regime has a System Leaders Group, chaired by an independent clinical chair, Dr Anita Donley, a consultant from Plymouth Hospitals NHS Trust and clinical vice-president of the Royal College of Physicians.

Further information

A more detailed briefing is available on our website. Please visit:

http://castlepointandrochfordccg.nhs.uk/success-regime

If you would like further information, to arrange a meeting or you would like to send us your views, please write to us at
england.essexsuccessregime@nhs.net

Key contact:
Wendy Smith, Interim Communications Lead
Mid and South Essex Success Regime

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Tuesday, 1 March 2016

PRESS RELEASE

Mid and South Essex Success Regime - latest progress and start of discussions

The Mid and South Essex Success Regime has today (1 March) issued an update on work to date. A stakeholder briefing, outlining areas for service change is available online. Over the coming weeks and months more detail will follow to develop options.

The three main areas that may involve service changes are:

- Faster progress towards joined up health and social care based around localities
- More collaboration and shared services across the three main hospitals in Basildon, Chelmsford and Southend
- Changes in urgent and emergency care in line with national recommendations.

The other three areas involve simplifying commissioning and contractual arrangements, developing the healthcare workforce and improving IT and access to shared care records. The intention is to have clinically sustainable services in financial balance by 2018/19.

Dr Ronan Fenton, Medical Director of Mid Essex Hospital Services NHS Trust leads the Clinical and Professional Leaders Group, which includes lead clinicians from all of the NHS organisations in mid and south Essex and public health and social care professionals from Essex County Council, Southend-on-sea Borough Council and Thurrock Council.

Said Dr Ronan Fenton;

“The Success Regime provides the programme structure and support for our organisations to work together to get the best of modern healthcare to local people.

“This is our opportunity to put services in mid and south Essex at the leading edge of health and social care. This is the chance for clinicians and staff to do what they believe in and have the potential to achieve – safer, more effective, more compassionate care for patients.

“If we don’t change, the current estimated deficit across mid and south Essex could rise to £216 million by 2018/19; and we would not be able to meet year on year growing demands.

“New technologies and treatments are making it possible to do more for people without the need to be in an expensive hospital, even in some crisis situations. Our challenge is to make organisational changes as quickly and as smoothly as possible to put the system back into balance in 2018/19 and deliver the best joined up and personalised care for patients.”

From now until September there will be opportunities for staff, clinicians and local people to get involved in developing options for consultation. Consultation on options for proposed changes is likely in the autumn.

The stakeholder briefing, *Mid and South Essex Success Regime: A programme to sustain services and improve care* is available for download at http://castlepointandrochfordccg.nhs.uk/success-regime

Notes to editors

1. Five examples of ways in which change is improving care for patients:

    - More emphasis on helping people to stay well and tackling problems at an earlier stage to avoid crises.

    - Joined up health and care services to provide more care for people at home and in the community, avoiding the need for a visit to hospital.

    - New technologies and treatments to do more for people without the need to be in hospital, even in a crisis.

    - When people do need the specialist care that only a hospital can provide, collaboration between hospitals and other services will ensure the best possible clinical staff and facilities.

    - By reconfiguring some hospital services, the improvements in staffing levels and capability will mean safer, more effective, more compassionate care for patients.

2. The Mid and South Essex Success Regime is currently one of three such programmes concentrating on areas in the country where there are deep-rooted, systemic pressures. It is overseen jointly by a tripartite of national organisations - NHS England, NHS Trust Development Authority and Monitor, which looks after NHS Foundation Trusts. The other two Success Regimes are in Devon and Cumbria.

3. The Mid and South Essex Success Regime involves the following main organisations:

    Service providers
    Basildon and Thurrock University Hospitals NHS Foundation Trust
    East of England Ambulance Service NHS Trust
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Clinical commissioning groups (CCGs)
Basildon and Brentwood
Castle Point and Rochford
Mid Essex
Southend
Thurrock

Local authorities:
Essex County Council
Southend-on-sea Borough Council
Thurrock Council

4. The Success Regime is part of the NHS Five Year Forward View, which is a blueprint for the NHS to take decisive steps to secure high quality, joined-up care. The Success Regime offers an important opportunity for mid and south Essex by bringing management and financial support to local delivery and helping to unblock any barriers to change.

5. Local clinicians, supported by managers, will drive change with the involvement of partners and local people.

6. The work programmes will be governed locally through a System Leaders Group, led by an independent chair, and a number of working groups involving all of the local statutory health and care organisations. The independent chair is Dr Anita Donley, a consultant physician in acute medicine at Plymouth Hospitals NHS Trust and clinical vice-president of the Royal College of Physicians.

7. For further information, please e-mail england.mediahub@nhs.net or call 0113 825 3231.

8. For further background on the Mid and South Essex Success Regime, please visit http://castlepointandrochfordccg.nhs.uk/success-regime

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