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

# Health and Wellbeing Board

The meeting will be held at **1.00 pm** on **17 November 2016**

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

**Membership:**

Councillors James Halden (Chair), Robert Gledhill, Susan Little, Leslie Gamester and Steve Liddiard

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board
Liv Corbishley, Lay Member for Public and Patient Participation NHS Thurrock CCG
Steve Cox, Corporate Director of Environment and Place
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Roger Harris, Corporate Director of Adults, Housing and Health
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust
Clare Panniker, Chief Executive Basildon and Thurrock Hospitals Foundation Trust
Rory Patterson, Corporate Director of Children's Services
David Peplow, Independent Chair of Local Safeguarding Children's Board
Andrew Pike, Director of Commissioning Operations, NHS England - Essex and East Anglia Region
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust
Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust
Ian Wake, Director of Public Health

**Agenda**

Open to Public and Press

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| **1** | **Apologies for Absence** | |
| **2** | **Minutes** | **5 - 12** |
| | To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 15 September 2016. | |
| **3** | **Urgent Items** | |
| | To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972. | |
| **4** | **Declaration of Interests** | |
| **5** | **Annual Public Health Report** | |
| | Item to be presented by Ian Wake using a Microsoft PowerPoint presentation. | |
| | Papers to follow. | |
| **6** | **Essex Success Regime (ESR) and Sustainability Transformation Plan (STP). Followed by ESR / STP Key Principles** | **13 - 24** |
| | ESR / STP Update Item paper to be accompanied by Microsoft PowerPoint Presentation provided by Andy Vowles | |
| | Key Principles for ESR / STP to be presented by Councillor Halden | |
| **7** | **Item in Focus: Health and Wellbeing Strategy Goal C, Better Emotional Health and Wellbeing** | **25 - 80** |
| | Action Plans and copies of presentations are included within papers. | |
| | Microsoft PowerPoint presentations to be provided as follows: | |
| | Action Plan and presentation for objective C1: Give parents the support they need<br>Sue Green | |
| | Action Plan and presentation for objective C2: Improve children's | |

emotional health and wellbeing

Malcolm Taylor / Helen Farmer

Action Plan and presentation for objective C3: Reduce isolation and loneliness

Les Billingham

Action Plan and presentation for objective C4: Improve the identification and treatment of depression, particularly in high risk groups

Funmi Worrell

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| **8** | **Local Implementation Plan - Five year forward view, mental health** | **81 - 102** |

Item to be presented by Jane Itangata

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| **9** | **ICE and Health and Wellbeing Board Executive Committee Minutes** | **103 - 112** |
| **10** | **Health and Wellbeing Board Work Programme** | **113 - 116** |

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

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

Agenda published on: **9 November 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.

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

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

### Pecuniary

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

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

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

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

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

### Non- pecuniary

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

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

***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 Health and Wellbeing Board held 15th September 2016 at 1.00 pm**

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| **Present:** | Councillors James Halden (Chair), Robert Gledhill, Sue Little, Leslie Gamester and Steve Liddiard.<br><br>Mandy Ansell Acting Interim Accountable Officer, Thurrock CCG<br>Roger Harris, Corporate Director of Adults, Housing and Health<br>Steve Cox, Corporate Director of Environment and Place<br>Liv Corbishley, Lay Member for Public and Patient Participation, Thurrock CCG<br>David Peplow, Independent Chair of Local Safeguarding Children's Board<br>Kim James, Chief Operating Officer, Thurrock Healthwatch<br>Ian Wake, Director of Public Health<br>Rory Patterson, Corporate Director of Children's Services<br>Dr Anjan Bose, Clinical Representative, Thurrock CCG<br>Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust<br>Malcolm McCann Executive Director of Community Services and Partnerships |
| **Apologies:** | Andrew Pike, Director of Commissioning Operations, NHS England Essex and East Anglia<br>Kristina Jackson, Chief Executive, Thurrock CVS<br>Michelle Stapleton, Director of Integrated Care Basildon and Thurrock University Hospitals Foundation Trust<br>Dr Anand Deshpande, Chair of Thurrock NHSCCG<br>Clare Panniker, Chief Executive of Basildon and Thurrock University Hospitals Foundation Trust<br>Jane Foster-Taylor, Executive Nurse, Thurrock CCG<br>Graham Carey, Chair of Thurrock Adults Safeguarding Board |
| **In attendance:** | Tom Abell, Deputy Chief Executive, Basildon and Thurrock University Hospitals Foundation Trust<br>Andy Vowles, Programme Director, Essex Success Regime<br>Jeanette Hucey, Director of Transformation, Thurrock CCG<br>Les Billingham Head of Adult Social Care and Community Development<br>Kirsty Paul, Principal Planning Officer<br>Grant Greatrex, Sport and Leisure and Policy Development Manager<br>Ceri Armstrong, Strategy Officer<br>Darren Kristiansen, Business Manager, Health and Wellbeing Board |

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## 1. Welcome and Introductions

Apologies were noted.

## 2. Minutes

The minutes of the Health and Wellbeing Board held on 14th July were approved as a correct record.

## 3. Urgent Items

There were no urgent items provided in advance of the meeting.

Councillor Halden informed members that he had visited Basildon and Thurrock University Hospital on 14 August. Roger Harris made the Board aware the joint working between Adult Social Care and the Hospital continued to be excellent and that work to identify collaborative solutions to system issues was continuing. Current challenges for the system included:

- Domiciliary Care and Joint Reablement services are experiencing unprecedented pressure and increased demand;
- An increase in demand is being experienced at the Hospital. For example, on 14 September approximately 130 ambulances arrived at the Hospital compared with the expected average at this time of year of approximately 70;
- There has been an increase in delayed discharges from hospital;
- There are ongoing workforce issues including difficulty recruiting staff for domiciliary and residential care across Thurrock and recruitment of nursing staff at the Hospital.
- Cllr Halden will revisit Basildon and Thurrock University Hospital with the Director of Adults Housing and Health in December for an update on progress with identifying opportunities for more joint working.

Tom Abel stated that the Trust is considering how to further support partners with patients that are released from hospital but who require support in the community. A multi-agency Accident and Emergency Delivery Board has been established replacing the System Resilience Group and meets on a fortnightly basis.

## 4. Declaration of Interests

There were no declarations of interest.

## 5. Sustainability and Transformation Plan

Andy Vowles, Programme Director, Essex Success Regime provided the Board with an update on the Essex Success Regime (ESR) and the Mid and South Essex Sustainability and Transformation Plan (STP). In summary:

- All areas in England are required to have a STP in place – there are 44 areas. The key difference with the Success Regime is that it was

announced prior to the requirement for STPs and only applied to three areas of the Country – Essex, Devon and Cumbria. The STP and Success Regime requirements were now aligned;

- The programme comprises two strategic elements. The first focusses on Local Health and Care which involves considering the development of local teams and integrated hubs, the creation of care pathways (initially a frailty care pathway) and access to emergency care. The second focusses on hospitals and considers clinical services and the delivery of wider services including emergency care, surgery, women and children and paediatric services;
- The Out of Hospital strategy focusses on joining up Primary and Secondary Care services and considers physical and mental health as well as Social Care service delivery;
- The STP refresh is scheduled for 21 October and will be considered by Health and Wellbeing Board at its meeting in November.

During discussions the following points were made:

- It was acknowledged that Thurrock has effective partnership arrangements which facilitate the planning and delivery of Health and Social Care services. It is important to ensure that broader governance arrangements established as a consequence of the STP does diminish a Thurrock focus. Cllr Halden stated that it was important that the STP did not disempower local decision making and that decisions should be taken via the Health and Wellbeing Board;
- Cllr Halden advised members that he has been engaging with Councillor Salter (Southend Borough Council) and Councillor Butland (Essex County Council) to develop a set of key principles that provide the basis upon which Success Regime decisions affecting Thurrock, Southend and Essex should be made. Board members were advised that the principles will be presented at a future Health and Wellbeing Board, once they have been agreed and endorsed by Essex and Southend Health and Wellbeing Board chairs.
- Board members were reassured that mental health remains a priority area of focus within the STP and ESR programmes.

RESOLVED:

The update was noted and the Board agreed to continue participating in discussions within the Mid and South Essex Success Regime and STP engagement and consultation programmes, which include stakeholder meetings and meetings of the Essex, Southend and Thurrock Health and Wellbeing Boards.

**6. Item in Focus – Health and Wellbeing Strategy Goal B 'Healthier Environments'**

The Health and Wellbeing Strategy contains five Strategic Goals. The Item in Focus for this meeting was Goal B, which comprises four objectives:

- B1 Create outdoor places that make it easier to exercise and be active. B2 Develop Homes that keep people well and independent.

- B3 Build strong, well connected communities.
- B4 Improve Air Quality in Thurrock

Cllr Halden advised Board members that action plan B4 has been deferred and the Air Quality Strategy and action plan will be presented at a future meeting. The remaining action plans, created to support the delivery of Health and Wellbeing Strategy's objectives and goals were presented to Board members. In summary:

Action Plan B1 was presented by Kirsty Paul, Principal Planning Officer. During the presentation the following points were made:

- Evidence demonstrating the relationship between environment and health is acknowledged. Some of the challenges currently experienced in Thurrock include high levels of inactivity and high levels of adult and childhood obesity (10–11 year olds)
- It is important to address engagement feedback received as part of developing the Active Places Strategy and Local Plan consultation which shows that members of the public:
    - Have a varied opinion on the overall quality of the environment and open spaces
    - Lack of facilities for older children
    - Have raised concerns about safety surrounding open spaces, air quality and road safety.
- There are a wide range of interrelated Strategies that support the development of places that comprise high quality streets and civic spaces with well-connected walking and cycling routes.

Engagement feedback was presented by Kim James, Chief Operating Officer Healthwatch Thurrock:

- 179 people were engaged and provided feedback on B1and key themes reinforced feedback received as part of the Active Places and Local Plan consultation exercises and included:
    - Improved access to parks by including a wider range of activities on offer, tackling anti-social behaviour and maintaining equipment.
    - Communities are keen to assume responsibility by engaging in local groups to maintain parks and green spaces.

During discussions the following points were made:

- It is important to ensure that synergies are created between emerging strategies and plans and compliment Thurrock's 'Clean It, Cut It, Fill It' agenda.
- Consideration should be provided to the impact of new housing developments on the capacity of existing facilities, such as leisure centres.
- The Council's Infrastructure Requirements List (which forms the basis for all future Section 106 negotiations including new applications) remains an important instrument for ensuring that new developments give due consideration to improving health and wellbeing outcomes.

- Consideration should be given to how other partners can support health and wellbeing outcomes. For example, how school facilities could be used for the benefit of the wider community.

Action Plan B2 was presented by Les Billingham, Head of Adult Social Care and Community Development. During the presentation the following points were made:

- Funding had been successfully secured to develop HAPPI Housing which aimed to improve the quality of life of Thurrock's ageing population through complying with a set of specific design requirements. Thurrock also secured £787,000 for 6 specialised homes for young people with Autism or Learning Disabilities to be built in Grays in partnership with Family Mosaic.
- The Health and Wellbeing Housing and Planning Advisory Group is a multi-agency group (including Public Health, the CCG and NHS England) which considers the health and well-being implications of major planning applications, and provides advice and guidance on the health, social care and community impacts of proposed new developments.

Engagement feedback provided by Healthwatch included:

- People living in twenty six sheltered housing accommodation facilities across the Borough were engaged.
- It is important to ensure that local people have an opportunity to inform the design of housing developments to ensure that they can accommodate individuals with wide ranging health needs.

During discussions the following points were made:

- The relationship between the place and the impact on health and wellbeing was acknowledged. It is important to ensure that health and wellbeing continues to remain a key element of the design, planning and delivery of new housing developments. In relation to this point, Councillor Halden raised concerns about the lack of attendance from officers leading on the regeneration agenda.
- It remains vital that new housing developments and section 106 agreements are informed by health and social care requirements.
- It was acknowledged that while the Well Homes programme is targeted at the private sector lessons can be learnt and adopted within public sector tenancy and property management.

Action Plan B3 was presented by Les Billingham, Head of Adult Social Care and Community Development. During the presentation the following points were made:

- The Voluntary and Community Sector plays a key role in designing and delivering the Stronger Communities agenda. It is important to acknowledge that Thurrock Council is utilising expertise and knowledge across the VCS and local communities to build resilience that empowers members of the community and provides alternatives to the existing health and social care service offer.

- The ‘strong well-connected communities’ agenda is managed through the cross-agency Stronger Together Partnership. The programme recognises that people live more fulfilled lives if they can connect with the communities they live in.
- Basildon Council are interested in learning lessons from effective practice demonstrated by Thurrock’s Local Area Coordinator (LACs) programme.

Engagement feedback provided by Healthwatch included:

- Groups primarily consulted in this instance were young mothers and members of the polish community across Thurrock.
- 7 additional volunteers were secured as part of consulting with the public on action plan B3

- 55% of consultees feel that they are active in their community
- 26% of consultees are members of a local community group
- 57% of consultees were aware of community hubs.

During discussions the following points were made:

- It is important to ensure that services are developed across the Borough and are not focussed on specific geographical areas.
- GP practices have been engaged to determine their appetite for Social Prescribing. While there is currently limited funding available to develop this programme it is hoped that Social Prescribing will be rolled out across the Borough in due course.
- The positive impact that Community Hubs have on local communities was recognised and acknowledged.
- There is clear evidence that demonstrates how well connected communities facilitate an increase in personal resilience amongst members of the public and that this leads to good mental and physical health outcomes.

RESOLVED:

Action plans developed to support the achievement Thurrock’s Health and Wellbeing Strategy Goal B, Healthier Environments were agreed.

**7. For Thurrock in Thurrock**

Jeanette Hucey, Director of Transformation, Thurrock CCG provided the Board with an update on the For Thurrock in Thurrock Programme. In summary:

- The scope of this programme includes Out of Hospital adult care, Community Health and Mental Health;.
- Intermediate care beds will be reconfigured from 49 beds across 6 sites to 32 beds at Thurrock Community Hospital and 5 additional beds at Collins House, creating 37 beds for Thurrock in Thurrock.
- The For Thurrock in Thurrock programme will inform and respond to the Essex Success Regime programme

During discussions the following points were made:

- Reassurance was provided to Board members by Dr Bose that GPs are totally committed to the Programme and the Programme remains a regular item at the Clinical Engagement Group and CCG Board meetings.

RESOLVED:

The update was noted by members as recommended.

**8. Ofsted Safeguarding Inspection Action Plan**

Rory Patterson, Corporate Director of Children's Services provided the Board with a summary of the Ofsted Inspection Report and action plan. In summary:

- The previous inspection in 2012 provided an assessment rating of good. The 2016 inspection provided an assessment rating of requiring improvement
- While 75% of all authorities have received an assessment rating of requiring improvement it was acknowledged that Thurrock's inspection demonstrates a decline in the quality of service provided.
- An action plan has been developed to address all areas of service requiring improvement and has been approved by Ofsted.
- It remains vital that individuals that are placed in under the care of Thurrock experience improved personal outcomes.
- It should be acknowledged that the Ofsted inspection also identified areas of particular strength within Thurrock which included:
    - A strong multi-agency safeguarding hub
    - A strong offer being provided for adolescents
    - A strong approach for tackling child sexual exploitation
    - Thurrock's Safeguarding Board has been assessed as good.

During discussions the following points were made:

- Board members welcomed the Council's recognition that improvement is required across a number of inspection domains and the positive action that has been taken to address areas that have been assessed as requiring improvement;
- It was difficult to achieve a rating of 'good' whilst employing a high level of agency staff, but innovative approach were being used to respond to this challenge

RESOLVED:

Health and Wellbeing Board members noted the outcomes of the recent Ofsted Inspection and approved the draft action plan, created to address the recommendations made by Ofsted.

**9. Integrated Commissioning Executive – Meeting minutes**

RESOLVED:

The minutes of the Integrated Commissioning Executive were noted.

**10. Health and Wellbeing Board Executive Committee Minutes**

RESOLVED:

The minutes of the Health and Wellbeing Executive Committee were noted.

**11. Work Programme**

Board members agreed that the Essex Success Regime should remain a standing item and an update should be provided at each meeting.

A paper on integrated data management will be brought to a future meeting.

Tania Sitch requested that a paper on the Single Point of Access be brought to a future Board meeting.

**The meeting finished at 3.16 pm.** Approved as a true and correct record

**CHAIR……..**

**DATE……**

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| **17 November 2016** | **ITEM: 6** |
| **Thurrock Health and Wellbeing Board** | |
| **Update on Mid and South Essex Success Regime** | |
| **Wards and communities affected:** All | **Key Decision:** For information and discussion |
| **Report of:** Andy Vowles, Programme Director, Mid and South Essex Success Regime | |
| **Accountable Head of Service:** Not applicable | |
| **Accountable Director:** Chief Executive | |
| **This report is** public | |

**Executive Summary**

This paper provides an update on the progress of the Mid and South Essex Success Regime (SR) and Sustainability and Transformation Plan (STP). It follows previous reports to the Health and Wellbeing Board. The last report was considered at the 15 September Health and Wellbeing Board meeting.

The STP covers all aspects of health and care, including coordination with other pre-existing strategies that are Essex-wide, such as mental health and learning disabilities. The SR concentrates on some specific priorities for transformation as recommended by a diagnostic review that reported in December 2015.

While the STP is still in draft and subject to further discussions with NHS England and other arms-length bodies, the SR is currently in a period of wider engagement prior to public consultation later in 2016/17.

## 1. Recommendation(s)

**1.1 The Board is asked to note the update.**

**1.2 The Board is recommended to continue participating in discussions within the Mid and South Essex Success Regime and STP engagement and consultation programmes, which include stakeholder meetings and meetings of the Essex, Southend and Thurrock Health and Wellbeing Boards.**

## 2. Introduction and background

2.1 The Success Regime and the STP cover the same geographical area, the same five-year planning period and have the same strategic objectives. The STP includes strategic change programmes for all aspects of health and care from prevention to specialist services, including plans for mental health and learning disabilities.

2.2 The Success Regime (SR) is an intensive programme designed to tackle the most significant challenges. The current focus of the work is on:

- the potential to develop localities where GP services, community, mental health, social care and other public services could work closer together (as in the local strategy *For Thurrock in Thurrock*)
- the development of care to help people stay well for longer, including a new model of care for older and frail people (which is being led by Thurrock CCG)
- the potential to improve hospital care by the three main hospitals in mid and south Essex working together as a group.

2.3 Since the last update for the Health and Wellbeing Board, there have been a number of developments, including the following:

- **Further work on the draft STP**
  NHS England and all national arm's length bodies have commended a high level draft STP submitted for mid and south Essex on 30 June. The next draft is to be submitted on 21 October for further discussions at national level. Subject to these further discussions, we will publish a summary for local people later in the year.

- **Engagement**
  There have been a further 13 open public workshops across mid and south Essex in addition to the 14 discussion workshops that we reported at the last Health and Wellbeing Board meeting. We are now collating substantial evidence from service user experience and local views to inform the development of the SR/STP and, in particular, to inform potential options for hospital reconfiguration. *See further details later in this report*.

- The overall SR/STP plan and an update on current thinking was discussed at the recent Thurrock CVS and Healthwatch Thurrock conference on 14 September. We look forward to receiving the outcome report from the conference and this will be included in our overall report on local views.

- **Work in progress**
  The hospital working groups highlighted in our last update are developing recommendations supported by national and local clinical evidence. These are due to be considered in a detailed review at the end of November,

together with the input from service users and local people and other evidence.

- The medical directors for the mid and south Essex Success Regime have consulted the regional Clinical Senate on the developing recommendations. The Clinical Senate provides independent clinical scrutiny and advice. Following a rigorous panel session, the Senate was supportive of the overall transformation plans, however we are anticipating a detailed written report with a view from the Clinical Senate and this will also provide evidence for consideration at the November review.

- The outcome of the review at the end of November will inform the content of a pre-consultation business case for regional assurance prior to consideration by the national arms-length bodies.

- **Timescales**

    - Submission of next draft STP to the national bodies – 21 October
    - STP publication later in the year, subject to national discussions
    - Draft pre-consultation business case to be reviewed in December
    - Public consultation subject to approval of the pre-consultation business case in early 2017.

## 3. Issues, Options and Analysis of Options

3.1 In this section, we provide a summary update on current thinking in terms of potential hospital reconfiguration and redesign.

### 3.2 Reiteration of key points in case for change

- An aging population is placing pressure on the health and care system. Health outcomes are notably worse for those on lower incomes and those living with higher deprivation. The SR/STP must review capacity and capability to meet the needs of a future population.

- Services in the community are in some instances fragmented. Some parts of primary care have numerous independent practices with limited integration. Primary care and end of life care are two examples of where access in mid and south Essex is below national levels.

- In acute hospitals, key services are falling short of some clinical quality and safety standards. For example, only 81% of A&E patients are seen within 4 hours, where the national standard is 95%.

- Emergency attendances in A&E are growing at double the national growth rate (8% versus 4% in 2014/15, for example). Emergency admissions are also higher than the national average. With development in community and primary care, there is great potential to reduce these pressures and improve the quality of care for people.

- Neither acute care nor primary care services are currently configured to meet rising demand.

- There are clinical workforce gaps in primary, community and acute care due to recruitment challenges, which also leads to a higher than average spend on locum care and agency staff. Hiring more staff is not a sustainable option given national and local workforce shortages. There are similar recruitment challenges for social care. The potential for improvement lies with new ways of working across the spectrum of professional roles.

- The annual financial challenge for the NHS in mid and south Essex reached £101 million in 2015/16. A "do nothing" scenario would increase the deficit to some £430 million by 2020.

3.3 **Overall strategic direction for SR/STP**

The SR/STP has refined its priorities for action, with the aim of improving health, quality and financial balance, achieving long term sustainability and reducing health inequalities. The current thinking is to:

- Build stronger health and care localities, including a focus on prevention, self-care and mental health
- Develop urgent and emergency care pathways to provide care closer to home, earlier interventions and avoid the need for a hospital admission
- Reconfigure services in the three acute hospitals to improve patient outcomes and develop a sustainable clinical workforce
- Redesign clinical pathways

3.4 **Update on "In Hospital" workstream**

- The main changes for consultation in 2016/17 lie within the "In hospital" workstream of the Success Regime/STP. Developments in primary and community services will continue to build on health and wellbeing strategies that were already in progress and reported on regularly within the Health and Wellbeing Board programme.

- The following summarises the main points of potential change in hospital care:

    - **One designated specialist emergency hospital**
      Guided by national evidence, emergency care should be improved by developing a network of urgent and emergency care services, with as much as possible in the community. For hospital emergencies, there should be one designated specialist emergency hospital, as recommended by national clinical evidence for a population of our size (1.2 million)

- **Centre(s) of excellence for planned surgery**
  Planned care should be separate from emergency care. Planned operations should be protected from the effects of sudden surges in emergency demands, which often lead to cancellations.

- **Single teams of specialists across the hospital group**
  Specialist services should be consolidated in one or more centres, where the clinical evidence suggests that this would improve patient care and outcomes.

- Within the emerging models of clinical services the following centres of excellence should remain as is:

  - Cardiothoracic centre at Basildon
  - Plastics and Burns at Chelmsford
  - Cancer and Radiotherapy services at Southend

- For the majority of hospital care the aim is to provide as much as possible close to where patients live, balanced against potential benefits of consolidating some specialist services. This includes identifying where there is potential to transfer some services to GP surgeries or local health centres, and opportunities to use telemedicine and other technologies to run virtual clinics.

- Across the range of hospital services, the majority of what people might need from their local hospital would continue at each hospital site, such as day surgery, outpatient clinics and beds for a short stay for observation and recovery.

- All three hospitals would continue to provide an A&E for walk-in patients and for ambulances carrying patients who have been referred by their GP.

- There would be assessment units for children, older and frail people and for people who may need emergency surgery. These assessment units would ensure quick access to tests and scans and prompt treatment, including an overnight stay if necessary, so that most people needing urgent treatment could receive it at their local hospital.

- The local hospital would also be able to look after people who need a few days for recovery and rehabilitation following specialist surgery or other treatment, which they may have had in a specialist centre elsewhere.

- Further work is ongoing to develop and appraise the potential models and possible combinations across the hospital group. The November review will consider in detail the benefits and disadvantages of the models, informed by all of the evidence gathered from clinicians, service users and local people.

3.5 **Service user engagement in this work**

- In the last report to the Health and Wellbeing Board we gave an interim report on some of the issues and common themes from public feedback gathered from July workshops. We are currently collating and analysing the feedback from the September and October workshops and can provide an oral update on this at the meeting on 17 November.

## 4. Reasons for Recommendation

4.1 The Health and Wellbeing Board is a key partner in the Success Regime and STP. The Board oversees improvement in the health and wellbeing of the people of Thurrock. It is important that the work of the SR and the aims of the STP align with Thurrock's Health and Wellbeing Strategy and that the partnership across mid and south Essex is to the greater benefit of all residents.

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

5.1 The SR/STP programme team is also in discussion with the Thurrock Health and Wellbeing Overview and Scrutiny. We have already reported to the Committee with an overview of the Success Regime and noted the views of members. We will continue to update the committee via Democratic Services and make arrangements for further consultation.

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

6.1 The Essex Success Regime will contribute to the delivery of the community priority 'Improve Health and Wellbeing'.

## 7. Implications

### 7.1 Financial

Verified by: Jo Freeman
Position: Management Accountant Social Care & Commissioning

One of the objectives of the Essex Success Regime is to respond to the current NHS funding gap across the Mid and South Essex geographical 'footprint'. A number of work streams have been established as part of the Success Regime to drive forward necessary savings and to improve quality of care provided to users of services. As a system-wide issue, partners from across the health and care system are involved in the work of the Success Regime. This will help to ensure that any unintended financial consequences on any partners of what is planned as part of the Success Regime are identified at the earliest opportunity and mitigated. Further implications will be identified as the work of the Success Regime continues and these will be reported to the Health and Wellbeing Board as part of on-going updates.

Thurrock has a finance representative involved in the Success regime and any financial implications, when known, will be reflected in the MTFS.

7.2 **Legal**

Verified by: **Christopher Pickering, Principle Solicitor, Employment and Litigation.**

Legal implications associated with the work of the Success Regime will be identified as individual work streams progress. The Success Regime process itself will meet the requirements of NHS statutory duties, including the Duty to Involve and Public Sector Equality Duty.

Implications will be reported to the Board as part of on-going updates.

7.3 **Diversity and Equality**

Verified by: **Rebecca Price**

Position: **Community Development Officer**

Within the SR programme, we will undertake actions that take full consideration of equality issues as guided by the Equality Act 2010.

During the wider engagement phase and as part of the full consultation phase, we will make use of the Essex Equality Delivery System that was first established in 2011/12. This includes details and guidelines for involving minority and protected groups, based on inputs from and agreements with local advocates.

We will incorporate discussions with such groups, as part of service user engagement within individual workstreams, to test equality issues and use the feedback to inform an equality impact assessment to be included in the pre-consultation business case and decision-making business case.

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

None identified

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

For further background information please visit:
http://castlepointandrochfordccg.nhs.uk/success-regime

**Report Author:**

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

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| 17 November 2016 | ITEM: 6 (additional paper) |
|---|---|

# Health and Wellbeing Board

# Principles for the forward work of the STP / ESR – Joint agreement between Thurrock, Southend and Essex

**Report of:** Councillor J Halden Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board

This report is public.

**Executive summary**

The work to make the local NHS more sustainable requires full partnership buy in from a range of stakeholders. Following the establishment of strong working relationships between the 3 Chairs and Cabinet Members for Health in Thurrock, Southend and Essex, as well as lead officers, these principles have been drafted to fully articulate the conversations of the last few months in regards to the STP.

This approach has been fully endorsed by the three local authorities; if these principles are accepted then it will be the basis of a truly united approach to make the STP the massive success we know that it can be.

The following principles will be submitted to the Independent STP Chair from the three local authorities.

1.1 It is important that **any proposals are reported to the appropriate Health and Wellbeing Board**, particularly those that directly affect the planning, commissioning and provision of health and social care services.

This approach will help to make sure that the STP can continue to be informed by relevant Councils, Clinical Commissioning Groups and NHS providers. It will also reduce the risk of the STP growing outside its parameters and halting other work that is in progress because partners lose sight of who and what the correct driving force is. The vital role of independent and separate CCG' and Health and Wellbeing Boards (and their associated Heathwatches) must be definitive.

1.2 There should be **clear acknowledgement that the STP cannot be a success without local authority and CCG buy in** – for example, both Southend and Thurrock have coterminous councils and CCG's meaning that the health agenda can be fully integrated and supported with the place making agenda. A weakening of the Council/CCG link via an overly executive structure would be massively detrimental.

1.3 There will be some occasions when it makes financial and clinical sense to operate on a larger footprint – e.g. south west Essex for urgent care, south Essex for acute mental health and the whole of Essex where it is in the best interest of all residents, regardless of local authority boundaries.

**We will aggregate up where it makes sense not the other way round**. Pan STP working should be on clearly defined principles and certainly not the default position.

1.4 It is **vital that close links are retained with our own patients, carers and service users** and the links to Healthwatch are vital to get that service user experience.

For example, local authorities will know their own populations more intimately than the STP board due to the sheer range of services that are delivered at close quarters. The STP must be very clear that engagement etc is best placed to be delivered via local authorities and via Healthwatch.

1.5 We want to **ensure that there is a democratic input and voice into the process through Health and Wellbeing Overview and Scrutiny Committee, Cabinet and the Health and Wellbeing Boards**.

It is important that elected members can provide input into the key decisions that are taken through these mechanisms and that the system remains 'democratically accountable' to Thurrock residents. This political and clinical input must be an integral part of the STP structure and should not sit as some type of external or limited body which would have an arms distant input.

1.6 There are some **very significant savings that will be needed and some radical transformation in the way that services are delivered locally**. This will need more than just superficial reorganisation but fundamental change. This will include a much better understanding of patient/client flows through the system, integration of health and social care data sets and use of evidence based solutions.

This also requires vital linkages with the planning agenda, housing, regeneration and so on. The STP must be clear that it is a structure and not a way of working in itself.

1.7 The **priority has to be strengthening and improvement in the quality and capacity of primary care**. This is the single biggest reason that is holding back health advances and leading to greater inequalities in the provision of health care.

While the big financial challenges are very apparent at the Hospital stage, we must be clear that primary care insufficiencies are driving much of this. Hospital deficits must be seen, in part, as a symptom of poor primary care and the STP must support local work on primary care improvements, not the other way around.

1.8 Across the board we want to **see an investment shift towards early intervention and prevention**. This will require systematic embedding of prevention programmes within the day to day practice of the NHS in line with "The NHS Five Year Forward View" and use of NHS resources to deliver

prevention. The Public Health Grant alone is insufficient to deliver prevention at the scale required to make the system sustainable.

The **work of the STP must be given time to bed in and be correctly tested** i.e. we cannot look to continuing a conversation about structures while we have the more pressing issue of paying for intervention. It is for this reason that we will not be looking towards any pan-Essex commission for social care and health and instead will work to ensure that collaborative but not restrictive working, via the STP, is a success.

1.9 We need to be **clear in regards to forward planning and delivery** i.e. making sure we compliment the working between health providers and councils to rationalise old estate and build integrated services that are fit for a long term future. The STP cannot just consider health structures and not consider concrete delivery. This needs the fullest political buy-in to realise ambitions.

1.10 **Social care needs strengthening**. The NHS has seen significant increase in resources not matched in social care. This needs to be rebalanced and local authorities have recently submitted a joint paper to the DCLG Select Committee which is reviewing the funding of adult social care.

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| 17 November 2016 | ITEM: 7 |
|---|---|
| **Thurrock Health and Wellbeing Board** | |
| **Thurrock Health and Wellbeing Strategy Goal C, Better Emotional Health and Wellbeing Summary Report** | |
| **Wards and communities affected:** All | **Key Decision:** To note action plans |
| **Report of:** Councillor James Halden, Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board | |
| **Accountable Head of Service:** N/A | |
| **Accountable Director:** Roger Harris, Corporate Director of Adult Housing and Health | |
| **This report is** Public | |

**Executive Summary**

The Health and Wellbeing Strategy 2016-2021 was approved by the Health and Wellbeing Board in February 2016 and the CCG Board and Council in March 2016.

At its meeting in February, the Health and Wellbeing Board agreed that action plans and an outcomes framework should be developed to support the delivery of the Strategy and to measure its impact.

This paper provides action plans that have been developed to support the achievement of Thurrock's Health and Wellbeing Strategy Goal C, Better Emotional Health and Wellbeing. It follows the previous action plans considered by Health and Wellbeing Board members at their meeting in July for Goal A, Opportunity For All and in September for Goal B, A Healthier Environment.

## 1. Recommendation(s)

**1.1 The Board is asked to agree action plans developed to support the achievement Thurrock's Health and Wellbeing Strategy Goal C, Better Emotional Health and Wellbeing.**

**1.2 Agree to the setting up of a review meeting for all of Thurrock Health and Wellbeing Strategy Goals.**

## 2. Introduction and Background

2.1 Thurrock's Health and Wellbeing Strategy comprises five strategic goals which make the most difference to the health and wellbeing of the people of Thurrock.

2.2 Goal C, Better Emotional Health and Wellbeing, focusses on strengthening mental health and emotional wellbeing.

2.3 We know that at least one in four people will experience a mental health problem in their life and one in six adults will have a mental health problem at any one time. We also know that half of those with lifetime mental health problems first experience symptoms by the age of 14. Creating better emotional health and wellbeing throughout their lives will help to keep people well for as long as possible.

2.4 Four key objectives have been established as part of clearly defining and determining what needs to be done to create a healthier environment for Thurrock:

i. Parents will be given the support they need
ii. Improve the emotional health and wellbeing of children and young people
iii. Reduce social isolation and loneliness
iv. Improve the identification and treatment of depression, particularly in high risk groups

2.5 Each of the objectives would be supported by an action plan containing the key actions needed to meet the objective. Health and Wellbeing Board members approved an outcome framework containing a number of related performance indicators at your meeting in July. Individual action plans now contain specific indicators that will help to measure the impact of specific actions and the success of the Health and Wellbeing Strategy.

## 3. Issues, Options and Analysis of Options

3.1 Action plans are being presented to the Health and Wellbeing Board that have been subject to consultation. Health and Wellbeing Board members are asked to note the action plans for Goal C, Better Emotional Health and Wellbeing and invited to provide feedback on the actions and delivery timescales

## 4. Reasons for Recommendation

4.1 Health and Wellbeing Board members are responsible for driving forward Thurrock's Health and Wellbeing Strategy. Action plans have been developed for each of the Strategy's five Goals. Health and Wellbeing Board members have agreed to consider action plans for one of the Strategy's Goals at each meeting.

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

5.1 Action plans are developed in partnership between Thurrock Council, CCG, VCS and key stakeholders. Community engagement is a key part of the development of action focussed plans to support the achievement of Thurrock's Health and Wellbeing Strategy.

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

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

6.3 As part of giving parents the support they need a Healthy Families Programme will be commissioned by August 2017 which will ensure parents have access to universal support, advice and guidance through Health Visitors and School Nurses and that this is integrated with wider service delivery. An analysis of the Early Offer of Help Programme will be undertaken by December 2016 to inform re-commissioning of targeted parenting support. This will provide support for parents in need of targeted, specialist support is available, based on what works and linked to the Early Offer of Help integrated offer.

6.4 Actions identified to improve the emotional health and wellbeing of children and young people include ensuring the delivery of the Transformation Plan, "*Open Up Reach Out*" Including the new Emotional Wellbeing Mental Health Service. This aims to make sure that children and young people have increased access to high quality, community based services to support their Emotional Wellbeing and Mental Health needs. Guidance on the Prevention of Suicide and Self Harm to be reviewed/developed and distributed to schools colleges and other agencies by March 2017 which will ensure young people will have good support in schools and colleges with regard to self-harm behaviours and concerns regarding suicide.

6.5 Actions identified to reduce social isolation and loneliness include developing a Living Well @ Home Programme which will Increase in the proportion of the public can remain at home without the need for more *intensive* care. Living Well @ Home will enable people to establish local neighbourhood connections, enabling continued independence. Other actions include Increasing the time banking initiative by 10% by April 2017. Increasing the number of time-banks will help to stimulate volunteering and reduce isolation experienced by service users

6.6 As part of improving the identification and treatment of depression, particularly in high risk groups, actions to be taken comprise increasing the percentage of patients with CVD or COPD, and without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool. This will delay the requirement residential care admissions in older people and improve the quality of life for affected residents of Thurrock.

## 7. Implications

### 7.1 Financial

Implications verified by: **Jo Freeman, Management Accountant Social Care and Commissioning**

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

### 7.2 Legal

Implications verified by: **Christopher Pickering, Principle Solicitor, Employment and Litigation**.

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

### 7.3 Diversity and Equality

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

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

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

None identified

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

- None

## 9. Appendices to the report

- Action plans for Goal C, Better Emotional Health and Wellbeing.
    - Action Plan C1, Give parents the support they need
    - Action Plan C2, Improve the emotional health and wellbeing of children and young people.

- Action Plan C3, Reduce social isolation and loneliness
- Action Plan C4, Improve the identification and treatment of depression, particularly in high risk groups

**Report Author:**

Darren Kristiansen, Business Manager, Health and Wellbeing Board and Adult Social Care Commissioning, Housing and Health, Thurrock Council

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**Health and Wellbeing Strategy Action Plan**

**Goal: Better Emotional Health and Wellbeing**

| **OBJECTIVE:**<br>**C1: Give parents the support they need** | | | **OBJECTIVE LEAD:**<br>**Sue Green** | | |
|---|---|---|---|---|---|
| **Action** | **Outcome** | **Action lead** | **Link to outcome framework** | **Delivery Date** | **Reference to existing strategy or plan** |
| A. Commission the Healthy Families Programme and ensure there is engagement with schools as a part of the 0-19 Wellbeing Programme | Parents have access to universal support, advice and guidance through Health Visitors and School Nurses and that this is integrated with wider service delivery | Beth Capps | 1,2,3 | August 2017 | Children's Commissioning Strategy;<br>Public Health Service Plan |
| B. Complete an analysis of the Early Offer of Help Programme to inform re-commissioning of targeted parenting support | Support for parents in need of targeted, specialist support is available, based on what works and linked to the Early Offer of Help integrated offer | Mark Livermore | 1 | December 2016 | Children's Commissioning Strategy |
| C. Secure funding and re-commission the Early Offer of Help Commissioned Offer and review Key Performance Indicators | Support for families at the edge of statutory intervention is available and can evidence an impact on the lives of parents and children. | Mark Livermore | 1 | August 2017 | Children's Commissioning Strategy |
| D. To deliver children's centres and to implement service changes that will provide an integrated offer as a part of the 0-19 Wellbeing Programme and the development of support to develop adult skills. | A sustainable model of delivery that meets the needs of families as a part of an integrated offer is implemented. | Andrea Winstone | 3 | August 2017 | Children's Commissioning Strategy; School Improvement Service Plan |

**Outcome Framework**

| **Objective** | **C1: Give parents the support they need at the right time.** | | | | | |
|---|---|---|---|---|---|---|
| **Indicators** | **2016 Baseline** | **2017** | **2018** | **2019** | **2020** | **2021 Target** |
| **Outcome Framework indicator 1**<br><br>**% of parents achieving successful outcomes from early intervention prevention parenting programmes.** | | | | | | |
| This indicator quantifies the proportion of parents who successfully complete 10 or more out of 12 sessions of the 'Strengthening Families' targeted parenting programme and evidence improvements in 3 or more of the 8 outcome areas.<br>In general, there is evidence to indicate that certain parenting programs can reduce problem behaviour in children and improve parental mental health and wellbeing.<br>It should be noted that the indicator definition may be subject to change if the commissioned offer changes between 2016 and 2021. | **72%** (2015/16) | 72.6% | 73.2% | 73.8% | 74.4% | **75%** |
| **Outcome Framework Indicator 2**<br><br>**Number of families known to Troubled Families Service** | | | | | | |
| This quantifies the number of families that the Troubled Families team have provided support to. The headline criteria, underpinned by the DCLG Financial Framework 2015<br>for identifying families is as follows:<br>• Parents and children involved in crime or anti-social behaviour<br>• Children who have not been attending school regularly<br>• Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan | **370** (2016/17) | 528 | 686 | 844 | 1002 | **1160 by May 2020 (nationally-set target)** |

| | | | | | | |
|---|---|---|---|---|---|---|
| • Adults out of work or at risk of financial exclusion or young people at risk of worklessness<br>• Families affected by domestic violence and abuse<br>• Parents and children with a range of health problems | | | | | | |
| **Outcome Framework Indicator 3 ***<br><br>Increasing the proportion of children who achieve a 'Good Level of Development'1 (GLD is at 75% in 2016) and reducing the gap between the most and least deprived groups by supporting child development and<br>school readiness; | | | | | | |
| This indicator supports a child's ongoing development and is one of the key outcomes being supported through the development of the 0-19 Wellbeing Programme. It also provides a good indication of work to reduce inequalities across the Borough, this is a key indicator for children's centres. The baseline performance is above the national level of 69% (2016) and the target performance aims to remain at least 2% above national levels. | **75%** | 76% | 77% | 78% | 79% | **80%** |

***New indicator identified by action plan lead**

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# Health and Wellbeing Strategy Action Plan: C1 Give parents the support they need



Sue Green – Strategic Leader Children's Commissioning and Service Transformation

# Why this is a priority – recent research

- The quality of the inter-parental relationship, specifically how parents communicate and relate to each other, is increasingly recognised as a *primary* influence on effective parenting practices and children's long-term mental health and future life chances.
- Parents/couples who engage in frequent, intense and poorly resolved inter-parental conflicts put children's mental health and long-term life chances at risk.
- Children of all ages can be affected by destructive inter-parental conflict, with effects evidenced across infancy, childhood, adolescence and adulthood.
- The context of the wider family environment is an important factor that can protect or exacerbate child outcomes in response to exposure to inter-parental conflict. In particular, levels of negativity and parenting practices can exacerbate or moderate the impact of inter-parental conflict on children.
- Inter-parental conflict can adversely affect both the mother-child and father-child relationship, with evidence suggesting that the association between inter-parental conflict and negative parenting practices may be stronger for the father-child relationship compared to the mother-child relationship

http://www.eif.org.uk/publication/what-works-to-enhance-inter-parental-relationships-and-improve-outcomes-for-children-3/

# Where are we now?

- Range of support services available across agencies including evidence based, accredited parenting programmes.
- Early Offer of Help commissioned parenting programmes available to approx. 200 parents per year
- Troubled Families programme offering support to 370 families per year by March 2017

# Current demand

- Demand for commissioned EOH services outstrips supply:
  - 180 places for parenting support commissioned – waiting list of 60 places
  - Support for parents who are victims of sexual violence continually over commissioned amount
- iMPOWER work on demand prevention shows:
  - 32% of contacts did not lead to social care action
  - Opportunities to improve when EOH interventions are offered and to improve partnership working to reduce demand

# Current Performance

## Early Offer of Help Parenting Programmes:

- All 200 places allocated with a waiting list of approx.  50. Of 130 parents who responded to post service questionnaires:
- 94% of parents feel better able to deal with their child's response to emotional distress
- 87% report improved communication within the family
- 86% report being better able to manage their own emotions and stress that were impacting on their children
- 90% report improved self-esteem and confidence in their children
- 92% report improved relationships with their child's school
- 99% of parents reported at least one improvement (of a total of 8) in their parenting
- 87% of cases that were referred prior to statutory involvement not subsequently re-referred into services (pre-statutory or statutory) nine months after case closure

## Troubled Families:

- Target of 370 families for 16/17 and by the end of October 16 - 273 currently being worked with.
- Our 5 year total was 1160 and has now been increased to 1240 by DCLG.
- Forecast for meeting target is good.

# Current Performance

## Additional Parenting Support:

- 140 parents per year who have been subjected to domestic abuse and violence accessing support to improve parenting capacity through awareness, resilience building and safety and support planning
- 40 parents per year who are victims of sexual abuse and violence to improve parenting capacity
- 10 parents per year who are perpetrators of domestic violence – behavioural change programme
- Ongoing support through wider services including Children's Social Care, Health Visiting Teams, School Nursing Teams, Children's Centres



## Health and Wellbeing Strategy KPI's

| KPI | Current Performance | Target 31.03.17 |
|---|---|---|
| % of parents achieving successful outcomes from early intervention parenting programmes | 72% (March 2016) | 72.6% (March 2017, collected annually) |
| Number of families known to Troubled Families Service | 273 (October 2016) | 370 (March 2017) |

# Where do we want to be?

- Significant opportunities to integrate Children's Centres, 0-19 Health Services, Early Offer of Help Services through 21St Century Wellbeing Offer.
    - Support and services
    - Commissioning
    - Buildings
    - Single point of access
- Further integration with Community Hubs, Integrated Healthy Living Centres
- A clear demand management strategy to appropriately reduce the numbers of children moving into statutory intervention

# How will we get there?

- Development of the 21st Century Wellbeing 0-19 Services for Children and Young People Model
    - Cabinet October 2016
    - Integrating Children's Centres, Health Visiting, School Nursing, Early Offer of Help
    - Consultation October – December 2016
    - Procurement commences January 2017
    - Changes implemented from April 2017 on a phased basis

- Aligned commissioning that is integrated where practical
    - To ensure we assess demand and develop solutions in partnership
    - Maximising opportunities and reducing duplication
    - Recognising that procurement may be in separate lots but will be part of a whole integrated approach

# How will we get there?

- Mapping of preventative services that reduce demand across partners
  - Building on existing work
  - Providing an overview of spend on preventative services
  - Contributing to the design of services, particularly those that have the biggest impact on improving outcomes

- Integration of different elements to provide a pathway of support
  - Identifying opportunities to improve joint working and delivery including through the 0-19 children and young peoples pathway and integrated commissioning
  - Integration of Troubled Families and Early Offer of Help

# Thank You

**Health and Wellbeing Strategy Action Plan**

**Goal: Better Emotional Health and Wellbeing**

| **OBJECTIVE:**<br>**C2: Improve the emotional health and wellbeing of children and young people** | | | **OBJECTIVE LEAD:**<br>**Malcolm Taylor / Helen Farmer** | | |
|---|---|---|---|---|---|
| **Action** | **Outcome** | **Action lead** | **Link to outcome framework** | **Delivery Date** | **Reference to existing strategy or plan** |
| A. Ensure the delivery of the Transformation Plan, "*Open Up Reach Out*" Including the new Emotional Wellbeing Mental Health Service | Children and Young people have increased access to high quality, community based services to support their Emotional Wellbeing and Mental Health needs | Helen Farmer / Malcolm Taylor | 1, 2 | August 2017 | Children and Young People Plan /Emotional Health and Wellbeing strategy |
| B. Deliver participation and engagement events that bring together the views and needs of children and young people to inform service delivery | Children and Young people will have good levels of awareness of how, when and where they can access support advice and direct service in relation to emotional wellbeing and mental health needs. | Helen Farmer / Malcolm Taylor | 1, 2 | August 2017 and ongoing | Joint CCG /LA Transformation Plan |
| C. Guidance on Prevention of Suicide and Self Harm to be reviewed/developed and distributed to schools colleges and other agencies. | Young people will have good support in schools and colleges with regard to self-harm behaviours and concerns regarding suicide. | Malcolm Taylor | 1, 2 | March 2017 | Children and Young People Plan, Public Health Service Plan |
| D. Review and publish new anti-bullying strategy and actions including LSCB Walk on Line building on good practice in schools and views of children and young people.<br><br>Education and public health to | Children and young people have good access to support regarding bullying and schools are engaged in good anti-bullying practice. Children and young people report feeling safe and low levels of bullying in schools. | Malcolm Taylor / Alan Cotgrove | 1, 3 | July 2017 | Children and Young Peoples Plan , LSCB plan |

| | | | | | |
|---|---|---|---|---|---|
| continue working together to break the generational issue of emotional issues that become mental health issues | | | | | |

**Outcome Framework***

| Objective | C2: Improve the emotional health and wellbeing of children and young people. | | | | | |
|---|---|---|---|---|---|---|
| **Indicators** | **2016 Baseline** | **2017** | **2018** | **2019** | **2020** | **2021 Target** |
| **Outcome Framework Indicator 1.**<br><br>**% of children and young people reporting that they are able to cope with the emotional difficulties they experience.** | | | | | | |
| This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this. | | | | | | |
| **Outcome Framework Indicator 2**<br><br>**% of children and young people reporting that they know how to seek help when experiencing difficulties with emotional health and wellbeing.** | | | | | | |
| This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this. | | | | | | |
| **Outcome Framework Indicator 3**<br><br>**% of children reporting being bullied in the last 12 months.** | | | | | | |
| This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this. | | | | | | |

***Indicators are currently being developed and trajectories will be identified in due course**

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# Better Emotional Health and Well being

OBJECTIVE:

C2: Improve the emotional health and wellbeing of children and young people

# National Context

- Incidence of mental health
- Future in Mind
- 5 Year Forward view for mental health
- Local transformation plan Open Up Reach Out
- Transforming Care development of Children's Workstream

# Open Up, Reach Out

The transformation plan describes a major change in Thurrock to improve the emotional well being and mental health of children and young people.

We have moved from a traditional tiered service delivered by fragmented, multiple providers to a single integrated service across seven localities.

Over the next five years, we will be promoting a cultural transformation from a traditionally reactive service to one that invests in prevention, early intervention and resilience for children, families and communities.

# Where are we now:

Spa – total number of referrals received

| CCG | @30/11/15 | @31/3/16 | 31/5/16 | 30/6/16 | @30/7/16 |
|---|---|---|---|---|---|
| Thurrock | 96 | 470 | 159 | 249 | 314 |

Case load data for core EWMHS

| CCG | @31/3/16 | 31/5/16 | 30/6/16 | @30/7/16 |
|---|---|---|---|---|
| Thurrock | 552 | 626 | 551 | 550 |



Case load data for crisis team

| CCG | @30/11/15 | @31/3/16 | 31/5/16 | 30/6/16 | @30/7/16 |
|---|---|---|---|---|---|
| Thurrock | 6 | 12 | 9 | 5 | 3 |

A & E Crisis activity – total number of crisis undertaken including out of hours – no and % of those presenting assessed with 4 hours of referral.

| | | Target | | Ap 16 | May 16 | Jun 16 | Jul 16 |
|---|---|---|---|---|---|---|---|
| | | 100% | <4 hours | 6 | 7 | 9 | 5 |

# Increased access.

- **Improving access and equality**
- Establishment of a single point of access for each of the three local authority areas, enhanced by an increased workforce and workforce development
- Enhance crisis services and extend home treatment.
- Extended children's and young people's IAPT, with the aim of achieving 100% coverage by 2018
- A significant investment and development in eating disorder services
- Improvements in support for vulnerable and disadvantaged children and young people
- Medicines management review
- Increased capacity to respond to complex needs (such those of children with learning disabilities and mental health needs) and serious disorders (such as ADHD), supported by a new intake of junior doctors
- Improvements in transitions between services e.g. for long term needs of young people moving into adulthood

# Additionally

- NELFT  as part of the service specification have actively sought to engage young people in service design and development going forward, this not only includes reviewing products to improve participation but most notably have ensured their views on service experience are accurately recorded

# Waiting times

**The performance around waiting times as @ end Q1 – June 2016.**
Referral to Assessment (RTA) waiting times – as @ end Q1 June 2016

- 69% CYP receive their assessment within 12 weeks
- 48% CYP receive their assessment in less than 4 weeks
- 31% CYP waited over 12 weeks for their assessment

- Referral to Treatment (RTT) waiting times – as @ end Q1 June 2016

- 61% CYP receive their first treatment intervention within 12 weeks
- 51% CYP receive their first treatment intervention in less than 6 weeks
- 74% CYP receive their first treatment intervention within 18 weeks

# Suicide and self harm

The project brief ( 16/17) was to

- review the existing guidelines for schools to test their use and effectiveness and establish any further support that is required to enable all partners to prevent suicide and support children and young people at risk
- include recommendations on awareness raising and capacity building.
- Guidance to be distributed to schools March 2017

# The plan for 16/17

- Suicide - revise existing guidance, test with focus groups and re-launch
- Develop new guidance for schools
- Campaign with schools and parents on Mental Health
- Working with colleagues in schools admission guidance to include MH & Schools to cover their 'MH offer' on their websites
- Information Portal for schools with range of information and advice on Emotional wellbeing and mental health
- Request to explore collation of different data requirements – via CCF
- Checking with West Essex CCG what data we get on Tier4 cases
- Incident review Panel to gain learning and insight

# Anti Bullying

- Current policy to be reviewed by July 2017
- Preparation for Anti – Bullying week in October
- Review of Schools policies
- Review of data and learning

**Health and Wellbeing Strategy Action Plan**

**Goal: C – Better emotional Health and Wellbeing**

| **OBJECTIVE: C3 – Reduce Social Isolation and loneliness** | | **OBJECTIVE LEAD: Les Billingham** | | | |
|---|---|---|---|---|---|
| **Action** | **Outcome** | **Action lead** | **Link to outcome framework** | **Delivery Date** | **Reference to existing strategy or plan** |
| A. Develop Living Well @ Home Programme<br><br>Pilot Programme to inform its development prior to rollout across Thurrock Pilot evaluation to include the extent to which the new service provides a more holistic approach to supporting people at home including signposting to key services such as housing, primary care and community support. | Increase in the proportion of the public can remain at home without the need for more *intensive* care.<br><br>Living Well @ Home will enable people to establish local neighbourhood connections, enabling continued independence | Michelle Taylor | 2 | Pilot commences in November 2016 | |
| B. Increase time banking initiative by 10%<br><br>[Cross referenced with Action Plan B3] | Increasing the number of time-banks will help to stimulate volunteering and reduce isolation experienced by service users | Natalie Warren | 2/3 | April 2017 | |
| C. Continue to support the Local Area Coordination Programme and review Key Performance Indicators | The LAC programme has been since April 2014 and has produced clear evidence of impact in terms of preventing, avoiding and delaying the need for care. Supporting and developing the programme will enable this positive impact to become embedded within the whole system and expand its coverage. | Les Billingham | 1 | Ongoing | |

| | | | | | |
|---|---|---|---|---|---|
| D. Retender of Carers advice, support and guidance contact | Reach and greater number of carers across Thurrock and improve outcomes. The new contract will help to ensure that support for carers is available across the borough, providing an equitable service for the residents of Thurrock who assume caring responsibilities | Catherine Wilson | 2 / 3 | New contract in place for 1 February 2017 | |
| E. Active Choices Framework Development (previously Day Opportunities) | Development of an accredited Framework to provide more choice of activities and support a available across Thurrock. | Kelly Jenkins | 2 / 3 | Pilot exercise to commence on 1 April 17 | |
| F. Peer to Peer Mentoring Project for people experiencing mental health challenges | Providing people with peer to peer support. Creation of networking opportunities and contributing towards reducing loneliness and isolation. | Thurrock CCG – Kelly Redston | 2 / 3 | Outcome report setting out early evaluation of the project to be available by November 2016 | |
| G. Social Prescribing Pilot | To enable GPs to prescribe social interventions as appropriate in addition to medical interventions that GPs can currently prescribe | Kristina Jackson | 2 / 3 | 18 months pilot exercise | |
| H. Introducing screening for depression for people aged 65+ | Training to be provided to social workers to enable them to screen people aged 65+ for depression enabling people to be referred to the most appropriate service at the earliest opportunity. | | 2 / 3 | To be confirmed | |

**Outcome Framework**

| Objective | C3: Reduce social isolation and loneliness. |
|---|---|

| Indicators | 2016 Baseline | 2017 | 2018 | 2019 | 2020 | 2021 Target |
|---|---|---|---|---|---|---|
| **Outcome Framework indicator 1**<br>**Number of people who are supported by a Local Area Coordinator.**<br>This is the number of people recorded by Thurrock Council as being in receipt of support from a Local Area Coordinator.<br><br>Local Area Coordinators are based in their communities and their role is to help people, who may be isolated or excluded due to disability, mental health needs, age/frailty, to re-connect with their communities. They focus on helping to reduce isolation and offering earlier support to those who otherwise may end up requiring statutory support. | **558** (Jan - Dec 2015) | 576 | 595 | 613 | 632 | **650** |
| **Outcome Framework indicator 2**<br>**% of people whose self-reported wellbeing happiness score is low.**<br>This indicator quantifies the proportion of adults who rated their happiness as of the preceding day to have a score of 4 or below (maximum = 10) in the Annual Population Survey.<br><br>Perceived poor wellbeing has been linked to depression and suicide risk.<br>This is also an indicator on the Public Health Outcomes Framework. | **10.7%** (2014/15) | 10.16 % | 9.62% | 9.08% | 8.54% | **8.0%** |
| **Outcome Framework indicator 3**<br>**The directly standardised average health status (EQ-5D) for individuals reporting that they are carers.**<br>This indicator quantifies the directly standardised average health status score for those who report that they are carers from their responses to the annual GP Patient Survey. The health status is derived from the responses to question 34 of the GP Patient Survey, which asks respondents to describe their health status using the five dimensions of the EuroQol 5D (EQ-5D™) survey instrument: Mobility, Self-care, Usual activities, Pain/discomfort, Anxiety/depression.<br>People who are carers may have a lower quality of life than those who are not, and those that care for more hours may have a lower quality of life than those who care for fewer hours.<br>This is also an indicator on the CCG Outcomes Framework. | **0.798** (2014/15) | 0.799 | 0.8 | 0.802 | 0.803 | **[0.804 was the national average in 2014/15]** |

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# Health and Wellbeing Strategy Action Plan: C3 Reduce Social Isolation and Loneliness



Les Billingham – Head of Adult Services

# Why this is a priority

**The scale of the problem**

- **Loneliness has doubled**: 40 percent of adults in two recent surveys said they were lonely, up from 20 percent in the 1980s.

**The Impact of Loneliness / Social Isolation**

- In the US, a follow-up of 800 older adults over four years found that lonely people were **more than twice as likely to develop Alzheimer‟s disease** than those who were not lonely

One study concludes lonely people have a **64% increased chance of developing clinical dementia** (Holwerda et al, 2012)

- Loneliness and social isolation are harmful to our health: research shows that lacking social connections is as **damaging to our health as smoking 15 cigarettes a day** (Holt-Lunstad, 2015).

**Effective ways to tackle loneliness**

- A White Paper released by The Second Half Foundation in July 2013 suggests that reducing social isolation amongst older people through the **creation of local hubs can produce returns of over 135% a year to the NHS and local Clinical Commissioning Groups** (CCGs).

# Where are we now

- Acknowledge continued challenge to identify people who feel lonely. A **survey of 2,256 people about their experiences of loneliness**, alongside interviews with mental health professionals and providers found that:
  - 42% of people felt depressed because they felt alone
  - Of all of the people involved in the survey**, 30% felt too embarrassed to admit to being lonely**

- Continue to **consider how we can improve our evidence base** to better understand the challenge:
  - Sure Start for older people
  - Community Engagement
  - JSNA for Purfleet integrated healthy living centre showed that the South Ockendon Locality has several of the wards with the highest proportions of older people that live alone (in Aveley and Uplands, 38.8% of pensioners live alone and 38.0% of those who live in Ockendon, compared to the Thurrock average of 31.9%).

- Available evidence therefore indicates that there is a **significant problem in Thurrock**, particularly amongst older people

- Important to recognise that more **traditional approaches to addressing social isolation and loneliness can have a limited impact** on an individual's quality of life

# Adopting a new approach – Our Action Plan

- Multi Faceted, coordinated and fresh approach to tackle loneliness and social isolation

  - **Local Area Coordinators** are designed to connect lonely and vulnerable individuals with the social capital and community assets within their community.

  - Piloting of **Social Prescribing**, enabling GPs to prescribe social interventions in additional to medical treatment

  - Increasing **Timebanking by 10%** helping to stimulate volunteering and reducing social isolation experienced by service users

  - Introducing **screening for depression** for people aged 65+ enabling people to be referred to the most appropriate service at the earliest opportunity

  - Through Thurrock's CCG **supporting a peer to peer mentoring project** for people experiencing mental health challenges, creating networking opportunities and contributing to reducing isolation and loneliness

  - Establishing **Community Hubs across Thurrock,** providing a range of services for members fo the community, including day activities and clubs

# Impressive progress but more to be done

- Living Well in Thurrock

- Living Well @ Home

# Thank You

**Health and Wellbeing Strategy Action Plan**

**Goal: Better emotional health and wellbeing**

| **OBJECTIVE:**<br>**C4: Improve the identification and treatment of depression, particularly in high risk groups** | | | **OBJECTIVE LEAD:**<br>**Funmi Worrell** | | |
|---|---|---|---|---|---|
| **Action** | **Outcome** | **Action lead** | **Link to outcome framework indicator** | **Delivery Date** | **Reference to existing strategy or plan** |
| A. Increase the % of patients on a GP depression QOF register with a record of accessing IAPT | • Mental health Joint Strategic Needs Assessment Product to be completed<br>• Identify areas to improve mental health identification and treatment in Thurrock<br>• Ensure recommendations are actioned | Funmi Worrell<br><br>Jane Itangata | Outcome Framework Indicator 1 People entering IAPT as a % of those estimated to have anxiety / depression. Also monitor QOF data on depression prevalence | By December 2016 | Public Health service plan |
| B. Increase the % of people who recover after IAPT treatment | • Mental health Joint Strategic Needs Assessment Product to be completed<br>• Identify areas to improve mental health identification and treatment in Thurrock<br>• Ensure recommendations are actioned | Funmi Worrell<br><br>Jane Itangata | Outcome Framework Indicator 1 People entering IAPT as a % of those estimated to have anxiety / depression. | By December 2016 | Public Health service plan |
| C. Increase the % of patients with CVD or | • Delaying residential care admissions in older people | Funmi Worrell/ Jane Itangata | % of patients on community | Pilot starting on 1st July | Public health service plan |

| | | | | | | |
|---|---|---|---|---|---|---|
| | COPD, and without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool | • Improving quality of life<br>• Making financial savings for adult social care | | LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool.<br><br>GP scorecard | 2016, completion by March 2017<br><br>2017 | Public Health service plan |
| D. | Increase % of ASC clients over 65 screened for depression by frontline Thurrock Council social care staff | • Delaying residential care admissions in older people<br>• Improving quality of life<br>• Making financial savings for adult social care | Funmi Worrell/ Les Billingham | % of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff | Pilot starting on 1st July 2016, completion by March 2017 | Public health service plan |
| E. | (Action is a cross reference to that contained within action plan C2) Improve the emotional health and wellbeing of children and young people | • Children and young people to report improved emotional health and wellbeing via appropriate survey | Malcolm Taylor/ Helen Farmer/ Funmi Worrell | Link with C2 action plan | By March 2017 | Public Health service plan |
| F. | Children Centre Outreach to young people | • Children's centre to provide outreach service to young people | Malcolm Taylor/Helen Farmer/Funmi Worrell | Link with C2 action plan | By 2017 | Public Health service plan |

| Objective | C4: Improve the identification and treatment of depression, particularly in high risk groups. | | | | | |
|---|---|---|---|---|---|---|
| **Indicators** | **2016 Baseline** | **2017** | **2018** | **2019** | **2020** | **2021 Target** |
| **Outcome Framework Indicator 1**<br><br>**People entering IAPT as a % of those estimated to have anxiety / depression.** | **15.1%** (Sep 2015) | 17.08% | 19.06% | 21.04% | 23.02% | **25%** |
| This indicator captures the number of people entering Improving Access to Psychological Therapy (IAPT) services as a proportion of all those estimated to have anxiety and/or depression.<br>The ambition for increasing IAPT access for those with a common mental health disorder was set out in the Five Year Forward View for Mental Health report in February 2016, setting a national target of 25% by 2020/21. | | | | | | |
| **Outcome Framework Indicator 2**<br><br>**% of people who have completed IAPT treatment who are "moving to recovery".** | **39.3%** (Mar 2016) | 41.44% | 43.58% | 45.72% | 47.86% | **50.0% (current national target)** |
| This indicator is a measure of IAPT patient outcome, as it shows the proportion of people that were above the clinical threshold for anxiety/depression before treatment but below following treatment. | | | | | | |
| **Outcome Framework indicator 3**<br><br>**% of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool.** | **Baseline data not available yet** | | | | | **95%** |
| The indicator looks to quantify the proportion of patients known to long term conditions services who have been screened for depression using a validated tool (PHQ9) within the last 24 months. | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| This has been included as there is evidence to indicate that those with an existing long term condition are at high risk of depression.<br>This has only recently been added into the service contract as a requirement and as a result, baseline data is difficult to obtain at this stage. | | | | | | |
| **Outcome Framework indicator 4**<br><br>**% of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff** | | | | | | |
| This is a new indicator aiming to quantify the proportion of clients known to adult social care services who have been screened for depression. Work is in progress to start this as a pilot programme from 1st July 2016. | | | | | | |

thurrock.gov.uk

# Health and Wellbeing Strategy

Improving the identification and treatment of depression, particularly in high risk groups

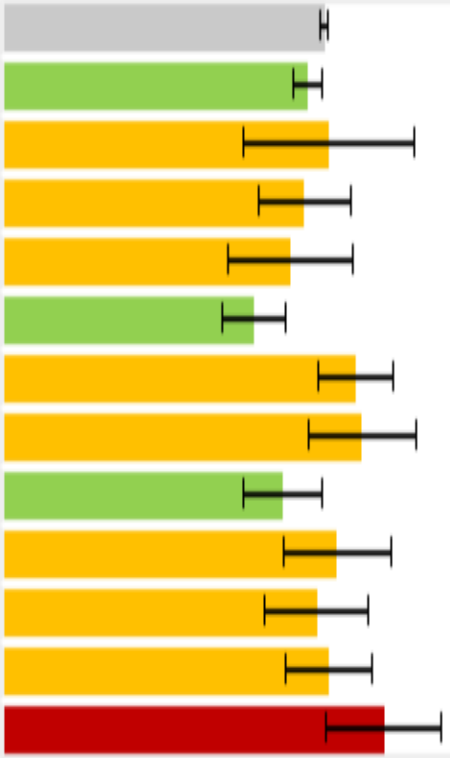


Funmi Worrell
Public Health Registrar

# Where are we now?

**2.23iv - Self-reported wellbeing - people with a high anxiety score** 2014/15 Proportion - %

| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|
| England | - | 19.4 | 19.1 | 19.7 |
| East of England region | - | 18.3 | 17.4 | 19.2 |
| Bedford | - | 19.6 | 14.4 | 24.9 |
| Cambridgeshire | - | 18.1 | 15.3 | 21.0 |
| Central Bedfordshire | - | 17.3 | 13.4 | 21.1 |
| Essex | - | 15.1 | 13.2 | 17.0 |
| Hertfordshire | - | 21.2 | 18.9 | 23.6 |
| Luton | - | 21.6 | 18.3 | 24.9 |
| Norfolk | - | 16.8 | 14.4 | 19.3 |
| Peterborough | - | 20.1 | 16.9 | 23.4 |
| Southend-on-Sea | - | 18.9 | 15.6 | 22.1 |
| Suffolk | - | 19.6 | 16.9 | 22.3 |
| Thurrock | - | 22.9 | 19.4 | 26.4 |



*Source: Annual Population Survey (APS); Office for National Statistics (ONS).*

# Where are we now?

- People entering IAPT as a % of those estimated to have anxiety / depression – 15.1%
- % of people who have completed IAPT treatment who are "moving to recovery" – 39.3%
- % of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff – pilot started
- % of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool – 0%

# Where do we want to be?

- People entering IAPT as a % of those estimated to have anxiety / depression – 15.1% to 25% by 2021
- % of people who have completed IAPT treatment who are "moving to recovery" – 39.3% to 50% (national target)
- % of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff – Pilot ongoing, 30 staff trained, including LACs.
- % of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool – 0%

# How will we get there?

- Increase screening for depression in primary care and social care
- Increase awareness and training in social care staff
- Increase self and supported referrals into IAPT services (Inclusion Thurrock)
- Increase awareness of the Recovery College launched in October 2016

# Thank you!

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| 17 November 2016 | ITEM: 8 |
|---|---|
| **Thurrock Health & Wellbeing Board** | |
| **"Implementing the Five Year Forward View for Mental Health" – Local implementation.** | |
| **Wards and communities affected:** All | **Key Decision:** N/A |
| **Report of:** Jane Itangata – Senior Commissioning Manager MH & LD Commissioning, NHS Thurrock CCG | |
| **Accountable Head of Service:** Mark Tebbs, Director of Commissioning NHS Thurrock CCG | |
| **Accountable Director:** Mandy Ansell, (Acting) Interim Accountable Officer NHS Thurrock CCG | |
| **This report is:** Public | |

**Executive Summary**

"*For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths*."[1]

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. One in four adults experiences at least one diagnosable mental health problem in any given year.

People can, and do, recover from mental ill health. The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality.

The purpose of this report is to inform the Health and Wellbeing Board on the local response to the recently published "Five Year Forward View for Mental Health" strategy and "Implementing the Five Year Forward View for Mental Health" guidance.

[1] *"The Five Year Forward View for Mental Health, (Department of Health, 2016)"*

## 1. Recommendation(s)

**1.1 The Health and Wellbeing Board are asked to note the content of this report that defines Thurrock's response to the recently published recommendations of the *"Five Year Forward View for Mental Health"* strategy and subsequent *"Implementing the Five Year Forward View for Mental Health"* guidance.**

**1.2 That the Health and Well Being Board are aware of the progress of the work on the Mental Health Crisis Care Concordat – development of the approach to a 24/7 Mental Health Crisis Response pathway.**

## 2. The Five Year Forward View for Mental Health

### 2.1 The Context

In March 2015 Simon Stevens on behalf of the NHS, commissioned an Independent Mental Health Taskforce chaired by Paul Falmer, Chief Executive of Mind which brought together health and care leaders, people who use services and experts in the field to create a Five Year Forward View for Mental Health strategy.

The independent report of the Mental Health Taskforce published in February 2016, sets out the start of a ten year journey for that transformation, signifying for the first time a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health arm's length bodies.

Key to the report was communicating the views of more than 20,000 users of mental health services who unequivocally expressed that the priorities were prevention, access, integration, quality and a positive experience of care to enable them achieve their life ambitions and take their places as equal citizens in society.

The taskforce made 57 recommendations broadly targeted at:

- The six NHS arm's length bodies – to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people.
- Wider action – many people indicated that as well as access to good quality mental health care in the NHS, their ambition was to have a decent place to live, a job and good quality relationships in their local communities, therefore *"mental health is everyone's business!"*
- Tackling health inequalities – mental health problems disproportionately affect people living in poverty, the unemployed and those already facing discrimination and their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital.

*"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".*

## 2.2 Implementing the Five Year Forward View for Mental Health

The Five Year Forward View for Mental Health strategy has made an unarguable case for transforming mental health care. Implementing the Five Year Forward View for Mental Health provides the guidance and plan of what the system will need to focus on in further transforming mental health services and embed lasting change.

Whilst the Implementation plan is focused primarily on the role of the NHS in delivering its commitments, it is also a blueprint for mobilising partners in local government, housing, education and the voluntary sector to enable the best possible outcomes for people; this cannot be achieved by the NHS alone. Delivery of the *Five Year Forward View for Mental Health* is underpinned by significant additional funding.

### 2.2.1 Priorities for Implementing the Five Year Forward View for Mental Health

- A 7 Day NHS – right care, right time, right quality to include Crisis Care by 2020/21
- Integrating mental and physical health
- Promoting good mental health and preventing poor mental health and helping people lead better lives as equal citizens

### 2.2.2 Key Common principles

- Co-production with people with lived experience of services, their families and carers;
- Working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing;
- Identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery;
- Designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives; and,
- Underpinning the commitments through outcome-focused, intelligent and data-driven commissioning.

## 3. Mental health problems in the population

### 3.1 The nature and level of need

- Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. (1 in 10 children aged 5-16 years have a diagnosable mental health disorder).

- 1 in 5 mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease.
- Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England.
- In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent.
- Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high.
- For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population.
- People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work
- One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression.
- People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.
- People in marginalised groups are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others.
- As many as nine out of ten people in prison have a mental health, drug or alcohol problem.
- Suicide is rising, after many years of decline.

## 3.2 **Current experiences of Mental Health Care**

- Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.
- Nine out of ten adults with mental health problems are supported in primary care. Whilst there is significant expansion in access to psychological services since the introduction of the national IAPT programme (Improving Access to Psychological Therapies) there is still considerable variation in services with waiting times varying from 6 to 124 days.
- One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.

- In its recent review of crisis care, the Care Quality Commission found that only 14% of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service.
- Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police.
- Admissions to inpatient care have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.
- Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances outside of their area.
- Mental health accounts for 23% of NHS activity but NHS spending on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services.
- Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be re-invested to meet the significant unmet mental health needs of people of all ages, and to improve their experiences and outcomes.

### 3.3 **Local perspective**

We are aware the position nationally is reflected quite closely locally and in Thurrock partners have over the last 2 years been working very closely together to achieve our vision:

*"The Health and care experience of the people of Thurrock will be improved as a result of our working effectively together."*

#### 3.3.1 **Thurrock Mental Health Priorities**

- Improving urgent and emergency care
- An integrated social care, mental and physical health approach – care closer to home
- Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

#### 3.3.2 **Our Transformation context**

To enable us deliver on our priorities as well as implement the "*Five Year Forward View for Mental Health",* we are collaboratively engaged in key transformation

programmes with clearly defined strategies for transforming mental health services namely:

- For Thurrock in Thurrock
- Living Well in Thurrock
- The Primary Care Strategy
- Better Care Fund
- The Health and Wellbeing Strategy

### 3.4 **Our Mental Health response to "Implementing the Five Year Forward View**

#### 3.4.1 **The Thurrock Mental Health JSNA and Mental Health Strategy**

The CCG, Local Authority and Public Health commissioners are working together on developing a Mental Health JSNA product that will inform the Thurrock Implementation Plan of the Essex, Southend and Thurrock Mental Health Strategy and this will be aligned to the Health and Wellbeing Strategy. To ensure an informed plan is developed we will also involve and engage:

- users of services, their families and carers
- providers both statutory and voluntary

It is anticipated that the JSNA will be complete by December 2016 and this will provide a starting point to help us measure the impact of our transformation programmes, whilst the strategy implementation plan that will be in place by the end of March 2017 will define and guide the direction of travel to enable us achieve the best outcomes for our residents and deliver our vision.

#### 3.4.2 **IAPT and Recovery College (primary care and community)**

##### 3.4.2.1 **Treating common mental disorders**

The prevalence of people with depression and anxiety 2015/16 is estimated at 20,614 and current evidence suggests that 3093 would benefit from NICE approved psychological therapies per year via the Improving Access to Psychological Therapies (IAPT) national programme. IAPT services should be integral to community-wide efforts to develop person and family-centred services, which promote emotional and psychological well-being. Those people suffering from common mental health disorders often have concerns relating to employment, housing, debt or relationship difficulties, regardless of other issues.

We have recently commissioned a new service that combines an IAPT pathway with a Recovery College, first time this has been done nationally as Recovery Colleges have tended to grow organically in secondary care. The service has been delivered by South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Inclusion Thurrock) since 1st April 2016 and works in partnership with a number of our voluntary sector organisations including being in a subcontract arrangement with Thurrock Mind.

To access the service people are assessed for not just their mental health needs but also their social inclusion, housing, employment, benefits and social care needs are

taken into consideration to ensure holistic packages of care is defined with individuals.

3.4.2.2 **Building and promoting resilience**

The Recovery College will facilitate an educational approach that focuses on developing people's strengths, and enabling them to understand their own challenges and how they can best manage these in order to pursue their aspirations. It facilitates the learning of skills that promote recovery and underpin greater confidence and the self-belief that comes with recognising one's abilities and potential.

Recovery is a personal journey of discovery.[2] It involves making sense of, and finding meaning in, what has happened; becoming an expert in your own self-care; building a new sense of self and purpose in life; discovering one's own resourcefulness and possibilities and using these, and the resources available to pursue personal aspirations and goals. We felt that there are significant synergies between IAPT and the Recovery College and the two services would promote therapeutic and educational approaches to support people with recovery and build resilience.

3.4.2.3 **Long Term Conditions**

Evidence clearly demonstrates the people with Long Term Conditions (LTCs) have comorbid underlying mental health problems. As part of this pathway we have also commissioned a psychological therapies service for people with LTCs, embedded in teams in the community. The service has also been skilling up other professionals e.g. District Nurses in screening for depression and anxiety as part of core patient care and ensuring support is provided as flexibly as possible.

3.4.2.4 **Social Care support**

Inclusion Thurrock has been delivering professional support to social care teams to enable them also screen for depression and anxiety as part of core social care assessments. We hope that this will facilitate good practice so that instead of just defaulting to additional care hours – a cost pressure to the LA, the underlying mental health problems that are normally indicated can be treated and facilitate independence and a better quality of life for the service user.

3.4.2.5 **Learning Disabilities**

Whilst people with LD can access the IAPT/RC service with support and reasonable adjustments being done further work is on-going to develop specific modules and learning materials so that people are supported in the most inclusive and effective way.

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[2] Repper, J. & Perkins, R. (2012) Recovery: A journey of discovery for individuals and services, in Phillips, P., Sandford, T, & Johnston, C. (Ed) *Working in Mental Health: Practice and policy in a changing environment*, Oxford: Routledge

### 3.4.3 **Mental Health Shared Care Protocol**

We are cognisant that a significant number of people are currently on secondary care caseloads but receiving no to minimal clinical input – not an effective or efficient use of specialist resource and the poor service user outcomes.
Thurrock developed and piloted a 'Mental Health Shared Care Protocol' in 2013/14 to test primary and secondary care working together to support good patient flow. The results were significant and positive and well received by all GPs and patients who were supported in the least restrictive environment with the assurance that if they required quick access back into secondary care that this would be facilitated appropriately.

Learning from the pilot has informed the review of the Protocol enhancing and mainstreaming it as a critical enabler to ensure that secondary care resources are used well, that the patient is treated by the right person, right place, right time in light of our Transformation programmes, recent national guidance and the move to outcomes based contracts for mental health.

### 3.4.4 **24/7 Crisis Response Care**

#### 3.4.4.1 **Background**

In its recent review of crisis care, the Care Quality Commission found that only 14% of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am.

Too often, people in mental health crisis are still accessing mental health care via contact with the police. There have long been concerns about the way in which health and social care services and police forces work together in response to mental health crises.

In recognition of this the Mental Health Crisis Care Concordat was launched in February 2014 and it sets out a new agreement between the police, NHS and other emergency partners in a bid to improve mental health crisis care.

Key to the implementation of the Concordat is the challenge it gives to local health, social care and criminal justice partnerships to provide strong leadership, develop and improve local responses to support people experiencing a mental health crisis. This not only serves the individual concerned better, but also helps those emergency services perform their roles better.

In response to sign up to the Crisis Care Concordat in December 2014, a Pan Essex Crisis Care Concordat multi-agency group (now Urgent Care Mental Health – UCMH) was set up to take forward the mandate of addressing the gaps in service for managing people in a mental health crisis.

The Mandate from the Government to NHS England in 2014 established specific objectives for the NHS to improve mental health crisis care. The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times accessible, responsive and high quality as other health emergency services.
- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.
- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in the Concordat.

The Policing and Crime Bill (2016) was placed before Parliament in February of this year, tabling amendments to the Mental Health Act (1983). Main changes proposed are:

- No children or young person (under 18) should be taken to police stations as a POS under any circumstances.
- Adults can be taken to custody as a POS, only in circumstances to be specified in regulations, yet to be determined, by the Secretary of State. *It is anticipated the criteria will be exceptionally violent individuals, those who cannot be safety managed elsewhere.*
- Maximum assessment time of 72hours in a POS reduced to 24 hours – which can be extended to 36 hours if authorised by the doctor leading the assessment, or a Superintendent if a custody suite has been used as the POS.
- A requirement, *where practicable*, to consult a doctor, mental health Professional or AMHP prior to removing a person to a POS. No such requirement presently exists.

These changes are scheduled to be in place on 1st April 2017 and will also mean that police vehicles will not be used to convey patients to places of safety except in exceptional circumstances where violence is an overriding factor. Statistics released earlier this year show that Essex has the 2nd highest usage rate of custody as a place of safety (POS) nationally.

A system wide preparedness approach is therefore required to mitigate the potential impact and respond to the changes.

3.4.4.2 **Local approach to legislative changes and national guidance**

The Essex STP felt there was a need to identify a team to define an approach and take forward the development of a 24/7 mental health crisis response pathway as well as ensure the system is in a state of preparedness to respond to the proposed changes to the Mental Health Act. Thurrock CCG was asked to take on this responsibility.

A project mandate (embedded below) describing the approach the team would take was developed and ratified by the 7 Essex CCGs' AOs on 14th September, 2016. Consequently workstreams comprising representatives from the CCGs, LAs, MH

Trusts, Acute Trusts, Police and Ambulance service have been pulled together to undertake identified tasks with a view to implementing required responses by 31st March 2017.

Mental Health Crisis Care 24-7 Response

3.4.4.3 **Street Triage**

To mitigate the proposed amendments to the MHA (2003) coming into effect on 1st April 2017, the project team is reviewing the Street Triage service which has been in operation from 2014/15 with significantly positive results. Options are being explored on the best fit model that will meet the needs of people when in a crisis but also ensure that agencies are working more collaboratively to support service users frequently needing emergency services. The intention is to finalise the business case for this element of the response by 31/10/2016 so that governance can be undertaken in November in time for contracts sign off on 23/12/2016.

Progress updates from the project team are circulated to the system on a fortnightly basis.

## 4. Reasons for Recommendation

4.1 To ensure that the Health and Well Being Board are well informed about the developments in Mental Health service provision in Thurrock and the strategic programmes Thurrock is leading.

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

5.1 N/A

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

6.1 The failure to deliver high quality services and support to people with mental health problems especially when in a crisis would affect a significant number of Thurrock residents, it is important therefore to raise awareness of the provision available and ensure partnership working with those who use services is key to future developments

## 7. Implications

7.1 **Financial**

Implications verified by: **Jo Freeman**

**Management Accountant Social Care and Commissioning**

None identified at this stage. The delivery of this programme can currently be met through existing budgets. A further report will be provided to the Health and Wellbeing Board in future if financial implications are identified at a later date.

7.2 **Legal**

Implications verified by: **Christopher Pickering**

**Principle Solicitor, Employment and Litigation**

None identified.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

**Community Development and Equalities Team**

A Diversity and Equality Assessment was completed as part of developing the business case for this programme. The programme is fully inclusive and extends beyond equality and diversity requirements by focussing on the wider population as well as individuals with protected characteristics.

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

From 1st April 2017 no-one detained under s136 will be conveyed to police custody as a place of safety, unless in exceptional circumstances where violence is indicated.

**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):

- Mental Health Crisis Care 24/7 (Embedded within report)

**9. Appendices to the report**

- N/A

**Report Author:**
Jane Itangata

Senior Commissioning Manager – MH & LD, NHS Thurrock CCG

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# Mental Health Crisis Care 24/7 Response Service

## Introduction

Mental illness is a challenge for all of us. When a person's mental state leads to a crisis episode, this can be very difficult to manage, for the person in crisis, for family and friends, and for the services that respond. There have long been concerns about the way in which health services, social care services and police forces work together in response to mental health crises.

In recognition of this the Mental Health Crisis Care Concordat was launched in February 2014[1]. The concordat is a national agreement between services and agencies involved in the care and support of people in crisis. The concordat sets out a new agreement between police, the NHS and other emergency partners in a bid to improve mental health crisis care. The system signed up to the delivery of the Crisis Care Concordat in December 2014.

It builds on the NHS England Mandate commitment that every community should have plans to ensure no-one in mental health crisis should be turned away from health services. Key to the implementation of the Concordat is the challenge it gives to local health, social care and criminal justice partnerships to provide strong leadership, develop and improve local responses to support people experiencing a mental health crisis. This not only serves the individual concerned better, but also helps those emergency services perform their roles better.

A Pan Essex Crisis Care Concordat group (now Urgent Care Mental Health – UCMH) was set up to coordinate the implementation of the Action Plans developed to evidence response to the Concordat mandate, using a consistent approach and collaboratively exploring opportunities where economies of scale would achieve the best outcomes for people in crisis using services as well as deliver value for money.

Five of the seven CCGs are also part of the Essex Success Regime with a focus on transforming acute services. A need was identified under the Success Regime to undertake the development of a 24/7 Mental Health Crisis Response Service. In response to this a project team (Appendix 1) was set up to progress a work plan that will set out the requirements the system will need to meet for a 24/7 Crisis Response Service. Appendix 2 indicates the respective organisations/stakeholders represented in this work.

The purpose of this project mandate is to describe the approach that this collaborative team will take to define the requirements of a Pan Essex Mental Health 24/7 Crisis Care Response Service in line with the Concordat objectives of ensuring that there is:

1. Access to support before crisis point
2. Urgent and emergency access to crisis care
3. The right quality of treatment and care when in crisis
4. Recovery and staying well, and preventing future crises

## Background

In its recent review of **crisis care**, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments have 24/7 cover from a liaison mental health service,

[1] *Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis. (Department of Health, 2014)*

even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often people in crisis end up in a police cell rather than a suitable alternative place of safety.[2]

People facing a crisis should have access to mental health care 7 days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Better access to support when in crisis is one of the top priorities identified by people with severe and enduring mental health problems.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. Improving the 7 day crisis response service across the NHS will help save lives as part of a major drive to reduce suicide by 10 per cent by 2020/21.

Failure to provide care early on means that the acute end of mental health care is under immense pressure. Waiting times – for first appointments and for the right follow-on support – are unacceptably long. Basic interventions are in short supply, services are under pressure and thresholds for access are being raised. As a result, people's needs often escalate and they can become acutely unwell or experience a crisis, resulting in poorer outcomes and a reliance on higher cost care.

The Mandate from the Government to NHS England in 2014 established specific objectives for the NHS to improve mental health crisis care. The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times accessible, responsive and high quality as other health emergency services.

- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.

- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in the Concordat.

The Policing and Crime Bill 2016 was placed before Parliament in February of this year. Sections 59-61 represent the amendments to the Mental Health Act 1983 that were announced by the Minister for Preventing Abuse Exploitation and Crime, Karen Bradley, in February. The estimated timescales are Royal Assent and effect from April 2017. Main points/changes identified are:

- No children or young person (under 18) should be taken to police stations as a POS under any circumstances.
- Adults can be taken to custody as a POS, only in circumstances to be specified in regulations, yet to be determined, by the Secretary of State. *It is anticipated the criteria will be exceptionally violent individuals, those who cannot be safety managed elsewhere.*
- Maximum assessment time of 72hours in a POS reduced to 24 hours – which can be extended to 36 hours if authorised by the doctor leading the assessment, or a Superintendent if a custody suite has been used as the POS.

[2] *The five Year forward View for Mental Health: A Report from the independent Mental Health Task Force to the NHS in England. (Department of Health, 2016)*

- A requirement, *where practicable*, to consult a doctor, mental health Professional or AMHP prior to removing a person to a POS. No such requirement presently exists.

**Project objectives**

The project objectives are to:

- Define a Contingency Plan that will be in place by 1st April 2017 when the Policing and Crime Bill proposed amendments to the MHA will be implemented.
- Develop a specification for a Mental Health Crisis Care Response service that is consistent, compassionate, comprehensive and operates 24/7 so that anyone who needs urgent support during a mental health crisis has access.
- Deliver a business case to inform commissioning plans for the service and resource implications taking into account the recently published Implementing the Five Year Forward View for Mental Health investment and savings indications[3]
- Explore external funding opportunities to support project and contingency plan implementation e.g. U&EC Capital Funding Bid.

**Scope of the project**

The following national policy recommendations inform the scope of this project:

1. By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that a 24/7 community-based mental health crisis response is available in all areas and that these teams are adequately resourced to offer intensive home treatment and not just assessment as an alternative to an acute inpatient admission. (For children and young people, an equivalent model of care should be developed within this expansion programme).
2. By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum[4].
3. Implementation of the Policing and Crime Bill 2016 proposed amendments to the Mental Health Act 1983, in April 2017.

Whilst there is recognition that an All Age approach would be beneficial a significant programme is already underway for Children and Young People developed over two years and is just initiating the implementation of a new model. Opportunities will be explored to align both processes so as to ensure any gaps in transition are minimised.

The scope for this project will therefore cover adult services and focus on two objectives of the Crisis Care Concordat (outlined above) i.e.:

- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis

The system will need to define how the other objectives will be met by reviewing current models of care and ensure efficient and effective utilisation of resources in order to support all levels of future service provision in this rather financially challenged environment

[3] Implementing the five year forward view for mental health. (Department of Health, 2016)

[4] *The five Year forward View for Mental Health: A Report from the independent Mental Health Task Force to the NHS in England. (Department of Health, 2016)*

The workstreams underpinning this project are broadly:

Service model development workstream

- Define parameters of a 24/7 service and what it needs to do
- Service mapping and gap analysis
- Needs assessment – respective system JSNAs and MH Strategies
- Police & Crime Bill – amendments to the MHA
- Contingency Plan for implementation by 01/04/2017
- Essex s136 Suites bid

Commercial workstream

- Resource requirements to meet project delivery
- Financial and activity analysis and modelling
- Costing future proposed model and financial envelop

Communication workstream

- Governance
- Communications and engagement strategy
- Stakeholder engagement

## Key Milestones

The project will have specific milestones in respective workstreams as they are developed. Appendix 3 summarises high level key milestones that the project will endeavour to deliver bearing in mind system governance requirements. Detail will be added as the project progresses.

## Benefits

Whilst the benefits of delivering this project will be defined more fully as the plan develops high level short, medium and long term indications will be:

1. Non – Cashable (Quality and Activity savings)

- Alleviation of the suffering of individuals in a mental health crisis
- Support emergency services to perform their roles better and efficiently
- Seamless pathways and better utilisation of resource to deliver value for money
- Reduction in A&E attendances of people in a mental health crisis
- Reduction in mental health admissions and re-admissions
- Reduction in suicide rates
- Elimination of Out of Area Placements for acute health cares for adults

2. Cashable (Financial savings)

- Quantified through the financial and activity modelling part of the project.
- Aligned with the proposed analysis indicated in the 5YFVFMH implementation plan[5]

[5] Implementing the five year forward view for mental health. (Department of Health, 2016)

## Dependencies

- This project is significantly contingent on the system being able to reconfigure mental health services to release resources in order to deliver a comprehensive 24/7 Crisis Response service.
- There is recognition that to minimise any adverse impact on the system by the implementation of the Policing and Crime Bill (2016) proposed amendments to the Mental Health Act in April 2017; is significantly dependent on the completion of this project.

## Key Risks

- Whilst it is hoped that the project would deliver a cost neutral business case it's likely gaps in service provision may not be met adequately by current resources in the system which would lead to cost pressures in an already financially challenged system.
- Project team may be stretched too thin if expertise/resource is not flexibly available from the system to undertake tasks within the workstreams

## Stakeholders and Communication

This part will be defined as the workstreams are worked through. To ensure this work is embedded in respective partner work plans and alignment with the CCGs' financial cycles for planning and allocation and to meet governance requirements, a communications and engagement plan is being developed so that all agencies and stakeholders have regular updates on developments and can input into the process.

## Governance

The mandate for this project was signed off at the AOs meeting on 14th September 2016 and will be on a Pan Essex footprint. Collectively the 7 Essex CCGs' AOs will be the sponsors of this project. Thurrock CCG will lead and coordinate all the work required to ensure that the intended outcomes of the project are achieved. The UCMH group will be a critical forum and driver for this work as developing a 24/7 crisis response service is part of the work plan for the Crisis Care Concordat. Formal governance arrangements for the UCMH are being worked through.

**Appendix 1**

| Function | Responsibility | Membership |
|---|---|---|
| **Project group** | • Project leadership<br>• Own the project mandate (PID)<br>• Coordinate workstreams | Commissioners<br>• Mark Tebbs (Project lead)<br>• Jane Itangata (Co-ordination)<br>• Catherine Harrison<br>• Ben Hughes<br>• Christine Dickenson<br>• Sipho Mlambo<br>Emergency Services<br>• Craig Wiggins<br>• Duncan Moore<br>• Lisa Grannell<br>Clinical<br>• Dr Caroline Dollery<br>• Dr Rajan Mohile<br>• Dr Sunil Gupta |
| **Service model development workstream** | • Define parameters of a 24/7 service and what it needs to do<br>• Service mapping and gap analysis<br>• Needs assessment – respective system JSNAs and MH Strategies<br>• Police & Crime Bill – amendments to the MHA<br>• Essex s136 Suites bid<br>• Contingency plan | • Jane Itangata (W. Lead)<br>• Catherine Harrison (W. Lead)<br>• Sue Waterhouse (CPT&FG lead)<br>• Craig Wiggins<br>• Caroline Bogle<br>• Julie West<br>• Jo White<br>• David Stratford<br>• Jo Dickinson<br>• Carla Fourie<br>• Tendayi Musundire<br>• Alfred Bandakpara-Taylor<br>• Funmi Worrell<br>• Ibrahim Bakarr<br>• Glyn Halksworth<br>• Kim James<br>• Sarah Range<br>• Emma Strivens<br>• Ron Gutu |
| **Commercial workstream** | • Resource requirements to meet project plan needs<br>• Financial and activity modelling<br>• Costing future proposed model and financial envelop | • Femi Otukoya (W. Lead)<br>• Christine Dickenson<br>• Jane Itangata<br>• Funmi Worrell<br>• Ben Hughes<br>• Craig Wiggins<br>• Simon Ford |
| **Communication workstream** | • Governance<br>• Stakeholder engagement | • Dr Caroline Dollery (lead)<br>• Mark Tebbs<br>• Richard Stone<br>• Communication reps |

**Appendix 2**

| | Name | Organisation | Title |
|---|---|---|---|
| 1 | Mark Tebbs | Thurrock CCG | Director of Commissioning |
| 2 | Jane Itangata | Thurrock CCG | Head of MH & LD Commissioning |
| 3 | Christine Dickenson | North East Essex CCG | Head of MH - North Essex CCGs |
| 4 | Catherine Harrison | Essex County Council | MH Social Care Commissioning Lead |
| 5 | Ben Hughes | Essex County Council | Head of Commissioning PH and Wellbeing |
| 6 | Craig Wiggins | Essex Police | Detective Sergeant |
| 7 | Duncan Moore | East of England Ambulance Service NHS Trust | Area Clinical Lead (Mental Health) |
| 8 | Lisa Grannell | Essex Police | |
| 9 | Dr Caroline Dollery | Mid Essex CCG | MH GP Clinical Lead |
| 10 | Dr Rajan Mohile | Thurrock CCG | MH GP Clinical Lead |
| 11 | Dr Sunil Gupta | Castle Point & Rochford CCG | MH GP Clinical Lead |
| 12 | Sue Waterhouse | SEPT | Director of MH South Essex |
| 13 | Caroline Bogle | Castle Point & Rochford CCG | MH Commissioner |
| 14 | Julie West | North East Essex CCG | |
| 15 | Jo White | NEP | AMHP Practice Lead |
| 16 | David Stratford | Essex County Council | Service Manager EDS |
| 17 | Jo Dickinson | Southend Borough Council | Strategy and Commissioning Manager MH & Dementia |
| 18 | Carla Fourie | SEPT | Associate Director of Social Care and Partnerships |
| 19 | Tendayi Musundire | NEP | |
| 20 | Alfred Bandakpara-Taylor | Basildon & Brentwood CCG | Senior Commissioning Manager (MH & LD) |
| 21 | Funmi Worrell | Thurrock Council | Public Health Registrar |
| 22 | Ibrahim Bakarr | Thurrock Council | Interim Service Manager |
| 23 | Glyn Halksworth | Southend Borough Council | Strategy Manager, Drugs & Alcohol Commissioning Team |
| 24 | Femi Otukoya | Thurrock CCG | Head of Financial Management |
| 25 | Sipho Mlambo | Castle Point & Rochford CCG | Senior Commissioning Manager - MH |
| 26 | Ron Gutu | SEPT | Interim Associate Director of Adult Inpatient Services |
| 27 | Simon Ford | Southend Borough Council | Senior Public Health Manager |
| 28 | Richard Stone | Thurrock CCG | Head of Communications |
| 29 | Kim James | Healthwatch Thurrock | Chief Operating Officer |
| 30 | Sarah Pope | BTUH | Head of Safeguarding |
| 31 | Emma Strivens | NEP | Operational Service Manager |
| 32 | Sarah Range | Southend Borough Council | |
| 33 | | | |

**Appendix 3**

| Phase | Work area | Actions | Timescales |
|---|---|---|---|
| **Phase 1** | Project Mandate (PID) | • Set up project group | 23/06/2016 |
| | | • Develop project mandate (PID) | 07/07/2016 |
| | | • Define work streams (and necessary task & finish groups) | 18/08/2016 |
| | | • AOs PID sign off | 14/09/2016 |
| | | • Project plan (detailed) | 30/09/2016 |
| | | • Communications Plan | 07/10/2016 |
| | Project governance | • Confirm governance requirements in view of STPs/Pan Essex footprint | 06/09/2016 |
| | | • PCC meeting with CEOs of provider Trusts | 22/09/2016 |
| | | • PCC meeting with AOs and Directors of Social Care | Oct 2016 (TBC) |
| | Contingency plan (changes of Policing & Crime Bill) | • Street Triage Business Case | 30/09/2016 |
| | | • S136 suites central management plan | 31/10/2016 |
| | | • S136 suites refurbishment | On-going |
| | | • System central bed management plan | 30/11/2016 |
| | | • Information sharing for repeat attenders | 31/01/2017 |
| | | • RAID/Psychiatric Liaison review | 30/09/2016 |
| | | • AMHPH service review to support contingency plan | 31/10/2016 |
| | | • Review of Crisis Resolution and Home Treatment Teams (CRHTTs) | 31/10/2016 |
| | Business case | • Develop a business case to support contingency plan. | 31/10/2016 |
| | | • Sign off of business case | 30/11/2016 |
| | | • Sign off contract | 31/12/2016 |
| | Implementation plan | • Mobilisation plan | 31/01/2017 |
| | | • Mobilisation start | 01/02/2017 |
| | | • Mobilisation completion | 31/03/2017 |

| | | | |
|---|---|---|---|
| **Phase 2*** | Crisis response Integrated service | • Pan-Essex Liaison and Diversion, Street Triage and Police Forensic Medical Examiner Draft Specification and Project Plan | 2017/18 |
| | 111 procurement | • Mental health specification development for 111 service | |
| | Service redesigns | • Wider system pathway redesigns and developments to support crisis prevention and aftercare | |
| | Engagement strategy | • Develop engagement plan<br>• Consultations | |
| | Service specification | • Develop a specification for service model to deliver quality 24/7 Crisis Response by 2021 | |
| | Business case | • To inform commissioning intentions 2018/19 | |
| **Phase 3*** | Roll out | • Procured services<br>• Implementation of redesigned pathways | 2018/19 |

* Phases to be developed further

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NHS Thurrock Clinical Commissioning Group

# MINUTES

## Integrated Commissioning Executive
29th September 2016

| Attendees |
|---|
| Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair) |
| Mandy Ansell (MA) – Acting Interim Accountable Officer, NHS Thurrock CCG (Joint Chair*) |
| Ade Olarinde (AO) – Chief Finance Officer, NHS Thurrock CCG |
| Mike Jones (MJ) – Strategic Resources Accountant, Thurrock Council |
| Mark Tebbs (MT) – Director of Commissioning, NHS Thurrock CCG |
| Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council |
| Ceri Armstrong (CA) – Directorate Strategy Officer, Thurrock Council |
| Allison Hall (AH) – Commissioning Officer, Thurrock Council |
| Iqbal Vaza (IV) – Strategic Lead for Performance, Quality and Information |
| Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement, Thurrock Council |
| Jeanette Hucey (JH) – Director of Transformation, NHS Thurrock CCG |

| Apologies |
|---|
| Sean Clark (SC) – Director of Finance and IT, Thurrock Council |
| Ian Wake (IW) – Director of Public Health, Thurrock Council |
| Les Billingham (LB) – Head of Adult Social Care and Community Development, Thurrock Council |

| Item No. | Subject | Action Owner and Deadlines |
|---|---|---|
| **1.** | **Notes of the last meeting 25th August 2016** | |
| | The notes of the 25th August meeting were agreed.<br><br>CW stated that a project brief for the Enhanced Care Home pilot would be brought to the October meeting. | CW October meeting |
| **2.** | **Better Care Fund Plan 2016-2017** | |
| | **a) Progress Report – Scheme 2**<br>**Integrated Community Older Adults HWB Service**<br>MT gave an update on the initiatives that were part of scheme 2. With regard to the Integrated Community Older Adults, MT said it would be important to demonstrate that the initiative was delivering the expected outcomes.<br><br>MT said that it would be important to identify what had been | |

| | | |
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| | spent to date. Any underspends needed to come back to ICE so a decision could be made as to what the money should be spent on.<br><br>MT stated that Mayfield Ward had now closed.<br><br>An update on the Integrated Community Older Adults HWB Service would be given to the next System Resilience Group. | MT October meeting |
| | **Single Point of Access**<br>A separate report on the SPA would be brought to the October meeting. MT asked that Irene Lewsey be invited to Project Group meetings. | Tania Sitch October meeting |
| | **For Thurrock In Thurrock**<br>JH stated that there had been a good Executive to Executive meeting between the CCG, Health Providers and the Council. MT added that Commissioning Intentions had been developed and there was an opportunity for these to go out jointly from the CCG and Council. The focus of the commissioning intentions was 'Not In Hospital' services and would be sent to all three NHS providers.<br><br>RH commented that he had concerns about how the Multi-Speciality Community Provider would operate and wanted clarification about the direction of travel.<br><br>JH responded that the purpose of the current direction of travel was to develop an Out of Hospital Model to deliver the 5-year Forward View. SEPT would have the overall lead but would co-ordinate with the other providers.<br><br>SEPT had been asked to develop a clear proposal to bring staff together under joint teams – but with each provider retaining their sovereignty.<br><br>JH said that the conditions for developing a MCP were not right at the moment which is why a different model was being developed initially. The learning from the current Vanguards was that moving towards a MCP model should take place in bite-size chunks.<br><br>The CCG had agreed with providers that they would be given a two year period of stability so they could develop plans.<br><br>CS asked for the legal advice that had been given to CCGs to be sent to him as there could be a link to the Council's plans for the possible spin out of Adult Social Care fieldwork and provider services.<br><br>MT said that a commissioning and provider forum would be established and would oversee the development and delivery of plans for the Out of Hospital model. | JH to provide the legal advice given by Hampsons |

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| | **Integrated Healthy Living Centres**<br>A budget had been agreed to oversee the development of IHLCs. The LA would contribute 50% (£75k) and the CCG would provide the remainder.<br><br>It was likely that services would move from Basildon Hospital to the IHLCs – one of which was likely to be located within the grounds of Thurrock Hospital.<br><br>**Carers**<br>CW stated that work was taking place to retender the current Carers contract. The aim would be to increase the volume of contact made with carers through the new contract. Only a small percentage of carers in Thurrock currently came in to contact with the CARIAD service.<br><br>**b) Finance**<br>AO updated ICE on year to date performance. This included clarification of financial values for service lines related to NELFT and SEPT. The BCF would be updated accordingly and ICE agreed to increase the value of the BCF pot by £710,228.<br><br>The payment for performance amount and the 2015/16 carried forward amount was now shown separately.<br><br>MJ clarified that overspends would be capped up to the value of the Better Care Fund.<br><br>Out of the amount carried forwards from 2015/16, £100k was still to be allocated.<br><br>Out of the amount allocated to one-off projects from the carried forwards money, ICE members stated that they wanted reports on what had been spent to date. This included:<br><br>Hypertension – the pilot needed to be delivered within the amount allocated by the ICE (£100,800). Any additional amounts would need to be covered by the Public Health Grant. Emma Sanford to be asked to provide an update on the project, and the spend to date.<br><br>Care Home Support – MT to asked Irene Lewsey to provide an update on what has been spent to date and progress.<br><br>Falls – clarity was required on the value of the project – the business case had stated £152,615 but the amount requested was £229,346. Irene Lewsey would be asked to provide an update for the October meeting.<br><br>AO would follow up on the pharmacy input to Care Homes as CA thought this was included as part of the Integrated Community Older Adults HWB Service.<br><br>**c) Performance** | ES to provide update to October meeting<br><br>IL to provide update to October meeting<br><br>IL to provide update to the October meeting<br><br>AO to confirm |

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| | IV provided an overview of performance to date against indicators contained within the BCF scorecard.<br><br>Two of the indicators were currently RAG-rated as 'red'. Once of these was Delayed Transfers of Care. IV had undertaken some additional analysis on the DTOC figures and stated that a significant number of these attributable to adult social care were from SEPT.<br><br>IV added that pressure on the Council's in-house domiciliary care provision was contributing to DTOC numbers. This, together with the on-going issue of recruiting sufficient numbers of carers had resulted in an increased number of people waiting for support. There was also insufficient residential bed capacity so compounding pressure on the system.<br><br>MA raised concerns that the impact of ASC pressures could lead to more people being admitted to hospital.<br><br>RH agreed that this was a possibility and that Council staff were being asked to volunteer for 'step-up' training.<br><br>**NHS Operating Guidance 2017/18**<br>AO commented that the NHS Operating Guidance had been received for 2017-18. There were changes to how CQIN was allocated with none of the possible 2.5% determined locally. As a consequence, AO suggested that contract values within the BCF be without the CQIN amount. This might mean a reduction in value for those lines.<br>The net uplift for 2017-2018 was 0.1%.<br><br>However, it was agreed to leave the values for 2017/18 as shown in AO's tabled spreadsheet. | |
| **3.** | **Delayed Transfers of Care** | |
| | Update as above. | |
| **4.** | **Integrated Data Set** | |
| | Emma provided an update on the development of the integrated data set across health and social care.<br><br>ES said that after a short delay, the procurement exercise had begun. The closing date was 26th October and the evaluation of bids would follow.<br><br>A paper would be brought to the November ICE by the Tender Evaluation Panel recommending the award of contract to the preferred bidder. | ES to bring IDS paper to November ICE |
| **5.** | **Living Well in Thurrock** | |
| | A highlight report was provided on Living Well in Thurrock.<br><br>In addition to the report provided:<br>• 2 tenders had been received for Shared Lives;<br>• A bid was being prepared for the 28th October which | |

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| | if successful would release capital funding to establish a supported living-type scheme in Chichester Close for people with learning disabilities;<br>• Meetings were taking place with domiciliary care providers in Thurrock to further the Living Well at Home pilot.<br><br>With regard to the Single Point of Access, it was important that the service linked to other points of access – e.g. 101 and Out of Hours. | |
| **6.** | **For Thurrock In Thurrock** | |
| | An update has been provided in relation to the scheme 2 progress report. | |
| **7.** | **Possible areas of saving/efficiency** | |
| | A paper on proposals for the 2017/18 budget would be brought to the next meeting. | MJ to bring paper to October meeting. |
| **8.** | **Sustainability and Transformation Plan – Joint Principles across Essex, Southend and Thurrock HWBBs** | |
| | RH updated ICE that the Chair of Thurrock HWBB (Cllr Halden) had drafted a paper containing a set of principles to ensure that commissioning, planning and provision of health and social care was in the first instance on a Health and Wellbeing Board footprint.<br><br>The principles had been sent to Essex County Council and Southend Council Health and Wellbeing Board chairs for endorsement. | |
| **9.** | **Any Other Business** | |
| | 1. There was a proposal to establish a new slimmed down programme board for the Success Regime.<br><br>2. AO stated that there had been no billing for the payment for performance monies to date and a decision was needed as to how the monies should be apportioned. Irene Lewsey would be asked to calculate the update from NELFT.<br><br>3. AO said with the establishment of the BCF we could expect to shape a programme of performance improvement, efficiencies and potentially savings. MT said that ICE should consider placing the total value of contracts contained within the Accountable Care Organisation within the Better Care Fund. RH stated that some time should be spent at the next ICE meeting considering what the BCF for the future should look like. | Irene to confirm amount spent to date by NELFT on the Care Home Support project<br><br>October ICE to consider BCF for the future, and future DoT for integration |

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**FINAL MINUTES**

**Health and Wellbeing Board Executive Committee**
13 October 2016, 3.00 - 4.30pm

**Attendees Present**
Roger Harris (Chair), Ian Wake, Rory Patterson, Malcolm Taylor, Les Billingham, Kim James, Jane Foster-Taylor, Ceri Armstrong, and Darren Kristiansen.

**Apologies**
Mandy Ansell, Steve Cox, Maria Payne, Ade Olarinde.

| Item No. | Subject | Action |
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| 1. | **Welcome and apologies** | |
| | The Chair noted apologies, as recorded. | |
| 2. | **Notes from the last meeting** | |
| | Notes of meeting on 25 July were agreed. The Chair noted completed actions. Actions that are in progress and have been carried forward are:<br>• Arrange for Cllr Halden to meet with Dr Mallik (College Health). | **Action DK** |
| 3. | **Reflections on September Health and Wellbeing Board meeting** | |
| | Executive Committee members agreed that the results of engagement activity should continue to be provided to Health and Wellbeing Board members directly after each individual action plan presentations. | |
| 4. | **Agenda for Health and Wellbeing Board meeting on 17 November** | |
| | Executive Committee members agreed timing necessary for each agenda item, which will be reflected on the agenda and included within the Chair's Brief.<br><br>It was agreed that the Annual Public Health Report will be presented to the Board by Ian Wake using a Microsoft PowerPoint presentation.<br><br>It was agreed that the STP/ESR update should also be provided to the Health and Wellbeing Board via powerpoint presentation<br><br>The Chair advised Executive Committee members that Cllr Halden has been working with Essex and Southend Health and Wellbeing Board Chairs to develop a set of key principles for the STP/ESR. The key principles have now been sent to | **Action Ian Wake**<br><br>**Action Secretariat**<br><br>**Action Secretariat** |

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| | Dr Anita Donley, Independent Chair of the STP/ESR. It was agreed that the key principles will be circulated to Executive Committee members with these minutes | |
| **5.** | **Health and Wellbeing Strategy Action Plan and presentations for Goal C, Better Emotional Health and Wellbeing** | |
| | Executive Committee members considered action plans and available presentations. During discussions the following comments were made:<br><br>**Action Plan C1, Give parents the support they need**<br>• It will be important to ensure that the presentation to Health and Wellbeing Board members provides context and sets out why it is necessary to provide support to parents as part of improving emotional health and wellbeing outcomes<br>• The Health and Wellbeing Board will be advised about the increase in demand and the improved early offer of help parenting programmes across Thurrock<br>• HWB members should be advised about how the action plan links with wider programmes including the 0-19 Public Health offer.<br><br>**Action Plan C2, Improve the emotional health and wellbeing of children and young people**<br>• It was agreed that the HWB presentation should follow a similar format to that provided for action plan C1 and that Board members should be provided with contextual information about why the actions and outcomes are important to the people of Thurrock.<br>• It was agreed that the delivery date for action C2C, guidance on Prevention of Suicide and Self Harm to be reviewed/developed and distributed to schools colleges and other agencies, should be amended to March 2017.<br>• It was agreed that Framework service indicators should be included within the action plan outcome framework. It was also agreed that the action plan outcome framework should also include a footnote that explains when baselines and targets are likely to be determined<br>• Committee members acknowledged the level of transition that has been necessary to improve the service<br>• Indicators demonstrating a successful service will include:<br>  ○ Speedy referrals to services for those who need them<br>  ○ Therapies that are more targeted to support individual needs<br>• Executive Committee members were informed about a new service that is being implemented across Thurrock to support young people with eating disorders.<br>• Executive Committee members were made aware that | **Action Rory Patterson**<br><br>**Action Malcolm Taylor**<br><br>**Action Malcolm Taylor** |

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| | national statistics indicate that 1 in 4 people are victims of bullying. Committee members were advised that there is no direct funding available to support anti-bulling initiatives. However, consideration is being provided to how data can be collected to establish the type of bullying that is taking place across Thurrock including homophobic and race related bullying.<br>• Committee members were informed about Healthwatch's engagement with young people about emotional health and wellbeing. It was agreed that feedback received about young people not feeling safe in Thurrock should be provided to Thurrock's Community Safety Partnership<br><br>**Action Plan C3, Reduce isolation and loneliness**<br>• Members agreed that amendments should be made to the action plan to better reflect owners and delivery dates.<br><br>**Action Plan C4, Improve the identification and treatment of depression, particularly in high risk groups**<br>• Members agreed that amendments should be made to the action plan to better reflect owners and delivery dates.<br><br>It was agreed that all amendments to action plans and PowerPoint presentations will be provided to Secretariat by no later than Thursday 20 October. | **Action Kim James**<br><br>**Action Secretariat**<br><br>**Action Secretariat**<br><br>**Action – owners of action plans** |
| **6.** | **Progress report on engagement feedback activity for Goal C** | |
| | It was agreed that engagement feedback will be aligned to the relevant action plan.<br><br>DK would meet with action plan owners as appropriate to ensure that engagement feedback was informing the development of action plans and that feedback can be provided to members of the public about how their views have influenced and informed action plan development.<br><br>It was agreed that an engagement report will be provided to Executive Committee members at the next meeting concerning action plan owner responses to feedback on goals A and B. | **Action Kim James**<br><br>**Action Secretariat**<br><br>**Action Secretariat/Action Plan Owners** |
| **7.** | **Strengthening Financial Performance and Accountability within Thurrock CCG** | |
| | Committee members noted the paper in Ade's absence | |
| **8.** | **Health and Wellbeing Board and Executive Committee Forward planner** | |

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| | It was agreed that the Health and Wellbeing Board Executive Committee meeting scheduled for 7 November will be cancelled<br><br>It was agreed that, subject to Cllr Halden's approval, the Health and Wellbeing Board meeting scheduled for 5 January will be rearranged for the middle of January. | **Action Secretariat**<br><br>**Action Secretariat** |
| **9.** | **AOB** | |
| | Executive Committee members were updated on progress being made with addressing challenges being experienced by the potential closure of one of East Tilbury's GP surgeries. Work was being carried out by the Council and CCG to find a possible solution. KJ reported that the public meeting held during the week had been very well attended and that local people were extremely concerned. There was concern about why people had been informed so late about the surgery's closure.<br><br>JFT raised concerns about there being no interpreter service for Unaccompanied Asylum Seekers.<br><br>Executive Committee members agreed that the Care Quality Commission's State of Care report published in October should be circulated to Health and Wellbeing Board members. The report described Adult Social Care being at a 'tipping point'. LB recommended that a summary of the report should be presented at a future Board meeting.<br><br>RP made the Board aware of a National Audit Office report on children's services. The report identified the increased number of children in need. The report sets out the characteristics of a 'good' and 'outstanding' authority. | **Action DK** |

## Health and Wellbeing Board Meeting Planner

**Summary of meeting dates**

| Meeting | Date | Agenda | Key Deadlines | Papers to members | Secretariat Notes |
|---|---|---|---|---|---|
| **Health and Wellbeing Board** | **17 November 2016** | • Annual Public Health Report **(1 hour) (PowerPoint presentation)**<br>• ESR and STP Update. **(20 minutes) (PowerPoint presentation)**<br>  ○ Key Principles for STP and ESR<br>• Item in Focus: Goal C **(40 minutes includes PowerPoint presentations)**<br>  ○ Presentation and action plan C1<br>  ○ Presentation and action plan C2<br>  ○ Presentation and action plan C3<br>  ○ Presentation and action plan C4<br>• Local Implementation Plan – five year view mental health. **(15 minutes)**<br>• Health and Wellbeing Board work programme. **(5 minutes)**<br>• ICE and HWB Executive Committee minutes **(5 minutes)** | Implications: 20 Oct 16<br><br>Papers ready to brief Cllr Halden: 31 Oct 16<br><br>**Publishing Date and papers and sending papers to members: 9 Nov 16** | | |

| Meeting | Date | Agenda | Key Deadlines | Papers to members | Secretariat Notes |
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| **Health and Wellbeing Board** | **5 January 2017**<br><br>**Changed to Wed 18 Jan (Cllr Halden Approved)**<br><br>**2-4:30pm Committee Room 2** | • ESR / STP<br>• Item in Focus, Health and Wellbeing Strategy Goal D<br>  ○ Presentation and Action Plan D1<br>  ○ Presentation and Action Plan D2<br>  ○ Presentation and Action Plan D3<br>  ○ Presentation and Action Plan D4<br>• Air Quality Strategy<br>• Active Places Strategy<br>• Essex, Southend and Thurrock MH Strategy<br>• Paper on Data Management (IDS)<br>• HWB Development Session<br>• HWB Executive Committee and ICE Minutes<br>• Work Programme | Implications: 1 Dec 16<br><br>Papers ready to brief Cllr Halden: 9 Dec 16<br><br>**Publishing date and sending papers to members: 22 Dec 16** | | Essex, Southend and Thurrock MH Strategy – see email from Roger of 18 October |

| Meeting | Date | Agenda | Key Deadlines | Papers to members | Secretariat Notes |
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| **Health and Wellbeing Board** | **16 March 2017** | • ESR<br>• Item in Focus: Goal E<br>  ○ Presentation and Action Plan E1<br>  ○ Presentation and Action Plan E2<br>  ○ Presentation and Action Plan E3<br>  ○ Presentation and Action Plan E4<br>• Health and Wellbeing Board Executive Committee and ICE Minutes<br>• Work Programme | Implications: 7 Feb 17<br><br>Papers ready to brief Cllr Halden: 15 Feb 17<br><br>**Publishing date and sending papers to members: 27 Feb 17** | | |
| **Health and Wellbeing Board** | **Mid – end of May 2017** | • Considering all Goals (As per Cllr Halden recommendation for paper in November 2016 on Goal C)<br>• Agreeing year two action plans | | | |
| **Health and Wellbeing Board** | **July 2017** | • Annual Health and Wellbeing Strategy Reports | | | |

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