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

Health and Wellbeing Board

The meeting will be held at **1.00 pm** on **19 July 2017**

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

Membership:

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

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

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes **5 - 14**

Minutes To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 15 March 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 Declaration of Interests

5 Air Quality Strategy

Item will be presented to the Board through a PowerPoint presentation that will be delivered by Fred Raphael, Transport Development Manager Thurrock Council

6 ESR / STP Update

Item will be presented to the Board through a PowerPoint presentation that will be delivered by Wendy Smith Interim Communications Lead, Essex Success Regime

7 Transforming Care Programme **15 - 24**

Board members have been provided with a report with the meeting papers. This item will be presented by Mark Tebbs, Director for Commissioning, Thurrock Clinical Commissioning Group.

8 Dementia Strategy **25 - 70**

Board members have been provided with a report in the meeting papers.

Item will be presented by Mark Tebbs, Director of Commissioning, Thurrock Clinical Commissioning Group

9 Health and Wellbeing Strategy Annual Report **71 - 108**

Board members have been provided with a report and a draft copy of the Health and Wellbeing Strategy Annual report in the papers for

this meeting. Item will be presented by Ceri Armstrong, Strategy Officer, Thurrock Council

10 Health and Wellbeing Board Terms of Reference **109 - 116**

Board members have been provided with a report within the meeting papers. This Item will be presented by Ceri Armstrong, Strategy Officer, Thurrock Council

11 Health and Wellbeing Board Executive Committee and Integrated Commissioning Executive Minutes **117 - 122**

12 Work Programme **123 - 128**

Board members are asked to note that a Special Health and Wellbeing Board meeting is being arranged to consider the Better Care Fund.

The meeting previously scheduled for Wed 20 Sept 2017 has been amended to Friday 22 September 2017

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - Commissioning by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **11 July 2017**

This page is intentionally left blank

Information for members of the public and councillors

Access to Information and Meetings

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

Recording of meetings

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

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

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

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

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

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

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

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

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

Thurrock Council Wi-Fi

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

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

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

Evacuation Procedures

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

How to view this agenda on a tablet device

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

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

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

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

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

↓

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

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

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

1. Create a great place for learning and opportunity

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

2. Encourage and promote job creation and economic prosperity

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

3. Build pride, responsibility and respect

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

4. Improve health and well-being

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

5. Promote and protect our clean and green environment

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

Minutes of the Meeting of the Health and Wellbeing Board held on 15 March 2017 at 1.30 pm

Present:	Councillors James Halden (Chair) and Susan Little Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group Liv Corbishley, Lay Member for Public and Patient Participation NHS Thurrock CCG Kristina Jackson, Chief Executive Thurrock CVS Kim James, Chief Operating Officer, Healthwatch Thurrock Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust Rory Patterson, Corporate Director of Children's Services Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust Ian Wake, Director of Public Health
Apologies:	Councillors Robert Gledhill, Leslie Gamester, Steve Liddiard, Dr Anjan Bose, Carey, Steve Cox, Foster-Taylor, Roger Harris, Rogers and Stapleton
Did not attend:	Dr Anand Deshpande, Chair of Thurrock CCG David Archibald, Independent Chair of Local Safeguarding Children's Board
In attendance:	Andy Vowles, Programme Director, Essex Success Regime (ESR) and Sustainability and Transformation Plan (STP) Anita Donley Chair ESR/STP Executive Board Tom Abell (Deputy Chief Executive, BTUH) Gemma Curtis (Thurrock CCG) Jeanette Hucey (Director of Transformation, Thurrock CCG) Funmi Worrell, Public Health Registrar Helen Horrocks (Strategic Lead Commissioner for Public Health) Kevin Malone (Public Health Manager) Emma Sanford (Strategic Lead- Health and Social Care public Health) Ceri Armstrong (Senior Health and Social Care Development Manager)

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 Board held on 18th January were approved as a correct record.

2. Urgent Items

There were no urgent items provided in advance of the meeting. Cllr Halden congratulated Mandy Ansell on being appointed as Accountable Officer for Thurrock CCG.

3. Declaration of Interests

There were no declarations of interest.

4. ESR / STP Update

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

- Focus was on the acute side of the programme and options appraisal.
- STP Plans have been published and are available on the success regime website
- The Programme comprises three main blocks:
    - Live well, focussed on prevention and self-care
    - Localities
    - 3 hospitals working together as a group overseen by Clare Panniker as Chief Executive Officer and therefore accountable officer at all three Trusts. Shared Executive team beginning to look at Clinical Teams and their functions.
- The vast majority of services across all three hospitals are unlikely to change
- 5 Options were assessed against four criteria outlined in the presentation (Quality outcomes and Safety, Workforce, Access, Efficiency and Productivity)
- Next steps will comprise, developing the business case and submitting it to the Programme Board for consideration. The business case will be subject to approval from the CCG Board, be considered as part of a national assurance process and consultation with members of the public.

During discussions the following points were made:

- Board members were informed about an initial consultation event that took place in Southend on Tuesday 14 March and a subsequent consultation event which took place at the Beehive during early March. The event provided the opportunity to discuss different models with the public.
- Board members were keen to ensure that future consultation events are publicised widely and take place to ensure a wider group of the community can attend. Board members were reassured that future consultation activity will be promoted and publicised through social media and other methods to ensure that patients, staff and partners can actively engage and inform the future direction.
- It was confirmed that the CCG is statutorily responsible for approving the business case and leading consultation activity. Any plans will require approval from the CCG Board. Board members were reassured that the Health and Wellbeing Board will be provided with opportunities to inform and influence the direction of travel of the STP.

RESOLVED:

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

5. Item in Focus: Health and Wellbeing Strategy Goal 5, Healthier For Longer

Ian Wake introduced the item as corporate sponsor for Goal 5 by explaining that the Health and Wellbeing Strategy contains five Strategic Goals. The Item in Focus for this meeting Goal 5 (Healthier for Longer) comprises four objectives:

- 5A Reduce Obesity, increase the number of people in Thurrock of a healthy weight
- 5B Fewer people in Thurrock will smoke
- 5C The identification and early treatment of long term conditions such as diabetes or high blood pressure will be significantly improved
- 5D More cancers will be prevented, identified earlier and treated better

Action Plan 5A was presented by Helen Horrocks, (Strategic Lead Commissioner for Public Health). During the presentation the following points were made:

- The national trend shows and increase in obesity
- An obesity systems map was included within the Forsyth report, published in 2007
- There are over 100 variables that influence obesity including:
    - Individual psychology including stress, role modelling and food literacy
    - Activity environment and access to opportunities to increase physical activity, what it costs to get active, perception of danger such as can we cycle
    - Individual activity
    - Societal influences such as education, media and TV watching
    - Food production such as the availability and cost of healthy food
    - Food consumption
    - Biology

During discussions the following points were made:

- It is important to consider the types of shops that are available, particularly in more deprived areas.
- Schools in Birmingham restricted pupils from leaving the premises during lunchtimes which supported healthier eating by reducing opportunities to access local fast food shops.
- It is important to note that Air Quality may impact on the likelihood of an individual participating in outdoor exercise and the benefits of that exercise
- Public feedback received from Thurrock Healthwatch was the need to make healthier food more readily available and an increase in cookery classes as part of helping people to make the right choices. There may be opportunities to create pop up shops that link with owners of allotments who cannot donate food to food banks.

- The importance of working in partnership with schools to tackle obesity and encourage healthy eating was acknowledged by members.

Action Plan 5B was presented by Kevin Malone (Public Health Manager). During the presentation the following points were made:

- The What About Youth (WAY) survey 2014, states the combined occasional and regular smoking prevalence is 4.7%. The WAY national average is 8.2%. We think we can achieve a 1% reduction in the regular and occasional prevalence and a 6% reduction in the ever smoked prevalence rate by 2021.
- Reduce adult smoking prevalence by 1% per year. Achieve below national average of 16.9%. We will achieve this by focussing on those most in need:
    - People with Long Term Conditions
    - Pregnant mothers
    - People experiencing mental health difficulties
- We have also been involved in initiatives including tackling counterfeit tobacco which provides high impact at a low cost.
- Emerging evidence shows that the use of e-cigarettes is less harmful to individuals than tobacco.

During discussions the following points were made:

- It will be important to consider how to enforce no smoking areas such as within hospital grounds and outside of public buildings.
- One example was in Manchester involved children helping to change the behaviour of their parents. This was done by children creating signs encouraging parents not to smoke outside of the school playground, which produced positive results.
- It will be important for people not to normalise smoking by increasing use of e-cigarettes
- The Chair advised that he would welcome more evidence on the benefits of using e-cigarettes and whether they are a sustainable option for Thurrock.

Action Plan 5C was presented by Emma Sanford (Strategic Lead- Health and Social Care public Health). During the presentation the following points were made:

- Within each GP practice individuals have been identified who have hypertension. There are also a number of people that are estimated to have hypertension but have not yet been formally identified.
- During the period 2014/15 there are a number of patients that have been diagnosed with Atrial Fibrillation, also known as an irregular heartbeat, who had not been prescribed an anti-coagulant.
- We are currently working with GP practices across Thurrock to improve their QOF results. QOF comprises a set of indicators that show how well patients' conditions are being managed.
- A new long term conditions profile card has been developed in partnership with GPs across Thurrock. This will enable comparatives to be made between practices on how well long term conditions are being managed, facilitating the sharing of emerging effective practice.

During discussions the following points were made:

- It is important to consider how to engage a wider group of partners to support GPs and provide accessible community based services. This might include pharmacies, community hubs and health living centres proactively checking blood pressure for patients.
- Board members welcomed the development of a GP score card to measure the management of long term conditions.

Action Plan 5D was presented by Funmi Worrell, Public Health Registrar. During the presentation the following points were made:

- Preventing and Treating Cancer has traditionally been a challenge within Thurrock
- A cancer deep dive took place in November 2015 and subsequent recommendations are being reflected and taken forward.
- The current approach for identifying and treating cancer focusses on:
    - Prevention of smoking
    - Improved cancer screening
- The 62 day cancer standard improvement plan has been created and addresses the issue of limited diagnosis capacity to increase referrals and consultancy capacity deficits in Essex
- A Cancer Implementation Group has been established that meets every six weeks. 4 Key Performance Indicators have been developed that focus on:
    - A 62 day treatment standard
    - Cancer diagnosis through emergency routes
    - Colorectal cancer screening update rates
    - Improvements in one year survival rates from breast cancer

The Health and Wellbeing Board welcomed the presentation and positive action being taken to improve the identification of cancer and early treatment.

RESOLVED:
Action plans developed to support the achievement Thurrock's Health and Wellbeing Strategy Goal 5, Healthier for Longer were agreed.

The setting up of a review meeting for all of Thurrock Health and Wellbeing Strategy Goals was agreed.

6. Thurrock Better Care Fund Section 75 Agreement

Ceri Armstrong, Senior Health and Social Care Development Manager, provided the Board with a progress report on the Better Care Fund which included:

- The Council is still to receive the final Better Care Fund guidance. Draft Better Care Fund guidance states that areas will be required to produce two-year Plans. As a result and if this is confirmed, the section 75 agreement for 2017 will also span a two-year period. Cabinet has been asked to agree to the Council entering in to the Better Care Fund Section 75 Agreement over a two-year period: 2017-2019. This will be subject to the Council's annual budget setting arrangements, and any changes to the Section 75 can be made with agreement of both parties – Thurrock Council and NHS Thurrock CCG.
- Draft guidance outlines expected changes for 2017 which include:
    - Plans to span two-years;

    - Number of national conditions reduced from 8 to 3 – i) plans must be agreed by the Health and Wellbeing Board with minimum contributions met, ii) maintenance of social care via CCG contributions, and iii) ring-fenced amount for use on NHS out-of-hospital commissioned services;
    - Additional contributions to the Fund from the Improved Better Care Fund (announced in the 2015 Spending Review) over the next three years; and
    - Expected to act as an Integration Plan.
- The Council as host of the Fund enters into contracts with third party providers – namely NHS providers. The standard NHS contract is used for these services with the Council becoming an equal commissioning partner. This arrangement will continue in to 2017-19 with the majority of the Fund likely to relate to existing NHS contracts.

RESOLVED:
The Health and Wellbeing Board noted the arrangements for entering into a Better Care Fund Section 75 Agreement for 2017-19 and agreed to convene a special Health and Wellbeing Board meeting to agree the final BCF plan, if necessary.

7. For Thurrock in Thurrock

Jeannette Hucey (Director of Transformation, Thurrock CCG) and Ceri Armstrong (Senior Health and Social Care Development Manager) provided the Health and Wellbeing Board with an update on For Thurrock in Thurrock which included:

- For Thurrock in Thurrock is the umbrella brand for developing a collaborative approach across the local health and care economy
- Developing alternative delivery models and expanding market choice
- Working in partnership with the public to identify and provide the best solution for them
- Is flexible enough to respond and adapt to the public and neighbourhood's changing circumstances
- The majority of the support that people need will be accessible from within their neighbourhood and as a result they will need to access health and care services less frequently

RESOLVED:
The Board noted and welcomed the approach being adopted as part of the For Thurrock in Thurrock programme.

8. Thurrock Provider Partners Out of Hospital Services Proposal

Malcolm McCann Executive Director of Community Services and Partnerships, South Essex Partnership Foundation Trust presented this item. Malcom's presentation included:

- Establishing an Accountable Care Partnership (ACP) for the locality of Thurrock, but to demonstrate proof of concept by focussing initially on the area of Tilbury, which is one of the four CCG locality areas.
- It is anticipated that the Accountable Care Partnership will evolve into an Accountable Care Organisation over a three to four year period. Clinical and professional care staff across physical health, mental health and social care will be at the centre of driving the change.

- The ACP for Tilbury will aim to transform health and care services in the short term (six to twelve months), and subject to demonstrating proof of concept roll the transformation programme out to the other three locality areas of Thurrock.
- The Executive Partner lead will be Malcolm McCann, SEPT Executive Director of Community Services and Partnerships, who will work with a Thurrock ACP Executive. The precise make up of this executive is to be confirmed. However there is a commitment to ensure that a genuine partnership approach is adopted with one organisation receiving one vote as part of decision making.

During discussions the following points were made:

- This approach provides an opportunity to develop and deliver primary and secondary care in a completely different way.
- The approach is underpinned by the 5 year forward view for Primary Care.
- The new approach provides opportunities to develop a common understanding of how services will be delivered, provides potential to pool budgets and to realign services.
- Partnership working enables and encourages partners to adopt and consider a whole system approach, changing from the traditional organisational approach.
- It is important to consider potential conflicts of interest and ensure that the governing body is not responsible for commissioning and providing services

RESOLVED:
The Board agreed to receive a further update at a future Health and Wellbeing Board meeting

9. Evidence on the use of Primary Care HUBs

Mandy Ansell, Accountable Officer, Thurrock CCG introduced the item and explained that £750,000 had been used to put in place out of hours primary care hubs.

Gemma Curtis, Locality Manager, Primary Care, Thurrock CCG explained that:

- The Thurrock Health Hubs provide additional pre-booked access to Primary Care services in Thurrock.
- In May 2015 the first of the 4 weekend health hubs opened in Corringham, closely followed by Tilbury in June 2015, Grays July 2015 and finally South Ockendon in October 2015. All 4 hubs offer 2 sessions per week, initially these were on Saturdays and Sundays. The locations of the hubs were arranged by Thurrock CCG's 4 geographical localities:
    - Corringham
      Neera Medical Centre
    - Tilbury
      Tilbury Health Centre
    - Grays
      Thurrock Community Hospital
    - South Ockendon
      Purfleet Care Centre

- In 2015/16 the hubs offered 6,102 GP appointments, 3,248 of these were booked. It is thought that the low uptake at the start of the hubs was due to patients not being aware of the service and not knowing what the service offered. Communications regarding the hubs increased in the later part of 2015, this included newspaper articles, posters and hand-outs, and this assisted with uptake increased.
- The service has also been flexible to account for Holiday Periods in both 2015/16 and 2016/17. The hubs have also been able to cover the festive periods to relieve pressure on the Primary Care system.
- The average Did Not Attend (DNA) rate for the hubs is 3.5%. The average percentage of DNA rates within practice in Thurrock is 4.6%. The hubs have found that by booking appointments closer to the date, and not 4 weeks in advance the DNA rate is lower than the practice average.

During discussion the following points were made:

- The Board would like future reports to include the name of GP Practices instead of practice codes.
- Board members requested that future reports separate practices who legitimately do not refer patients to primary care hubs from those that are reluctant to do so.
- It would be helpful for the Board to know the impact that Primary Care Hubs have had on accident and emergency admission rates. It is important that accident and emergency departments refer individuals to the out of hours primary care hubs and not provide treatment when not essential.
- Anecdotal feedback suggests that some people do not wish to use out of hours primary care hubs as they like continuity of treatment with their own GP.

RESOLVED:
Members noted the report regarding the Thurrock Health Hubs and the progress to date.

10. Establishment of a Primary Care Improvement and Delivery Group

Councillor Halden introduced the proposal to create a Primary Care Improvement and Delivery Group and explained that:

- He remains committed to delivering strong political leadership across the Primary Care landscape, in conjunction with key partners including NHS Thurrock CCG and NHS England, to improve the capacity and quality of Primary Care provision in Thurrock.
- NHS Thurrock CCG has had a Primary Care Development Team in place over 12 months. The team has made significant progress in working with and turning around failing GP surgeries.
- The group will act as a joint strategic delivery group between Council and CCG Chief/Senior Officers and Portfolio Holder for Education and Health, with regard to improving clinical capacity and standards within Primary Care in Thurrock and address clinical variation.
- The first meeting will take place in April 2017.

RESOLVED:
The Board agreed the establishment of the Primary Care Improvement and Delivery Group

11. Health and Wellbeing Board Executive Committee Minutes

RESOLVED:
The Board noted the minutes of February's Health and Wellbeing Board Executive Committee.

12. Work Programme

RESOLVED:
The current work programme for the Health and Wellbeing Board was noted.

The meeting finished at 4.45 pm

Approved as a true and correct record

CHAIR

DATE

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

This page is intentionally left blank

19 July, 2017	ITEM: 7
Thurrock Health and Wellbeing Board	
Transforming Care Programme	
Wards and communities affected: None	**Key Decision:** Non-key
Report of: Roger Harris, Corporate Director for Adult Housing and Health Thurrock Council / Mandy Ansell Accountable Officer Thurrock CCG	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Corporate Director for Adults, Housing and Health	
This report is Public	

Executive Summary

This document provides an update on the Transforming Care Programme to the Health and Well Being Board. Transforming Care is a national programmed led by NHS England and the Association of Adult Directors of Social Services in response to the abuse that took place at Winterbourne View Hospital. The programme nationally consists of 48 Transforming Care Partnerships. The local partnership covers the three local authorities and seven CCGS of Thurrock, Southend and Essex.

The objective of the programme is to implement the national service model for people with learning disabilities and / or autism that display behaviour that challenges which was published in October 2015. This should deliver the following outcomes:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community). The target set is to reduce the number of in-patients from 73 in April 2016 to 46 by March 2019
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings.

This document provides an update on the following:

- The scope of the work;
- Updates against the four separate projects across the programme;
- A more detailed update against the critical project that relates to the Adult Specialist pathways;
- Next steps.

1. Recommendation(s)

1.1 That Health and Wellbeing board members note the update and agree to a further update in due course.

2. Scope of the Work

2.1 The core focus for the programme is to implement the national service model for adults with a learning disability and / or autism that display behaviour that challenges. At the same time there are three other strands of work, namely:

- A review of the outcomes and pathways for children with a learning disability and / or autism who display behaviour that challenges to assure that the right support is in place to prevent crisis for these children;
- A review of the pathways for adults with autism only (no learning disability) who display behaviour that challenges to assure that the right support is in place to prevent crisis and address any gaps;
- Implementation of the requirement to undertake a review into all deaths for all children or adults with a Learning Disability (LeDeR).

2.2 To support these projects there is a cross-cutting workstream on Finance. An "Experts by Experience" group consisting of people with learning disabilities and family carers is involved in all aspects of the programme, and a professional reference group consisting of practitioners and clinicians have contributed to the development of the proposed service model and pathways for the adult work stream.

3. Programme Updates Options

3.1 The work to review the pathways and outcomes for children with a learning disability and / or autism consists of the following key steps:

- Analysis of the data to understand the numbers of crises that children with learning disabilities and / or autism experience, comparing these with outcomes for children without a diagnosis of either autism or learning disability. The crises being explored are either an episode of in-patient treatment; a period of time in an independent residential school; or engagement with the criminal justice system
- Some desk-based reviews of cases that have reached crisis to capture the learning about what could have been done differently at the point of crisis (T-1), in the year leading up to the crisis (T-2) and earlier than one year before the crisis (T-3)
- Interviewing a number of families and individuals who also experienced crisis to capture their views and experiences. An independent organisation has been commissioned to undertake this work
- Mapping current service and referral pathways to identify any gaps, duplication or potential for better alignment / closer working.

3.2 The project is planned to finish with a workshop event in October to agree the findings and recommendations from these strands of work. The approach has been co-produced with parents / carers who sit on the project board for this work. There are key dependencies to other projects including the SEND reform, and Mental Health transformation.

Adults with Autism only pathway reviews

3.3 The approach to the work to review pathways for adults with autism only is following the same steps as the work across the children's pathways, namely:

- A review of the data
- Some desk-based review of cases that reached crisis
- Some interviews with individuals who have ended up in the criminal justice system; or admitted to an in-patient facility; or experienced another crisis.
- Review of the existing service and referral pathways.

3.4 The timing for the completion of the work is also a similar timeframe and is also being delivered alongside the Autism Partnership Boards from the three Local Authorities.

LeDeR

3.5 A paper has been presented at the Childrens Safeguarding Board and the Adults Safeguarding Board outlining the scope and progress in implementation of the LeDeR. The estimate is that there are about 70 deaths every year across Southend, Essex and Thurrock for people who have a learning disability. The objective of the LeDeR programme is to determine any learning about whether any of these could have been prevented through more robust health and care support. As the reviews happen, any findings will be reported back to the Safeguarding Boards.
The first test review is planned for this month looking at the death of a child who had a learning disability. The current planning is that the review process will go live from September.

Adult LD Pathways

3.6 The core project is to implement the national service model and reduce the numbers of people with learning disabilities and / or autism who are in hospital. The update covers the following:

- Summarises the achievements and successes during 2016/17
- Outlines the key differences between the current model and the proposed future model
- Outlines the next steps and timeframes.

3.7 As a Partnership across Southend, Essex and Thurrock the project has had some notable achievements during 2016/17. In particular:

- We have discharged 35 people with LD and / or Autism from in-patient settings, including 9 who had been in hospital for over 3 years. This includes

one person from Thurrock who has spent almost all their adult life (30 years) in hospital.

- We have commissioned and implemented a pilot “Community Forensic” service which provides support to people who are at risk of offending with support to both enable discharge and avoid the need for hospital admission.
- We have been successful in securing additional funding across the partnership including:
    - over £2 million of capital funding – against a total national pot of £20 million
    - £500,000 of one-off transformation revenue funding from NHS England to fund projects including the new community forensic service.

3.8 The partnership has made good progress, but the next 2 years provide further step-changes in the challenges and complexity of the people who are planned for discharge.

3.9 As we move into 2017/18 the plan is to re-procure the current specialist learning disability health services. This decision is planned for CCG approval in October. This will put in place the appropriate health resources to align to the national service model and in moving to a single contract across the Partnership footprint will also create the efficiencies to sustain enhanced community services including the new forensic function. There are also plans to then address any gaps in community services, notably related to housing and crisis accommodation.

3.10 The table in the appendix provides a summary of the key differences between the current health contracts and the future service that is being proposed.

4. Next Steps

4.1 The table below provides an overview of the next steps for the procurement and the associated timeframes:

Activity	Completion date
Confirmation of the health procurement envelope and financial modelling	End July 2017
Local agreement (sign off) of Collaboration Agreement 1 by CCGs	End August 2017
Completion of the Contract Specification	End August 2017
Completion of procurement documentation	End August 2017
Business Case to TCPB seeking permission to go to tender (inc procurement documentation)	September 2017
Sign off of procurement decision by each of the CCGs	September and October 2017
Tender launch date via Bravo online portal	November 2017
Completion of the stage 2 (Contract Management) Collaboration Agreement by procurement group and distribution	February to March 2018

5. Reasons for Recommendation

5.1 It is vital that Health and Wellbeing Boards across Essex, Southend and Thurrock have an opportunity to influence and remain updated on the local implementation of a national programme.

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

6.1 The Health and Wellbeing Board leads on the community and corporate priority ‘improve health and wellbeing’. It is important that its membership is appropriate to influencing and setting that agenda and allows health and wellbeing in Thurrock to be improved and inequalities in health and wellbeing to be reduced.

7. Implications

7.1 **Financial**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

This report is for the Health and Wellbeing Board’s information. Financial implications will be considered as the programme develops further

7.2 **Legal**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

This report is for the Health and Wellbeing Board's information. Legal implications will be considered as the programme develops further

7.3 **Diversity and Equality**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

This report is for the Health and Wellbeing Board's information. Diversity and Equality implications will be considered as the programme develops further

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):

- Not applicable

9. Appendices to the report

- None

Report Author:

Phil Brown, Essex County Council

Appendix A

Requirements from the National Service Model	What happens now in the specialist LD contracts	What will be different in the new contract
Integrated, community-based, specialist multidisciplinary support to: • support to enable people to access mainstream health and social care services, • work with mainstream services to develop their ability to deliver reasonable adjustments • support to commissioners in service development and quality monitoring • delivery of direct assessment and therapeutic support.	No specific requirements for providers to work as part of community MDT's. No consistent approach to health facilitation across the partnership. No formal role in quality monitoring. The provision of therapeutic support is inconsistent across the TCP and reflects legacy arrangements rather than population need. There are multiple referral routes, IT and EPR systems resulting in fragmented provision and potential patient safety issues.	Contract will require providers to work in partnership with local authority social care teams as part of community MDT's. Consistent approach to health facilitation across the TCP and the monitoring of its effectiveness. (i.e. uptake of AHC's) The provision of therapeutic support will be transparent and mapped against population need. Contracts will be outcome based rather than activity based incentivising more effective and innovative ways of working. Single referral point and reduced risks to patient safety.
Hands-on **intensive 24/7 multi-disciplinary health and social care support** delivered by members of highly-skilled and experienced MDT's with specialist knowledge in managing behaviours that challenge	Intensive Support is only available during office hours in south Essex (9-5 Mon-Fri) and 8-8 Mon-Fri, 9-5 weekends in north Essex.	Intensive Support function will be enhanced to provide a minimum of 8-8 coverage. A&T services will provide an outreach service outside these hours.

Requirements from the National Service Model	What happens now in the specialist LD contracts	What will be different in the new contract
Specialist MDT support for people who have come into contact with or may be at risk of coming into contact with the criminal justice system (i.e. a community forensic function)	ECOS (Community Offending Behaviour Service) is only funded up until October 2018 with national funding.	Community Forensic capacity will be part of new contract.
High quality assessment and treatment in **non-secure hospital services** with the clear goal of returning them to live in their home. This should be integrated into their broader care and support pathway.	South has more A&T beds than north Essex despite smaller population. South CCGs spend similar levels on A&T and Community, whereas the north CCGs invest 3x more in community than A&T. All beds require modernising to be fit for purpose.	Reduction of 2 A&T beds in south Essex. Greater investment in community services in south. All A&T services will be expected to meet national standards (i.e. AIMS accreditation) Contract length will enable provider to invest in the in-patient building infrastructure. Contract will include a small number of longer term beds where there are issues of supply, quality or cost.
People should have choice and control over how their health and care needs are met, including expanded use of Personal Health Budgets and Integrated Budgets.	No ability to develop the offer due to funding being constrained within current block contacted arrangements.	An ability to re-structure the funding over the length of the contract to develop a clear PHB offer and potential for Integrated Budgets.

Requirements from the National Service Model	What happens now in the specialist LD contracts	What will be different in the new contract
People should be supported to have good everyday lives including access to employment, social and sports & leisure facilities.	No requirement to employ people with learning disabilities.	Contracted requirement to employ people with learning disabilities within their workforce. Contracted requirement to work in partnership with community and Third sector organisations to develop innovative solutions that deliver health outcomes.

This page is intentionally left blank

19 July 2017	ITEM: 8
Health and Well Being Board	
Southend, Essex and Thurrock Dementia Strategy 2017 - 2021	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Catherine Wilson Strategic Lead Commissioning and Procurement and Mark Tebbs Director of Commissioning	
Accountable Head of Service: Les Billingham Head of Adult Social Care	
Accountable Director: Roger Harris Corporate Director Adults Housing and Health and Mandy Ansell Accountable Officer Thurrock CCG	
This report is Public	

Executive Summary

The Southend, Essex and Thurrock Dementia Strategy 2017-2021 is a collaborative piece of work between people living with dementia, their carers, the three Local Authorities and the seven CCG's within Greater Essex. The vision for future development detailed in the strategy is:

People living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain physically and emotionally healthy for as long as possible.

Dementia is a term which can cover a range of symptoms that have resulted in damage to the brain. This damage can affect memory, attention, communication, problem solving abilities and behaviour. People living with dementia may also experience depression, aggression, and wandering. Each person's experience of dementia is different and it's progression for each individual can be at very different paces.

The strategy is a response to a growing understanding that the range of support available for people living with dementia across Greater Essex is fragmented and perceived as difficult to access by those requiring it. The strategy sits alongside the Southend Essex and Thurrock Mental Health and Well Being Strategy supporting a comprehensive all age vision for positive mental health across Greater Essex.

The Southend, Essex and Thurrock Dementia Strategy is also building on the National Dementia Strategy: Living Well with Dementia published in 2009,

which focused on improving the care and experiences of people with dementia and their carers.

1. Recommendation(s)

1.1 That Heath and Well Being Board agree to recommend that Thurrock Council and Thurrock CCG endorse the Southend, Essex and Thurrock Dementia Strategy 2017-2021

1.2 That Health and Well Being Board agree that a local Thurrock implementation plan is developed to deliver the Dementia Strategy in Thurrock with a specific focus to review all care options and to the quality and capacity of our residential /nursing home provision in Thurrock and how that can be improved and a wider offer considered.

1.3 That the implementation plan is brought back to Heath and Well Being Board for consideration.

2. Introduction and Background

2.1 Thurrock Council and Thurrock CCG have and continue to be very proactive is raising awareness of dementia and supporting those living with dementia and their carers. The South Essex Dementia Strategy 2014 to 2017 has delivered and supported a number of initiatives in Thurrock. Thurrock is a dementia friendly Council and dementia friends training has been made available to all employees and Councillors, this has been widely taken up and has resulted in Thurrock Council being recognised as a Dementia Friendly Council. The training is ongoing delivered by the Alzheimer's Society and is open to anyone within Thurrock to attend. On the 22nd June 2017 the Alzheimer's Society held an awareness raising stall at the Civic Offices one of many events frequently held across Thurrock. Thurrock Council and Thurrock CCG jointly fund the Alzheimer's Society to deliver a number of services including a memory clinic, Dementia Café's, and a motivational men's group. The Alzheimer's workers are co-located in the Civic Offices within Adult Social Care. The funding for the Alzheimer's Society has recently been increased by Thurrock Council and Thurrock CCG recognising the growing need.

2.2 The new Southend, Essex and Thurrock Dementia Strategy has been developed to continue and expand on this positive work. There are five main elements that underpin the approach within the strategy; the first is that there are great benefits in working across Greater Essex to develop a strategic approach. The second area is the development of a new model of specialist support which will develop a clearer pathway from early intervention to diagnosis and ongoing support. The third element which clearly builds on our local successes is to ensure that support is personalised, empowering and delivered within local dementia friendly communities. Fourthly using assistive technology imaginatively and creatively can offer support around safety and independence within a family and community environment delaying and reducing the need for wider service intervention supported by the Care Act

2014. Finally the voice of those with lived experience is essential to develop the local implementation plans that will come from the overall strategy.

2.3 The Southend, Essex and Thurrock Dementia Strategy lays out nine priority areas of work which Thurrock Council and Thurrock CCG fully support. These nine priorities are focused on improving the lived experience of those with dementia and their families and carers by addressing the fragmentation of response and lack of understanding of dementia. It is important that the pathway for those living with dementia is clear and where services are required accessible. Working across Greater Essex may offer some opportunities to work together particularly around timely diagnosis, building a knowledgeable and skilled workforce and reducing risk of crisis. As yet the local implementation plan has not been developed however it is clear that we would want to ask for support from Healthwatch and the wider voluntary sector to ensure that those living with dementia and their cares are guiding how support should be available in Thurrock, from statutory health and social care services to living well with dementia in local communities. The nine priorities are detailed on pages 9, 10 and 11 of the strategy attached at appendix 1. For reference the priorities are as follows, early intervention and prevention, making available good information and advice, developing a clear diagnostic pathway with ongoing support. Supporting people living with dementia to be full members of an understanding community, supporting carers and reducing risks with good education, training and emergency planning. Living well in long term care which may be residential care. Developing positive end of life planning and care. Ensuring the workforce has the skills to support those living with dementia. The delivery of these priorities are framed in measures of success, within our Thurrock Implementation plan we would want to build on these to have measures of success specific to Thurrock.

2.4 The implementation plan at the close of the strategy will require further revision once we have developed the Thurrock Local Implementation Plan and we are clear that a number of areas will be more locally focussed.

3. Issues, Options and Analysis of Options

3.1 The Southend, Essex and Thurrock Dementia Strategy 2017 – 2021 offers opportunities to work closely together across Greater Essex to utilise economies of scale for service development where appropriate.

3.2 There is no additional funding available and the Local Implementation Plan will need to address reinvestment of current resources creatively and imaginatively.

4. Reasons for Recommendation

4.1 That the Southend, Essex and Thurrock Dementia Strategy 2017-2021 is endorsed by Thurrock Council and Thurrock CCG as a positive response to

the growing numbers of people living with dementia and the need to ensure a continued personalise approach to support and care.

4.2 The strategy will support the development of a locally focussed implementation plan enhancing what is already happening in Thurrock and developing that further.

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

5.1 The Strategy has been developed in consultation with individuals with lived experience of dementia and their carers together with the voluntary sector and other services across Greater Essex. This was not extensive in Thurrock and we are clear that as we move forward with the local implementation plan wider consultation will take place building on the nine priorities and focusing on what is important to people in Thurrock.

5.2 A report was presented to Health and Well Being Overview and Scrutiny Committee on the 3rd July 2017.

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

6.1 Thurrock Council is already a Dementia Friendly Council meaning that Offices and Councillors are aware that dementia should be highlighted in the policies and priorities of the wider Council. Dementia Friends training is offered on a regular basis within the Council and to the wider Community which will support the implementation of the strategy as a key priority is a person living with dementia being part of their local community.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant (Social care and Commissioning) Corporate Finance

Currently there are no financial implications for this report. This will be reviewed as the Thurrock Implementation Plan is developed.

7.2 Legal

Implications verified by: **Roger Harris**

Corporate Director Adults Housing and Health

There are no legal implications for this report.

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

It is important that Dementia is viewed as an integral part of the Community of Thurrock, that those living with Dementia are not disadvantaged by the condition and they have continued and where necessary supported access to their everyday lives. The principles within the strategy are a positive foundation for the local implementation plan. A Community Equality Impact Assessment will be prepared alongside the development of the Thurrock strategy to improve equality outcomes. It will be essential to ensure that in any future service development is underpinned by social value opportunities.

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 Southend, Essex and Thurrock Dementia Strategy 2017-2021 - provided alongside this report

Report Author:

Catherine Wilson

Strategic Lead Commissioning and Procurement

Adults Housing and Health

This page is intentionally left blank

Southend, Essex and Thurrock Dementia Strategy (DRAFT)

2017-2021

Version 5.5

7th February 2017

Southend, Essex and Thurrock Dementia Strategy

Table of Contents

Living well with dementia in Southend, Essex and Thurrock,

This strategy is for everybody in Southend, Essex and Thurrock, (Greater Essex), who is living with dementia or supporting someone who is. It describes what we want support for people with dementia to look like in the future and identifies 9 priorities for action to make this happen.

The strategy has been developed in partnership between Essex County Council, Southend on sea Borough Council, Thurrock Council, and Clinical Commissioning Groups across Greater Essex. It sits alongside Greater Essex's Mental Health and Wellbeing strategy, to form a new and comprehensive, all—age ambition for mental health and emotional well-being in our county.

There are real opportunities for change and innovation across Greater Essex to ensure that people have the best support available to live well with dementia. We want to make Greater Essex more inclusive for everyone living with dementia and empower people to live the life they want in the community for as long as possible.

Over the past year Essex County Council has worked with partners to talk extensively to people who live with dementia and worked to develop the understanding of people's current experience of dementia in Greater Essex. The Public Office also produced a report following a range of engagement activity in Greater Essex and this insight was used to inform this strategy.

Southend Borough Council also conducted a wide range of public and stakeholder consultation activities. The key themes identified reflected similar challenges and needs to those across Essex, with some local differences.

These engagement activities highlighted some challenging truths about existing systems, which involve all of the partners above who commission dementia services in their specific geographical areas:

- Systems are fragmented and bureaucratic. The "battle" to find what they need wears carers down and professionals find it difficult to navigate too.
- Services do not consider people as part of a family – or even in partnership with their carer.
- Support is not personalised – and doesn't enable people to maintain their capabilities, interests or relationships
- Systems rely heavily on the carer, but don't support them very well. Carers carry on until they can no longer cope, and then health or care services often need to intervene in the midst of a crisis.

- Carers are often unable to access services when they are available and have few options available over night and at weekends
- Current avenues of support don't help people and families to withstand the emotional pressures they face – stress, relationship breakdown, loneliness
- Existing systems push people towards residential care because they can't find the support they need in the community

These are stark revelations, but ones that emphasise the need and opportunity for change and innovation to ensure that people have the best support available to live well with dementia.

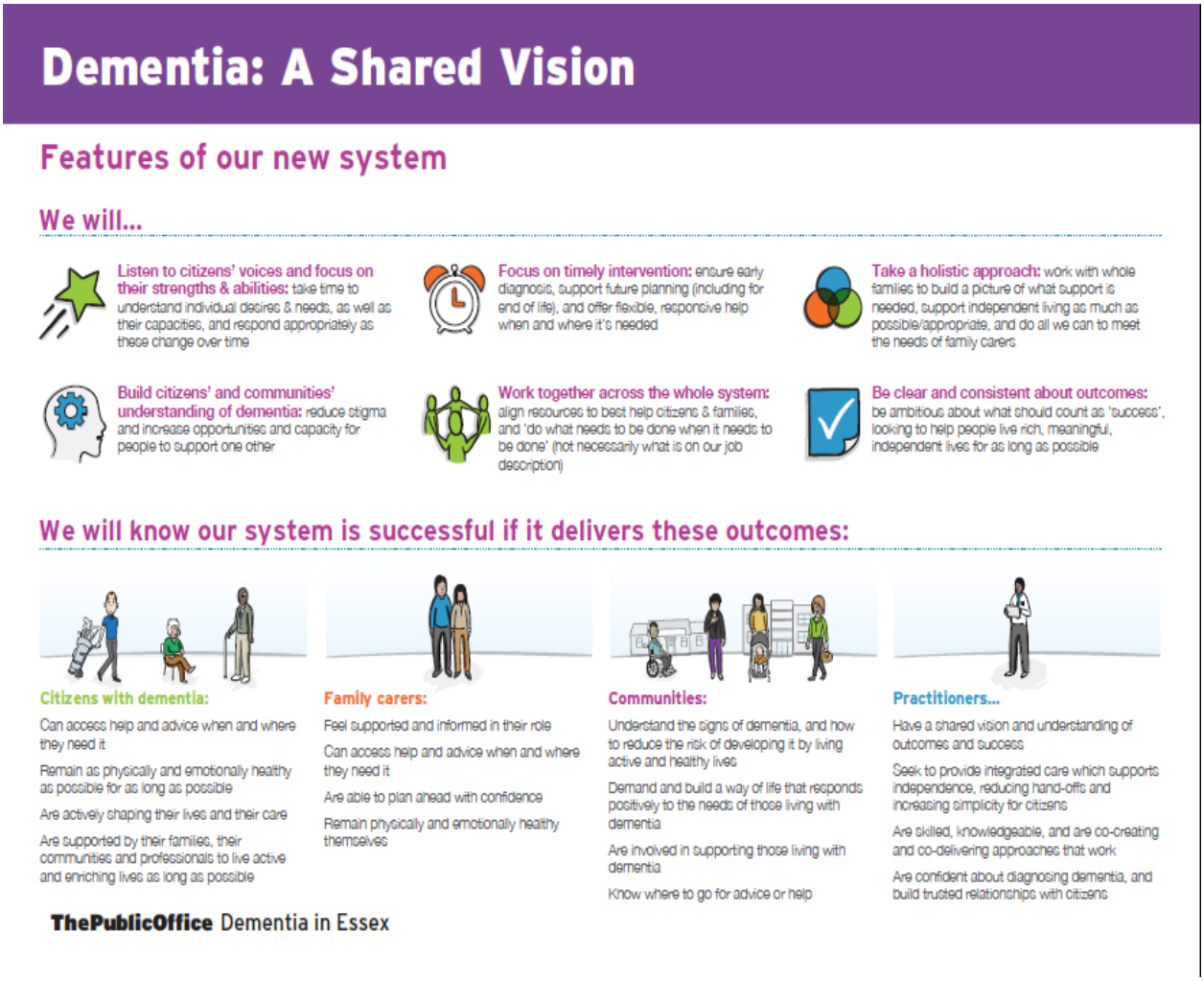
Rethinking dementia: A collaborative enquiry

Vision

Our vision for the future is one in which:

> **People living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain as physically and emotionally healthy for as long as possible.**

Our strategy to achieve this is organised around nine priorities that reflect specific aspects of people's life with dementia. However there are five key elements to our approach that underpin the whole strategy:



1. A joint strategic approach to dementia in Greater Essex

The range of support for people with dementia is fragmented; people often get lost trying to navigate an intricate web of information and services. We know people living with dementia face a spectrum of challenges and have a range of needs; so to achieve our vision it is vital that organisations work together to collectively transform the approach to dementia in Greater Essex.

Our vision aspires to create systems where organisations work towards the same goal; All localities are addressing challenges in both health and social care, and developing Sustainability and Transformation Plans setting the future direction for health and mental health services (including as part of the NHS Success Regime in Mid and South Essex). Supporting people living safely with dementia to remain as physically and emotionally healthy for as long as possible is key to this.

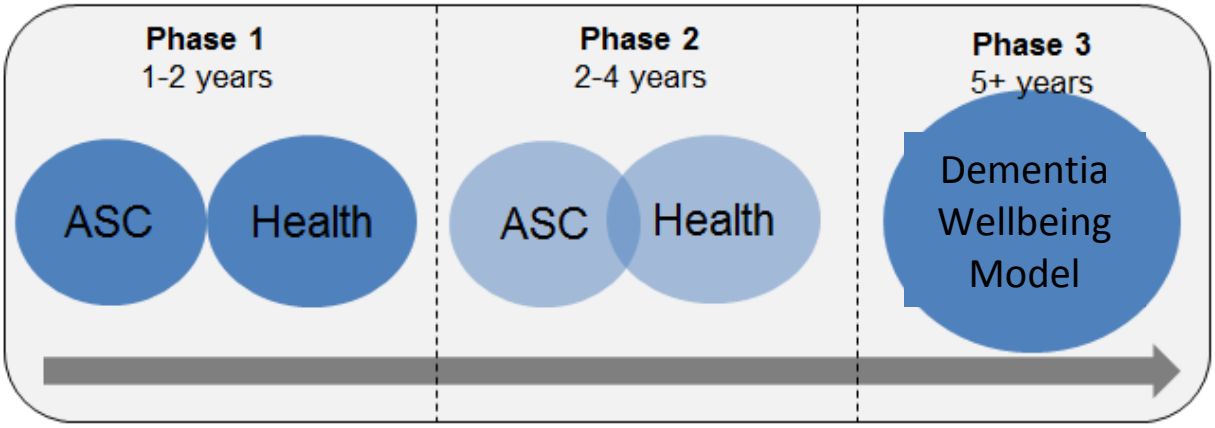
We aim to design systems that reflect the unique local and demographic needs of communities across Greater Essex but are able to;

- support people to receive a timely diagnosis,
- intervene earlier to inform and support people to adapt to a life with dementia and;
- develop communities that are inclusive to people living with dementia.

We want our systems to help families develop support networks to manage, or avoid times of crisis, explore independent living situations and not have to turn to hospital or long term care settings to manage. Collectively, our systems need to be structured to promote solutions that build upon people's strengths and support networks to achieve the outcomes they want, rather than impose service-based solutions.

A single dementia pathway that joins up health and social care services is the aspiration of this strategy; as we recognise the benefits this will bring to people living with dementia and the wider health and social care system. In an agreed locality, we aspire to having a single assessment, a single care plan and clear route to information and support that works around a person, their family and wider network

We recognise the vital role Primary Care play and strive to work with their skills, knowledge and expertise to develop a model that enables closer working between General Practitioners and the wider dementia care system. We recognise these aspirations are transformational changes and plan to approach these changes in phases, to achieve the aspiration of fully integrated models of dementia care within 5 years, across Greater Essex. Equally we recognise these changes should not happen in isolation to the wider health and social care system, and should align with the local priorities set out in Sustainable Transformation Plans as part of the Five Year Forward View.



2. A new model of specialist support

People with more complex needs or challenging behaviours cannot always find specialist advice or support when they need it. The lack of specialist advice can also lead to hospital or residential care admission when this might be avoided. Expertise on dementia tends to be concentrated in services for older people, which is not always appropriate for younger people with dementia or people with learning disability.

An integrated all-age dementia service for those with the most complex needs that will provide specialist advice and support across the Health and social care system in Essex, and possibly Southend , will support those that can sometimes be overlooked by the current system of support.

3. Support that is personalised and empowers people within an inclusive community

People living with dementia want information and support that enables them to adapt, but keep living the life they led prior to their diagnosis. They often feel isolated from the wider community and many feel scared to go out of their home. We think that a community-wide response is needed to address this problem.

Support should build upon a person's strengths, their skills, their qualities and their own resources. We want to empower people to embrace outdoor space, be physically active and take positive risks that enable them to live they life they want to lead. We recognise early intervention is a key part in achieving this; and strive to ensure people have access to timely intervention that enables it to happen. We need to change the culture of assessment, support planning and care, through the "Good Lives" approach (or Live Well, the approach used In Thurrock) to ensure that the person, and their family, are kept at the heart of what we do and enable them to live independently in the community for as long as possible. All people with dementia should be offered a personal budget, where applicable under the Care Act to give them maximum control over the kind of help they receive.

We have established a Pan-Essex Dementia Action Alliance to shape and influence a county wide response to dementia in Greater Essex; and worked with District Councils to form local alliances that can drive change in local towns, villages and Greater Essex Communities. We will continue to grow these alliances and aspire to engage a breadth of organisations across the private, public, community, third, health and social care sectors to commit to ways they will transform the lives of people living with dementia.

In Southend people living with dementia and their carers along with 44 businesses, services and community groups are working in partnership with Southend Borough Council to maintain the 'Working towards becoming Dementia Friendly' status awarded in March 2016. Southend is very fortunate to have a variety of members within the Southend Dementia Action Alliance (SDAA), including the UK's first dementia friendly airport, a committed community support approach from Essex Police Southend and Essex Fire & Rescue Southend. There are examples of dementia friendly support within Health, with a local GP Surgery working towards becoming a dementia friendly practice and a dedicated team of professionals within Southend Hospital creating dementia friendly wards through changing policies and cultures. Building on this work we feel confident that Southend will be a place where people affected by dementia can live their lives with access to the services and support they need to fully participate in community life.

We want Carers to feel supported in their own right and to be respected as partners in care. We will work with Carers to develop a network that enables their loved one but ensures they remain connected to information and support should they need it.

4. Maximise the use of technology

There are a growing number of ways that technology can be used to support people to remain independent, give Carers more freedom and peace of mind and reduce dependence on formal services all of which are outlined in the Dementia Technology. We will work with people to raise their awareness of technology as an enabler to independent living and we will create environments that enable the use of technology. We are working with partners to find and promote new tools that address some of the obstacles to independence faced by people with dementia and their Carers and will align with wider programmes of work taking place across Essex focused on developing digital response to health and social care needs.

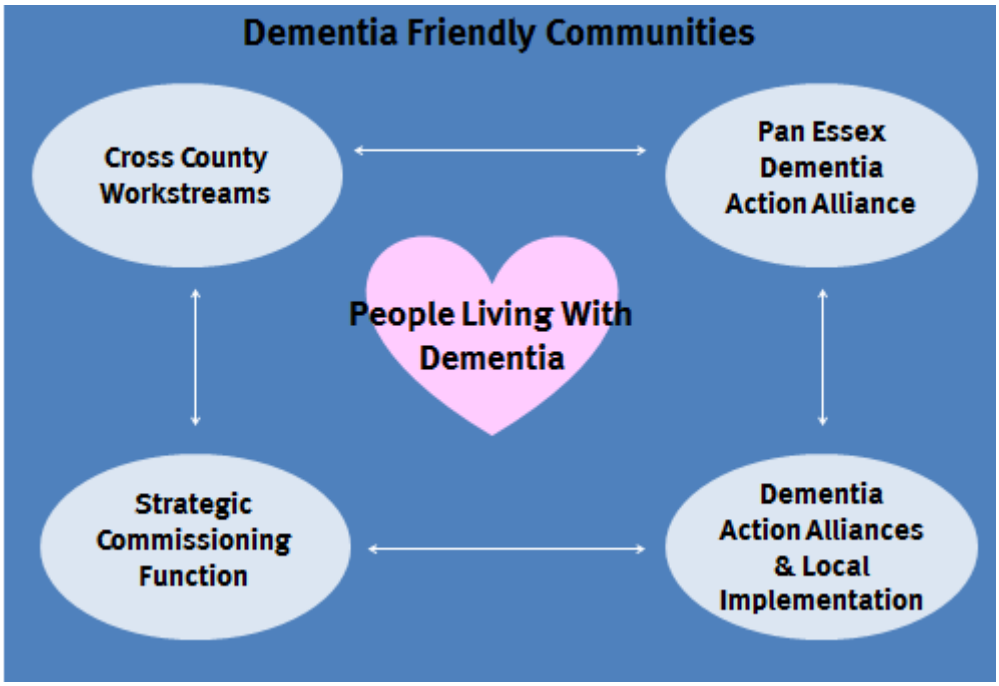
5. The voice of lived experience

We know to really meet the needs of people living with dementia, it's vital we listen to the voice of those living with the condition, not only to better understand the challenges they face but identify solutions to overcoming these challenges. We want to facilitate activity in the community that responds to need, and recognise the only way of doing so is to speak to those that are living with dementia day in, day out. We will involve those living with dementia in helping us achieve the aspirations set out in this strategy and continue to re-visit our vision to ensure the voice of lived

experience not only remains central to the transformation within the system, but helps to measure the impact of the new system. To underpin this strategy a sustainable way of engaging with people, in a relevant and meaningful way, will be developed. This, along with the community response, will be supported through the ongoing delivery of local Dementia Action Alliances and specific user groups to support engagement and to change the messaging around dementia in Greater Essex Communities.

To achieve our vision; and drive forward the actions set out in this strategy we recognise the need to bring together the five key elements listed above, to form a whole systems partnership function. A function that is responsible for mobilising activity, and implementing change but one that is accountable to the wider health and social care infrastructure that it works within.

Future partnership model:



Priorities

We have worked with our partners and through the Public Office engagement, to identify nine priorities that reflect key aspects of the lives of people living with dementia:

We want to intervene earlier to prevent needs from increasing and help people to continue to live independent lives, building on their strengths and the resources available to them within their personal network and the wider community.

For those who need ongoing support, we want to make sure this responds to the needs of individuals and supports the wider family network, with the offer of a personal budget to give them maximum control over their care and support.

Priority	Outcome	Success Measures
Prevention	People in Greater Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.	• Using the Making Every Contract Count approach, people understand the link between healthy and active lifestyles and are able to make positive changes in their lives • People have an increased awareness of Mild Cognitive Impairment • People are aware of how to access information and support should they be concerned about dementia • Increased percentage of people diagnosed with dementia receive an annual face to face review of their health needs, including medication, and whose vital health indicators are checked • People in BAME Greater Essex Communities have increased awareness of dementia and the warning signs. …. • Carers have access to annual health check and have access to Improved Access to Psychological Therapies
Finding information and advice	Everyone with dementia will have access to the right information at the right time.	• A comprehensive whole system Information and guidance offer is available. • People living with dementia will feel supported to navigate the system and access information and support that is relevant to them
Diagnosis and support	All people with dementia will receive appropriate and timely diagnosis and integrated support.	• GP's across Greater Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe • Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process • There is a clear referral pathway to diagnosis with appropriate information and support offered • BAME Greater Essex Communities are accessing assessment and diagnostic services • There is appropriate screening for people who are considered to be at high risk of dementia

		• People with dementia have access to post diagnostic support that is relevant and personalised • People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia, and plan for the future • People are offered a direct payment upon diagnosis of dementia where appropriate
Living well with dementia in the community	All people with Dementia are supported by their Greater Essex communities to remain independent for as long as possible	• There is a whole community response to living well with dementia • Environments and physical settings in the community are dementia friendly • People living with dementia are able to take advantage of open space and nature • The voice of lived experience helps to shape how Greater Essex Communities respond to dementia • People living with dementia are encouraged to access information and support that helps themselves to live well and independently • The lives of people living with dementia in the community are transformed through the DAA activity • Young people are part of the community support for people living with dementia • The market is able to respond to people living with dementia and support them to live well • People with dementia have awareness of alternative accommodation options
Supporting carers	Carers are supported to enable people with dementia to remain as independent as possible	• Carers are a driving force behind shaping the response to dementia in Greater Essex • Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia • Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy • Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges • Carers are able to access a range of opportunities to take a break from their role as a Carer
Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	• All hospitals to aspire to being dementia friendly care settings • People living with dementia, with complex needs such as co-morbidities are offered specialist information and support • Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively • Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments

		• The Community and Primary Care are able to respond to episodes of crisis in care homes appropriately
Living well in long term care	All people with dementia live well when in long term care	• All care homes for people with dementia in Greater Essex will be supported to be dementia friendly by 2020 • People living with dementia, their families and carers understand what high quality care looks like and where to find it • People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings through linking Dementia in to LD health checks • People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting • People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate
End of life	People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes	• People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP • People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate • People are not delayed in being discharged from hospital • People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose • Carers and families receive bereavement support at a time that is right for the individual or family
A knowledgeable and skilled workforce	All people with dementia receive support from knowledgeable and skilled professionals where needed	• There is a framework for dementia training across Greater Essex to ensure all people receive training relevant to their role • To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so. • To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well.

The stages of dementia

"Dementia" is a term that covers a range of symptoms that result from damage to the brain that can affect memory, attention, communication, problem-solving and behaviour. Every individual's "dementia journey" is very different. Some people may live for years without any obvious decline, while others experience rapid deterioration. However there are similarities in the challenges and pressures people experience as symptoms develop.

In the early stage, people may dismiss forgetfulness or difficulty concentrating as normal signs of ageing or attribute disorientation and mood swings to stress. Once symptoms begin to impact on normal life, diagnosis can be a relief but also lead to fear and denial about the future. People may feel a sense of loss, a loss of their identity and the person they believe they once were.

People with dementia say that it is important to feel that their life still has meaning. Some achieve this by maintaining relationships with important people in their lives or by keeping up interests. Others struggle through lack of opportunity, lack of confidence or other barriers. In the Alzheimer's Society Dementia 2014 survey, only 60% said that they left the house every day and 40% said that they felt lonely.

Dementia is a progressive condition which means that the symptoms will become worse over time. People's ability to make decisions about their lives or even day-to-day situations will decline. To compound these problems, a large proportion of people with dementia will also have other medical conditions or disabilities, such as arthritis, hearing problems, heart disease or mobility problems. The Alzheimer's Society found that 72% of respondents to their Dementia 2014 survey were living with another medical condition or disability – some were living with up to twelve conditions.

As the disease progresses, people gradually find normal activities challenging and may fear losing control as they become increasingly dependent on others. People may become depressed and anxious when diagnosed as well as when they begin lose their ability to do everyday things for themselves. In the late stage, people can become totally dependent on others for basic life tasks and this is often when they consider moving into a care home.

Ethnicity

Dementia among black, Asian and minority ethnic (BAME) Greater Essex Communities is significantly under-diagnosed and research by the Social Care Institute for Excellence has found that these groups are less likely to use dementia services. There are low levels of awareness, late diagnosis and a lack of culturally sensitive services. All of which makes it more difficult for people from these Greater Essex Communities to get the support they need. Greater Essex has a relatively small BAME population (5.7% in Essex and 13% in Southend) but the proportion of people receiving services is even smaller (1.2%) suggesting they are under-represented.

Early onset dementia

Care for younger people (ie under 65) with dementia is a challenge. Younger people with dementia face different issues, not least that they are more likely still to be working or have a young family. Support designed for older people with dementia is often not suitable for younger adults. This means that people with early onset dementia can find themselves isolated within the community. Those with more challenging needs can find it difficult to find suitable long term care options with the majority of solutions aimed either at older people or people with learning disability. The majority of people with dementia in Greater Essex are over 70 but 7.5% are younger than this and there are a few are under 30. In Southend 98% of people living with dementia are over 65 and just 38 people are registered under the age of 65.

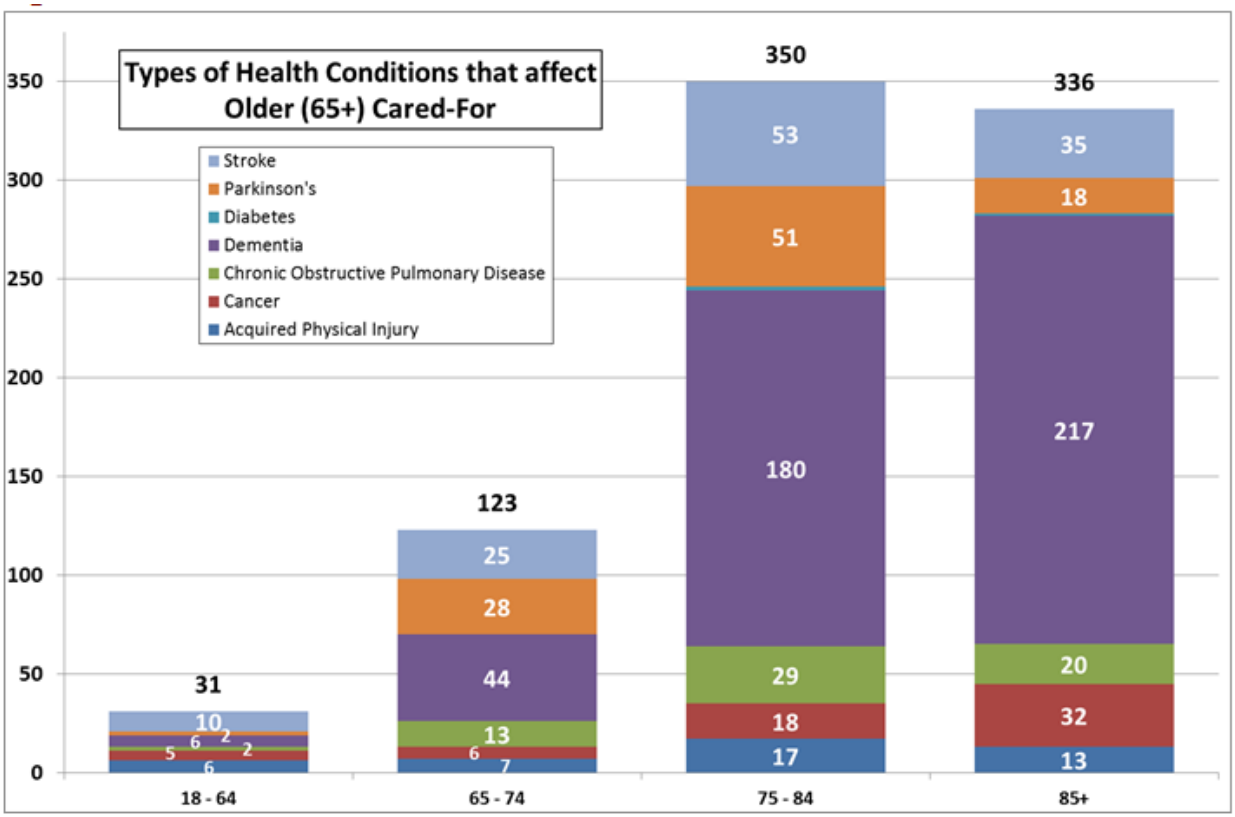
Learning disability and dementia

People with learning disabilities have a higher risk of developing dementia than other people and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s. Symptoms of dementia can present differently so that people often don't recognise changes as being dementia related. Because of this, opportunities for early intervention are lost. In Greater Essex we have found that mainstream diagnostic services are not geared up to assess people with learning disability, are not making reasonable adjustments and often refer people back to learning disability services. Likewise, mainstream dementia services are not geared to support people with learning disability or their carers.

Carers

Over 21 million people in the UK people know close friends or family affected by dementia and it is estimated that one in three people will care for a person with dementia in their lifetime (Prime Minister's Challenge on Dementia). Approximately one third receive no support from either social services or the voluntary sector. In Southend, Thurrock and Essex an estimated 145,000 provide care and support for someone who needs help (not specific to Dementia) with their day to day life of which about 32,000 are estimated to provide care for more than 50 hours per week. We know that over half of people who have approached ECC for a social care assessment have an unpaid family carer and there will be even more in the community who have not yet sought support from us (ECC Dementia Specialist Topic Needs Assessment (2015)). The support of family carers is often crucial to enabling people with dementia to remain in their community. They are often the first to spot changes in the person's health or behaviour and can support communication and sharing of information.

However carers of people with dementia can face a particularly challenging range of symptoms and behaviours that can persist over several years. Research shows that carers of older people with dementia experience greater strain and distress than carers of other older people (Carers Trust: The Triangle of Care: A guide to best practice in dementia care). In addition, many carers are themselves older people with physical frailty and health conditions of their own. The below graph has been taken from data provided at assessment:



Priority 1: Prevention

The issue

The risk of developing dementia increases with age. We estimate there are 19,000 people in Greater Essex with dementia, of which 55.4% are likely to have mild symptoms, while 12.5% are likely to have severe dementia requiring intensive levels of care and support. Most (81%) of people with dementia live in the community. A predicted 34% increase of dementia in Greater Essex (based on Office for National Statistics population projections (2014)) is larger than the national average and has huge implications for the local health and social care system.

According to Alzheimer's Society research (Dementia UK Update 2014), as many as 70% of people with dementia will also have other medical conditions or disabilities, such as arthritis, hearing problems, heart disease or mobility problems. Many will have one or two conditions, some will have far more. This emphasises the importance for people to receive advice and support that is tailored to their needs. The ability to measure awareness around cardio vascular risk factors, and general health and wellbeing will be key in supporting people to think in a preventative way.

The Blackfriars Consensus Statement (2014) made clear that the risk of some types of dementia can be reduced but it cannot be eliminated. There is growing evidence that cardiovascular factors, physical fitness, and diet have a major part to play in keeping the brain healthy and thus reduce the risk of developing dementia in later life. Other lifestyle choices such as not smoking, keeping low cholesterol and blood sugar can also help.

The economic impact of dementia is enormous. The Alzheimer's Society calculate the average annual cost per person with dementia as about £30,000 for those living in the community versus c. £37,000 for those in residential care. For people living in the community, three quarters of the cost relates to the indirect costs associated with the contribution of unpaid family carers. For those people in residential care, £32,700 relates to social care, this is £26.5bn a year, enough to pay for every household's energy bills in the UK. (Source Dementia 2015) Alzheimer's Society.

To maintain independence and quality of life as long as possible, it is essential we prioritise the health and wellbeing of people with dementia and that of their carers and support them to self-manage any co-existing health problems. Social isolation and loneliness can be a significant problem and can lead to anxiety and depression. However in Greater Essex the percentage of those diagnosed with dementia receiving an annual review from their GP or recording of vital health indicators is currently among the lowest in the country.

Outcome: People in Greater Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.

Success measures

- Using the Making Every Contract Count approach, people understand the link between healthy and active lifestyles and are able to make positive changes in their lives
- People have an increased awareness of Mild Cognitive Impairment
- People are aware how to access information and support should they be concerned about dementia
- Increase percentage of people diagnosed with dementia receive an annual face to face review of their health needs, including medication, and whose vital health indicators are checked
- People in BAME Greater Essex Communities have increased awareness
- Carers have access to annual health check and have access to Improved Access to Psychological Therapies

Priority 2: Finding information and advice

"There's so much information … where am I supposed to start?"

"I have been given a lot of information, cannot make head nor tail of it and not sure what it all means…"

"It is difficult for carers to find out what help is out there and how to access it." Counsellor

The issue

Information and advice is fundamental to enabling people, carers and families to take control of their care and make well-informed decisions about the support they need. We need to help people find and connect to resources and support that will help them get on with their life and develop technological solutions that make it easier for them to do this. However people tell us that they struggle to navigate the large amount of information available about dementia and identify the right support in their area. This can be really distressing when people are at a vulnerable point, such as when they have just received a diagnosis or when they have an immediate need for help. The offer of information and advice needs to be personalised because people will have different preferences for how they want to receive information.

GPs and their surgeries can be key sources of information but the quality and availability of information available is variable. From April 2015, everyone with dementia should have access to a named GP with overall responsibility for their care.

Outcome: Everyone living dementia will have access to the right information at the right time.

Success measures

- A comprehensive whole system Information and guidance offer is available.
- People living with dementia will feel supported to navigate the system and access information and support that is relevant to them

Priority 3: Diagnosis and assessment

"Getting a diagnosis took so long. It was a huge relief when it finally came … I knew then I wasn't

imagining it. We could start to make plans."

"I was given this devastating news, given a folder of stuff and left to get on with it in the darkness."

"At the point of diagnosis we need someone who is there for the family. Not just bits of paper and a crisis line. … We need practical, real advice from someone who knows what we're experiencing. … Someone who can walk you through it and who can say "well done" … Carer

The issue

Early diagnosis of dementia is vital because it helps people to understand what is happening to them, make plans and gain access to the most appropriate support and treatment. Some professionals can be reluctant to refer people for diagnosis because of a perceived lack of post-diagnostic support, amongst other reasons. In Essex, 52% of the estimated dementia population have a diagnosis. In Southend the diagnosis rate at December 2016 was 72.6%. The national target is 67%.

Some groups are at higher risk of not being diagnosed. Greater Essex has a relatively low BAME population (5.7%) but the proportion of people of BAME origin receiving services generally, is even lower (1.2%), suggesting they are underrepresented. In Southend the BAME population in the 2011 census was 13%

Early onset dementia can be harder to recognise and diagnose and people may still be working and have young children. In Greater Essex 7.5% of those with dementia are under 70 and a few are under 30. Finally, people with learning disabilities are at significantly higher risk of developing dementia and at a younger age. There are no specialist services for people with both LD and dementia in Greater Essex.

Following diagnosis, people need personalised ongoing support and advice both to understand their condition; the support available (including for their carers) and the importance of planning in advance. They should have an assessment of their needs and a personalised care plan covering both health and social care.

Outcome: All people with dementia will receive appropriate and timely diagnosis and integrated support.

Success measures

- GP's across Greater Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe
- Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process
- There is a clear referral pathway to diagnosis with appropriate information and support offered
- BAME Greater Essex Communities are accessing assessment and diagnostic services
- There is appropriate screening for people who are considered to be at high risk of dementia
- People with dementia have access to post diagnostic support that is relevant and personalised
- People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia, and plan for the future
- People are offered a direct payment upon diagnosis of dementia

Priority 4: Living well with dementia in the community

"People don't know what to say or do … your world gets very small all of a sudden."

"I'd love to jump on the bike and go for a 20 mile bike ride, but I couldn't see the carers doing that. You've got to tone yourself down to suit them, rather than the other way round."

"my mother … wishes to stay living in the home she has known for 40 years, where she is comfortable; where she is known. It is proving almost impossible both practically and financially … My mother is still very sociable and very active. She has many friends and loves her family and her community." Carer

"At first he didn't think "activity centres" were really for people like him. Who can blame him really? Who else is a grown up and goes to an "activity centre"?" Carer

"I don't want to spend my life doing too many dementia connected activities. And neither does Cathy. It's not fun for her. She wants to go to her sewing classes and for lunch." Carer

"Communities aren't ready. Most Communities are unaware, are fearful of dementia and shut their eyes to it … Other than the odd good neighbour; Communities are painfully unaware of dementia in their Communities." Social worker

"It should be possible for people to do what they can for as long as they can, not wrapped in cotton wool. This would also help avoid crisis point for relatives of people with dementia." Service provider.

The issue

Especially in the early stages, people with dementia tell us that they want to continue to live their life as normally as possible. This means staying in their own home, being included in their local community, maintaining friendships and interests. As people's symptoms worsen they become more dependent on others for transport and general help to be able to do this. Fear about becoming confused or getting lost also leads to people going out less and restricting themselves to less demanding activities, which can lead to them becoming more isolated from the community. Loneliness is an increasing problem and can lead to depression or anxiety – over half of those we support who have dementia are widowed and about 4% live alone.

We know that there are gaps in the support available for people with dementia in Greater Essex. Greater Essex is above average in providing equipment or adaptations to help people stay in their own homes but below average in its provision of home care. Services are also not personalised. They often group people together without taking account of their individual capability or their personal preferences, experiences or personality. There is a limited range of activity to choose from in some areas and few services at evenings or weekends. Transport is a problem, particularly in more rural parts of the county. There is little support to help people maintain friendships or relationships or make new ones.

The traditional approach to assessing people's needs can be too focused on assessing for services. In fact formal services are just part of a wider network of community support which encompasses other public services, voluntary and commercial services, local amenities and the informal help and support that Greater Essex residents give to each other.

We want to promote a more inclusive approach to help people live independently in their community, maintaining the relationships and activities that matter to them. We will do this by helping people and their families to use their existing strengths and resources and connect to things that will help them get on with their lives. Where people

need more intensive support we will make sure this is tailored to their individual needs and preferences, with the option of a personal budget to give them maximum control over the kind of help they receive.

In a Dementia Friendly Community people are empowered to have aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them. But we know that there is still stigma and misunderstanding in our Greater Essex Communities and that people are not knowledgeable about dementia or how to help someone with the disease live well. Key services including blue light services, supermarkets, banks, etc. do not always have staff able to recognise and support people with dementia.

Outcome: People living with dementia feel able to access and contribute to their community, undertaking day to day tasks that supports them to remain as independent for as long as possible.

Success measures

- There is a whole community response to living well with dementia
- Environments and physical settings in the community are dementia friendly
- People living with dementia are able to take advantage of open space and nature
- The voice of lived experience helps to shape how Greater Essex Communities respond to dementia
- People living with dementia are encouraged to access information and support that helps themselves to live well and independently
- The lives of people living with dementia in the community are transformed through the DAA activity
- Young people are part of the community support for people living with dementia
- The market is able to respond to people living with dementia and support them to live well
- People with dementia have awareness of alternative accommodation options

Priority 5: Supporting Carers

"The diagnosis was a difficult experience … I walked in a daughter and walked out a carer." Carer

"We had a really bad night a few weeks ago. He was in one of his moods, and I was stressed out of my mind trying to deal with him… it was maybe 3am and I just wanted to be able to call someone – anyone – to get some advice or just to hear a friendly voice." – Carer

"**I have to stop myself from thinking about more than one day ahead because if you try, it overwhelms you. It destroys you."** Carer

"Carers find it really difficult to leave the people they are caring for … they feel guilty at taking time for themselves and worry about the person they have left … On a practical level it is sometimes impossible as Carers don't have anyone to stay with their loved one, of if they do it is for such short amounts of time and they need to reserve that time for essentials. This is more difficult for dementia carers because it is harder to find someone their loved one feels safe with." Counsellor

"[Carers] need better, easier information and they need the peace of mind that someone is there for them at any time … that does a huge amount. … they just want to know someone is there … it can be so worrying and stressful for a 70 year old caring for a partner." Social Worker

The issue

The impact on the family of a person diagnosed with dementia is significant, especially on family members who take on the responsibility of caring for the person. Diagnosis can be a difficult time for the carer as much as for the person with dementia. The condition can have a major impact on their relationship as the person becomes more dependent on their family for day to day support. Carers tell us they need help to understand the condition and how it is likely to affect their family member and may need help to find support for them both.

People with dementia become increasingly dependent on others and in the later stages may develop behaviours and psychological symptoms that make them among the most challenging to care for. Many carers gain personal satisfaction from caring and want to continue but caring comes at great personal cost. 40% of carers experience psychological distress or depression with those caring for people with behavioural problems experiencing the highest levels of distress (Carers Trust: Triangle of Care: Best practice for dementia care). Yet their ability to continue caring may be essential to the person being able to remain in the community. Carers tell us that they need practical support and reassurance in caring and someone to turn to when things get tough.

Carers find it difficult to take time for themselves, whether to take a break or for essential activities such as their own health appointments, because it can be hard to find others they trust who are willing or able to look after someone with dementia. Services are not always the best answer. They are often at the wrong time or place and may not offer things that people really want. But carers of people with dementia often end up relying on a narrow range of day services and dementia cafés for lack of alternative forms of support.

When it comes to longer breaks, carers evidently find it hard to find suitable options and gain access to them. In addition there are limited options for people with more complex needs or who are more challenging to care for. We need to work with people with dementia and their carers to understand what they need and examine the full range of options within their own network and the wider community that would allow them to take a break, whether on their own or with the person they care for.

It is also important that health and care professionals listen to the carer and work with them to support the person with dementia. As well as giving the carer peace of mind, working in partnership with the carer can achieve better outcomes for the person with dementia and ensure services have a fuller picture of the person's needs. Yet carers report feeling disconnected from the process and frustrated that they are not listened to.

Outcome: People caring for someone living with dementia feel informed and able to support their loved one, whilst able to maintain their own health and wellbeing

Success Measures

- Carers are a driving force behind shaping the response to dementia in Greater Essex
- Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia
- Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy
- Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges
- Carers are able to access a range of opportunities to take a break from their role as a Carer

Priority 6: Reducing the risk of Crisis

"I was so exhausted by it all I almost gave in and said "do what you want" but I managed to make it in the end" – Carer

"If you're kicking off at home because you don't recognise it is home, what help is it to be whisked into the middle of the night to be with complete strangers?" Carer

"She called us because she wanted someone to talk to. … As her condition was progressing she felt scared. She had gone into her local town shopping as she always had but had got lost and was found walking round the roundabout." Advice service

"It is so easy to get lost in the "firefighting" element of managing the disease on a day-to-day basis and not be more proactive in looking at how to develop coping techniques. … People need to be helped to have a "roadmap" of the progression of the disease and what problems they will face. … Care Manager

"People don't contact us until they're in crisis. And when they do contact us, there are often two people in crisis … the individual with dementia and their carer. We wait for people to come to us and by then the dementia has progressed quite far … we have to be more proactive." Social Worker

The issue

Dementia is not a generic condition. People with dementia can develop a wide range of symptoms that are particularly challenging for carers and put unprecedented demand on services. These can include aggression, agitation, delusions, wandering, night time waking, hoarding, loss of inhibition and shouting. Behavioural and Psychological Symptoms of Dementia (BPSD) can lead to crisis and care breakdown resulting in admission to acute services or residential care. Some people with dementia also have other conditions, such as learning disability or long term health problems, that can make their condition even more complex.

Other crises can occur as a result of the carer themselves becoming injured, ill or unable to continue caring, leaving the person with dementia unsupported. Carers can be at increased risk of becoming ill as a result of caring. Studies have shown that providing carers with breaks from caring, emotional support and access to training can significantly delay the need for the person receiving care to go into residential care. It may also prevent emergency hospital admission.

Finally, people with dementia can experience other physical or mental health problems which, if not identified and addressed, can lead to admission to acute hospital or mental health services. Nationally, 25% of hospital beds are thought to be occupied by someone with dementia (Fix Dementia Care; Hospitals Report 2016 (Alzheimer's society), and in Greater Essex we know that people living with dementia stay in hospital 50% longer than those without. Care Managers say that it can take days or even weeks for mental health services to respond to a referral. Social workers told us that mental health teams are focused on preventing escalation to residential and acute services but that we need to identify and support people earlier and look at the role of community psychiatric support to keep people out of hospital.

Outcome: All people with dementia receive support to reduce the risk and manage crisis

Success Measures

- All hospitals to aspire to being dementia friendly care settings
- People living with dementia, with complex needs such as co-morbidities are offered specialist information and support

- Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively
- Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments
- Primary Care are able to respond to episodes of crisis in care homes appropriately

Priority 7: Living well in long term care

"**I can't trust that they're going to follow his care plan … I can't switch off**" – Carer

"I had to place someone four times due to his dementia. His behaviour wasn't difficult – he just needed personalised support. His behaviour deteriorated due to the transfers but this should have been anticipated." Social Worker

"The biggest impact … to assist those living with dementia is education. To educate people and eradicate the stigma that is related to care homes and dementia. There is not enough positive media reporting with care homes that focus on the positive good work that they do rather than the poor homes" Care Home Manager

"We'll always have a member of staff in the lounge who can make sure people don't get out of their chairs." Care Home

"Care homes need to be enabled to provide outings, passionate about taking people outside, but I accept care homes are not staffed to provide regular outings for people in their care. We need to find another way to ensure people have a life." Service manager

The issue

In 2014 the Care Quality Commission found that whilst many hospitals and care homes deliver excellent care, the quality of care for people with dementia varied greatly. A key issue was that some hospitals and care homes did not comprehensively identify all of a person's care needs and there was variable or poor staff understanding and knowledge of dementia care.

The government wants to avoid people with dementia requiring long term care by improving the provision of local community services, education and training. The majority (85%) of people with dementia say that they would prefer to remain in their own home. In Greater Essex over 80% of people with dementia live in the community but the proportion of people with dementia supported in residential care is still higher in this county than in similar local authorities.

There are currently 252 care homes and 81 nursing homes for people with dementia across the county. There is a lack of data about the quality of residential care in the market and carers and families tell us that they struggle to find appropriate care for the person they care for.

The government wants all hospitals and care homes to meet agreed criteria to become dementia friendly by 2020.

Outcome: All people with dementia live well when in long term care and able to access their community as appropriate

Success Measures

- All care homes for people with dementia in Greater Essex to be dementia friendly by 2020
- People living with dementia, their families and carers understand what high quality care looks like and where to find it
- People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings through linking Dementia in to LD health checks
- People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting
  People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate

Priority 8: End of life

"People's wishes are not known. We need to get this information earlier … " Social Worker

"People don't plan … we need to help people plan for the inevitable whilst they've still got the capability." Social Worker

The issue

It is important to have early conversations with people with dementia about advance planning and end of life care so that people can plan ahead and ensure that their wishes are known and acted upon. The government has said that all people with a diagnosis of dementia should be given the opportunity for advance care planning early on to ensure the person and their carer are fully involved in decisions on care at end of life.

The aim should be to maximise the person's quality of life and support carers. All people with dementia and their carers should receive coordinated, compassionate and person-centred care towards the end of their life. This includes palliative care for the person with dementia and bereavement support for carers.

Outcome: People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes

Success Measures

- People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP
- People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate
- People are not delayed in being discharged from hospital
- People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose
- Carers and families receive bereavement support at a time that is right for the individual or family

Priority 9: A knowledgeable and skilled workforce

"People think you can't communicate with people with dementia; there is a general lack of awareness." Support worker

"The biggest impact that could happen to assist those living with dementia is education. To educate people and eradicate the stigma … " Care home manager

The issue

If health and care professionals and all other care workers understand the complexity of dementia; its impact upon the person and their family and know how to provide effective help and support, this will improve the quality of information, advice and care that people receive in all areas. Poor quality care has a major, negative impact on the quality of life of the person with dementia and causes stress and anxiety for their carer. It can also lead to higher care costs when health and social care professionals do not know how to support people to maintain their independence and quality of life in the community.

Across health and social care there is a lack of consistency or a clear pathway around dementia training. Training is provided at different levels and there is no clear picture of what the training is meant to deliver.

Outcome: All people with dementia receive support from knowledgeable and skilled professionals where needed

Success Measures

- There is a framework for dementia training across Greater Essex to ensure all people receive training relevant to their role
- To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so.
- To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well.

Key Documents

Alzheimer's Society (2010). *My name is not dementia*

Alzheimer's Society (2013). *Building dementia-friendly Greater Greater Essex Greater Greater Essex Communities: a priority for everyone*

Alzheimer's Society (2014). *Dementia 2014: Opportunity for Change*

Carers Trust & Royal College of Nursing (2013). *The Triangle of Care: Carers Included: a Guide to Best Practice for Dementia Care*

Department of Health (February 2015): *Prime Minister's Challenge on dementia 2020*

Greater Essex County Council (April 2015). *Carers count in Greater Essex: Greater Essex Carers Strategy 2015-2020*

Greater Essex County Council (June 2015). *Dementia specialist topic needs assessment.*

Greater Essex County Council (June 2015): *Literature review of interventions to support the dementia needs assessment*

ESRO and ThePublicOffice (2015). *Living well with dementia in Greater Essex: ethnographic research findings*

Joint Commissioning Panel for Mental Health (2013). *Guidance for commissioners of dementia services*

National Institute for Health and Care Excellence (2006, modified March 2015). *Clinical Guideline 42: Dementia: supporting people with dementia and their carers in health and social care*

National Institute for Health and Care Excellence (April 2013). *Quality Standard 30: Supporting people to live well with dementia*

The Princess Royal Trust for Carers and the Royal College of General Practitioners (2011). *Supporting carers: an action guide for general practitioners and their teams*

Public Health England and UK Health Forum (2014). *Blackfriars Consensus on promoting brain health: reducing risks for dementia in the population.*

Royal College of General Practitioners (2013). *Commissioning for Carers*

Southend on sea borough Council (Jan 2016) Themes From the Consultation Workshops

Southend on sea Borough Council (December 2016)Dementia JSNA (draft)

Technology Charter https://www.alzheimers.org.uk/technologycharter

Glossary

ASC	Adult Social Care
BAME	Black and minority ethnic groups
BPSB	Behavioural and psychological symptoms of dementia
DAA	Dementia Action Alliance
GP	General Practitioner
LD	Learning Disability
MCI	Mild Cognitive Impairment
Good Lives	ECC approach to Social Care

Appendix – Implementation Plan

Business as Usual Delivery

The following can be achieved within the current budget envelope for the Dementia Service to contribute to delivering our vision for all people living with Dementia, their families and carers in Essex. You can see from the table how the activity links in to the priorities and outcomes outlined in the strategy as well as how we propose we will measure whether or not we are successful. The Transition states show how the emphasis for delivery will shift from Greater Essex led delivery (Pan Essex which includes Health) to Local Implementation (LI) and Community delivery:

Priority Area	Outcome	Success Measure	Measurement	Activity	Transition State 1 : Years 1-2				Transition State 2 : Years 3-4				Transition State 3 : Years 5+				Cost
					Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	
Prevention	People in Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.	People understand the link between healthy and active lifestyles and reducing their cardio vascular risk factor	Number of people who are able to identify ways to reduce their cardio vascular risk factor Number of people enaged in activity for mental wellbeing Number of people living active and healthy lifestyles	PH activity to increase understanding / Campaign	X				X				X				H
		People have an increased awareness of MCI	Number of people accessing MCI information	IAG offer developed	X				X				X				L
				Community awareness raising	X				X				X				L
		People are aware how to access information and support should they be concerned about dementia	Number of people accessing IAG Number of referrals to Community Agent+	As above	X				X				X				L
Finding Information and Advice	Everyone with dementia will have access to the right information at the right time.	A comprehensive whole system Information and guidance offer is available.	Is there one? What is its reach? Who is accessing it?	Definition of Comprehensive	X	X			X	X	X		X	X	X	X	L
				Development of Offer	X	X			X	X	X		X	X	X	X	L
				Linking in with Technology Enabled Care	X	X			X	X	X		X	X	X	X	H

		People living with dementia will feel supported to navigate the system and access information and support that is relevant to them		As above	X	X			X	X	X		X	X	X	X	L
Living well with Dementia in the community	All people with Dementia are supported by their communities to remain independent for as long as possible	There is a whole community response to living well with dementia	Number of Dementia Friendly Communities Coverage of DAA across Essex	Delivery of the DAA across Essex	X						X					X	L
				Commissioning a Dementia Friendly Co-ordinator to drive the demential friendly network	X						X					X	L
				Promotion of Dementia Friends in the communities of Essex	X						X					X	L
		Environments and physical settings in the community are dementia friendly	As above	As above	X						X					X	L
		People living with dementia are able to take advantage of open space and nature	Number of "green" commmunities with Dementia Friendly Number of people engagin with green spaces as part of their dementia support	Green prescription project focused on enabling communities to do this	X						X					X	L
		The voice of lived experience helps to shape how communities respond to dementia	Number of Lived Experience conversations to support shaping community action	Delivery of Lived Experience training	X						X					X	L
				Process by which commissioned services use this type of conversation to shape support	X						X					X	L
				Ongoing development of Healthwatch sustainable process for engaging with people with Dementia to shape their support and offer	X						X					X	L
		People living with dementia are encouraged to access information and support to help themselves	Number of people accessing the service that received low level support/signposting	Family Navigation and Information Support service delivery	X						X					X	L

		The lives of people living with dementia in the community are transformed through the DAA activity	Reduction in admission to hospital Reduction in admissions to long term care Number of people who feel their lives have improved since becoming involved with their communities	As above	X						X					X	L
		Young people are part of the community support for people living with dementia	Number of under 18's involved in community dementia support Number of under 18 dementia friendly	As above	X						X					X	L
		The market is able to respond to people living with dementia and support them to live well	Number of dementia champions within each provider setting Number of dementia Friendly Care settings	Delivery of Residential and Domicillary Provider forums	X						X					X	L
		People with dementia have awareness of alternative accommodation options	Number of people with Dementia accessing alternative accomodation options	Family Navigation and Information Support service delivery	X						X					X	L
Supporting Carers	Carers are supported to enable people with dementia to remain as independent as possible	Carers are a driving force behind shaping the response to dementia in Essex	Number of carers engaging in Dementia quality assurance Number of carers on design forum	Development of Dementia Carers network to assess all settings where Dementia support is offered	X				X		X				X		L
				Development of Dementia Carers service design forum for developing support where needed	X				X		X				X		L
		Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy	Number of crisis for carers Number of carers who have accessed support networks following our intervention	Family information and support network developed to provide them with relevant information and timely appropriate support	X				X		X				X		M
				Development of community neighbourhood model	X				X		X				X		M

				Development of DAA to support carers	X				X		X				X		L
Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	All hospitals to aspire to being dementia friendly care settings	Number of dementia friendly hospitals	Collectively share best practise around supporting people with Dementia in an acute setting	X				X		X				X		L
				Explore contractual changes with acute settings	X				X		X				X		L
		People living with dementia, with complex needs such as co-morbidities are offered specialist information and support	Number of family group conferences carried out Number of hospital/long term care admissions	Identification of "high risk" people and working together to co-ordinate a care plan to support them	X				X		X				X		L
				Development of process for linking multiple condition systems	X				X		X				X		L
		Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively	Number of crisis plans developed Number of crisis Acute Admissions	Support Good Lives centres to support individuals to plan for and manage crisis	X				X		X				X		L
				An all age dementia offer developed for those who required their complex needs managed	X				X		X				X		H
				Develop Care Home response to Crisis and approaches for managing times of crisis	X				X		X				X		M
		Emergency planning is addressed as part of all carer's assessments	Number of carers assessment that incllludes emergency planning	As above	X				X		X				X		L
Living well in Long Term Care	All people with dementia live well when in long term care	All care homes for people with dementia in Essex to be dementia friendly by 2020	Number of Dementia Friendly Care Homes	Comms exercise to promote Dementia Friends programme and local alliance	X				X		X		X		X		M
				Explore contractual changes with Care Homes	X				X		X		X		X		L
		People living with dementia, their families and carers understand what high quality care	Number of people who are aware of the varying options they have for care	How we can work with carers to understand how their voice can support the quality of care	X				X		X		X		X		L

		looks like and where to find it		Development of a best practise guide for Carers to use when researching long term Dementia Care in Essex as part of IAG offer	X				X		X		X		X		L
		People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings	Number of people with Learning Disabilities who have a holistic assessment of need	Ensure that Care settings are able to "Identify how best to meet individuals needs" especially for those considering "high risk" of developing dementia	X				X		X		X		X		L
				Developing a pathway link that supports people with learning disabilities to obtain a timely diagnosis	X				X		X		X		X		L
				Dementia Champions within LD care settings	X				X		X		X		X		M
		People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting	Number of People with Dementia accessing the Dementia Friendly network in Essex	Dementia friendly network in Essex developed to be inclusive	X				X		X		X		X		:L
				Support the care workforce to link with the dementia friendly network and to look outside of their setting to provide support	X				X		X		X		X		M
				Carers knowledge and confidence increased to allow them to become part of the network outside of the care setting	X				X		X		X		X		L
		People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate	Increase No. of MCA referrals	Process and guidance change/communication	X				X		X		X		X		L
End of Life	People with dementia and their families plan ahead, receive good end of life care	People assessed as not having capacity, with no family or friends are referred to an Independent	Increase No. of MCA referrals	Process and guidance change/communication	X				X		X		X		X		L

	and are able to die in accordance with their wishes	Mental Capacity Advocate as appropriate																
		People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose	Number of people who "feel informed" about EOL options Number of people completing EOL Advanced Care Plans Number of people who die in their place of choice	Delivery of the above	X				X		X		X		X		-
		Carers and families receive bereavement support	Number of people who are offered berevement support following the death of a relative with Dementia	Determining current market offer for berevement support and forging links to sign post people to	X				X		X		X		X		
A Knowledgeable and Skilled Workforce	All people with dementia receive support from knowledgeable and skilled professionals where needed	There is a framework for dementia training across Essex to ensure all people receive training relevant to their role	Framework in place for training	Link in with Health Education England to see if there is an existing framework we can use	X				X				X				-
				Identify whether a national framework is useful for Essex	X				X				X				-
				Link Health and ECC Training programmes to map how what is currently delivered sits against the framework	X				X				X				-
				Task and finish group to identify gaps and solutions to improve this	X				X				X				L
		To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so.		Development of the above framework	X				X				X				-

Additional Delivery

The following activity will help us delivery our aspirations and vision set out in the strategy but will required addition investment to deliver. It is expected that an Outline Business Case (OBC) will be developed to request the level of investment needed to improve the lives of people living with dementia, the families and carers. Again, you can see from the table how the activity links in to the priorities and outcomes outlined in the strategy as well as how we propose we will measure whether or not we are successful. At this time the level of investment/cost is not given as a financial figure as this will be part of the OBC:

Priority Area	Outcome	Success Measure	Measurement	Activity	Transition State 1 : Years 1-2				Transition State 2 : Years 3-4				Transition State 3 : Years 5+				Cost
					Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	
Prevention	People in Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.	People are aware how to access information and support should they be concerned about dementia	Number of people accessing IAG Number of referrals to Community Agent+	Commissioning Integrated Offer of peri-diagnosis services			X				X						
		Increase percentage of people diagnosed with dementia receive an annual face to face review of their health needs, and whose vital health indicators are checked	Number of people diagnosed Number of f2f reviews Number of vital health indicator checks	Developing a clear pathway from Community to primary care			X				X						L
				Developing a clear pathways from primary to secondary care			X				X						M
				Development of an integrated model of care with Health	X	X			X	X							H
		People in BAME communities have increased awareness	Number of BAME accessing services Number of BAME diagnosed	Commissioning of Dementia Co-ordinato	X						X					X	L
				Development of Community Agent + service	X				X				X			X	M
				Dedicated promotion in these communities	X				X	X					X	X	M

		Carers have access to annual health check and have access to Improved Access to Psychological Therapies	Number of Carers having annual health checks Number of carers accessing Pychological Therapies	As above - pathways		X				X	X				X	X	L
Diagnosis and Support	All people with dementia will receive appropriate and timely diagnosis and integrated support	GP's across Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe	Number of GPs who use the identified process Number of people diagnosed before crisis by GPs Number of GPs maintaining a diagnosis rate of at least two thirds Waiting time between referral and diagnosis Number of memory clinic referrals	Work with Primary care to develop an integrated diagnostic model that is centred around GPs	X	X			X	X	X				X		H
				Develop compreheisve post diagnositc offer that can be accessed from the point of diagnosis	X	X			X	X	X				X		H
				Communication of Dementia within GP clinics	X	X			X	X	X				X		H
				Develop action plan for Increasing the numbers of people receiving dementia diagnosis within six weeks of GP referral	X	X			X	X	X				X		H
				Develop Community Agent + capacity to support	X	X			X	X	X				X		H
				Promoting timely diagnosis within GP training networks	X	X			X	X	X				X		H
		Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process	Number of people using appropriate pathway	Development of a clear pathway across the dementia system that is visible to all including access/exit points	X	X			X	X	X				X		M
		There is a clear referral pathway to diagnosis with appropriate information and	Number of people using appropriate pathway	Development of Customer Journeys	X	X			X	X	X				X		H
				Investment in primary care to support timely diagnosis	X	X			X	X	X				X		H

		support offered		IAG with communities to understand the process for delivery	X	X			X	X	X				X		H
				Community Agent + resource within GP surgeries	X	X			X	X	X				X		H
		BAME communities are accessing assessment and diagnostic services	Number of BAME accessing services	Development of visible services that are communicated sensitively for those who wish to access it	X	X			X	X	X				X		L
				Development of DAA to support BAME communities	X	X			X	X	X				X		L
		There is appropriate screening for people who are considered to be at high risk of dementia	Number of people diagnosis from a high risk categeory	Identification of "high risk" people and working together to co-ordinate a care plan to support them	X	X			X	X	X				X		H
				Development of an All Age Dementia response service	X	X			X	X	X				X		H
		People with dementia have access to post diagnostic support that is relevant and personalised	Range of post-diagnosis support linked to the system	Range of tools developed to support people to access the level of support that is appropriate to them post diagnosis	X	X			X	X	X				X		M
				Agree an affordable implementation plan for the prime minister's challenge on dementia 2020, including to improve the quality of post diagnosis treatment and support	X	X			X	X	X				X		M
		People living with dementia and their entire network are supported to draw on their strengths and	Number of Family group conferences carried out Number of collaborative care plans	As above	X	X			X	X	X				X		L

		assets to adapt to living a life with dementia, and plan for the future															
		People are offered a direct payment upon diagnosis of dementia	Number of people with a direct payment following Diagnosis	As above	X	X			X	X	X				X		L
Supporting Carers	Carers are supported to enable people with dementia to remain as independent as possible	Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia	Number of referrals for carers assessments Number of carers offered support and guidance Number of carers on Carers registers	Family information and support model developed to take Carers views in to account and identifying opportunities to empower them to remain healthy	X				X		X				X		L
				Development of carers specific IAG offer	X				X		X				X		L
				Identifying how Primary Care currently support and record carers	X				X		X				X		M
				Working with primary care to develop carers registers	X				X		X				X		H
		Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges	Number of carers who feel informed and equipped	Access to relevant information and timely appropriate support from the point of concern developed and communicated to Essex	X				X		X				X		M
		Carers are able to access a range of opportunities to take a break from their role as a Carer	Number of opportunities available for Carers Number of carers actively taking a break from their role Number of carer breakdowns	Working with carer programme to identify an action plan to support carers of people living with Dementia	X				X		X				X		L
Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	Primary Care are able to respond to episodes of crisis in care homes appropriately	Number of acute admissions from Care Homes following Primary Care involvement	Development of response teams with GPs and the community to avoid hospital admissions from Care Homes because of crisis (Community Models)		X			X				X		X		H

End of Life	People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes	People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP	Number of advanced care plans completed Number of advanced care plans completed in consultation with people living with dementia	Agree a central system of recording Care plans	X				X		X				X		H
				Review existing care plans in localities and ensure that people with Dementia have had input	X				X		X				X		M
				Work with GPs to define requirements for system	X				X		X				X		M
				Define "end of life" champion approach to drive support where identified	X				X		X				X		L
				Improve Care Homes ability to respond to EOL	X				X		X				X		L
				Working with Advocacy network to ensure that best interest decisions take in to account the views of the most vulnerable	X				X		X				X		L
				Link in with EOL programmes to define best approach for Dementia	X				X		X				X		
				Link Dementia care in to hospice network to ensure advanced care plans are being adhered to	X				X		X				X		L
		People are not delayed in being discharged from hospital	Reduction in delayed discharge for people with dementia	Specialist Market Capacity developed that is responsive to need	X				X		X				X		M
				Develop dementia champions within the provider network	X				X		X				X		L
				Responsive family and information network to provide tailored support	X				X		X				X		M

				Integrated discharge teams work effectively to plan and effective discharge and links well in to how we can support someone at home for their long term needs not in hospital	X				X		X				X		M
A Knowledgable and Skilled Workforce	All people with dementia receive support from knowledgeable and skilled professionals where needed	To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well.	Difference in quality of care before and after implementation	Identifying current position of the market against the framework	X				X				X				M-H
				Workstream to develop detail action plan to work activtly with the market to collaboratively develop ways of improving dementia care	X				X				X				M-H
Partnershiopss	Integrated model	Fully integrated commissioning	Jointly commissioning provision and operational delivery	forming strategic commissioning partnership	X				X		X		X		X		
				Aligning commissioning intentions	X				X		X		X		X		
				Developing OBC to request investment to deliver Strategy	X				X		X		X		X		
				Desiging Local Implementation plans with DAAs	X				X		X		X		X		
				Commissioning of model	X				X		X		X		X		
				Delivery	X				X		X		X		X		

19 July 2017	ITEM: 9
Thurrock Health and Wellbeing Board	
Thurrock Health and Wellbeing Strategy Annual Report	
Wards and communities affected: All	**Key Decision:** To approve the contents and publication of Thurrock's Health and Wellbeing Strategy Annual Report.
Report of: Councillor James Halden, Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris, Corporate Director of Adult Housing and Health	
This report is Public	

Executive Summary

The Health and Wellbeing Strategy 2016-2021 was approved by the Health and Wellbeing Board in February 2016 and the CCG Board and Council in March 2016. At its meeting in February 2016, the Health and Wellbeing Board agreed that action plans and an outcomes framework should be developed to support the delivery of the Strategy and to measure its impact. The Health and Wellbeing Board also agreed that a report would be published annually which describes how action taken each year supports the achievement of Health and Wellbeing Strategy outcomes.

This paper provides the first annual report on Thurrock's Health and Wellbeing Strategy for the Health and Wellbeing Board's consideration. The annual report is a stand-alone document that:

- Explains the Health and Wellbeing Board's function, membership and how it drives forward the development and implementation of the Health and Wellbeing Strategy;
- Describes Thurrock's Health and Wellbeing Strategy and reports year one key achievements; and
- Demonstrates how the public's views have been reflected and have informed action plans that have been developed as part of implementing the Strategy.

Subject to the Health and Wellbeing Board's approval the annual report will be published on Thurrock Council's website. Board members will wish to note that the Strategy report has been approved by the Council's Corporate Communication Team colleagues so meets required publishing standards.

1. Recommendation(s)

1.1 The Board is asked to approve the structure and contents of the first annual report and that it should be published on the council's website.

1.2 The Board is asked to approve amendments to the Health and Wellbeing Strategy that comprise:

- **Goal 3, Better Emotional Health and Wellbeing could be further enhanced by comprising an objective that specifically focusses on mental health. The Health and Wellbeing Board are asked to agree that objective 3D improve the identification and treatment of depression, particularly in high risk groups should be amended to improve the mental health and wellbeing of the residents of Thurrock. The new objective will continue to focus on identifying and treating depression, particularly in high risk groups. It will also capture wider mental health work including the Essex, Southend and Thurrock Dementia Strategy and Thurrock's action plan, developed as part of the Essex, Southend and Thurrock Mental Health Strategy.**

2. Introduction and Background

2.1. Thurrock's Health and Wellbeing Strategy comprises five strategic goals which make the most difference to the health and wellbeing of the people of Thurrock. The Strategy comprises five strategic goals, each containing four defined objectives.

GOALS	1. OPPORTUNITY FOR ALL	2. HEALTHIER ENVIRONMENTS	3. BETTER EMOTIONAL HEALTH & WELLBEING	4. QUALITY CARE CENTRED AROUND THE PERSON	5. HEALTHIER FOR LONGER
OBJECTIVES	1A. All children in Thurrock making good educational progress	2A. Create outdoor places that make it easy to exercise and to be active	3A. Give parents the support they need	4A. Create four integrated healthy living centres	5A. Reduce obesity
	1B. More Thurrock residents in employment, education or training	2B. Develop homes that keep people well and independent	3B. Improve children's emotional health and wellbeing	4B. When services are required, they are organised around the individual	5B. Reduce the proportion of people who smoke
	1C. Fewer teenage pregnancies in Thurrock	2C. Build strong, well-connected communities	3C. Reduce social isolation and loneliness	4C. Put people in control of their own care	5C. Significantly improve the identification and management of long term conditions
	1D. Fewer children and adults in poverty	2D. Improve air quality in Thurrock	3D. Improve the identification and treatment of depression, particularly in high risk groups	4D. Provide high quality GP and hospital care to Thurrock	5D. Prevent and treat cancer better

2.2 Following the Health and Wellbeing Strategy being launched in July 2016 impressive progress has been made. Goal sponsors have now been identified and comprise corporate directors across Thurrock Council and Senior representatives of key partner organisations, including Thurrock CCG. Goal sponsors have identified lead officials who are responsible for driving forward the development of action plans for all of the Strategy's objectives.

2.3 Goal sponsors are also responsible for ensuring that actions are delivered and targets are monitored effectively. Over the last twelve months Goal Sponsors have reported progress on developing all twenty action plans to the Health and Wellbeing Board.

2.4 The commitment to publish an annual report that is scrutinised and approved by the Health and Wellbeing Board provides continued accountability and that momentum is sustained over the five year lifespan of the Strategy.

3. Issues, Options and Analysis of Options

3.1 The public and partners were actively involved in the development of Thurrock's Health and Wellbeing Strategy and subsequent action plans that have been developed to support the achievement of the Strategy's outcomes. Publishing an annual report will help to ensure that engagement is sustained and that the council and partners can be held to account on progress that has been made.

4. Reasons for Recommendation

4.1 Health and Wellbeing Board members are responsible for driving forward Thurrock's Health and Wellbeing Strategy. Board members previously agreed that report showing progress made with achieving the Strategy's Goals is published annually.

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

5.1 Partner and community engagement is a key part of the development of action focussed plans to support the achievement of Thurrock's Health and Wellbeing Strategy. Publishing the annual report that explains how action plans have been developed to reflect feedback received from stakeholders reinforces Thurrock's continued commitment to genuine engagement.

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

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

7. Implications

7.1 **Financial**

Implications verified by: **Jo Freeman**
Management Accountant (Social care and Commissioning) Corporate Finance

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

7.2 **Legal**

Implications verified by: **Fiona Taylor, Director of Law and Governance**

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

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**
Community Development and Equalities Manager

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

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

None identified

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

- Thurrock Health and Wellbeing Strategy https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy

9. Appendices to the report

- Thurrock Health and Wellbeing Strategy Annual Report

Report Author:

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


Thurrock Health and Wellbeing Strategy
2016 - 2021
Annual Report
2016 - 2017
Adding years to life and life to years
thurrock.gov.uk

Foreword

Cllr James Halden
Chair of Thurrock Health and Wellbeing Board

I am pleased to welcome you to the 2016-17 annual report on Thurrock's Health and Wellbeing Strategy. The five year Health and Wellbeing Strategy was launched in July 2016 and was the result of a genuine partnership approach, driven forward by Thurrock's Health and Wellbeing Board.

I have been Chair of Thurrock's Health and Wellbeing Board since 2016 and it's my strong belief that the Board and Health and Wellbeing Strategy's primary purpose is to reduce health inequalities across our borough and improve outcomes for local people. We want to make sure that people remain healthier for longer and can remain in their own homes, in their own communities for as long as possible. We want the people of Thurrock to be able to live a good life, regardless of who they are or where they live.

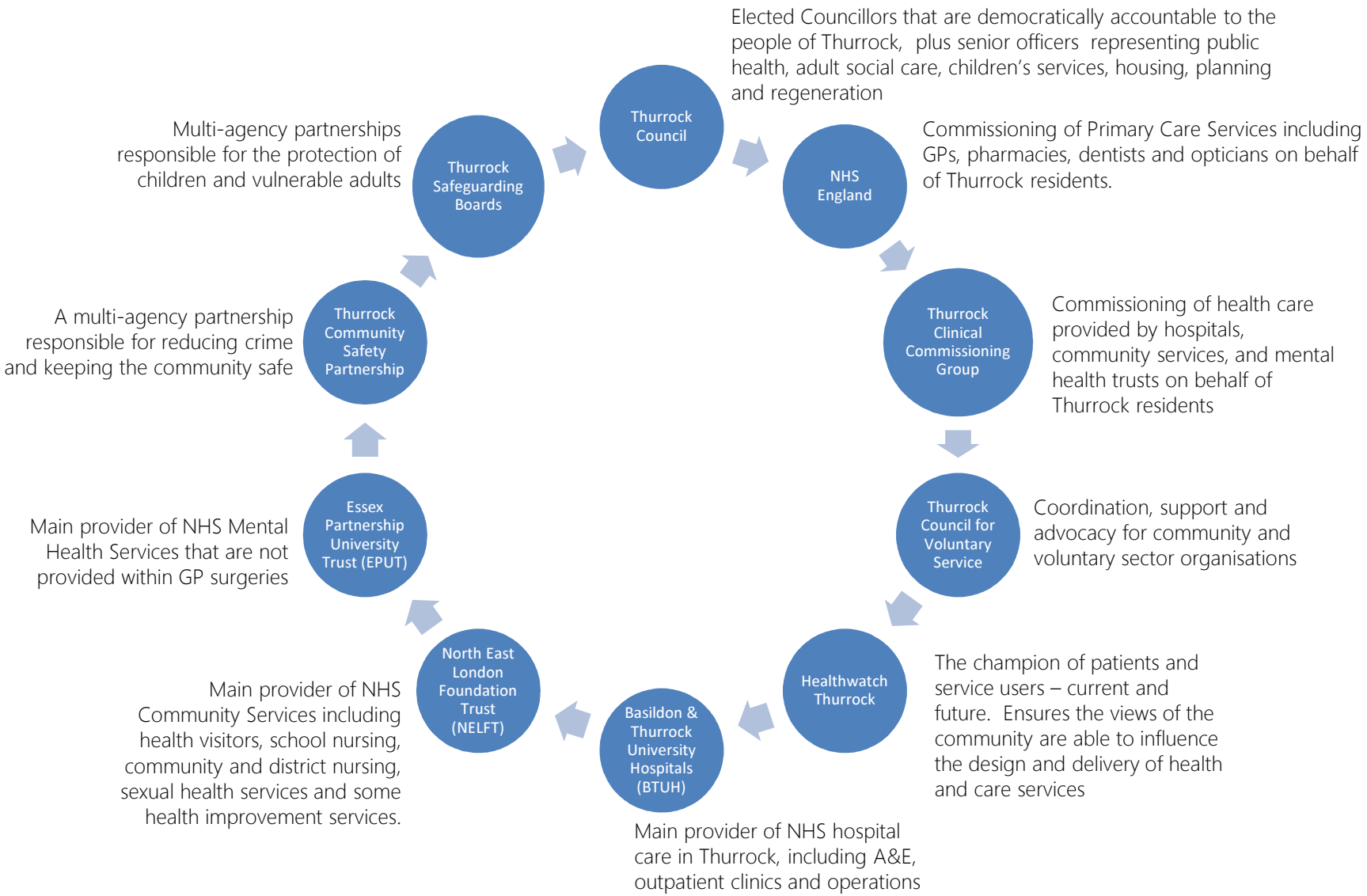
The Board recognises that improving health and wellbeing requires action that affects all parts of people's lives. We know for example, that improved educational outcomes increases the likelihood of gaining employment which in turn helps to address child poverty in the future. That is why our Strategy identifies five strategic goals that focus on the areas within which we can make the most difference to the health and wellbeing of the people of Thurrock.

I am confident that we can make the resource we have go further by increasing the number of us who stay well and by intervening at the earliest opportunity. This means continuing to change the way some of our services operate. It also means we must utilise the strength of our communities and the individuals living in those communities as part of building alternatives to the traditional service response. The Health and Wellbeing Strategy is one of the key drivers for stimulating those changes and continuing to improve health outcomes for Thurrock's residents.

This report:

- Describes the range of strategic partners who are members of the Health and Wellbeing Board
- Sets out our jointly agreed vision and key principles for the strategy
- Provides a snapshot of the strategy's five strategic goals and explains why they have been prioritised
- Sets out some key achievements for the first year of the strategy
- Shows how the views of the public continue to inform action that we are taking

Thurrock Health and Wellbeing Board are responsible for our Health and Wellbeing Strategy
Who we are and what we do



Thurrock's Health and Wellbeing Strategy Vision and Principles

Our Vision

Our vision for improving the health and wellbeing of Thurrock people is to:

Add years to life and life to years

We want Thurrock to be a place where people live long lives which are full of opportunity, allowing everyone to achieve their potential. To achieve this, we have set five goals, which we are all committed to achieving. The goals are ambitious and will require a lot of hard work from Thurrock Council, the NHS, voluntary organisations and communities themselves but we think that by working together, we can achieve these goals and make a real difference to the people of Thurrock.

Our Principles

Reducing inequality in health and wellbeing
We want things to get better for everyone but we are also committed to ensuring that the poorest communities enjoy the same levels of opportunity, health and wellbeing as the most affluent.

Prevention is better than cure
Rather than waiting for people to need help, we want Thurrock to be a place where people stay well for as long as possible.

Empowering people and communities
We don't just want to do things to people, but give people the opportunity to find their own solutions and make healthy choices.

Connected services
Good health and care services should be organised around the needs of people, not around the needs of organisations.

The Health and Wellbeing Strategy: An Introduction

How the Health and Wellbeing Strategy is structured

The Health and Wellbeing Strategy comprises 5 high level, strategic goals and to ensure that they are clearly defined and action taken focusses on the right areas, each of them are supported by four key objectives that have been agreed by the Health and Wellbeing Board.

How we will achieve our goals and improve outcomes

The goals we have set out are ambitious. They cannot be achieved by a single organisation or group of people but require the transformation of systems and communities. That means that everyone has a part to play. Shared goals are now being translated into collective action.

Each of the four objectives that define individual goals are supported by an action plan that set out who is responsible for delivering what. Communities and individuals are an essential part of the 'how' we deliver our Strategy, so we have continued to engage with members of the public to inform actions that are being taken forward.

Good work is already taking place so action plans include new action that has been identified and how existing initiatives contribute to achieving our goals.

How we know if the strategy is working.

We want to be clear about whether or not our Strategy is working and to hold each other to account for achieving our goals. That's why we are continuing to develop and refresh an Outcomes Framework with measurable targets and trajectories for what we expect to achieve over the next five years. Outcomes specific to individual objectives are incorporated into each of the action plans.

A snapshot of the strategy's goals and supporting objectives follow overleaf

A snapshot of the Health and Wellbeing Strategy Goals and Objectives

"It's easy for me to be active where I live"

"Thurrock has great health services and it's easy to get to them"

"I was able to get a good job, and I now feel differently about life"

"My children have a great chance of getting good exam results and I'm optimistic about their future"

"There are plenty of activities in my community that I can get involved in"

GOALS	1. OPPORTUNITY FOR ALL	2. HEALTHIER ENVIRONMENTS	3. BETTER EMOTIONAL HEALTH & WELLBEING	4. QUALITY CARE CENTRED AROUND THE PERSON	5. HEALTHIER FOR LONGER
OBJECTIVES	1A. All children in Thurrock making good educational progress	2A. Create outdoor places that make it easy to exercise and to be active	3A. Give parents the support they need	4A. Create four integrated healthy living centres	5A. Reduce obesity
	1B. More Thurrock residents in employment, education or training	2B. Develop homes that keep people well and independent	3B. Improve children's emotional health and wellbeing	4B. When services are required, they are organised around the individual	5B. Reduce the proportion of people who smoke
	1C. Fewer teenage pregnancies in Thurrock	2C. Build strong, well-connected communities	3C. Reduce social isolation and loneliness	4C. Put people in control of their own care	5C. Significantly improve the identification and management of long term conditions
	1D. Fewer children and adults in poverty	2D. Improve air quality in Thurrock	3D. Improve the identification and treatment of depression, particularly in high risk groups	4D. Provide high quality GP and hospital care to Thurrock	5D. Prevent and treat cancer better

The Health and Wellbeing Strategy: Goals, achievements and public feedback

Following the Health and Wellbeing Strategy being launched in July 2016 impressive progress has been made. A genuine partnership approach has been adopted in both developing and now implementing the strategy.

Lead officials have been identified across Thurrock Council, Thurrock Clinical Commissioning Group (CCG) and beyond to drive forward the development of action plans for all of the strategy's objectives. Goal sponsors have also now been identified and comprise corporate directors across the council and senior representatives of key partner organisations, including Thurrock CCG.

Goal sponsors are responsible for ensuring that actions are delivered and targets are monitored effectively. Goal sponsors have reported progress with developing action plans to the Health and Wellbeing Board.

Thurrock Coalition
01375 389864
be part of the solution

healthwatch Thurrock

Thurrock is committed to meaningful community engagement, providing members of the public with opportunities to influence the design and delivery of services that meet their needs. As part of ensuring that action plans developed to support the achievement of improved outcomes that meet the needs of the people of Thurrock members of the public have been consulted and asked to provide views on the Health and Wellbeing Strategy.

Groups that have been consulted include:

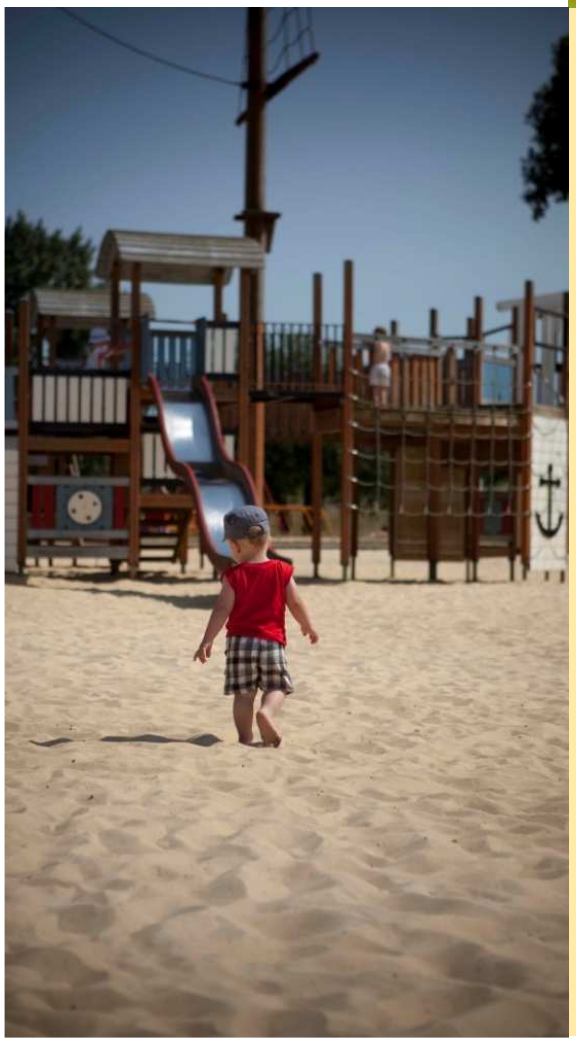
- The general public
- Thurrock Older People's Parliament
- Thurrock's Disability Partnership Board
- Thurrock Mental Health Service User and Carer Forum

Themes have been selected which describe key issues identified by the public for specific objectives within each of the five strategic goals and responses have been included which demonstrate how the public's views have been considered and reflected in our work.

GOAL 1

Opportunity for all

Summary



We want to achieve better educated children and residents who can access employment opportunities

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- Objective 1A. All children in Thurrock making good educational progress
- Objective 1B. More Thurrock residents in employment, education and training
- Objective 1C. There will be fewer teenage pregnancies
- Objective 1D. Fewer children and adults will live in poverty

Detailed action plans have been developed during year one that drive forward the achievement of each of the objectives.

Why this goal is a key element of the Health and Wellbeing Strategy
'*Disadvantage starts before birth and accumulates throughout life*'

The best way to break the cycle of disadvantage and poor health is to take action early. Ensuring that children have a good start in life can lead to life-long improvements in health and wellbeing.

We know that more than one in five Thurrock children live in poverty. That makes it much harder for them to achieve their full potential in life. Our target is to halve this by 2020.

Thurrock is a place of opportunity. The ambitious programme of regeneration in the borough means new jobs are being created – for example through London Gateway (DP World) in the east of the borough. Thurrock people must be able to access these jobs. That means people need to leave school with good qualifications and go on to get the skills they need to secure good jobs.

GOAL 1: Opportunity for all - Key achievements Year 1

- We have developed strategic programmes to support the recruitment of medical students recognising the need to encourage more of our young people into medicine
- We have developed a Youth Employment Initiative, which has won accolades from the Deputy Director of the European Union Structural Programme on youth employment following an EU audit
- Our Inspire – Your Future Programme, through our Grangewaters facility now offers a wide range of outdoor education activities to support the our residents and we are working closely with health partners to develop further programmes to support healthy lifestyles

Key achievements : Objective 1A - All children in Thurrock making good educational progress

- As part of our plans to integrate our children's centres with health and social care to provide early intervention and support to families in greatest need we have created a single point of access so that every child maximises their early learning to ensure readiness for Reception in their primary school
- 75% of Thurrock children leaving reception and going into Year1 last summer gained a Good Level of Development (GLD). This is an improvement on the previous year and is 6 percentage points higher than the National Average (69%)
- Thurrock now boasts one of the most improved statistics nationally for the provision of schooling for Thurrock families. 96% of all our schools are now good or better, meaning parents can be assured their child receives an education which has the potential to maximise their progress and attainment and so gain higher education and employment locally

How we have addressed feedback from the public

To facilitate **all children in Thurrock making good educational progress** key themes raised by the public included:

- Improving discipline in schools and ensuring that bullying and intimidation is tackled effectively
- Ensuring children and young people to continue to recognise that their future does not depend only on academic achievement and that there are opportunities for securing high quality employment and gain vocational qualifications through apprenticeship schemes

The public's views have been reflected and addressed in our work through:

- Stronger links are being developed with all our schools and academies to create a partnership of providers to promote joint working across the borough through the effective use of our Teaching Schools Alliance offering in-service training
- Programmes are also being developed in the partnership of providers to work with the Adult College (TACC) to up-skill local residents and improve the likelihood of securing even higher assessment grades for both children and adults

GOAL 1: Opportunity for all - Key achievements Year 1

Key achievements : Objective 1B. More Thurrock residents in employment, education and training

- Strategic development of programmes to support the recruitment of medical students. Recognising the need to encourage more young people into medicine given our current recruitment challenges the Director of Public Health and *Inspire – Your Future* have met with a local university and are looking to pilot a programme around a career in medicine
- To support this we have submitted a bid to support a summer school programme around medicine and the career pathways that are available
- Delivery of Youth Employment Initiative and positive feedback around audit and recent visit. Our YEI has recently undergone an EU audit and this received very positive feedback. We have also hosted the Deputy Director of EU Structural programme and she was very positive about the work we are undertaking
- Opportunity Thurrock & Thurrock's Next Top Boss raising the profile around job opportunities. Recent awards evening for TNTB was well received and shows how businesses and school are working together
- Grangewaters – Part of *Inspire – Your future* offer a range of outdoor education activities and looks to address some of the health issues across Thurrock. Exciting opportunities are being developed to support the wellbeing of Thurrock residents and we are working closely with health to explore further programmes to support healthy lifestyles

How we have addressed feedback from the public

To support more Thurrock residents into employment, education and training key themes raised by the public included providing:

- More opportunities for adult learning and development
- An increased focus on skilled labour and jobs
- Alternative routes that do not rely on achievement of academic qualifications

The public's views have been reflected and addressed in our work through:

- Stronger links being developed with new employers, including Amazon to create pre-employment programmes which will support residents into work.
- Programmes are also being developed in partnership with local Higher Education providers to up skill local residents and improve the likelihood of securing higher skilled based employment.
- Continuing to work with local employers to increase apprentice opportunities at all levels.
- Working with Community and Voluntary Sector organisations to support residents with Learning Disabilities into extended work placements that are pathways into employment

GOAL 1: Opportunity for all - Key achievements Year 1

Key achievements : Objective 1C - Fewer teenage pregnancies in Thurrock

- The teenage pregnancy rate in Thurrock has continued to decline and is currently at its lowest level since record began (24.5 per 1,000 females)
- Rolling out an electronic C-Card online, giving young people have easier access to condoms. The electronic C-Card scheme is now also available to Thurrock professionals. This new method has removed barriers to young people and professionals. Young people no longer have to carry a physical card and professionals do not have to complete time consuming paperwork.
- Setting up a specific young person's Sexual Health Clinic accepting both drop-ins and booked appointments, allowing greater flexibility for young people
- Working with the Youth Cabinet to obtain young people's ideas regarding how to improve service delivery. This engagement led to the development of a Teenage boys Pregnancy Programme and improving the content of the Delay and Go Girls programmes, which raise aspirations among young people.

How we have addressed feedback from the public

To facilitate **fewer teenage pregnancies in Thurrock** key themes raised by the public included providing:

- Education, advice and guidance to young people.
- Services across Thurrock that are accessible to different groups within the community and ensuring that young people know how to access those services.

The public's views have been reflected and addressed in our work to ensure there are **fewer teenage pregnancies in Thurrock** through:

- The commitment to work with Thurrock Careers Service Aspire and relationship sessions in all secondary schools. Education about the consequences of teenage pregnancy is being addressed for girls and boys through the plan to redesign the Delay and Go Girls programme for confidence and aspirations and the creation of a bespoke programme for boys.
- Drop in sessions and booked appointments are available within schools and the young persons sexual health clinic. Our provider NELFT have produced new leaflets, posters and contact cards with the inclusion of an electronic C-Card scheme and have also launched a website in May 2017 to improve accessibility.

GOAL 1: Opportunity for all - Key achievements Year 1

Key achievements : Objective 1D - Fewer children and adults in poverty

- Youth Employment Initiative (YEI) funding application success which enables us to provide bespoke programmes to unemployed 16-29 year olds

How we have addressed feedback from the public

As part of ensuring that **fewer children and adults in poverty** key themes raised by the public included providing:

- better education and health starting pre-school with families
- Intervention - apprentices for local young people – more support for young people to get into university and advice around managing costs
- jobs for parents

The public's views have been reflected and addressed in our work through:

- our links with local academy chains to promote adult learning in schools – and utilising the children centres to support family learning
- we commissioned a Top Achiever programme to support young people in Thurrock to access Russell Group Universities – recruit local young people into apprenticeship opportunities within the council.
- joint work with Economic Development Team has enabled some planning to be undertaken with the new employers in Thurrock to ensure that the work is flexible to support parents across the authority

GOAL 2

A healthier environment

Summary

We want to achieve places and communities that keep people well and independent

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- Objective 2A. Outdoor spaces that make it easy to exercise and to be active
- Objective 2B. More homes will be built that keep people well and independent
- Objective 2C. Communities will be stronger and better connected
- Objective 2D. Air quality will be improved

Why this goal is a key part of the Health and Wellbeing Strategy

We want to keep people well for as long as possible. For this to happen, we need communities that are strong and inclusive. We also need the way Thurrock's neighbourhoods are designed and built to make it easy for people to lead active and healthy lives.

If children and adults are to be more active we need to create environments that encourage them to be more active – either at school or where they live. We also need to ensure that public space is attractive and that people feel safe when they use it.

Much has already been done to empower local communities to be strong and inclusive. The Stronger Together partnership is a ground-breaking initiative which promotes community activities that strengthen connections between people. It also encourages people to have a greater say in what happens in their neighbourhood, taking control over the decisions that affect them. We want to build on that work to build strong, well-connected communities.

GOAL 2: A healthier environment - Key achievements Year 1

Much has already been done to empower local communities to be strong and inclusive

- The Stronger Together Partnership is a ground-breaking initiative which promotes community activities that strengthen connections between people. It also encourages people to have a greater say in what happens in their neighbourhood, taking control over the decisions that affect them. We want to build on that work to build strong, well-connected communities.
- Officers in the Public Health and Planning and Environment teams organised a joint health and planning summit last year, attracting praise from across the region.
- Our officers across the council continue to work in an integrated way to ensure that the regeneration of Tilbury and Purfleet capitalise on opportunities to create new physical environments that promote wellbeing, such as making it easier to walk and cycle.

Key achievements: Objective 2A - Create outdoor places that make it easy to exercise and to be active

- The following Components of the Active Place Strategy have been completed: Indoor Built Facilities Needs Assessment; Playing Pitch Strategy Needs Assessment and Draft Strategy; Open Space Needs Assessment; Parks, Play and Open Space Improvement Plan.
- Work commenced the Active Travel plan and working group including key strategic partners established.
- A question was included within the residents' survey to asses views on "how easy Thurrock Council makes it easy for residents to exercise in parks and open spaces". This gives a baseline for future comparison.

How we have addressed feedback from the public

To **create outdoor spaces that make it easier to exercise and be active** key themes raised by the public included:

- Considering the merits of considering alternative management arrangement and making better use of volunteers
- Providing more facilities that are accessible to all and facilitate exercise and leisure, informed by members of the public

The public's views have been reflected and addressed in our work through:

- The council already had several friends of groups and community forums that work with the council to manage and maintain parks and open spaces. The emerging Active Place Strategy is currently looking at a range of delivery and management options in more detail these will be discussed in the coming months with a decision reached by summer 2017
- Suggestions relating to physical improvements to spaces including outdoor gym equipment and improving accessibility will be considered when determining future projects to be included in the Infrastructure Requirement List and the Active Place Strategy. In addition, a capital bid has been prepared for providing outdoor gyms and related equipment at strategic sites which are to be identified via the Active Place Strategy
- As part of sustaining community engagement specific question has now been built into the residents survey and asks - if the council "makes it easy for residents to exercise and or be active in the parks and open spaces"

GOAL 2: A healthier environment - Key achievements Year 1

Key achievements : Objective 2B - Develop homes that keep people well and independent

- The preparatory work to build a HAPPI scheme in Tilbury is well progressed and a planning application has been submitted

How we have addressed feedback from the public

To **develop homes that keep people well and independent** key themes raised by the public included:

- Considering the design of the physical structure of home, which may need to be adapted as people's physical health changes
- To supply a list of services, equipment and support networks to those in sheltered accommodation or needing home care. Giving more choice and independence. To consider Put lifts into existing sheltered housing flats to enable easier access in and out of the home and to prevent people from becoming housebound who cannot manage stairs

The public's views have been reflected and addressed in our work through:

- The design of new homes in the social sector are required to incorporate lifetime homes standards which seek to ensure homes remain suitable for people as their needs change over time, or are easily adaptable to meet specific needs. The Council have also adopted 'HAPPI' standards in the development of new social housing for people approaching and beyond retirement age. Due regard is given in the planning and design process to have appropriate space standards, good access to local amenities and outdoor space, good levels of storage space and a requirements to ensure flexibility so that the homes are 'care ready'
- Sheltered housing is in a period of restructuring as a result of the number of schemes that require redevelopment and the changing profile of need amongst our older population. Where schemes are no longer appropriate and there is no value for money case for significant improvements they will be de-commissioned, if there is still a case for maintaining a scheme then investment will be available for improvements; this may include the provision of lifts where required.

GOAL 2: A healthier environment - Key achievements Year 1

Key achievements : Objective 2C - Build strong well-connected communities

- Thurrock Giving has now been fully implemented
- Social Prescribing has been introduced with two social prescribers working with interested Primary Care providers
- As set out at objective 3C, four new Local Area Coordinators are being recruited, building on the success of the team over the last 3 years. The new posts will be used to respond to a significant rise in demand for LAC intervention

How we have addressed feedback from the public

To **build strong, well connected communities** key themes raised by the public included:

- Providing Trial sessions at Gym and local exercise clubs 'try before you buy'.
- Maintaining Parks/Recreation Grounds, as reduced mowing and lack of repair mean space cannot be used – reducing the availability of spaces to exercise and increase social inclusion.
- Ensuring community hubs and Local Area Co-Ordinators (LACs) bring communities together more and develop partnerships.

The public's views have been reflected and addressed in our work through:

- Providing access to local gyms for people who will benefit most through the social prescribing model. Once evaluation is complete we will seek to extend those areas where there is evidence of success
- The council's key strategic objective and "Clean it, Cut it, Fill it" Campaign we aim to maintain parks and recreation grounds
- There are plans to expand the LAC service and increase the number of Community Hubs which will enhance and extend impact. This will also help to raise awareness of activities that are available for members of the public

GOAL 2: A healthier environment - Key achievements Year 1

Key achievements : Objective 2D - Improve air quality in Thurrock

- Thurrock Council has formally approved an Air Quality Strategy, which has a wide-ranging number of measures across the borough to tackle poor air quality and to reduce the number of AQMAs to the agreed 2021 target of eight (8) AQMAs down from the current 18

- Thurrock Council is supporting National Clean Air Day on 15 June 2017 in collaboration with two (2) primary schools to raise awareness of the health impacts of emissions by idling vehicles on the school children

How we have addressed feedback from the public

To **improve air quality in Thurrock** key themes raised by the public included:

- Reducing idol engines in cars and public transport
- Ensuring that the Air Quality Strategy covers the whole of Thurrock and not specific areas
- Looking at the current bus routes and where needs are unmet or routes are inadequate e.g. East Tilbury.
- Considering park and ride options in Thurrock to reduce traffic congestion

The public's views have been reflected and addressed in our work through:

- Demonstrating that we are keen to reduce unnecessary engine idling across the borough for all vehicles. For example, we are piloting a scheme to tackle idling as part of National Clean Air Day (15 June 2017)
- The Air Quality and Health Strategy seeks to implement measures that relate to the whole of Thurrock and is not focussed on small areas, with the exception of actions to address air quality issues in the borough's AQMAs
- The council is always keen to improve accessibility to buses across the borough, which is supportive of the council's Transport Strategy to encourage modal shift away from single-occupancy private vehicles. The council currently has no plans to investigate or implement a park and ride scheme within Thurrock. Thurrock's profile does not currently fit with the operating model for a Park & Ride

GOAL 3
Better emotional health and wellbeing

Summary

We want to strengthen mental health and emotional wellbeing

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- Objective 3A. Parents will be given the support they need when they need it
- Objective 3B. Children will have good emotional health and wellbeing
- Objective 3C. Fewer people will feel socially isolated or lonely
- Objective 3D. Identification and treatment of depression will be improved, particularly for those at greatest risk

Why this goal is an important part of the Health and Wellbeing Strategy

We know that at least one in four people will experience a mental health problem at some point in their life and that one in six adults will have a mental health problem at any one time. We also know that half of those with lifetime mental health problems first experience symptoms by the age of 14. Depression is the most common mental health problem making it a priority for us.

There are a number of things we can do to lessen the chance of poor mental health from occurring, or to prevent it from worsening. This includes ensuring that parents receive good support when they need it and identifying problems as early as possible. Tackling bullying is also important because it not only affects the mental health of children but can have long-term effects stretching into adulthood.

For people who do require long term medical care, we want to ensure that people are identified before they reach crisis point and that the service they receive is of high quality and tailored to the individual. People with poor mental health often have poor physical health too, and we must ensure that we consider mental, physical and emotional wellbeing together.

We know that within our communities, particularly with Thurrock's older population and those with caring duties, many people will be suffering due to social isolation. Social isolation can have a significant impact on physical health as well as mental and emotional wellbeing. We must give people opportunities to connect.

GOAL 3: Better emotional health and wellbeing - Key achievements Year 1

- A new IAPT (Increase Access to Psychological Therapies) provider *Inclusion Thurrock* began to offer services to our residents in April 2016 and have quickly settled in Thurrock.
- *Inclusion Thurrock* has received huge levels of positive feedback from patients/service users as well as health and social care colleagues who work with them. *Inclusion Thurrock* are very forward thinking and have built relationships proactively with the public health team as well as various teams in the CCG, council and secondary care.
- *Inclusion* began to work with diabetes and COPD clinics run by NELFT in February 2017, as a way of finding clients who are more likely to require their services (evidence shows that those with long term conditions are more likely to be affected by anxiety and/or depression). In October 2016, a recovery college was opened by *Inclusion* and this will help Thurrock residents improve their mental health, wellbeing and resilience

Key achievements : Objective 3A - Give parents the support they need

- Whilst there have been many achievements across the range of services that support parents perhaps the biggest success has been the development of the Brighter Futures offer through the integration of the Healthy Families Programme, Early Offer of Help Commissioned Services, Children's Centres, Early Offer of Help team and Troubled Families team. This means that for the first time an integrated offer across health, education and social care is available to support families and link with other professionals such as school staff, GP's and Social Workers. The procurement of the commissioned elements of the offer will be delivered from the Autumn onwards with delivery in children's centres, schools and health clinics. This integrated offer will provide families with a single registration for services and access to targeted support when it is needed.

How we have addressed feedback from the public

To **give parents the support they need** key themes raised by the public included:

- Increasing the awareness of support for parents with children who have disabilities and make it easier for parents to access this support.
- Providing disability support groups and ensure sessions at the Thurrock Children Centres are suitable and accessible to children with a disability.

The public's views have been reflected and addressed in our work through:

- The redesign of the 0-19 Wellbeing programme including Children's Centres will take into account the need to improve access to support for parents of children with a disability. In addition as a part of the SEND Local Offer the feedback provided will be passed to the Family Information Service to improve awareness of the support available.

GOAL 3: Better emotional health and wellbeing - Key achievements Year 1

Key achievements : Objective 3B - Improve children's emotional health and wellbeing

- In 2016-17 the new Emotional Wellbeing and Mental Health service has been mobilised. The service in Thurrock offers one point of contact where families can talk to a qualified clinician directly to receive advice and support while waiting for their assessment. The new service model has improved access for families and professionals who refer to the service with many more children receiving interventions to manage their mental health needs. The waiting times have improved and Thurrock are currently seeing children and young people within 18 week target.
- The last year has also seen the development of a specialist service for children and young people who are presenting with Eating Disorders. This provides specialist support whilst building the capacity and knowledge within local teams. Training has been an identified need to ensure quality and responsiveness of the service. Interventions delivered must be based on what we know works and the service have a plan in place to ensure all staff are trained in IAPT and other specialist courses by 2018. A number of children present in crisis with urgent needs and 100% of these children have been assessed within 4 hours of presenting at A&E by a specialist. Next year plans to review how the crisis model can develop to see children in their homes and prevent escalation of problems.

How we have addressed feedback from the public

To **improve children's emotional health and wellbeing** a key theme raised by the public included:

- Raising the profile of the help available within schools and colleges to support people experiencing mental-ill health challenges and to promote a culture of asking for help when needed rather than doing nothing. Make it easy for people to seek help, e.g. through use of social media.

The public's views have been reflected and addressed in our work through:

- The Transformation plan , Open up, Reach Out which identifies the need to build resilience within our community. Schools and colleges play an essential role in understanding mental health issues and providing support. There are plans to develop a website for children and young people emotional wellbeing and mental health giving information to schools and online techniques, such as self-help toolkits. Additionally, schools and community leaders we work together with young people to develop a peer mentoring scheme that equips young people themselves to be able to help others.
- The Emotional health and wellbeing service are also co-designing a pilot with schools to develop training and capacity within groups of schools .Covering training, common understanding of emotional wellbeing and mental health and developing links with the new EWM. The school support team will work on four areas including; Self –harm, suicidality, anxiety and bereavement; Regular and specialist consultations on complex cases; Regular supervision for pastoral staff and school leaders; Access to a range of courses for teachers and staff and through links with independent sector partners.

GOAL 3: Better emotional health and wellbeing - Key achievements Year 1

Key achievements : Objective 3C - Reduce social isolation and loneliness

- Pilot programme for Living Well in Thurrock has been successfully concluded and the evaluation outcomes used to inform the specification for the domiciliary care contract being tendered later this financial year.
- Detailed work has been undertaken with a wide range of stakeholders to ensure that we have a clear specification for the delivery of Domiciliary care to ensure that new delivery models can be implemented
- The development of wellbeing teams based upon Buurtzorg and Local Area coordination models is nearing completion and will form part of the implementation of a new service model under the Accountable Care Partnership for Tilbury.
- Four new Local Area Coordinators are being recruited, building on the success of the team over the last 3 years. The new posts will be used to respond to a significant rise in demand for LAC intervention.

How we have addressed feedback from the public

To **reduce social isolation and loneliness** key themes raised by the public included providing:

- Continue to strengthen social relationships and opportunities for community connection for individuals and families, especially those in greatest need e.g. the most vulnerable and isolated. For example through use of the local area coordinators
- Advertise for more volunteers to increase time-banking initiative
- Publication/notification of local community activities. Many people in the community are not aware of everything that is going on

The public's views have been reflected and addressed in our work through:

- Local Area Co-ordinators, social prescribers and Timebanking initiatives, along with a number of other projects are all focused upon strengthening community connections and building social relationships for marginalised groups and individuals. This will continue to be a major objective of their work
- Timebanking continues to go from strength to strength in Thurrock and some impact upon providing transport for vulnerable people has already been a feature. In addition the LACs have some impressive evidence of using volunteers as providers of transport and we have made the use of our day centre transport more available to others in recent months. However there is always more we can do and this will be a focus area for development in future
- The Stronger Together website, particularly the development of Community Asset Maps, should enable improved awareness of what is happening or available within communities

GOAL 3: Better emotional health and wellbeing - Key achievements Year 1

Key achievements : Objective 3D
Improve the identification and treatment of depression, particularly in high risk groups

- A new IAPT provider began to offer services to Thurrock residents in April 2016 and have quickly settled in Thurrock. Inclusion Thurrock have had lots of positive feedback from patients/service users as well as health and social care colleagues who work with them
- Inclusion are very forward thinking and have built relationships proactively with the public health team as well as various teams in the CCG, council and secondary care. Inclusion began to work with diabetes and COPD clinics run by NELFT in February 2017, as a way of finding clients who are more likely to require their services (evidence shows that those with long term conditions are more likely to be affected by anxiety and/or depression)
- In October 2016, a recovery college was opened by Inclusion and this will help Thurrock residents improve their mental health, wellbeing and resilience

How we have addressed feedback from the public

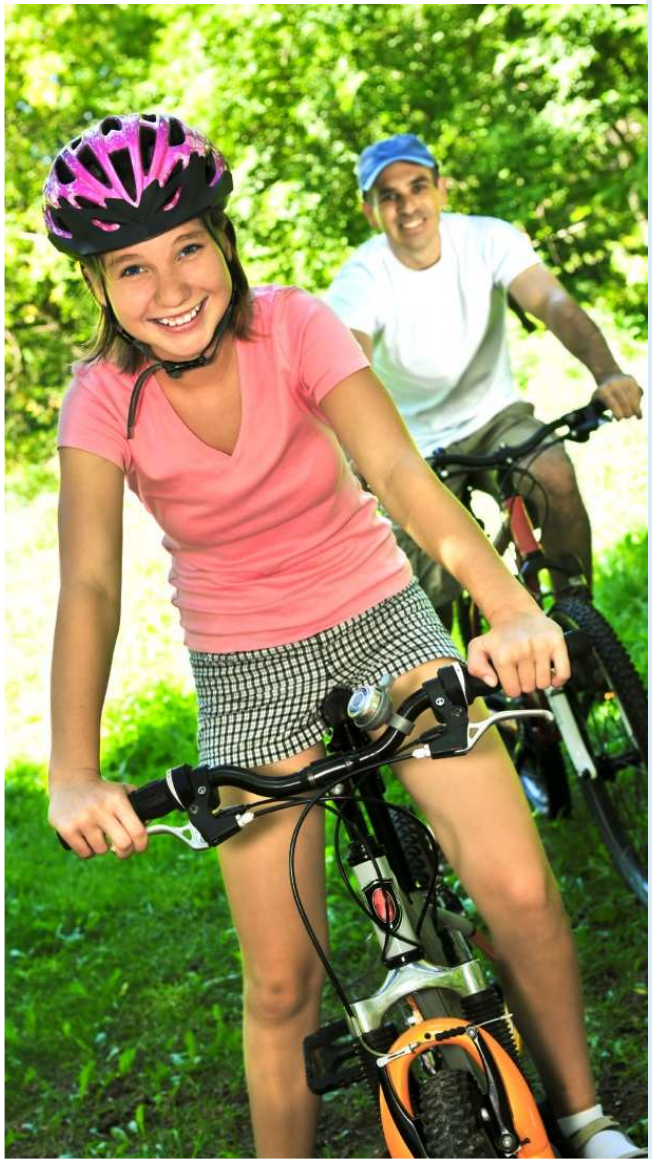
To **improve the identification and treatment of depression** key themes raised by the public included providing:

- Counselling services should be able to recognise and understand the links between LTCs and mental health. It was suggested (by Stroke Group) that often counsellors do not understand that having a LTC can be the main cause of depression. Living with a LTC greatly impacts on a person's quality of life and can lead to mental health conditions
- Screen early – Doctors/nurses refer to helpline, family members to screen
- Have a 24 hour local helpline for depressed people in crisis, potentially utilising expertise of local people

The public's views have been reflected and addressed in our work through:

- A depression screening pilot was launched in July 2016 where council social care team members are now identifying those aged over 65 with a long term condition. These clients are offered the opportunity to use a depression screening tool to determine if they are appropriate for a referral to Inclusion Thurrock, our local Improving Access to Psychological Therapies (IAPT) service
- Not only do doctors and nurses make referrals, we also have social care colleagues make referrals and clients are made aware that they can self-refer into services
- There are 24 hour local helplines available. There are currently no plans to establish a localised helpline within Thurrock

GOAL 4
Quality care, centred around the person
Summary



We want to remodel health and care services so they are more joined up and focus on preventing, reducing and delaying the need for care and support.

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- Objective 4A. Four new healthy living centres will be built with GPs, nurses, mental health services, wellbeing programmes, community hubs and outpatient clinics under one roof
- Objective 4B. Care will be organised around the individual
- Objective 4C. People will feel in control of their care
- Objective 4D. High quality GP and hospital care will be available to Thurrock residents when they need it

Why this goal is an important part of the Health and Wellbeing Strategy

There will always be times when people need treatment or care from GPs, hospitals, social care or other services. When they do, we want to ensure that services in Thurrock are joined up and organised around people's needs rather than the needs of organisations. When people are passed from one organisation to another to receive different services they often don't get the best package of care and valuable resources are wasted. That's why we have a vision to create four Integrated Healthy Living Centres in Thurrock which will provide a whole range of health and care services under one roof. This is part of providing holistic solutions, which go beyond treating conditions to supporting people.

Hospitals are under huge pressure but much of that could be avoided if we get better at providing support at an early stage, to stop things progressing. So, instead of waiting for people to develop serious illnesses before we treat them, we want services to act at an early stage to prevent, reduce and delay the need for care and support. When people use health and care services in Thurrock we want to make sure that healthcare is easy to access and that they get the best possible treatment. As far as possible, people should be in control of their own care. That is especially important for people who have long term conditions and we have already begun to develop some of these approaches, but we must work together and with communities to take this further.

GOAL 4 Quality care, centred around the person - Key Achievements Year 1

- We continue to work closely with our key partners in NHS Thurrock CCG and other NHS Providers to ensure health and care for our residents becomes more joined up. Hospitals are under huge pressure but much of that could be avoided if we get better at providing support at an early stage, to stop things progressing. So, instead of waiting for people to develop serious illnesses before we treat them, we are implementing a range of services to intervene early to act at an early stage to prevent, reduce and delay the need for care and support. We have developed a joint strategic commissioning plan *For Thurrock in Thurrock*, with our CCG partners and are piloting an Accountable Care Partnership in Tilbury. More detail is set out in the Health Programmes section of this report.

Key achievements : Objective 4A - Create four integrated healthy living centres

- This is an ongoing piece of project. The Clinical Commissioning Group (CCG) and the council have already started work on developing business case for building two new Integrated Medical Centres (IMC) in Tilbury and Purfleet. CCG and the council are working with NELFT to inform the services that will be delivered from the new IMC that will be built in Corringham and Stanford-le hope locality
- A working group has been set up that is reviewing the existing Thurrock Community Hospital estates and how best to reconfigure to deliver integrated services for the Grays locality

How we have addressed feedback from the public

To **create four integrated living centres** key themes raised by the public included providing:

- carers support services, advice and guidance should be provided within the integrated living centres
- as part of ensuring accessibility for members of the public it will be important to ensure that centres publicise their services and when they are available
- it will be important for integrated living centres to provide services targeted at various age ranges: young people; disability and older people
- it will be important to ensure that services offered in integrated living centres are accessible, possibly by being open during the evening and at weekends

The public's views have been reflected and addressed in our work through:

- Carers support services, advice and guidance are recognised as an integral part of the service that will be provided from the healthy living centres
- As part of ensuring accessibility to services within centres We aim to develop and publicise a directory of services which will have information on the services being offered from the healthy living centres
- Services provision from the health living centres will align with the Joint Strategic Needs Assessment (JSNA). This will ensure that the services are delivered as per the need of the local population
- Services to be delivered from the centres are being designed on a 7 day working week model to ensure patients are able to access services outside the core working hours

GOAL 4 Quality care, centred around the person - Key Achievements Year 1

Key achievements : Objective 4B - When services are required they are organised around the individual

- Frailty Identification and Care Planning – improved care pathway has strengthened pathways between primary and secondary care;
- GPs have identified patients with 'severe' and 'moderate' frailty;
- NELFT have determined if known to community services;
- Patient not known to community services have been added for discussion at Primary Care MDT;
- Specialist nurse attends frailty unit MDT three times per week to discuss and plan discharges;
- Patients discharged from the frailty unit at BTUH and are known to NELFT now have a named accountable community professional (NACP) and a care coordination plan (CCP);
- Patients who are not known to NELFT are now discussed in GP MDTs so that care can be coordinated to meet the patients' needs; and the most appropriate person to coordinate their care is identified to coordinate that care.

Patient feedback has included:

"I would recommend this service 110% it exceeded my expectations. Mr A.D. Grays".

How we have addressed feedback from the public

As part of ensuring that **when services are required they are organised around the individual** key themes raised by the public included providing:

- As part of ensuring care is focussed around the individual it is important for patients to understand their rights and be provided with support to do so. It will also be important for patients to understand their treatment pathway and the process. This could be achieved by ensuring that practitioners proactively advise people about the potential medical services that may be required to address their medical condition.
- As part of providing care centred around the person it will be important that services are available when patients can access them, such as weekends and evenings.

GOAL 4 Quality care, centred around the person - Key Achievements Year 1

Health and Wellbeing Strategy Objective 4B. When services are required they are organised around the individual

How we have addressed feedback from the public

The public's views have been reflected and addressed in our work through:

- There is an increasing focus on shared decision making. This forms part of the CCG demand management plan. Patients need to understand their rights but also their responsibilities.
    - There are a number of areas of work focussed on early detection and prevention which aim to empower patients to make better decisions and take more responsibility for their health. These include:
    - A Recovery College model of support and self-help has been implemented for Patients with LTCs and MH to assist recovery. The service went live on 1st October 2016. The recovery college use peer mentors to help support people to understand their condition and empower patients to develop effective self-management techniques.
    - Extending the number of local area co-coordinators. Local area co-ordinators work with local populations to offer third sector support groups specific to their individual needs.
    - Tier 3 adult weight management has been commissioned to support patients to lose weight and avoid the necessity of bariatric surgery by encouraging people to adopt healthier lifestyles and avoid medical complications.
- As part of ensuring services are available when patients can access them there are a number of work streams focussed on this area. For example;
    - The acute contract is focussed on delivering 4 key clinical standards 7 days a week
    - We have developed 4 primary care hubs open at weekend and some evenings
    - The development of a 7 day a week single point of access 'Thurrock first'

GOAL 4 Quality care, centred around the person - Key Achievements Year 1

Key achievements : Objective 4C. Put people in control of their own care

- The new advocacy contract is in place supporting choice and control independently from the council
- The pilot for Individual service funds has been established ending a block contract and working in partnership with people who use services, the provider and adult social care. This has been very positively received and is working well
- Transforming care for people with learning disabilities has been very positive regarding ensuring numbers are small for admissions to assessment and treatment units supporting people to return home as quickly as possible. One notable achievement has been supporting one individual who has been in a hospital setting for over 20 years to move into their own house with a support team with very positive outcomes
- The development of a new specification for support at home focused on outcomes and early intervention and prevention and setting the foundations for new ways of working

How we have addressed feedback from the public

To **put people in control of their own care** key themes raised by the public included providing:

- It would be helpful if a Learning Disability Advocate can support individuals to ask questions when visiting a GP.
- As part of ensuring care is focussed around the individual it is important for patients to understand their rights and be provided with support to do so. It will also be important for patients to understand their treatment pathway and the process

The public's views have been reflected and addressed in our work through:

- Advocates, by the nature of the service, support individuals to take informed decisions about their care. The role of an advocate is to ensure individuals are aware of implications of decisions that they take and can support people to ensure that their wishes are understood. Advocates do not focus on particular groups of individuals who have substantial difficulty in expressing their views.
- As previously explained, there is an increasing focus on shared decision making. This forms part of the CCG demand management plan. Patients need to understand their rights but also their responsibilities.

GOAL 4 Quality care, centred around the person - Key Achievements Year 1

Key achievements : Objective 4D - Provide high quality GP and hospital care to Thurrock

- Our GP quality improvement programme is an ongoing piece of work and to date from a base line of only two GP practices out of 32 practices rated as Good by CQC only 18 months ago, we now have 21 Good practices. The aim is to have no inadequate practices by the end of 2017/18.
- Thurrock residents will benefit from further improved care by the initiatives developed by the CCG to implement the recommendations from GP five year forward view and the creation of 4 IMCs.

How we have addressed feedback from the public

To **provide high quality GP and hospital care to Thurrock** key themes raised by the public included:

- Hospitals should be able to refer patients to other hospitals when there is a long waiting list to access specific services, enabling patients to access treatment sooner in another setting that may have more capacity than the original hospital to which they were referred.
- It will be important for patients to be provided with single points of contact who have an overview of their treatment requirements. In some instances patients access different experts who may not be aware of the patient journey and provide advice in isolation-

The public's views have been reflected and addressed in our work through:

- Onward referral is in place and patients do have a Choice under E-referral system to make choice of hospital based on waiting times.
- The new single point of access, known as Thurrock First, commenced in February 2017. This enables people to access one point of contact for community care, mental health and social care. This will enable us to ensure that people get the most appropriate response first time.

GOAL 5
Healthier for longer
Summary

We want to reduce avoidable ill-health and death

The following four objectives have been identified as part of defining this goal and describing what achieving it will look like:

- A greater proportion of our population will be a healthy weight
- Fewer people in Thurrock will smoke
- The identification and early treatment of long term conditions such as diabetes or high blood pressure will be significantly improved
- More cancers will be prevented, identified early and treated better

Why this goal is a key element of the Health and Wellbeing Strategy

Thousands of us will be ill or die each year from diseases which are preventable. Promoting healthy lifestyle choices is vital. Smoking is still by far the most common cause of preventable ill health and death, and obesity is a growing problem which is particularly acute in Thurrock.

These issues affect physical and mental health, they result in shortened lives and poorer quality of life, and they put huge strain on families and health services. Tackling these issues is vital, therefore, if we are to improve health and wellbeing in Thurrock.

To do this, we want to help people make healthy choices. For example, help people maintain a healthy weight we want to make it easy to be active, have a healthy diet and provide people with good information on how to live a healthy life.

Cancer is one common reason for ill health and death. Many cancers are avoidable through lifestyle changes but when people do have cancer we want to ensure that it is identified early through screening programmes and treated effectively when it does happen.

GOAL 5 Healthier for longer – Key achievements Year 1

- We refreshed our Tobacco Control strategy for Thurrock in 2016 with a focus away from chasing meaningless 'four week smoking quit targets' but offering stop smoking support to smokers who are truly motivated to quit. We have also shifted the focus to concentrate on groups who are at most risk and most motivated to quit including those with mental health problems and long term physical health conditions related to smoking including COPD and heart disease.
- We have also commissioned the evidence based ASSIST programme within our schools, to dissuade younger people from becoming addicted to cigarettes in the first place, and delivered a high impact enforcement operation in partnership with our Trading Standards team, that has resulted in thousands of pounds worth of illegal illicit tobacco being removed from sale in our borough.
- Finally we have brought the ground breaking "Daily Mile" to our schools. This simile concept means that every child in the school runs one mile a day during the school day. Evidence shows this has a major impact on childhood obesity. Over 40% of our schools have already adopted the programme, with more coming on line each week.

Key achievements : Objective 5A - Reduce obesity

- Daily Mile target for the year reached and exceeded – 41% of Primary Schools (target 40%)
- Health, Well-being and Planning Summit September 2016 delivered and the subsequent work falling out from the summit
- Brighter Futures Healthy Family Service re-procured which includes NCMP and healthy weight services for 0-19 years
- New single point of contact Healthy Lifestyles Service
- Launch of Weight Management Care Pathway

How we have addressed feedback from the public

To **increase the number of people in Thurrock who are of a healthy weight** key themes raised by the public included:

- Look at possible ways of making healthier options more accessible and affordable especially in areas where a larger supermarket is not nearby. E.g. a mobile fruit and vegetable stall or small market. Parents given information on lifestyle changes to improve diets of families.
- Reach the families to educate in a fun way – food labelling, food tasting, portion sizes
- More community activities i.e. fun runs/walks – needs to be free or minimal cost.

The public's views have been considered:

- Some excellent, insightful and creative views from the public consultations and these will be taken into account through the strategy and action plan development. We will only tackle obesity and achieve healthy weight with a true partnership with the community in addition to looking at built infrastructure, environments and local support services available at the 'treatment' end of this work.

GOAL 5 Healthier for longer – Key achievements Year 1

Key achievements : Objective 5B - Reduce the proportion of people who smoke

- The Tobacco Control Strategy was refreshed in 2016 and its action plan will help achieve the related HWBB objectives
- We have a new integrated healthy lifestyles service that will embrace e-cigarettes and the treatment opportunity that they offer
- We have commissioned and implemented ASSIST, which will help fewer young people take up smoking
- We have delivered a high impact but low cost enforcement operation in partnership with Trading Standards to tackle illicit tobacco
- Our drug and alcohol treatment providers now work with helping some of our most vulnerable residents quit smoking
- We are working with BTUH and EPUT to help ensure robust smoke free practices are implemented and maintained in acute settings

How we have addressed feedback from the public

To **reduce the proportion of people who smoke** key themes raised by the public included providing:

- Consider e-cigarettes as an option for smoking cessation.
- Parents and schools require education on the subject
- Encourage workplaces to have strategies for reducing smoking in their work force.

The public's views have been reflected and addressed in our work through:

- E-cigarettes already feature as an option for smoking cessation in our new service specification from 1st April 2017
- Schools have a duty to address healthy lifestyles with pupils, and our Providers are tasked with working in partnership with schools to enhance their core offer within the curriculum. In addition, our sexual health Provider offers programmes to educate girls and young women on self-esteem and body image. This also constitutes preventative work Schools also endeavour to engage parents and carers to help address such matters via home-school liaison, parents' evenings, bespoke training events and such-like.
- Under the old Public Health Responsibility Deal we had a framework to offer strategies to local businesses, which included reducing smoking in their workforce. It will be possible for businesses to work with our healthy lifestyles provider to help promote stop smoking campaigns across their workforce

GOAL 5 Healthier for longer – Key achievements Year 1

Key achievements : Objective 5C. Significantly improve the identification management of long term conditions

- Key achievements in year one have been the recruitment of two Health Care Public Health Improvement Managers. These two posts have been instrumental in achieving what has been achieved to date against this action plan and have also taken steps towards improving our links with Primary Care, Pharmacy, and CVS.
- The support and help we have received from GPs, Practice Managers, Pharmacies, and CVS in developing the different streams of the Hypertension detection programme has been extremely helpful to get us to where we are at, and this achievement should result in the implementation of the different streams running smoothly and being successful.
- The Long Term Condition Profile Card has also been developed. The output of this piece of work has far exceeded what we originally set out to achieve. The card is not only easy to read and understand but the indicators included are based on evidence from the 2016 APHR and other sources; indicators included, if improved on really should start to make an impact on the identification and quality of care for LTC patients, thus reducing future demands on Hospital and ASC services. The card will act as a tool to aid discussions in General Practice and help us to identify where support and development is required.
- We have appointed North 51 and who have expressed their support regarding the improved targeting of health checks. We strongly feel that this will make the implementation of this programme easier and more successful.
- The work done to date would not have had an impact on the trajectory yet.; it has mainly been planning work that will lead to interventions having a direct impact. Any reduction that may be observed will be due to other factors or random variation.

How we have addressed feedback from the public

To **significantly improve the identification and management of long term conditions** key themes raised by the public included providing:

- Thurrock Health Professionals should be provided with the knowledge of local support groups or networks for those with LTCs by use of either a tool or easy to access document.

The public's views have been reflected and addressed in our work through:

- The new Healthcare Public Health Managers have begun undertaking an exercise to map out and engage with our third sector/voluntary groups and incorporate them into the relevant LTC care management pathways, and this will therefore mean we will have accurate information on the types & locations of these groups to share at a later date.

GOAL 5 Healthier for longer – Key achievements Year 1

Key achievements : Objective 5D – Prevent and treat cancer better

- A Cancer Implementation Group has been set up between council, CCG and voluntary sector colleagues. This group has been very effective in addressing issues relating to cancer in secondary care, primary care and the community. The action plan created by the group has been updated regularly (every 6 weeks) with many actions successfully completed e.g. emergency presentation audit for cancer.
- Good relationships have been built between colleagues and GP practices therefore ensuring that awareness raising for cancer has been successful through all GP practices in Thurrock. Most of the actions have been achieved for the indicators in the outcome framework. Work has been generated that will continue in year 2 e.g. another emergency presentation audit is being organised for 2017/18.
- One other major achievement has been the new relationships built with St. Luke's hospice, whose health promotion activities help to improve the health and wellbeing of the people of Thurrock

How we have addressed feedback from the public

To **prevent and treat cancer better** key themes raised by the public included:

- Lots of cancers missed on plan
- Provide written information regarding cancer type and treatment options including possible treatment side effects
- Risk areas comprise smoke, drink, weight

The public's views have been reflected and addressed as follows:

- It is acknowledged that there are very many types of cancers. This plan cannot address them all. Therefore the most common ones that affect Thurrock residents have been addressed and given key performance indicators to monitor the outcomes for people with these specific cancers.
- Written information should be provided by GP practices and this can be addressed in practice visits
- With regards to smoking, drinking and weight, we have lifestyle services that we commission in public health, which address these issues and seek to improve the health of Thurrock people via these services.

As part of developing the annual report we identified that Goal 3, Better Emotional Health and Wellbeing could be further enhanced by comprising an objective that specifically focusses on mental health.

The Health and Wellbeing Board has agreed that **Objective 3D improve the identification and treatment of depression, particularly in high risk groups** should be amended to **improve the mental health and wellbeing of the residents of Thurrock**.

The amended objective will continue to focus on identifying and treating depression, particularly in high risk groups. It will also capture wider mental health work including the Essex, Southend and Thurrock Dementia Strategy and Thurrock's action plan, developed as part of the Essex, Southend and Thurrock Mental Health Strategy.

19 July, 2017	ITEM: 10
Thurrock Health and Wellbeing Board	
Consequential amendments to the Health and Wellbeing Board's Terms of Reference and membership	
Wards and communities affected: None	**Key Decision:** Non-key
Report of: Councillor James Halden, Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Corporate Director for Adults, Housing and Health	
This report is Public	

Executive Summary

The Health and Wellbeing Board is a committee of the Council. As such, its terms of reference are agreed by Council and are contained within the Council's Constitution.

Statutory provisions for Health and Wellbeing Boards are contained within the Health and Social Care Act 2012. This includes provisions about changes to Board membership which require Council approval, following approval from the Health and Wellbeing Board. The Monitoring Officer has the authority and power to make consequential amendments to the constitution including this Board's Terms of Reference, which are then approved by the Governance Groups, comprising the three leaders, Chief Executive and the Monitoring Officer.

Once Health and Wellbeing Board members have considered recommendations in this report a further paper will be provided to the Council's Governing Group and Monitoring Officer requesting that the amendments to the Terms of Reference, as agreed by the Board are approved.

This paper asks the Health and Wellbeing Board to agree to the following amendments to its Terms of Reference. Key changes proposed are:

- The inclusion of the Health and Wellbeing Board's Vision, Principles and Goals, which reflect the published Health and Wellbeing Strategy 2016 - 2021 within the Terms of Reference.
- Changes to job titles to ensure the Board continues to accurately reflect the roles of existing members.
- Amending the Chair of Safeguarding Adults Partnership Board to Chair of the Safeguarding Adults Board or their senior representative

- Amending the Chair of the Safeguarding Children's Board to Chair of the Safeguarding Children's Board or their senior representative
- To amend Board representation for Basildon and Thurrock University Trust from the Chief Executive to an Executive of Basildon and Thurrock Hospitals University Foundation Trust, reflecting current representation and availability.
- Chair of Thurrock NHS Clinical Commissioning Group amended to Chair of Thurrock NHS Commissioning Group or a clinical representative from the Board
- NHS England representative amended from Director of Commissioning Operations NHS England, Essex and East Anglia Region to Director level Executive of NHS England Midlands and East of England Region
- That the commitment for the Board to host at least one stakeholder forum each year is removed

1. Recommendation(s)

1.1 For the Health and Wellbeing Board to agree to the changes to the Terms of Reference as outlined within the report.

2. Introduction and Background

2.1 The Health and Wellbeing Board is a statutory partnership board governed by s194 of the Health and Social Care Act 2012 (the Act). The Act specifies who must be a member of the Board and specifies how additional Board members are to be appointed. The Act states that at any time after a Health and Wellbeing Board is established, the Local Authority must, before appointing another member of the Board or amending the Terms of Reference, consult the Health and Wellbeing Board.

2.2 A commitment provided in the Board's Terms of Reference is that it will be reviewed and refreshed on an annual basis. The purpose of this report is to ask the Health and Wellbeing Board to endorse the recommended changes prior to them being considered by the Council's Governance Group and Monitoring Officer.

3. Issues, Options and Analysis of Options

3.1 The inclusion of the Health and Wellbeing Board's Vision, Principles and Goals within the Terms of Reference will provide more transparency about the functions of the Board for members of the public and local partners. The principles published in Thurrock's Health and Wellbeing Strategy have been amended to include:

- The Board will ensure that commitments are delivered and all partners are accountable.
- The Board will not settle for poor levels of service, continually striving to improve the planning and delivery of local services, ensuring that they meet the needs of the people of Thurrock.
- To make sure that clear links continue to be established between health and education services, improving accessibility.

3.2 Amending the functions and job titles for Board membership will ensure that the Terms of Reference continues to accurately reflect the roles of existing members of the Health and Wellbeing Board. Positions amended are as follows:

- Chief Operating Officer for Thurrock NHS Clinical Commissioning Group amended to Accountable Officer.
- Director of Commissioning Operations NHS England, Essex and East Anglia Region amended to Director level representative for NHS England Midlands and East of England Region
- Chair of Thurrock Adult Safeguarding Board amended to Senior Representative of Thurrock Adult Safeguarding Board
- Chief Executive of Basildon and Thurrock University Hospitals (BTUH) Foundation Trust amended to Executive member of Basildon and Thurrock Hospitals University Foundation Trust.
- Executive Director of Community Services and Partnerships, South Essex Partnership Foundation Trust (SEPT) amended to Executive representative of Essex Partnership University Trust (EPUT)

3.3 The request to amend the requirement for the Chair of the Safeguarding Adults Board to be amended to Chair of the Safeguarding Adults Board or their senior representative reflects advice received from the Chair of the Safeguarding Adult's Board. The Chair of the Safeguarding Board is recruited for a set number of days per year which makes their ability to attend meetings outside the Safeguarding Board or directly related to Safeguarding Board business difficult. The Safeguarding Board will still retain a presence on the Board and be able to reflect any key issues. The same amendment has been provided for the Safeguarding Children's Board to ensure representation options remain consistent.

3.4 Board members are asked to consider removing the commitment provided under the Engagement Section of the Terms of Reference to hold one stakeholder event each year. This is because members of the community and partners are regularly engaged and provided with an opportunity to inform the implementation of the Health and Wellbeing Strategy.

4. Reasons for Recommendation

4.1 As set out in section 3, the recommendations aim to ensure that the Terms of Reference for the Health and Wellbeing Board accurately reflect members' roles and functions and ensures appropriate representation.

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

5.1 The report is being provided to Health and Wellbeing Board as part of consulting members about proposed changes.

5.2 A further report will be provided to the Council's Governance Group and Monitoring Officer which reflects the Board's feedback and seeks final approval on the refreshed Terms of Reference.

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

6.1 The Health and Wellbeing Board leads on the community and corporate priority 'improve health and wellbeing'. It is important that its membership is appropriate to influencing and setting that agenda and allows health and wellbeing in Thurrock to be improved and inequalities in health and wellbeing to be reduced.

7. Implications

7.1 **Financial**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

There are no financial implications.

7.2 **Legal**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

The membership of the Board is in keeping with the requirements of the Health and Social Care Act 2012. The process for amending the Board's membership also complies with the Health and Social Care Act 2012.

7.3 **Diversity and Equality**

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

The Board's membership ensures representation is able to identify and respond to diversity and equality implications for Thurrock to ensure that all Thurrock citizens can achieve good health and wellbeing outcomes.

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):

- Not applicable

9. Appendices to the report

- Health and Wellbeing Board Terms of Reference

Report Author:

Darren Kristiansen, Business Manager, Thurrock Health and Wellbeing Board

Appendix A

Thurrock Health and Wellbeing Board
Revised Terms of Reference

	THURROCK HEALTH AND WELL-BEING BOARD
Appointed by: The Council under section 102 of the Local Government Act 1972	**Number of Elected Members:** Five
Chair and Vice-Chair appointed by: The Chair will be the Portfolio Holder for Education and Health and shall be appointed by the Council	**Political Proportionality:** There is no requirement for elected Members to be appointed in accordance with Political Proportionality
Quorum: One quarter of the whole number of Board Members, provided that in no case shall the quorum of a Committee be less than three	**Co-opted Members to be appointed by Council:** None

Membership:

- Leader of the Council*
- Portfolio Holder for Education and Health (Chair)
- Portfolio Holder for Children's and Adult Social Care
- Opposition Group Representative from each political group
- Clinical Representative: Thurrock NHS Clinical Commissioning Group
- Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board
- Accountable Officer: Thurrock NHS Clinical Commissioning Group*
- Executive Nurse: Thurrock NHS Clinical Commissioning Group
- Lay Member Patient Participation: Thurrock NHS Clinical Commissioning Group
- Corporate Director of Children's Services *
- Corporate Director of Adults, Housing and Health *
- Corporate Director of Environment and Place
- Director level Executive, NHS England Midlands and East of England Region*
- Director of Public Health*
- Chief Operating Officer HealthWatch Thurrock *
- Chair Thurrock Community Safety Partnership Board
- Chair of the Adult Safeguarding Board or their senior representative
- Chair Thurrock Local Safeguarding Children's Board or their senior representative
- Integrated Care Director Thurrock, North East London Foundation Trust (NELFT)
- Executive member, Basildon and Thurrock Hospitals University Foundation Trust
- Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
- Chief Executive Thurrock CVS

* denotes mandatory organisational representation

Our Vision

- Adding Years to Life and Life to Years:

Our Principles

- Reducing inequality in health and wellbeing
- Prevention is better than cure
- Empowering people and communities
- Connected services
- Our commitments will be delivered
- Continually improving service delivery
- Continuing to establish clear links between health and education services, improving accessibility for all

Our Goals

- Opportunity for All
- Healthier Environments
- Better Emotional Health and Wellbeing
- Quality Care Centred Around the Person
- Healthier for Longer

1. Purpose

1.1 To improve health and wellbeing and reduce inequalities in health and wellbeing;

1.2 To develop and facilitate the delivery of transitional arrangements to meet statutory requirements within the emerging health agenda; and

1.3 To determine the health improvement priorities in Thurrock.

2. Functions

2.1 Identify and join up areas of commissioning across the NHS, social care, public health, and other services directly related to health and well-being and reducing health inequalities;

2.2 Encourage and develop integrated working – for the purpose of advancing the health and well-being of and reducing health inequalities amongst Thurrock people;

2.3 Oversee the on-going development and refresh of the Joint Strategic Needs Assessment (JSNA);

2.4 Oversee the on-going development, refresh, and implementation of Thurrock's Joint Health and Well-Being Strategy (JHWS) – ensuring that it provides an overarching framework for commissioning plans related to Health and Well-Being and Health Inequalities;

2.5 Sign-off key commissioning plans, strategy, and policy related to Health and Well-Being;

2.6 Oversee the development of the pharmaceutical needs assessment; and

2.7 Performance manage the achievement of and progress against key outcomes

identified within the JHWS and against key commissioning plans.

3. Meeting Frequency

3.1 The Board will meet a minimum of six times a year as far as practicable

4. Governance and Approach

4.1 The Board will function at a strategic level, with priorities being delivered and key issues taken forward through existing partnership arrangements – which may at times include the establishment of task and finish groups

4.2 Only a small number of permanent sub-groups will exist to support the work of the Board: Health and Wellbeing Executive Committee; Integrated Commissioning Executive and Health and Wellbeing Housing and Planning Advisory Group

4.3 Decisions taken and work progressed will be subject to scrutiny by the Health and Well-Being Overview and Scrutiny Committee – and other Overview and Scrutiny Committees as appropriate (note: HealthWatch has a scrutiny function)

4.4 The development of the Health and Wellbeing Board and its agenda is a dynamic process. As a result, the Board's Terms of Reference will be reviewed at least annually and altered to reflect changes as appropriate.

4.5 Elected members will be nominated by the Leader of the Council

4.6 The Local Authority may nominate additional Board members in consultation with the Health and Wellbeing Board

4.7 The Board may appoint additional members as it thinks appropriate

5. Wider Engagement

5.1 The Board will ensure that the decisions it makes and the priorities it sets take account of the needs of all of Thurrock's communities and groups – particularly those most in need

5.2 The Board will ensure that stakeholders including providers are engaged, with a Health and Well-Being Stakeholder Network established to assist with this purpose

Functions determined by Statute

The Health and Wellbeing Board will operate in accordance with the provisions of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The Health and Wellbeing Board may appoint one or more sub-committees of the Board to advise it with respect of any matter relating to the discharge of functions by the Board.

Functions of the Health and Wellbeing Board may also be discharged by a sub-committee of the Board or by an officer of the authority.

This page is intentionally left blank

FINAL MINUTES

Health and Wellbeing Board Executive Committee

25 May 2017, 3.30 - 5.00pm

Attendees Present

Roger Harris (Chair), Ian Wake, Rory Patterson, Jeanette Hucey and Darren Kristiansen.

Apologies

Mandy Ansell, Kim James, Maria Payne, Julie Rogers, Les Billingham, Malcolm Taylor, Jane Foster-Taylor and Ceri Armstrong

Item No.	Subject	Action
1.	**Welcome and apologies**	
	The Chair noted apologies that had been received.	
2.	**Notes from the last meeting**	
	Notes of HWB Executive Committee meeting in March were agreed. The Chair noted completed actions.	
3.	**Action Plan refresh**	
	Executive Committee members were updated about progress on the annual action plan refresh which included: • Over half of the twenty action plans have now been refreshed and progress is continuing to be made with action plan leads. • Solid progress is being made across all action plans, with many actions having been completed and subsequent actions developed. • Action plan leads are continuing to finalise the outcome framework, ensuring that progress can be regularly monitored, providing accountability and reassurance that strategic outcomes are being achieved. Executive Committee members recognised the merits of Goal Sponsors regularly reviewing progress being made against action plans with leads as part of helping to further embed them into every-day business. It was agreed that Goal Sponsors may wish to consider including a regular item on the Health and Wellbeing Strategy at DMT meetings. Executive Committee members were advised about proposals received to create a web-based version of the Health and Wellbeing Strategy. Executive Committee agreed that the Strategy is easily accessible to the public and partners and is provided in format that is user friendly. Members welcomed the proposal but agreed that a web-based version of the Strategy, without graphics, is not required at this time.	**Action Goal Sponsors** **Action Darren (complete)**
4.	**Health and Wellbeing Board Terms of Reference**	
	The Health and Wellbeing Board's Terms of Reference includes a	

	commitment that they are subject to an annual review. Executive Committee members were advised that consequential amendments were being proposed to ensure that the TOR reflects current membership. Executive Committee members were informed that Democratic Services colleagues have advised that Council has agreed that consequential amendments to the Health and Wellbeing Board's Terms of Reference can be approved by the Monitoring Officer, supported by the Governance Group, comprising the three leaders and the Monitoring Officer. Executive Committee members agreed that substantial engagement activity undertaken to inform emerging programmes and policies facilitates the removal of the Board committing to host at least one stakeholder forum each year. Executive Committee members agreed further amendments to the TOR and that once made the reviewed TOR should be circulated with these minutes	**Action Darren (Complete)**
5.	**Health and Wellbeing Strategy Emerging Annual Report**	
	Executive Committee members agreed that the format of the annual report should be consistent with the Health and Wellbeing Strategy. Executive Committee members acknowledged the importance of setting out key achievements across all five goals and where practicable, all twenty action plans. Executive Committee members agreed that the draft annual report should be circulated to action plan leads for further contributions and to provide opportunities for leads to amend contributions already provided. Executive Committee members welcomed the progress that had been made and agreed that another draft will be considered at their meeting in June.	**Action Darren / HWB Strategy Action Plan Leads** **Action Darren**
6.	**Agenda for HWB meeting of 10 May**	
	Executive Committee members considered the agenda for the next Health and Wellbeing Board meeting. It was agreed that an updated meeting planner would be circulated with these minutes to reflect decisions taken.	**Action Darren**
7.	**AOB**	
	No items were raised	

Meeting concluded at 4:49pm

MINUTES
Integrated Commissioning Executive
22nd June 2017

Attendees
Mandy Ansell (MA) – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Tendai Mnangagwa (TM) - Head of Finance, NHS Thurrock CCG
Mike Jones (MJ) – Strategic Resources Accountant, Thurrock Council
Jo Freeman (JF) – Management Accountant, Thurrock Council
Jeanette Hucey (JH) – Director of Transformation, NHS Thurrock CCG
Mark Tebbs (MT) – Director of Commissioning, NHS Thurrock CCG
Jane Foster-Taylor (JFT) – Chief Nurse, NHS Thurrock CCG
Les Billingham (LB) – Head of Adult Social Care and Community Development, Thurrock Council
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement, Thurrock Council
Iqbal Vaza (IV) – Strategic Lead for Performance, Quality and Information, Thurrock Council
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council

Apologies
Ian Wake (IW) – Director of Public Health, Thurrock Council
Ade Olarinde (AO) – Chief Finance Officer, NHS Thurrock CCG
Sean Clark (SC) – Director of Finance and IT, Thurrock Council
Allison Hall (AH) – Commissioning Officer, Thurrock Council
Ceri Armstrong (CA) – Senior Health and Social Care Development Manager , Thurrock Council

Item No.	Subject	Action Owner and Deadlines
1.	**Welcome and Introductions**	
	MA agreed to Chair the meeting and introductions were made. No conflicts of interest were declared.	
2.	**Notes of the last meeting 25th May 2017**	
	The minutes of the meeting on 25th May were agreed. There were no matters arising not on the agenda.	
3.	**Better Care Fund 2016-17**	
	Expression of Interest in Graduation and the delayed publication of the guidance CS said that an email from the Better Care Fund Support	

	Team had been received. This confirmed that the expressions of interest have been assessed by representatives from Department of Health, Department for Communities and Local Government, NHS England and the Local Government Association (LGA) and the provisional scores moderated. Recommendations from this initial sift have also been considered by senior officials from these organisations and will be discussed at the Integration Partnership Board (IPB) next week. Once the IPB has made a final decision on the pilot wave of graduates, advice will be sent to Ministers and senior managers in NHS England with a view to getting a final decision. We will be informed of decisions once they are finalised. MA confirmed that Andrew Pike has supported our expression of interest. It was noted that in the Eastern Region, Luton have also entered an expression of interest. CS reported that at the monthly teleconference with the Better Care Support Team yesterday it was confirmed that we are no nearer to receiving a date for the publication of the Guidance and are therefore no nearer to being clear about timescales for the submission of the Better Care Fund (BCF) Plan. It appears NHS England and Association of Directors of Social Services/LGA have still not reached agreement with regard to Delayed Transfers of Care (DTOC) conditions and expectations. **Finance Report** MJ said that because of annual leave commitments it has not been possible for him and AO to meet to finalise the expenditure plan for 2017/18. However, the plan has now been updated to show actual spend and consequently the total pooled fund was now expected to be in the region of £40m. A number of issues still need to be resolved, including what uplift may be applied to the value of the scheme to reflect inflation – a column has been added to give indicative values for this. A row has also been added to show the £838k development fund. There is a small underspend (£6k) to be carried over from 2016/17. RH asked if other expenditure should be added to the pooled fund. It was suggested Continuing Health care (CHC) funding could be included, as well as the £3 per head funding for primary care. In relation to the latter it was noted that the Clinical Commissioning Group (CCG) Board had agreed this should be aligned to For Thurrock In Thurrock (and so could be included in the pooled fund) but that the funds could only be spent on the primary care workforce. JFT noted that the cost of commissioning services for people with learning disabilities had been reducing and the inclusion of them in the BCF provides greater flexibility. RH noted that the podiatry service is a very specialised and this means many local people have limited access to it. He	AO/MJ to meet to agree detailed expenditure plans and to provide a summary report for the next meeting.

	would like to see a proposal for a service with greater availability. RH also noted that the main element of the Improved Better Care Fund has been used to ensure market stability. MA said that in her view our strategy and plan is in line with what we know of the Better Care Fund guidance. MT/JFT/AO will meet to consider what other CCG funding could appropriately be added to the pooler fund. **Business Cases for new investment proposals** As agreed at the last meeting the Business Cases were presented with reference to the high level population outcomes, and the objectives of For Thurrock in Thurrock. MA said that a report with recommendation was needed so that the Integrated Commissioning Executive (ICE) could sign off the commitments it agreed to support. The evaluation and scoring of the proposals would provide the audit trail for the decisions. CW said that duplication needed to be watched for. MT asked Finance to identify the available funds in each category - BCF/Improved BCF/£3 per head etc – to ensure the correct funding stream is applied to each proposal. He also noted that some proposals would necessarily deliver over a longer time frame and it would have to be accepted that this may mean, for example, they have less impact on DTOC this coming winter. RH also asked that account be taken of the potential for slippage and the fact that some proposals were non-recurring. It was agreed an expert panel would be convened to appraise the business cases (to include JFT/JH/CW). CW will ask AH to co-ordinate this work. **Performance report** IV presented a revised scorecard asking that new targets for 2017/18 be agreed. Indicators 5.1; 5.2 and 5.3 were agreed at the meeting. It was noted that the 2016/17 out-turn value for indicator 5.4 was very significantly above the target although it still compares well with the rest of England. RH asked for further analysis to be undertaken on DToC so that a further discussion about the target, as well as measures to reduce the out-turn in 2017/18, could be agreed.	MT/JFT/AO to discuss inclusion of further CCG funding JFT/JH/CW to evaluate Business Case and to report to next ICE IV to provide a further report on DToC to next meeting.
4.	**For Thurrock in Thurrock**	
	Accountable Care Partnership It was noted that a Governance meeting for the Accountable Care Partnership was scheduled for 2pm today although RH had not received an invitation. Andy Vowles is understood to be attending. However, the meeting clashes with the opening of the Mayflower unit. It was noted that IW has taken the work as far as he can. JH said that further work has been undertaken on Terms of Reference, and an issue has arisen as to where the Accountable Care Partnership sits with the Sustainability	

	and Transformation Plans. Specifically questions had been raised about the focus on Tilbury/Chadwell area, rather than the whole of south west Essex which NHS providers favour. LB said that the proposal was in fact for the ACP to start in Tilbury/Chadwell in part because of the complexity of the south west Essex area which would slow progress. MT said that when the ACP is formed and functioning he felt a different approach to commissioning may be needed with a focus on capitation and outcomes. RH confirmed that Tania Sitch has been agreed as the Project Lead for the Accountable Care Partnership and he will ask her for an update following the 2pm meeting. The minutes and draft Terms of Reference will be circulated to the Integrated Commissioning Executive. JH agreed to circulate a publication explaining how an accountable care organisation can work. **Adults, Housing and Health – Highlight report.** CS presented the monthly report on the transformation workstreams for Adults Housing and Health. The report was noted. MT raised a concern about a number of interim care beds in Collins House currently being empty. It was agreed IL would be asked to advise on current patterns of need for interim care.	TS to provide an update on the progress with the ACP IL to provide an update on the utilisation of Interim Care Beds
5.	**Improving our DTOCs position**	
	This item was deferred pending further analysis of the 2016/17 out-turn.	
7	**Annual Governance Statement and Review of the Section 75 Agreement**	
	This was agreed. The statement will be attached to the Annual Report to the Health and Well-Being Board later in the year.	
8.	**Any Other Business**	
	With regard to the Grenfell Tower fire in west London, RH advised the meeting that checks had confirmed that all residential tower blocks owned by the Council comply with all current fire regulations. This has been communicated to tenants by letter, and a number of meetings with tower block residents have also been scheduled. MA confirmed that MT has now been appointed Director of Mental Health services for the STP footprint. This new responsibility is in addition to his role as Director of Commissioning in Thurrock. IV asked what was known about the requirements of the Digital workstream in the Better Care Fund. CS confirmed that there had been no new developments.	

Health and Wellbeing Board and Health and Health and Wellbeing Board Executive Committee
Meeting Planner

Summary of meeting dates

Meeting	Date	Agenda	Key Deadlines
Health and Wellbeing Board **(Special Meeting)**	**To be determined**	**1. Better Care Fund (1 hour) Ceri Armstrong**	Implications **Publishing date and sending papers to members:**

Meeting	Date	Agenda	Key Deadlines
Health and Wellbeing Board	Wed 20 Sept 2017 1 – 3:30pm Committee Room 1 **Amended to:** **Friday 22 September 2 – 4:30** **Committee Room 1** (Room booked from 1:30 – 5pm)	1. **STP Update** 2. **Collins House?** 3. **Local Plan (Sean Nethercoat)** 4. **Active Places Strategy Grant Greatrex/ Kirsty Paul 15 mins** 5. **For Thurrock in Thurrock Improving Outcomes and Population Health – ACP Pilot update (Malcolm McCann) –** 6. **Essex Southend and Thurrock Mental Health and Wellbeing Strategy – Thurrock Action Plan (Catherine Wilson, as recommended in her paper to the Board in January) 15 mins – To be combined with item on children's mental health – results of children's survey will be available (suggested by Rory) (Lead: Catherine Wilson / Sue Green)** 7. **Action Plan 5C (Emma Sanford) - Management of long term conditions - The finalised LTC Profile Card and an update on how it has been aiding discussions, further actions resulting from those discussions and general feedback – suggested time slot 10-15 mins.** 8. **Action Plan 5D (Funmi Worrell) Emergency Prevention Audit** 9. **Action Plan 5A Approval of vision and strategy for Whole Systems Obesity (Helen Horrocks)** 10. **Action Plan 5B - To review progress with smokefree implementation at EPUT and an update on our Provider working with Vape Shops to enable them to offer stop smoking support to people who wish to quit smoking. This will also provide a draft summary of Year 1 of ASSIST. (Kev Malone)** 11. **Action Plan 1A – All Children making good educational progress – agenda item on results from schools on GCSE achievements (which are available in August) – Roger Edwardson** 12. **Health and Wellbeing Strategy Outcome Framework report on progress – Suggested by Cllr Halden** 13. **Annual Report from the Housing and Planning Advisory Group (Christopher Smith) – Previously considered by HWB July 16** 14. **Work Programme** 15. **HWB Exec Committee and ICE minutes**	**For Friday 22 Sept** Implications and papers ready to brief Cllr Halden: Thurs 31 Aug **Publishing date and sending papers to members: Tuesday 12 Sept**

Meeting	Date	Agenda	Key Deadlines
Health and Wellbeing Board	Wed 22 Nov 2017 1 – 3:30pm Committee Room 1 **Amended to** **Tuesday 14 November 2 – 4:30 Committee Room 1** (Room booked 1:30 – 5pm)	1. **STP Update** 2. **HWB Exec Committee and ICE minutes** 3. **Work Programme** 4. **Action Plan 4C Living Well at Home progress report November 2017 (Catherine Wilson)** 5. **Action Plan 4C Personal Budgets progress report and evaluation of the pilot for Individual Service Funds November 2017 (Catherine Wilson)** 6. **Action Plan 3B. Children's mental health in Thurrock (to include Open Up Reach Out Strategy / Survey Results / SEND Update / Collaborative Commissioning Forum (Malcolm Taylor)** 7. **For Thurrock in Thurrock - Update on the Tilbury and Chadwell Project / ACP (Ian Wake) 25 mins –** PowerPoint	Implications and papers ready to brief Cllr Halden: **[To be inserted]** **Publishing date and sending papers to members: [To be inserted]**

Meeting	Date	Agenda	Key Deadlines
Health and Wellbeing Board	Wed 24 Jan 2018 1 – 3:30pm Committee Room 1 **Amended to Tuesday 30 January 3:00 – 5:30pm** **Committee Room 1** **(Room booked 2:30 – 6:00pm)**	1. **STP Update** 2. **HWB Exec Committee and ICE minutes** 3. **Work Programme** 4. **Action Plan 5C Emma Sanford. An update and preliminary results from the 3 hypertension streams (Pharmacy, General Practice, and Community HUB). This will include and further actions we have taken (or not) to roll these programmes out across Thurrock Suggested time slot 20 mins** . 5. **A Teenage Pregnancy update within the new Integrated Sexual Health Service. To summarise it will include:** - An overview of the new Integrated Sexual Health Service and provider - Elements of the specification relating specifically to teenage pregnancies - Any proposed actions relating to the Teenage Pregnancy Strategy (if applicable) 6. **Pharmaceutical Needs Assessment (Suggested by Maria Payne)** 7. **5A Ensure people of Thurrock are of a healthy weight. update against the action plan and progress (Helen Horrocks)** 8. **4C Transforming Care for people with Learning Disabilities progress report January 2018 (Catherine Wilson)**	Implications and papers ready to brief Cllr Halden: 10 January 2018 **Publishing date and sending papers to members: Monday 22 January 2018**

Meeting	Date	Agenda	Key Deadlines
Health and Wellbeing Board – March 18	**March 2018**	1. **STP Update** 2. **HWB Exec Committee and ICE minutes** 3. **Work Programme** 4. **Objective 3A: Parents will be given the support they need when they need it (Sue Green)** 5. **March 2018. An update on targeted health checks and preliminary results. Suggested time slot – 10-15mins**	Implications and papers ready to brief Cllr Halden: TBD **Publishing date and sending papers to members: TBD**

This page is intentionally left blank