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Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **7 September 2017**

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

Membership:

Councillors Graham Snell (Chair), Victoria Holloway (Vice-Chair), Gary Collins, Clifford Holloway, Joycelyn Redsell and Angela Sheridan

Ian Evans (Thurrock Coalition Representative) and Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Tim Aker, Oliver Gerrish, Jane Pothecary and David Potter

Agenda

Open to Public and Press

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1. Apologies for Absence

2. Minutes **5 - 16**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 3 July 2017.

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. Declarations of Interests

5.	**Items raised by HealthWatch**	
6.	**Long Term Conditions Profile Card - Update**	**17 - 22**
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9.	**Joint Committee across STP Footprint - Implications for Scrutiny Committee - Briefing Note**	**43 - 54**
10.	**Carers Support, Information and Advice Service**	**55 - 68**
11.	**Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Plan/Success Regime for Mid and South Essex**	**69 - 86**
12.	**Work Programme**	**87 - 90**

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **29 August 2017**

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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

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 3 July 2017 at 7.00 pm

Present:	Councillors Graham Snell (Chair), Gary Collins, Angela Sheridan, Oliver Gerrish (substitute for Clifford Holloway) and Jane Pothecary (substitute for Victoria Holloway) Ian Evans, Thurrock Coalition Kim James, HealthWatch
Apologies:	Councillors Clifford Holloway, Victoria Holloway and Aaron Watkins
In attendance:	Councillor Halden, Portfolio Holder for Education and Health Roger Harris, Corporate Director of Adults, Housing and Health Tom Abell, Managing Director, Basildon and Thurrock University Hospital Andrea Clement, Public Health Registrar Tim Elwell-Sutton, Consultant in Public Health Irene Lewsey, Head of Transformation, NHS Thurrock CCG Mark Tebbs, Director of Commissioning, NHS Thurrock CCG Jenny Shade, Senior Democratic Services Officer

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

1. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 15 March 2017 were approved as a correct record.

2. Urgent Items

There were no items of urgent business.

3. Declarations of Interests

No interests were declared.

4. Terms of Reference

Members agreed the Health and Wellbeing Overview and Scrutiny Committee Terms of Reference.

5. Items Raised by HealthWatch

Kim James updated Members on HealthWatch's concerns by the increased number of complaints being received on the services being delivered by Basildon Hospital. This number had increased over the last three to four months with low level incidents such as appointment information being sent to the incorrect address to some incidents being incorrectly categorised. With one particular incident being an incorrect diagnosis which had now been identified as serious and investigations are underway. Kim James stated she felt it appropriate to bring this matter to Member's attention as HealthWatch recorded all complaints which were available for the Quality Care Commission to view.

Councillor Gerrish noted his concerns and asked that further information to the background to this serious incident be available after the committee due to the confidentiality of the matter.

Councillor Collins echoed Councillor Gerrish's concerns and questioned whether there was any theme to the complaints. Kim James stated that they were sporadic and from all different areas of the hospital.

Councillor Collins asked whether there were co-ordinators at Basildon Hospital. Kim James stated that there should be a service manager for each area who should pick up issues such as complaints and deal with incidents as they arose.

Councillor Snell stated that the Committee had discussed similar situations in previous years and had been assured that those kinds of failings would not happen again but here we are again discussing those very same issues.

Kim James stated that the Quality Care Commission looked at the action plan and would pick up individual incidents.

Tom Abell stated that HealthWatch had raised this matter prior to the committee and that the Site Leadership Team would be investigating such incidents alongside the clinical teams involved. Tom Abell stated that the information collated by the hospital staff would be analysed, lessons would be learnt on how staff may be missing incidents and ensure that all patients had the right information on how to report incidents. Members requested that an update report be brought back to committee.

Councillor Snell agreed to what was being put in place to ensure that such incidents do not happen in the future.

Councillors Collins asked if complaint score cards were kept to identify whether the same staff were missing these incidents. Tom Abell stated that individual score cards were kept which identified the name, date, time, type of patient, carer and outcomes. Reviews were undertaken using the Incident Management System and immediate action would be taken where necessary.

Councillors Collins questioned whether qualification checks were undertaken on Basildon Hospital staff. Tom Abell confirmed that routine validation checks were undertaken.

Councillor Pothecary questioned those patients that presented themselves at other hospitals and what mechanisms were in place to map treatments. Tom Abell stated that the Children Safeguard system would trigger any inconsistencies between different hospitals for children but adults could choose which hospital they attended.

6. Update on Mid and South Essex Success Regime / Sustainability and Transformation Partnership (STP)

Tom Abell thanked Members for including the report on the work programme and provided Members with an update on the current thinking, the key events leading to the current position and the next steps for changes in local health and care across the Mid and South Essex Sustainability and Transformation Partnership. Members were asked for their feedback from the report and on the future plans to undertake a public consultation.

Tom Abell briefed Members on the commissioning functions of the Clinical Commissioning Group Joint Committee and the strategic functions. The consultation programme would commence December 2017 through to March 2018 with a final decision shortly after. The Group were scheduled to meet on the 7 July to make decisions on any final consultations and would be happy to discuss further with this Committee.

Councillor Snell thanked the Officer for the report.

Councillor Gerrish asked with the focus on becoming sustainable what would be the scale of the challenge. Tom Abell stated that the sustainability gap in the National Health Service locally would be five years at a cost of £200 million and that the plans in the Sustainability and Transformation Partnership would address measures to bridge this gap.

Ian Evans queried the onward transfer of patients and whether any projectors or indicators as to the numbers and availability were available. Tom Abell confirmed that this data was not to hand at this time; this would depend on the work undertaken by the clinicians on the pathways which would be best suited and would deliver benefits to patients.

Ian Evans asked if the Joint Committee consisted of any service user or lay members. Tom Abell stated that no lay member or HealthWatch were on the committee and that decisions would be currently made by Chairs of the CCGs and Accountable Officers of the CCGs which made up the Joint Committee membership.

Councillor Pothecary questioned the centralisation of certain services for example the stroke services at Southend Hospital and asked what the plans would be to assist residents getting to these locations. Tom Abell stated that it

was the intention to keep residents at these specific hospitals for a shorter time as possible and then rehabilitation would be undertaken closer to home. That work was currently underway with the Clinical Commissioning Group to identify what transport was available. Tom Abell stated that with the right conditions these services should run alongside general practitioners and managed locally which in turn would prevent the 999 service being required.

Roger Harris stated that it was fair to say that the pace of the Success Regime had been frustrating with a lot of work being done on different models of care. The focus seemed to be on acute services rather than out of hospital models. The aim should be to get the right primary care services and identify when early intervention was required. Roger Harris noted his concern that the Joint Committee's functions would be extended too far and would undermine the local Clinical Commissioning Group and local services such as HealthWatch.

Councillor Gerrish asked how advanced was the thinking in terms of the offer with regards to the size and shape of future hospital configuration and would the extension include the expansion of services at Basildon Hospital.

Tom Abell replied that work had to be done to refine the offer to a define set of clinical services and work through the numbers and would present these findings at a future Health and Wellbeing Overview and Scrutiny Committee. Tom Abell stated that extra buildings would be required to cope with the demand.

Councillor Snell stated that as predicted this would take away the services and undermine work already done locally.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted the update and gave views on the emerging thinking, the importance of local issues and the future plans for public consultation.

7. Integrated Medical Centre Delivery Plan - Phase 1

Roger Harris presented the report and updated Members on the details of the proposed model of care; he outlined the proposed delivery mechanism for the capital build project and considered the Council's role in both delivery and occupying part of the facility. The first stage of the process was the delivery of the Tilbury and Chadwell Integrated Medical Centre with this report being presented to Cabinet in July 2017.

Councillor Collins questioned the opening hours of the Integrated Medical Centres and would this take the pressure of Accident and Emergency. Roger Harris stated that the Centres would offer extended hours of opening and that other services would be available such as general practitioners, Local Area co-coordinators, community and voluntary services. The design and size of

the centres would be discussed and agreed by the Design Team at the design stage. Roger Harris stated the Centres would not offer overnight bed facilities.

Kim James stated that a public engagement had taken place in Tilbury with 4000 residents being consulted with their views being taken on board.

Ian Evans asked about the quality of general practitioners considering many areas were under-doctored.

Mark Tebbs stated that a European Recruitment exercise of general practitioners was underway to bring the number of general practitioners up to capacity. These would work with primary health colleagues and offer primary care services.

Councillor Pothecary questioned the name change from Hubs to Integrated Medical Centres. Councillor Halden stated that residents were in the past unaware of appointments being made available at Hubs therefore this new model would be a clear package for residents to understand that appointments and services would be available locally and to use them instead of going to accident and emergency.

Councillor Pothecary questioned the duplication of services at each of the centres. Roger Harris stated that this detail would form part of the final design package for each Centre.

Councillor Snell stated that it was the intention to close Orsett Hospital and what reassurances would be given that these Centres would be open before this happened. Tom Abell stated that as part of a consultation they looked at what services were available at both Orsett and Basildon Hospitals and how these could be moved to Thurrock. There was a full commitment that services offered at Orsett Hospital would not be moved to Basildon Hospital and that Orsett Hospital would not close until such time as the Integrated Medical Centres were up and running.

Councillor Snell questioned whether there was any timescales on when Orsett Hospital would close. Tom Abell stated not specifically but with new stringent building regulations coming into force they would be looking around 2020/2021.

Councillor Gerrish questioned the budgets available. Roger Harris stated that the business case part of Phase 2 would include this but budgets would not be dependent on the closing of Orsett Hospital first.

Ian Evans questioned the floor space available at the Centres. Roger Harris stated that it would be shared with flexible space that could be used by other organisations and voluntary services.

Councillor Sheridan asked about the increase of population in Thurrock and had this been considered. Roger Harris stated that this had been an element

of the design brief for future proofing and would be built into the specification accordingly.

Councillor Gerrish asked what the timescales would be for all four Centres to be up and running. Roger Harris stated that all Centres were running on slightly different arrangements and once the business case had been agreed it could be up to 18 to 24 months for building to be completed and before patients see the services up and running.

Councillor Snell thanked Officers for the report and that it was encouraging to finally see some activity.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee note the current status of the project and commented on the proposed mechanism for securing the delivery of the Tilbury and Chadwell Integrated Medical Centres.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee support the Council in taking the role outlined within the report including the decision to tender and appoint the design team.**

Tom Abell and Councillor Halden left the Committee Room at 8.20pm.

8. Podiatry Services in Thurrock

Mark Tebbs, Clinical Commissioning Groups, National Health Service England, provided Members with a broad overview of the current local provisions compared to the society of chiropodists and podiatrists best practice guidance (2010). This report had been requested by the Portfolio Holder for Children's and Adults, Councillor Sue Little.

Councillor Sheridan thanked the Officer for the report and asked why residents would have to pay a £5 registration fee. Mark Tebbs stated that this was a charge made by Age UK as this was a provision being supplied by a voluntary service.

Councillor Sheridan questioned what support would be given for those residents on low income. Roger Harris stated that monies from the Better Care Fund would be used to bridge that gap for those on low income.

Ian Evans questioned the demographic of services available and the number in demand for those with a learning disability. Tim Ewell-Sutton stated that Learning Disability Health Checks would address this service and that the demand number could be found in the Annual Public Health Report which was in the public domain.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee Members noted the contents of the report.

9. The Procurement of an Integrated Sexual Health Service for 2018-2023

Andrea Clement presented the report on the proposal to proceed to tender to procure a fully Integrated Sexual Health Service that was due to start from the 1 April 2018. Currently in Thurrock the majority of sexual health services were commissioned from the North East London Foundation Trust (NELFT) with some small contractors with general practitioners and pharmacies. This contract was due to expire on the 31 March 2018 and this provided an opportunity to identify further savings could be made through competitive procurement.

Councillor Pothecary stated she would have liked to have seen the Equality Impact Assessment undertaken based on the services that were under tender. Those sub-contractors may be hard to hold to account and how this will be monitored. Andrea Clement stated that only a very small number of sub-contractors were commissioned mainly around the on-line chlamydia screening and HIV testing. This would be developed as part of the specification as a feedback mechanism and patient engagement.

Roger Harris stated that some sub-contractors would be general practitioners and pharmacists which is currently the normal practice.

Councillor Collins questioned the number of cases of sexual transmitted diseases and had the numbers in chlamydia screening decreased over time. Andrea stated that the chlamydia screening levels were lower than the UK average and less than in 2014. With mixed results there were still lots more work to do. Figures on the number of AIDS referral were not to hand but would find out and report back to Members.

Ian Evans questioned Officers on the consultation timescales and whether any consultations had been undertaken with stakeholders. Would any section of the tender support people with learning disabilities in attending sexual health checks and accessing surgeries. Ian Evans also questioned if the Council Social Value Framework would be used and what weighting would be given to the social value in the tender.

Andrea Clement stated that a survey had been undertaken on what sexual health services people wanted and to identify any current gaps. Unfortunately this was delayed due to Purdah but now other methods of receiving this feedback would be looked into and would be engaging with the voluntary services going forward.

Andrea Clement stated that a social value key performance indicator would be incorporated into the specification and would feedback to Members at a later date.

Councillor Sheridan asked whether a process was in place to detect any signs of Female Genital Mutilation. Tim Elwell-Sutton stated that there was a national protocol and the National Health Service duty to report any signs of Female Genital Mutilation.

Kim James stated that HealthWatch had received a large number of complaints particularly with regard to the long waiting time for some services with over a four month wait for a service. Only a few general practitioners offered this service and if it wasn't your GP this was dependent on patients bringing a prescription. With there being no key performance indicators it was impossible to hold North East London Foundation Trust to account and that a monitoring tool should be added to the specification.

Andrea Clement stated that the Council were aware of long waiting times and that changes to the specification would be made to tackle this problem by introducing a key performance indicator on waiting times and possibly incorporate a penalty fine.

Councillor Gerrish echoed the comments on key performance indicator monitoring and to ensure that adequate sanctions were put in place. Councillor Gerrish asked how the Genito-Urinary Medicine service would be delivered in the future. Andrea Clement stated that there were plans to locate some of the sexual health services into the Integrated Medical Centres but it would be likely that Level 3 services may have to be located in one central clinic.

Councillor Snell registered his concerns over the waiting list times but noted that this was now being addressed.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee commented on the plan to proceed to tender as set out in this report for the delivery of Integrated Sexual Health Services starting on the 1 April 2018 prior to submission to Cabinet.

10. Southend, Essex and Thurrock Dementia Strategy 2017 - 2021

Mark Tebbs and Irene Lewsey presented the report and explained that the Southend Essex and Thurrock Dementia Strategy for 2017-2021 was a collaborative piece of work between people living with dementia, their carers and the three Local Authorities and the seven Clinical Commissioning Groups within Greater Essex. The vision was for future development as set out in the strategy. Mark Tebbs guided Members through the nine priorities of the strategy and stated that the strategy would support the development of a locally focussed implementation plan enhancing what was already happening in Thurrock and developing that further.

Councillor Sheridan thanked the officer for an excellent and caring report and asked whether a dementia check could be included in health checks that

residents have with their general practitioner. Irene Lewsey stated that checks were already taking place on residents over 65 and that pathways were being developed to identify when referrals were required.

Councillor Sheridan stated that when consultations or tests were taken place that partners or carers should be in attendance also to provide assistance and information. Irene Lewsey stated this issue was being covered by having partner or carer contact details on all correspondence.

Councillor Collins thanked officers for the report and highlighting the role of the carer but stated that he was annoyed with the wording when referring to early intervention and prevention. Irene Lewsey stated that the headings had been taken from the National Dementia Strategy.

Councillor Collins stated that to improve the care of those suffering from dementia the Council should be looking at those carers who had the heart and capacity to love, care and be compassionate towards others rather than those with qualifications that who do not have the time to spend with individual patients.

Ian Evans asked what future roll outs of dementia training would be undertaken and how could the community be looked at as a whole to where dementia patients lived so that members of the public could be trained.

Mark Tebbs stated that Dementia Friendly and the Dementia Council were working closely in the community and would continue to train as many new members as possible.

Councillor Snell stated that he found the strategy frustrating that it appeared written only for those with early stages of dementia and did not go far enough for those suffering with severe dementia. Roger Harris stated that this would be covered in the Thurrock Specification Action Plan and would look at the services available and how these would be made fit for purpose.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee agree to recommend to Cabinet that Thurrock Council endorse the Southend, Essex and Thurrock Dementia Strategy 2017-2021.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee agree that a local Thurrock implementation plan is developed to deliver the Dementia Strategy in Thurrock.**

3. **That the Health and Wellbeing Overview and Scrutiny Committee agree that the implementation plan is brought back to the Health and Wellbeing Overview and Scrutiny Committee for consideration.**

11. Work Programme

The Chair asked Members if there were any items to be added or discussed for the work programme for the 2017-18 municipal year.

Members agreed to add a report on The Carers Information, Support and Advice Service to the 7 September 2017 Committee.

Members agreed to add a report on 2016/17 Adult Social Care Complaints to the 7 September 2017 Committee.

Members agreed to add a report on Non-Residential Charging Options to the 7 September 2017 Committee.

Members agreed to add a report on Basildon Hospital – Update on the Number of Complaints to the 16 November 2017 Committee.

Members agreed to add a report on Action Plan for Dementia to the 16 November 2017 Committee.

Members agreed to remove the report on Living Well in Thurrock from the 7 September 2017 Committee and add to the 16 November 2017 Committee.

Members agreed to remove the report on Cancer Deep Dive Update from the 7 September 2017 Committee and add to the 16 November 2017 Committee.

RESOLVED

1. **That the item The Carers Information, Support and Advice Service will be added to the work programme for 7 September 2017 Committee.**

2. **That the item 2016/17 Adult Social Care Complaints will be added to the work programme for 7 September 2017 Committee.**

3. **That the item Non-Residential Charging Options will be added to the work programme for 7 September 2017 Committee.**

4. **That the item Basildon Hospital – Update on the Number of Complaints will be added to the work programme for 16 November 2017 Committee.**

5. **That the item Action Plan for Dementia will be added to the work programme for 16 November 2017 Committee.**

6. **That the item Living Well in Thurrock will be added to the work programme for 16 November 2017 Committee.**

7. **That the item Cancer Deep Dive Update will be added to the work programme for 16 November 2017 Committee.**

The meeting finished at 9.20 pm

Approved as a true and correct record

CHAIR

DATE

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

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7 September 2017	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
Long Term Conditions Profile Card - Update	
Wards and communities affected: All	**Key Decision:** Key
Report of: Monica Scrobotovici, Healthcare Public Health Improvement Manager	
Accountable Head of Service: Emma Sanford, Strategic Lead, Health and Social Care Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

The Long Term Condition (LTC) profile card was created by the Healthcare Public Health Improvement Team to respond to the high levels of variation within primary care across Thurrock in regards to the individual needs, available resources and overall quality of services.

Similar to a dashboard, the LTC profile card is a visual overview of each practice, focusing on the LTC case finding and management while also including some of the potential drivers and secondary care outcomes. However, the delivery of the LTC profile card work does not resume to sharing the profile card with each practice, but it also includes visits and discussions with the practice managers and GP leads, identification of priorities and development of individualised action plans for each clinic.

The report, therefore, provides a brief description of the LTC profile card and a summary of the current implementation steps and outcomes.

1. Recommendation(s)

1.1 That Health and Wellbeing Overview and Scrutiny Committee note the progress that has been made by the Healthcare Public Health Improvement team in delivering the LTC profile card work and comment on this programme of work.

2. Introduction and Background

2.1 The sustainability and cost-effectiveness of our healthcare system heavily relies on a balanced use of all the components of the system. Based on the 2016 Annual Report of The Director of Public Health (APHR), a thorough analysis of the current state of our local resources and demand, the Public Health team has recommended a series of local intervention to reduce the increased demand on the most expensive part of the system, the secondary and social care services. The recommendations focus on the need to tackle the high variation of the long-term conditions detection and management in primary care. The LTC profile card is extremely helpful in identifying the main priorities for each practice in order to create a feasible action plan, personal to each practice.

2.2 The LTC profile card has been previously presented to and has been very well received by the Primary Care Improvement and Delivery work group.

3. Issues, Options and Analysis of Options

3.1 Based on Public Health England estimates, there are thousands of people currently suffering of a long term condition who are not diagnosed or treated yet. It is an absolute priority to find these people and to treat them correspondingly in order to prevent any complications from happening. By finding and managing these patients in primary care we preserve the quality of their lives and prevent them from accessing the secondary or social care services.

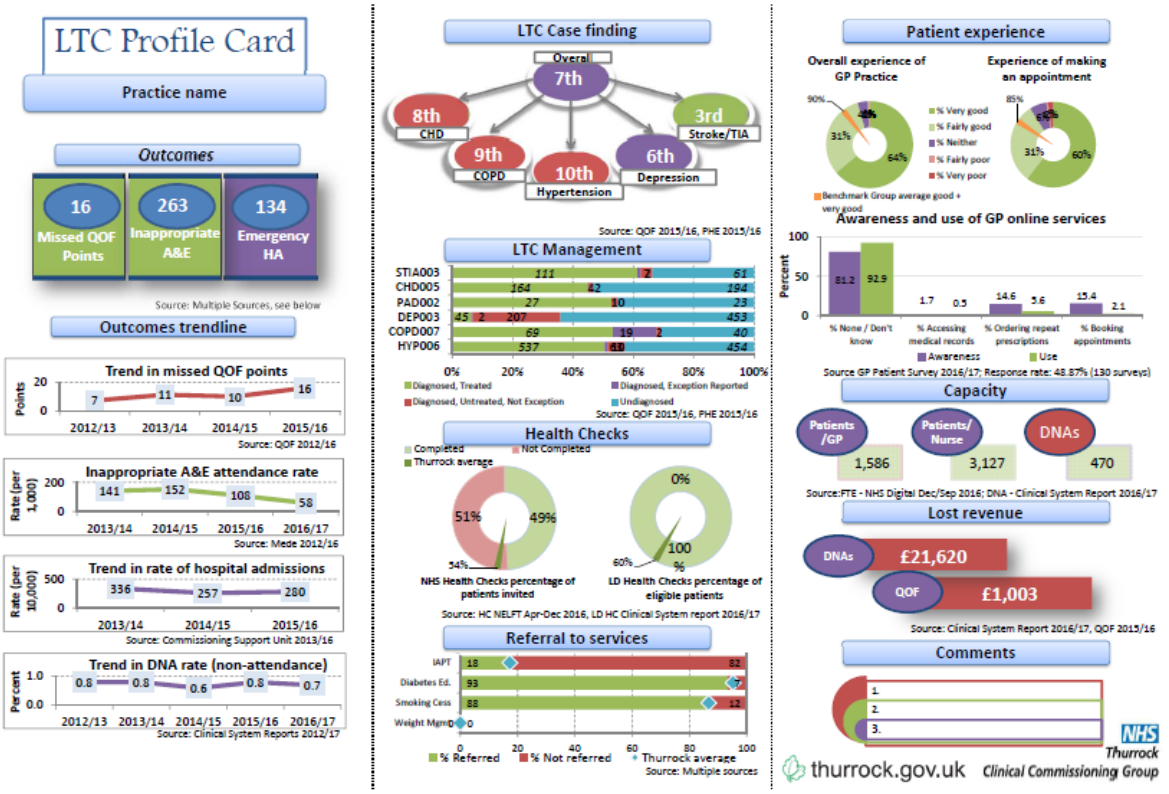
Table 1 – LTC detection in Thurrock

Long Term Condition	Recorded Prevalence (i.e. people already diagnosed)	Estimated Prevalence	Additional Number of Undiagnosed Patients based on the estimated prevalence
Stroke (2016)	1.51%	3.70%	3,540
Hypertension (2016)	14.08%	20.95%	10,983
CHD (2016)	2.78%	7.58%	7,521
COPD (2016)	1.8%	2.22%	642
Diabetes (2016)	6.3% (17+)	7.9% (16+)	2,109

3.2 Moreover, patients are not always guaranteed the best management of the condition by getting on the disease register. There is a high variation in the management of long term conditions patients receive based on the practice they are registered with. The LTC profile card not only analyses the percentages of undetected and untreated patients, but also looks at the possible reasons why, such as lack of capacity, increased workload or lack of engagement from the practice population.

3.3 The LTC profile card brings together a series of high importance information on all the drivers of LTC detection and management in primary care and displays it in a very easy to read format.

Fig 1 – LTC Profile Card



3.4 For a better understanding of the current situation and possible need of support, practices are compared against a personalised benchmark group. The benchmark group consists of 20 practices from across England which matches the population size, deprivation index and age distribution of the practice. By comparing a Thurrock GP practice with 20 practices across England serving populations that are similar to their own, we can identify those indicators which stand out as being particularly high or low and whilst controlling for variations in performance due to factors attributable to underlying characteristics of the registered GP practice population. This provides us with the opportunity to direct our resources towards addressing genuinely poor performance and making the maximum impact on the health of the population of Thurrock. Similarly it allows us to identify surgeries that are performing highly on specific indicators, learn how they are working and share this best practice across the borough.

3.5 By the 14 of August 2017 14 of the 32 practices have received visits from the Healthcare Public Health (HCPH) Improvement Managers to discuss their profile card and to develop an individualised action plan for the following three months. There has been an overall positive response to the visits from GPs and other surgery staff, with 13 action plans being developed in collaboration with the practice manager and sometimes the lead GP. The action plans can only include a maximum of three action steps for the practice in order to make the plan realistic and concentrate on the most important issues first. Most of the time the practice managers are not surprised by the highest priorities

identified during the discussion and welcome the opportunity for assistance from Public Health to address them. In this case, the HCPH Improvement Managers are supporting with best practice ideas, evaluation needs or just an organized platform for their plans.

3.6 Considering the positive feedback already received from the practice managers, general practitioners, the Clinical Commissioning Group and Public Health England, we are envisioning the LTC profile card work to become a fundamental part of our core job duties in the future.

3.7 The LTC profile card has also been recognised by the Centre Director of Public Health for the East of England, as a regional model of best practice. Furthermore, during a recent visit to Thurrock, the Chief Executive of Public Health England – Duncan Selbie requested that the Long Term Conditions Profile Card and associated work outlined within this report, be presented at the Department of Health's National Prevention Board, such that our approach in Thurrock may be replicated nationally.

3.8 An interactive presentation of the LTC Profile card will be delivered during September 2017 HOSC to allow members to see the functionality of the product in action.

4. Reasons for Recommendation

4.1 The LTC Profile card represents a key programme of work in improving standards in Primary Care across Thurrock; one of the key public health priorities.

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

n/a

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

6.1 The LTC Profile Card and associated Practice based Action Plans supports delivery of the following Objectives in the Joint Thurrock Health and Wellbeing Strategy 2016-2021.

6.2 It also will form part of the Tilbury and Chadwell Accountable Care Partnership 'Case for Change' Business Case, currently being developed. This will be brought to a future HOSC once developed.

7. Implications

7.1 Financial

Implications verified by: **Joanne Freeman**
Management Accountant

There are currently no financial implications with this project.

7.2 **Legal**

Implications verified by: **David M G Lawson**
Deputy Head of Law & Governance

The report's recommendation is for the committee to note progress consequently there are no direct legal implications at this stage but legal Services is available to provide advice on specific matters as any need arises.

7.3 **Diversity and Equality**

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

Whilst there are no specific diversity implications arising from the recommendations outlined in this report, the profile card does help to establish possible reasons for undetected and untreated patients with long-term conditions. Means for tackling issues arising from lack of patient engagement will be set out in supporting action plans where appropriate.

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

n/a

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

Annual Report of The Director of Public Health. Thurrock Council Public Health Team, Nov 2016

9. Appendices to the report

n/a

Report Author:

Monica Scrobotovici

Healthcare Public Health Improvement Manager

Public Health

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7 September 2017	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
2016/17 Annual Complaints and Representations Report	
Wards and communities affected: All	**Key Decision:** Key
Report of: Tina Martin, Statutory & Corporate Complaints Manager	
Accountable Assistant Director: Les Billingham, Assistant Director – Adult Social Care	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing & Health	
This report is Public	

Executive Summary

The annual report for Thurrock Council on the operation of the Adult Social Care Complaints Procedure covering the period 1 April 2016 – 31 March 2017 is attached as Appendix 1. It is a statutory requirement to produce an annual complaints report on adult social care complaints.

The adult social care complaints procedure is operated in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The report sets out the number of representations received in the year including the number of complaints, key issues arising from complaints and the learning and improvement activity for the department.

A total of 300 representations were received during 2016-17 as detailed below:

- 142 compliments
- 98 complaints received
- 8 MP enquiries
- 41 Member enquiries
- 10 MEP enquiries
- 1 Local Government Ombudsman enquiry

1. Recommendation(s)

1.1 That scrutiny committee consider and note the report.

2. Introduction and Background

2.1 This is the annual report for Thurrock Council on the operation of the Adults Social Care Complaints Procedure covering the period 1st April 2016 – 31st March 2017. It is a statutory requirement to produce an annual complaints report on Adults Social Care complaints.

2.2 The Adult Social Care complaints procedure is operated in accordance with the Local Authority Social Services and National Health Service Complaints (England) regulations 2009.

3. Issues, Options and Analysis of Options

3.1 This is a monitoring report for noting, therefore there is no options analysis. The annual report attached as Appendix 1 includes consideration of reasons for complaints, issues arising from complaints and service learning and improvement activity in response.

3.2 **The headline messages for this report are:**

3.3 **Summary of representations received 2016/17**

- 142 compliments
- 98 complaints received
- 8 MP enquiries
- 41 Member enquiries
- 10 MEP enquiries
- 1 Local Government Ombudsman enquiry

Further detail on compliments, complaints and enquiries is outlined in Appendix 1.

3.4 **Local Government Ombudsman**

There was one case received from the Ombudsman's office for this reporting year, as was the case for the previous year.

The complainant raised concerns regarding treatment of service user(s) in a nursing home; the LGO concluded that there was no maladministration by the council and they were satisfied with how the council managed the concerns which had been raised.

3.5 **Learning from Complaints**

Complaints and feedback provide the service with an opportunity to identify things that can be improved; they provide a vital source of insight about people's experience of social care services.

Upheld complaints are routinely analysed to determine themes and trends and services are responsible for implementing learning swiftly. Robust monitoring and evidencing of corrective actions is a key theme for the next reporting year.

Some case studies showing lessons learnt are in the attached report.

3.6 **Looking Forward**

Adult social care is continuing to undergo a period of significant transformation across all services within Thurrock with high pressure on resources against an increase in demand for services which can have an impact on the community and provision of social care services. This may lead to further queries and complaints received within the department and the focus will be to continue to ensure that a high quality and responsive complaints service is delivered in accordance with the statutory requirements.

Further detail on work priorities is outlined in Appendix 1.

4. Reasons for Recommendation

4.1 It is a statutory requirement to produce an annual complaints report on adult social care complaints. It is best practice for this to be considered by Overview and Scrutiny. This report is for monitoring and noting.

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

5.1 This report has been agreed with the Adult Social Care senior management team. Consideration of complaints issues and learning and improvement arising from them are identified as an ongoing priority in the report.

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

6.1 All learning and key trends identified in the complaints and compliments reporting has a direct impact on the quality of service delivery and performance. The reporting ensures that valuable feedback received from service users and carers is captured effectively and regularly monitored with the primary focus on putting things right or highlighting and promoting where services are working well.

7. Implications

7.1 **Financial**

Implications verified by: **Laura Last**
Management Accountant

There are no specific issues arising from this report.

7.2 **Legal**

Implications verified by: **David Lawson**

Deputy Head of Law and Governance

There are no legal implications as the report is being compiled in accordance with regulation 18 of the Complaint Regulations.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development & Equalities Manager

There are no specific diversity issues arising from this report.

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

- None

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

- None

9. Appendices to the report

Appendix 1 – Adult Social Care Complaints and Representations Annual Report 2016/17

Report Author:

Tina Martin

Statutory & Corporate Complaints Manager

HR, OD & Transformation

APPENDIX 1

Adult Social Care

Annual Complaints & Representations Report

April 2016 – March 2017

Tina Martin
Statutory & Corporate Complaints Manager
HR, OD &Transformation
June 2017

Thurrock Council

Adult Social Care

Annual Complaints Report 2016/2017

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1. Introduction

This report provides information on complaints for Thurrock Council Adult Social Care services for the period 1st April 2016 to March 2017.

Thurrock adult social care arranges and supports provision of a wide range of commissioned and in-house care, to support people to live independently in their homes and to increase levels of choice and control over the support they receive. It also supports residential or nursing care when this becomes necessary. The department also has lead responsibility for safeguarding adults and provides / commissions some services jointly with Health partners.

The complaints process provides the council with an additional means of monitoring performance and improving service quality and provides an important opportunity to learn from complaints made by service users and advocates.

We have an established IT system in place to capture a range of complaints information, including the nature of the complaint, the action taken, the outcome of each complaint and whether there has been compliance with the time periods specified in the regulations.

By publishing the annual complaints report, the Council demonstrates its commitment to transparency and a positive approach to dealing with and learning from complaints.

2. Key facts

2.1 We believe that dealing effectively with complaints is essential to providing good services and we use feedback from complaints to improve our services

2.2 In December 2015 the statutory complaints service for adults integrated with the Corporate Complaints Team to enable a streamlined, transparent and cohesive complaints service to be delivered council wide.

2.3 In 2016/2017 we received 98 Stage 1 complaints about Adult Social Care services.

2.4 Of the 98 complaints received during the year, one case was determined by the Local Government Ombudsman.

3. Background

Adult social care is required, under statutory regulations, to prepare an annual report for the preceding year on its performance in dealing with complaints, including the numbers received and how many were upheld.

Adult social care is required to operate a prescribed statutory complaints procedure in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Local Authority Social Services

Complaints (Amendment) Regulation 2009. Any complaint which does not fall under these provisions will be considered under the Council's corporate complaints procedure.

4. Complaints Procedure

This is a single stage process which provides the opportunity for the service that has primary responsibility for the case, to make efforts to resolve issues of dissatisfaction at a local level as early as possible.

The time limit for making a complaint is within 12 months of the matter being complained about; however the council can use its discretion to allow complaints that are made over the 12 month rule, where it is satisfied that the complainant has good reason and where it is still possible to investigate the complaint effectively and fairly.

Our aim is to resolve complaints within 20 working days for most complaints, and within 3 months for complex complaints.

Once the single stage process has been concluded and if dissatisfaction still remains, the complainant has the right to refer their complaint to the Local Government Ombudsman (LGO) for further consideration. The LGO is the independent organisation authorised to investigate complaints where the council's own investigation and response has not resolved the issues to the complainant's satisfaction.

The person making the complaint retains the right to approach the LGO at any time. However, the LGO's policy is that the local authority should be given the opportunity to consider the complaint first and it will normally refer complaints back to the council to investigate unless exceptional circumstances apply.

5. Advocacy for vulnerable people

The council commissions advocacy services including Mental Capacity advocacy encompassing Deprivation of Liberty Safeguards. It is available for people who have substantial difficulty in understanding decisions that need to be made or in expressing their views, when there is no one else who can assist or speak on the person's behalf. The scope of our contract covers older people, older people with mental health needs aged 65 and over, adults of working age with mental ill health and adults who have a learning disability, sensory impaired or physical disability aged over 18 years.

The service is independent of statutory organisations and service provider agencies. POhWER is the main commissioned provider for advocacy within Thurrock and supports service users with various concerns and queries across a range of services including housing, social care and debt management.

6. Summary of Representations

A total of 300 representations were received in the reporting period, which is a decrease on the previous year (324).

	2016/2017	2015/2016
Complaints	98	54
MP	8	16
Member enquiries	41	45
MEP	10	12
Concerns	N/A	23
Local Government Ombudsman	1	4
ILF Appeals	0	4
Compliments	142	166
TOTAL	**300**	**324**

7. Complaints Received

Adult social care received a total of 98 complaints in the reporting period. This is an increase of 44 on the number of complaints (54) received for 2015/2016. However, the concerns category has been removed and most of that previous category will now be showing under the complaints heading.

8. Complaints by service

Complaints are received with regard to both internal and externally commissioned providers, detailed below are the figures for the reporting period.

Internal Provider	2016/2017
Customer Finance	7
Occupational Therapy	5
Safeguarding	1
Collins House	1
Re-ablement Team	4
Complex Care & Transition Team	4
Early Intervention & Prevention (East) / (West)	0
CM Mental Health	0
Emergency Duty	1
Kynoch Court	0
General ASC / more than one service area	43
Contracts & Commissioning	10
Community Solutions	3
Performance Quality & Information Team	4

External Provider	2016/2017	2015/2016
Triangle Care	0	1

Grays Court Care	2	1
Bennett Lodge	0	1
Bluebell Court	2	0
John Stanley	1	4
Carolyn House	2	0
Piggs Corner	7	0
Professional Care LTD	1	0

9. Externally Commissioned Services

The Care Quality Commission (CQC) requires all care providers to have in place clear and robust complaints procedures. Anyone who receives a service from an external provider will usually complain to the provider directly and these will be responded to in accordance with the provider's own complaints procedure. The Contract & Compliance Team closely monitor these services in accordance with the statutory contractors monitoring framework and will review all complaints as part of their Contract Compliance Visits (CCV).

Direct Payment Scheme

Personal budgets, when taken as a direct payment, are used to pay for support for services such as homecare, or to employ a personal assistant (PA). The council has a contract with Essex Coalition of Disabled Peopled (ECDP), for the delivery of the Direct Payment Support Service for Thurrock residents to manage the scheme and raise awareness of how social care users can have greater choice and control in relation to their care.

Residential Care

The council commissions independent sector care home providers for service users requiring residential care, based on an assessment of their individual needs. The Home Provider investigates any complaints in line with their own complaints procedure – these are then monitored through our contract compliance visits.

Domiciliary Care

There is a high demand for home care within Thurrock and the commissioned provider agencies work closely with Thurrock's commissioning and contracts team to ensure that service users receive care packages that directly meet their needs. The Contract, Compliance Monitoring Team are key to ensuring that any complaints received are thoroughly investigated.

In all instances of complaints regarding adult social care, the complaints procedure may be superseded by the safeguarding procedure if a referral is made which identifies safeguarding alerts. The complaint will be placed on hold awaiting the outcome of the safeguarding investigation.

10. Root causes and complaint outcomes

The table below shows the root causes of complaints within the reporting period together with the volume either upheld or partially upheld against each root cause. This management information provides key areas for development and learning.

It should be noted that this data does not match the data outlined in the total number of complaints received as it relates to complaints which have been closed during the course of the year – some complaints were still under investigation.

Root cause of the complaint	2016/2017	No. upheld	No. Partially upheld
Assessment / Decision Making	10	3	1
Communication	4	1	1
Service Quality & Care	33	12	6
Delays in service	9	3	0
Finance / Charging	9	5	1
Late appointments	3	3	0
Missed appointments	10	7	0
Safeguarding	0	0	0
Welfare	2	0	0
Staff conduct	16	9	3
Other	2	1	0

Complaint outcome	2016/2017
Upheld	44
Partially upheld	12
Not upheld	26
Withdrawn or cancelled	12
Out of jurisdiction	2
Ongoing	2
TOTAL	**98**

Of the 96 complaints completed (2 were still ongoing at 31.3.17):

46% were upheld

12% were partially upheld

27% were not upheld

(NB – the remainder were withdrawn or out of jurisdiction)

Service, Quality & Care: Key learning identified is improved communication; managers have confirmed that this has been addressed with teams to aid service improvements.

Missed appointments: Key learning identified is improved communication, a review of processes to ensure a more streamlined approach when there are staff change-overs, and also training.

Staff conduct: Key learning has identified training issues for some staff, including specific training courses, policy and procedure refreshers, individual 1-2-1 advice and support.

11. Learning from complaints

Complaints provide a vital source of insight about people's experience of social care services, and how those services can improve.

The complaints process enables us to identify service problems and make improvements to services we work in. It also helps us improve staff learning and enhance professional development.

Services are required to complete learning material for all upheld and partially upheld complaints and these are submitted to the Complaints Team. One of the priorities for the forthcoming year is to ensure that each service can identify continuous service improvements as a result of learning lessons from upheld complaints.

Attached are some case studies where learning has been identified.

A key priority for the forthcoming year is to ensure learning is publicly available on the You Said We Did section of the council's webpage.

12. MP, MEP & Members Enquiries

MP, MEP & Members enquiries are received on behalf of services users and services have 10 working days to issue a response. However, it is recognised that in some instances, particularly for complex cases, it is not always possible to meet this target and this has been identified as a work priority for the forthcoming year.

Number of enquiries received within the reporting period is outlined below together with comparable data.

	2016/2017	% on time	2015/2016	% on time
MP	9	6 (67%)	16	13 (81%)
MEP	9	5 (56%)	-	-
Members	25	17 (68%)	45	35 (78%)

13. Compliments

The council welcomes compliments from its services users. Compliments help to highlight good quality service and give staff encouragement to continue delivering

services of the highest standard particularly at challenging times and when faced with competing demands.

The reporting period has seen a decrease in the number of compliments recorded compared to the previous year.

	2016/2017	2015/2016
No of compliments	142	166

14. Local Government Ombudsman

The Local Government Ombudsman cannot question whether a Council's decision is right or wrong simply because the complainant disagrees with it. The LGO must consider whether there has been fault in the way the decision was reached. If there has been fault, the LGO considers whether this has resulted in injustice and will recommend a remedy, this can be monetary and/or otherwise.

The reporting period has seen a decrease in the number of formal enquiries considered compared to the previous year.

	2016/2017	2015/2016
LGO enquiries received	1	4

15. Work Priorities for 2017/2018

During the year 2017/2018 the Complaints Team will focus on:

- Supporting services by undertaking the initial assessment and subsequent complaint plan agreement with complainants to instil confidence and evidence transparency of the complaints procedure

- Improved monitoring of active complaints to ensure swift resolution where possible and supporting service areas wherever possible

- Robust monitoring of corrective actions that have arisen from complaints to ensue continuous service improvements can be made and uploaded onto the council webpage

- Working with service areas and in consultation with staff to ensure more timely responses to MP, MEP & Members enquiries

- Working with service areas and staff in social care to ensure a coordinated, effective, timely and comprehensive complaints service is embedded, including continuous review of the processes and procedures to ensure they are fit for purpose and that a cost effective service is being delivered.

- Provide advice, guidance and support though training and/or workshops as appropriate

- Ensuring that learning from upheld complaints is evidenced and made publicly available on the council's You Said We Did section of our webpage.

- Continued close liaison with the Local Government Ombudsman to ensure that enquiries are responded to and recommendations are actioned promptly.

Complaints - case studies

Mr G complained that his father, who is in receipt of services, had not received a call on the scheduled day and had not been given a wash in over a week

The investigation concluded that on the day(s) that the carer in question was not at work his shift is covered by another carer, however this carer is female and the service user did not want a female carer attending to his personal care – he wanted a male carer.

The service should have considered this as part of any cover arrangements and staff should have shared this information with others. Whilst it is recognised that there is a shortage of male carers the service accepted that there had been a breakdown in communication and an apology was extended.

The service committed to a recruitment drive for male carers and reminded staff of the importance of information sharing to ensure that that the dignity and wishes of services users are respected at all times.

Miss M complained that her partner had received an unannounced visit by two council workers, one of which did not show their ID. He was unhappy and confused about this visit and did not know one of the officers

The investigating officer interviewed both officers who attended the property and whilst one officer did show their ID the other didn't (although the ID badge was visible).

The officer was reminded of the importance in showing her ID so as not to cause any unnecessary distress to service users. This was also reiterated to the wider team via the team meetings.

There should be no repeat incidents of this type as a result of this corrective action.

Mrs V, the mother of a service user complained about the standard of care that is being provided to her daughter. Mrs V states that although her daughter only has 3 calls per week she is constantly being left or telephoned with some excuse as to why the carers are not coming or that they are going to be late. All the calls are after 11am and Mrs V thinks that this is too late in the day to arrange for cover. This appears to be a repeating theme

As part of the investigation the officer spoke with the care worker, care coordinator and it was concluded that the care working, on this occasion, was not meeting the standards required. A change of care worker was swiftly implemented and a further management meeting took place to ensure there were no repeats of this nature.

As a result of this action there were no further reported incidents.

7 September 2017	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
National Health Service, Thurrock Clinical Commissioning Groups Primary Care Update	
Wards and communities affected: All	**Key Decision:** Key
Report of: Rahul Chaudhari, Head of Primary Care	
Accountable Head of Service: Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group	
Accountable Director: Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group	
This report is Public	

Executive Summary

To provide a summary of the key developments in Primary Care in Thurrock and to provide an overview of the development of the Integrated Medical Centres (IMCs).

1. Recommendation(s)

1.1 The Health and Wellbeing Overview and Scrutiny Committee are asked to note the contents of the report.

2. General Practice Development

2.1 Care Quality Commission (CQC)

Thurrock Clinical Commissioning Groups (CCG) now has a total of 22 practices rated GOOD with East Thurrock Medical Centre practice being the most recent addition.

2.2 Primary Care Hubs

These are operational across five sites over weekends and on Wednesday evenings. The hubs offer eight sessions of General Practitioners (GPs) and nurse per week and based on the patient feedback, the hubs have now introduced referral for diagnostic tests and complex wound dressings. Following on the success from last year the hubs will be offering Learning Disability Health Checks for opted out practices in 2017/18 starting September 2017.

2.3 European (EU) GPs

As part of the Essex wide project to recruit EU GPs in the area; Thurrock CCG has been successful in recruiting 2 EU GPs within our practice. There will be a further recruitment of one additional EU GP in the third quarter of this year.

3. Procurements and Contracts

Currently there are two live Primary Care procurements underway these are:

- Lot 1 - Tilbury Health Centre, Dilip Sabnis and Chadwell Medical Centre
- Lot 2 - Thurrock Health Centre

4. Integrated Medical Centres (IMCs)

A paper was presented to Cabinet last month seeking approval to progress to the next phase of the project. The paper was approved by Cabinet to appoint the design team. The Council is now in the middle of procuring the design team that will work alongside the health planners to confirm the design and the foot print of the building. The design team is expected to be appointed by end of September 2017.

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

N/A

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

6.1 It is envisaged that the above approaches will not have an adverse impact on the current service provision.

7. Implications

N/A

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

N/A

9. Appendices to the report

N/A

Report Author:

Rahul Chaudhari
Head of Primary Care Development
NHS Thurrock Clinical Commissioning Group

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BRIEFING NOTE for Health and Wellbeing Overview and Scrutiny Committee – 7 September 2017
Joint Committee across STP Footprint – Implications for Scrutiny Committee

Introduction and Background

There are five CCGs within Essex who form the Mid and South Essex STP, namely: NHS Basildon and Brentwood CCG, NHS Thurrock CCG, NHS Southend CCG, NHS Mid Essex CCG and NHS Castle Point & Rochford CCG.

The Joint Committee

A STP Joint Committee is being formed under which will sit a management team (for which the arrangements are currently being formalised). The STP Joint Committee (terms of reference attached for information) will be a committee of each CCG with the purpose of overseeing and providing the appropriate governance for commissioning arrangements across the STP footprint. This will enable the CCG to commission services across the STP footprint 'once' to reduce red tape and the complexities of commissioning with five separate organisations and ensure the best quality and value for our patients. The following services are included within the STP:

- Acute services (NHS and independent sector) commissioning and contracting
- Integrated Urgent Care services (including NHS 111) commissioning and contracting
- Ambulance services commissioning and contracting
- Patient Transport Services commissioning and contracting
- Learning Disability decision making (within the existing pan-Essex arrangements);
- Mental Health services contracting and commissioning of Acute Mental Health services.

Overview of CCG functions

The CCG will maintain overall accountability and responsibility for the STP Joint Committee, although services will be commissioned once across the STP footprint.

Consequently the NHS Thurrock CCG will then be able to focus its commissioning intentions on out of hospital care and a model that will see a movement of services to a community setting in accordance with the needs of our patients.

Implications for HOSC

There are no direct implications for the HOSC and as such it should been seen to be business as usual in terms of how the HOSC interacts with the NHS Thurrock CCG. The Accountable Officer will continue to represent the CCG and will provide updates in relation to the STP Joint Committee and progress in joint commissioning arrangements. Representatives from HOSC, in line with the public in general can attend the STP Joint Committee public meetings should they so wish.

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APPENDIX 1

Dated: 15 August 2017

(1) NHS Basildon and Brentwood CCG

(2) NHS Castle Point & Rochford CCG

(3) NHS Mid Essex CCG

(4) NHS Southend CCG

(5) NHS Thurrock CCG

MID AND SOUTH ESSEX CCGS

STP JOINT COMMITTEE TERMS OF REFERENCE

V,6

Version	Author	Date
V3	Viv Barnes	18 May 2017
V4	Viv Barnes	8 June 2017
V5	Viv Barnes	12 June 2017
V6	Viv Barnes	15 August 2017

STP Joint Committee

Terms of Reference

1 **Context**

1.1 NHS Basildon and Brentwood CCG, NHS Castle Point and Rochford CCG, NHS Mid Essex CCG, NHS Southend CCG and NHS Thurrock CCG (the CCGs) are working together as part of the Mid and South Essex Sustainability and Transformation Plan (STP) and the Mid and South Essex Success Regime (SR).

1.2 The CCGs are forming a joint committee using their power under Section 14Z3(2A) of the National Health Service Act 2006 to enable them to take certain commissioning decisions jointly.

2 **Establishment**

The CCGs are seeking to form the joint committee with effect from 7 July 2017 to be known as the STP Joint Committee. The joint committee will be established as a committee of each CCG, not of the CCG's governing bodies, and therefore will sit alongside the CCG governing bodies rather than being accountable to them.

3 **Members of the STP Joint Committee**

3.1 The core Membership of the Joint Committee will comprise:

3.1.1 An independent clinical Chair (with casting vote when required)
3.1.2 5 x Clinical Chairs from each CCG (voting)
3.1.3 5 x Accountable Officers from each CCG, including the lead Accountable Officer for the STP (voting).

3.2 The Joint Committee will appoint an independent Chair. NHS England will be consulted on this appointment and, whilst directions are in force relating to the establishment of a Joint Committee, this appointment will be subject to the final approval of NHS England.

3.3 The Joint Committee will appoint a Deputy Chair, drawn from the membership of the committee.

3.4 The Joint Committee will appoint a Lead Accountable Officer who will be accountable for the delivery of its functions. The lead accountable officer will also hold the Accountable Officer portfolio for one of the constituent CCGs. NHS England will be consulted on this appointment and, whilst directions are in force relating to the establishment of a Joint Committee, this appointment will be subject to the final approval of NHS England.

3.5 The Joint Committee will appoint a suitably qualified Board Secretary.

3.6 The Joint Committee will ensure that there is a suitably qualified executive team to support the discharge of its functions.

4 Principles

4.1 In performing their respective obligations under this Agreement and the Commissioning Contracts, the CCGs must:

4.1.1 at all times act in good faith towards each other;

4.1.2 act in a timely manner;

4.1.3 share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

4.1.4 at all times, observe relevant statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information, and Nolan principles and Professional Standards Organisation's Standards for CCG Governing Bodies; and

4.1.5 have regard to the needs and views of all of the Commissioners, irrespective of the size of any of the respective Holdings of the Commissioners and as far as is reasonably practicable take such needs and views into account.

4.1.6 Make decisions on behalf of the 1.2 million STP population, not upon CCG populations

4.1.7 Exercise functions effectively, efficiently and economically at all times;

4.1.8 Ensure clinical engagement remains at the forefront of decision making throughout the STP area.

5. Grounds for Removal from Office

5.1 Members of the STP Joint Committee shall vacate their office:-

5.1.1. If in the majority opinion of the Joint Committee (having taken appropriate professional advice in cases where it is deemed necessary) he/she becomes or is deemed to be unsuitable or of unsound mind.

5.1.2. If he or she is a Board appointed member and ceases to meet the criteria for CCG Board membership as set out in Schedules 4 and 5 of The NHS Clinical Commissioning Group Regulations 2012.

5.1.3 If he or she has been absent for a period of [3] consecutive meetings of the Joint Committee then he or she shall, at the discretion of the Joint Committee, be vacated from his/her office.

6. Commissioning Functions

6.1 The principal function of the Joint Committee is to enable the CCGs to - where appropriate - act collectively in the planning, securing and monitoring of services to meet the needs of the population of Mid and South Essex, as well as represent the STP footprint for services commissioned over a larger area.

6.2 The functions of the Joint Committee will include:

6.2.1. Decisions on relevant STP wide service configurations;

6.2.2 Leadership of relevant public consultations on significant service changes that affect the whole STP area

6.2.3 Agreement of STP wide service restriction policies

6.2.4 Agreement of relevant STP wide outcomes, frameworks and pathways

6.2.5 Agreement of the STP local health and care strategy

6.2.6 Receiving and providing reports on the delivery of the STP local health and care strategy

6.3 The Joint Committee will also have delegated responsibility for commissioning of a range of services on behalf of the CCGs, including:

6.3.1. Acute services (NHS and independent sector) commissioning and contracting

6.3.2 Integrated Urgent Care services (including NHS 111) commissioning and contracting

6.3.3 Ambulance services commissioning and contracting

6.3.4 Patient Transport Services commissioning and contracting

6.3.5 Learning Disability decision making (within the existing pan-Essex arrangements);

6.3.6 Mental Health services contracting and commissioning of Acute Mental Health services.

6.4 Although the Joint Committee will be responsible for all of the commissioning contracts referred to in 6.3.1, 6.3.2, 6.3.3, 6.3.4, 6.3.5 and 6.3.6, these contracts will take account of the priorities identified by individual CCGs. It is anticipated that in many areas the Joint Committee will agree the strategic framework for the STP footprint, with operational delivery of key areas – such as demand management - being shaped locally.

6.5 For contracts held under 6.3.6, it is envisaged that elements of mental health services will need to be shaped and specified by individual CCGs, but there will be strategic alignment across the STP, facilitating a suite of contracts for which the Joint Committee is responsible.

6.6 For all contracts outlined in 6.3, the Joint Committee will ensure there are appropriate arrangements in place to:

6.6.1 Develop the commissioning strategy for the areas delegated, including where relevant setting commissioning intentions and the desired outcomes for the STP population

6.6.2 Establish and manage contracts for the areas/services delegated

6.6.3 Manage the delegated Commissioning Contracts, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services by assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

6.6.4 Manage variations to the Commissioning Contracts or Services in accordance with national policy, service user needs and clinical developments

6.6.5 Manage procurement of services in line with commissioning decisions and manage risk associated with such procurements

6.6.6 Ensure delivery of relevant savings programmes as agreed in the STP Joint Committee annual plan

6.7 The CCGs' Governing Bodies may decide, from time to time, to delegate additional functions to the STP Joint Committee, in which case the list of commissioning functions set out above shall be updated accordingly.

7. Decision-making

7.1 The Joint Committee will have delegated responsibility to make decisions that bind the CCGs in relation to those commissioning functions delegated to the Committee.

7.1 Each member of the STP Joint Committee shall have one vote, with the exception of the independent Chair who will have a casting vote in the event that there is a tied vote. The Deputy Chair will not have a casting vote when deputising for the independent Chair, in which case the same options for achieving a quorum (paragraphs 10.3 and 10.4) should be followed in the event of a tied vote.

7.2 Each CCG is responsible for ensuring that its nominated members to the STP Joint Committee have sufficient delegated authority, in accordance with that CCG's constitution, to act on behalf of that CCG within the remit of the Committee;

7.3 It is the intention that the Joint Committee will arrive at a consensus regarding the decisions to be reported to the CCGs concerning the Services or the Commissioning Contracts.

7.4 Where a consensus is not reached, a decision may be reached by simple majority vote of the Joint Committee. Any recommendation of the Joint Committee arrived at by majority vote will also contain reference to any minority views.

7.5 If members choose to abstain from voting, their abstentions will be noted but will not contribute to the yes or no counts and will not affect the majority vote.

8 Financial delegation

8.1 The Joint Committee has a responsibility to ensure that the services and contracts for which they are responsible stay within the resources allocated to it by the CCGs.

8.2 The Joint Committee and the CCGs will agree, within its implementation plan, detailed arrangements for delegating relevant budgets.

8.3 The Joint Committee implementation plan will outline the decision-making process relating to any future risk/gain share arrangements.

9 Other Attendees

9.1 The Chair may at his or her discretion permit other persons to attend meetings of the STP Joint Committee but, for the avoidance of doubt, any persons in attendance at any such meetings shall not count towards the quorum or have the right to vote.

10 Meetings

10.1 The STP Joint Committee shall meet at such times and places as the Chair may direct on giving reasonable written notice to the members of the STP Joint

Committee, but will meet at least once every eight weeks. Meetings will be scheduled to ensure they do not conflict with the CCGs' respective Governing Body meetings.

10.2 Special meetings of the Joint Committee may be called by any member of the Joint Committee, with the agreement of the Chair, by giving at least 48 hours' notice by e-mail to each member.

10.3 Meetings of the STP Joint Committee shall be open to the public unless the STP Joint Committee considers that it would not be in the public interest to permit members of the public to attend all or part of a meeting.

11 Quorum

11.1 The quorum for conducting a meeting of the Joint Committee shall be a minimum of 50% of total voting members, including the Chair or Deputy Chair, and at least one CCG Chair and one CCG Accountable Officer.

11.2 Any quorum of the Joint Committee shall exclude any member affected by a Conflict of Interest. If this has the effect of rendering the meeting inquorate, then the Chair shall decide on one of the following options:-

11.3 Inviting on a temporary basis one or more additional members to make up the quorum (where these are permitted members of the Joint Committee) so that the Committee can progress the item of business.

11.4 Adjournment of the item, reconvening the meeting when appropriate membership can be ensured.

12. Participation in Meetings

12.1 The Chair may agree that the members of the STP Joint Committee may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting.

13. Conflicts of Interest

13.1 If, at any meeting of the STP Joint Committee, a member of the committee has a conflict of interest or a potential conflict of interest in relation to the scheduled or likely business for the meeting, he or she shall declare the conflict of interest or potential conflict of interest to the Chair at the start of the meeting

13.2 If during the course of an STP Joint Committee meeting, a member of the committee becomes aware that he or she has a conflict of interest or potential conflict of interest

in relation to a matter being discussed at the meeting, he or she shall immediately declare such conflict of interest or potential conflict of interest to the Chair.13.3 The Chair shall be responsible for determining the arrangements that will apply in the event that any member of the committee declares an actual or potential conflict of interest at an STP Joint Committee meeting. It will usually be appropriate for the individual to withdraw from the meeting whilst the relevant item of business is discussed.

13.4 If the Chair declares an actual or potential conflict of interest in any matter before the STP Joint Committee then the Deputy Chair will be responsible for determining what arrangements will apply and will chair the meeting for the relevant item of business.

14. Administrative

14.1 Secretariat support for the STP Joint Committee will be provided by the Board Secretary.

14.2 The papers for each meeting will be sent to the members of the STP Joint Committee no later than 5 working days prior to each meeting and earlier if possible. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

14.3 The draft minutes from each STP Joint Committee meeting will be circulated to the members of the STP Joint Committee with the papers for the next meeting.

15. Reporting

15.1 The Chair shall arrange for a copy of the minutes for each STP Joint Committee meeting, once approved (the Approved Minutes), to be sent to the members of the STP Joint Committee.

15.2 The CCG Commissioners shall be responsible for ensuring that their respective Governing Bodies receive a copy of the Approved Minutes.

16 Review of Terms of Reference

16.1 To be reviewed annually and ratified by the Joint Committee.

Appendix 1

Authorisation Form – STP Joint Committee – Appointment of Deputies

1. Where a CCG nominated representative is unable to attend an STP Joint Committee meeting, the terms of reference permit the Governing Body of the relevant CCG to authorise another member of its Governing Body to deputise for its CCG representative.
2. It is the responsibility of each CCG's Governing Body to use reasonable endeavours to ensure that its CCG Representatives, or duly authorised deputies, attend each meeting of the STP Joint Committee.
3. This form should be completed for each individual who is authorised to deputise for a CCG representative at meetings of the STP Joint Committee and a copy should be sent to the Chair of the STP Joint Committee and the Board Secretary.
4. Where the Governing Body is authorising an individual to deputise for a CCG representative at a particular meeting, a copy of the completed form should be returned to the Chair no later than the day before the relevant meeting.

Name of CCG .....

The Governing Body confirms the individual(s) named below are members of its governing body and authorises them to deputise for its CCG representative [as and when required] OR [at the meeting on [date]

(1) Name: .....

Title: .....

(2) Name: .....

Title: .....

Signed on behalf of the Governing Body:

Name & Title: .....

Date: .....

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7 September 2017	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Carers Support, Information and Advice Service	
Wards and communities affected: All	**Key Decision:** Key
Report of: Catherine Wilson: Strategic Lead – Commissioning and Procurement	
Accountable Assistant Director: Les Billingham – Assistant Director, Adult Social care and Communities	
Accountable Director: Roger Harris – Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

The purpose of this report is to ensure that the Health and Well Being Overview and Scrutiny Committee are fully updated regarding the procurement of a Carers Support, Information and Advice service.

A report was presented to HOSC on the 15 September 2016 outlining the intention to tender the Carers Support, Information and Advice Service. This procurement was delayed to allow further discussion with the existing provider and to give more time to review the specification. The contract was extended for a further year with CARIADS (Thurrock Mind) ensuring continuity of the service.

All issues have now been resolved and a new draft specification for the service designed – this will be circulated separately to members. The provider will be asked to deliver increased capacity within the same financial envelope; in addition the specification now includes first line, initial carer's assessments. This development to the specification will improve and hopefully increase the Council's number of carers assessments/reviews compared with national and regional averages. Currently Thurrock deliver approximately 300 assessments per 100,000 population compared to a national average of 885 per 100,000 population – so we are some way below comparable authorities. It is common practice elsewhere for such assessments to be carried out by a Carer's Support Service.

The specification also looks to introduce a 'Carers Emergency Scheme'.
The successful provider will support carers to complete an emergency plan which considers the support required for the cared for person if the carer was unable to support them due to an emergency or unplanned situation. It would work by a unique identifier being logged with the Council. The Carer will carry this information with

them and any agency e.g. police, ambulance service etc. will be able to activate the emergency plan by giving this unique reference number.

The procurement will deliver a Carers Support, Information and Advice Service for Carers aged 18 and over ensuring that the Council is fully compliant with Local Authority responsibilities outlined within the Care Act 2014.

The new contract will be delivered within the existing financial envelop.

1. Recommendation(s)

1.1 For the Health and Wellbeing Overview and Scrutiny Committee to comment on the draft specification for the provision of the carers support, information and advice service.

1.2 For the Health and Wellbeing Overview and Scrutiny Committee to note that the procurement will commence on the 18 September 2017.

2. Introduction and Background

2.1 The current provision for Carers Support, Information and Advice is now due to expire in April 2018. The service is required to meet the needs of Carers and ensure the council continues to meet legislative requirements under the Care Act 2014.

2.2 Thurrock Council Adult Social Care Directorate has a statutory duty to facilitate the provision of a Carers Support, Information and Advice Service for carers aged 18 and over. The Care Act 2014 defines a 'carer' as an adult who provides or intends to provide care for another adult needing care.

2.3 The 2011 national census for England, Wales and Northern Ireland concludes a significant increase in the number of carers since the last census.

- The number rose from 5.22 million in 2001 to 6 million in 2011. This is an increase of 629,000 over the 10 year period.
- Of these, 2.2 million people are undertaking caring responsibilities in excess of 20 hours a week and 4 million in excess of 50 hours a week.
- It is anticipated that the number of carers are likely to increase in the future as people are living longer and with more complex needs.
- The age profile shows the peak age for caring is 50 to 59 and that 1 in 5 people in this age group (1.5 million across the UK) are providing some unpaid care.

2.4 The census showed that in Thurrock;

- 26% of those identifying as caring provided more than 50 hours of care per week. This is higher than regional (23%) and national averages (22%)
- 94% of those who identified as caring stated that it had either a big or some impact on their day to day life and a third (34%) said that their health had deteriorated in the last 6 months.

2.5 Thurrock Council currently commissions Thurrock Mind to provide a Carers Support, Information and Advice Service (CARIADs) for Carers aged 18 and over.

2.6 In 2016/17, 306 Carers were actively supported by our Carers Service. In addition, nearly 1800 people have chosen to remain in contact with the service in other ways e.g. by receiving a newsletter etc.

2.7 Over 60% of the carers identified during 2016/17 were unknown to the council and were primarily providing support for older people or people with a long term illness. The majority of Carers were aged 51-64 and resided in the Grays area of Thurrock. As such, the specification has been strengthened to ensure equitability across all parts of the borough

2.8 The current contract value is £117,118 per annum and is commissioned to provide:

- Support: support groups, counselling services for carers, ad-hoc therapeutic and health promoting activities, carer training and early identification
- Information and Advice: Telephone and drop in services, newsletter, carers week and carers rights events, maintain carers support directory and carers support pack, provide input to council web-based information
- Appropriate staffing to support the delivery of the service

2.9 In addition to the above the new specification now requires the introduction of low level assessments and a Carers emergency scheme.

2.10 The proposed timetable for procurement is detailed below.

KEY EVENT	DATE
ITT Publication	18 September 2017
Deadline for clarification requests	12 October 2017
Closing date for tender submissions	19 October 2017
Interviews	W/C 30 October 2017
Notification of result evaluation	6 November 2017
Standstill period	7 – 16 November 2017
Expected date of award of contract	17 November 2017
Contract Commencement	1 April 2018

3. Issues, Options and Analysis of Options

3.1 The additional time has afford the Commissioner the opportunity to extend the review of the current provision, it is clear that whilst, as before, the Local Authority will not delegate its statutory duties an addition to the specification to deliver low level assessments is key. This is one mechanism within the specification that strengthens the requirement to proactively identify unknown carers.

3.2 Current provision of carers support, information and advice has been reviewed to ensure it meets the current and future needs of carers in Thurrock and our responsibilities under the Care Act 2014.

3.3 As part of the review, three options were identified and presented to Officers for Adult, Housing and Health.

1. **To remain the same** - Continue to commission the service as set out in the current specification at the current price (£117k per annum)
2. **To Increase the capacity** - Continue to commission the service at the same price (£117k per annum) but increase the capacity to meet the identified growth in future carers. Ensure equitability across the borough of access to the service and introduce low level assessments.
3. **To fully delegate our responsibilities** - Devolve most functions including assessments and budget allocation (excluding safeguarding and charging) to the new provider.

4. Reasons for Recommendation

4.1 All three options were reviewed. The **preferred option is number 2** – **To increase capacity for the same contract price.**

4.2 Option 1 no longer meets Thurrock Council's new responsibilities under the Care Act or our identified areas for improvement.

4.3 Option 3 could increase cost at a time of austerity. There is a risk that devolving the budget and thereby control, could result in larger care support packages and increased cost. There would also be an additional cost to the organisation carrying out these functions.

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

5.1 A questionnaire is being sent to all current service users to ensure they are involved and able to shape future service design as any comments will be added to the final specification; the attached specification is in draft form for your information. Verbal feedback regarding the results of the Thurrock Carer's questionnaire will be available at HOSC. In addition the Council will specifically request that the service is able to deliver low level carers assessments and that a Carers Emergency Scheme as described above is developed, this is in line with other carers services nationally.

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

6.1 The tender of a Carers Support, Information and Advice service primarily meets the priority 'To improve health and well-being'. By commissioning this service, we will continue to ensure that the needs of carers are met.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant

As the service will be re-tendered within the current financial envelope there will be no financial implications.

7.2 Legal

Implications verified by: **Lindsey Marks**

Principal Solicitor for Safeguarding

This contract supports to council to deliver its responsibilities under the Care Act 2014

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The purpose of this tender is to increase the identification and access of carers to support, information and advice. The results of the current survey will inform an equality impact assessment that will support the tender and development of the service

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

N/A

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

N/A

9. Appendices to the report

Appendix 1 - Performance Schedule

Appendix 2 - Carers Information Advice and Support Service Specification (To be tabled)

Report Author:

Catherine Wilson
Strategic Lead, Commissioning and Procurement
Adult Social Care

Performance Schedule

There are two types of outcomes

1. Hard Outcomes – Usually quantitative data, objective measurement e.g. statistical data;
2. Soft Outcomes – Usually qualitative data, some element of subjectivity e.g. peoples opinion.

Hard outcomes will be measured via the contract and be returned by the provider on a quarterly basis. Soft outcomes will also be measured via the contract and a narrative report covering the soft outcomes should be produced and returned by the provider on a 6 monthly basis. We reserve the right to audit this data on at least an annual basis.

In addition, the Provider is expected to produce an action plan on an annual basis which details what actions will be taken throughout the year to meet the performance requirements attached to the contract. This plan will also address any areas requiring improvement issues identified through the Carers Survey.

Please note – performance measures on the emergency scheme and self-assessments will be agreed in conjunction with the provider upon the implementation of these service attributes.

1. Hard Outcomes and their Measurement

No	Outcome	Indicator	How Measured	Frequency	Target	By Whom	Method
1	Referrals Received/Accepted	Breakdown of referrals received and accepted	a) Total number of contacts received in the quarter b) Number of contacts (from a) above) signposted c) Number of contacts (from a) above) refused/inappropriate d) Number of contacts (from a) above) that were DNA's e) Number of contacts (from a) above) accepted by the service (new carers). This is the sum of a – (b+d)	Quarterly	N/A	Provider	Excel Workbook
2	Total Supported	Breakdown of	a) Number of contacts/cases	Quarterly	N/A	Provider	Excel

		total carers supported	carried over from previous quarter b) Total number of carers supported in the quarter (sum of 1e + 2a) c) Number of contacts/cases closed in the quarter d) Number of contacts/cases to be carried over to the next quarter				Workbook
3	Breakdown of Accepted Referrals	Breakdown of accepted contacts	Breakdown of accepted new contacts in the quarter (from 1e) above) into the following categories: a) New carers unknown to the Council b) New carers previously known to the Council c) Returning carers with new issues d) Returning carers	Quarterly	a + b = 100 per quarter	Provider	Excel Workbook
		Breakdown of referral source	Breakdown of accepted new contacts in the quarter (from 1e above) by referral source.	Quarterly	N/A	Provider	Excel Workbook
		Breakdown of how contact was made	Breakdown of accepted new contacts in the quarter (from 1e above) into the following categories: a) Telephone b) Email c) Letter d) In Person e) Website f) Unknown	Quarterly	N/A	Provider	Excel Workbook
4	Profile of Carers	Profile of accepted/new carers	Number of accepted new contacts in the quarter (from 1e above) into the following categories: • Gender • Ethnicity • Age	Quarterly	N/A	Provider	Electronic Workbook

			• Location/Area of Residence • Employment Status • Primary reason for referral • Number of carers who consider themselves to have disability • Number of parent carers				
5	Profile of Cared-For Person	Breakdown of the primary condition of the cared-for person	Number of accepted new contacts in the quarter (from 1e above) into the following primary conditions of the cared-for person: • Dementia • Problems connected with ageing • Physical Disability • Learning Disability or Difficulty • Sight or Hearing Impairment • Long-Standing Illness • Mental Ill-Health • Terminal Illness • Alcohol or Drug Dependency • Other • Unknown	Quarterly	N/A	Provider	Excel Workbook
6	Key Activities Undertaken	Breakdown of key activities undertaken in the quarter	Number of carers helped with the following key activities, broken down by new and existing carers (please note this list is not exhaustive): • Counselling • Support Groups (peer support) • Sitting/Befriending service offered through volunteers • Referral to Social Care • Added to Mailing List • Signposted to Other Organisations	Quarterly	N/A	Provider	Excel Workbook

			• Education/Training Support • Employment Support • Volunteering Support • Peer Support • Information & Advice • Medical Resources/Information • Information on Direct Payments • Carers Benefits/Welfare Forms • Lasting Power of Attorney • Access to social activities • Other • Unknown				
7	Support Groups	Number of peer support groups in operation	Number of peer support groups in operation in the quarter	Quarterly	N/A	Provider	Excel Workbook
8	Peer Support	Number of carers offering peer support	Number of carers offering peer support in the quarter (i.e. trained to carry out support groups)	Quarterly	N/A	Provider	Excel Workbook
9	Volunteer Support	Number of carers offering volunteer support	Number of carers offering volunteer support in the quarter (i.e. befriending, sitting service)	Quarterly	N/A	Provider	Excel Workbook
		Number of sits carried out	Total number of sits carried out in the quarter from volunteer support	Quarterly	Upward Trajectory	Provider	Excel Workbook
10	Work Based Activity	% of carers in work preparation activities	Number of carers who had support in work preparation activities, as a proportion of the number of carers who required support with work based activities in the quarter	Quarterly	N/A	Provider	Excel Workbook
		% of carers in volunteering	Number of carers who had support to participate in volunteering, as a proportion of the number of carers who required support with work based activities in the quarter	Quarterly	N/A	Provider	Excel Workbook
		% of carers in training/education	Number of carers who had support to participate in training/education, as a	Quarterly	N/A	Provider	Excel Workbook

			proportion of the number of carers who required support with work based activities in the quarter				
		% of carers in full time employment	Number of carers who had support to participate in full time employment, as a proportion of the number of carers who required support with work based activities in the quarter	Quarterly	N/A	Provider	Excel Workbook
		% of carers in part time employment	Number of carers who had support to participate in part time employment, as a proportion of the number of carers who required support with work based activities in the quarter	Quarterly	N/A	Provider	Excel Workbook
11	Young Carers in Transition	Number of young carers supported through transition	Number of young carers supported through transition in the quarter	Quarterly	N/A	Provider	Excel Workbook
12	Mailing List	Number of carers on the mailing list	Number of carers on the mailing list as at the end of the quarter	Quarterly	N/A	Provider	Excel Workbook
13	Promotional Events	Number of promotional events	Number of promotional events the service has undertaken and/or attended in the quarter	Quarterly	N/A	Provider	Excel Workbook
14	Complaints	Number of complaints received	Number of complaints received in the quarter	Quarterly	N/A	Provider	Excel Workbook
15		Outcome of complaints	Number of complaints received (from 14 above) broken down into the following categories: • Upheld/Partially Upheld • Not Upheld • Ongoing	Quarterly	N/A	Provider	Excel Workbook
16	Compliments	Number of formal compliments received	Number of compliments received in the quarter	Quarterly	N/A	Provider	Excel Workbook

2. Soft Outcomes and their measurement

No	Outcome	Measurement	Evaluation	Frequency	By Whom
1	Consultation with Carers	• Details of what schemes have been established • Evidence/case studies of how changes have been made as a result of carer input	• Results of consultations showing carers (including carers from BME groups) views of how well they have been consulted in the design and running of their services	6 monthly	Provider
2	Access to Service	• Details of what information is available, where located, and in what formats • Details of what range of services and advice are being provided • Details of support, information and advice provided in adapted formats to reach a specific target audience	• Carers report that they are able to get the information they require, in the format they prefer, at the time it is needed	6 monthly	Provider
3	Support Groups	• Details of support groups available (to evidence range available)	• Carers report that there are a sufficient number of support groups that are relevant to them and that make a positive difference to their caring role as well as their life outside of caring	6 monthly	Provider
4	Employment, Education & Training	• Case studies to show how carers have been supported in this outcome • Details of what types of support have been provided in the quarter, e.g. CV writing, interview skills etc	• Carers report that they have been supported to access work, education and training	6 monthly	Provider
5	Carers Promotion	• Details of events/training sessions held in the period to increase awareness of carers in Thurrock • Copy of newsletter provided to carers evidence that they are being kept informed • Details of the activities undertaken as part of the Carers Forum, including number of attendees, frequency of meetings.	• Results or feedback from event/training attendees • Professionals and the public report that they have a greater understanding of carers issues	6 monthly	Provider

6	Young People's Transition	• Number and details of any inter-generational activities undertaken in the quarter, levels of attendance and breakdown of numbers of young and adult carers attending • Details of feedback from the attendees • Details of any joint working initiatives carried out in the period • Evidence of what improvements have been made in carer outcomes, particularly with regard to transition of young carers into adult carer services	• Carers report that there are closely aligned services that the transition between children's and adult services is improved	6 monthly	Provider
7	Personalisation	• Targeted efforts to improve the identification and support of under-represented carer groups leads to improvements in this area • Culturally sensitive ways of working which encourage people to access services are adopted • Details of activities undertaken in the period to identify and target support to under-represented carer groups	• Carers report that services are personalised and relevant to them	6 monthly	Provider
8	Continuous Improvement	• Details of any innovative work undertaken to support carers • Evidence of any improvements made to service delivery or reviews of the quality of the service • Unmet need is reported to highlight areas which need to be targeted/improved. This includes examples of carers that the service has been unable to signpost or engage with and the reasons why • Details of positive outcomes that arise as a result of changes made to the service following a compliment or complaint	• Innovative and effective ways to support carers are continuously explored and services are regularly tested to determine what works and what must be improved • Evidence of any improvements made to service delivery or reviews of the quality of the service • Carers report that they are consulted about the quantity, location and content of support, information and advice	6 monthly	Provider

9	Joint-Working	• Details of joint-working undertaken and how this has led to better carer outcomes	• Carers report that there is improved communication and joint-working between services	6 monthly	Provider

7 September 2017	ITEM: 11
Health and Wellbeing Overview and Scrutiny Committee	
Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Plan/Success Regime for Mid and South Essex	
Wards and communities affected: N/A	**Key Decision:** Non Key
Report of: Roger Harris, Corporate Director of Adults, Housing and Health	
Accountable Head of Service: N/A	
Accountable Director: N/A	
This report is Public	

Executive Summary

The Thurrock Health and Wellbeing Overview and Scrutiny Committee has been approached by the Essex and Southend Councils to look at the possibility of forming a Joint Committee to look at the Mid and South Essex Sustainability and Transformation Plan (STP) / Success Regime.

1. Recommendation(s)

1.1 Officers continue to explore the most appropriate way for Essex, Southend and Thurrock to co-ordinate their approach to the STP and report back in due course.

2. Introduction and Background

2.1 The purpose of the Joint Committee would be to scrutinise the implementation of the Mid and South Essex Sustainability and Transformation Plan/Success Regime and how it would meet the needs of the local population in Essex, Southend and Thurrock.

2.2 The Joint Committee would act as the mandatory Joint Committee in the event that a National Health Service body is required to consult on any variation or development in this service that could affect the three local authorities.

2.3 The Joint Committee would consist of Members from all three authorities and consideration would need to be given to the political proportionality of those

Members. Any decision to establish such a Committee would require the approval of the General Services Committee.

2.4 Southend Council has agreed to support the setting up of a Joint Committee but the Lead Authority would need to be decided by negotiations between the three local authorities.

2.5 The Lead Authority would bear staffing costs of arranging, supporting and hosting the meetings of the Joint Committee but other costs, such as obtaining expert advice, would be apportioned between the three local authorities.

3. Issues, Options and Analysis of Options

3.1 There are concerns that this is creating another layer of bureaucracy and is potentially taking power and authority away from the Thurrock Scrutiny process and as such it is not recommended by officers that we join up to this proposal at this stage.

3.2 Clearly within the regulations there is a requirement to establish a Joint Committee for service reconfigurations that cut across more than one area – e.g. review of cancer services, and this has happened in the past. However, this appears to be establishing a new and more permanent body and as such we feel requires further discussion.

3.3 Thurrock wants to continue to work with Essex and Southend to ensure that there is a strong local government voice in the various discussions relating to the STP e.g. around the sustainability of social care, improving our collective position over delayed transfers of care etc. This is why we are recommending those discussions continue and all possibilities are explored before we go ahead and join a Joint HOSC at this stage.

4. Reasons for Recommendation

4.1 To allow for officers to continue joint discussions with Essex County Council and Southend Borough Council.

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

5.1 N/A

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

6.1 N/A

7. Implications

None

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

See below

9. Appendices to the report

Appendix 1 - Draft Terms of Reference

Appendix 2 - Report on "Update on Mid and South Essex Success Regime/ Sustainability and Transformation Partnership (STP)" presented at the Health and Wellbeing Overview and Scrutiny Committee on the 3 July 2017

Report Author:

Roger Harris

Corporate Director of Adults, Housing and Health

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ESSEX, SOUTHEND AND THURROCK JOINT HEALTH SCRUTINY COMMITTEE ON THE SUSTAINABILITY & TRANSFORMATION PLAN / SUCCESS REGIME FOR MID AND SOUTH ESSEX

DRAFT TERMS OF REFERENCE

1.	**Legislative basis**
1.1	The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Localism Act 2011 sets out the regulation-making powers of the Secretary of State in relation to health scrutiny. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 which came into force on 1st April 2013.
1.2	Regulation 30 (1) states two or more local authorities may appoint a joint scrutiny committee and arrange for relevant health scrutiny functions in relation to any or all of those authorities to be exercisable by the joint committee, subject to such terms and conditions as the authorities may consider appropriate.
1.3	Where an NHS body consults more than one local authority on a proposal for a substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that Joint Committee may: • make comments on the proposal to the NHS body; • require the provision of information about the proposal; • require an officer of the NHS body to attend before it to answer questions in connection with the proposal.
1.4	This Joint Committee has been established on a task and finish basis, by Essex Health Overview and Scrutiny Committee (County Council), Southend-on-Sea People Scrutiny Committee (Unitary Council) and Thurrock health & Wellbeing Overview and Scrutiny Committee (Unitary Council).
2.	**Purpose**
2.1	The purpose of the Joint Committee is to scrutinise the implementation of the Mid and South Essex Sustainability & Transformation Plan (STP) Success Regime and how it is meeting the needs of the local populations in Essex, Southend & Thurrock, focussing on those matters which may impact upon services provided to patients in those areas.
2.2	The Joint Committee will also act as the mandatory Joint Committee in the event that an NHS body is required to consult on a substantial variation or development in service affecting patients in the 3 local authority areas as a result of the implementation of the STP.
2.3	In receiving formal consultation on a substantial variation or development in service, the Joint Committee will consider:- • the extent to which the proposals are in the interests of the health service in Essex, Southend and Thurrock;

	• the impact of the proposals on patient and carer experience and outcomes and on their health and well-being; • the quality of the clinical evidence underlying the proposals; • the extent to which the proposals are financially sustainable. and will make a response to relevant NHS body and other appropriate agencies on the proposals, taking into account the date by which the proposal is to be ratified.
2.4	The Joint Committee will consider and comment on the extent to which patients and the public have been involved in the development of the proposals and the extent to which their views have been taken into account as well as the adequacy of public and stakeholder engagement in any formal consultation process.
3.	**Membership/chairing**
3.1	The Joint Committee will consist of 4 members representing Essex, 4 members representing Southend and 4 members representing Thurrock, as nominated by the respective health scrutiny committees.
3.2	Each authority may nominate up to 2 substitute members.
3.3	The proportionality requirement will not apply to the Joint Committee, provided that each authority participating in the Joint Committee agrees to waive that requirement, in accordance with legal requirements and their own constitutional arrangements.
3.4	Individual authorities will decide whether or not to apply political proportionality to their own members.
3.5	The Joint Committee members will elect a Chairman and 2 Vice-Chairmen at its first meeting, one from each authority, so that each authority is represented.
3.6	The Joint Committee will be asked to agree its Terms of Reference at its first meeting.
3.7	Each member of the Joint Committee will have one vote.
4.	**Co-option**
4.1	By a simple majority vote, the Joint Committee may agree to co-opt representatives of organisations with an interest or expertise in the issue being scrutinised as non-voting members, but with all other member rights. This may be for a specific subject area or specified duration.
4.2	Any organisation with a co-opted member will be entitled to nominate a substitute member.
5.	**Supporting the Joint Committee**
5.1	The lead authority will be decided by negotiation with the participating

	authorities.
5.2	The lead authority will act as secretary to the Joint Committee. This will include: • appointing a lead officer to advise and liaise with the Chairman and Joint Committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned; • providing administrative support; • organising and minuting meetings.
5.3	The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference.
5.4	The lead authority will bear the staffing costs of arranging, supporting and hosting the meetings of the Joint Committee. Other costs will be apportioned between the authorities. If the Joint Committee agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred.
5.5	The non-lead authorities will appoint a link officer to liaise with the lead officer and provide support to the members of the Joint Committee.
5.6	Meetings shall be held at venues, dates and times agreed between the participating authorities.
6.	**Powers**
6.1	In carrying out its function the Joint Committee may: • require officers of appropriate local NHS bodies to attend and answer questions; • require appropriate local NHS bodies to provide information about the proposals; • obtain and consider information and evidence from other sources, such as local Healthwatch organisations, patient groups, members of the public, expert advisers, local authorities and other agencies. This could include, for example, inviting witnesses to attend a Joint Committee meeting; inviting written evidence; site visits; delegating committee members to attend meetings, or meet with interested parties and report back. • make a report and recommendations to the appropriate NHS bodies and other bodies that it determines, including the local authorities which have appointed the joint committee. • consider the NHS bodies' response to its recommendations;
6.2	In the event the Joint Committee is formally consulted upon a substantial variation or development in service as a result of the implementation of the STP, and considers:- ➢ it is not satisfied that consultation with the Joint Committee has been

	adequate in relation to content, method or time allowed; ➢ it is not satisfied that consultation with public, patients and stakeholders has been adequate in relation to content, method or time allowed; ➢ that the proposal would not be in the interests of the health service in its area the Joint Committee will consider the need for further negotiation and discussions with the NHS bodies and any appropriate arbitration.
6.3	If the Joint Committee then remains dissatisfied on the above 3 points it may make recommendations to Essex, Southend and Thurrock Councils. Each Council will then consider individually whether or not they wish to refer this matter to the Secretary of State or take any further action.
6.4	The power of referral to the Secretary of State is a matter which will not be delegated to the Joint Committee.
6.5	Each participating local authority will advise the other participating authorities if it is their intention to refer and the date by which it is proposed to do so.
7.	**Public involvement**
7.1	The Joint Committee will meet in public, and papers will be available at least 5 working days in advance of meetings
7.2	The participating authorities will arrange for papers relating to the work of the Joint Committee to be published on their websites, or make links to the papers published on the lead authority's website as appropriate.
7.3	A press release may be circulated to local media at the start of the process and at other times during the scrutiny process at the discretion and direction of the Chairman and the 2 Vice Chairmen.
7.4	Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend.
7.5	Members of the public attending meetings may be invited to speak at the discretion of the Chairman.
8.	**Press strategy**
8.1	The lead authority will be responsible for issuing press releases on behalf of the Joint Committee and dealing with press enquiries, unless agree otherwise by the Committee.
8.2	Press releases made on behalf of the Joint Committee will be agreed by the Chairman and Vice-Chairmen of the Joint Committee.
8.3	Press releases will be circulated to the link officers.
8.4	These arrangements do not preclude participating local authorities from issuing individual statements to the media provided that it is made clear that these are not made on behalf of the Joint Committee.

9.	**Report and recommendations**
9.1	The lead authority will prepare a draft report on the deliberations of the Joint Committee, including comments and recommendations agreed by the Committee. Such report(s) will include whether recommendations are based on a majority decision of the Committee or are unanimous. Draft report(s) will be submitted to the representatives of participating authorities for comment.
9.2	Final versions of report(s) will be agreed by the Joint Committee Chairman.
9.3.	In reaching its conclusions and recommendations, the Joint Committee should aim to achieve consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report/s shall be drafted by the appropriate member(s) or authority (ies) concerned.
9.4	Report(s) will include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review or scrutiny; and an explanation of any recommendations on the matter reviewed or scrutinised.
9.5	In addition, in the event the Joint Committee is formally consulted on a substantial variation or development in service:, if the Joint Committee makes recommendations to the NHS body and the NHS body disagrees with these recommendations, such steps will be taken as are “reasonably practicable” to try to reach agreement in relation to the subject of the recommendation.
9.6	The Joint Committee itself does not have the power to refer the matter to the Secretary of State.
10.	**Quorum for meetings**
10.1	The quorum will be a minimum of 6 members, with at least 2 from each of the participating authorities. This will include either the Chairman or one of the Vice Chairmen. Best endeavours will be made in arranging meeting dates to maximise the numbers able to attend from the participating authorities.

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3 July 2017	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Update on Mid and South Essex Success Regime / Sustainability and Transformation Partnership (STP)	
Wards and communities affected: All	**Key Decision:** For information and discussion
Report of: Andy Vowles, Programme Director, Mid and South Essex Success Regime	
This report is Public	

Executive Summary

This paper provides an update on current thinking and next steps for changes in local health and care across the Mid and South Essex Sustainability and Transformation Partnership (STP).

1. Recommendation(s)

1.1 The Committee is asked to note the update and to give views on: i. the emerging thinking local issues; and ii. future plans for public consultation.

2. Introduction and background

2.1 **Key events leading to our current position**

2015	NHS England and other national bodies designate Essex Success Regime, one of only three in the country.
1 March 2016	Outline plan published for health and care across mid and south Essex, including potential hospital reconfiguration.
March – May 2016 Early engagement	• Set up of clinical working groups to develop and lead change. • Three hospital trust boards agree joint committee • CCGs identify areas of collaboration • Engagement with health and wellbeing boards (HWBs), other stakeholders and service users. **Outcomes** • Clinicians (with service users) agree decision rules and criteria for potential hospital reconfiguration and service redesign. • Agreed objectives for hospital change: - Designate a specialist emergency hospital

	- Separate emergency and planned care - Identify where some specialist services could benefit from consolidation across three hospital sites.
June – Aug 2016 Developing options and decision-making criteria	• CCGs and partners collaborate on blueprints for joined up health and care in localities, frailty, end of life and other pathways. • Hospital clinicians refine potential options for reconfiguration and consult independent Clinical Senate. • Programme of staff workshops and focus groups with service users. Continued discussions with HWBs and other stakeholders **Outcomes** • Outline sustainability and transformation plan submitted to NHS England in June • Insight from service users and staff informs weighting of decision-making criteria and influences draft STP • Independent Clinical Senate supports direction of travel, advises on consideration of more radical options for emergency care, obstetrics and paediatrics.
Sep 2016 – Jan 2017 Engagement in STP and options for hospital service change	• Programme of public workshops and staff briefings provides insight on priorities for change and potential implications • Acute clinical leaders narrow down potential options for hospital reconfiguration to two broad models, one model with three variations and one model with two variations • Continued discussions with HWBs and other stakeholders **Outcomes** • Full STP published with public summary, influenced by service user feedback • Second review by independent Clinical Senate – commends clear case for change, supports direction, advises on pace of change, "*long term sustainable services should take priority over speed*" • Local clinicians advise further discussion – options appraisal shifted from November 2016 to February 2017.
Feb – March 2017 Options appraisal	• Discussions continue with staff, stakeholders and local groups – over 100 stakeholder meetings and events since March 2016 • Four panels (including service users) consider options for potential hospital reconfiguration **Outcome** • Options appraisal points towards a future model of three hospitals each providing different specialist services, while all three hospitals continue to provide around 95% of hospital care for their local population, including 24 hour A&E. • Local discussions highlight further work needed on operational and practical implications of change. **Quote from stakeholder briefing issued 15 March:**

	While the options appraisal process is an important part of evidence-based planning, there are also a great many operational and practical concerns to address, most of which will benefit from insights from front line staff and local people. This will include details of how a change could be implemented over the next three to four years through a carefully managed and staged approach so that patient safety and care quality is assured at every stage and alongside changes in community care.
April to date	• CCGs agree to form a joint committee to lead system-wide planning and joint commissioning. • Hospital clinical working groups continue to develop detailed clinical blueprints. • Programme Executive reviews timescales.

2.2 **Recap on the Mid and South Essex Sustainability and Transformation Plan**

- Plans are in progress to invest in GP, mental health and community services to develop innovation and early treatment that will help people stay well and avoid hospital emergencies. These are specific to each of the five CCGs (e.g. *For Thurrock in Thurrock*), but all five CCGs are working to broadly consistent models of care including:

    - Self-care programmes to support people to stay well for longer
    - Locality based joined up health and care services to extend the range of expertise and care in the community, including a shift from hospital to community where possible
    - Integrated services to provide support at the earliest possible stage to reduce the risk of serious illness, with priority development in complex care, frailty and end of life.
    - Development of urgent and emergency care pathways, including integrated 111, out of hours and ambulance services.
    - Integration and development of mental health services with primary, community and acute hospital care

- The three acute hospitals in Basildon, Chelmsford and Southend are working as one group to meet rising demands. As a group, the hospitals can save money by sharing corporate functions and support services, while clinicians are looking at the opportunities to improve patient care by centralising some specialist services at each hospital.

2.3 **Addressing current local concerns**

There has been considerable local engagement in Thurrock through the work of the CCG and Thurrock Council with *For Thurrock in Thurrock,* as well as the STP wide programme. We are extremely grateful for the support of Thurrock Healthwatch and other local groups.

From this engagement, there are a number of Thurrock service user representatives who are actively involved in the STP Service Users Advisory Group, which played a significant role in the appraisal of options for hospital reconfiguration earlier this year.

Feedback from discussions tends to focus on access to primary care, which informs Thurrock CCG plans, and the sustainability of high quality hospital emergency care.

Some of the main concerns around the potential hospital reconfiguration are addressed in summary below:

- There are no plans to close A&E at any of the three hospitals.

- In all options currently being discussed, there would continue to be an A&E department, supervised by consultants and open 24/7 at each of the three hospitals in mid and south Essex.

- Our A&E departments would continue to respond to unplanned needs, and manage a broad spectrum of illnesses and injuries. The approach to patients would continue, which is to assess, treat and transfer or discharge.

- Similar to current practice, a transfer may be:

    - Back to a GP or other service in the community
    - To another unit within the same hospital for further assessment and treatment
    - To an inpatient ward or specialist centre, which could be in the same hospital or in another hospital
    - In some instances, where it would be safer to do so, people could be taken by ambulance straight to a specialist centre, by-passing the local A&E. Current examples of this include major trauma, head injuries and acute heart attacks.

- The potential hospital configuration for the future includes 24 hour assessment units for older and frail people, children and people who may need surgical or medical care. These units would provide fast access to mental health and social care as well as acute hospital care. They could accommodate an overnight stay if necessary, but would aim to help people avoid a stay in hospital. This would ensure a faster and better response to most of the emergency needs of older people and children, linked to a range of community services for ongoing support if needed.

- All three local A&Es would retain the skills to provide immediate stabilisation and management of all emergencies that arrive at the hospital and, where appropriate, arrange onward transfer.

3. Issues, Options and Analysis of Options

3.1 What could be different in the future?

- Greater emphasis and capability in terms of prevention and early intervention to manage rising risks of serious illness.

- A wider range of expertise available in Thurrock, with joined up services and multi-disciplinary teams to improve capacity in primary and community care.

- A future hospital configuration where around 95% of hospital activity would continue at each hospital, while some specialist services, including some life-saving care, could be consolidated in one or two of the hospitals.

- Emergency inpatient care increasingly separated from planned inpatient care to improve capacity and avoid cancelled operations due to surges in emergencies.

- Current thinking identifies Basildon as having the greater potential to provide a specialist emergency hospital, Southend as having the greater potential to provide a centre of excellence for planned care and Broomfield providing a combination of emergency and planned care.

- The questions that clinicians and partners are currently investigating include:

    - What specialist services could be safely consolidated in a way that would improve patient care and outcomes? There is considerable scope to improve patients' chances of survival and rapid recovery in cardiac, vascular and stroke care, for example.

    - What would be the best way to access these services? When is it better to treat and transfer from a local A&E, and when is it better to transport patients directly to the specialist team?

    - What are the opportunities to consolidate planned inpatient care in one or two centres of excellence?

    - How could we improve patient pathways from preventative care and treatment closer to where people live through to hospital services when needed and back to rehabilitation and support?

3.2 **CCG Joint Committee**

- The CCG Joint Committee, which is due to meet for the first time in July, will lead the PCBC and public consultation.

- Commissioning functions of the CCG Joint Committee cover:
    - Acute services
    - NHS 111 and out of hours services
    - Ambulance services
    - Patient transport services
    - Services for people with learning disabilities
    - Services for people with mental health problems

- Strategic functions include:
    - Delivery of the STP local health and care strategy
    - Decisions on STP wide service configurations
    - Agreement of relevant STP wide patient pathways and restriction policies
    - Leadership of relevant public consultations that affect the whole STP area

3.3 **Next stages of development leading to public consultation**

- The Mid and South Essex Sustainability and Transformation Partnership is developing a pre-consultation business case (PCBC) that will present the case for change and proposed way forward, based on clinical evidence. It will include financial plans and proposed capital investment.

- Subject to national assurance, there would then follow a public consultation.

- The programme is now exploring a phased approach to implementation, where the vision (to separate elective and non-elective and consolidate services where it makes sense to do so) remains the same, but a step-by-step approach is taken to service change.

- Within the hospital trusts, some thirteen clinical working groups are developing patient pathways and clinical protocols for:

    - Emergency and A&E services, including assessment centres
    - Acute admissions e.g. vascular, stroke, renal, cancer surgery
    - Planned care e.g. urology, neurology, ophthalmology, orthopaedics, cancer surgery
    - Paediatrics

- There will be further opportunities for service users and local people to get involved in developing patient pathways before, during and after public consultation.

3.4 **Current timescales**

Discussions with stakeholders on draft PCBC	June – Sept 2017
Completion of PCBC	September 2017
Local regional and national assurance process	Oct – Nov 2017
Consultation programme	Dec 2017 – March 2018
Analysis of outcomes and review of proposals	April 2018
Decisions based on outcome of consultation	May 2018

4. Reasons for Recommendation

4.1 The Health and Wellbeing Overview and Scrutiny Committee is a key stakeholder with a statutory duty to scrutinise health services and public engagement in potential service change. We very much value members' views and advice to ensure meaningful consultation.

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

5.1 The Mid and South Essex STP will contribute to the delivery of the community priority 'Improve Health and Wellbeing'.

6. Implications

6.1 **Financial**

One of the objectives of the STP is to respond to the increasing NHS deficit across mid and south Essex. As a system-wide issue, partners from across the health and care system are involved in financial planning. This will help to ensure that any unintended financial consequences on any partners of what is planned are identified at the earliest opportunity and mitigated.

6.2 **Legal**

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

6.3 **Diversity and Equality**

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

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 seldom-heard groups 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.

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

None identified

Report Author:

Wendy Smith

Interim Communications Lead, Mid and South Essex Success Regime

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Health Overview & Scrutiny Committee
Work Programme
2017/18

Dates of Meetings: 3 July 2017, 7 September 2017, 16 November 2017, 18 January 2018 and 22 March 2018

Topic	Lead Officer	Requested by Officer/Member
3 July 2017		
The Procurement of an Integrated Sexual Health Service for 2018-2023	Andrea Clement / Sareena Gill	Officer
Podiatry Services in Thurrock	Mark Tebbs	Cllr S Little
Update on Mid and South Essex Success Regime / Sustainability and Transformation Partnership (STP)	Wendy Smith	Members
Southend, Essex and Thurrock Dementia Strategy 2017 - 2021	Catherine Wilson	Officers
Integrated Medical Centre Delivery Plan – Phase 1	Rebecca Ellsmore	Officers
7 September 2017		
Primary Care Update	Rahul Chaudhari - CCG	Officers
Joint Committee Across STP Footprint – Implications for Scrutiny Committee – Briefing Note	Mandy Ansell	Officers
Carers Information, Support and Advice Service	Catherine Wilson	Officers
Long Term Conditions Profile Card Update	Monica Scrobotovici	Officers
2016/17 Adult Annual Complaints and	Tina Martin	Officers

Last Updated: August 2017

Representations Report		
Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Plan/ Success Regime for Mid and South Essex	Roger Harris	Officers
16 November 2017		
2018/19 Budget Setting Update	Carl Tomlinson	Officers
Fees & Charges Pricing Strategy 2018/19 (Adults)	Carl Tomlinson	Officers
Basildon Hospital – Update on number of complaints	Tom Abell	Members
Non-Residential Charging Options	Ian Kennard	Officers
21st Century Residential Care Strategy	Roger Harris	Members
Tilbury Accountable Care Partnership	Ian Wake	Officers
Annual Public Health Report	Sarah Hurlock	Officers
18 January 2018		
Learning Disability Health Check	Jane Itangata, CCG	Members
Thurrock First	Tania Sitch	Members
Business Case for Tilbury Integrated Medical Centre	Roger Harris	Officers
Living Well in Thurrock	Ceri Armstrong	Members
Update - Action Plan for Dementia	Catherine Wilson / Mark Tebbs	Members
General Practitioner 5 Year Forward Review	Mandy Ansell, CCG	Officers
22 March 2018		

Cancer Deep Dive Update	Funmi Worrell (Public Health)	Members

Future reports:

- Formal consultation on Orsett Hospital
- Business Case for Success Regime

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