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

Health and Wellbeing Board

The meeting will be held at **2.00pm – 4.30pm** on **14 November 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
Julie Rogers, Chair Thurrock Community Safety Partnership

Agenda

Open to Public and Press

		Page
1	**Apologies for Absence**	
2	**Minutes**	**5 - 10**
	To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 22 September 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	**STP Update on Consultation**	**11 - 16**
	A report is included in today's papers. The report will be presented by Andy Vowles, Programme Director, Essex Success Regime (ESR) and Sustainability and Transformation Plan (STP). NHS England	
6	**Health and Wellbeing Strategy Objective 1A - All children in Thurrock making good educational progress.**	**17 - 36**
	Education Strategic Priorities 'Plan on a Page' is included in today's papers. Also included is a report on educational outcomes and school performance. Two appendices are embedded within the report should members wish to access data about individual schools. Both items will be presented by Andrea Winstone, School Improvement Manager, Thurrock Council	
7	**New Models of Care - A Case for Change**	**37 - 108**
	A detailed report is included within today's papers. Also included in today's papers is a copy of the PowerPoint presentation which will be presented by Ian Wake, Director for Public Health	

8	**Health and Wellbeing Strategy Outcomes Framework**	**109 - 142**

Members have a detailed report in today's paper. The report sets out proposals to amend some Outcomes Framework Key Performance Indicators and provides an update on progress made against existing KPIs where data is available.

Appendix 2 which accompanies the report provides members with details of individual KPIs and includes baselines, annual trajectory target and an overall target for 2021.

Ceri Armstrong, Senior Strategy Officer, Thurrock Council will present the item.

9	**Integrated Executive Committee (ICE) Minutes**	**143 - 154**
10	**Health and Wellbeing Board Work Programme**	**155 - 160**

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **6 November 2017**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

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

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

1. Create a great place for learning and opportunity

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

2. Encourage and promote job creation and economic prosperity

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

3. Build pride, responsibility and respect

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

4. Improve health and well-being

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

5. Promote and protect our clean and green environment

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

Minutes of the Meeting of the Health and Wellbeing Board held on 22 September 2017 at 2.00pm

	Councillors James Halden (Chair) and Steve Liddiard Mandy Ansell Accountable Officer, Thurrock CCG Liv Corbishley, Lay Member for Public and Patient Participation, Thurrock CCG Jane Foster-Taylor, Executive Nurse, Thurrock CCG Roger Harris, Corporate Director of Adults, Housing and Health Kim James, Chief Operating Officer, Thurrock Healthwatch Rory Patterson, Corporate Director of Children's Services Michelle Stapleton, Director of Integrated Care Basildon and Thurrock University Hospitals Foundation Trust Clare Culpin, Managing Director Basildon and Thurrock University Hospitals Foundation Trust Kristina Jackson, Chief Executive, Thurrock CVS Malcolm McCann Executive Director of Community Services and Partnerships, South Essex Partnership Foundation Trust Ian Wake, Director of Public Health Tom Abell, Deputy Chief Executive and Chief Transformation Officer Basildon and Thurrock University Hospitals Foundation Trust
Apologies:	Councillor Robert Gledhill, Sue Little and Leslie Gamester Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust Andrew Pike, Director of Commissioning Operations, NHS England Essex and East Anglia Clare Panniker, Chief Executive of Basildon and Thurrock University Hospitals Foundation Trust Dr Anjan Bose, Clinical Representative, Thurrock CCG Graham Carey, Chair of Thurrock Adults Safeguarding Board David Archibald, Independent Chair of Local Safeguarding Children's Board Steve Cox, Corporate Director of Environment and Place Julie Rogers, Chair Thurrock Community Safety Partnership
Did not attend:	Dr Anand Deshpande, Chair of Thurrock CCG
In attendance:	Ceri Armstrong, Senior Health and Social Care Development Manager, Thurrock Council Rita Thakaria North East London Foundation Trust Darren Kristiansen, Business Manager, Health and Wellbeing Board / Adult Social Care Commissioning, Thurrock Council Helen Horrocks, Strategic Lead, Public Health Wendy Smith, Interim Communications Manager, STP, NHS England

1. Minutes

The minutes of the Health and Wellbeing Board held on 8 September were approved as a correct record.

2. Urgent Items

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

3. Declaration of Interests

There were no declarations of interest.

4. STP Update

Tom Abell, Deputy Chief Executive and Chief Transformation Officer, Basildon and Thurrock University Hospitals FT and Wendy Smith, Interim Communications Manager, STP, NHS England provided board members with an update on the STP. Key points included:

- During the engagement period over the summer concerns were raised by a range of stakeholders about proposals for all 'blue light' ambulances going to Basildon. Proposals have now been revised which ensure ambulances continue to convey patients to their nearest A&E. Once seen by doctors in the local A&E, stabilised, diagnosed and treated, patients would then either be: discharged; referred for follow-up treatment; admitted locally for further tests and treatment; or transferred if needed to a specialist team, which could be in a different hospital for some patients.
- The three main hospitals (Basildon, Chelmsford and Southend) are now working together as a group and this offers opportunities to improve patient care by taking advantage of a greater scale for some services.
- The Mid and South Essex STP is finalising a business case for potential service changes over the next five years, including proposals to reconfigure some hospital services.
- It is envisaged that public consultation will commence at the end of October 2017. The business case and consultation plans will be presented to the national committee of NHS England on 4 October.

During discussions the following points were made:

- It was recognised that the acute element of the STP is predicated on the success of a capital bid for financial resources being submitted to NHS by November 2017. It is envisaged that a capital investment of £120million will be necessary in addition to between £20m - £30m for health and social care service provision.
- The importance of ensuring that the public are provided with opportunities to engage and provide their views on STP proposals was reinforced by Board members. The STP team provided a commitment to working with Thurrock CCG and Thurrock Healthwatch to ensure that the STP consultation exercise is meaningful and accessible for the people of Thurrock.

RESOLVED: Health and Wellbeing Board members noted the update and welcomed further progress reports at future meetings

5. Joint Strategic Needs Assessment - Whole system obesity

Helen Horrocks, Strategic Lead, Public Health provided Board members with a PowerPoint presentation. Key points included:

- The whole system obesity map set out within the Forsyth Report describes the complexity of tackling obesity and ensuring that more people are of a healthy weight which includes but is not restricted to the physical environment, cultural, social, physiological, economic and political drivers.
- NICE reports that for every 1000 employees, obesity in employees equates to more than £126,000 a year in lost productivity. In Thurrock, using a median hourly wage of £14.28 (NOMIS, 2016) and applying on-costs to the employer at 30%, this could result in up to £170,343.26 a year in lost productivity.
- There appears to be a correlation between deprivation and obesity.
- A number of recommendations have been made as part of the JSNA which include:
    - Shifting from treating the individual to promoting small lifestyles changes at a population level;
    - Considering the options around restriction of the proliferation of fast food outlets in Thurrock;
    - Ensuring the nutritional quality of food in early years settings and school remains high quality;
    - Improving the quality and quantity of local sport and leisure, green spaces and pitch and play provision;
    - Giving greater strategic focus to Physical Activity

During discussions the following points were made:

- Board members welcomed the robust and comprehensive whole systems obesity JSNA and accompanying presentation.
- It is important to ensure high quality parks and leisure facilities are available for Thurrock residents. It was acknowledged that some of the high quality facilities are situated in more deprived parts of Thurrock. and that it is important that the facilities remain accessible to the public.
- The merits of integrating and collocating future sport and leisure facilities alongside existing facilities were acknowledged by Board members.
- Board members agreed with the need to ensure that services are available to facilitate individuals being referred to services that are suitable for their specific needs.
- Board members welcomed Public Health providing a commitment to work with education colleagues to identify how to increase the proportion of school children having school meals (currently 54%) and how to reduce a pack lunch culture where meals may have more limited nutritional value.
- The importance of creating and sustaining links with relevant healthcare professionals was acknowledged by Board members. It was agreed that Michelle Stapleton will consider relevant partners to engage within Basildon and Thurrock University Hospitals Foundation Trust and provide feedback to Public Health colleagues.

Action Michelle Stapleton BTUH and Public Health

- It was agreed that Public Health should consider providing the whole system obesity JSNA presentation to the Headteacher's Forum.

Action Public Health

RESOLVED: Health and Wellbeing Board members supported recommendations made in the JSNA for whole systems obesity and supported the report's publication.

6. Basildon and Thurrock University Hospital and recent issues raised by HealthWatch

Clare Culpin Managing Director Basildon and Thurrock University Hospitals Foundation Trust provided Board members with a PowerPoint presentation. Key points included:

- The BTUH leadership team has a full complement of Directors to manage the hospital site, overseen by Clare Culpin.
- A balanced score card has now been introduced to monitor performance on quality, workforce, finance and operations. Performance is monitored on a monthly basis.
- There has been a steady increase in the number of patients who have attended the hospital as emergency patients - an additional 18 patients per day including the weekends (Q1 this year compared to Q1 last year).
- The cancer waiting list continues to reduce. There are currently no patients waiting in excess of 104 days to receive treatment.
- BTUH have considered resilience. Following a review of the entrances to the hospital it was established that patients end up being cared for in the safest space available rather than in a ward or department best suited to their needs. To address this, BTUH are creating more 'front doors' to stream patients more effectively and better facilitate patient flow.

During discussions the following points were made:

- Members received confirmation that BTUH is continuing to work towards achieving the target of 85% of patients receiving treatment for cancer within 62 days from the first referral.
- Board members welcomed progress that has been made in addressing issues raised by Thurrock Healthwatch about the quality of service being provided at BTUH. Complaints that have been raised by Thurrock Healthwatch have been managed by advocates and feedback has been positive.
- Board members learned that BTUH site leadership team focus on operational management of the hospital while the Joint Executive remain focussed on the strategic shift stimulated by the STP, ensuring that the three hospitals can continue to work closely together and align service provision.

RESOLVED: Health and Wellbeing Board members welcomed the positive progress that has been made by BTUH with addressing concerns previously raised by Thurrock Healthwatch.

7. Health and Wellbeing Board Work Plan

Health and Wellbeing Board members noted the future work plan and proposed agenda items for future meetings.

RESOLVED: The Health and Wellbeing Board workplan was noted by members.

The meeting finished at 3.50pm

Approved as a true and correct record

CHAIR

DATE

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

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14 November 2017	ITEM:5

Thurrock Health and Wellbeing Board

Update on Mid and South Essex STP

Wards and communities affected:	Key Decision:
All	For information and discussion

Report of: Andy Vowles, Programme Director, Mid and South Essex Success Regime

Accountable Head of Service: Not applicable

Accountable Director: Not applicable

This report is public

Executive Summary

This paper provides an update on the progress of the Mid and South Essex Sustainability and Transformation Partnership (STP). It follows previous reports to the Health and Wellbeing Board (HWB).

The STP is currently progressing through a rigorous national assurance process to finalise a pre-consultation business case (PCBC) and prepare for public consultation. As reported in the last update for the Health and Wellbeing Board, the consultation process would start once the national assurance process is complete.

To date NHS England and other national regulators involved have been supportive of the work done thus far, but have suggested some further work on details of the proposed clinical model and the associated activity, capacity and financial plans. This means that the earliest likely start for consultation will be mid to late November.

In the meantime, we will continue to work with local authority partners and others to prepare the materials and process for consultation. This includes sharing draft documents for comment.

This update provides a summary of the process so far and highlights of the plan for consultation.

1. Recommendation(s)

1.1 The Board is asked to note the update.

2. Introduction and background

2.1 In the last update for the Health and Wellbeing Board, we gave a recap of the process by which we have arrived at current proposals for a potential hospital reconfiguration, including a modification of the proposed clinical model for access to specialised emergency care. The change in thinking that was published in July meant that all three hospital A&E departments would be able to continue to receive "blue light" ambulances and that most patients would be diagnosed, stabilised and would receive the start of their treatment at the nearest local A&E, rather than all "blue light" ambulances transporting people direct to a specialised emergency centre in Basildon.

2.2 Having modified our thinking in terms of access to specialised emergency care, we are still proposing to improve some specialised hospital services by bringing them together in one place; and to protect planned operations for complex orthopaedics by separating these from emergency medical care. The forthcoming consultation document will explain proposals for:

- Enhancing A&E at all three hospitals
- Specialised stroke services
- Specialised vascular services
- Specialised cardiac services
- Specialised respiratory services
- Specialised gynaecological surgery
- Specialised urological surgery
- Specialised renal services
- Trauma and orthopaedics surgery

The consultation document will also include proposals for transferring some outpatient services from Orsett Hospital to new centres in Thurrock, Basildon, Brentwood and Billericay, which the Board has discussed previously. Subject to discussion with partners in Thurrock Council and the CCG, this is likely to involve a dedicated consultation document in addition to the main document.

2.3 We also reported in the last update to the Health and Wellbeing Board that the consultation document would cover the overall strategic context for changes in health and care. This will include some examples of what is happening in each CCG area, including examples of:

- Locality based joined up health and care services to extend the range of expertise and care in the community, including a shift from hospital to community where possible.

- Integrated services to provide support at the earliest possible stage to reduce the risk of serious illness, with priority development in complex care, frailty and end of life.

- Development of urgent and emergency care pathways, including integrated 111, out of hours and ambulance services.

- Integration and development of mental health services with primary, community and acute hospital care.

3. Current progress

3.1 The Joint Committee of the five CCGs considered and approved the draft pre-consultation business case for submission to the national regulators. The Joint Committee will sign off the final business case and consultation documents on behalf of the five CCGs, prior to the start of consultation. The final PCBC will be published just before the start of consultation.

3.2 The STP has presented the draft pre-consultation business case to:

- A regional panel
- The national oversight group for service change and reconfiguration
- The national Investment Committee

There will be a final national review of follow-up actions in early November.

3.3 Details of the specific clinical models for proposed hospital changes have been reviewed independently by the East of England Clinical Senate, which has given broad support with some recommendations for further development. The reports of the Clinical Senate will be published at the start of consultation.

3.4 We are continuing discussions with the Health and Wellbeing Overview and Scrutiny Committee, Healthwatch Thurrock, CCG and trust service user representatives, and voluntary sector partners to shape the content of the consultation document and support materials. A high level briefing on the consultation plan is due to be considered at the next HWOSC meeting in November.

3.5 Current milestones:

Action	Dates
Continued engagement/discussion with key stakeholders	On-going
NHSE Investment Committee	Early November 2017
Joint Committee decision on final pre-consultation business case, consultation document and plan	Mid-November
Consultation launch (subject to approval by Joint Committee)	Mid to late November
Consultation and engagement activities	14 weeks from start of consultation
Post consultation outcomes analysis	Feb-Mar 2018
Decision-making process	April-May 2018

4. Reasons for Recommendation

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

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

5.1 The STP programme team is also in discussion with the Thurrock Health and Wellbeing Overview and Scrutiny. We have already reported to the Committee with an overview of the consultation plan and are due to attend the next meeting to receive a view from the Committee.

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

6.1 The STP programme will contribute to the delivery of the community priority 'Improve Health and Wellbeing'.

7. Implications

7.1 Financial

Verified by: Roger Harris
Position: Corporate Director, Adults Housing and Health

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

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

7.2 Legal

Verified by: Roger Harris
Position: Corporate Director, Adults Housing and Health

Legal implications associated with the work of the STP will be identified as individual work streams progress. The CCGs and trusts will continue to be responsible for meeting the requirements of NHS statutory duties, including the Duty to Involve and Public Sector Equality Duty. Implications will be reported to the Board as part of on-going updates.

7.3 **Diversity and Equality**

Verified by: Roger Harris
Position: Corporate Director, Adults Housing and Health

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

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

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

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

None identified

Report Author:

Wendy Smith, Interim Communications Lead, Mid and South Essex STP

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Thurrock Education Strategic Priorities 2017-18
Plan on a Page

I want all of our pupils to be confident, self-assured learners who are proud of their achievements and are exceptionally well prepared for the next stage of their life.

Rory Patterson – Corporate Director of Children's Services

WHY ARE WE HERE?

1. TO ENSURE EVERY SCHOOL AND SETTING IN THURROCK IS CONTINUING THE JOURNEY TO OUTSTANDING AND PROVIDING EXCELLENT LEARNING EXPERIENCES AND OUTCOMES FOR ALL OUR CHILDREN AND YOUNG PEOPLE. (CYP) SO THEY ARE THE BEST THEY CAN BE.

2. THE PRIORITIES FOR 2017/18

Improve pupil attainment and progress so that all Thurrock educational provision is good to outstanding. Differences between disadvantaged pupils and all other pupils nationally are diminished. Ensure that every child including the most able receive the support they need to reach their full potential.	As part of the Recruitment & Retention Strategy, ensure high quality leadership, teaching and learning in all schools, colleges and settings, including the six planned new free schools and new Alternative Provision (AP) for primary pupils across the borough.	As part of the new Health & Wellbeing Strategy ensure Safeguarding, Personal Development, Health & Wellbeing, including mental health services are improved in order to better meet the needs of all children and young people in Thurrock.	Produce a meaningful SEND strategy and action plan; ensuring value for money and improved outcomes for some of our most vulnerable and disadvantaged pupils. Developing appropriate alternative provision, where possible, in borough.	Working with a range of partners, continue to develop our cultural entitlement within a high quality curriculum- to include culture, music, sport and work experience.

2.1 To do this together we will:

- **Increase the pace of improvement and accelerate progress especially in English, mathematics and science whilst maximising the unique benefits of working in partnership with Royal Opera House and other outstanding external cultural partners to ensure our pupils have a rich and varied curriculum that meets the need of all pupils**
- **Reduce exclusions; improve attendance; reduce differences in progress and attainment in pupils with the same starting points**
- **Develop the primary hub and spoke Alternative Provision with the hub at East Tilbury Primary and satellite centres across the borough and implement the new primary fair access procedures**
- **Work with the three teaching schools to develop more effective use of best practice within the borough, promoting school to school support and building on the good practice.**
- **Develop a range of high quality employment, apprenticeships and training opportunities supported by settings, schools, academies, higher educational establishments and local business to ensure no one is NEET.**
- **Recruit high quality teaching staff through the 'Teaching in Thurrock' website, attend university recruitment fairs, develop a key worker scheme, seek to reduce workforce workload with clear focus on CYP and staff being at the heart of all that we do.**
- **In partnership with colleagues from health, deliver the new Health & Wellbeing strategy with a specific focus on CYP mental health.**

3. Outcomes

3.1

Performance

- 100% of schools, settings & colleges are good and increase the number moving to outstanding
- From different starting points, the progress in English and in mathematics is high compared with national figures
- The progress of disadvantaged pupils from different starting points matches or is improving towards that of other pupils nationally
- The attainment and progress of all groups of pupils is at least in line with national averages or better
- Pupils are exceptionally well prepared for the next stage of their education

Recruitment & Retention

- All schools subscribe to and are making effective use of the Teaching in Thurrock Website
- There is a key worker scheme in place that benefits teacher recruitment and retention
- All schools are fully staffed with high quality teachers, leaders and support staff

Safeguarding & Wellbeing, Early Offer

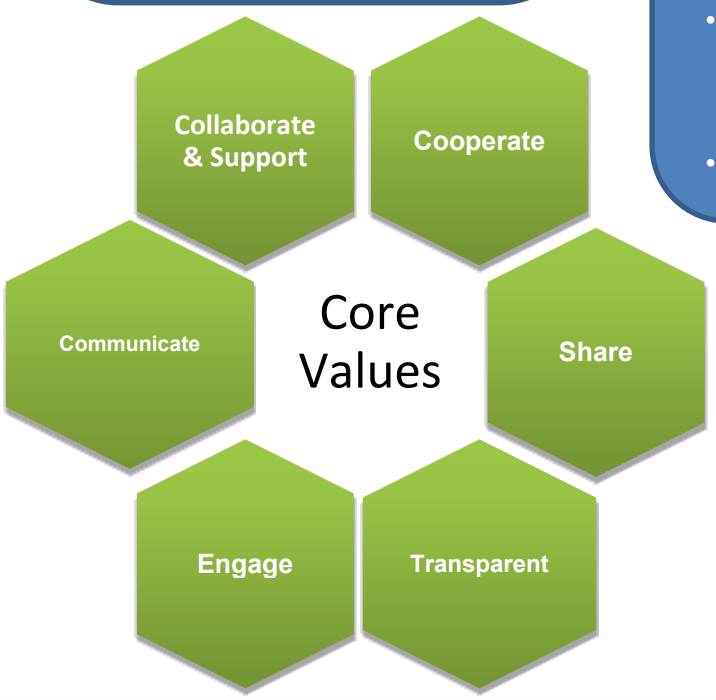
- There are fewer 'no further action' referrals to MASH due to the Brighter Futures Prevention & Support Service (PASS)
- The Thurrock Health & Wellbeing Strategy has an impact on the lives of the children in Thurrock
- CSPA* referrals result in improved access to EHWM services for all children and young people

SEND/ Local Offer/ CLA/EAL

- Outcomes for vulnerable and disadvantaged CYP are improved in the light of the application of the new SEND strategy
- Thurrock's schools are supported effectively to make relevant provision in borough that meets the needs of all children including those at SEN support/ EHCP; so that most CYP who live here are able to be educated here
- Improved Alternative Provision (AP), using a hub and spoke model, for primary pupils

Cultural Entitlement

- Through access to a wide range of cultural, sporting and musical experiences talent is nurtured and CYP are introduced to a range of new experiences
- CYP in Thurrock understand and have positive experiences of the world of work.



In Thurrock we share performance data and use the analysis of it to improve outcomes for all children and young people. We will work together as one community for the benefit and ongoing improvement of all education establishments in the borough.

**Children's Single Point of Access*
***Emotional Health and Wellbeing*

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14 November 2017	**ITEM: 6**
Health & Wellbeing Board	
Schools' Performance	
Wards and communities affected: all	**Key Decision:** all
Report of: Roger Edwardson – Strategic Lead, School Improvement , Learning & Skills	
Accountable Head of Service: Roger Edwardson	
Accountable Director: Rory Patterson, Corporate Director of Children's Services	
This report is public	

Executive Summary

Raising achievement in all areas of education remains a key priority and the Council has seen considerable success in the last five years as attainment and progress have risen significantly, particularly in the primary sector. However a new curriculum was introduced in 2015 and new assessment procedures applied last year which resulted in national curriculum levels being abandoned and new more rigorous tests being introduced. As a result comparisons can only be made between this years' data and the last academic year. A new system of grading GCSEs has been introduced this year in English literature, English language and maths with numbers 1-9 replacing letters (9 being the highest). Students can achieve combined English and maths with either English language or literature. The English and maths exams were more rigorous this year because coursework has been abandoned in favour of an end of curriculum test.

1. Recommendation(s)

1.1 That the Health & Wellbeing Board notes the provisional outcomes of the summer 2017 tests and examinations and commends schools, pupils, and parents/carers on their achievements

1.2 That the board recognises that data can't be compared to previous years due to a change in curriculum and assessment methods.

2 Introduction and Background

2.1 The target for Thurrock Schools and Academies is to be improving year on year and at least above the national average at end of year assessment in Reception, Phonics in Y1, KS1, KS2, KS4 and KS5 and to reduce the gaps in attainment for vulnerable children.

2.2 As a result of a continued support for Early Years teaching & moderation in schools, outcomes at the end of Reception (GLD – Good Levels of Development) are above national for the fifth year running.

GLD (End of Reception- 5 year old)
KS1 (7 year old)
KS2 (11 year old)
KS4 (16 year old)
KS5 (18 year old)

2.3 KS1 assessments have been reported as standard since 2016 and therefore this year's data can only be compared to last year's. The results are still based on teacher assessments and for the first time this year include a combined reading, writing and maths measure.

2.4 In KS2 a new more challenging national curriculum was introduced three years ago. This has been assessed by new tests for reading and maths and a teacher assessment of writing since 2016, therefore we are able to compare this year's results with last year's.

2.5 The 2017 GCSE results show an improvement on last year. The key measure of combined English (EN) and mathematics (MA) is being used by the Department of Education this year and will be supplemented to include Progress 8 and Attainment 8 (see graphs).

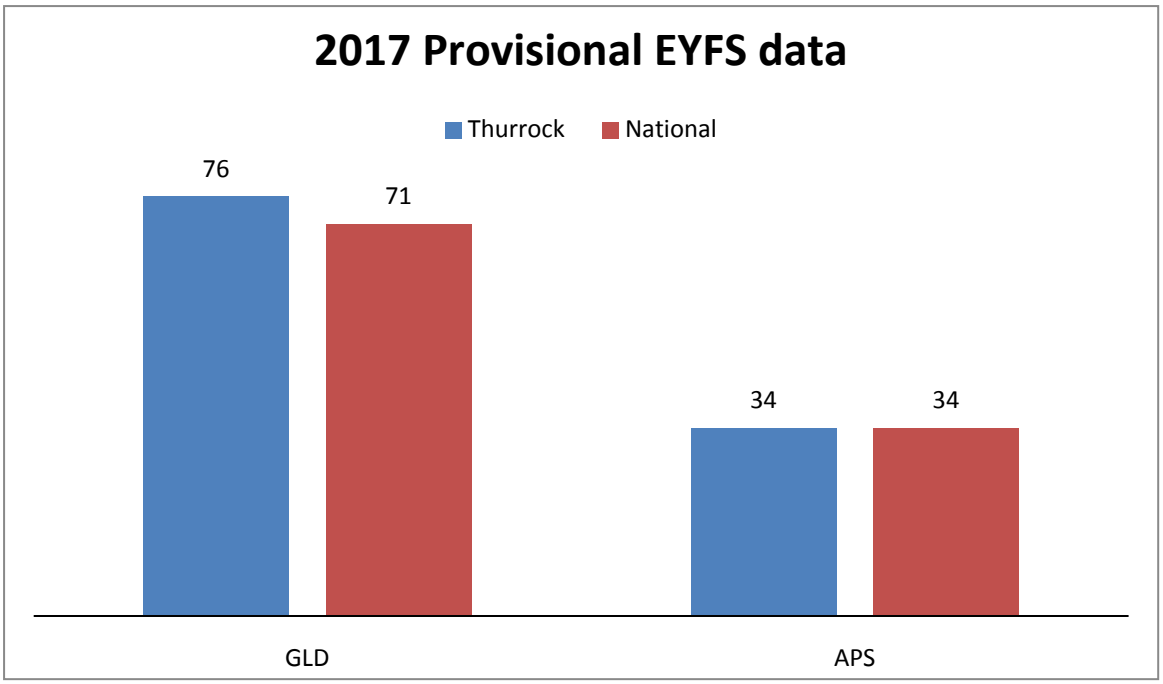
3. Issues, Options and Analysis of Options

3.1 None

4. Early Years Foundation Stage (EYFS age 5)

4.1 The Good Level of Development (GLD) measure is awarded at the end of EYFS when a pupil has achieved at least the expected level in the entire prime areas of learning and in literacy and mathematics.

4.2 Early indications suggest the GLD has risen again and exceeds the national average for the fifth year. (NA 71% and Thurrock 76%)



4.3 To reach the percentage of children making a good level of development, each child is assessed against 17 Early Learning Goals; whether she/he meets the level, has not yet reached the level or exceeded it and points are awarded accordingly in a range 17 - 51. If a child meets every Early Learning Goal, she/he will receive at least 34 points.

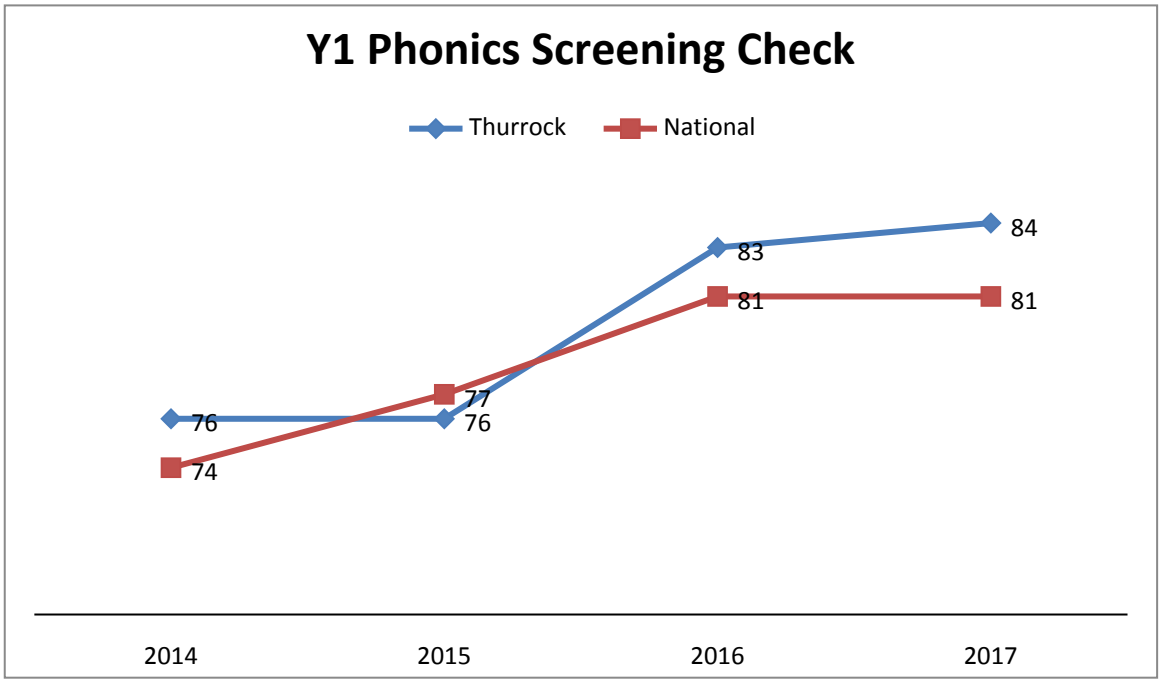
4.4 The provisional GLD result for Thurrock is very encouraging as it puts the borough scores above the national and above others in the East of England region. This is an outcome of significant investment in school improvement staff for this phase and expertise in training and supporting staff in schools and settings.

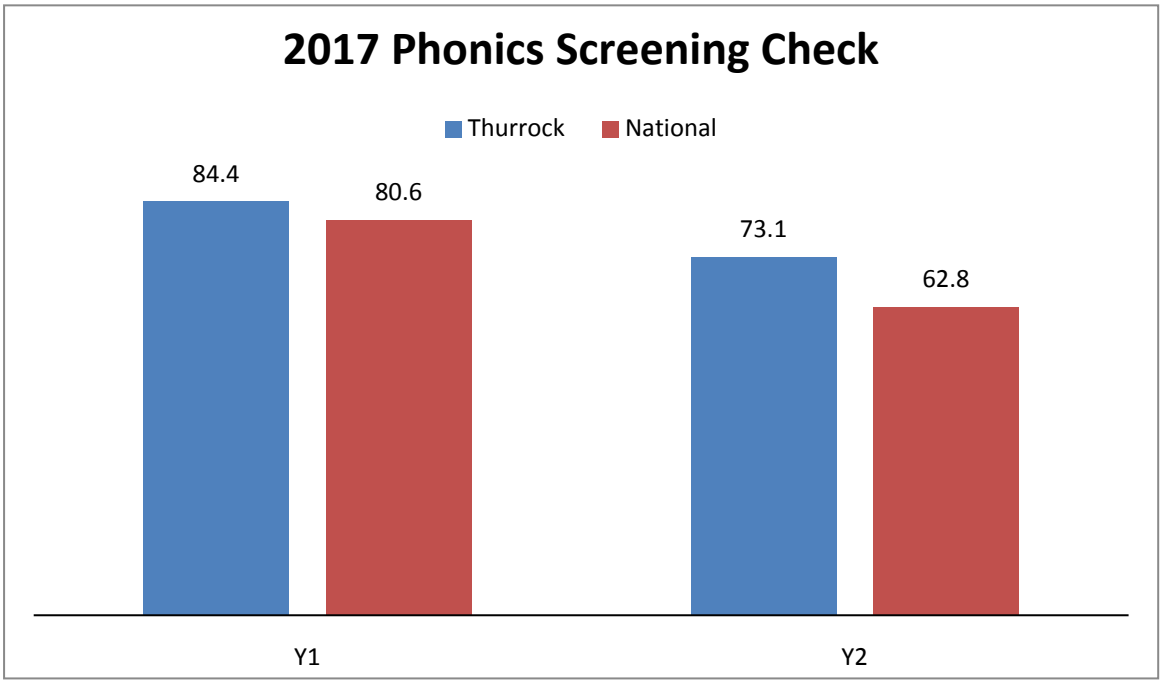
4.5 The inequality gap measures the percentage gap in achievement between the lowest 20% of achieving children (mean score), and the median score for all children. Thurrock was 5.1 percentage points below the national average in 2014 at 28.8%. The gap last year improved by 0.9%. Last year saw the gap close by a further 1.9 percentage points to 26%. 2017 national data is not yet available for this indicator.

4.6 The national gender gap remains with 77% of girls achieving a GLD compared to only 62% of boys; a gap of 15%. In Thurrock the gap is narrower at 12%, with 82% of girls achieving a GLD compared to 70% of boys. The gap has reduced by 4% since 2016.

5 Year 1 Phonics (age 6)

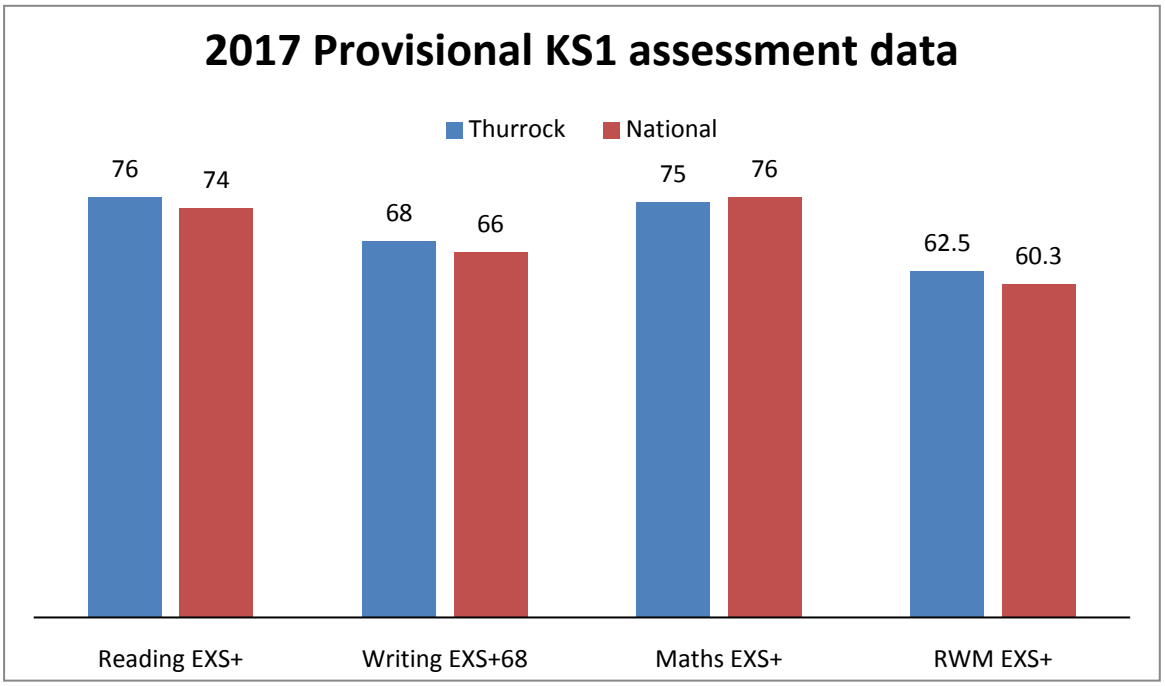
5.1 The year 1 phonics screening check is undertaken in June by all year 1 pupils and those pupils in year 2 who did not achieve age related expectations whilst in year 1. The percentage of children who reached the expected standard has risen by 1 percentage point; the national average has remained the same as 2016. Thurrock average is now above national by 3 percentage points.



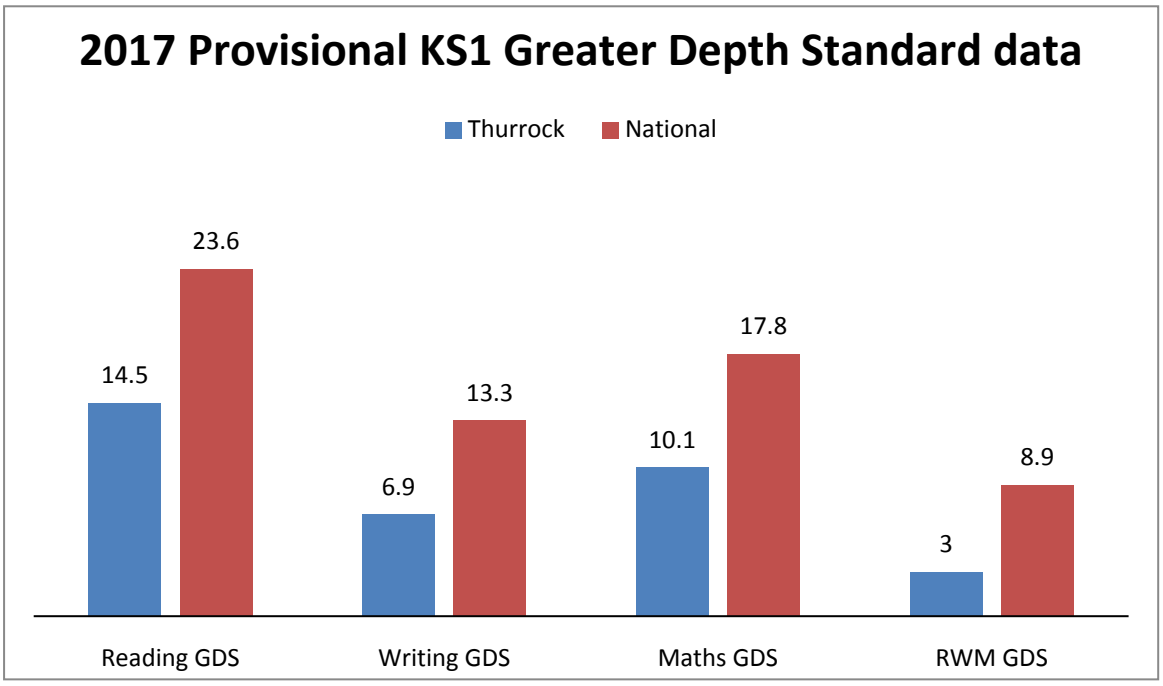


6 Key Stage 1 (age 7, year 2)

6.1 The results are still based on teacher assessments which are informed by standardised assessment tasks (SATs).



6.2 In most areas the Thurrock averages are two percentage points above the national for the percentage of pupils achieving the expected standard, except in mathematics.



6.3 The percentage of pupils assessed to be working at greater depth is low compared to

those nationally. This could be due to teachers not feeling confident in using the interim assessment frameworks as well as a new more rigorous curriculum. This will be a focus for all schools this year.

7 Key Stage 2 (age 11, year 6)

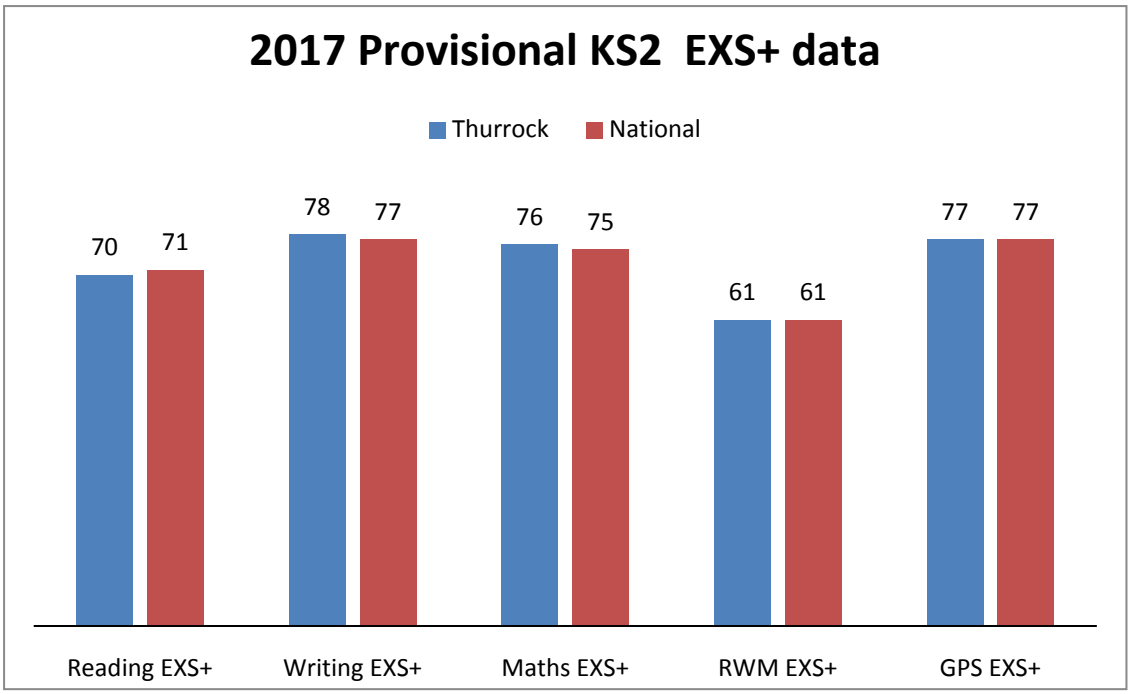
7.1 In mathematics, the proportion of pupils reaching the expected standard nationally is 75%, up by 5 percentage points. In Thurrock, attainment at the expected standard in the mathematics tests increased by 7 percentage points from 71% to 78% in 2017. This is a significant improvement and has been a focus for Thurrock schools in the last year.

7.2 Attainment at the expected standard in grammar, punctuation and spelling (GPS) is 77% nationally, compared to 73% in 2016. In Thurrock, attainment at the expected standard in the grammar, punctuation and spelling test increased by 7 percentage points from 71% to 78% in 2017. Attainment in GPS is the highest of all test subjects. This is a significant improvement.

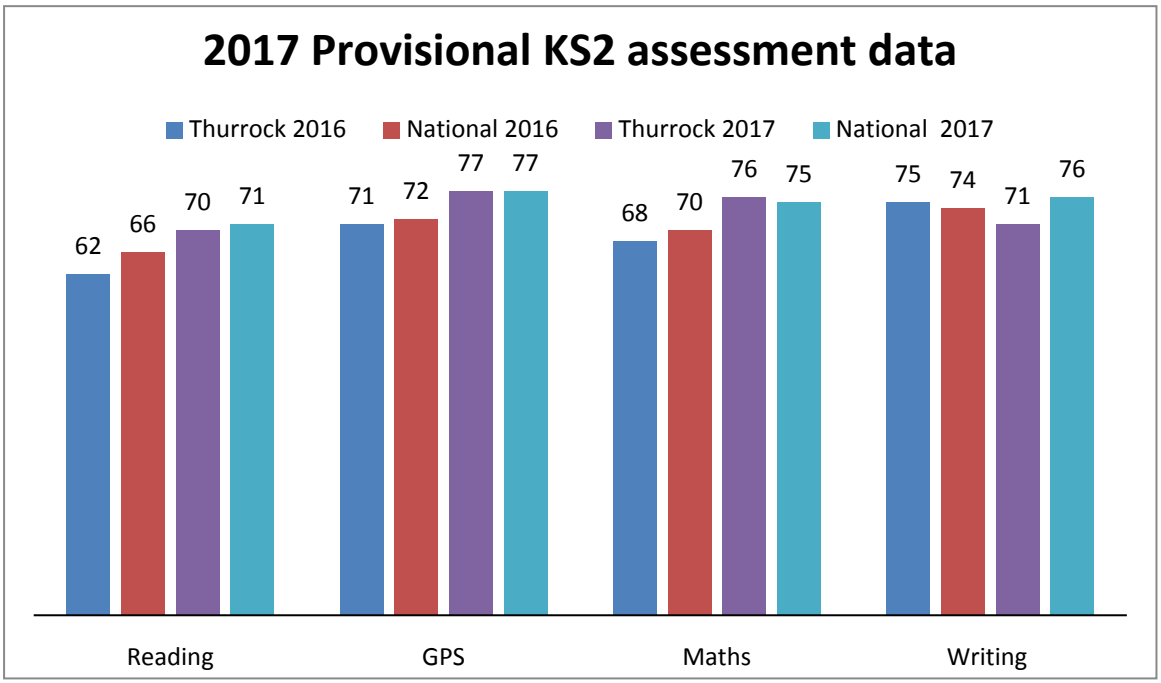
7.3 The proportion reaching the expected standard in the writing through teacher assessment (TA) is 76% nationally, compared to 74% in 2016. In Thurrock the proportion of pupils reaching the expected standard in the writing (TA) is 71%, compared to 75% in 2016. This is disappointing but reflects more accurate teacher assessments than in previous years.

7.4 The average scaled scores also show that on average performance has increased across all subjects from 2016. The average scaled score in grammar, punctuation and spelling is higher than in the other subjects.

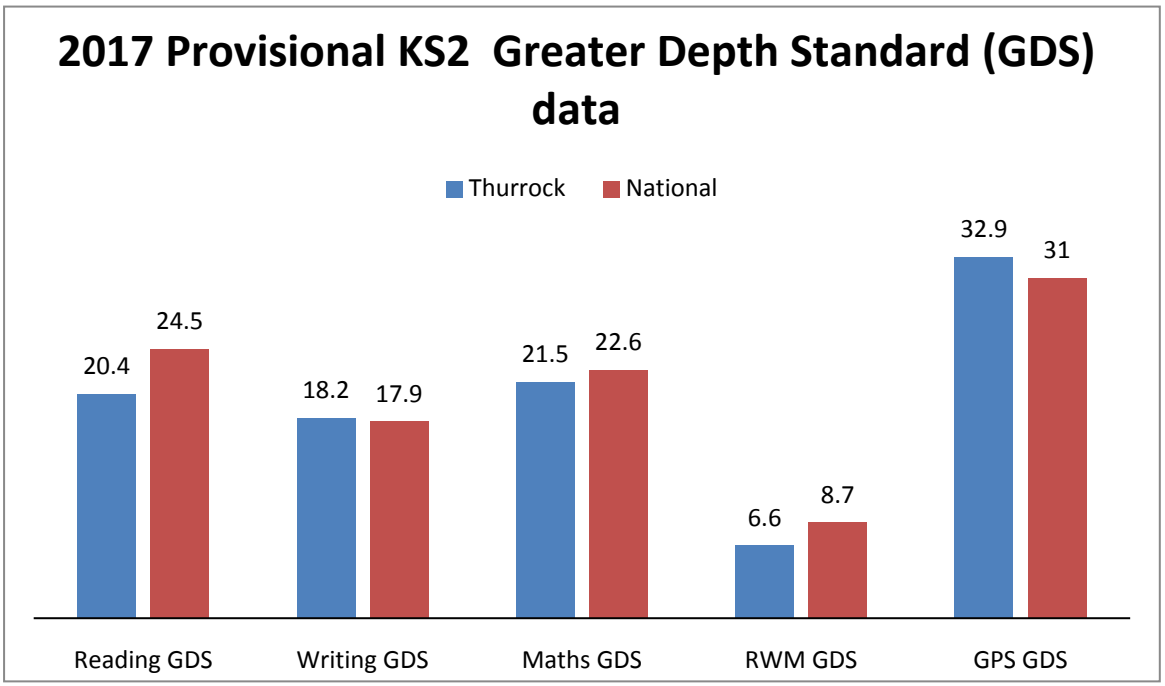
7.5 The combined reading, writing and maths measure for Thurrock is in line with the national data. This outcome is a significant increase on last year and represents a closing of the gap.



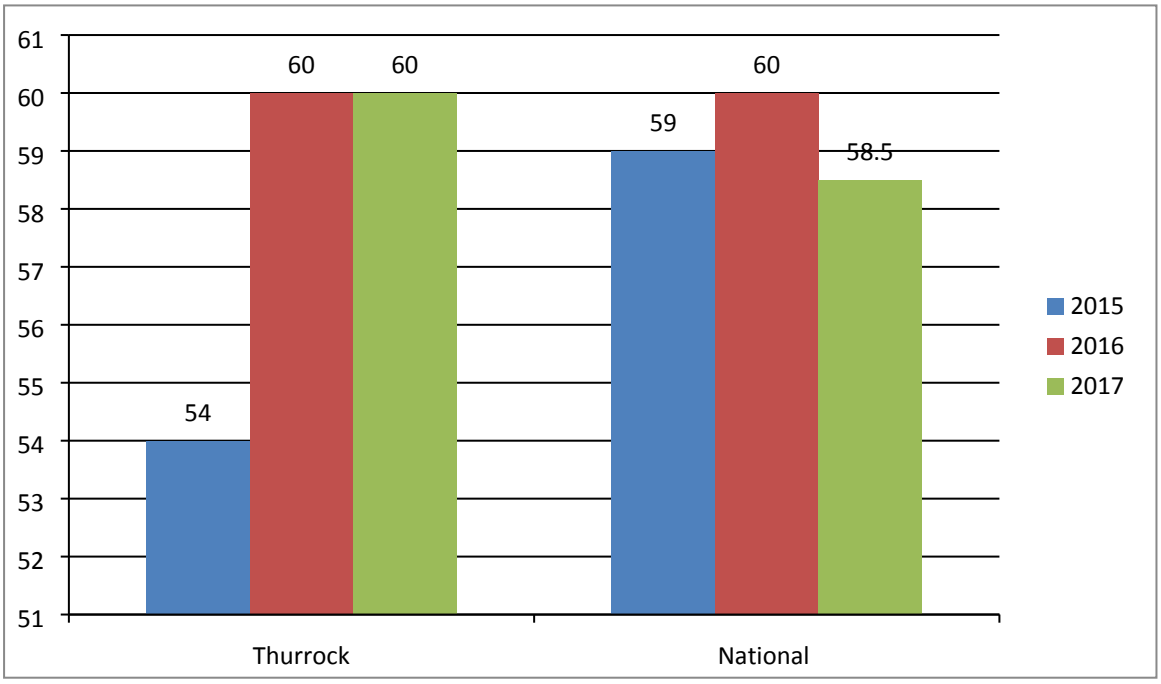
7.6 (RWM – Reading, writing and maths combined, GPS – Grammar, punctuation and spelling test)



7.7 Two Year trends



8 GCSE KS4 (age 16) – un-validated results



A*-C (9-4 in 2017) in both English and maths

8.1 National averages for 2017 were released in October.

8.2 Provisional results for Thurrock schools and academies shows an improvement from

last year in terms of combined results for English and mathematics. The provisional results indicate 60% of pupils achieved the benchmark which would show this year's performance is above the new national average for all schools in the country.

8.3 Early GCSE results from our schools suggest that 60% of the Thurrock entry gained a pass grade in English and maths combined. This moves the performance in Thurrock schools even closer to the National Average of state funded schools (63.5%). The exams and the grading system have changed this year making it difficult to determine how this year's results compare with previous years. There are now two GCSE grading systems running alongside each other for the next few years. As the reforms are phased in, our young people received a mix of letters and numbers. Pupils will be awarded numerical grades (from 9 (high) to 1 (low)) in the new English language and literature and in maths GCSEs today, but they will still receive A*- G in all their other subjects. The nine number scale does not directly compare with the 8 letter scale and a grade 4 in the three subjects named above will be equivalent to the old "C" grade.

8.4 As part of changes to the secondary accountability system Progress 8 and Attainment 8 will be key measures of school performance in 2017. They have replaced the old 5+ A*-C including English and maths headline measure, and the existing expected progress measures, for all schools.

8.5 Progress 8 captures the progress a pupil makes from the end of primary school to the end of secondary school. It is a value added measure, which means that pupils' results are compared to the results of other pupils with the same prior attainment. The greater the Progress 8 score, the greater the progress made by the pupil compared to the average of pupils with similar prior attainment.

8.6 Attainment 8 measures the achievement of a pupil across 8 qualifications including mathematics (double weighted) and English (double weighted), three qualifications that count in the English Baccalaureate (EBacc) measure and three further qualifications that can be GCSE qualifications (including EBacc subjects) or any other approved non-GCSE qualifications.

8.7 The performance tables will be adjusted in line with these new accountability measures and breakdowns will be amended accordingly. For the majority of schools, the performance tables will only show Progress 8 and Attainment 8 data for 2016, as this is the first year that they will be held accountable to the new measures.

8.8 These results remain unvalidated and the first release from the DfE is due in October. The Department for Education will confirm national figures this autumn. These results are provisional and are currently subject to appeals by a number of schools across the borough.

8.9 Significant changes to GCSE have occurred this year. The scoring system changes from the current range of A*-E pass grades to a 1-9 framework where 9 is equivalent to the "A*" grade in English and mathematics. The other foundation subjects have continued to use the A-U nomenclature.

8.10 The strategic priority for 2017/18 is to ensure young people achieve above the

national average and that pupils in receipt of pupil premium make accelerated progress so narrowing the gap in performance for low income families.

9 Key Stage 5 – "A" level results

9.1 Students taking A-levels in Thurrock have maintained the positive performances of recent years.

9.2 Palmers' College again maintained an impressive 97% pass rate for the fifth year in a row with 20 subjects gaining a perfect 100% pass rate. The Stanford & Corringham 6th Form Centre also celebrated another good year of GCE Advanced Level and Vocational results as achievement hit a new high. The subject pass rate was 100% and all students achieved two or more passes. 44% of entries achieving an A*, A or B grade.

9.3 At The Ockendon Academy and Studio School the overall pass rate was 93% with a significant number of students achieving the higher grades A*- C at 70% of the entry and 40% A*-B grades.

9.4 Harris Academy Chafford Hundred reported 100% of their students passed their A-levels for the second year in a row. 120 students at the Academy collected an excellent set of A-level results. Overall, 100% of entries across the 27 subjects on offer achieved pass marks, with 52% achieving A*-B grades. Ormiston Park Academy has seen the number of students going to university increase, more A-Level entries than ever before and more students achieving higher grades. Similarly, vocational outcomes were its best yet, with more students than ever achieving Distinction* grades. The academy achieved a 96% overall pass rate and a 51% pass rate at A*-B.

9.5 Thurrock Careers continues to offer impartial information advice and guidance about future career pathways. There is always a Personal Adviser (PA) available for support in school and opportunities for further help can be obtained through The Inspire Youth Hub.

10 Looked After (CLA)

10.1 Foundation Stage – 5 Year Olds

	2012/2013	2013/2014	2014/2015	2015/2016	2016/17
Cohort Size	6	9	5	11	2
Good Level of Development	17%	44%	80%	64%	50
National Figure	62%	62%	65%	69%	71

10.2 Although there were seven children in this cohort at the start of the 2016-2017 academic year, by the end of the year this had been reduced to 2 pupils. Of these 2 pupils one child achieved a GLD whilst the other did not.

11 Year 1 Phonics Score Results 2017

11.1 The year 1 phonics screening check is undertaken in June by all year 1 pupils and those pupils in year 2 who did not achieve age related expectations whilst in year 1.

11.2 The percentage of children who reached the expected standard has decreased compared to the previous year. In 2017 there were 8 pupils in the cohort and 5 pupils [63%] passed the screen.

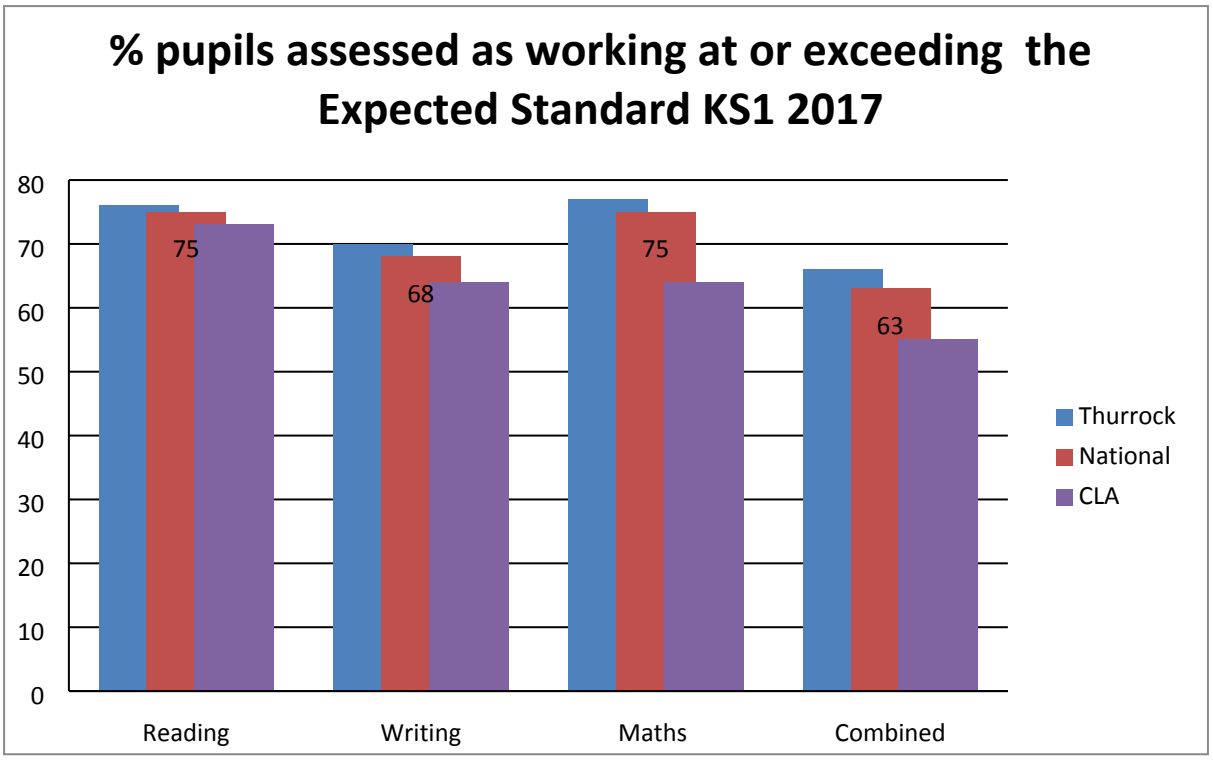
Year	12 Total Cohort Size	13 Number who passed
2015	7	4 pupils – 57%
2016	9	7 pupils – 78%
2017	8	5 pupils – 63%

11.3 This year the Virtual School will continue to discuss with schools their phonics provision to ensure that those who did not reach the expected standard are supported during Year 2. 3 pupils [63%] passed. The two who failed are currently going through the EHCP process but they have improved on their score from the previous year. The Virtual School require schools to monitor and evidence progress in phonics to measure those on track and those needing extra support. This process worked very effectively last year.

12 Key Stage 1 – 7 year olds

12.1 From 2016, KS1 assessments are no longer reported as levels and cannot be compared to previous years. In the table and graph below, it is possible to see how Children Looked After performed against National and Thurrock non-CLA.

13 Subject	14 15 Number of Pupils	16 Percentage [2017]	17 National [2016]	CLA
Reading	8	73%	50%	
Writing	7	64%	37%	
Maths	7	64%	46%	
Combined	6	55%	Not provided	



12.2 Comparison for National and Thurrock Non-CLA [2017].

12.3 The above data is based upon a cohort size of 11 pupils and the difference compared to non-CLA is diminishing. What is difficult to gauge is a comparison with those who are looked after nationally due to lack of data at the time of this report.

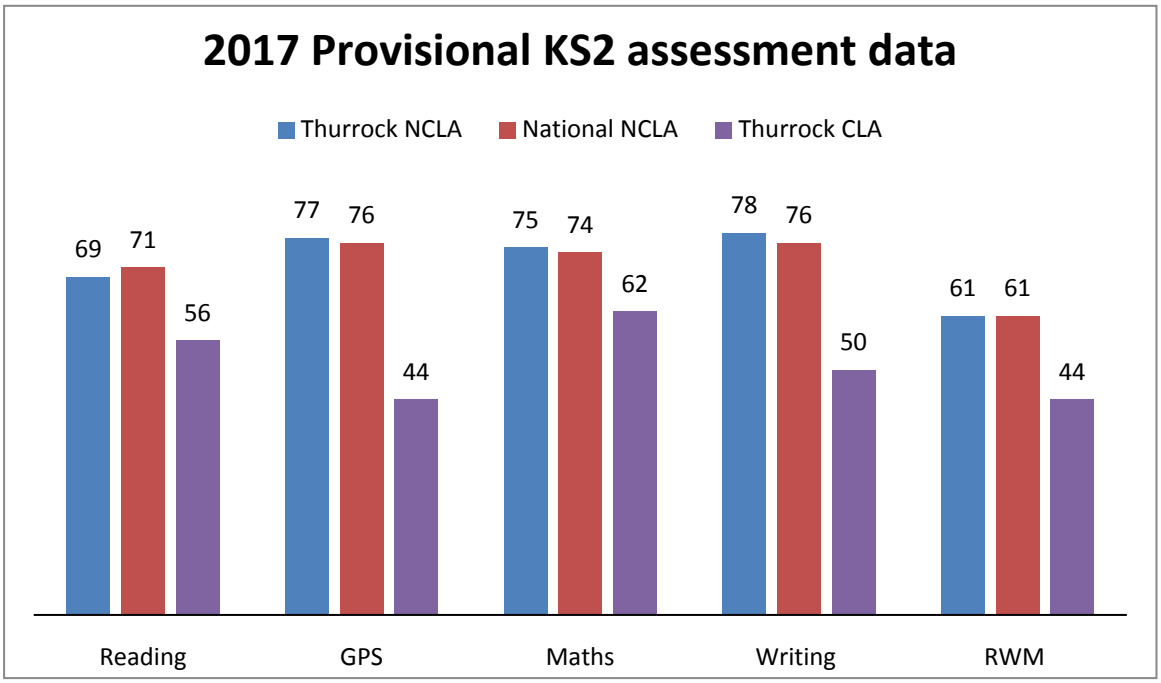
13 Key Stage 2 SATS 2017- Unvalidated Data

13.1 KS2 results are no longer reported as levels: each pupil receives their test results as a scaled score and teacher assessments based on the standards in the interim framework.

13.2 The cohort size for the 2017 Key Stage 2 SATS was **16 pupils**. There were a further 7 pupils who were disapplied from SATS due to the setting they attended or SEND needs. For Thurrock CLA the statistics for those achieving the expected standard were as follows: reading 56% [9 pupils], GPS 44% [7 pupils], maths 62% [10 pupils] and writing was 50% [8 pupils].

13.3 The graph below illustrates the comparisons with non-CLA nationally and all pupils in Thurrock for 2017 results. National CLA statistical comparisons are not available at the time of this report due to the time of publication of the Statistical First Release.
Reading 56%
Writing 50%
Maths 62%
GPS 44% (Grammar, punctuation and spelling)

Combined 44% (Thurrock average 61%)



13.4 Monitoring and tracking was extensive for this cohort of pupils. Schools were required to provide termly tracking data and evidence how pupil premium plus was supporting learning and progress. 15 pupils out of the 16 who took their tests [94%] made at least expected progress from their prior attainment at Key Stage 1. Some made greater than expected progress. The Year 6 cohort contained 6 pupils [37%] out of the 16 entered for SATS with SEND. As mentioned above, pupils with SEND have additional learning and/or emotional needs which affect their learning and this affected their attainment within the harder tests. However, these pupils made at least expected progress except for 1 pupil as mentioned above.

14 Key Stage 4 GCSE Results for CLA 2017 - Unvalidated results

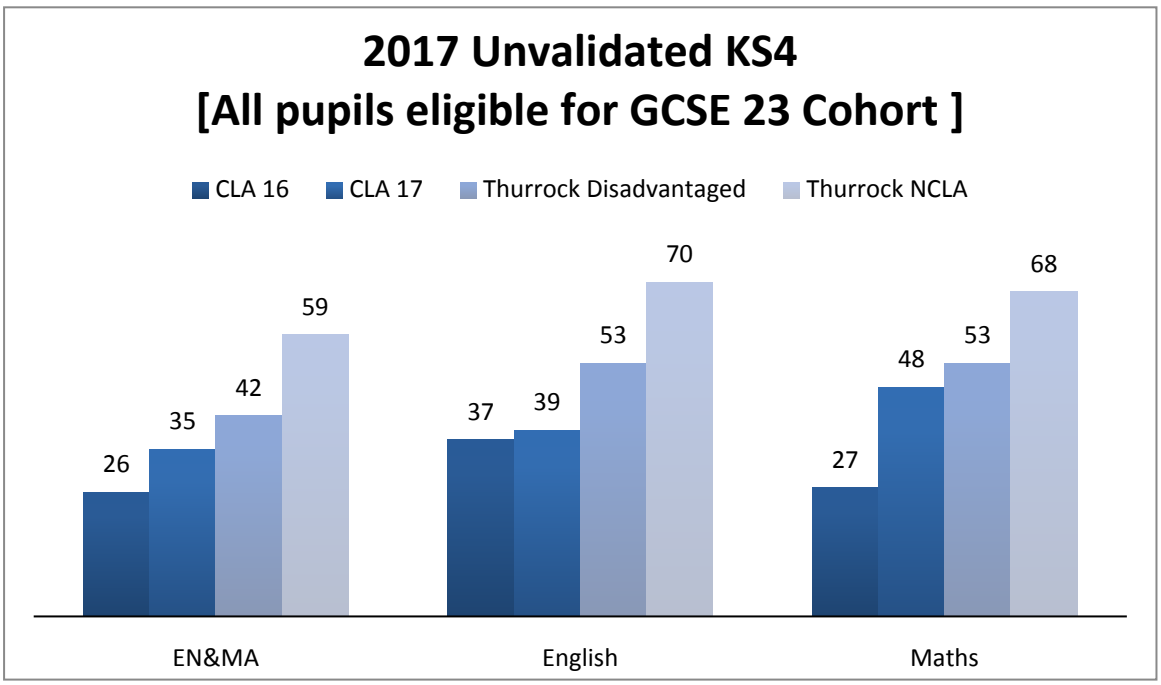
14.1 The following section of this report includes the 2017 data for GCSE. Progress 8 and Attainment 8 is not being reported in the following section due to the availability of data at the time of this report being compiled. The 2017 will include the performance of all pupils in the 2016-2017 Year 11 Virtual School cohort irrespective of the length of time in care. The data used for this report is currently unvalidated data.

15 Key Headline Data [Cohort of 40]:

15.1 There were a total of 40 pupils in the year 11 cohort and 23 pupils [57.5%] were eligible to take GCSE exams. Although the cohort is reduced from last year's size of 55 pupils to 40, more students were eligible for taking GCSEs this year which is an improvement from the previous academic year as a result of the reduction in UASC. 8 pupils [20%] achieved English and maths combined for the equivalent of grade C level 4 or above.

16 Key Headline Data [Cohort of 23 eligible for GCSE]:

16.1 Unvalidated data shows that 5 pupils [22%] of the total cohort achieved 5 A*-C grades at GCSE including English and Maths. 8 pupils [35%] achieved English and maths combined for the equivalent of grade C [point 4] or above For English language, 7 pupils [30%] achieved the expected standard or above In English literature, 9 pupils [39%] achieved the expected standard or above In Maths, 11 pupils [48%] achieved the expected standard or above.



17 For the year 2017/18 the Virtual School is:

17.1 Providing half termly Designated Teacher Forums, monthly social worker forums and termly foster carer forums to promote the educational outcomes of pupils by communicating key messages and training and to provide information advice and guidance for individual cases.

17.1.1 Supporting social care to minimise the change of school or college when their placement changes.

17.1.2 Actively seeking to expand our team with professionals to build capacity and improve impact on outcomes for Children Looked After.

18 Reasons for Recommendation

18.1 None.

19 IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

19.1 This report relates to the council priority to improve to create a great place for learning and opportunity.

20 IMPLICATIONS

20.1 Financial

Implications verified by: **Nilufa Begum**

Telephone and email: **nbegum@thurrock.gov.uk**
01375 652466

There are no direct implications in this report.

This report requires the Committee to note its contents only. No decision is required. However, there are relevant general duties on the Council, of which are:-

i) A duty is imposed on the Council by S13A of the Education Act (EA)
ii) 1996 duty to promote high standards and the fulfilment of potential.
iii) S22(3)(a) of the Children Act 1989 imposes a duty on the Council to safeguard and promote the welfare of any child it looks after, and this includes in particular a duty to promote their educational achievement.

The vulnerable and gender data will not be available until November and therefore we are unable to include implications at this point in time.

20.2 Legal

Implications verified by: **Lucinda Bell**

Telephone and email: **Lucinda.bell@BDTLegal.org.uk**

There are no direct implications in this report.

This report requires the Committee to note its contents only. No decision is required. However, there are relevant general duties on the Council, of which are:-

i) A duty is imposed on the Council by S13A of the Education Act (EA)
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The vulnerable and gender data will not be available until November and therefore we are unable to include implications at this point in time.

20.3 Diversity and Equality

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

Telephone and email: **reprice@thurrock.gov.uk**

There are no direct implications in this report.

This report requires the Committee to note its contents only. No decision is required. However, there are relevant general duties on the Council, of which are:-

i) A duty is imposed on the Council by S13A of the Education Act (EA)
ii) 1996 duty to promote high standards and the fulfilment of potential.
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21 <u>Other implications</u> (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental

21.1 None.

22 RISKS

22.1 Schools, including academies that do not meet the floor standard are at risk of inspection by Ofsted and intervention by the relevant accountable body.

22.2 A failure to raise standards will exacerbate recruitment and retention difficulties and make it harder for children and young people to reach age related expectations and to progress to further education, training and employment in the jobs that growth in the borough will generate.

23 CONCLUSION

23.1 Pupils and those who support them in and beyond school are to be praised for the progress that has been made again this year. It is important that the good progress in many areas is now built on to ensure that in every subject, at every age, improvement which outstrips the national standard is made. Forensic analysis of data to target support and extensive use of school-to-school mechanisms in addition to interventions commissioned by the Thurrock Education Alliance, the School Improvement team and external consultants has proven to be effective;

23.1.1 Where schools have found it more difficult to improve standards a number of contributory factors may be identified;

23.1.2 Continuing recruitment and retention issues at all levels including at leadership level;

23.1.3 Further changes to the curriculum and assessment regimes;

23.1.4 Achieving a consistently high standard of teaching and learning;

23.2 None.

24 Appendices to the report

24.1 2017 Data Spreadsheets for provisional data

25.2 Appendix 1 – Thurrock Attainment Summary

Copy of Thurrock Attainment Summary

25.3 Appendix 2 – Thurrock Provisional KS4 Results 2017

Thurrock Provisional KS4 Results 2017.xls

25 Report Author:

Roger Edwardson
Strategic Lead - School Improvement, Learning and Skills
Children's Services

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The Case for Change: A New Model of Care for Tilbury and Chadwell

Author:

Ian Wake
Director of Public Health

September 2017

Acknowledgements

The author would like to thank and acknowledge the following colleagues whose ideas, content, statistical analysis and input have all assisted in the creation of this *Case for Change* document.

- Emma Sanford, Strategic Lead - Healthcare Public Health, Thurrock Council
- Maria Payne, Senior Public Health Programme Manager - Health Informatics, Thurrock Council
- Funmi Worrell, Strategic Lead Public Health, Thurrock Council
- Monica Scrobotovici, Healthcare Public Health Improvement Manager, Thurrock Council
- Jo Pitt, Healthcare Public Health Improvement Manager, Thurrock Council
- Les Billingham, Assistant Director of Adult Social Care, Thurrock Council
- Tania Sitch, Integrated Care Director, Thurrock Council and North East London Foundation NHS Trust
- Jeanette Hucey, Director of Transformation, NHS Thurrock Clinical Commissioning Group
- Sharon Hogarth, Area Operations Manager, College Health Ltd.
- Kelly Clarke, Public Health Intelligence, Information Support Officer

1. Introduction and Background (1/3)

This document sets out a case for change for A New Models of Care in Tilbury and Chadwell. It has been developed in consultation with key stakeholders including Essex Partnership University NHS Foundation Trust (EPUT), Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH), North East London NHS Foundation Trust (NELFT), NHS Thurrock Clinical Commissioning Group (TCCCG), local GP surgeries and Thurrock Council's Adult Social Care and Public Health Teams.

This document follows the production of a detailed needs assessment for the area of Tilbury and Chadwell which can be by clicking the link at the bottom of this page.

The programme of work stemmed from the publication of the Annual Report of the Director of Public Health (2016) which set out the current state of demand on the local health and social care system, along with the key influences on activity. This report aimed to understand the increasing demand on local health and care services and provided a list of evidence-based recommendations to reduce current unsustainable growth.

As a population, we are living longer but not necessarily healthier lives. The rate of growth in the population aged 65+ locally is increasing at a rate that far exceeds that of the general population (Figure 1). In addition, older patients are more likely to develop multiple long term conditions (Figure 2), resulting in increased demand for health and social care services with fewer working age people that can be taxed to pay for this increased demand.

Currently approximately 70% of all health and social care funding is now spent on treating and caring for people with long term conditions. Effective demand management to create an operationally and sustainable Adult Health and Social Care System requires a system response.

Our local adult Health and Care economy faces significant financial and operational challenge. There is currently a £59.4M financial deficit across the three hospitals within south and Mid Essex and our Sustainability and Transformation Plan (STP) footprint is forecasting a £99.6M system deficit. Thurrock Council is predicting an £16.6M financial deficit over the next three years without strategic transformational action.

The situation can be summed up by figure three; rising and unsustainable demand for emergency care within the most expensive part of our Health and Care system; hospitals. However, this is largely a symptom of failures elsewhere within the system rather than a cause of the crisis itself. Actions taken by one organisation alone in isolation of others cannot achieve system sustainability as the management of patients in Primary and Community Care directly influence demand on secondary care, and all three influence demand on Adult Social Care.

A copy of the full report is available on the Thurrock Council Website at the following address:
https://www.thurrock.gov.uk/healthy-living/health-statistics-and-information

Figure 1

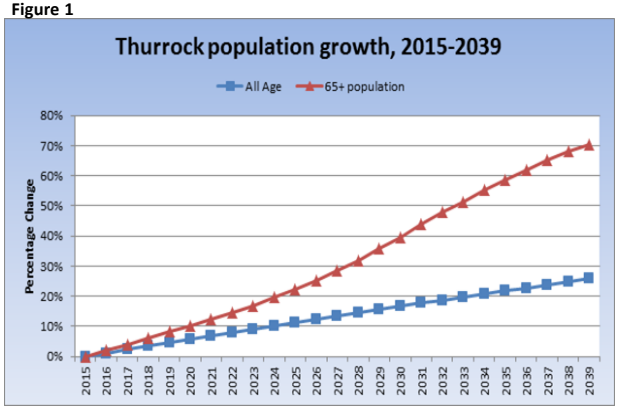
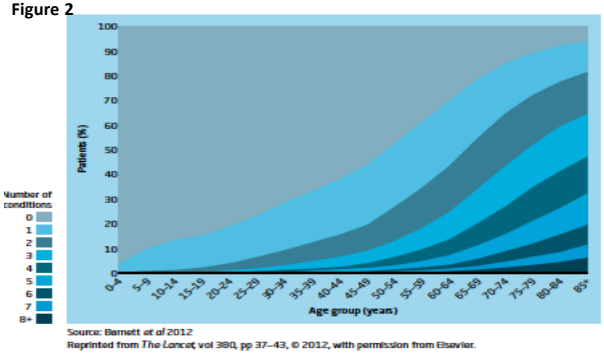
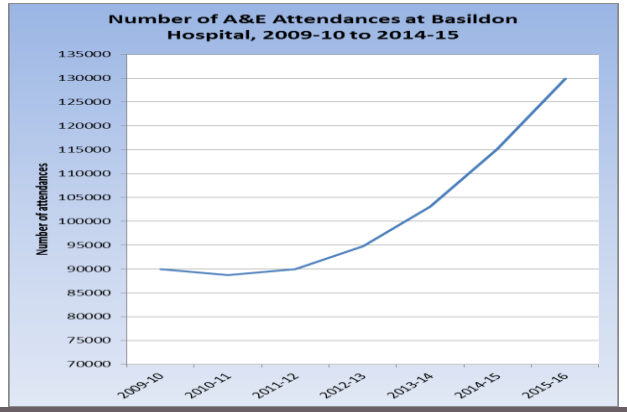


Figure 2



Source: Barnett *et al* 2012
Reprinted from *The Lancet*, vol 380, pp 37–43, © 2012, with permission from Elsevier.

Figure 3



1. Introduction and Background (2/3)

Some of the fundamental reasons driving demand and hence spend in the two most expensive parts of our system; secondary and social care services are demonstrated in the simplified diagram of it (figure 4). Without understanding how and why our residents flow through the entire system, we have little chance of making it sustainable. As such, by setting out the current state of demand on the health and social care system, along with the key influences on activity, the APHR 2016 quantified and linked activity and spend in terms of:

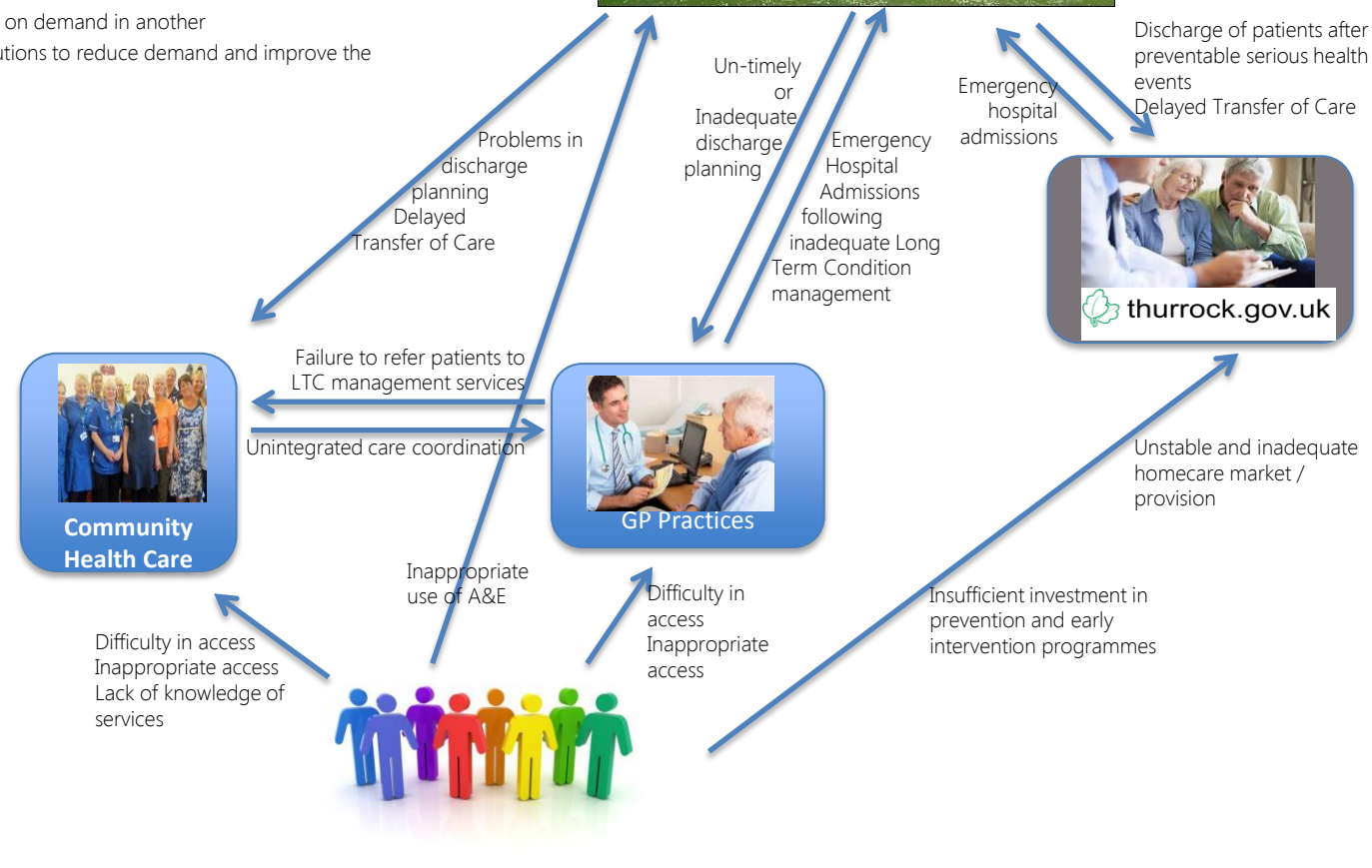
- Demand on all parts of the system
- How clinical practice in one part impacts on demand in another
- The most cost-effective system wide solutions to reduce demand and improve the health of our local population.

Following publication of the APHR 2016, EPUT, BTUH, NELFT, TCCG and Thurrock Council decided to collaborate in order to pilot a New Model of Care (NMC) in Tilbury and Chadwell; one of the four localities within Thurrock.

The aim of the NMC is to act as a pilot to demonstrate proof of concept, that if investment and quality and capacity of Primary, Community and Mental Health care is improved, and a single lead provider ensures that all out of hospital services are integrated, that we will have a positive impact on reducing demand on the two most expensive parts of our local health and care economy; acute hospital services and residential care services.

This will then release funding for re-investment in similar models across the rest of the Borough and beyond.

Figure 4



1. Introduction and Background (3/3)

Tilbury and Chadwell, the place

Figure 5

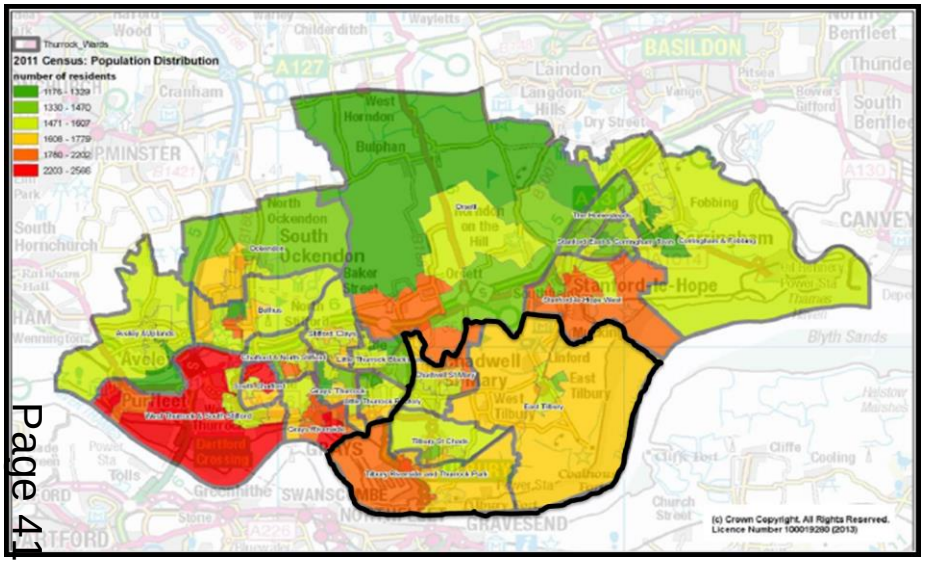
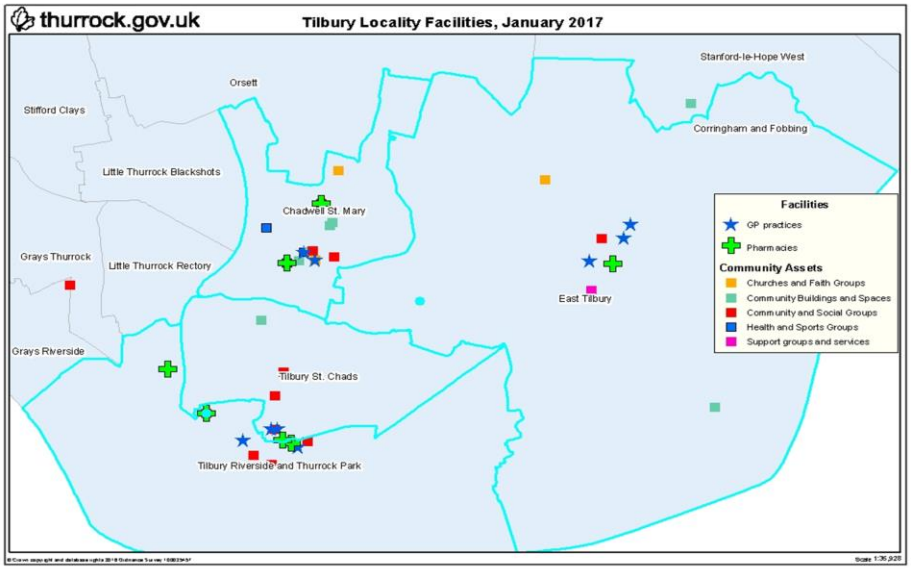


Figure 6



The locality of Tilbury and Chadwell is shown in the thick black line in figure 5. It comprises the four wards of Tilbury St. Chads; Tilbury Riverside and Thurrock Park; Chadwell St. Mary and East Tilbury.

The area is served by a number of GP practices: four surgeries run by College Health Ltd (Thurrock Medical Centre, The Shehadeh Medical Centre (Tilbury), East Tilbury Medical Centre; Chadwell Medical Centre); and four independent GP surgeries (Sai Medical Centre, Rigg Milner, Dilip Sabnis and Dr. Ramachandren's surgery).

The locality also has nine community pharmacies, a community hub and a variety of community and social groups. (Figure 6)

Examples of key assets within the locality include:

- Two Community Hubs, one in Chadwell and one in Tilbury. Both host a variety of activities such as the Credit Union, IT classes, and Local Area Coordinators
- Active Tilbury – funded through Sport England.
- Park Run – open to all Thurrock but situated on Orsett Heath – near Chadwell
- Nature Reserve, Coalhouse and Tilbury Forts providing outdoor opportunities
- Arts Centre offering Dementia walks etc.

The locality has a total population of approximately 35,000 people, although this is predicted to increase by almost 68% within the next 13 years through a combination of natural population growth and Thurrock Council's plan to encourage the building of 10,000 new homes within the locality. Thurrock Council also a comprehensive regeneration plan for Tilbury Town Centre including provision of a new Integrated Medical Centre.

Major employers include The Port of Tilbury. Amazon plan to create 3500 new jobs in a new Citation and Fulfilment Centre currently under construction.

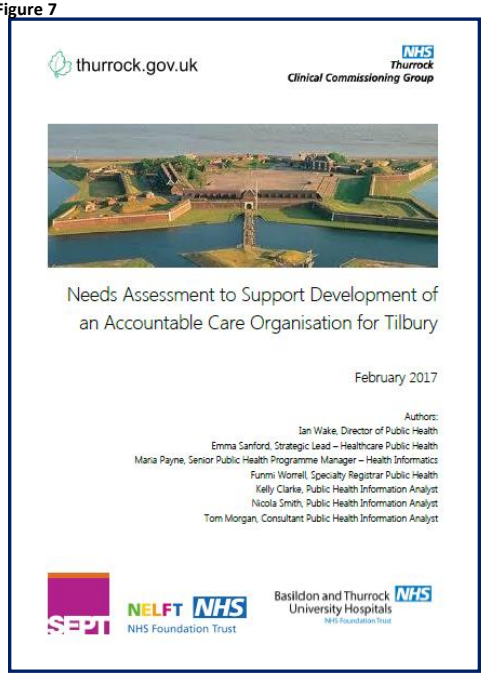
Chapter 2:

A whole system's understanding, a whole system's approach

2. A whole system understanding, a whole system approach (1/2)

The first stage the programme to develop this Overarching Case for Change was to undertake a detailed needs assessment of the locality of Tilbury and Chadwell. (Figure 7) This was published in February 2017. It aimed to address the issue that a detailed understanding of patient/client flow between different constituent services within the local health and care system is fundamental to building a programme of work that reduces demand on secondary acute NHS and residential care services. A full copy of the document can be accessed by clicking the hyperlink below figure 7.

Figure 7



https://www.thurrock.gov.uk/healthy-living/health-statistics-and-information

The detailed analyses contained within the needs assessment can be summarised in five high level conclusions below and overleaf:

1. Too much money and too many patients are in the most expensive parts of the system:
   - There were 453 potentially avoidable emergency hospital admissions for ambulatory care-sensitive conditions in 2015/16 costing £19,000.
   - There were 1,844 delayed days for delayed transfers of care in 2015/16, with a net wastage of £2.31M, had adequate NHS community services been available (Thurrock wide figures). This has increased since the publication of this needs assessment.
   - 77% of A&E attendances were for issues that needed "advice only and no treatment", or the most minor for of investigation and treatment, and could potentially been treated in Primary Care. The net wastage to the system in treating this cohort of patients in 2015/16 was £0.5M
2. Inadequate quality and capacity in Primary Care, Community Care and ASC keeps the money and the people in the wrong place
   - Tilbury is one of the most "under-GP'd" and "under-practice nurse'd" localities in England
   - Thousands of patients with long term conditions have not been diagnosed, and so are not being treated, putting them at high risk of serious health events and emergency hospital admissions
   - For those patients who have received a diagnosis of a long term condition, many are receiving inadequate care within the community. In 2015/16, 4575, 2011 and 893 NICE recommended clinical interventions for patients diagnosed with diabetes; cardio-vascular disease; and COPD were not delivered putting them at increased risk of serious health events and emergency hospital admissions
3. Solve the capacity and quality issues highlighted in (2), and the money will follow is reduced hospital and ASC costs
4. Solving the capacity and quality issue highlighted in (2) requires integrating the system (and the money)
   - There needs to be further integration between ASC and Health. The organisational sovereignty of budgets creates perverse incentives not to address issues such as delayed discharges.
   - The interface between GP surgeries and Community Services needs to be improved. Too few patients on GP Long term condition registers are not being treated by Long Term Condition Management Services commissioned from NELFT
   - Primary Prevention needs to be "ramped up" and integrated into the day job of all front line health and care staff, rather than being commissioned separately by the Public Health Team.
   - Mental and Physical Health Services operate largely in silos and need to be integrated
   - Self care and the third sector sit largely completely outside clinical care pathways
5. We require a period of "double running" (non-recurrent investment) to solve the problem.
   - We cannot simply decommission services provided by BTUH and ASC whilst we invest in prevention and early intervention programmes, and address the issue of capacity and capability within Primary Care

2. A whole system's understanding, a whole system's approach (2/2)

The aim of the New Model of Care is to move from the current fragmented system of individual services (figure 8), to one single integrated community care offer wrapped around a network of world class primary care GP surgeries, with the resident at its heart (figure 9). Our New Model of Care will have four high level aims, shown in box 1.

BOX 1: Aims of the New Model of Care

1. Reduce the number of unplanned hospital admissions
2. Reduce the number of A&E attendances for conditions that could have been treated elsewhere within the community
3. Reduce the number of Delayed Transfers of Care
4. Keep people as independent as possible for as long as possible, and reduce/prevent/delay entry into care and support services

These will be achieved by delivering the key objectives shown in box 2. These aims and objectives make up an agreed "investment framework" for our Better Care Fund.

BOX 2: Key objectives of the New Model of Care

1. Significantly increase the capacity and quality of Primary Care provision and reduce variation in current provision
2. Significantly increase the diagnosis rates of those with un-diagnosed long term conditions (case finding).
3. Significantly improve the care of patients with Long Term Conditions within the community
4. Empower individuals and communities to take responsibility for their own health and wellbeing
5. Transform the way community health and care services are delivered including making care more flexible, holistic and person-centred, and to reduce duplication and improve outcomes.
6. Harness, and empower the resident, community and third sector as equal partners in health and wellbeing
7. Address wider determinants of health and wellbeing including housing, the environment and employment
8. Improve the mental health and emotional wellbeing of the population
9. Bringing health and care services and resources together in order to reduce duplication, improve efficiency and provide a better response such that people get the right solution at the right place and the right time;
10. Deliver a single live, shared care record.

Figure 8: The current fragmented system

Figure 9: The new ACP

Chapter 3:

A new set of values, a new way of working

3. A new set of values, a new way of working (1/3)

Our new ACP requires the integration of services provided by the NHS, Local Government, the third sector, and the harnessing of the capacity within the community itself. Bringing these different elements together in a new way of working presents a challenge in that different parts of the system work in very different ways and have very different cultures and philosophies. The NHS has traditionally worked through a medical 'deficit based' model. Its service users are 'patients'. The function of its services is to 'diagnose what is wrong with the patient' – the deficit, and then to 'fix' the deficit through treatment hopefully leading at best to cure, though more recently with the increase of long term conditions, to management and control of the deficit. The relationship is largely one of services full of highly skilled experts doing "to" patients. The services are provided free at the point of delivery.

The third sector, and increasingly Adult Social Care work on an "asset" based model. They see their role not as trying to diagnose and fix problems, but to empower citizens to maintain or re-regain independence and/or improve wellbeing. What 'wellbeing' looks like is a more loosely defined concept that is negotiated between the practitioner and resident. Service users are 'clients' or residents and the services provided are more likely to consider more holistic issues of 'well-being' that encompass individual and community resilience and wider determinant of wellbeing such as employment, education and social connectivity. Furthermore, when services are delivered they are not necessarily free at the point of delivery but are paid for in part of full by the resident.

Both models of care have merit. It would be highly inappropriate to take an asset based approach with a resident going into a cardiac arrest, but equally prescribing medication to a person who is depressed because they are unemployed, lonely or in debt may not necessarily be the most effective solution.

A new approach to health and care that integrates both philosophies in a flexible and appropriate way around the person is highly desirable, but this also requires front line health and care staff who may have worked have worked purely to one model for decades, to break down historical professional hegemony and embrace new ways of seeing the world. We do not under-estimate the challenge of changing organisational and professional cultures in order to achieve this.

As such we have developed an are currently consulting on some high level principles that all partners in our new ACP will sign up to, grouped under three main headings (box 3) and defined what success will look like and how this will be different to the current approach. (box 4 overleaf)

Box 3: Our Values

Partnership with you and your community

- We will listen to you and help you identify what your own needs are
- We will focus on supporting you to achieve the outcomes and solutions that you define
- We will treat you as an equal partner in your health
- We will work "with you", not "do to" you
- We will help you to access the community assets available within your local area and not simply focus on our own health services
- Responsibility for maintaining and improving your health and wellbeing is shared with you and with your neighbourhood;

Proactive prevention

- Our starting point will always be to help you remain as healthy and independent as possible
- We will prevent, reduce and delay you from requiring a social care and health service by intervening as early as possible

Integrated accessible services

- When you do need a health or care service, we will seek to integrate care around you, not require you to access lots of different services
- We will provide you with a single named accountable person who coordinates your care
- With your permission, our care providers will talk to each other so that you should only have to "tell your story" once.

3. A new set of values, a new way of working (2/3)

We have also defined what "success looks like", in terms of the proposed new way of working for our ACP. This is again group under three key headings, set out in box 4

Box 4: What does success look like?

A strong, connected community

- You are less isolated and have the opportunity to be well connected where you live;
- You are able to get the majority of the support you need from within your neighbourhood and as a result you access health and care services less frequently;
- You are enabled to live a healthy and happy life.

Shared responsibility

- You take responsibility for staying as healthy as possible
- We all use health and care resources appropriately and responsibly

Holistic, flexible and proactive care, provided locally

- Our health and care system treats you as an individual and does not define you by your illness or condition;
- You can get the support and care you need at the right place and the right time;
- By bringing health and social care services and resources together we will reduce duplication, improve efficiency and provide a better response
- We act before you reach crisis point and reduce the number of times you need emergency health or care services

3. A new set of values, a new way of working: Beryl's stories (3/3)

What would happen now

Beryl is an 81 year old woman living in Chadwell who has recently become widowed. Simon, her son lives in the Newcastle and sees his mum three times a year. Alice, her daughter lives in North America and is only able to keep in contact via telephone which is difficult given Beryl's hearing loss.

Beryl has lived in the same house for forty years. It is the home in which she raised her family and where she lived with her husband until he died nine months ago. The house has three bedrooms and a large garden which she can no longer maintain. The home is draughty and the heating system is too expensive to run for more than a few hours a day. However the house contains all of her happiest memories and is home. Beryl knows that her house is not manageable anymore and makes her life much more difficult. She feels there is nowhere she would want to move to and so cannot contemplate moving. Beryl has become almost totally isolated since her husband died. She has a reasonable income as he left her well provided for but has lost all interest in mixing with people. As a consequence of her isolation Beryl feels very low, and there are many days when she feels like there is little reason to carry on. As a consequence of this feeling, Beryl has continued to use the sleeping tablets prescribed following her husband's death, she has continued to take these on repeat prescription as she feels that they help to take the edge off of her loneliness.

Two months ago Beryl accidently doubled up on her dose. This led to her falling down the stairs late at night and not being able to get help until the morning. Beryl had broken her hip and suffered other cuts and bruises. After a period in hospital Beryl was discharged home with a package of re-ablement. Beryl was unsure what this meant but now understood that this was care and support for her in her own home that would assist her to regain her independence. The service she received was very good but despite everyone's best efforts Beryl was unable to improve to the same level of independence she enjoyed previously. Beryl now receives a home care package to assist her in her personal care needs and to prompt her medication use. Beryl is now on much more medication than before and gets confused about what she needs to take and when. The longer term prognosis for Beryl would seem to lead inevitably to a period of decline and ultimately to residential or nursing care

What should happen in the future

Beryl watched a new HAPPI housing scheme – Grove Park being built and she and her husband talked about selling their house and using their capital to buy a new equity share home. They recognised that the heating bills would be much lower and there would be fewer worries if they moved to purpose built, attractive housing. Beryl had also joined the Chadwell choir which had been set up by U3A volunteers at the new Chadwell Community Hub – just five minutes down the road from her home. Her husband has been active in the steering group of the community hub and had set up a reading club. A local volunteer has set them up on Skype so they can maintain contact with family in the UK and abroad.

When her husband and prime carer died suddenly, Beryl was contacted by someone who was based at the Chadwell hub and who was called "Initial Support". They explained that their team worked with people who were identified as possibly in need of some help and advice to ensure that their quality of life and independence was being maintained. In Beryl's case the referral had come from the practice nurse in her GP surgery. The worker arranged to visit Beryl in her home and was able to provide her with a few aids that would assist in daily living tasks, and some minor adaptations to her house that would help to prevent Beryl from falling. Also the worker reviewed Beryl's medication and was able to provide good advice about the possible detrimental impact of using the sleeping tablet she had been prescribed for too long. The worker also provided a medication dispensing system that ensured it was very difficult for Beryl to take too many tablets. Finally the worker referred Beryl to a "community Connector" who was a volunteer working in the local community who had established excellent links with a wide number of local groups and networks with whom Beryl could become involved if she wanted. Through the community connector, Beryl felt able to discuss her concerns about continuing to live in her family home in the longer term and how she might get help to move into Grove Park. When she was ready, a local community interest company – 'People Movers' helped Beryl with all the practical arrangements for down-sizing to her new home. With the community support she has in place, the lovely new home and new friends she has made at Grove Park, Beryl's use of medication has reduced as her health has improved. The family who moved into Beryl's house come to visit her, bringing home-made jams made from the fruit trees that Beryl and her husband planted when they were first married. Beryl in turn, helps their daughter with her French homework. The people mover company – set up with the advice of Thurrock CVS found a good home for some of Beryl's surplus furniture.

Grove Park, in tandem with our new Community service hub and our local volunteer services will mean that Beryl's life in older age, after the death of her husband can still be a quality life where health and independence are encouraged. Beryl has just taken over the role of management secretary for the group running the day to day management and maintenance of the scheme. This means that the scheme benefits from her administrative and managerial skills she has from her previous career as the school secretary.

4. Segmenting the Population

Figure 10: Percentage of population and cost of Hospital Services use. (A&E, Outpatients and Inpatients)

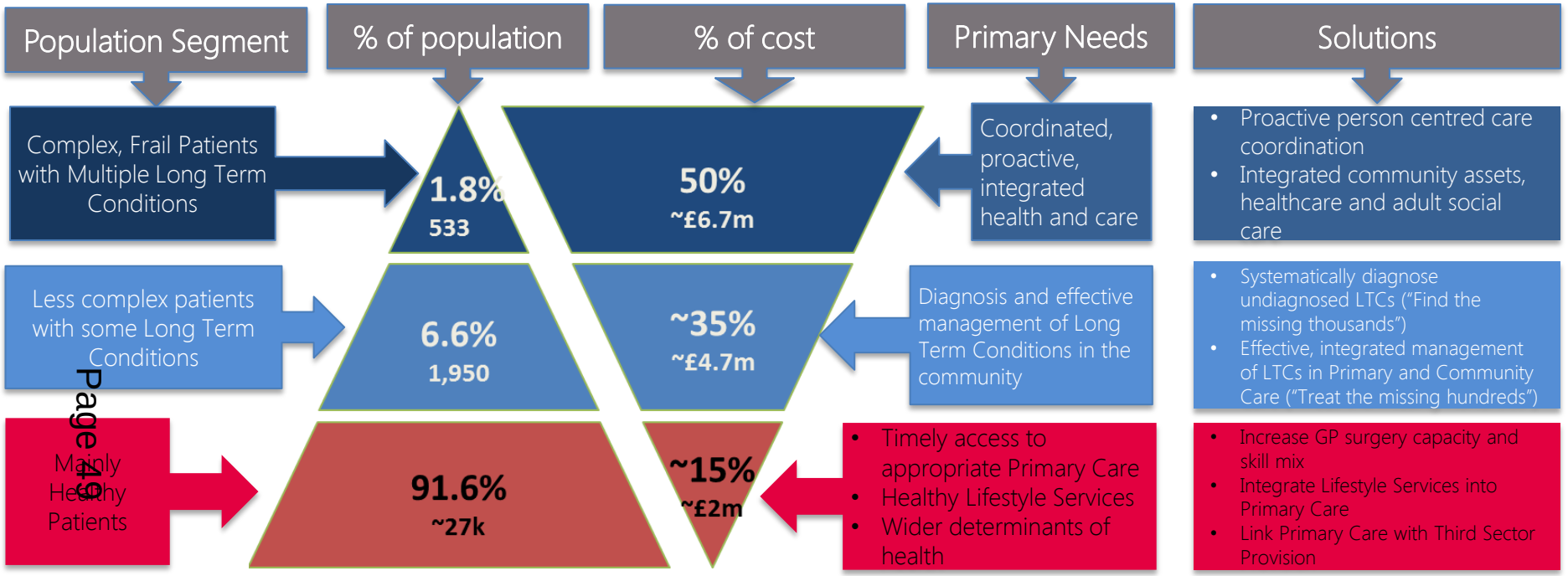


Figure 10 above shows the healthcare (A&E, out patient and in-patient) costs of different segments of the population. 50% of all spend on hospital services is generated by only 1.8% of the population. These residents are likely to be older people with multiple complex needs who are likely to have experienced a number of hospital admissions. There main need in the community is likely to centre around proactive health and social care, with a single named professional responsible for coordinating all of their care needs. The main purpose of such a service needs to be to maximise independence, keep them as well as possible, reduce the number of unplanned hospital admissions and delay entry into residential care.

A further 35% of health care costs is generated from only a further 6.6% of the population. These are likely to be patients with some long term conditions that may or may not have been diagnosed. If not properly managed within Primary and Community Care, they are at risk of more serious health events such as heart attacks and strokes, and are likely to move up into the 'Complex Frail' category. Their main need is to have their long term conditions effectively diagnosed and managed within Primary/Community Care.

The vast majority of the population (91.6%) account for only 15% of hospital healthcare costs. This population is likely to consist of mainly healthy patients who have acute illnesses. There main experience of the healthcare service will be in Primary Care and their main concerns are likely to be timely access to a GP or other healthcare professional to assist with acute illness. They may visit A&E inappropriately if they are unable to access these services in a timely way. In addition, they may benefit from and wish to access lifestyle modification services such as stop smoking or weight management or services that help address the wider determinants of health such as housing advice, debt or employment issues.

The remainder of this New Model of Care *Case for Change* is divided into three chapters, each of which focus on solutions required to address the primary needs of each of the above three segments. We recognise that residents may not fit neatly into one segment, and may have needs that span all three. We also recognise that individuals may move between segments during their lifespan. The separation of our proposed initiatives into three chapters is simply a neat way to categorise different types of initiative.

Chapter 5:

Enhance the capacity and capability of Primary Care

Mainly Healthy Patients

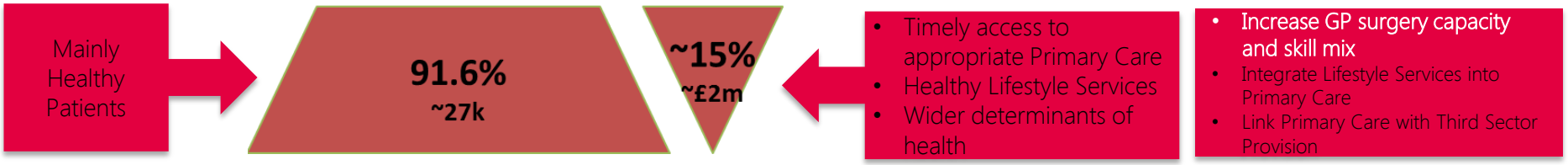
91.6%
~27k

~15%
~£2m

- Timely access to appropriate Primary Care
- Healthy Lifestyle Services
- Wider determinants of health

- Increase GP surgery capacity and skill mix
- Integrate Lifestyle Services into Primary Care
- Link Primary Care with Third Sector Provision

5. Enhancing the capacity and capability of Primary Care (1/18)



5.1 Introduction

This chapter explores the issue of enhancing the capacity and capability of Primary Care in Tilbury and Chadwell. High quality primary care services that are easily accessible are key to both population health and system sustainability. Over 90% of the population will visit their GP each year and over 95% will use a pharmacy, making Primary Care the most frequently accessed element within the local health and care system.

5.2 GP Under-doctoring in Tilbury and Chadwell: The Current Capacity Gap

Thurrock is one of the most under GP'd and under Practice Nurse'd area of England, and Tilbury has the worst ratio of Full Time GPs and Practice Nurses: Registered Patients in Thurrock. All of the practices in Tilbury and Chadwell have a greater than ideal number of patients per permanent WTE GP. The picture does look slightly different when we include locums in the figures, however this does not provide any continuity of care and is an expensive way to "prop up" capacity. Figure 11 shows the FTE:weighted patient ratio for each surgery in Tilbury together with the 2014 national average ratio of 1:1321.

This current situation translates into fewer available GP appointments per head of population depending on the average length of appointment offered. GP appointment length is amongst the shortest in Europe often meaning that GPs can only deal with a single issue in one appointment. Demand on GP surgeries nationally is increasing at a rate that is not sustainable, and which has not kept pace with increases in either funding or workforce. Analysis of 30 million patient contacts from 177 practices[1] found that consultations grew by more than 15 per cent between 2010/11 and 2014/15. Over the same period, the GP workforce grew by 4.75 per cent and the practice nurse workforce by 2.85 per cent.

Furthermore, within the Borough there is strong association between levels of under-doctoring and levels of practice population deprivation. This means that the practice populations likely to be suffering from the greatest levels of ill-health are worst served in terms of numbers of GPs available to care for them. Figure 12 suggests that almost 30% of the variation between levels of under-doctoring between different GP practice populations in Thurrock can be explained by differences in levels of deprivation within those populations.

Multiple Regression Analyses models produced by the Thurrock Healthcare Public Health Team for the 2016 Annual Report of The Director of Public Health, demonstrated that Improving access to Primary Care services provided from GP Surgeries has the potential to prevent serious adverse health events and avoid unnecessary secondary care admissions and costs. For Thurrock as a whole, we predict that:

For every one percentage point increase in the availability of GP appointments (as measured by the question "last time you wanted to see/speak to a GP were you able to?" in the GP patient survey) we estimate a reduction in

- 6543 emergency hospital admissions for COPD
- 109 emergency hospital admissions for Heart Failure
- Save the NHS in Thurrock £2.9M

Figure 11

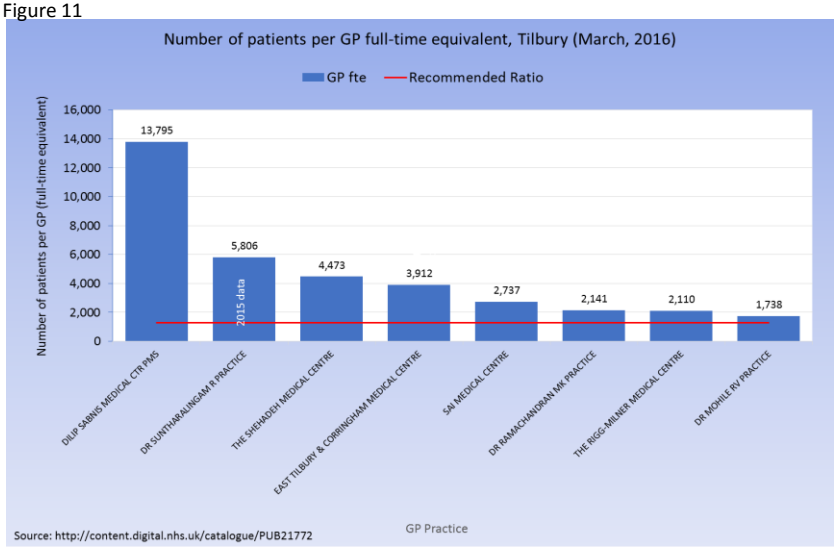
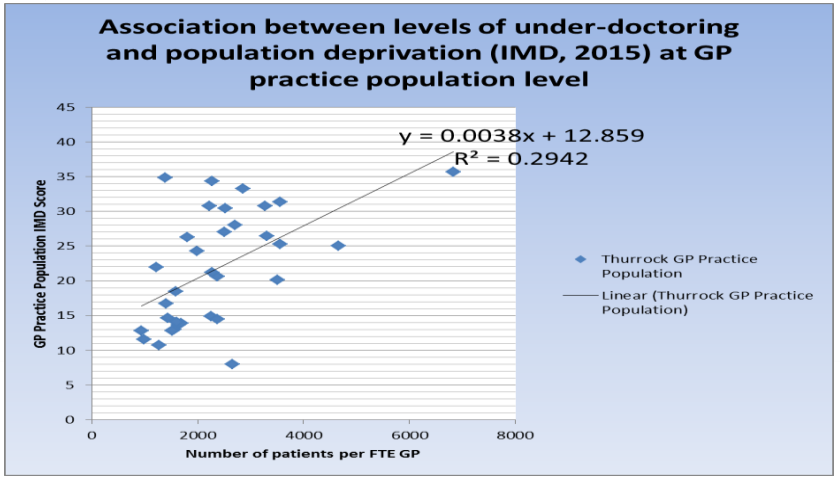


Figure 12



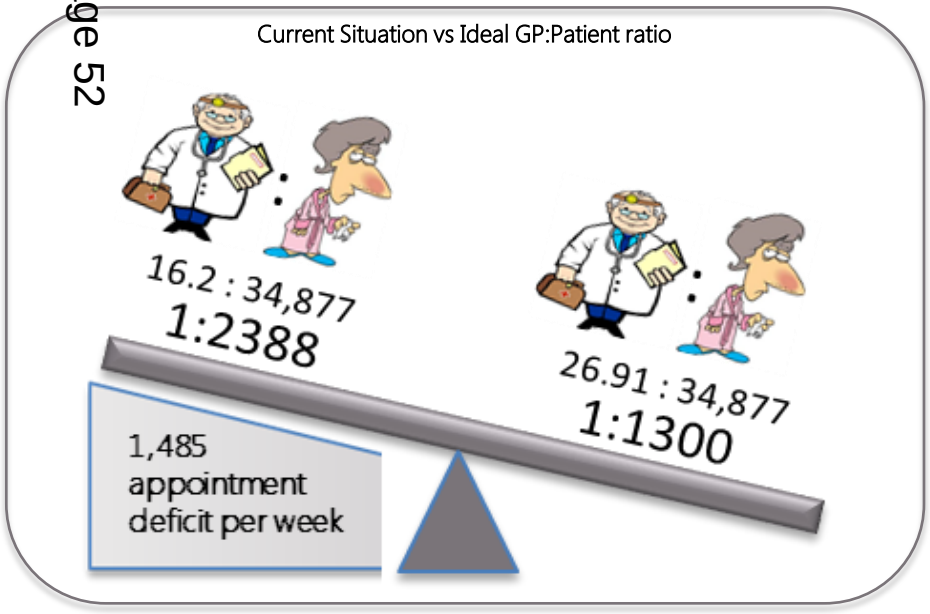
5. Enhancing the capacity and capability of Primary Care (2/18)

GP Under-doctoring in Tilbury and Chadwell: The Current Capacity Gap (cont.)

There are currently 16.2 FTE GPs in Tilbury and Chadwell, giving a FTE GP to patient ratio of 1:2388. We calculate that in order to bring FTE GP: patient ratios in line with the 1FTE GP per 1300 patient ratio (approximately in-line with the 2014 England mean ratio) set out in the ACP Needs Assessment , we require a further 10.71WTE GPs in Tilbury and Chadwell. Under new APMS contract rules, we calculate that each additional FTE delivers 138.72 appointments per week. The current lack of these GPs in Tilbury and Chadwell leaves an appointment deficit of 1486 appointments per week (shown in figure 13).

Lack of timely access to Primary Care in Tilbury and Chadwell is a significant concern for residents and a pressing problem both in terms of population health terms and system sustainability. Residents who are unable to get an appointment in their surgery risk delays in treatment for health conditions and are more likely to access A&E for more minor clinical issues that should be dealt with in the community. (Box 5). However, given the national shortage of GPs and current difficulties in recruitment, we are operating in a competitive market and it is not feasible to recruit this number to Thurrock quickly. Building the four new proposed Integrated Medical Centres should make Thurrock an attractive place for GPs to work in and assist in recruiting new GPs, however this is a medium term solution.

Figure 13



Box 5: Financial Impact of Inadequate Primary Care Access

In 2015/16:

- 77% of A&E attendances from Tilbury and Chadwell residents were for clinical issues that could have been dealt with in the community
- This resulted in **£950,000** of net excess cost to our local health system

[2] Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015

5. Enhancing the capacity and capability of Primary Care (3/18)

5.3 Why the historical model of General Practice is broken

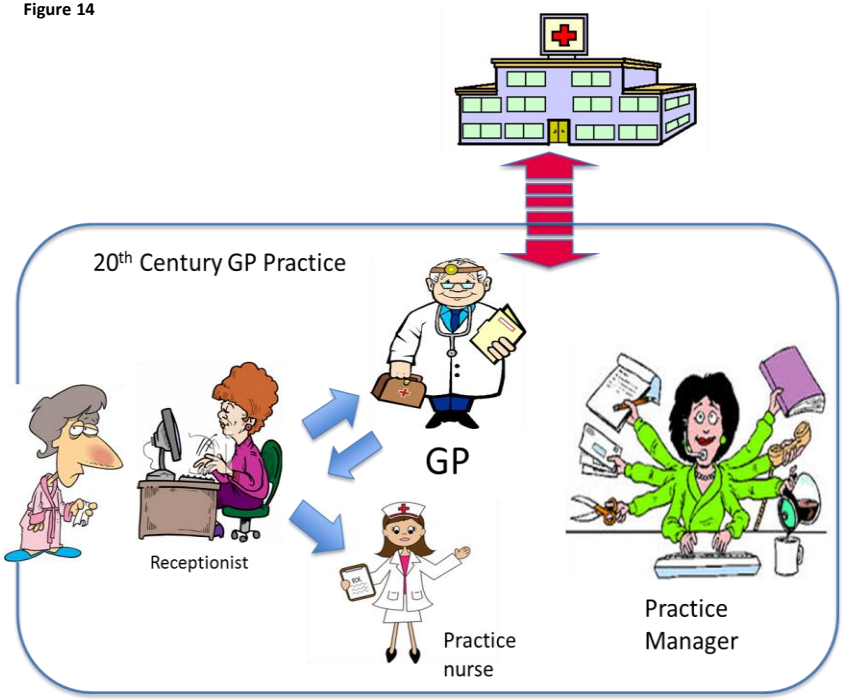
Although increasing GP numbers may help ease the burden on overstretched surgeries, research suggests that the historical model of General Practice, little changed from before the inception of the NHS itself is no-longer fit for the 21st century.

Figure 14 shows a simplified model of a traditional GP practice. In order to access the GP the patient books an appointment either in the surgery or via telephone with the receptionist. Most (if not all) patients see the GP first, who may decide to pass care on to a practice nurse, if the practice has one within the surgery. This may necessitate booking further appointments via the receptionist. There is a back office administrative function run by the practice manager who is responsible for multiple administrative tasks from opening and directing post, chasing test results or out patient appointments from hospital or community health providers, organising call-recall systems to invite patients with long term conditions to attend surgery for clinical interventions, managing practice income and accounts, often through multiple payment mechanisms with different commissioners, keeping practice HR policies up to date and line managing other administrative tasks. The traditional surgery has generally consisted of small teams and the model is replicated many times within a given locality.

The model is no-longer fit for purpose in the 21st century against a backdrop of rising patient demand, an ageing population, advances in treatment and patients living with multiple long term conditions.. Key problems identified in *Making Time in General Practice*[1] (a published report based in a comprehensive national survey of issues faced by GPs and their surgeries' workforce) and by a recent report by *The Kings Fund*[2] and in the ACP needs assessment include:

- A lack of triage. Patients are allocated time with the GP in the order that they present to the receptionist, and clinical need of the patient is not generally taken into account in prioritising appointments as the receptionist lacks the clinical skills to triage effectively.
- Patients generally all see the GP first who then makes onward referral to either the practice nurse or other hospital specialist. This is not efficient if the GP is not the most appropriate person to deal with the patient's clinical need
- The GP may spend time undertaking tasks that could be completed more efficiently by another professional, for example medication reviews that could be undertaken by a pharmacist, seeing patients with low level acute illnesses that could be dealt with by a prescribing nurse; triaging post that could be done by a highly skilled physician's assistant, or dealing with patients with an underlying need that is not clinical for example housing or debt issues, bereavement or loneliness.
- Appointment times are generally ten minutes meaning only one issue can be dealt with in each appointment. This may not meet the needs of today's patients who are living with multiple long-term conditions
- The relatively small size of the surgery team makes its level of resilience low, and risks service disruption due to absence. It also reduces opportunities for peer support and learning between clinicians, sharing best clinical practice, and risks care being reactive rather than proactive.

Figure 14



- Practice nursing support is generally low and not undertaken at scale. Nurses in different practices may have different skill sets leading to a non-uniform offer to patients between different practices.
- Administration tasks such as call-recall systems, HR or clinical governance policies or contracting that could be done more efficiently at scale are duplicated multiple times across different surgeries. This is inefficient and expensive.
- Patients are referred on to other services for clinical procedures that could be provided in Primary Care if there was greater capacity. Examples include common diagnostic tests, MSK services and long term conditions management e.g. COPD, diabetes management, IAPT and health improvement services.
- The interface between the surgery and hospital is often poor. GPs and Practice managers complain about discharge summaries being incomplete or late, and patients being sent back to surgery when out-patient appointment services have failed.

[1] Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015.
[2] Understanding Pressures in General Practice. Kings Fund, 2015

5. Enhancing the capacity and capability of Primary Care (4/18)

Large numbers of GP Appointments are Potentially Avoidable

Making Time in General Practice conducted research in 50 GP surgeries covering 5,000 consultations and concluded that overall, 27% of GP appointments were judged by respondents to have been potentially avoidable, with changes to the system around them. The results of the research are shown in figure X. The most common potentially avoidable consultations were amendable to action by the practice, often with the support of the CCG. The biggest categories were:

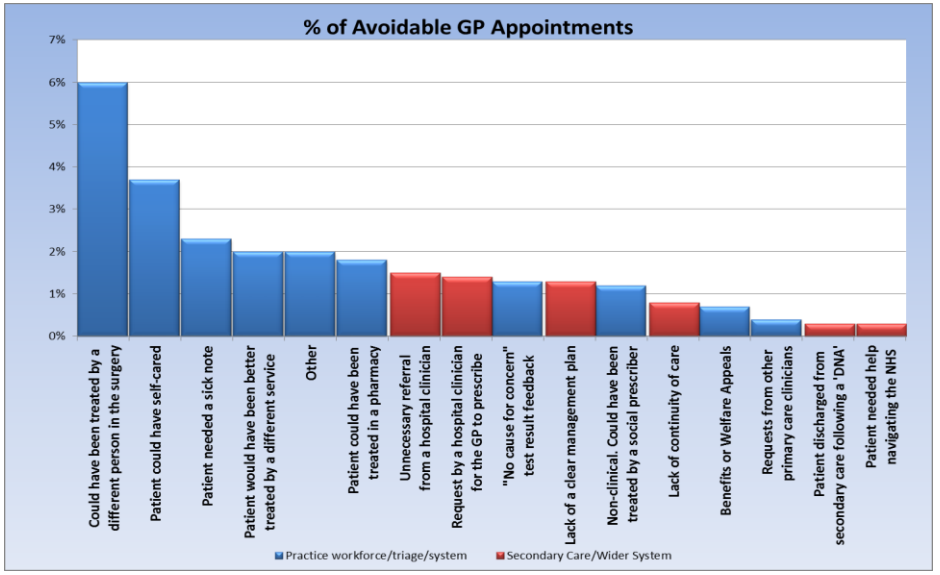
- Where the patient would have been better served by being directed to someone else in the wider primary care team, either within the practice, in the pharmacy or a so-called 'wellbeing worker' (e.g. care navigator, peer coach, health trainer or befriender). Together, these three, which could be improved by more effective triage or signposting system, together with a more diverse practice workforce and integrated support services, accounted for 16% of GP appointments.

- An additional 1% of appointments were to inform a patient that their test result was normal and no further action was needed. These could potentially be avoided if an IT solution or other system that allowed patients to access test results was implemented or communicated test results to patients was implemented at practice level.

- Demand created by hospitals accounted for a total of 4.5% of appointments. The largest category, creating 2.5% of appointment, comprised problems with outpatient booking (either a lapse in the outpatient booking process, such as failure to send a follow-up appointment), or a patient failing to attend an appointment, necessitating an entirely new GP referral. The other, creating 2%, was the result of hospital staff instructing the patient to contact the GP for a prescription or other intervention which was part of their hospital care.

- A further 1% of appointments would not have been necessary if continuity of care or a clear management plan had been established. This could be solved by more integrated working between health and care professionals

Figure 15



5. Enhancing the capacity and capability of Primary Care (5/18)

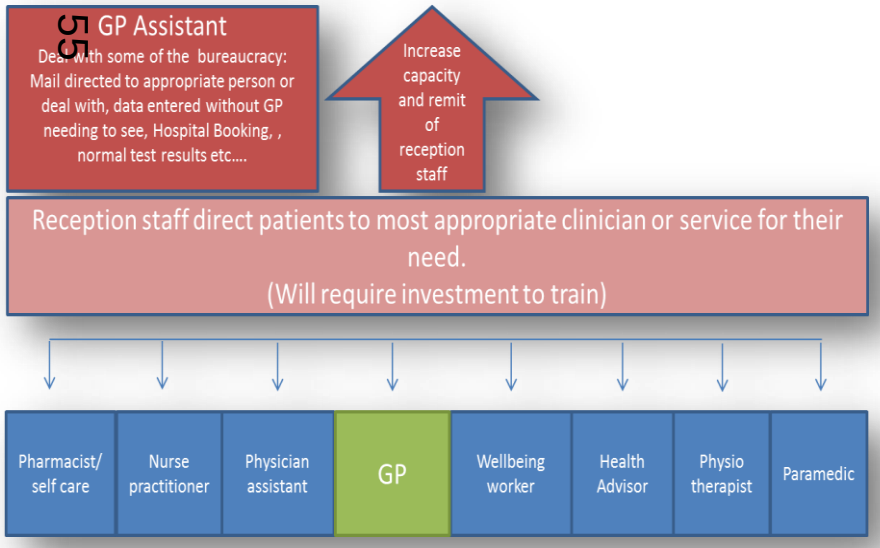
5.4 Increasing the Clinical Skill Mix within GP Surgeries

We calculate that in order to bring FTE GP: patient ratios in line with the England average, we require a further 12.88WTE GPs in Tilbury and Chadwell. However, given the national shortage of GPs and current difficulties in recruitment, we are operating in a competitive market and it is not feasible to recruit this number to Thurrock quickly. Building the four new proposed Integrated Healthy Living Centres should make Thurrock an attractive place for GPs to work in, however this is a medium term solution.

Making Time in General Practice[2] demonstrates that diversifying the workforce skill mix in Primary Care would release significant amounts of GP time and therefore capacity, allowing them to concentrate more time on patients with long term conditions and less time on tasks that could be better undertaken by other types of clinical staff. Figure X shows the original workforce model proposed in *Making Time in General Practice*.

We will invest the "£3 per head" Primary Care funding for Thurrock in Tilbury and Chadwell Surgeries as part of our ACP programme in order to deliver a diversified mixed skill clinical workforce, based on the model shown in figure X. This in turn will free up GP time to care for the most complex patients, and release additional clinical appointments for residents, addressing the problems of under-doctoring and inadequate timely access to surgery appointments.

Figure 1



Nurse Practitioner

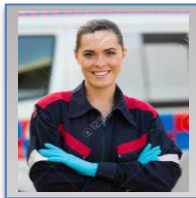
Highly qualified nurse practitioners with the skills and qualifications to prescribe are able to see and treat many patients who in a traditional surgery would require a GP appointment, for example patients with less complex conditions, for example those who need antibiotics for acute infections

Practice Based Pharmacist

With increasing number of patients living with multiple long term conditions, GPs are increasingly required to undertake complex medication reviews. These could be done by a surgery based pharmacist, often in a fraction of the time. One in two patients take their medication incorrectly. The pharmacist can help address this through medication compliance reviews

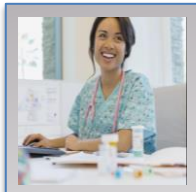
Physiotherapist

One in six GP consultations is for a musculo-skeletal problem. Basing physiotherapists in GP surgeries allows this cohort of patients to be treated directly without the need to necessarily see a GP for onward referral to a hospital or community based physiotherapy service.



Paramedic

Successfully piloted in some areas of the UK, including College Health in Medway, a paramedic can be used to undertake emergency home visits to assess and treat patients, calling upon GP or other clinical support only when necessary. They have also been used in systematic outreach to care homes and have shown to significantly cut avoidable hospital admissions.



Physicians Assistant

A Physician's Assistant (or Associate) is a new clinical role in the NHS. Their role includes the ability to diagnose, interpret data, devise care management plans and prescribe. They work alongside GPs and nurses in the treatment and management of a wide range of patients, come with a generic clinical skill set but can be trained by the surgery to specialise in key areas of need, for example sexual health.

Wellbeing Worker

The ACP Needs Assessment showed low referral of patients with poor lifestyles into health improvement services such as stop smoking, NHS Health Checks or sexual health clinics. These services have traditionally been commissioned and often remotely from GP surgeries. Placing health improvement at the heart of Primary Care will help address this, and make it easier for residents to make positive lifestyle changes

5. Enhancing the capacity and capability of Primary Care (6/18)

By implementing new models of working in Primary Care as set out in Making Time in General Practice and through other research, we calculate that we could release an additional 1495 number of GP appointments per day in Tilbury and Chadwell.

This has the potential to bridge this deficit in current number of appointment offered as shown in the boxes below. Figure 17 shows that with the current ratio of 1 FTE GP to 2,388 patients in Tilbury and Chadwell, the population faces a shortage of 1,485 appointments per week compared to what would be available if we met the ideal ratio of 1 FTE GP to 1300 patients.

Conversely, figure 18 shows the potential impact of implementing a new model of General Practice from modelling undertaken by the Healthcare Public Health Team by implementing a new model of General Practice for Tilbury and Chadwell, designed by the Healthcare Public Health Team based on the principles set out in *Making Time in General Practice*. We calculate that the new model would release 1,495 GP appointments per week (figure 18), closing the deficit shown in figure 17 without the need to recruit the additional 10.71 WTE GPs. Indeed the new model actually performs slightly better in terms of increasing capacity within General Practice compared to recruiting additional GPs to deliver the 1:1300 FTE GP:weighted patient ratio, delivering an additional 10 appointments per week (figure 19)

Figure 17

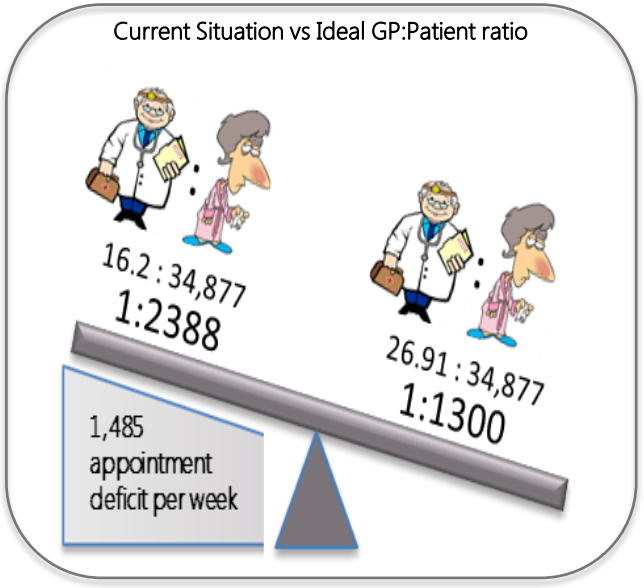


Figure 18

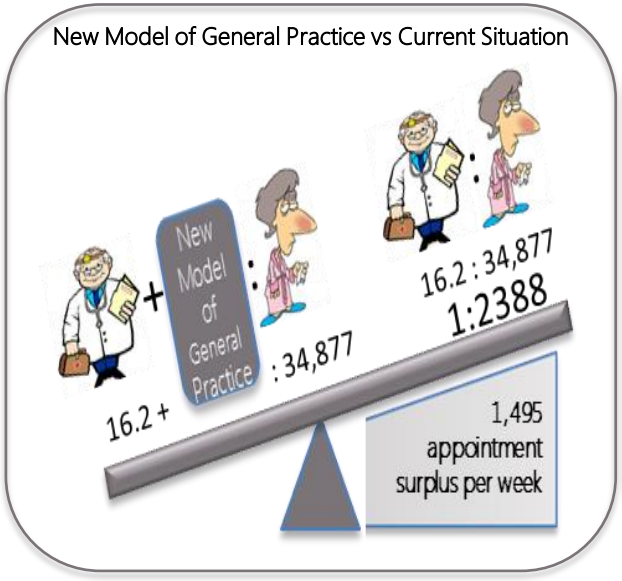
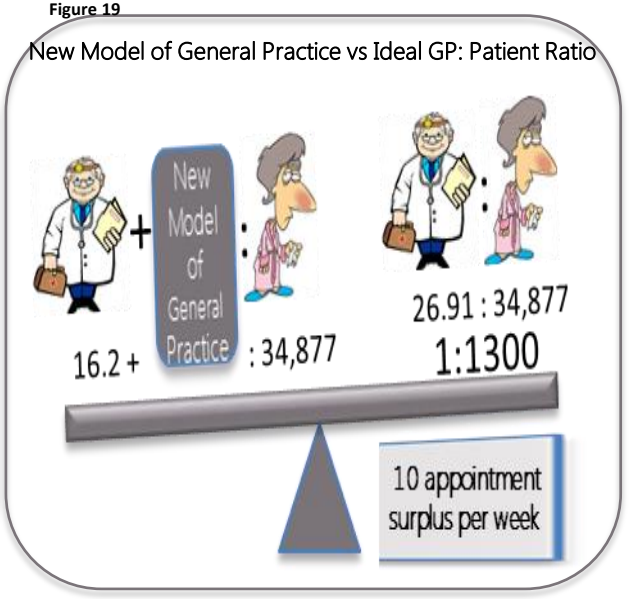


Figure 19



5. Enhancing the capacity and capability of Primary Care (7/18)

5.4 Increasing the skill mix within GP Practices (cont.)

Table 1 shows the costs of implementing the mixed skill work force in GP surgeries in Tilbury and Chadwell, and Box 6 shows the assumptions that underpin the modelling undertaken by Thurrock's Health and Social Care Public Health Team in relation to the number of additional appointments released (shown on the previous page).

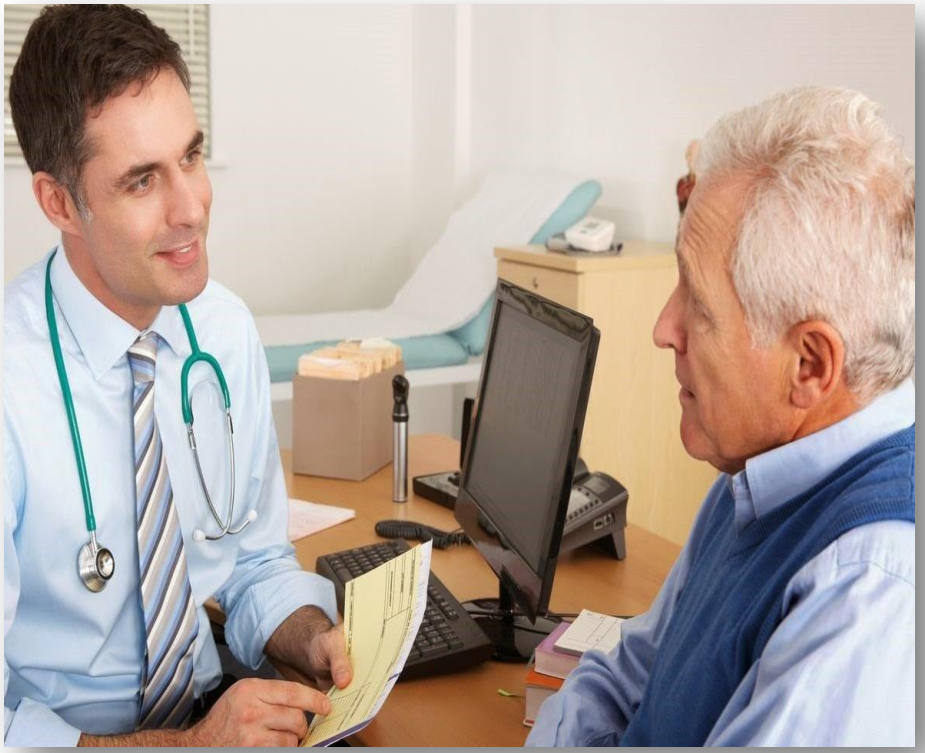
The new model will be funded through investment of Primary Care Transformation Funds that are attached to the Government's General Practice Five Year Forward View Strategy.

Table 1

Staff Group	Current FTE	NEW Model FTE	Aditional FTE required	Salary / AFC Band	Total Estimated Cost
GPs	16.2	16.2	0	N/A	£0
Nurse Practitioner	5.5	5.5	0	AFC 7	£0
Advanced Nurse Practitioner	7.1	8.5	1.4	AFC 8	£82,522
Physio Therapist	0	8	8	AFC 6-7	£337,033
Well-being worker	1	3	2	AFC 4	£53,178
Admin/Receptionists	34.4	34.4	0	AFC 3	£0
Physician Assistant (DPC)	3	4.8	1.8	AFC 6-7	£33,703
GP Assistant (Administrative)	0	3	3	AFC4	£82,103
Practice Based Pharmacist	1	2	1	N/A	£0
Health Advisor and health care assistant (FTE)	3.1	4.1	1	AFC 4	£27,368
Social Prescriber	0.2	2	1.8	£13.74/hr	£61,518
Total	71.5	91.5	20		£620,552

Box 6: Assumptions

1. We do not wish to reduce the number of GPs in the area under any new model. There is a shortage and we should at least maintain current levels.
2. The ideal number of GPs in Tilbury would result in a ration of patients to GP of 13,00:1 and for nurses 2765:1.
3. These results in a shortage that cannot be filled by GPs and nurses either physically or financially
4. The shortfall can be filled by other members of a mixed skill workforce
5. All WTE patient facing staff can spend 410 minutes per day with patients
6. Appointment lengths for GPs, Nurses, Pharmacists, and Nurse Practitioners are on average 10 minutes.
7. Appointment length for a wellbeing worker is on average 30 minutes
8. Appointment length for a physio-therapist is on average 15 minutes
9. A physician assistant can deal with 40 patients per day
10. The ratio of patients to GP assistants should be 5000:1 – this can save each GP 40 minutes per day
11. A receptionist has some kind of interaction with all of the patients dealt with by patient facing staff and each interaction lasts on average 3 minutes. (With on-line booking and touch screen check in this can be reduced).
12. Increase in Social Prescribers is based on the opinion of CVS.
13. Some manual alterations to admin/reception support and GP assistants have been made to reflect expert opinions.
14. Hourly rate of staff are as follows: GP
15. 30% on costs have been included but no employment costs are calculated. e.g. training.



Key Action

We will implement a new mixed skill workforce model within GP surgeries within Tilbury and Chadwell to release an additional 1495 appointments per week to residents, address the current levels of under-doctoring and improve access to clinical care within surgeries for our residents

5. Enhancing the capacity and capability of Primary Care (8/18)

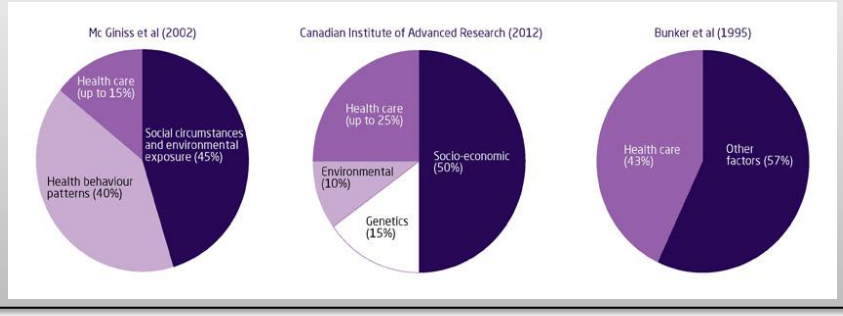
5.5 A Partnership with Patients and Community to address wider determinants of health

Traditional bio-medical models of medicine have placed the clinician in the role of 'expert' and the resident in the role of 'patient', too often being the passive recipient of care following a diagnosis. However a number of international studies suggest that in the most effective health systems world wide, there is are much more equal and partnership based relationship with the care receiver being empowered to both make choices and take responsibility for their own health, wellbeing and care.

Intuitively, this more modern approach feels correct. A strong body of research now exists showing that social and environmental factors; potentially within the control of the individual but largely outside of the scope of traditional clinical practice can have a major impact on health and wellbeing.

A recent systematic review that considered 218 published studies involving almost four million people concluded that loneliness and social isolation was more dangerous to health than obesity, and that those who were socially isolated were at a 50% increased risk of early death compared to those with strong social networks [4]. Professor Michael Marmot's report into Health Inequalities in England showed the significant impact that factors such as education, income, employment and housing can have on health [5], and a number of studies suggest that these 'wider determinants of health' have a greater impact on health and wellbeing than clinical health services. (Box X).

Box 7: Influences on Health



Residents of Tilbury and Chadwell are disproportionally affected by social and environmental factors that impact negatively on health outcomes. Two of the four wards covered by the ACP have a significantly greater proportion of overcrowded households than Thurrock or England (figure 20), and three have a greater proportion of residents with no formal qualifications

Addressing these wider determinants of health in order to break inter-generational embedded health inequalities is key to improving the health and wellbeing of Tilbury residents. However, for too long, statutory services that address wider determinants of health and wellbeing have been delivered in isolation to local health and care services. The ACP will address this by strengthening links between Primary Care and statutory services that address wider determinants of health including our *Brighter Futures* Children and Families Service, Employment, Debt and Housing Advice and seek to co-locate delivery of these services within the ACP, and ultimately within the new Integrated Medical Centre for Tilbury and Chadwell.

Figure 20

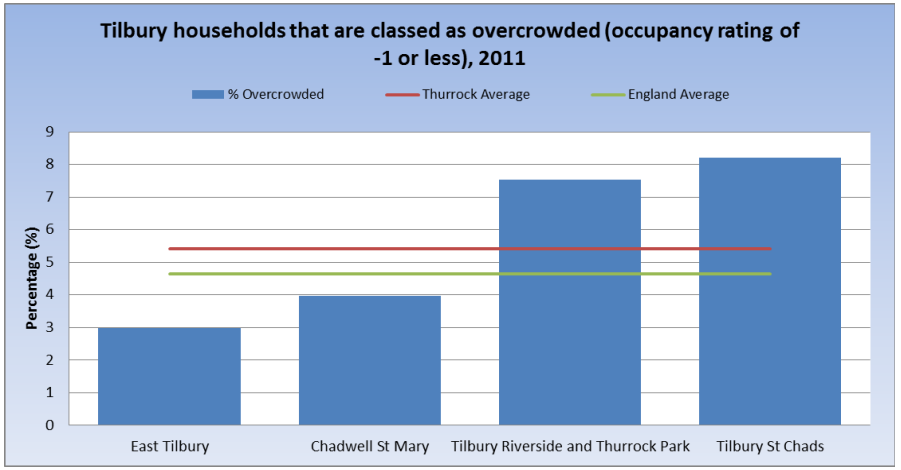
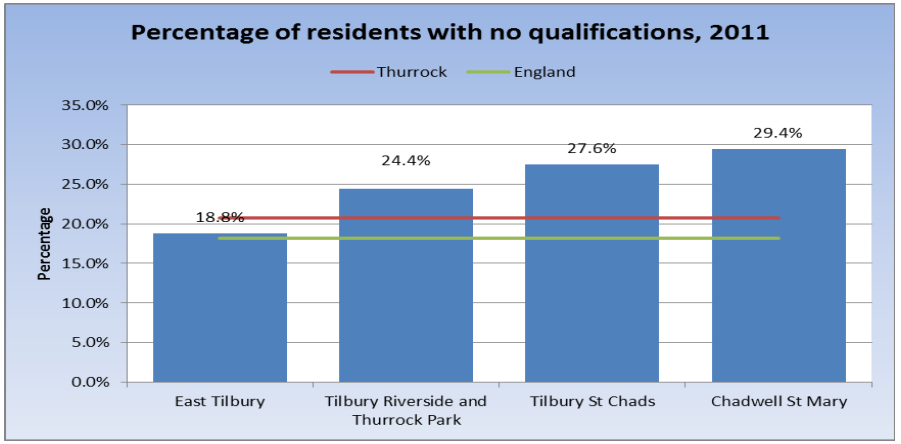


Figure 21



5. Enhancing the capacity and capability of Primary Care (9/18)

5.5 A Partnership with Patients and Community to address wider determinants of health (cont)

Thurrock has a proud tradition and strong story to tell relating to our community and third sector provision with over 500 community and voluntary organisations aligned to an active Council for Voluntary Services (CVS). This estimate includes registered organisations, such as charities, social enterprises and co-operatives, voluntary organisations, community/neighbourhood groups, informal interest groups and faith groups. Our *Stronger Together* and *Living Well in Thurrock Programmes* are recognised models of best practice. In terms of paid staff, based on the average number of FTE paid staff employed by respondents to the State of the Sector survey across Thurrock, it is estimated that the 500 organisations employed 1,315 FTE paid staff in 2014/15. There are also an estimated 7,429 volunteers, representing 4.6% of Thurrock's total population as are our Local Area Coordinators.

A *Community Hub* operates in Tilbury. Priorities for the hub are determined by residents but include:

- Support and advice for residents to self-serve for information, both via face-to-face and web-based support
- Increasing volunteering opportunities
- Hosting groups to encourage cohesion and reduce isolation such as craft groups
- Hosting groups to improve health and wellbeing (e.g. fitness classes)
- Facilitating meeting opportunities for residents with public sector staff (e.g. Local Area Coordinators)
- Community gardens

Community feedback to date has been very positive with residents, ward councillors and professionals providing good comments back to the Stronger Together partnership who oversee the Hubs programme, however historically this provision has been divorced from Primary Care commissioning. Our new ACP will address these issues by placing the individual, community and third sector at the heart of Primary Care.

5.5.1 Social Prescribing

One mechanism to achieve this will be through 'social prescribing' which is currently being piloted in some GP practices in Tilbury, East Tilbury, Aveley and Purfleet.

Individuals sometimes lack the confidence to discuss issues at the root of their anxiety and with GP's time pressure; social prescribing allows an individual time to discuss what matters in their life.

Social prescribing compliments other services; local area coordinators, community solutions, housing or the third sector, by finding out what matters to them rather than what's the matter, social prescribing is able to signpost or refer to the relevant person, without the individual ping-ponging around the system and connecting all agencies together.

There is emerging evidence that social prescribing can lead to a range of positive health and well-being outcomes. Studies have pointed to improvements in areas such as quality of life and emotional wellbeing, mental and general wellbeing, and levels of depression and anxiety. Social prescribing schemes may also lead to a reduction in the use of NHS services. A study of a scheme in Rotherham (a liaison service helping patients access support from more than 20 voluntary and community sector organisations), showed that for more than 8 in 10 patients referred to the scheme who were followed up three to four months later, there were reductions in NHS use in terms of accident and emergency (A&E) attendance, outpatient appointments and inpatient admissions. An evaluation of social prescribing in Shropshire suggested that it reduced GP consultations by 48% and A&E attendances by 33% in the cohort of patients accessing the programme.

The aim of the programme is to empower individuals to improve their own health and wellbeing and social welfare by connecting them to non-clinical and community support programmes to address social and wider determinants of health and wellbeing such as loneliness, debt, housing issues, employment or bereavement. A consultation with a social prescribing programme begins with a detailed discussion between the Social Prescriber and the resident which starts with the question "what does a good life mean to you?" The social prescriber and resident then formulate a joint action plan to achieve goals based on this answer.

5. Enhancing the capacity and capability of Primary Care (10/18)

5.5.1 Social Prescribing (cont).

The Social Prescribing programme will:

- build self-resilience amongst adult patients assisting them to better manage their holistic wellbeing
- reduce demand on primary care services, particularly from patients that could be better supported by other local services
- empower GPs and other clinical staff with a practical mechanism to assist patients who access their surgery with non-clinical issues. (National research suggests that patients with issues that have an underlying problem that is non-clinical can account for up to 20% of all GP appointments).

We will roll out social prescribing at scale across the ACP locality in order to link community sector capacity with GP surgeries and empower patients to address social causes of ill-health. In our new model of care, patients will be able to access a social prescriber either directly through the triage system at the 'front door' of their surgery or following a referral from a member of their surgery's clinical team.

The full Social Prescribing Business case can be accessed here:

5.5.2 Empowering Patients : Patient Participation Groups

From April 2016 it has been a contractual requirement for all GP practices in England to form a Patient Participation Group (PPG) during the year and make reasonable efforts to it to be representative of the practice population. PPGs can play a key role in assisting GP practices to improve patient care including:

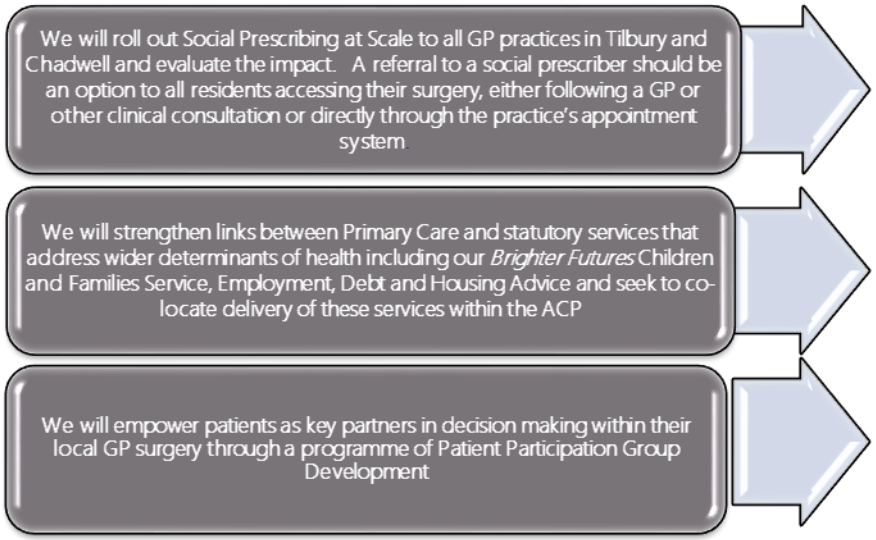
- Advising the practice on the patient perspective
- Providing a mechanism for patients to make positive suggestions about the practice and how it can improve
- Encouraging and organising health promotion activities within the practice and amongst the wider population it serves
- Communicating with the wider patient body
- Running volunteer services and support groups to support patients and the services of the practice
- Influencing the work of the practice or the wider NHS to improve commissioning
- Fundraising to improve services provided by the practice

We will deliver a new programme Patient Participation at GP practice level. Healthwatch will help support practices to set up a PPG where one currently doesn't exist, including engaging and recruiting patients, and will deliver a training programme including a free resource pack to those PPGs that are already operating. The training programme will increase the understanding and confidence of PPG members on issues such as PPG roles and responsibilities. Members of the Thurrock Public Health Team will support the delivery of the training programme by providing GP Practice population specific profiles that identify the main health needs of the practice population. The accompanying resource pack has been developed by Thurrock Healthwatch based on a model of best practice from the National Patients' Association

5.5.3 Measuring Success: GP Patient Satisfaction Survey

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people randomly selected across the UK within two waves and the results show how people feel about their GP practice and help's GP surgeries understand where they can improve. It includes topics such as making appointments; waiting times; perception of care; opening hours and out-of –hours services.

Response rate to the survey has historically been low for Tilbury and Chadwell (average of 31% of surveys returned). We increase the survey sample size for Tilbury and Chadwell and work with PPGs and patients to increase response rate as a further mechanism to evaluate patient satisfaction with our new model of Primary Care. The full business case for this programme can be accessed here.



5. Enhancing the capacity and capability of Primary Care (11/18)

5.6 Embedding Healthy Lifestyle Services within Primary Care and the wider Health and Care System

The Tilbury and Chadwell ACO Needs Assessment identified that residents in Tilbury and Chadwell are more likely than those in Thurrock and England to engage in health damaging behaviour such as poor diet, low levels of physical activity, smoking and being overweight. This increases the risk in the overall population of serious health events including cardio vascular disease and cancer and increases the overall level of morbidity within the population. Healthy lifestyle services are commissioned by Public Health and in 2016/17 were provided by North East London Foundation Trust (NELFT), who also sub-contracted some delivery of services, e.g. smoking cessation support directly to some GP surgeries and pharmacies.

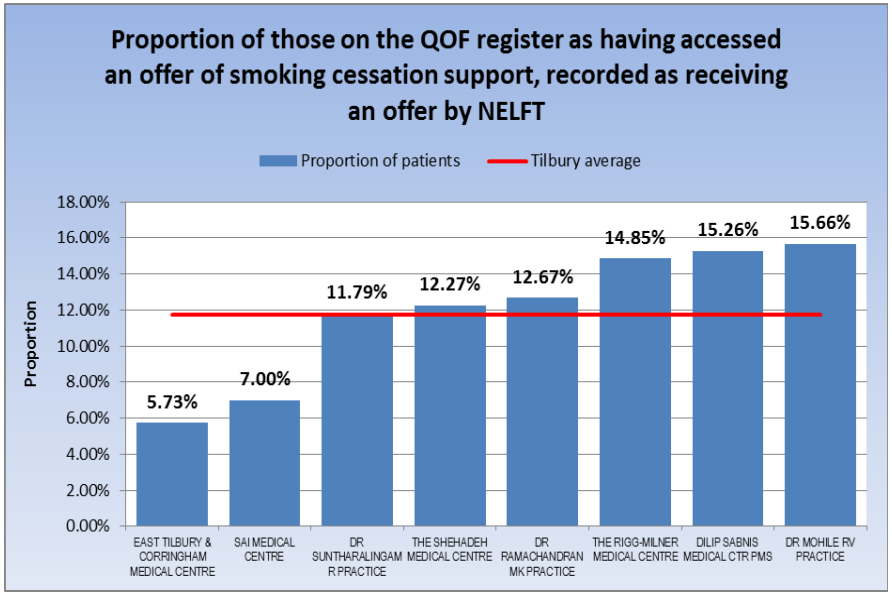
Ensuring these services are as accessible as possible to Tilbury and Chadwell residents who wish to make improvements in their lifestyle is key in terms of improving the overall health of the population and the needs assessment identified that there is still much opportunity for improvement. For example, the Quality Outcomes Framework (QOF) records the number of patients aged 15 or over who are current smokers and have a record of an offer of support and treatment within the preceding 24 months (QOF indicator SMK004). In 2015/16, this totalled 5,677 for all Tilbury and Chadwell practices. Data from the NELFT provided Healthy Lifestyle service found there to be 333 patients accessing smoking cessation support in 2015/16 – doubling this number to provide an estimate of those accessing support in the preceding 24 month period would still only give 666 patients, accounting for just 11.7% of the number on the QOF register. This variation by practice can be seen in Figure 22. East Tilbury Health Centre has the lowest proportion of their QOF patients receiving smoking cessation support by NELFT (5.73%) and Dr Mohile the highest (15.66%) – see figure below.

The finding that only 11.7% of those on the QOF register recorded as having an offer of support or treatment appeared to be supported by NELFT suggests there is variation in the support offered to patients, as quantifying this means that as many as 5,011 smokers may qualify for this support but be receiving something different.

In 2017/18, a new provider of Healthy Lifestyle Services was commissioned but failed to deliver satisfactory performance, and the Public Health Team is in the process of terminating the contract and bringing the service back "in house" as a holding measure whilst future options are explored. This providers an opportunity to reconfigure the service to better embed it within GP surgeries, pharmacies and the wider health and care system including hospitals.

We propose to locate healthy lifestyle "wellbeing workers" from the current provider directly within the enhanced Primary Care Team as a further resource for practices to use to work with patients who wish to make lifestyle improvements such as a stop smoking quit attempt.

Figure 22



We will also explore more effective ways of directly contracting with surgeries who with to offer healthy lifestyle services as providers including creating one contract with each surgery that covers all lifestyle programmes, with payments made on agreed population outcomes, reducing the administrative burden on surgeries. We will use the new MedeAnalytics system (see page ***) to help surgeries better identify and target patients with poor lifestyles, and provide direct marketing to them with regard to available support to help them make changes.

We will work with Basildon Hospital to embed healthy lifestyle programmes into clinical care pathways, targeting support to patients with early onset diseases causes by poor lifestyles, for example COPD and cardio-vascular disease.

Key Actions

- We embed Healthy Lifestyle Services directly within GP surgeries by locating "Wellbeing Workers" within the Enhanced Primary Care Team.
- We will consult with surgeries who want to contract with Public Health to provider Healthy Lifestyle Services about implementing a administration light single contract for all services
- We will work with Basildon Hospital to embed healthy lifestyle programmes into clinical care pathways, targeting support to patients with early onset disease caused by poor lifestyles.

5.7 Effective Front Door Triage

The mixed skill practice workforce model described previously requires effective 'front door' triage in order for it to work most effectively; The new model network model surgeries require an efficient system to direct the patient accessing a surgery to the most appropriate person or service within the ACP. The exact design of the triage system is a matter for the surgeries themselves, but one potential model may include a shared appointment booking system within the ACP/Surgery Management Hub.

Models that have worked well in other pilots throughout the country include:

5.7.1 Telephone Triage and Consultation by a GP

Use of the telephone for consultations is growing rapidly in general practice. Some practices have been offering this kind of consultation for ten years or more, but interest has grown significantly since about 2012. From a starting point of treating phone contacts as brief triage encounters, practices are increasingly recognising the feasibility and value of fully addressing the patient's need in a single phone contact where appropriate

This model works on the basis that the most experienced clinician in the workforce is best able to make the clinical judgement necessary to triage effectively, and that 60-70% of consultations can be handled entirely on the phone in an average to 4-6 minutes.

Where face-to-face consultation is required, a GP is usefully able to determine this within the first two minutes of the telephone call.

Where piloted, this approach has been shown to improve access, especially for carers and people in full time work, and reduces DNAs by up to 80%.

Implementation of the programme works best when actual demand is measured across the time of day and day of week and the supply of appointments is adjusted accordingly (for example increasing the supply of appointments on a Monday morning).

5.7.2 Highly trained reception staff

Training reception staff to connect the patient with the most appropriate service rather than simply book everyone in to see the GP first has been shown to be effective in pilots across the country.

Receptionists are trained to ascertain the patient's needs including "red flags" for medical emergencies. Directories of all available services (including services outside of the practice) are developed and the receptionist has access to these in order to aid decision making.

Receptionists are also encouraged to ask lots of questions, and trained in asking the patient about his/her needs.

One of the key barriers to implementation may be patient expectation and the acceptability of the approach to patients. This can be overcome through a systematic communications programme with patients that stresses the benefits to both them in terms of being directed to the person most appropriate to meet their needs, and also to the GP, in allowing them to focus on issues that only they can deal with. Use of the Patient Participation Group and patient news letters have been shown to assist implementation.

When trialled in West Wakefield, 960 GP hours were saved across six surgeries caring for 64,000 patients, in the first 10 months of the new triage system.

Highly trained triage reception staff have been shown to reduce GP appointments at over 1000 per annum for a 10,000 list size practice.

Other benefits have included faster access to the correct service for patients and increased staff satisfaction; receptionists feel that they're doing a better job for patients and making a larger contribution to their surgery.

5. Enhancing the capacity and capability of Primary Care (13/18)

5.7 Effective Front Door Triage (cont.)

5.7.3 E-Consultations (WebGP)

WebGP is an e-consultation system that integrates within the surgery's website. When a patient clicks on the WebGP icon they have a number of options including:

- Finding out more about their symptoms, a particular condition and treatment including access to written and video self help content
- Sign posting from the symptom checker to other more appropriate services including pharmacy and self care
- Requesting a repeat prescription
- Requesting a call back from a nurse
- Completing an "e-consult" form where they can fill out details of their symptoms on-line and have them reviewed by a clinician in the surgery who can then issue a prescription remotely, undertake a telephone consultation or call the patient in for a face-to-face consultation.

The main benefits of the system to patients are that they can gain reassurance about their symptoms/condition without having to make a GP appointment, or can take time to describe their symptoms accurately in writing, rather than have to do this face to face in a short GP consultation.

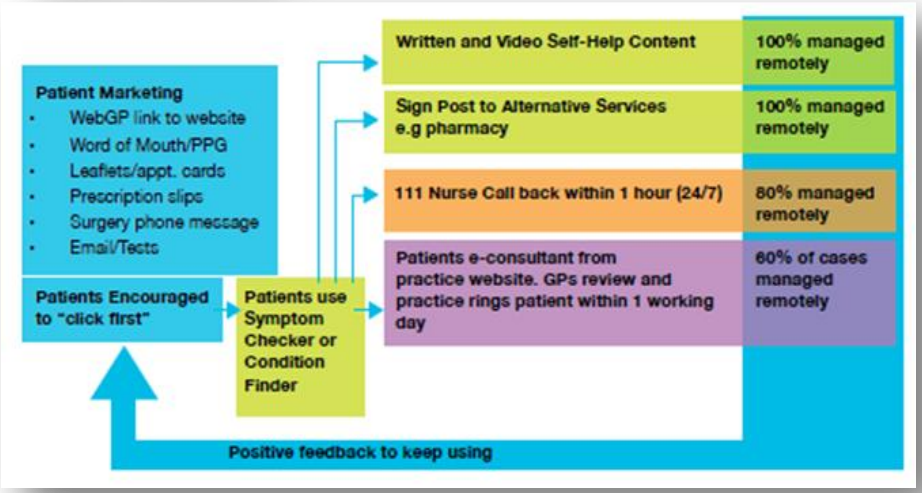
Where implemented, evaluation of the system demonstrates the following impacts:

- 91% of patients are 'extremely satisfied'.
- 90% of users don't contact the practice:
    - 60% use the 'symptom checker' / self help alone
    - 20% visit the pharmacy
    - 10% request a 111 nurse call back
- 10% of users have an 'online consultation' of whom:
    - 40% are dealt with by a GP remotely, in an average of 2.9 minutes
    - 20% receive a telephone consultation by a GP
    - 40% have a face to face appointment with a member of the surgery's clinical team

Evaluation has also suggested that the e-consultation is particularly welcomed by patients who may feel uncomfortable talking about certain conditions and is most widely used by those suffering from depression or other mental ill-health. There is also some evidence that it may reduce A&E attendances.

We have obtained funding to make WebGP available free of charge to all surgeries within the ACP. We will work with surgery staff through the Tilbury and Chadwell GP practice network to reach agreement on the best model of front door triage for the network and look to base this within the Surgery Management Hub.

Web GP Patient Flows



A full copy of the E-Consult business case can be accessed here:

Key Actions

We will work the GP surgeries to develop and implement a shared front door triage system for the Tilbury and Chadwell ACP surgery network.to capitalise on the mixed skill workforce model in Primary Care

We will support surgeries to implement WebGP

5.8 Building Surgery Resilience

The 20th Century GP practice lacks resilience because of its small size and low numbers of staff. GPs are often working in isolation and large numbers of different types of practice administration falls to one person. Recent history in Tilbury has demonstrated the issues caused for population health when small practices fail. Delivering Primary Care working 'at scale' was identified as a key priority in the GP Five Year Forward View. Networks of GP practices can bring the following benefits to both practices' workforce and ultimately to patients:

Resilience:

- Pooling of staff including nurses, reception staff, clerical staff and sessional GPs increases an individual practice's resilience to staff leave and also allows more comprehensive services to be offered to patients
- Overflow support is available at the busiest times including phone consultations and home visiting

Economies of Scale:

- Purchasing of indemnity, supplies and utilities becomes cheaper allowing more investment in front line services
- Key back office functions can be shared or done once for all surgeries in the network including policies and procedures, procurement, managing correspondence and ICT support
- Specialist functions that benefit all surgeries can be developed including HR, Finance, Clinical Governance and Business Intelligence.

Systems Partnerships

- Planning of workforce; infrastructure development; service reconfiguration; and public health can be done once at scale
- Provision and integration of a wide range of additional services including community pharmacy, optometry, social care, housing, welfare and the third sector can be integrated into the network

Increased Skill Mix

- A wide range of complementary clinical front line roles can be incorporated into the practice network's workforce including pharmacists, specialist nurses, physiotherapists, mental health therapists and paramedics.
- Similarly wellbeing worker roles can be incorporated including social workers, care navigators, health trainers and coaches and welfare advisors

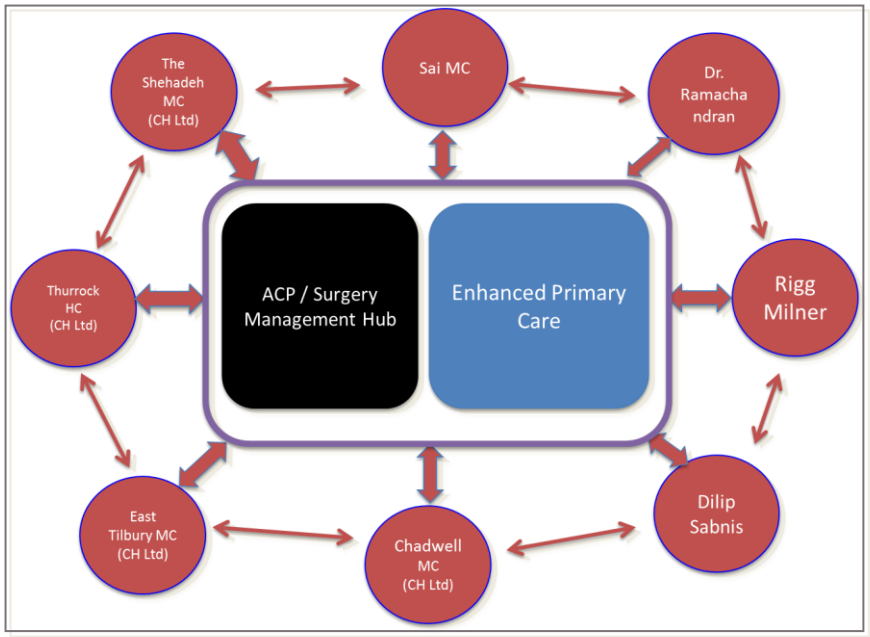
Innovation and Improvement

- Evidence scoping such as population health analytics and evidence based literature reviews can be undertaken at skill to ensure that the workforce is kept up to date with continuous professional development, and that the network is responding to the needs of the population it serves
- Analytics such as priority setting, benchmarking of performance and real time measurement can be incorporated into the work of the network

Staff Development

- A wider network of primary care workforce provides much greater opportunities for shared learning, CPD and career development including mentoring.

Figure 23



The ACP will implement a network model of surgeries in Tilbury and Chadwell to realise the benefits described in the first column (figure 23) Whilst the final form of the network is yet to be agreed by the surgeries involved, good progress has been made to date with all GP practices signing an Memorandum of Understanding setting out how they will collaborate together. Ultimately this paves the way for the model shown in figure A where administrative functions including appointments booking, call-recall of patients and all GP practice administration could be undertaken by a shared Surgery Management Hub, and the wider clinical and non-clinical patient facing staff could we shared in an 'Enhanced Primary Care Function'.

Key Action

We will implement a new network based model of Primary Care in Tilbury and Chadwell in order to build resilience amongst current surgeries and realise the benefits to both the workforce and residents of delivering Primary Care 'at scale'.

5. Enhancing the capacity and capability of Primary Care (15/18)

5.9 Reducing the Administrative Burden on Clinicians

Making Time in General Practice concluded that administration and bureaucracy were major burdens on surgeries. The chief sources of bureaucracy in general practice were:

- Getting paid
- Processing information from hospitals and other providers
- Keeping up to date with changes
- Reporting other information

Getting Paid

This was by far the biggest administrative burden facing general practice, with 45% of surgeries surveyed highlighting it as an issue. Practice income is now derived from a complex and diverse list of sources including the weighted capitation of the practice list size, performance on the Quality and Outcomes Framework and income from a wide range of individual contracts including AQPs (Any Qualified Provider) with Clinical Commissioning Groups for services such as phlebotomy, Directly Enhanced Services with the DH, and Public Health contracts both with Public Health England for screening and immunisation and with local authorities for lifestyle services such as stop smoking and NHS Health Checks.

Processing information from hospitals and other providers

This was cited as the next biggest administrative burden, almost en par with 'getting paid'. Surgeries report that processing discharge letters, chasing test results and coordinating outpatient or elective hospital appointments has increased substantially in recent years in line with an ageing population . The interface between hospital and surgery was reported as often inadequate both in terms of the administration processes (for example discharge letters were often late, or posted and emailed requiring the surgery the cross reference), and in terms of clinical content; GPs complained that hospital Consultants were too remote or that the content of discharge summaries detailed what had happened to a patient in hospital but failed to provide information on what clinical care needed to be on-going after discharge. Many surgeries also complained of having to deal with patients requiring re-referral to hospital outpatient clinics because appointments had been arranged at very short notice and/or times that they could not attend.

Keeping up to date with changes

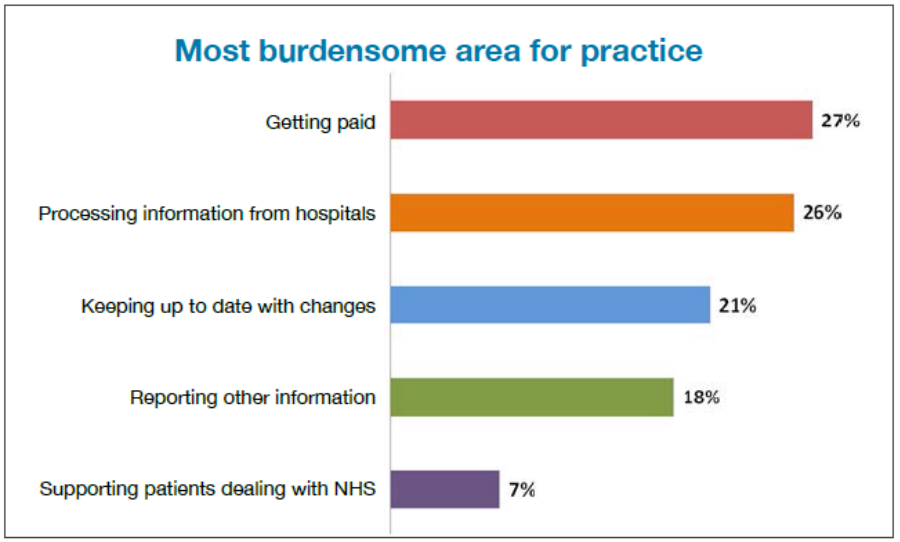
Keeping up to date with incoming information from commissioners and other bodies, particularly at a national level, was also a significant area of burden for practices. Managers reported that this was particularly problematic when later trying to retrieve information sent by email, letter or bulletin.

Reporting other information

The fourth most burdensome issue was reporting for contract monitoring or regulation. Here, surgeries cited frustration caused by multiple requests for similar information, sometimes from different teams in the same organisation (particularly NHS England), often at very short notice (eg 24 or 48 hours), and often formulated in ways which differed from how the information was stored. NHS England and CQC were described as frequently asking for information about the same aspect of the practice, but in different ways, at different times, and in a series of requests rather than a single one.

Supporting patients dealing with the NHS

Finally, supporting patients to navigate the health and care system was also cited by 7% of surgeries surveyed an area where practice workload is increasing.



Source: Making Time in General Practice[2]

At Scale Administration

Creating a centralised 'back office' Surgery Administration and Management Hub as discussed on page X will go some way to relieving the current bureaucratic burden being experienced by our surgeries by allowing administrative tasks to be done once and at scale for all surgeries within the Tilbury and Chadwell network. We will also explore with surgeries, how to better use information technology to streamline contract reporting and payment mechanisms for local contracts, for example by implementing systems to directly extract performance data from SystmOne.

The GP Assistant

Much of the administration that in the 20th Century GP Practice model has been the responsibility of the GP, can be dealt with by GP Assistants. These are new highly trained administrators who are skilled in reading, coding and actioning incoming clinical correspondence according to a standard protocol, for example following up late test results or discharge summaries from a hospital Their aim is to triage administration such that only that which is critical is dealt with by the GP. Where piloted, the following impacts have been observed:

- GPs typically save 30-60 minutes per day (e.g. mean of 45min in Brighton)
- With training and a standard protocol, safety is very good (e.g. zero adverse events in 15,000 letters, Brighton)
- Coding improves.
- Staff satisfaction improves: enhanced role and greater contribution to the practice.

We will provide funding to the Tilbury and Chadwell Surgery Network to pilot new GP Assistant roles in order to reduce the administrative burden on front line clinical staff, releasing them to deliver more patient care.

5. Enhancing the capacity and capability of Primary Care (16/18)

5.9 Reducing the Administrative Burden on Clinicians

Improving communication between surgeries and hospital

One of the strongest themes to come out of the national research in *Making Time in General Practice* is the unnecessary extra workload created by the lack of clear systems and processes for practices and their local hospitals to communicate with each other and their shared patients. We will work with the BTUH/Southend/Mid Essex tri-hospital network and our local surgery network to address this through developing consistent guidelines creating opportunities for clinicians to cut through all the unnecessary rules that get in the way of rapid and effective treatment of patients and lead to so many repeat consultations to chase up basic administrative tasks.

Specifically we will seek to implement:

- The ability for patients who don't attend a hospital appointment to rebook within two weeks without having to return to the GP
- A system for GPs to discuss a case with a hospital specialist and for hospital clinicians to speak to GPs within hours rather than days
- A standardised discharge letter with agreed clinical information structured and presented in a consistent way, electronically transferred to the patient's surgery within 24 hours of discharge
- Informal education networks that allow GPs to build better relationships with Hospital Clinicians and promote informal communication.

Case Study: Improving Discharge Summaries

Brighton and Hove CCG and Brighton and Sussex University Hospitals have developed a process to improve the transfer documentation sent by hospital to GPs. An important element of this is a specially designed form, which is based on published standards for handover documentation.

The form, designed to be completed by junior doctors as part of discharge processes, includes a text box entitled "clinical narrative" which asks the discharging clinician to tell the story of the admission, encouraging them to do so in a way that might be easily understood. Patients themselves receive a printed copy at discharge, aiming to reinforce the importance of making the narrative readable. The documentation also includes the list of medications on which a patient has been discharged as well as specific boxes to document any medications that have been discontinued and any changes made to dosages, flagging up those factors most important for a GP to have quick sight of.

The overall appearance and design of this summary is based on graphic design principles to enhance the impact of key messages on the clinicians completing and reviewing it. Attention was given to the coding so that as much as possible can be auto completed.

The introduction of this new form was accompanied by training for the junior doctors who would be using it, and this was backed up by a period of audit, where summaries were reviewed by consultants for quality prior to being sent, The form is emailed at the point of discharge, so is received in a timely fashion by the GP practice, delivering seamless transfer of care. This form has led to much improved transfer communication between hospital and surgeries.

Key Actions

- We will work with the Tilbury and Chadwell surgery network to create a shared administration 'hub' to undertake administration once at scale
- We will pilot GP Assistants in Tilbury and Chadwell to reduce the administrative burden on front line clinical staff, releasing them to deliver more patient care.
- We will implement the ability for patients to re-book outpatient appointments without the need to return to their surgery.
- We will agree standardised discharge information protocols from hospital to surgery
- We will improve communication between primary and secondary care clinicians through formal and informal networks.

5. Enhancing the capacity and capability of Primary Care (17/18)

5.10 Developing the role of Community Pharmacy

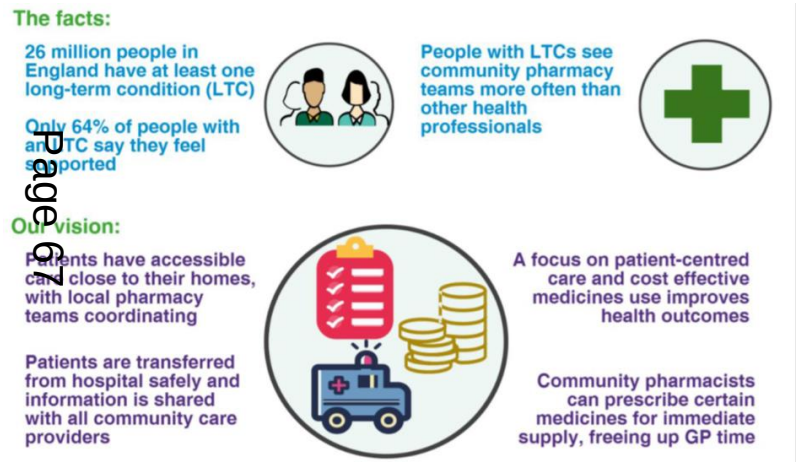
Community Pharmacy Forward View: A vision for future pharmacy care

Community pharmacies are the nation's most accessible healthcare providers: around 90% of the population live within 20 minutes walking distance of a pharmacy, and pharmacy services are available without an appointment. With even greater access in the most deprived areas, the community pharmacy network bucks the inverse care law, and is an invaluable resource in the fight against widening health inequalities. The diversity of the mixed market offers people choice in when, where and how they access primary healthcare services and this helps to promote and maintain quality. Community pharmacy teams have contact with large numbers of people, including those who may not regularly use other health services, and the ability to convey health messages, support self-care and provide advice opportunistically to 1.6 million people every day.

*The Community Pharmacy Forward View was published by PSNC and Pharmacy Voice, with the support of the Royal Pharmaceutical Society's English Pharmacy Board (2016).

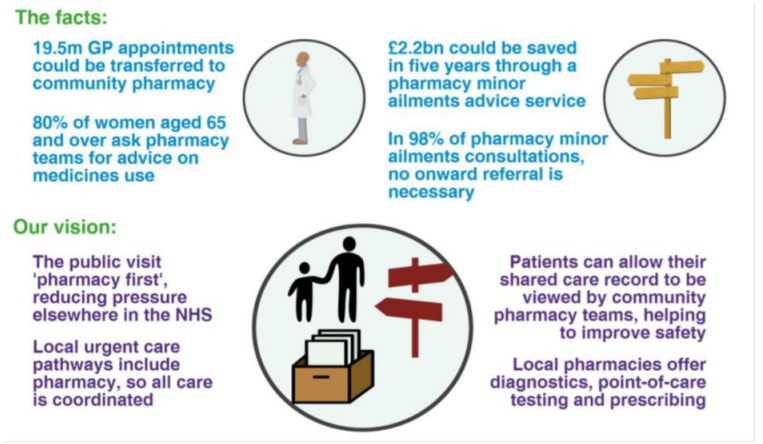
Community pharmacy has developed its Forward View setting out how it can develop, and it is looking to collaborate with all health and social care commissioners to develop services in three core areas:

1.Supporting people to manage their long-term conditions:



2. Offering a first port of call for healthcare advice and treatment

3. Becoming neighbourhood health and wellbeing hubs:



Key Actions

We will work with community pharmacy colleagues to help them realise the opportunities in the Community Pharmacy Froward View in Thurrock

We will improve communication between community pharmacy and wider health and social care organisations in order to optimise the health of the population

5. Enhancing the capacity and capability of Primary Care (18/18)

5.10 Developing the role of Community Pharmacy (cont.)

Community Pharmacy Forward View: A vision for future pharmacy care

Objectives with the Community Pharmacy Forward View are to:

- Demonstrate understanding of the aspirations of Government, the public and patients for health and healthcare in England, and set out a clear, shared vision for how community pharmacy can help deliver them
- Demonstrate the commitment to working as an integrated part of the NHS and wider public health system, and to help deliver improvements in quality, efficiency and outcomes
- Develop and share credible and constructive ideas for the medium to long term that will enable these improvements to be achieved while maintaining a thriving community pharmacy network that continues to generate wider economic and social value
- Show commitment to working together with Government and with other partners to develop and implement tangible plans for turning these ideas into reality, and seek a similar commitment in return constructively, as part of this partnership, to achieve the desired future

What will this look and feel like for people using community pharmacies in future?

- Whenever someone visits a community pharmacy for help with a minor injury or ailment, an urgent problem with their medicines or a query about an immediate health concern, they will be dealt with quickly by courteous and knowledgeable staff, will be listened to carefully, and will receive a personalised response.
- All community pharmacies will feel like professional healthcare environments. When people seek self-care advice, information or treatment from a community pharmacist or member of their team they are able to discuss this in an appropriate, private setting.
- People will be able to access 'pharmacy first' services via a variety of routes, including online as well as face-to-face.
- People can give community pharmacists and pharmacy technicians permission to both review and add information to their personal health record, so that advice and treatment they receive for urgent care takes into account their general health, any underlying conditions and medicines use.
- Community pharmacists and their teams will help people spot and address any patterns in when and how they access urgent care – for example, the recurrence of a minor condition which might need further investigation or regularly running out of medicines which might need to be managed differently.
- If someone visits a community pharmacy following referral from another service provider (e.g. NHS 111, their GP or A&E) the pharmacy will be expecting them when they arrive, and will have relevant information about why they are attending.
- After any self care consultation with a community pharmacist, people will understand the advice they have been given and how to use any products they have been supplied, feel confident on how to manage their condition and well informed on when and how to seek further help if necessary.
- When people do need to see another healthcare professional or service after speaking to a community pharmacist, because their condition is more serious or less clear-cut than they
- thought, organising this from the pharmacy will be quick and straightforward. Community pharmacists and their teams will be able to refer and book people directly into other services, fast-tracking them if they believe this is necessary.

Embracing change and addressing primary care workforce issues

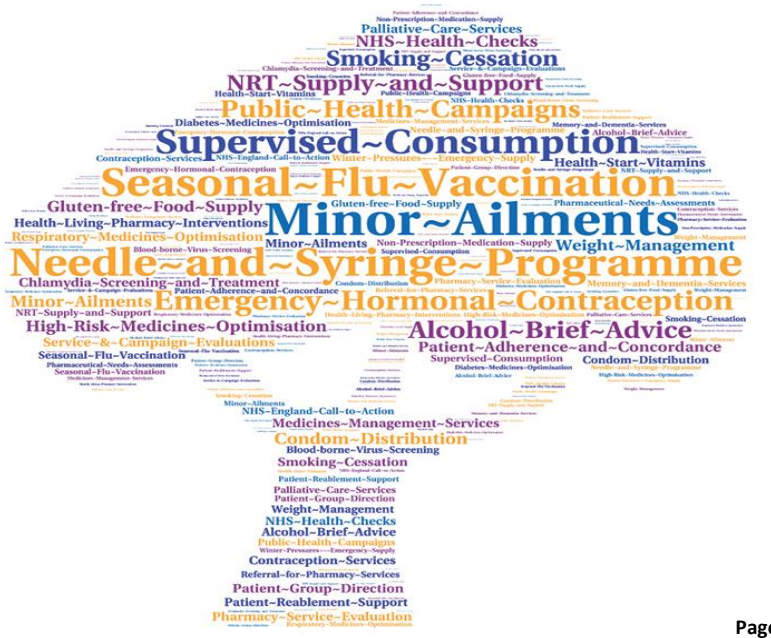
- As the NHS and society as a whole change over time, new approaches to delivering primary healthcare and supplying medicines will undoubtedly evolve. Right now, the community pharmacy network provides the vehicle that can deliver much of what the health system needs, in particular to address the workforce and capacity pressures in other parts of the primary care system.

Case studies

Long-term conditions: The Community Pharmacy Future (CPF) project helps people with long-term conditions to use their medicines effectively, improves their skills and confidence in managing their health, and enhances overall quality of life.

The first port of call: Devon's Pharmacy First scheme offers people walk-in consultations with a healthcare professional, close to their home and outside GP surgery opening hours. This scheme involved 134 community pharmacists and led to a reduction of 7000 GP appointments, 2600 out of hours consultations and 360 A&E attendances.

Health and wellbeing hub: The Priory Pharmacy makes a positive difference in the lives of people in its community, by being proactive about the opportunities for improving health outcomes.



Chapter 6: *Find the missing thousands, Treat the missing hundreds*

Improving Case Finding and management of Long Term Conditions

Less complex patients with some Long Term Conditions

6.6%
1,950

~35%
~£4.7m

Diagnosis and effective management of Long Term Conditions in the community

- Systematically diagnose undiagnosed LTCs ("Find the missing thousands")
- Effective, integrated management of LTCs in Primary and Community Care ("Treat the missing hundreds")

6. Find the missing thousands, treat the missing hundreds (1/14)

Less complex patients with some Long Term Conditions

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1,950

~35%
~£4.7m

Diagnosis and effective management of Long Term Conditions in the community

- Systematically diagnose undiagnosed LTCs ("Find the missing thousands")
- Effective, integrated management of LTCs in Primary and Community Care ("Treat the missing hundreds")

6.1 Introduction

This chapter explores the action most relevant to the segment of the population of Tilbury and Chadwell living with long term conditions.

As a population, we are living longer but not necessarily healthier lives. Increasingly many people are living with one or more long term physical or mental health conditions. More than 15 million people in England (30% of the population) have one or more long term-health conditions.[6] This includes people with a range of conditions that can be managed but often not cured, such as diabetes, high blood pressure (hypertension), other cardio-vascular disease such as Coronary Heart Disease (CHD) or Heart Failure (HF), and respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD) or Asthma.

The Tilbury and Chadwell ACO Needs Assessment Chadwell, demonstrated that there are significant numbers of people with long term conditions that have been both diagnosed and remain undiagnosed. have not yet been diagnosed. Identifying patients with long term health conditions who are unaware that they have them *("find the missing thousands"*), is an absolutely key priority for our New Model of Care, if we are going to intervene early with excellent clinical management to prevent chronic diseases progressing and patients' health deteriorating. Ensuring that once diagnosed, ALL patients with specific long term conditions receive the absolutely best evidence based treatment ("treat the missing hundreds") is equally important for the same reason. Promptly diagnosing and managing long term conditions is both good for population health and highly cost effective in terms of health and care system sustainability; for example, it is both better for the individual and health system to diagnose and manage high blood pressure than care for a patient once they have had a stroke caused by untreated hypertension (see box A)

Detailed estimates of the numbers of people with long term conditions "the expected number", numbers of people with diagnosed long term conditions (the "observed" number) and undiagnosed common long term conditions (the difference between "the expected" and "the observed") at GP practice population level are detailed in the ACO Needs Assessment document. A summary of these results is shown in table 2. It shows that the most common long term condition is Tilbury and Chadwell is hypertension, followed by depression and that these two conditions also have the greatest number of undiagnosed patients. COPD is the third most common long term condition, but our figures suggest that under-diagnosis of COPD is not an issue. However, although slightly less common, a significant number (1,649 patients) have undiagnosed Coronary Heart Disease (CHD).

Table 2

Condition	Observed number of patients	Total estimated number of patients	Additional Number of Undiagnosed Patients based on the estimated prevalence
Stroke (2016)	650	1,398	748
Hypertension (2016)	5,782	7,977	2,195
CHD (2016)	1,141	2,790	1,649
COPD (2016)	900	891	-9
Depression(2016)	3,034	4,754	1,720

6.2 Finding the missing thousands

6.2.1 Improve Performance of NHS Health Check Programme

NHS Health Checks are offered for those aged 40-74 years inclusive without a pre-existing long term condition. The aim of the programme is both to identify patients with undiagnosed LTCs and those with lifestyle or clinical biomarkers that put them at increased risk of developing a LTC in the future. Patients in the target cohort should be offered an NHS Health Check once every five years.

National evidence shows that the detection of disease is significantly more frequent among NHS Health Check attendees compared to non-attendees for:

- Chronic kidney disease.
- Familial hypercholesterolemia.
- Hypertension.
- Peripheral vascular disease.
- Type 2 diabetes.

As such, the NHS Health Checks programme is a key mechanism to *find the missing thousands*.

Local Authorities have a statutory duty to commission the NHS Health Checks programme from the Public Health Grant. Historically in Thurrock the programme has been delivered by GP practices and a central provider. Uptake of NHS Health Checks (i.e. the proportion of residents who are invited for a health check who receive one) is variable across practice populations in Tilbury and Chadwell, with an average ratio of those receiving checks: being invited of only one in two. (figure 24 overleaf)

Box 8

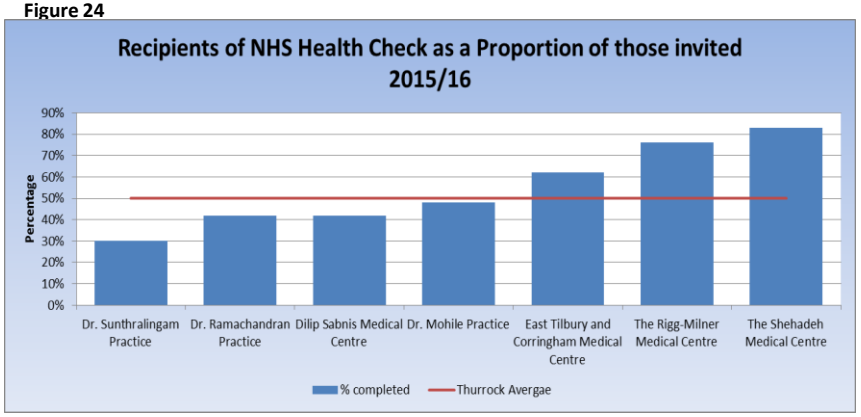
Multiple Regression Analysis Modelling by the Thurrock Public Health Team , reported in the 2016 Annual Public Health report allows us to estimate that in Tilbury practices, for each 10 0people with hypertension, that were previously un-diagnosed, who we identify we can prevent 10 stroke sover a 3 year period. We estimate that this would save the NHS £38,000 and Adult Social care £44,000 over three years. Furthermore if we were then able to treat these 100 patients effectively so that their Blood Pressure were maintained below 150/90 a further 2 strokes would be prevented producing further savings of £7,270 to the NHS and £8,420 to Adult Social Care.

This equates to 270 avoidable strokes in Tilbury every 3 years and a total avoidable cost of £1.8M making identification of hypertension extremely cost effective.

6. Find the missing thousands, treat the missing hundreds (2/14)

6.2.1 Improve Performance of NHS Health Check Programme continued

Figure 24



We will improve the diagnosis or undiagnosed cardio-vascular disease through improving the performance of the NHS Health checks programme, by targeting it more effectively to those with the highest cardio-vascular risk. Key actions to achieve this will include:

- Developing new SystmOne reports that prioritise invitations to those with the greatest CVD risk scores via application of the QRISK2 algorithm.
- Undertaking social marketing research with the target cohort to better understand the most effective invitation messages for different population segments within the target cohort and revising invitation letters in response to the findings

Over a three year period, we will aim to achieve an additional 282 hypertension, 120 CHD and 66 Diabetes diagnoses through this programme as a result of the new approach. We estimate that this will prevent 35 stroke admissions, and save the local health and care system £277k in reduced unplanned hospital admissions and adult social care packages (using the assumption on the previous slide). It is also expected that the earlier treatment of the CHD patients will result in 131 prevented admissions, and save the health system £605k over the three year period.

The full business case for this initiative can be accessed here:.

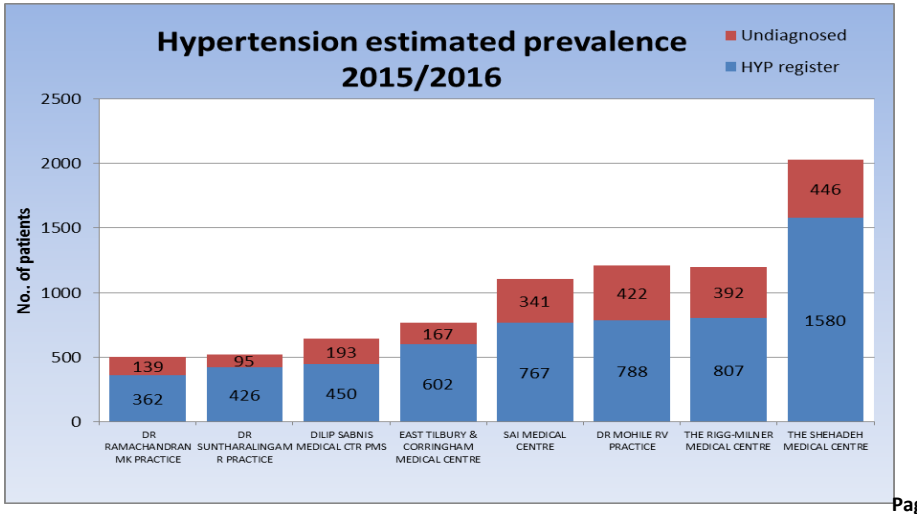
6.2.2 Improve Hypertension and Atrial Fibrillation Case Finding

The purpose of this project is to respond to the low case finding rates in Tilbury and Chadwell. The use of local assets, such as pharmacies and community hubs, will increase the access to high-quality services in safe environments. Additionally, capitalising on the already established contact with the local residents in general practice, a patient self-testing programme will be developed with blood pressure machines in the waiting area.

This project aims to increase the rate of people living with hypertension who are aware of their condition, and will thus increase the number of people properly managing their condition and receiving the appropriate care in a safe environment. As best practice recommends, people tested for high blood pressure will also be tested for irregular pulse.

The Tilbury and Chadwell locality has a higher prevalence of Hypertensive and Atrial fibrillation (AF) patients than the borough and England. Public Health England estimates show the average prevalence of HYP in Tilbury is 21.5% compared to 14.1% in Thurrock and 13.8% in England. With a detection rate of 73%, almost 2,200 patients from Tilbury have hypertension and not aware of it (Figure 25). Based on local statistical models, one out of five undiagnosed and untreated patients will develop a stroke in the next three years. (Annual Report of The Director of Public Health, Thurrock Council, 2016)

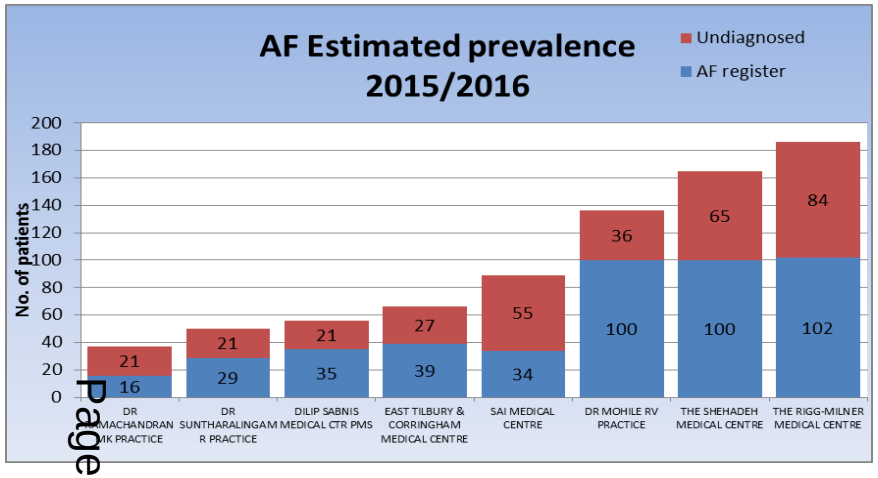
Figure 25



6. Find the missing thousands, treat the missing hundreds (3/14)

6.2.2 Hypertension and Atrial Fibrillation Case Finding continued

Figure 26



Similarly, with a prevalence of 2.12% and an even lower detection rate of 56%, there are 330 patients with AF who are not diagnosed and not treated in Tilbury. (Figure 26). If not treated in the next three years with the appropriate anti-coagulant, we predict that 1 in 2 patients will suffer a stroke. The money saved by the NHS and social care over a 3 year period following a single patient having a stroke has previously been estimated as £3,644 and £4,221, respectively.

Aims and objectives of programme

- Improve the access to hypertension and atrial fibrillation (AF) screening services;
- Lower the gap between estimated and diagnosed cases of hypertension and AF;
- Increase the number of people living with hypertension or AF who understand their condition and receive the appropriate medication;
- Reduced complications associated with uncontrolled hypertension or AF;
- Reduce pressure on secondary and social care;
- Reduce costs associated with preventable strokes.

In order to effectively address the health inequalities and variation in outcomes while accounting for the under doctoring and under nursing in this area, the "Tackling high blood pressure" report form Public Health England recommends a series of key approaches:

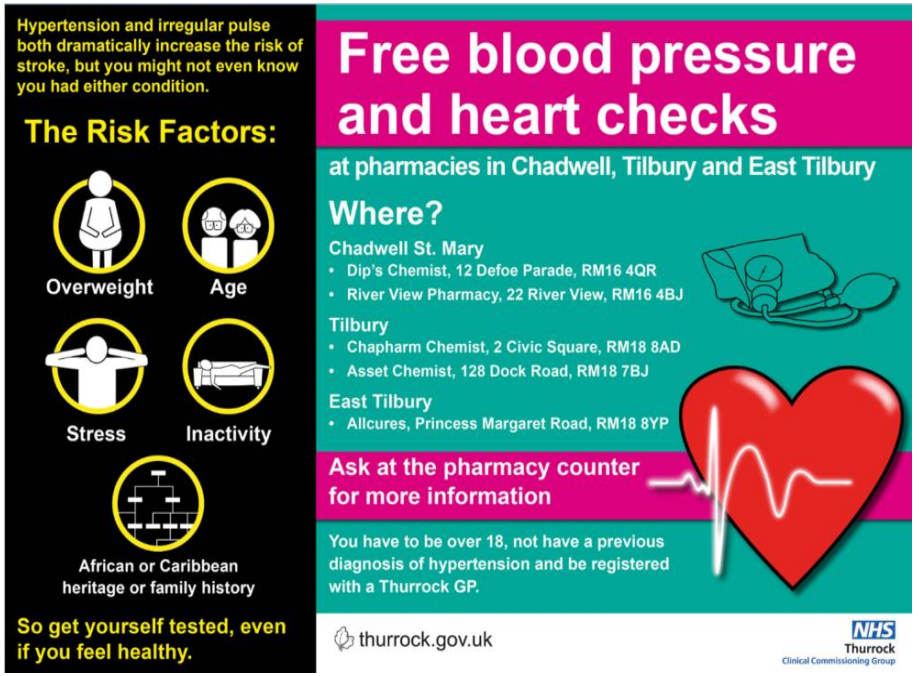
- pro-active provision of testing for high-risk and deprived groups of all ages through outreach testing beyond general practice, particularly through pharmacy
- more frequent opportunistic testing in primary care, achieved through using wider staff (nurses, pharmacy etc.), and integrating testing into the management of long term conditions
- targeting high-risk and deprived groups, particularly through general practice records audit and outreach testing"
- improving take-up of the NHS Health Check, a systematic testing and risk assessment offer for 40-74 year olds

Based on these recommendations and our local assets map, the hypertension and AF detection programme will be structured in three separate work-streams:

- Pharmacy detection,
- Community detection and
- General practice detection.

Pharmacy detection

One of the solutions to the GP and nurse shortage in primary care is the use of other community resources available. According to the 'Tackling high blood pressure' report the use of local pharmacies is particularly useful for reaching patients who might be less engaged in the health system, such as younger men, low income households and those in deprived areas.



The pharmacy detection programme is a 6-month pilot currently taking place in 5 local pharmacies in Tilbury and Chadwell. The pharmacist or the healthcare assistant will invite their clients to have their blood pressure checked based on their risk profile. However, it isn't necessary that the resident is asked by the pharmacy staff, anyone who is registered with a Thurrock GP can ask the pharmacy staff to check their blood pressure and pulse if they wish so. If the results are positive on 3 separate occasions, to rule out any false positives, the resident will be referred to their GP for further investigations and treatment. If proven to be cost-effective, the programme will be funded for a minimum of 3 years.

6. Find the missing thousands, treat the missing hundreds (4/14)

6.2.2 Hypertension and Atrial Fibrillation Case Finding continued

Community detection

For those who prefer a more private setting and wish to self-test, we equipped the Tilbury Community hub with a blood pressure and pulse regularity machine to be used by local residents at their convenience. This is a person-centred approach in partnership with the local volunteer sector which also aims at empowering the local residents to take responsibility of their own health and well-being. In order to use the equipment, individuals will have to sign a disclaimer and provide some anonymous information for statistical purposes. The volunteers in the hub were trained to guide individuals in the process if needed.

If the results are positive on separate occasions residents are encouraged to initially have their blood pressure values validated in a pharmacy, and, if confirmed, go to their GP for treatment. This way we prevent a high volume of residents making appointments with the GP.

The programme started on the 11th of September and, if successful, will be replicated in all Thurrock hubs.

General practice

Even though the general practice is the most common place for disease testing, because of the limited resources available, the current trend is to move away from it as much as possible, especially for such services that can be provided by other community partners. However, the surgery is a great resource itself for reaching people who are already engaged in the healthcare system and holds invaluable health-related information for each registered patient.

To free some of the clinical staff time and make a better use of the non-clinical staff members we will use self-test machines close to the waiting area where patients waiting for their appointment can test themselves. Each clinic will name a non-clinical hypertension champion to lead on this project and aid patients in the testing process. We will also construct SystmOne reports that highlight patients with high blood pressure readings but who are not on the surgery Hypertension register

Through the above programmes we aim to screen one patient per day per facility (pharmacy, community hub or general practice) and to detect between 532 and 904 hypertensive patients and 62 to 107 AF patients during a period of 3 years. Table 3 illustrates the maximum expected returns to the NHS and to ASC as a result of this number of people being detected and well managed, thus an approximate number of 234 strokes being prevented from happening

Table 3

	Patients detected	Stroked avoided	3-year NHS saving	3-year ASC saving	Total savings
HYP	904	113	£413,670	£476,556	£890,226
AF	107	121	£444,105	£511,618	£955,723
Total AF & HYP	1,011	234	£857,776	£988,174	£1,845,949

Each programme is a pilot and set to run for a different amounts of time. The table below gives the maximum cost of each pilot for the duration of the pilot and if the pilot was successful for a 3 year period:

	Period of Pilot (months)	Cost of pilot (including treatment)	Estimated 3 year cost (including treatment)
Pharmacy detection	6	£10,434	£55,106
Community detection	12	£2,293	£6,578
General practice	12	£41,064	£75,992
Total cost		£53,791	£137,676

If all of the pilots are considered successful and run for the full 3 year period in Tilbury and Chadwell, and detection levels were as described in table 1 then the return on investment would be 12. However actual ROIs will be calculated as part of the evaluation for each project.

The full business case for this initiative can be accessed here:.

Key Actions

- We will develop new SystmOne reports that prioritise Health Check invitations to those with the greatest CVD risk-scores via application of the QRISK2 algorithm.
- We will undertake social marketing research with the target cohort to better understand the most effective invitation messages for different population segments within the target cohort and revise Health Check invitation letters in response to the findings
- We will implement a Hypertension case finding programme in Pharmacies, General Practice and our Community Hubs
- We will assist GP practices to case find patients with undiagnosed hypertension by constructing SystmOne reports that highlight to surgeries patients with high blood pressure who are not on the Hypertension QOF register

6. Find the missing thousands, treat the missing hundreds (5/14)

Diabetes Case Finding
Improve Diabetes Case Finding

It is estimated that 2,238 people within Tilbury currently have diabetes both diagnosed and undiagnosed. The number of observed cases of diabetes in 2015-16 within Tilbury was 2,101, this equated to a prevalence of 7.4% compared to the England average of 6.6%. Based on the estimated prevalence of 7.9% it suggests that there are 137 individuals currently walking around undiagnosed. This is a modest estimate as with an increase in obesity projected for future years, it is expected there will be an increase in diabetes rising to 2,853 total cases by 2026 [7].

In 2012, NICE called for those working in dentistry to be involved in the identification of risk factors for diabetes due to the strong correlation with periodontitis [8]. This was further supported within a joint consensus report published in 2013 by the European Federation of Periodontology and American Academy of Periodontology [9] to identify undiagnosed diabetes within dentistry with the use of chair side blood tests [10].

The project aims to increase the detection rate of people living with Diabetes (Type 2) who are asymptomatic and are at risk of serious health implications if undiagnosed, such as stroke, sight loss, heart attacks, kidney failure, lower limb amputations and even death. Pre-diabetic range will also be considered and referred into the National Diabetes Programme for healthy lifestyle advice. It is intended that the project will increase the number of people receiving the appropriate care and treatment to manage their condition at an earlier stage leading to better health outcomes, whilst reducing costs of complications due to late diagnosis.

The early detection of diabetes will result in better management of the condition, reducing the risk of further serious life limiting or life changing illness. A&E attendances and emergency admissions for Diabetes and Diabetes related conditions should be reduced, and referrals into the National Pre-Diabetes programme should result in fewer patients becoming diabetic reducing the overall prevalence in the long term.

Initially this pilot is not a Tilbury Pilot but does include some of the areas within Tilbury. We have targeted areas across Thurrock which are estimated to have the highest numbers of un-diagnosed Diabetes Patients based on what is recorded on practice QOF registers. Using the business case for this pilot we have estimated how much it would cost to role out the Dentistry phase across the Tilbury ACP footprint area over 1 year. (Table X)

The role out of this programme in the three dentistry practices in Tilbury would cost an estimated total of £9,938. We expect that over a year it would be possible to test around 1,000 people and assuming a prevalence in the undiagnosed population of 1.3% (7.9%-6.6%) we would diagnose around 13 people per year. Diabetes .co.uk estimate the cost of treating complications of diabetes to be up to £2,500 per patient. By identifying 13 patients and treating them effectively so as to avoid these complications there is a total opportunity to avoid £32.5K costs to the NHS, plus any additional costs required to support patients after these complications (eg. Limb amputations etc...).

There is also the opportunity to identify patients with values in the pre-diabetic range. These patients can then be referred for intensive lifestyle interventions under our NDPP in order to reduce / delay the risk of developing Diabetes in the future. We currently do not have a reasonable estimate of how many this would be. We will populate this figure following the initial pilot.

The full Business Case can be found here:

Associated GP Locality	Reasoning
Chadwell St Mary (Dilip Sabnis surgery)	High recorded obesity prevalence, low levels of physical activity & high smoking prevalence
Tilbury (Tilbury Health Centre)	low levels of physical activity, low uptake of Health Checks (meaning they are not diagnosing through this mechanism), high smoking prevalence, and high rates of emergency admissions for Diabetes (indicating that there could be an issue with identification and management)
Tilbury (Dr Shehadeh)	High recorded obesity prevalence, high smoking prevalence and low levels of physical activity.
Grays (Dr Shehadeh)	Statistically similar to Tilbury branch, but with a higher ethnically diverse population which puts them at a disproportionate risk of the disease.
Chafford (Dr Abela)	Low levels of observed diabetes but high ethnically minority population which puts them at a disproportionate risk of the disease.
Grays (Acorns)	Low levels of observed diabetes, high smoking prevalence but high ethnically minority population which puts them at a disproportionate risk of the disease.

	Cost	Expected tests	Expected diagnoses	Expected Pre-Diabetic Diagnoses	Cost of complications for non-controlled Diabetes, NHS, per year
Dentistry	£9,156.00	800	10.4		£26,000.00
Mobile unit	£782.00	200	2.6		£6,500.00
Total	£9,938.00	£1,000.00	13.00	Unknown	£32,500.00

Key Actions

We will produce an acceptable SLA for dentists to sign up to deliver HbA1c, chair side, point of care testing in individuals wuth early onset gum disease or who are considered high risk using a questionnaire administered in the waiting area.

We will implement HbA1c testing in the new PHE mobile dental unit for those who fall outside of traditional services such as the travelling community, homeless, those with disabilities or those with additional needs.

6. Find the missing thousands, treat the missing hundreds (6/14)

6.2.4 Depression case finding

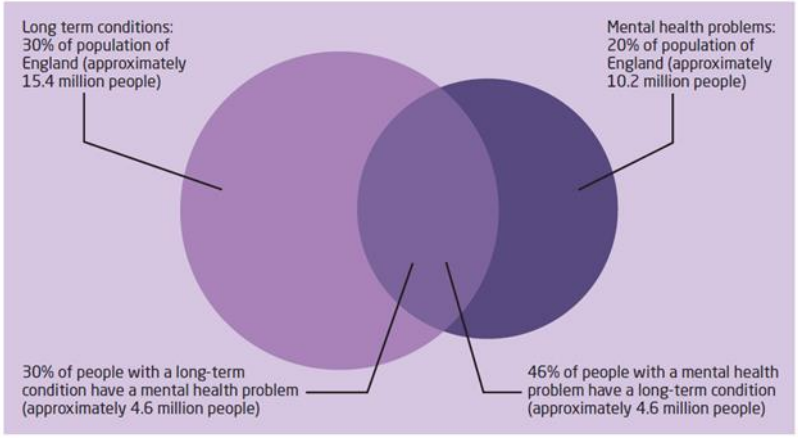
Figure 27 shows that over half (51%) of social care users self-report feelings of moderate to severe anxiety or depression in Thurrock.

Figure 27 Depression and anxiety among social care users: % people who use services who report that they feel moderately or extremely anxious or depressed (2013/14

Area	Value	Lower CI	Upper CI
England	52.8	-	-
East of England region	53.2	-	-
Bedford	53.8	-	-
Cambridgeshire	48.6	-	-
Central Bedfordshire	51.8	-	-
Essex	57.0	-	-
Hertfordshire	51.6	-	-
Luton	53.6	-	-
Norfolk	60.3	-	-
Peterborough	55.3	-	-
Southend-on-Sea	48.4	-	-
Suffolk	48.8	-	-
Thurrock	51.1	-	-

Source: Adult Social Care Survey

The relationship between Long Term Conditions s and Mental Ill Health



A patient with a physical long term condition (LTC) without depression is estimated to cost the NHS £1,760 a year less than a patient with both a long term condition and co-morbid depression (£3,910 vs £5,670). Early identification and subsequent management of depression would delay and reduce higher level interventions later on. The potential saving, if only 100 (approx. one third) of those newly identified LTC/depressed patients are better managed and clinical depression averted, is £176,000.

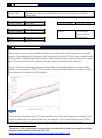
We will improve the diagnosis of common mental health disorders (depression and anxiety) through improving the screening for depression via social care and primary care colleagues by targeting those with the highest risk (those aged 65+ with at least one LTC. Key actions to achieve this will include:

- Developing new SystmOne reports that identify those with LTCs
- Embedding depression screening in LTC clinics in primary and community care
- Embedding depression screening into the work of front line Adult Social Care staff

Table 4. Modelled data on the numbers of those affected by LTCs and mental health problems in Thurrock and Tilbury

	Thurrock (nearest 100)	Tilbury (nearest 100)
Population (all age)	173,400	38,246
Long-term condition (30%)	52,000	11,500
Mental health problem (20%)	34,700	7,600
30% of people with a LTC also have a MH problem	15,600	3,400
46% of people with a MH problem also have a LTC	16,000	3,500

A full copy of the Depression Screening business case can be accessed here:



Key Actions

We will develop new SystmOne reports that highlight to surgeries those patients with long term conditions who have not been screened for depression

We will embed screening of clients with depression into the work of staff treating those with physical long term condition and front line adult social care staff

6. Find the missing thousands, treat the missing hundreds (7/14)

6.2.5 Systematic Case Finding of undiagnosed Long Term Conditions by interrogating GP Surgery Clinical Systems

Since the inception of the NHS, patient medical records have been held by their GP in their surgery. Historically, medical records were paper based, but more recently these have been moved onto electronic clinical record storage and management software, or which there are a number of differing types. The majority (88%) of Thurrock GP surgeries use the same software; *SystmOne,* which is also used by North East London Foundation Trust (NELFT) for NHS community services. However, four of our surgeries use different software databases for patient medical record management.

The move from paper to electronic databases for medical record storage presents opportunities for systematic interrogation of these systems in order to assist front line clinical staff identify key cohorts of patients that either have an undiagnosed long term condition or are diagnosed but whose conditional management could be improved. By linking medical records at patient level to health records held in adult social care and/or hospital enhances these opportunities further. For example, a patient who attends A&E with severe respiratory symptoms and is diagnosed at the hospital as having likely COPD, can be flagged electronically to their GP practice and placed on the surgery's COPD patient register if hospital and surgery records can be linked. Similarly, electronic interrogation of a GP surgery's clinical database can identify all patients who have had a series of high blood pressure readings or may even be being prescribed anti-hypertension medication, but are not recorded on the GP practice hypertension register and therefore may not be in receipt of the systematic care management for their condition.

Historically, a lack of time, resources and in some cases IT skills within the 20th Century model of GP surgeries have prevented such systematic approaches to case finding of patients with long term conditions being implemented. Similarly Information Governance (IG) restrictions and a lack of connectivity between hospital, social care, community care and primary care electronic patient record databases have acted as further barriers to delivering proactive, case-finding and integrated care.

Page 39

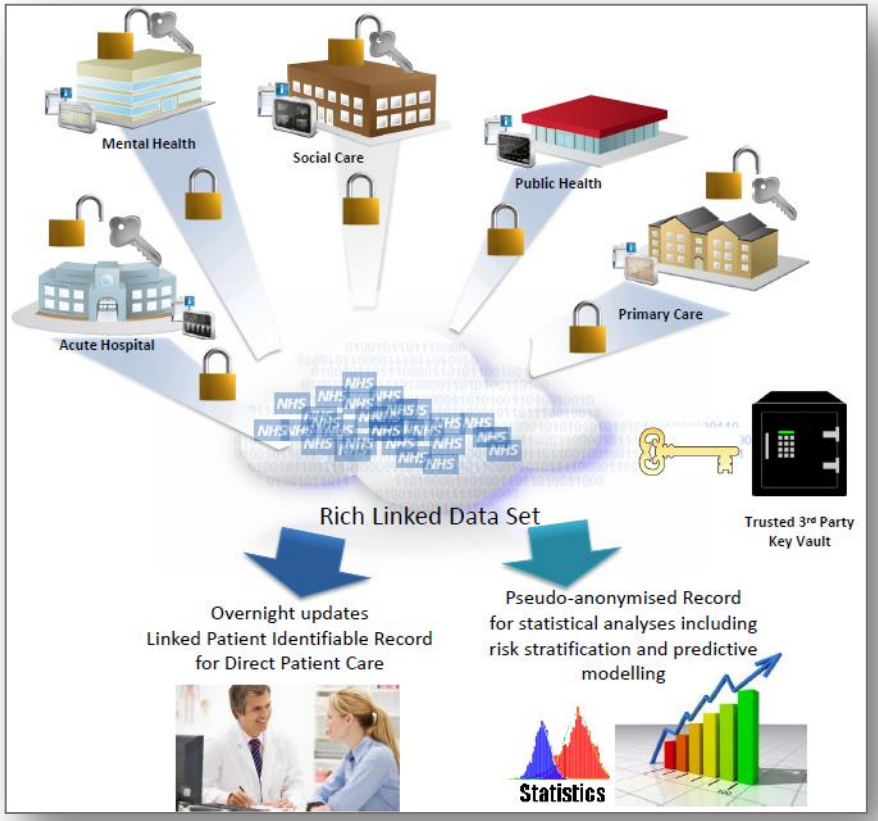
Mede/Analytics

An Integrated Data Solution: MedeAnalytics

MedeAnalytics is a cloud based analytics platform that aggregates and links patient records from a range of different clinical systems and providers including GP surgeries, hospital, adult social care, mental health and NHS community providers creating a single shared patient record linked on NHS number.

Figure 28 sows how MedeAnalytics operates. A third party trusted key is used to pseudo-anonymise patient records from different organisations and databases across the health and care system. These individual pseudo-anonymised data sets are then sent to MedeAnalytics, who link them on pseudo-anonymised NHS number to create a 'data lake' of linked health and care records at patient/client level. These can be analysed by Public Health in their pseudo-anonymised form to create tools that predict risks or outcomes in specific patient cohorts. For example, groups of undiagnosed patients with specific long term conditions can be identified as discussed above. These can then be sent back to the patients' GP surgery who can use their unique identifier to reverse the pseudo-anonymisation and identify patients that they can review.

Figure 28



Key Actions

We will procure and implement the MedeAnalytics IDS across Tilbury and Chadwell

We will assist surgeries to "find the missing thousands" by constructing and running automated reports through MedeAnalytics/SystmOne that identify patients who have risk factors or are on medication for specific long term conditions but have not been added the surgery's Long Term Condition Disease Register

6. Find the missing thousands, treat the missing hundreds (8/14)

6.3 Treat the missing hundreds: Improving the Management of Long Term Conditions in Primary and Community Care

The ACO needs assessment identified the challenge of inadequate clinical management of patients diagnosed with long term conditions in both primary and community care. Most patients diagnosed with a Long Term Condition are managed by their GP surgery under the Quality Outcomes Framework (QOF) which specifies a series of clinical management interventions that should take place each year of patients recorded on specific long term conditions disease registers. QOF rewards practices through payments based on the percentage of patients with a specific long term condition who meet the criteria for the intervention who actually receive it. However, QOF only rewards practices up to a maximum payment threshold (usually between 70% and 80% of all eligible patients in the cohort receiving the intervention), meaning that surgeries receive no additional payment for treating the remaining 20% to 30% of the eligible cohort (depending on the QOF indicator/intervention). This quirk in national commissioning in effect leaves significant numbers of patients with long term conditions untreated and therefore inadequately managed, placing at the at significant unnecessary risk of serious adverse health events and avoidable hospital admissions.

In addition, GPs can 'exception report' patients, removing them from the cohort eligible for treatment and hence the denominator used to calculate practice performance to reach the maximum payment threshold, if they meet certain criteria, for example refusing the clinical intervention, failing to respond to three invitations to attend surgery or if the intervention is contraindicated because of another diagnosis a patient may have or medication that they are prescribed. However, the needs assessment identified significant variation in rates of exception reporting on different indicators between surgeries. The reasons for this are unclear, and could be explained by populations with differing levels of morbidity, differing levels of willingness to agree to take recommended prescribed drugs, or differing abilities to access the surgery when appointments are offered. However, high levels of exception reporting are unfavourable in population health terms, leaving significant numbers of patients with long term conditions potentially under-treated and inadequately managed within the community.

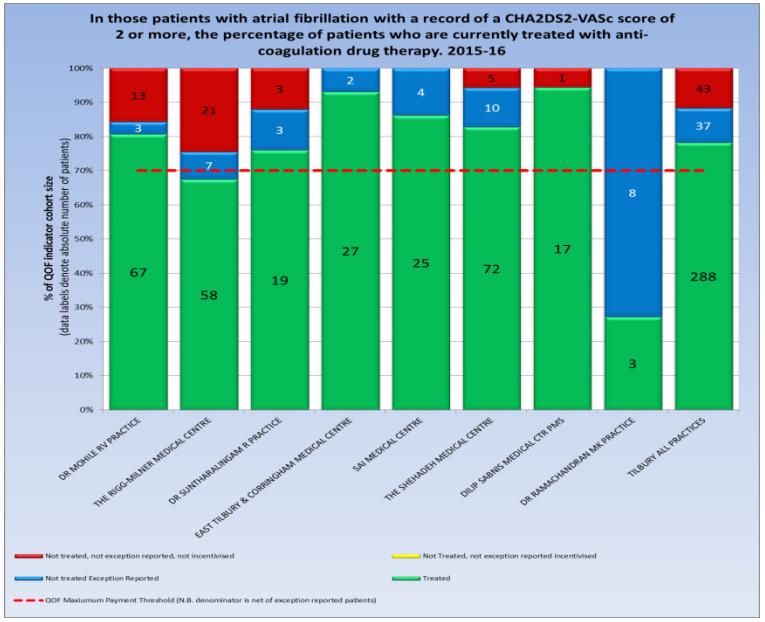
An example of the impact of the payment threshold and exception reporting is shown in figure 29, taken from the ACO Needs Assessment. National Institute of Health and Care Excellence (NICE) guidance states that those patients diagnosed with Atrial Fibrillation who have a CHADS2-VASc score of 2 or more should be treated with anti-coagulation drug therapy to reduce the risk of a stroke. Figure 29 shows performance on this indicator in 2015-16 across surgeries in Tilbury and Chadwell. However, because of the maximum QOF payment threshold of 70% (shown by the red dotted line in figure 29), QOF provides no funding to GP surgeries to treat 30% of patients in this cohort.

The green parts of each surgery bar show the numbers and % of the cohort successfully receiving this intervention; the blue parts the number and % who were exception reported and; the red parts the number and % that were neither exception reported nor treated. The negative impact, both on patient health and cost to our local health care system is shown in box one.

We will take urgent action to address a national commissioning directive that make no sense in either health nor financial terms. We will do so by implementing a local "stretched QOF" local commissioning framework across all key cardio-vascular, respiratory, diabetes, mental health and musculo-skeletal related QOF indicators, that abolishes the 'maximum QOF payment threshold' and provides adequate funding for GP surgeries to provide appropriate clinical interventions to **100%** of all patients on long term condition registers who require NICE approved clinical interventions.

We will also use the new MedeAnalytics Integrated Data Solution to run automatic reports on GP clinical databases that flag to surgeries, any patient that requires a QOF based intervention who has yet to receive one. We will work with the network of surgeries in Tilbury and Chadwell to offer a single, centralised patient 'call-recall' system that will manage the appointments and booking patients with long term conditions who need such interventions, on behalf of surgeries as part of the new Clinical Management Hub.

Figure 29



Box 9: The Perverse Impact of the QOF system on Patients with Atrial Fibrillation and the Health and Care System in Tilbury and Chadwell

- **80** patients with Atrial Fibrillation and a CHAD2 score >1 are not anti-coagulated
- **43** (60%) of these are not exception reported
- **Surgeries receive no funding** to treat any of them
- Providing additional **funding to** surgeries to **treat** these untreated **43 patients (**by raising the QOF threshold from 70% to 100%) would cost **£2,121**
- Left untreated, our modelling demonstrates that **50%** of these patients (22 Tilbury and Chadwell residents) **will have a stroke in the next three years**
- **The initial cost to the NHS** of treating **22 strokes is £84,202**, and the **cost to** Adult **Social Care is £129,145**

6. Find the missing thousands, treat the missing hundreds (9/14)

6.3.1 Implementation of the "Stretched QOF"

Evidence from the BMJ indicates that the introduction of QOF for the management on some Ambulatory Care Sensitive Conditions (ACSC) was associated in the reduction of emergency admissions for these conditions (Figure 30).

It is expected that by increasing the number of patients with long term conditions treated under QOF, this programme would result in a number of outcomes, including:

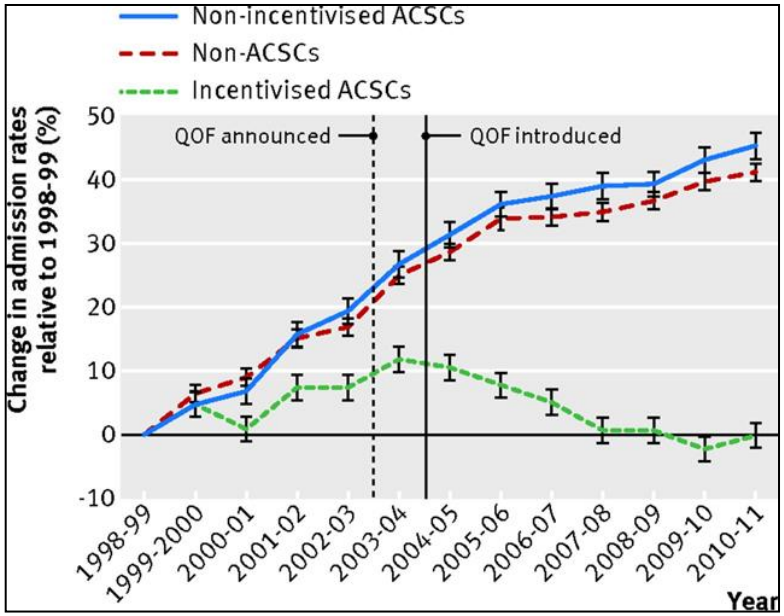
- Better management of patients with long term conditions
- Patients who are happier with their care
- Fewer serious adverse health events such as strokes, heart attacks, COPD exacerbations and serious complications from diabetes
- Reduction in avoidable emergency hospital admission rates because of complications resulting from badly managed long term conditions
- Reduction in avoidable demand for adult social care packages
- Significant system cost savings

The implementation costs are shown in the table 5 below, and will be funded as part of the joint Thurrock CCG/Council Better Care Fund:

Table 5

	Cost to achieve 100% on All indicators based on current detection rates	Proposed Increase in Detection Rates	Cost to achieve 100% on All indicators based increased detection rates	Proposed Increase in Detection Rates	Cost to achieve 100% on All indicators based increased detection rates
Hyp	£4,635.14	10%	£5,274.62	20%	£5,914.09
CHD	£1,471.00	5%	£1,638.00	10%	£1,806.00
AF	£3,815.43	0%	£3,815.43	0%	£3,815.43
HF	£4,786.00	0%	£4,786.00	0%	£4,786.00
PAD	£311.35	0%	£311.35	0%	£311.35
STIA	£1,981.50	0%	£1,981.50	0%	£1,981.50
DM	£10,800.40	5%	£11,180.98	10%	£11,450.63
COPD	£5,735.28	0%	£5,735.28	0%	£5,735.28
Asthma	£10,366.64	0%	£10,366.64	0%	£10,366.64
Dementia	£13,902.99	0%	£13,902.99	0%	£13,902.99
Mental Health	£2,455.66	0%	£2,455.66	0%	£2,455.66
Depression	£1,908.25	0%	£1,908.25	0%	£1,908.25
Oesteoporosis	£1,752.31	0%	£1,752.31	0%	£1,752.31
Rhumatoid Arthritis	£583.89	0%	£583.89	0%	£583.89
Total	£64,505.84		£65,692.90		£66,770.02

Figure 30



We can calculate potential outcomes and returns for three of the QOF indicators by using the Long Term Condition models produced for the 2016 APHR. These are detailed in table 6 (next page). We predict that implementing a Stretched QOF will save the Health and Social care system at least £640K based on only three QOF indicators to avoid CVD events. We are unfortunately unable to estimate this further for other conditions and indicators but it is logical to assume that additional saving

The Full Business Case can be found here:

Key Action

We will implement a Stretched QOF programme for all surgeries in Tilbury and Chadwell on Long Term Conditions Indicators to ensure funding is available for practices to treat 100% of patients on QOF disease registers

6. Find the missing thousands, treat the missing hundreds (10/14)

6.3.1 Implementation of the "Stretched QOF" (cont.)

Table 6

	Min additional cases treated	Maximum additional cases treated	Assumptions for range	Outcomes	Returns estimated	Potential Savings
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	893	1170	Excluding exception reporting and no detection increase to including exception reporting and 10% increase in detection	18-23 strokes avoided over 3 years	NHS - Stroke Avoidance Adult Social Care - Stroke Avoidance	£65,082 to £85,270 £75,387 to £98,771
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	48	85	Excluding or Including exceptions	62 - 110 strokes avoided over 3 years	NHS - Stroke Avoidance Adult Social Care - Stroke Avoidance	£227,385 to £402,662 £263,390 to £466,420
In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB	2	9	Excluding or Including exceptions	2.2 - 7.6 fewer non- elective admissions for CHD/HF over 3 years	NHS - admission avoidance	£10,058 to £45,263
Total measurable Returns					NHS Adult Social Care **Total**	£302,525 to £533,195 £338,777 to £565,191 £641,302 to £1,098,386

6. Find the missing thousands, treat the missing hundreds (11/14)

6.3.2 Improving uptake of flu vaccinations amongst high risk groups

Morbidity and mortality attributed to flu is a major cause of harm to individuals, especially vulnerable people, and a key factor in NHS winter pressures. The annual flu immunisation programme helps to reduce GP consultations, unplanned hospital admissions and pressure on A&E and is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services during winter. This project aims to increase the proportion of people vaccinated for flu who are at high risk of ill health or death if not vaccinated.

Various factors help to increase the levels of uptake of flu vaccination including the sending of personalised letters to the population from their GP practice.

The project aims to target two main groups of patients:

1) Those with long term conditions in the clinical risk groups covered by QOF [CHD, Stroke, Diabetes and COPD] where the GP could be incentivised via a 'stretched QOF' [see previous slide - the estimated cost of vaccinating patients in these groups has been included in the 'stretched QOF' programme and is therefore not repeated here.]
2) Those in high risk groups not covered via QOF. Current uptake in Tilbury is particularly low for groups such as carers (26% compared to a national target of 75%) and pregnant women (28% compared to a national target of 55%) – this can be seen in the table 7below.

Table 7

	6m-2yr olds (at risk)	Carers	Pregnant women (all)	Children (aged 2-7)	<65 At-Risk (Chronic Liver Disease)	<65 At-Risk (Asplenia or dysfunction of the spleen)	<65 At-Risk (Chronic Kidney Disease)	<65 At-Risk (Immuno-suppression)
Tilbury Avg (%)	33.0	26.0	28.0	42.5	29.0	35.0	39.0	40.0
National Target (%)	55.0	75.0	55.0	40.0	55.0	55.0	55.0	55.0

It is estimated that we would need to vaccinate 328 patients in these other high-risk groups; and the cost of vaccinating them is estimated to be £3,936 [including the vaccine cost and relevant promotional materials].

It is expected that reducing flu outbreaks will result in:

- Reduced ill health in patients
- Reduced hospital admissions (and therefore bed days and lengths of stay in hospital) - *there were 118 spells for influenza/pneumonia in 2015-16 from Tilbury residents costing £413,191.*

It is hypothesised that a large majority of these could have been prevented if the patient had had the flu vaccination. If we could prevent 80% of these by delivering the flu vaccination, that would result in a cost saving of £330,552.80.

- Reduction in sick leave taken by staff in all parts of the healthcare workforce (it is estimated that approximately 10% of sickness absences are related to flu.)

There will also be savings to Adult Social Care with reduced outbreak response costs (e.g. the additional staff, vaccine costs etc) which cannot be quantified.

A full copy of the Flu Immunisation Business Case can be accessed here: 

6. Find the missing thousands, treat the missing hundreds (12/14)

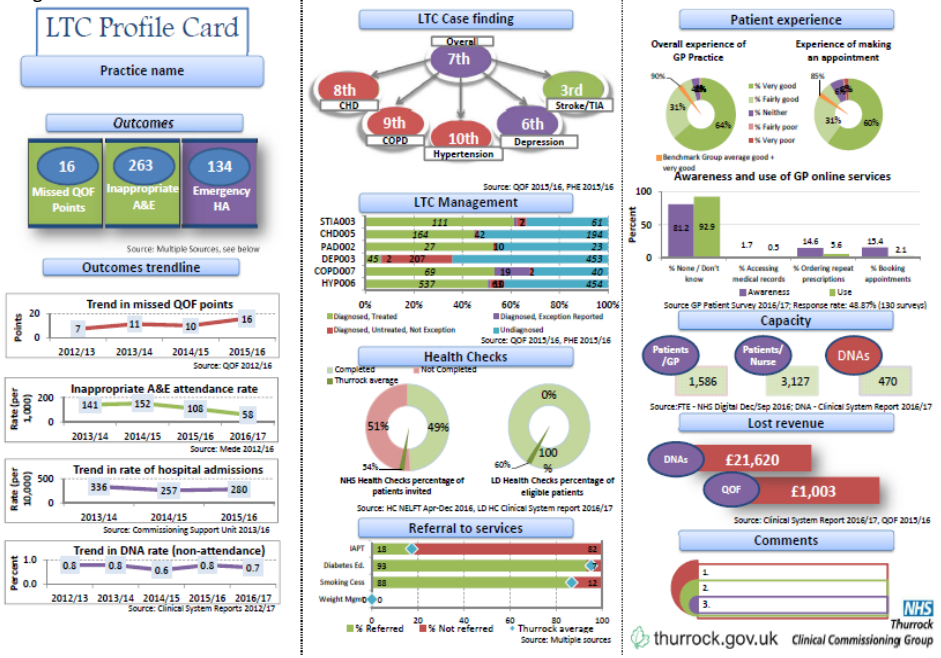
6.3.3 Working to Support Surgeries Deliver World Class Long Terms Condition Case Finding and Management

The Healthcare Public Health Team and Thurrock CCG's Primary Care Improvement Team will continue to work in partnership with GP surgeries to share and embed best practice relating to the diagnosis and management of patients with long term conditions.

We will continue to roll out our Long Term Conditions Profile Card (figure 31) which provides a benchmark of each of our GP surgery's performance relating to both the case finding and management of patients with long term conditions against a cohort of 20 surgeries across England that serve practice populations with demographic characteristics most similar to their own.

We will support our surgery practice managers and clinical teams to develop and implement surgery based action plans, based on the contents of their profile cards, with a view to encouraging a culture of shared learning and continuous quality improvement. At a Tilbury and Chadwell and Thurrock level, we will monitor performance on long term conditions case finding and clinical management over time to ensure that sustained improvements are being made, and we will triangulate this with analysis from MedeAnalytics to ascertain the impact that improved management of long term conditions is having on emergency hospital admissions and demand for adult social care packages, and publish the results.

Figure 31



Key Actions

We will use the new MedeAnalytics Integrated Data Solution to assist surgeries identify patients that need to be reviewed under QOF for their long term conditions management care and reduce avoidable exception reporting

We will work with the network of surgeries in Tilbury and Chadwell to offer a single, centralised patient 'call-recall' system that will manage the appointments and booking patients with long term conditions who need such interventions, on behalf of surgeries as part of the new Clinical Management Hub.

We will continue to roll out the LTC Profile Card and provide support to Practice Managers and Surgery Clinical Teams to develop and implement action plans to improve clinical quality and patient satisfaction

6. Find the missing thousands, treat the missing hundreds (13/14)

6.3.4 Increasing and Integrating Capacity to Manage Long Term conditions in Primary Care

Figure 32 shows the combined number of clinical interventions across all of the Diabetes QOF indicators delivered to patients, exception reported, not delivered and not exception reported but incentivised; and not delivered, not exception reported and not incentivised for each GP practice in Tilbury.

In total 4575 clinical interventions relating to the management of diabetes were not delivered to Tilbury patients on diabetes disease QOF registers in 2015-16. Of those only 1651 (35.5%) were because the patient had been exception reported. The 'yellow' parts of the bars (relating to a total of 1037) were for interventions that were incentivised through the existing QOF commissioning framework but not delivered. Similar charts are available within the Tilbury ACO needs assessment document for QOF interventions relating the cardio-vascular disease and respiratory disease, and show a similar pattern.

These data suggest that raising the threshold of the maximum level of QOF payment to 100% of eligible patients on all indicators (discussed on the previous page) may not be the entire solution to inadequate disease management of long term conditions in GP practices, as for some indicators, in some surgeries, patients did not receive interventions nor were exception reported, even though financial reward would have been payable under QOF. Rather, where patients are not receiving clinical interventions were funding is available to practices to deliver them, it would suggest that surgeries lack clinical capacity to review and manage patients with long term conditions.

NHS Thurrock CCG commission North East London NHS Foundation Trust (NELFT) to provide community long term conditions management clinics to support GP surgeries manage patients with diabetes, COPD, stroke and Heart Failure. The Tilbury ACO Needs Assessment demonstrated a minority of patients with these conditions, registered at GP practice level were referred to these clinics. Only 25%, 17% and 8% of patients with COPD, Heart Failure and Stroke respectively were referred to the relevant NELFT community commissioned service. (Figure 33). The reasons for this are unclear, but whilst GP practices are failing to deliver 100% of QOF long term conditions management interventions to the cohort of patients eligible to receive them, these relatively low levels of referral suggest cause for concern.

The needs assessment noted that possible causes for low referral rates included the separation of community LTC management services from surgery clinical teams, and the fragmentation of community LTC management into disease specific services. It noted that increasingly, Tilbury and Chadwell residents are living with more than one long term condition but needed to travel to different clinics, run at different times and locations to receive treatment for different long term conditions. This is clearly not the most optimal way to deliver services from a patient experience point of view, and having a single long term conditions management service that could support practices review patients once for all of their long term conditions would be a more optimal way of service delivery.

Figure 32

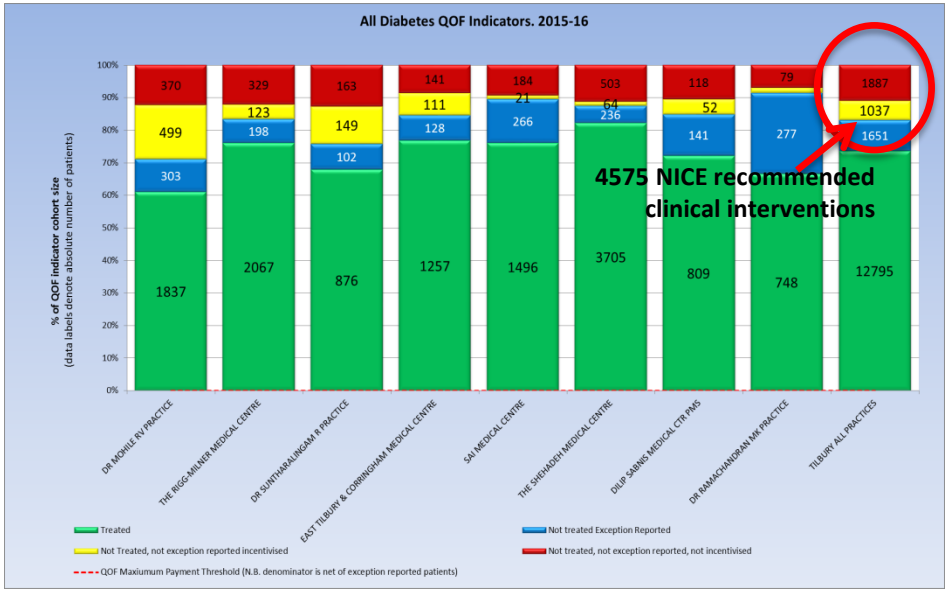
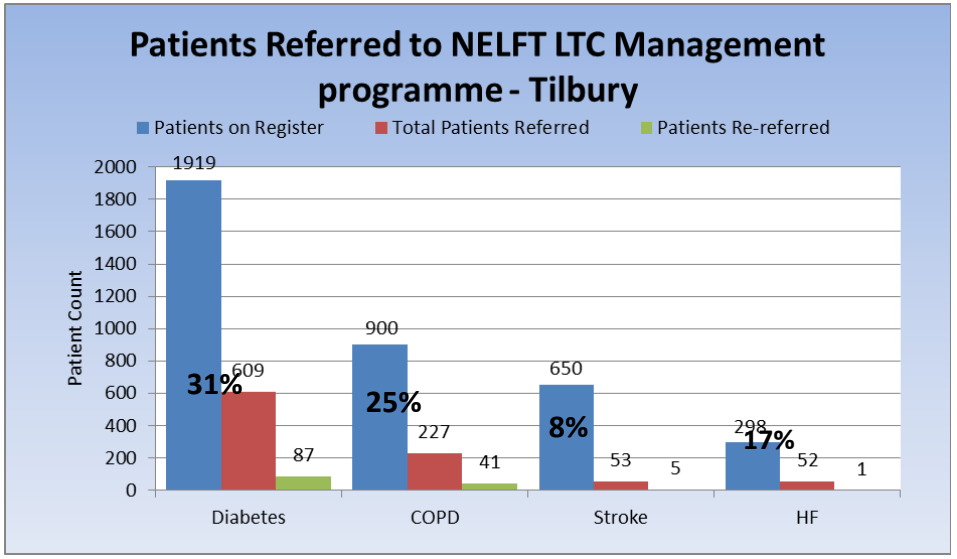


Figure 33



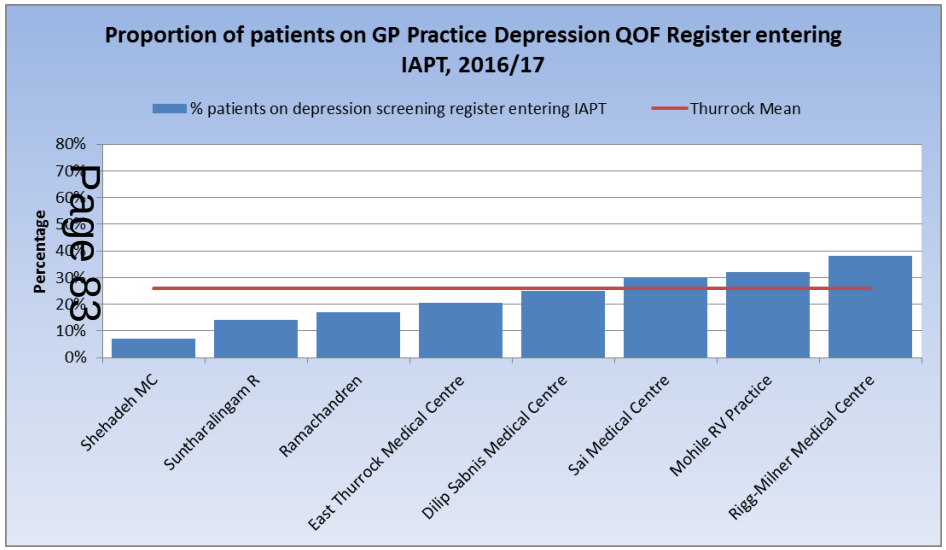
6. Find the missing thousands, treat the missing hundreds (14/14)

Increasing and Integrating Capacity to Manage Long Term conditions in Primary Care (cont).

Treatment for depression and anxiety is most commonly in Primary Care by GPs. NHS Thurrock CCG also commission Inclusion Thurrock to provide psychological talking therapies – IAPT (Increasing Access to Psychological Therapies), for patients with depression and anxiety.

Like referral to NELFT community LTC management clinics for physical long term health conditions, the proportion of patients on GP surgery depression registers entering IAPT is relatively low (7% to 39%), with half of all surgeries in Tilbury and Chadwell having a lower rate of patients with depression and anxiety entering IAPT than the Thurrock average in 2016/17. (Figure 34)

Figure 34

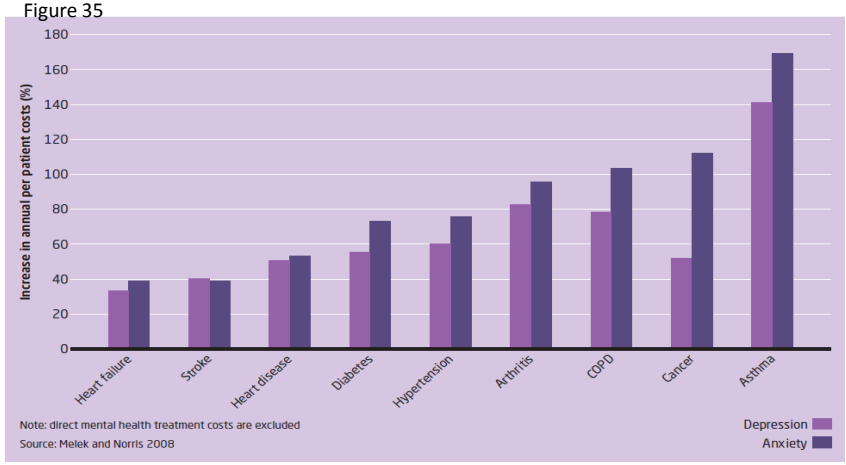


The relationship between physical long term health conditions and common mental health disorders (depression and anxiety) is well established and was discussed on page ***. 30% of people with long term physical health conditions also have co-morbid depression and/or anxiety, and that 46% of people with a mental health disorder, also have a co-morbid physical long term health condition.

Furthermore, patients with long term physical health conditions and comorbid untreated depression and anxiety have been shown to have significantly poorer health outcomes, and significantly greater health service usage and costs. (Figure 35).

We will address these issues by bringing community healthcare capacity for managing mental and physical long term conditions closer to Primary Care, and by integrating it into a single more streamlined service.

Figure 35



We will seek to create a single long terms condition management service within the Enhanced Primary Care Team, shared by the network of GP surgeries in Tilbury and Chadwell. The LTC management service will be able to provide additional support to GP surgeries to manage patients with diabetes, cardio-vascular disease and respiratory disease, rather than requiring referral to disease specific community services, as at present. The new arrangement will strengthen relationships between primary and community care clinicians for the management of patients with long term conditions. It will also allow patients to be seen once, closer to home for all of their long term conditions rather than having to attend different clinics specialising in different long term conditions.

We will integrate current IAPT services provided by *Inclusion Thurrock* within the shared Enhanced Primary Care clinical team, in order to increase the number of patients with diagnosed depression and anxiety entering treatment, and provide a single integrated service offer that treats depression and anxiety alongside physical long term health conditions.

Key Actions

We will integrate current disease specific physical long term conditions clinics into a single integrated LTC management service, based within the shared Enhanced Primary Care clinical team, to strengthen shared care arrangements between Primary and Community Healthcare services and provide a one stop shop for patients

We will integrate IAPT service provision within the Enhanced Primary Care clinical team to increase the number of patients with depression and anxiety entering treatment and to provide a single integrated service that can treat physical and mental ill health.

Chapter 7: *What does a good life look like for you?*

Proactive, Integrated Community Health and Wellbeing

Complex, Frail Patients with Multiple Long Term Conditions

1.8%
533

50%
~£6.7m

Coordinated, proactive, integrated health and care

- Proactive person centred care coordination
- Integrated community assets, healthcare and adult social care

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing (1/7)

Complex, Frail Patients with Multiple Long Term Conditions

1.8%
533

50%
~£6.7m

Coordinated, proactive, integrated health and care

- Proactive person centred care coordination
- Integrated community assets, healthcare and adult social care

Introduction

This chapter focuses on the 1.8% of residents that account for 50% of the healthcare spend in Tilbury and Chadwell. Although relatively small in number, this cohort has the greatest level of health and care need and uses a disproportionate amount of health and care resource. Residents represented within this group are likely to have multiple long term conditions, come in contact with NHS community healthcare services, be in receipt of domiciliary home care or other types of adult social care package, and experience admission to hospital or other secondary care services, perhaps multiple times within a year.

However, being in receipt of 50% of the total healthcare resource spent in Tilbury and Chadwell does not necessarily mean that this cohort receives the best possible health and care services. Anecdotal evidence from providers of health and care services suggest that services are often provided in a disjointed, inflexible and inefficient way. In order to demonstrate this, we have selected at random, the records of a client from Thurrock Council's Adult Social Care LAS, receiving domiciliary home care in 2015/16, whom we shall name "Beryl".

Beryl and her likely care in 2015/16

Beryl is a 89 year old woman who lives alone. She has a history of TIAs and has strokes, the last one resulting in her being admitted to Basildon Hospital. She also suffers from several cardio-vascular diseases including high blood pressure (hypertension) and Atrial Fibrillation, both of which are underlying risk factors for her strokes. As a lifelong smoker, she received a diagnosis of COPD ten years ago. She is monitored by her GP and different NELFT community long term conditions clinics for these conditions.

She has also been diagnosed with osteoporosis and has a history of falls and fractures. Her deteriorating long term conditions and her falls have resulted multiple visits to Basildon Hospital both as an outpatient and in terms of emergency A&E attendances. She has been admitted to Basildon Hospital as an inpatient, once due a fall/fracture, and twice because of stroke/TIA over the past 12 months.

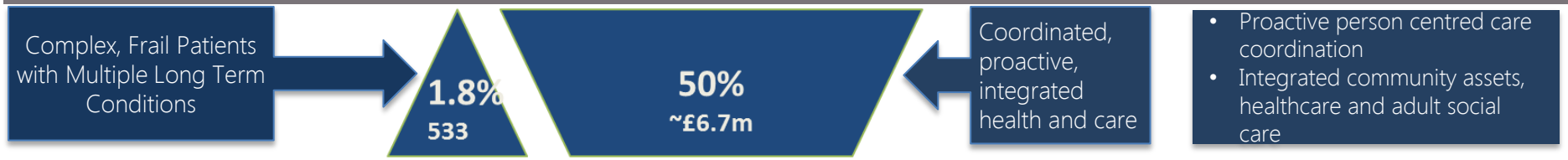
She also has some continence issues and repeated UTIs requiring treatment by her GP and the community continence team.

Following her last stroke, Beryl received some re-ablement at Basildon Hospital and then was assessed by the Hospital Social Work Team as requiring physical home care support, double handed, three times a day in order to meet her personal care needs as she now has impaired mobility. Her last stay in hospital has left her with some acquired pressure ulcers

Beryl is suffering from depression and anxiety because of her deteriorating health and because she feels lonely and isolated. Some mild confusion has been noted by the social work team.

The diagram to the right summarises the needs of Beryl as assessed by the Health and Care system

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing (2/7)



Historically, as a result of the way health and care has been commissioned and provided, the following different services would all be contributing to Beryl's care.

GP Surgery
Beryl's GP and surgery will hold Beryl's medical records and will be the first point of contact for Beryl on a day to day basis, and ultimately responsible for coordinating her care, including making referrals to other services that may be able to support her. Her GP surgery would be responsible for prescribing medication to treat infection and vaccinating Beryl against future infection e.g. influenza and pneumococcal infection. In addition, her surgery will be managing her COPD, Atrial Fibrillation, Stroke/TIA and depression through delivery of a series of clinical intervention under QOF.

Hospital
Have treated Beryl in A&E when she has had a COPD exacerbation or fall, as an in-patient following a stroke and fall, and as an outpatient for osteoporosis. Re-ablement was also provided at hospital when Beryl was most un-well following her stroke, as was assessment to determine her adult social care homecare need.

Community Respiratory Team
Beryl may receive further treatment and management for her COPD from the Community Respiratory Team. She is likely to have to access the team at a separate appointment by travelling to their clinic. Long term management of her COPD will be shared with her GP practice who will also undertake clinical management under QOF.

Community Stroke Rehabilitation Service
Beryl will be receiving further treatment and rehabilitation for her stroke from the Community Stroke Rehabilitation Service. The service, led by a specialist team provides specialist neuro-rehabilitation to minimise deterioration of her condition and enable optimum function levels to be reached and maintained. It also provides specialist support, resources and education to Beryl to enable self-management. Beryl is likely to have to access the team at a separate appointment by travelling to their clinic. Long term management of her stroke will be shared with her GP practice who will also undertake clinical management under QOF.

Integrated Community Team (ICT)
Members of the ICT are visiting Beryl at home to provide care following her hospital discharge. Clinical staff are treating her pressure ulcers and providing wound care. They may also undertake some prevention activity such as vaccinating Beryl against flu.

Community Falls Team
Given Beryl's history of falls, she may have been referred to the falls service. This service, provided by the NHS community provider, is responsible for conducting Medication Reviews, Postural stability training, eyesight checks and ensuring a home safety check is undertaken, with a view to reducing the likelihood and risk of Beryl having future falls. Beryl may have to travel to clinics for some of these services or they may be provided within her home.

Occupational Therapy
OTs would visit Beryl at home and assess how her home may need to be adapted in order to maximise independent living and help her to remain at home for as long as possible

IAPT
Beryl may wish to accessing talking therapies for her depression/anxiety. If so, she will need to either self-refer or be referred by her GP to her local IAPT provider, and travel to an appointment to receive the service

Dementia Crisis Support Team
Beryl has been referred to this team by her GP to investigate her memory and mild confusion issues. They are currently undertaking memory diagnostic testing with Beryl.

Domiciliary Home Care
Beryl's needs related to personal home care would were assessed on hospital discharge by the hospital social work team following some re-ablement. They have commissioned a private homecare provider, to provide three visits a day.

Meals on Wheels
Beryl's low level of current physical functioning requires Meals on Wheels to be delivered to her home each day.

MDT (Multi-disciplinary Team)
MDTs are formed of groups of clinicians that are involved in Beryl's care. Their aim is to review the care being provided to patients with complex or multiple needs and act in a proactive way to prevent the patient deteriorating and to better coordinate care. An MDT may or may not meet at Beryl's surgery (as not all surgeries have MDTs). Beryl may or may not be discussed at the MDT depending on the methodology used by her surgery to select patients for review. Whether or not the MDT meets at Beryl's surgery, **it is unlikely that her GP or any other single professional will have timely access to information on all clinical and care interventions provided to Beryl, and also unlikely that all services providing such interventions will be represented at the MDT**.

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing (3/7)

Problems with the current way care is provided

Figure 36 shows he current way that care is provided for Beryl. A number of immediate problems with the current system, detailed below:

Task and service focussed not holistic

Care providers are commissioned through, and therefore deliver care as, a series of discrete "tasks" rather than as a single holistic single package that meets all of Beryl's needs. For example different NHS community care staff arrive at Beryl's home to undertake different care tasks, usually centred around different clinical conditions. Similarly adult homecare providers are commissioned to deliver a fixed number of hours or minutes of care for a set number of times each day. with no flexibility relating to how Beryl may be feeling on a particular day or what her needs on that day may be.

Impersonal and Anonymous

Care is provided by multiple individuals from different teams in different organisations entering Beryl's. Beryl is likely to see many different individuals over the course of a week or even day, and these may be subject to change from day to day or week to week. The care providers may not have time to get to know Beryl personal basis or understand anything above her most basic needs of food, personal care and disease management. Further more, Beryl is subject to many visits of different people at differing times of the day making it impossible for her to plan her life outside of these care needs.

Inflexible

Because care is both task focussed and impersonal, the needs of the recipient of care, which may vary on a day to day basis are never taken into account. Similarly, the task focussed nature of how care is commissioned, risks resulting in a 'one size fits all' type of care delivery that meets only the most basic needs of the resident.

Fragmented

Multiple organisations and individuals provide different health and care tasks. Beryl's care is determined by how services are currently organised, not on her needs. Beryl has to travel to multiple care providers to receive different elements of her care. Intelligence about the needs or wants of Beryl is not shared adequately between care providers. Beryl has to "tell her story" many times to many different people. No one care provider (most particularly important, her GP) has adequate or timely access to a single comprehensive record of the all the care Beryl has received, nor has an oversight of all of Beryl's needs. Actions (or lack of them) in one part of the system drive demand and costs in another; for example if Beryl's cardio-vascular disease is poorly managed in the community, Beryl is likely to be admitted to hospital as an emergency.

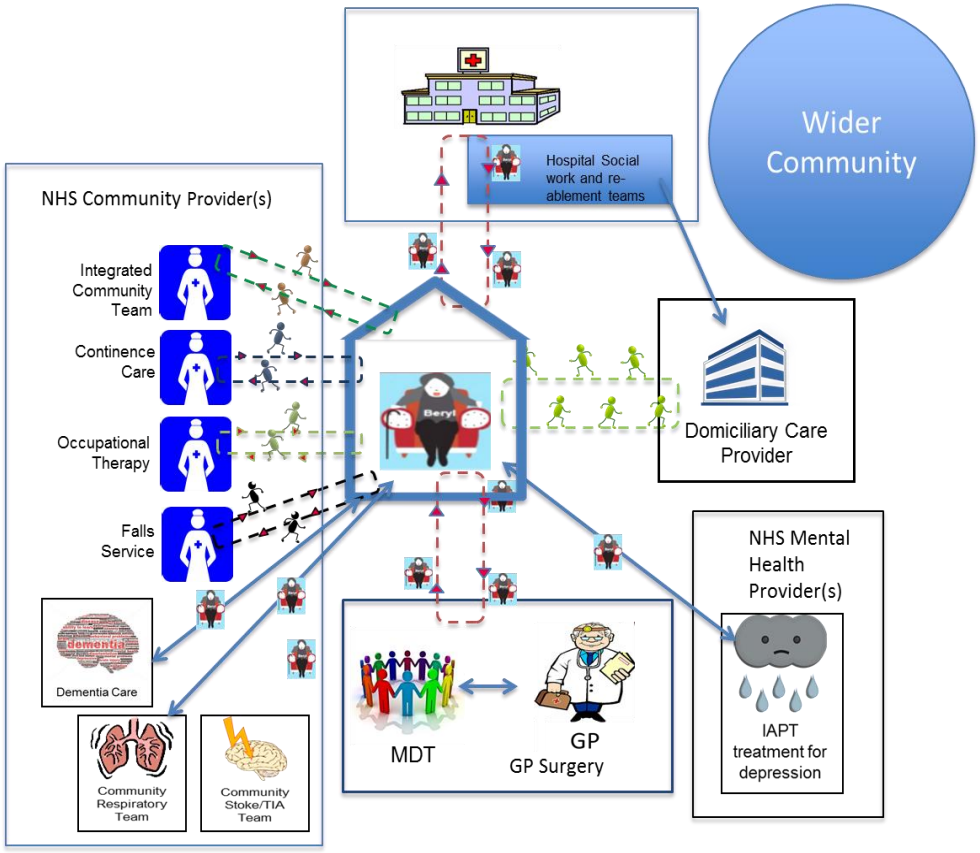
Inefficient

At an organisational level, staff may have to visit many different patients/clients across and beyond the Thurrock boundary, resulting in much time spent travelling between individual residents' homes rather than providing care. At a health and care system's level, multiple visits may be conducted by staff from different organisations to the same clients' home to undertake different tasks, when a single person could undertake all tasks more effectively.

Reactive not preventative

Each care provider delivers a specific intervention in reaction to Beryl's current situation. Insufficient consideration is given to any long term plan for Beryl that focuses on preventing her from deteriorating further. Self care does not feature highly enough in Beryl's long term care plan.

Figure 36



Biomedical and deficit based rather than person centred and asset based

Beryl's needs are determined separately by professionals based on their assessments of what she can't do or what is wrong with her. Care delivery focuses purely on "fixing" or managing Beryl's health and care deficits by doing things "to" Beryl. Beryl is a passive recipient of care. Insufficient consideration is given to Beryl as a person, what life she may want or what makes her happy. Options for Beryl gaining support from her wider community, (to address for example her isolation and loneliness) are widely ignored.

A better way for Beryl

The title for this chapter is taken from an observation made by a leader of one part of our local health care system who rightly suggested that instead of providing health and care services to residents from the starting point of current organisational forms or the deficits of the care recipient as organisations determine them, we should start from the point of view of those receiving services and ask the fundamental question *"what does a good life look like for you?"*

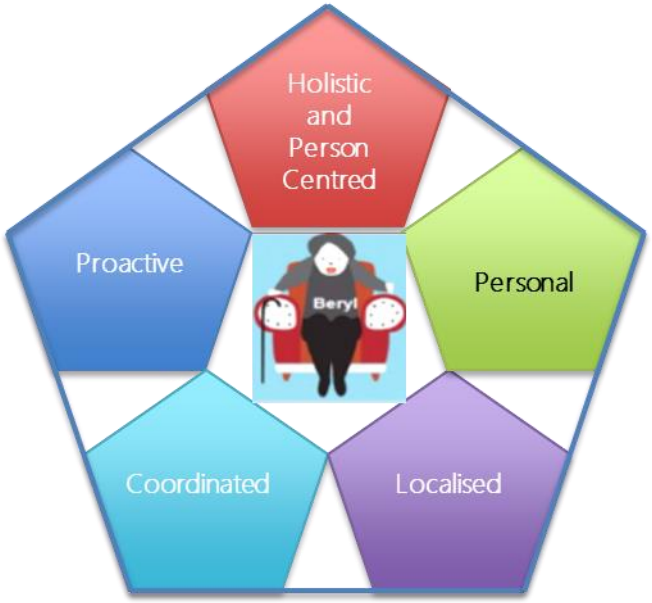
A Better Way for Beryl: Key Principles of a new model of integrated care

Addressing the challenges identified in figure X on the previous page requires fundamental reform of the way that health and care is organised at a local level. To achieve it requires a paradigm shift in thinking of those delivering health and care services, and may present a challenge to current established professional hierarchies. It is likely to require a new relationship between commissioners and providers, and between provider and provider, and potentially an entirely new provider landscape.

Such a level of system transformation will only be successful if there is 'buy in' a new vision for how health and care could be provided, across staff at all levels and throughout all organisations that make up our current health and care system; successful delivery will require co-design between commissioners, providers and residents. As such, this *Case for Change* document does not seek to specify in detail the precise organisational forms of a new health and care system, but sets out some high level principles centred around the needs of the care receiver, for a new model of care. We envisage that the detailed design work for realising this vision will take place in the *Integrated Models of Care* work stream and beyond it.

However, in order to address some of the issues being experienced by Beryl and the thousands like her receiving care in our current system, we propose that any new model of care needs to be based on the following five key principles:

The Five Pillars of a New Model of Care



1. Holistic and Person Centred

Too often, the care in the current system is determined by professionals and specified as a series of tasks. The new model of care needs to shift the focus of organisations from *"doing to"* to *"doing with"*. This requires a new relationship between care provider and care receiver based on empowerment and partnership. Fundamental to this new relationship is the opportunity for the care receiver to consider and specify "what a good life" means to them. It starts with a **single, common, comprehensive and holistic assessment** of their needs as *they* define them. Such an assessment needs to consider the individual in the context of their family, friends and community, rather than simply in the context of the physical functioning of their own body. Issues to be discussed and agreed with the individual in developing a care plan need to include:

- Physical health needs
- Mental and emotional wellbeing
- Functional ability
- Social health, social relationships, hobbies and interests
- Economic factors such as income, benefits and debt
- Educational factors and
- Cultural factors
- Housing
- Self care and empowerment

The single, comprehensive assessment needs to form a **single comprehensive agreed care plan** that all services work in partnership with the care receiver to deliver.

2. Personal

Figure X on page Y demonstrated the sheer number of different individuals that may be entering Beryl's home at any one time to deliver care "tasks". Even within a given category of care (for example domiciliary home care) different individuals may deliver the same type of task at different times. This situation is bad for both care receiver and care provider as there is little chance to form any kind of relationship or shared understanding of needs. From Beryl's point of view, care is provided by anonymous strangers to whom she constantly has to re-tell her "story"; from the care provider's point of view, care is provided "cold" to patients or clients whose needs they have little or no understanding of.

The new model of care needs to **limit the number of different people delivering care** to the resident to the absolute minimum and provide a **consistency in care relationship** between care giver and receiver. This will provide a more rewarding working environment for those providing care, and a more fulfilling and personal care experience for residents. It is also a more efficient way of delivering care as the needs of the resident will be known and understood by the individual or individuals delivering care to them. As such, opportunities for more holistic and preventative care will become available, and monitoring of changes in the health and wellbeing of residents become easier.

Personalised care is **also flexible care**. It represents a shift away from the current situation of delivering care as a set number of specific tasks, determined in advance and delivered in the same way each day, to one that adapts to the changing needs and wishes of the resident from day to day and week to week. It puts **the receiver of care in control** of the care they receive each day, and who provides it.

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing (5/7)

3. Localised

If personal, flexible and holistic care is to be provided, then care delivery needs to become much more localised. It will simply be impossible to deliver the rationalised number of care givers and flexible approach to care provided above, if care delivery is organised across a single large geographical footprint. The new model of care will require a number of **sub-borough or even sub-locality based wellbeing teams,** with **fewer staff members** in each team, **and each team member up-skilled** to undertake a more diverse range of tasks than at present. For example domiciliary care workers could be trained to undertake clinical bio-marker monitoring or routine clinical tasks such as HCA tasks – BPs, urinalysis, phlebotomy, peak flow for COPD, wound care. Stronger relationship with the GP to save the GP visiting. Current carer relationship with GP doesn't exist.

In order to gain maximum efficiency, we envisage localised wellbeing teams to be more **self-directed and self managing**. We will seeks to **eliminate any unnecessary administrative** burden on front line staff that comes from the current "KPI heavy" commissioner-provider relationship, and release time for resident facing care. Although there are some specialist services where small numbers of patients/clients accessing them require provision only at Borough wide level or above, we will seek to re-design and re-provide services on default locality or sub-locality footprint unless there are clear reasons why this is not possible.

Localised wellbeing teams are also **holistic** teams. They operate within the context of a **wider knowledge and understanding of the capacity, skills, and assets in their locality**. They will capitalise on these community assets and provide a link between the resident and their community, making it easier for the goals set out in the resident's care plan to be realised.

An example of this approach is shown in this You-Tube Video.

4. Coordinated

Although our new model of care aims to deliver services through small self-directed teams of multi-skilled professionals, we recognise in the case of residents like Beryl, the sheer number of different services they may require make this challenging. However we must move from the current situation of multiple task oriented services working directly with Beryl and in isolation of each other, to a single coordinated approach.

Our New Model of Care will therefore have a **single named accountable 'case manager'** assigned to Beryl and every other resident with complex needs. They will act as **the single point of contact** for Beryl and her GP, and will coordinate the care activities of all other health and care professionals in order to deliver the single care plan agreed with the resident as part of the single holistic assessment process. The case manager will be **responsible for maintaining the single common comprehensive holistic assessment and single agreed care plan, that all care providers will work to.**

The case manager **will "broker" care from all other parts of health and care system** on behalf of the Beryl and will be responsible for keeping her single shared care plan up to date. This new care coordination approach will ensure that activity is not duplicated between different parts of the system, and that everyone involved in delivering Beryl's care is sighted on every other part of it.

The case manager will play an active part in surgery based multi-disciplinary teams

5. Proactive

Our new model of care fundamentally shifts the emphasis of care from being reactive to being proactive. Care delivery moves from individual organisations and professionals completed set tasks specified in advance to one of contributing to achieving the goals set out in a single shared care plan based on a single common holistic assessment which **aims to deliver *the best life possible* as defined by the resident**. This will be achieved by **professionals working as equal partners with the resident** and the wider assets within their community.

We will also deliver proactive care by effective case finding of residents most likely to benefit from this new approach. Too often the current system of care delivery waits until a resident is in crisis or suffers a serious health event and is admitted to hospital, before providing a service. For example, in 2015/16 the most common route of entry to services commissioned or provided by Thurrock Council Adult Social Care was through the Basildon Hospital Social Work Team, following a hospital admission.

By using our new Integrated Data Solution and linked patient/client records from MedeAnalytics (see page 39), we **will develop more effective risk stratisfaction tools that will allow us to identify the characteristics of specific cohorts of residents at greatest risk of adverse health events, and intervene earlier** with our new integrated model of care. We will work with each GP surgery in the Tilbury and Chadwell network to ensure a systematic process of 'case finding' of patients who could benefit from care coordination is implemented using reports produced by the Healthcare Public Health Team in MedeAnalytics. We will also ensure that every GP surgery is supported to have an **effective Multi-disciplinary team** that meets regularly to review patient cohorts deemed to be most at risk and who could most benefit from our new Model of Care.

Our new Integrated Locality Wellbeing Teams will also play a key role in identifying vulnerable residents within their locality or sub-locality as a further mechanism for effective, proactive case finding.

Page 89

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing (6/7)

Community Wellbeing Teams

In order to achieve our vision of the five pillars of care we will implement new sub-locality "wellbeing teams". Whilst the precise make up of these teams is beyond the scope of this document and will be determined by stakeholders in the Integrated Workforce work stream of the New Models of Care programme, as a minimum they will include a new "Wellbeing worker" role who will be trained to undertake the following:

- Replace the domiciliary care provider function and provide personal care to residents
- Undertake monitoring of clinical biomarkers and provide some routine healthcare procedures that a traditional healthcare assistant might currently deliver, for example undertake blood pressure monitoring, wound care, phlebotomy or urinalysis. In doing so, they will provide a key link between homecare and the GP surgery
- Be partly 'outward facing' and have a good understanding of the wider assets within the resident's community, and be responsible for linking the resident into these in order to deliver "a good life", promote self care and maximise opportunities for prevention.

In short, the new "Wellbeing Worker" will combine elements of the traditional domiciliary homecare worker, HCA and social prescriber/Local Area Coordinator.

We envisage wellbeing workers to be matched with residents depending on the needs and wishes of the resident as identified and captured in the single holistic assessment, with a view to developing a longer term one to one relationship with the resident. This will be both rewarding for the resident in terms of consistency of individual assisting them with daily living and for the wellbeing worker who will be able to use their individual skills, interests and talents to enrich the lives of a specific group of residents. The longer term consistent care relationship will also maximise opportunities for monitoring and prevention. The new "Wellbeing worker" role will also give greater status to traditional domiciliary care roles, provide opportunities for training and career development and as such, should result in a more sustainable and stable ASC homecare provision.

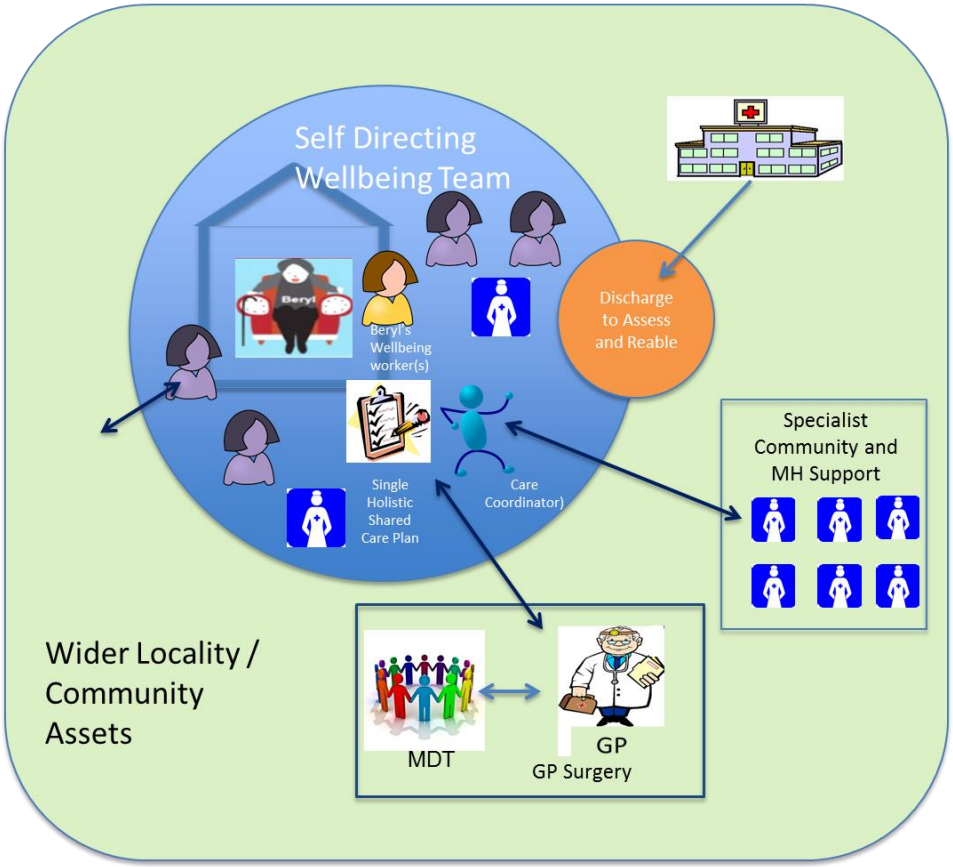
Community Wellbeing Teams may also include other community healthcare or GP surgery clinical team members, together with care coordinators. They will be absolutely critical members of future surgery based Multidisciplinary Teams. The Community Wellbeing Team, through the care coordinator will broker additional specialist clinical care from current providers where necessary to meet the resident's single shared care plan.

Community Wellbeing Teams will be sub-locality focussed and as self-directing as possible in order to maximise direct client contact time, minimise travel and gain the greatest possible understanding of the client in the context of his or her wider community. Evidence from similar models of self-directing teams e.g. Buurtzorg suggest that the team should be no-greater than 12 team members in size.

The Integrated Workforce work stream may also wish to consider adding additional functions into the wellbeing team or working alongside it, including a "discharge to assess" model, where patients are discharged back into the community and re-abled to their maximum ability before their long term single holistic assessment, single shared care plan and on-going community support it agreed.

This new model of care, may look something like figure 37

Figure 37



7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing (7/7)

Summary and Key Actions

Holistic and Person Centred

- We will assess all residents' needs once using a single, common, holistic assessment tool in partnership with the resident. The tool will consider and identify the physical, emotional, mental, functional, educational, economic, cultural, housing and self care needs of the resident, in the context of their wider family and community.
- We will develop a single, comprehensive shared care plan based on the assessment that all care providers will work to.

Personal

- We will rationalise the number of individuals providing care to the resident to the absolute minimum and up-skill the existing health and care workforce to deliver a wider range of health and care tasks.
- We will concentrate on having fewer people providing longer term care, and focus on developing consistent care relationships
- We will ensure that care is provided in a way that is flexible enough to change to meet the changing needs and wants of the resident on a day to day and week to week basis.

Localised

- We will create localised, self-directing community health and wellbeing teams at a sub-locality level to act as the primary interface between the resident and health and care services.
- We will create a new "Wellbeing Worker" role within these teams who will be responsible for providing traditional domiciliary home care, routine clinical monitoring and procedures traditionally undertaken by a Health Care Assistant, and providing a link between the resident and assets and capacity within his or her community
- We will develop a new relationship between commissioners and these teams, based on high level population health outcomes and the absolute minimum level of KPIs and administration

Coordinated

- We will introduce "care coordination" across all current providers of health and care, with a single named accountable professional responsible for brokering care for the resident from the current providers, as determined by their single comprehensive shared care plan, and acting as a single point of contact for the resident and their GP.
- We will ensure effective Multi-Disciplinary Teams operate within each GP surgery within the Tilbury and Chadwell network, and that all key professionals involved in the care of residents are in attendance.

Proactive

- We will shift the relationship between care provider and receiver from one that reacts to their current health status to one that empowers them to remain well and live the best life possible.
- We will implement proactive "case finding" mechanisms including use of risk stratification tools and systematic clinical and wellbeing worker judgement to identify residents at risk of adverse health events who would most benefit from care coordination, and intervene earlier

Chapter 8: *Making it happen*

Implementing and Evaluating our New Model of Care

8. Implementing and Evaluating our New Model of Care

8.1 Agreed Governance Structure

The Governance Structure shown in figure 38 has been agreed by all key stakeholders and has been set up.

A Thurrock Accountable Care Partnership Executive is meeting regularly and will be responsible for governance in terms finance, performance and future commissioning/provider contractual relationships across Thurrock. A Tilbury and Chadwell New Models of Care Steering Group will take over all responsibility for delivery of the New Model of Care as described within this document and will report to the ACP Executive Group. Terms of reference for this group are currently in development.

Below this, three working groups will be responsible for developing and delivering work programmes relating to the three key chapters in this document (5,6 and 7), and focusing on

- Improving and Enhancing the capacity and capability of Primary Care
- Improving the Diagnosis and Treatment of people with Long Term Conditions (*Find the missing thousands, treat the missing hundreds)*
- Delivering Proactive, Integrated Community Health and Wellbeing

The role of each working group will be to convert the high level "key actions" set out in each chapter into a detailed action plan, and then manage the implementation of that plan, transforming care in Tilbury and Chadwell around the three key topics set out in each chapter. Progress against these action plans will be monitored at the Tilbury and Chadwell Project Steering Group and ultimately the Thurrock ACP Executive

8.2 Evaluating Impact of the New Model of Care

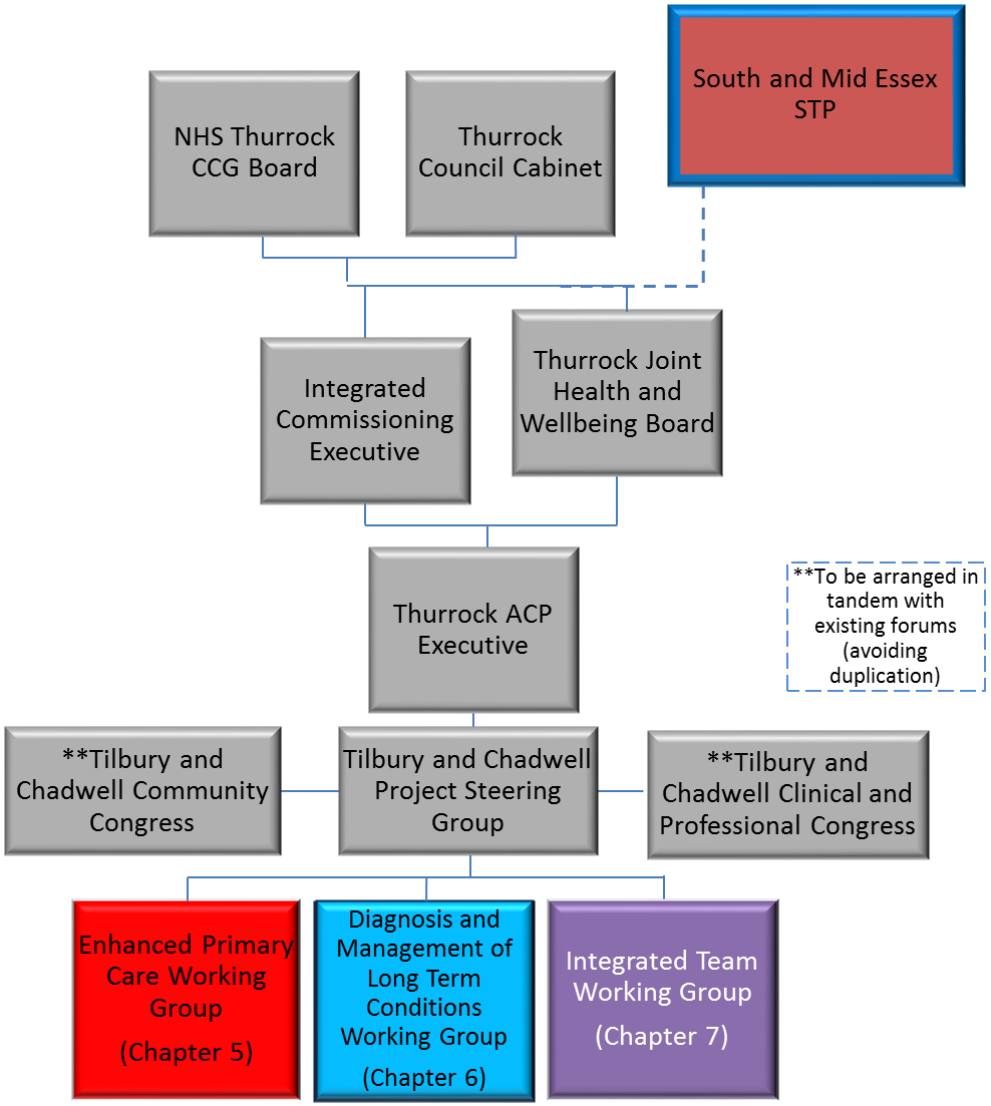
The key purpose of piloting the New Model of Care in Tilbury and Chadwell is to demonstrate "proof of concept", with a view to replicating it across Thurrock (and beyond) if shown to be successful. As such, building robust evaluation into the programme of work both in terms of an initial baseline of health and care activity and outcomes, and the impact of the work programme on that activity and outcomes will be key.

Overall responsibility for evaluation will rest with Thurrock Healthcare Public Health Team, with additional support provided through the Consultant in Public Health from Public Health England (East of England). However agreeing what indicators will be base-lined and measured needs to be one of the first tasks undertaken by each of the three working groups. By implementing the key actions set out in this document, we expect the New Model of Care to demonstrate sustainability in terms of reduced activity and cost in secondary health care (for example through reduced hospital admissions and A&E attendances) and in Adult Social Care (for example through reduced numbers of residents entering residential care). It is therefore essential that activity and cost in the cohorts of residents impacted by the New Model of Care are base-lined and monitored in detail.

We will produce an evaluation framework for the New Model of Care by December 2017 which lists all indicators agreed by the three working groups, together with agreed levels of investment required to implement the key actions, and expected impacts in terms of population health and financial return.

Agreed Governance Structure

Figure 38



8.3 Summary of Key Actions for each working group

The follow sections summarise the proposed key actions for each of the three working groups, as set out in Chapters 5,6 and 7 together with work to date on their potential impacts both in terms of population health and system sustainability. They have been produced as a starting point from which each working group can develop a more detailed action plan and evaluation framework.

8.3.1 Enhance the capacity and capability of Primary Care

Key Action	Investment Required	Investment Source	Impact	Lead(s)
Recruit a mixed skill workforce within a shared Enhanced Primary Care Team in Tilbury and Chadwell including practice based Pharmacists, Physio-therapists, Physicians Assistants, Wellbeing Workers, Nurse Practitioners and social prescribers	£620,552	From "£3 per head" GP Transformation funding	An additional 1495 surgery appointments per week Potential of up to £500K savings from A&E Category 1 and 2 tarrif if increase in Primary Care appointments mitigates against A&E use for non-emergency clinical conditions	GP Partners Area Operations Manager, College Health Ltd, Head of Primary Care, Thurrock CCG
Roll out social prescribing at scale across all GP practices in Tilbury and Chadwell and evaluate impact	£140,000	Better Care Fund	Contributes to the above	Director of Transformation, Thurrock CCG GP Partners Thurrock CVS
Strengthen links between GP surgeries and services that address the wider determinants of health such as housing, debt and employment advise			Contributes to the above	Healthcare Public Health Improvement Managers Relevant Provider service leads
Design and implement a shared "front door" patient triage programme that assess patient need and directs them to the most appropriate member of the Enhanced Primary Care Team without necessarily having to see a GP first		From existing resources	Contributes to the above	GP Partners Area Operations Manager, College Health Head of Primary Care, Thurrock CCG
Implement WebGP		Existing external grant	Contributes to the above	GP Partners Area Operations Manager, College Health Director of Transformation, Thurrock CCG
Implement a new network based model of Primary Care in Tilbury and Chadwell, including shared 'back office' functions, in order to build surgery resilience and realise the benefits to both workforce and residents of delivering Primary Care 'at scale'		From existing resources	Increased surgery resilience Improved economies of scale Systems Partnership working Improved clinical skill mix Improved opportunities for staff development	GP Partners Area Operations Manager, College Health Primary Care Development Team, Thurrock CCG Director of Transformation, Thurrock CCG
Strengthen and develop Patient Participation Groups	£40,000	Public Health Grant		Thurrock Healthwatch Healthcare Public Health Team
Embed Healthy Lifestyle Service workers within shared Enhanced Primary Care Team and ensure systematic offer of smoking cessation service to all patients recorded as smokers	£100,000	Public Health Grant	Reduced prevalence of smoking within population. Increased number of smoking quit attempts	Consultant in Public Health GP Partners Area Operations Manager College Health LTd
Embed Healthy Lifestyle Programmes into Clinical Care Pathways in Community and Secondary Care			Reduced prevalence of smoking within population. Increased number of smoking quit attempts	Consultant in Public Health

8.3 Summary of Key Actions for each working group

8.3.2 Improve the diagnosis and management of long term conditions

Key Action	Investment Required	Investment Source	Impact	Lead(s)
Target NHS Health check invitations to those most likely to be at risk of undiagnosed cardio-vascular disease, through development of SystmOne reports that make use of the QRISK2 algorithm	£39,000	Public Health Grant	An additional 94, 40 and 22 Hypertension, CHD and Diabetes diagnoses respectively Reduction in stroke unplanned care admissions and ASC packages attributable to stroke £650K NHS treatment and ASC costs avoided over three years	Healthcare Public Health Team
Improve the coverage of NHS Health checks through use of social marketing research and tailored invitation letters	As above	Public Health Grant	As above	Consultant in Public Health Healthcare Public Health Managers
Implement a systematic Hypertension Case Finding Programme	£138,000	Public Health Grant Better Care Fund	£1.846M through reduction in Healthcare and ASC costs attributable to stroke	Healthcare Public Health Team
Develop SystmOne reports that highlight patients with long term physical health conditions who have not been screened for depression			Potential up to £3.5M	Healthcare Public Health Team in collaboration with Southend Public Health Team
Embed depression screening into the work of front line staff treating patients with long term conditions and adult social care staff				Healthcare Public Health Team
	£10,000	Public Health Grant	An additional 10 diagnoses of diabetes. Net saving of £26,000 in avoided treatment costs from diabetes complications	Healthcare Public Health Team Local dental practices
Procure and implement the MedeAnalytics Integrated Data Solution, linking Primary, Community, Mental Health, Secondary Care and Adult Social Care records at patient/client level	£110,000	Better Care Fund		Strategic Lead, Healthcare Public Health
Assist surgeries to "find the missing thousands" by constructing and running automated reports through MedeAnalytics/SystmOne that identify patients who have risk factors or are on medication for specific long term conditions but have not been added the surgery's Long Term Condition Disease Register	As above	As above	Increase in undiagnosed hypertension, CHD, AF, HF, TIA and diabetes. Unable to quantify precisely	Healthcare Public Health Team GP Practice Managers GP Partners

8.3.2 Improve the diagnosis and management of long term conditions (continued)

Key Action	Investment Required	Investment Source	Impact	Lead(s)
Implement a Stretched QOF programme for all surgeries in Tilbury and Chadwell on Long Term Conditions Indicators to ensure funding is available for practices to treat 100% of patients on QOF disease registers	£64,770	Better Care Fund	Up to 110 stokes prevented over three years £554,195 NHS Treatment savings £565,191 ASC savings	Strategic Lead, Healthcare Public Health GP Practice Managers GP Partners
Improve the coverage of flu vaccination in at risk groups	£4,000	Better Care Fund	Up to 94 hospital treatment spells related to influenza Up to £330,553 NHS Treatment cost savings	Healthcare Public Health Team GP Practice Clinical Team GP Practice Managers
Identify patients who need to be reviewed under QOF for long term conditions and reduce exception reporting through use of the new Integrated Data Solution (MedeAnalytics)	Existing staff resources		Improved surgery capability to manage patients with existing LTCs	Healthcare Public Health Team GP Practice Managers GP Partners NELFT LTC Clinical Services
Develop a systematic centralised patient call-recall mechanism that automates and manages appointments for patients requiring LTC review	Existing staff resources		Improved surgery capability to manage patients with existing LTCs	Healthcare Public Health Team GP Practice Managers NELFT LTC Clinical Services
Roll out the LTC profile card to support practice managers and the Enhanced Surgery Clinical Teams to develop and implement action plans to improve clinical quality and patient satisfaction relating to LTC management	Existing staff resources	Public Health Grant	Improved surgery capability to manage patients with existing LTCs	Healthcare Public Health Team Surgery Clinical and Practice Management Team
Integrated the current disease specific physical LTC clinics into a single integrated LTC management service based within the shared Enhanced Primary Care Clinical Team, in order to strengthen arrangements between Primary and Community Health Care and Provide a Single one-stop LTC management service for patients	Existing staff resources plus £100K for additional LTC nursing support	Public Health Grant	Improved surgery capability to manage patients with existing LTCs Reduced numbers of serious health events including strokes, COPD exacerbations Reduced numbers of unplanned care admissions and demand on secondary healthcare and adult social care services	Healthcare Public Health Team Surgery clinical teams GP Practice Managers NELFT LTC Clinical Services
Integrate IAPT service provision within the Enhanced Primary Care clinical team to increase the number of patients with depression and anxiety entering treatment and to provide a single integrated service that can treat physical and mental ill health	Existing staff resources		Improved surgery capability to manage patients with existing LTCs Reduced numbers of serious health events including strokes, COPD exacerbations Reduced numbers of unplanned care admissions and demand on secondary healthcare and adult social care services	Healthcare Public Health Team Surgery clinical teams GP Practice Managers NELFT LTC Clinical Services IAPT

8.3.3 Proactive, Integrated Community Health and Wellbeing

Page 54 summarises the key actions of this work stream, based upon the proposed "five pillars of care".

It is difficult to quantify the impact in terms of activity and cost accurately of this integrated care coordination approach, but best evidence suggests it can reduce health and care costs by at least 20%. If this were realised in Tilbury and Chadwell it would represent a potential saving of £1.34M in healthcare costs alone.

References

[1] Baird, B. et. al. Understanding pressures in general practice. Kings Fund. May 2016

[2] Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015

3 Understanding Pressures in General Practice. Kings Fund, 2015

[4] Session 3328: "Loneliness: A Growing Public Health Threat," Plenary, Saturday, Aug. 5, 3-3:50 p.m. EDT, Room 151A, Street Level, Walter E. Washington Convention Center, 801 Mount Vernon Pl., Washington, D.C.

[5] Marmot M et. al., *Fair Society, Healthy Lives. The Marmot Review.* 2012. Strategic Review of Health Inequalities in England post 2010.

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[8.] NICE (2012) Type 2 diabetes: prevention in people at high risk Public Health Guideline (PH38) https://www.nice.org.uk/guidance/ph38

[9]. European Federation of Periodontology (2012) The EFP Manifesto: Perio and General Health http://www.efp.org/efp-manifesto/manifesto.html

[10.] Chapple et al (2013) Diabetes and periodontal diseases: consensus report of the Joint EFP/AAP Workshop on Periodontitis and Systemic Diseases J Clinical Perio. https://www.ncbi.nlm.nih.gov/pubmed/23631572

The Case for Change: A New Model of Care for Tilbury and Chadwell

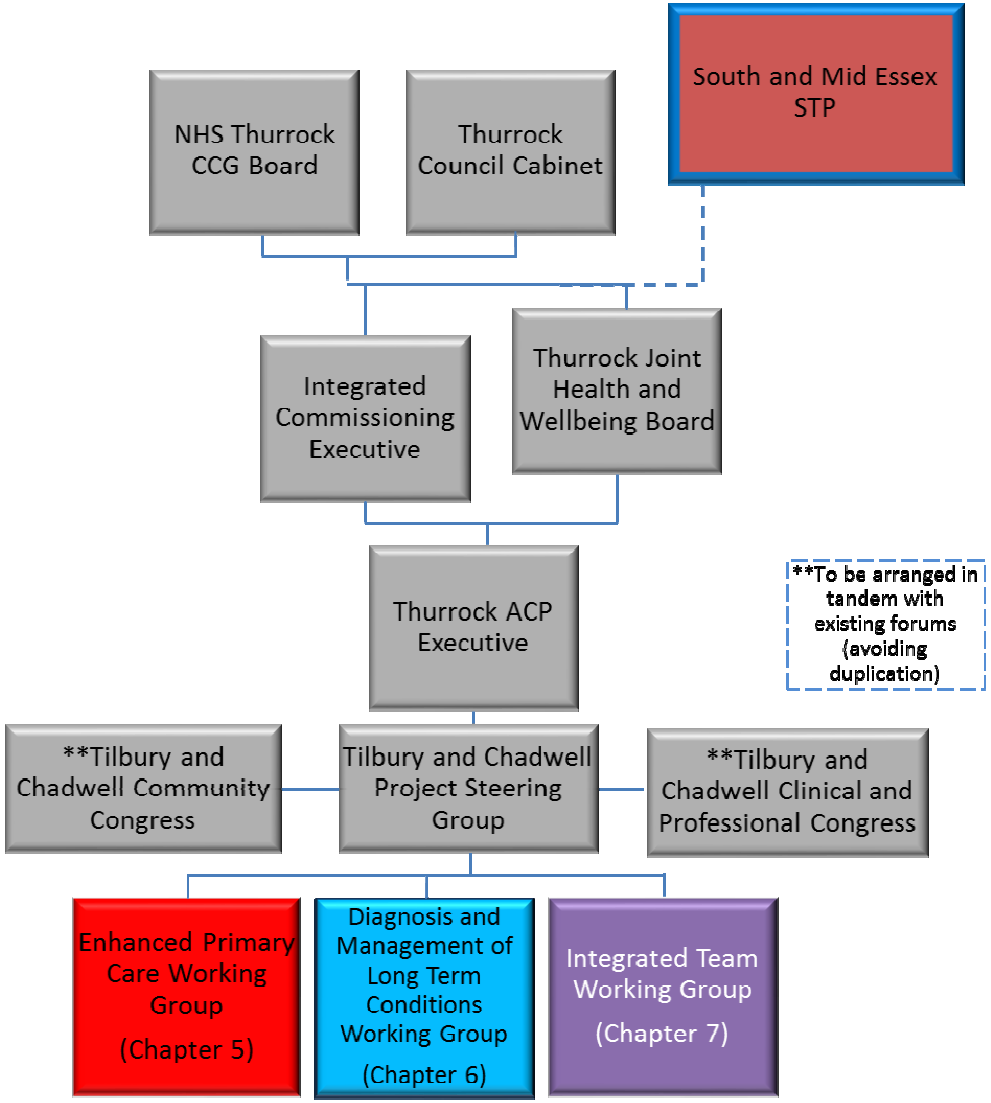
Ian Wake
Director of Public Health

September 2017

Chapter 8: *Making it happen*

Implementing and Evaluating our New Model of Care

Making it Happen: Governance

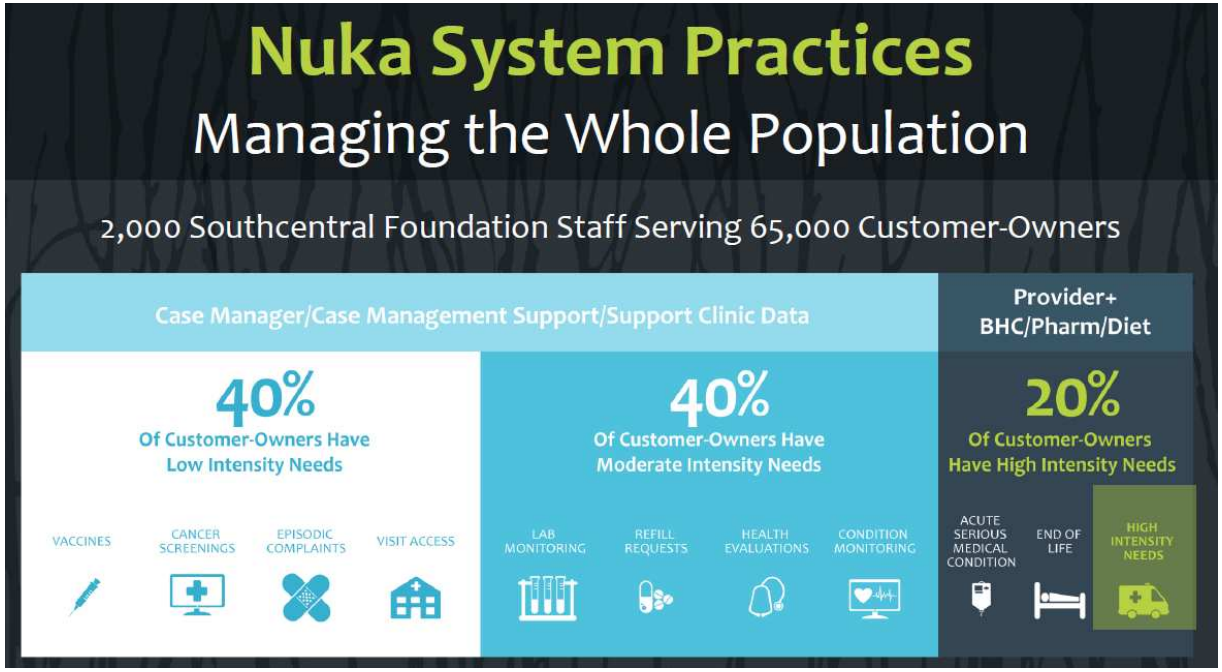


- Implementation Planning
- Evaluation
- Commissioning Arrangements

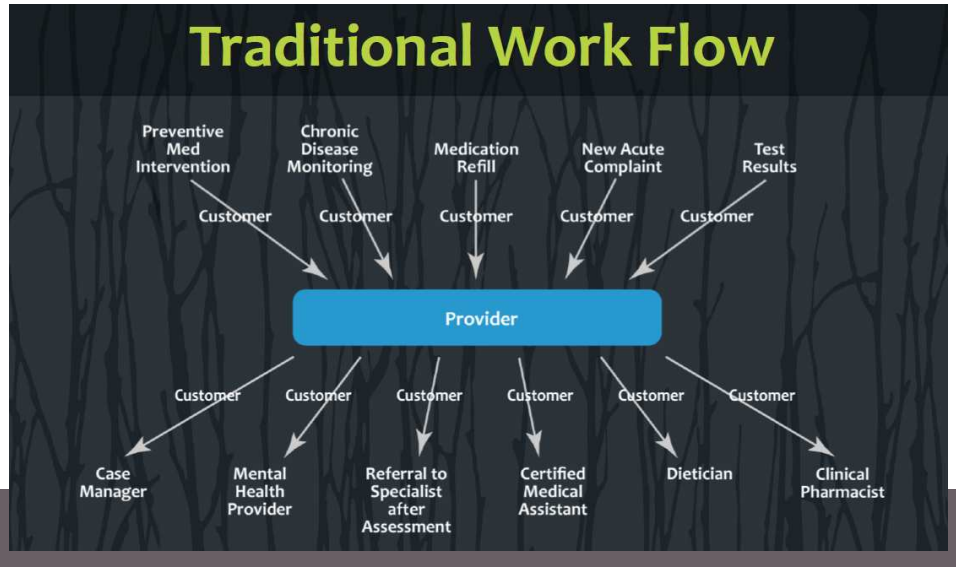
Don’t waste patients’ time. Delivery of seamless services should be the number one priority

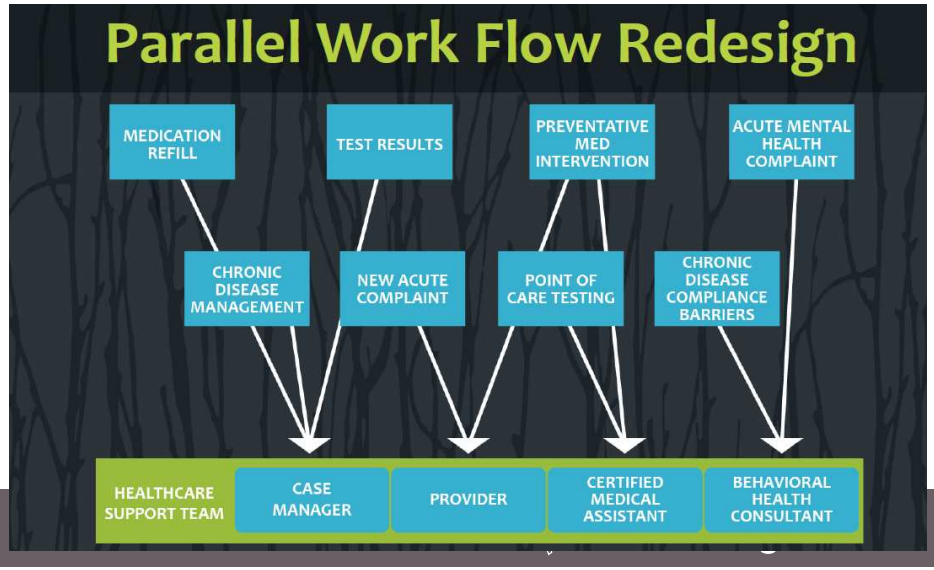
Segment the population, segment the offer

Acute Care		Generally well		Long term conditions		Complexity of LTC(s) and/or disability	
		Low risk	High risk	Low risk	High risk	Low risk	High risk
Children and Young People	• Neonates • Infants • Toddlers • Children • Adolescents						
Working Age Adults	• Young • Middle aged • Older working age	**Acute Team** Nurse Practitioner Paramedic GP			**Continuous Care Team** GP Pharmacist		**Multi-Agency Team** Specialist Case Management
Older People	• 65-80 • 80-90 • 90+						



- Mixed skill workforce
- Remove the queues
- Trust and empower the patient
- 96% customer satisfaction: create patient advocates
- 36% ER visit reduction





Trust the front line clinicians

- Empower and trust the Primary and Community Care clinicians to re-design the system

- Give General Practice the tools and the facilities closer to home to intervene to stop patients requiring hospital
  - Rapid diagnostics
  - Integrated acute nursing
  - Step up observational beds
  - Access to patient transport

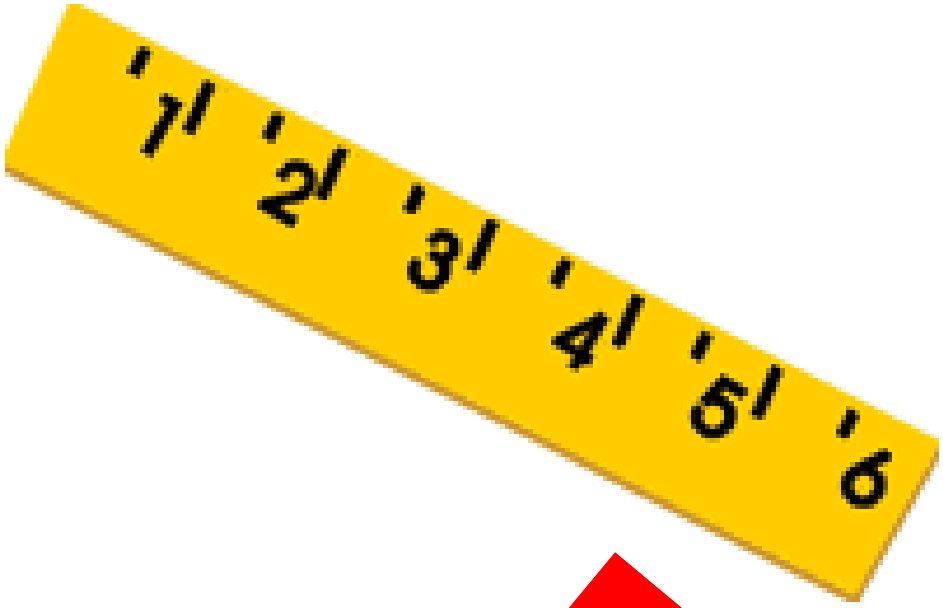
- Invest in Organisational Development around system's thinking
  - Hierarchy → Multi-disciplinary teams and shared decision making
  - High levels of communication and patient empathy
  - Bio-medical → holistic

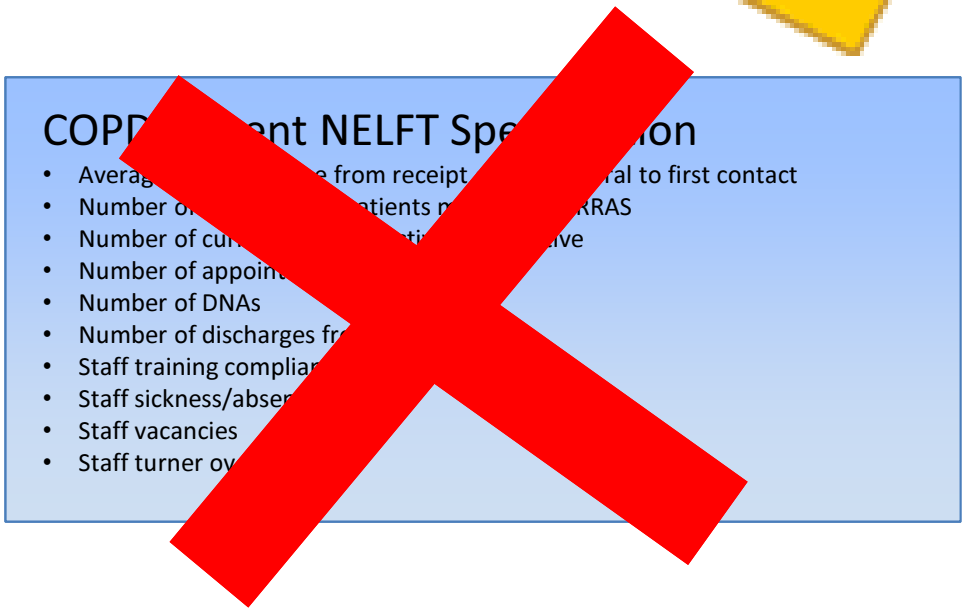
- Can't rush relationships.

- Relationships between Primary and Secondary Care

- Clear bureaucracy out of the way

Agree what matters. Measure what matters





- **Stop focussing on task outputs and start focussing on population outcomes and quality**
- Bonfire of current KPIs; "Taylorism"
  - COPD A&E attendances or bed days per 1000 expected prevalence of COPD
  - ED attendances per 1000 aged 65+
  - Fracture neck of femur per 65+
- Radical change in commissioner-provider relationship
- Patient voice
- Shared system vision
- Single, shared finance and governance arrangements aligned to single shared system population outcomes

- Fundamental reform of the system
- Agreed vision, aims and goals across the system
- Create a sense of urgency
- Senior executive buy in and air cover
- Aligned commissioning and governance arrangements at system level

“You can’t leap a chasm one step at a time”

- David Lloyd George

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14 November 2017	ITEM: 8
Health and Wellbeing Board	
Thurrock Health and Wellbeing Strategy Outcome Framework	
Wards and communities affected: All	**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 of Adults Housing and Health	
This report is Public	

Executive Summary

This report provides the Board with an update on the outcomes framework key performance indicators and provides members with an opportunity to review:

- The introduction of new indicators that have been proposed to measure progress against Strategy goals and objectives;
- The review of existing key performance indicators to ensure that they remain fit for purpose; and
- Progress made in achieving outcomes, where data is available.

1. Recommendation(s)

1.1 That the Board:

- **Agree proposed revisions to key performance indicators within the Outcomes Framework;**
- **Notes progress being made in achieving outcomes, where data is available;**
- **Agree that receive an annual update on the performance indicators alongside the annual report**

2. Introduction and Background

2.1 Thurrock's Health and Wellbeing Strategy has five goals with each of the goals supported by four objectives:

Goals	Objectives
1. Opportunity for All	1A. All children in Thurrock making good educational progress 1B. More Thurrock residents in employment, education or training 1C. Fewer teenage pregnancies in Thurrock 1D. Fewer children and adults in poverty
2. Healthier Environments	2A. Create outdoor places that make it easy to exercise and be active 2B. Develop homes that keep people well and independent 2C. Building strong well-connected communities 2D. Improve air quality in Thurrock
3. Better Emotional Health and Wellbeing	3A. Give parents the support they need 3B. Improve children's emotional health and wellbeing 3C. Reduce social isolation and loneliness 3D. Improve the identification and treatment of mental ill-health, particularly in high-risk groups (amendment agreed by the HWB July 2017)
4. Quality Care Centred Around the Person	4A. Create four integrated healthy living centres 4B. When services are required, they are organised around the individual 4C. Put people in control of their own care 4D. Provide high quality GP and hospital care to Thurrock
5. Healthier for Longer	5A. Reduce obesity 5B. Reduce the proportion of people who smoke 5C. Significantly improve the identification and management of long-term conditions 5D. Prevent and treat cancer better

2.2 Each of the Health and Wellbeing Strategy's objectives are supported by an action plan containing the key actions needed to achieve Strategy outcomes. Key performance indicators included within the Outcomes Framework provides members of the Board with a means of measuring the impact of the Strategy.

2.3 Key activities and achievements for the first year of the Health and Wellbeing Strategy have been set out in the annual report. This report provides Board members with an update on progress being made against specific key performance indicators, where data is available.

3. Issues, Options and Analysis of Options

3.1 The Health and Wellbeing Strategy Outcomes Framework is attached at Appendix 2. The Framework includes:

- Key performance indicators to support each objective;
- A baseline figure (where available);
- Annual trajectory targets; and
- A target for 2021 (where available).

3.2 Detailed information on proposed revisions to Outcomes Framework Key Performance Indicators is provided at Appendix 1 for the Board's consideration.

3.3 Health and Wellbeing Board members will be provided with opportunities to consider, inform and monitor progress on action being taken to achieve Health and Wellbeing Strategy Outcomes throughout the municipal year. In addition and as part of providing comprehensive and robust governance arrangements for monitoring progress with achieving improved health and wellbeing outcomes it has been recommended that the Board agrees to annual updates on the outcomes framework and key performance indicators, alongside the annual report.

4. Reasons for Recommendation

4.1 Recommendations to create new key performance indicators and to revise existing indicators will help to ensure that they remain fit for purpose and a means of measuring the impact of the health and wellbeing strategy on health and wellbeing in Thurrock.

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

5.1 Action plan lead officials comprising Council officers and key partner representatives have been engaged to inform and agree proposals set out in this report.

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

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

7. Implications

7.1 **Financial**

Implications verified by: **Roger Harris**
Corporate Director Adult Housing and Health

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: **Roger Harris**
Corporate Director Adult Housing and Health

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: **Roger Harris**
Corporate Director Adult Housing and Health

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

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

None.

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

- None.

9. Appendices to the report

- Appendix 1 – Updates on progress with achieving outcomes and proposals to revise Outcome Framework Key Performance Indicators
- Appendix 2 –Health and Wellbeing Strategy Outcomes Framework that provides Board members with proposed baselines, overarching targets and annual trajectory targets.

Report Author:
Darren Kristiansen
Business Manager, Health and Wellbeing Board, Adults, Housing and Health

Progress reports and proposed revisions to the outcome framework

1. This appendix sets out progress reports made against key performance indicators and proposed revisions to indicators that support the effective monitoring of outcomes achieved.

Goal 1 Opportunity for All

Objective 1A All children in Thurrock making good educational progress (Roger Edwardson)

Existing key performance indicators and proposed amendments

- EYFS Attainment - % of children achieving a Good Level of Development (GLD) at the end of Early Years Foundation Stage.
- KS2 Attainment – % Achieving the National Standard in Reading, Writing & Maths.
- EYFS Attainment - Percentage point gap between pupil premium children achieving GLD and others at end of Early Years Foundation Stage.
- % of children achieving 5 good GCSEs at A*-C including English and Maths
  It is proposed that this indicator will be replaced with (i) % of children achieving combined level 4 in English and Maths at GCSE (ii) Improvements in new progress 8 scores. This revision reflects national changes to this key performance indicator.

Progress reports for specific key performance indicators

- 76% of children are achieving a good level of development at the end of the Early Years Foundation Stage, exceeding the trajectory target of 73% and the national average of 71%.
- 61% of children are achieving the national standard in Reading, Writing and Maths, exceeding the trajectory target of 57%, consistent with the national average of 61%.
- EYFS Attainment - Percentage point gap between pupil premium children achieving GLD and others at end of Early Years Foundation Stage. Achieved 17 percentage points gap not meeting 2017 trajectory target of 11.76%. However, members may wish to note that the national average is 18%.

- New indicator subject to HWB approval. % of children achieving combined level 4 in English and Maths at GCSE
- New indicator subject to HWB approval .Improvements in new progress 8 scores

Objective 1B More Thurrock residents in employment, education and training (Michele Lucas)

Existing key performance indicators and proposed amendments

- % of the population of working age claiming Employment Support Allowance and incapacity benefits.
  It is proposed that this indicator is replaced with % of population claiming Universal Credit. This reflects national changes to the benefit system.

- % of the population of working age claiming JSA
- % of working age population who are economically active
  It is proposed that these two indicators are deleted and replaced by the new indicator %of population claiming Universal Credit.

- % of 16 – 19 year olds not in Employment, Education or Training.
  It is proposed that this indicator is amended to % of 16/17 year olds not in employment, education or training. This will reflect changes made by Government on the reporting framework.

Progress reports for specific key performance indicators

- 3.8% of 16/17 year olds are not in employment, education or training, achieving the trajectory target of 5%. Board members will wish to note that this data is based on 16/17 year olds and therefore considerably exceeds the trajectory target that was set for 16-19 year olds.

- New indicator subject to HWB approval. % of population claiming Universal Credit. Baselines, trajectory targets and the overall target for 2021 is currently being established.

Objective 1C Fewer teenage pregnancies in Thurrock (Sareena Gill)

Existing key performance indicators and proposed amendments

- Under 18 conception rate per 1,000 people

- A Key Performance Indicator is proposed that measures the number of teenage parents that are supported through a multi-agency approach. This will reflect a new service being developed by NELFT as part of Brighter Futures.

Progress reports for specific key performance indicators

- The under 18 conception rate of 24.5 people per 1000 people trajectory target has been achieved.

Objective 1D Fewer children and adults in poverty (Michele Lucas)

Existing key performance indicators and proposed amendments

- % of children in poverty (all dependent children).
- Number of homeless households supported by Thurrock Council.
- Number of places given out for the 2 year old offer.
  It is proposed that this indicator is deleted. This is because free places that are offered to 2 year olds do not necessarily help to identify children and adults in poverty.

- A new key performance indicator is proposed to increase in number of Housing of Multiple Occupancy for young people across Thurrock. Increasing HMOs for young people will help to reduce poverty by helping to ensure young people can be housed in Thurrock. This indicator will be subject to decisions taken at HOSC about creating HMOs for young people.

Progress reports for specific key performance indicators

- Data has not been made available to report progress against the Key Performance Indicators for this objective.
  - % of children in poverty (all dependent children).
  - Number of homeless households supported by Thurrock Council.

- New indicator subject to HWB approval. The number of Housing of Multiple Occupancy for young people across Thurrock.

Goal 2 Healthier Environments

Objective 2A Create outdoor spaces that make it easier to exercise and to be active (Grant Greatrex, Andy Millard, Robert Cotter, Kirsty Paul)

Proposed revision to the objective

- It is proposed that the word outdoor is removed from the objective so that it becomes create places that make it easier to exercise and be active. This will facilitate action being taken on improving leisure facilities across Thurrock can be captured and reported upon.

Existing key performance indicators and proposed amendments

- % of physically active adults
- % of physically active children
- % of new developments that conform to the minimum Design Standards as produced by the Council's Planning Team
  It is proposed that this indicator is deleted. This is because there is not currently a mechanism in place to record or evaluate the % of new developments that conform to the minimum design standards as produced by the Council's Planning Team indicator. To establish and report against this indicator a way to record and assess it would need to be determined and would be several months in the making. Following this, a 6 or 12-month recording and assessment period would be required to enable accurate statistical reporting.

- A new key performance indicator is proposed to report progress on the number of parks and play sites with improved quality and value.
- A new key performance indicator is proposed to report residents satisfaction with sports and Leisure facilities.
- A new key performance indicator is proposed to measure the proportion of residents who think that the Council make it easy to exercise in parks and open spaces

Progress reports for specific key performance indicators

- % of physically active adults. It should be noted that the way this indicator has been measured has changed – from 16+ to 19+
- % of physically active children. We are in the process of considering whether data will be available to measure this KPI

Objective 2B Develop homes that keep people well and independent (Keith Andrews, Kirsty Paul, Robert Cotter)

Existing key performance indicators and proposed amendments

- % of all major planning applications that have been assessed by the Health and Wellbeing Housing and Planning Advisory Group.
  It is proposed that this indicator is removed. This is because the existing indicator % of all major housing developments that have an approved Health Impact Assessment (provided below and currently being revised), will help ensure housing developments have been subject to a Health Impact Assessment.
- % of all major housing development ts that have an approved Health Impact Assessment.
- A new key performance indicator proposed to measure the number of right size schemes developed in Thurrock, reflecting a key action included within the action plan.
- A new key performance indicator to measure the number of people who are supported by the Housing First Scheme, reflecting a key action included in the action plan.

Progress reports for specific key performance indicators

- % of all major housing developments that have an approved Health Impact Assessment. Data has not been made available to report progress to the Board.

- New indicator proposed. The number of right size schemes developed in Thurrock. Data will be available from 31 March 2018 to report progress
- New indicator proposed. The number of people who are supported by the Housing First Scheme. Data will be available to report progress will be available from 31 March 2018.

Objective 2C Build strong, well connected communities (Les Billingham, Kristina Jackson)

Existing key performance indicators and proposed amendments

- Number of micro-enterprises operating in the area.
- Number of weekly hours of volunteering time.
  It is proposed that the number of weekly hours volunteering time is amended to the number of annual hours of volunteering time in Thurrock. This reflects that data is collected on an annual basis. It is also proposed that source data is amended from the State of the Sector Survey to the Voluntary Sector Development Fund reporting mechanism. This is because the data will be more consistently reliable

- Estimated Dementia Diagnosis Rate for people aged 65+
- % of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months.
  It is proposed that the two indicators above are removed as they do not measure 'build strong, well connected communities' and are not an effective measure of impact or outcome.

- A new key performance indicator is proposed for the number of businesses across Thurrock that facilitates volunteering for staff. This indicator will enable the monitoring of local businesses that support volunteering within the workplace. The data source would be Thurrock CVS.

Progress reports for specific key performance indicators

- The number of micro enterprises operating in Thurrock is 55, exceeding the trajectory target of 25.
- The number of weekly hours of volunteering time trajectory target of 769 hours per week has been exceeded with number of volunteering hours per week currently standing at 6,838 hours.
- New indicator. The number of businesses across Thurrock that facilitates volunteering for staff. Consideration is currently being provided to how to develop baselines, trajectory targets and the overall target for 2021. This will be progressed further if the HWB is minded to agree to its development.

Objective 2D Improve air quality in Thurrock (Ann Osola, Fred Raphael)

Existing key performance indicators and proposed amendments

- Number of AQMAs declared in Thurrock.

Progress reports for specific key performance indicators

- Data has not been provided to report progress.

Goal 3 Better emotional health and wellbeing

Objective 3A Give parents the support they need (Sue Green)

Existing key performance indicators and proposed amendments

- % of parents achieving successful outcomes from early intervention prevention parenting programmes.
- Number of families known to Troubled Families Service
- Increasing the proportion of children who achieve a 'Good Level of Development'1 (GLD is at 75% in 2016) and reducing the gap between the most and least deprived groups by supporting child development and school readiness

Progress reports for specific key performance indicators

- % of parents achieving successful outcomes from early intervention prevention parenting programmes. Data will be available to report trajectory target progress in March 2018.
- Number of families known to Troubled Families Service. As of October 2017 there are 613 families known to the troubled family service, exceeding the trajectory target of 567.
- Increasing the proportion of children who achieve a 'Good Level of Development'1 (GLD is at 75% in 2016) and reducing the gap between the most and least deprived groups by supporting child development and school readiness. Data of September 2017 shows that the trajectory target of 76% has been achieved.

Objective 3B Improve children's emotional health and wellbeing (Malcolm Taylor, Helen Farmer)

Existing key performance indicators and proposed amendments

- % of children and young people reporting that they are able to cope with the emotional difficulties they experience.
- % of children and young people reporting that they know how to seek help when experiencing difficulties with emotional health and wellbeing.
- % of children reporting being bullied in the last 12 months.

Progress reports for specific key performance indicators

- A school survey has been undertaken which captures data about children's mental health. The survey is currently being finalised. Public Health will use the results of the survey to inform the development of baselines, annual trajectory targets and an overall target for 2021 for each of the KPIs set out above.

Objective 3C Reduce social isolation and loneliness (Les Billingham)

Existing key performance indicators and proposed amendments

- Number of people who are supported by a Local Area Coordinator
- % of people whose self-reported wellbeing happiness score is low
- The directly standardised average health status (EQ-5D) for individuals reporting that they are carers
  It is proposed that the indicator 'the directly standardised average health status (EQ-5D) for individuals reporting that they are carers' is removed as it does not help to monitor the objective 'reduce social isolation and loneliness'

- A new key performance indicator is proposed that focuses on the proportion of carers who reported that they had as much social connection as they would like. This indicator reflects nationally collected data through the personal and social services survey of adult carers (SAC).
- Officials are currently considering the development of a new key performance indicator that measures on the amount of people living in sheltered accommodation that are supported through assistive technology. This indicator would measure the number of people who are being supported to remain in their own home.

Progress reports for specific key performance indicators

- The number of people who are supported by a Local Area Coordinator is 841 exceeding the trajectory target of 576.
- % of people whose self-reported wellbeing happiness score is low. Latest available data for 2015/16 has a value of 9.3%, demonstrating that the 2017 trajectory target of 10.16% has been exceeded
- The directly standardised average health status (EQ-5D) for individuals reporting that they are carers is currently 0.78, not achieving the 2017 trajectory target of 0.799 but consistent with the national average at 0.80.

Objective 3D Improve the identification and treatment of mental ill-health, particularly in high risk groups (Funmi Worrell replacement to be identified by Public Health, Catherine Wilson, Mark Tebbs, Maria Payne for data purposes)

Existing key performance indicators and proposed amendments

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

  With the development of the Southend, Essex and Thurrock Mental Health Strategy and the Mental Health JSNA, some time is spent reviewing what indicators are used to measure the impact of the strategy in improving the identification and treatment of mental ill-health. This will be reported back to the Board when the Mental Health Strategy and JSNA are reported.

Progress reports for specific key performance indicators

- 16.6% of people are entering IAPT as a % of those estimated to have anxiety / depression. Not achieving the 2017 trajectory target of 17%.
- 50.8% of people have completed IAPT treatment who are "moving to recovery", exceeding the trajectory target of 41%.
- A progress report has not been provided on the % of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool.
- A progress report has not provided on the % of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff.

Goal 4 Quality care centred around the person

Objective 4A Create four integrated healthy living centres (Rahul Chaudhari)

Proposed revision to the objective

- It is proposed that the objective is amended to create four integrated medical centres to reflects the name change of the centres

Existing key performance indicators and proposed amendments

- Identify localities for IMCs
- New key performance indicators are proposed to measure progress made with creating four integrated medical centres include:
  - Developing the business case for Integrated Medical Centres in 2018
  - Number of Integrated Medical Centres that are operational

Progress reports for specific key performance indicators

- Four localities have been identified for Integrated Medical Centres, achieving the key performance indicator of identifying all four localities in 2017.

Objective 4B When services are required they are organised around the individual (Mark Tebbs)

Existing key performance indicators and proposed amendments

- % of the 2% highest risk frail elderly in Thurrock with a care plan and named accountable professional.
- Establish a data system linking records from primary, secondary, community, mental health and adult social care
- % of Early Offer of Help episodes completed within 6 months.

Progress reports for specific key performance indicators

- % of the 2% highest risk frail elderly in Thurrock with a care plan and named accountable professional.
- Data not provided to report progress with establishing a data system linking records from primary, secondary, community, mental health and adult social care

- Data not provided to report progress on the % of Early Offer of Help episodes completed within 6 months.

Objective 4C Put people in control of their own care (Catherine Wilson, Wassim Fattahi-Negro for data)

Existing key performance indicators and proposed amendments

- % of people receiving self-directed support.
- % of people who have control over their daily life.

Progress reports for specific key performance indicators

- 74% of people have reported receiving self-directed support. The Board will wish to note that the figures provided are year to date figures. The end of year (31 March 18) projection shows that we are on target to meet or perhaps exceed the trajectory target of 76.24%.
- Data is not currently available to report progress on the % of people have reported having control over their daily life

Objective 4D Provide high quality hospital and GP care to Thurrock (Rahul Chaudhari)

Existing key performance indicators and proposed amendments

- % of GP practices with a CQC rating of at least "good".
- % of GP practices with a CQC rating of at least "requires improvement".
  It is proposed that that the 'requires improvement' KPI is deleted. This is because there is already an indicator measuring the % of GP practices with a CQC rating of at least good.
- % of patients who had a good experience of GP services.
- % of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge.
- Overall CQC Rating – BTUH retain good rating.
- Overall CQC Rating – SEPT retain good overall rating.
- Overall CQC Rating – NELFT achieve a good or working towards good assessment rating.
- Overall CQC Rating - East of England Ambulance Service achieve a good or working towards good assessment rating.

- The number of GPs per 1,000 patients.
- The number of nurses per 1,000 patients.
  It is proposed that the key performance indicators are revised to the number of GPs per 1,000 patients in all four CCG localities and the number of nurses per 1,000 patients in all four CCG localities. These revisions will reflect the approach being adopted within Thurrock and enable focus and priority to be provided on specific CCG localities.

Progress reports for specific key performance indicators

- 71% of GP practices have a CQC rating of at least "good'' exceeding the trajectory target of 40%.
- 77% of patients report having a good experience of GP services, not achieving the trajectory target of 81%. Board members may wish to note that part of the reason could be due to various primary care procurements that are ongoing which may have compromised on the satisfaction rate.
- Data has not been provided on the % of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge.

- Overall CQC Rating of good achieved for BTUH.
- Overall CQC Rating for SEPT will be available following inspection in November.
- The overall CQC rating – NELFT of good or working towards good has not been achieved with a rating of requires improvement being provided.
- The overall CQC Rating - East of England Ambulance Service of good or working towards good has not been achieved with a rating of requires improvement being provided.

Goal 5 Healthier for Longer

Objective 5A Reduce obesity / increase the number of people in Thurrock who are a healthy weight (Helen Horrocks)

Existing key performance indicators and proposed amendments

- % of children overweight or obese in year 6
- % of adults overweight or obese

- It is proposed that a new indicator is included to measure the % of physically inactive adults in Thurrock. This will measure the number of respondents aged 19 and over, with valid responses to questions on physical activity, doing less than 30 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days.

Progress reports for specific key performance indicators

- % of children overweight or obese in year 6. Data will become available in December 2017 to report progress.
- % of adults overweight or obese. Data is not available at present to report progress. However, the level % of adults overweight or obese is expected to remain consistent for 2017.

- New indicator subject to HWB approval. % of physically inactive adults in Thurrock

Objective 5B Reduce the proportion of people who smoke (Kev Malone, Beth Capps for children)

Existing key performance indicators and proposed amendments

- Smoking prevalence in those aged 18+.
- Smoking prevalence in those aged 15-17 years.
  It is proposed that this key performance indicator is removed. Smoking prevalence among young people cannot be updated because the What About Youth Survey 2014 was a one off survey and the Smoking, Drinking and Drug (SDD) Survey 2014 has not been repeated since 2014. The young people's health survey undertaken in Thurrock across some schools and canvassed young people up to the age of 15. Public Health are currently considering the merits of developing an indicator based on the young people's survey.
- % of mothers smoking at time of delivery.

Progress reports for specific key performance indicators

- There is currently a 20.8% rate of smoking prevalence in those aged 18+, which does not achieve the trajectory target of 19.3%. Board members will wish to note, however, that the data source for this key performance indicator has changed from the Integrated Household Survey to the Annual Population Survey. This has increased initial smoking prevalence data from 20.3% to 21.3%. While the estimated trajectory target has not been achieved Thurrock

has seen a reduction in smoking prevalence in those 18+ from 21.3% to 20.8%.

- There is no data available at the moment which shows the level of smoking prevalence amongst 15 -17 year olds.
- 9.0% of mothers are recorded as smoking at the time of delivery, exceeding the trajectory target of 9.45%.

Objective 5C significantly improve the identification and management of long term conditions (Emma Sanford)

Existing key performance indicators and proposed amendments

- Mean score on an agreed GP practice-based LTC management scorecard.
- Unplanned care admission rate for conditions amendable to healthcare.
- It is proposed that the key performance indicator for the mean score on an agreed GP practice-based Long Term Condition profile scorecard and key performance indicator on the unplanned care admission rate for conditions amenable to healthcare are replaced by a new indicator comprising the following data measurements:
    - The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Hypertension.
    - The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Stroke.
    - The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Coronary Heart Disease.
    - The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Peripheral Arterial Disease.
    - The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Depression.
    - The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of COPD.

Progress reports for specific key performance indicators

- This is a new data set. Baselines, targets and trajectories have been identified. The 2017 trajectory targets will be measured against data available in autumn 2018.

Objective 5D Prevent and treat cancer better (Mark Tebbs, Public Health lead to be identified to replace Funmi Worrell)

Existing key performance indicators and proposed amendments

- % of patients treated within 62 days of receipt of urgent GP referral for suspected cancer to first treatment.
- 1 year survivorship after breast cancer.
- Bowel cancer screening coverage
- % of cancer admissions diagnosed for the first time via emergency presentation.
- % of new cancer diagnosis at stage 1 and 2
  It is proposed that the key performance indicator on the % of new cancer diagnosis at stage 1 and 2 is removed. This is because:
    - This was an experimental indicator and the frequency of when data will be published in future
    - The existing indicator, % of cancer admissions diagnosed for the first time via emergency presentation, aims to reduce the number of cancer diagnosis at stage 4. If achieved this will demonstrate that a higher proportion of people are being identified at an earlier stage.

Progress reports for specific key performance indicators

- Key performance indicator trajectory target of 62% of patients treated within 62 days of receipt of urgent GP referral for suspected cancer to first treatment has not been achieved. This target has been difficult to achieve historically pan Essex and it is a focus of various other work streams.
- 1 year survivorship after breast cancer. Due to the issue being measured the baseline for this indicator was taken from 2013 data. While the target trajectory for 2017 of 95% has not been achieved 2014 data (95.7%) shows that the direction of travel is positive and progress continues to be made.
- Data has not been provide to report progress on bowel cancer screening coverage
- Data has not been provided on the % of cancer admissions diagnosed for the first time via emergency presentation.

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
1. Opportunity for All	1A. All children in Thurrock making good educational progress	Corporate Director for Corporate Services (Rory Patterson)	Roger Edwardson	EYFS Attainment - % of children achieving a Good Level of Development (GLD) at the end of Early Years Foundation Stage		72.5% (2015)	73% (Achieved 76% - National average 71%)	73.50%	74%	74.50%	75%	TBC	This indicator quantifies the proportion of children who achieve a Good Level of Development by the end of Reception Year / Early Years Foundation Stage. Children are defined as having reached a Good Level of Development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy. This is also an indicator on the Public Health Outcomes Framework.	Report on progress
				EYFS Attainment - Percentage point gap between pupil premium children achieving GLD and others at end of Early Years Foundation Stage		12.20%	11.76% (Achieved 17PP and national is 18%)	11.32%	10.88%	10.44%	10%	TBC	This indicator quantifies the gap between those eligible for pupil premium and all others in achievement of GLD by the end of Reception Year / Early Years Foundation Stage. Children from poorer backgrounds are more at risk of poorer development, and the evidence shows that differences by social background emerge early in life.	Gap widening so trajectory to be revised - Roger Edwardson to advise
				KS2 Attainment – % Achieving the National Standard in Reading, Writing & Maths		51%	57% (Achieved 61%, national is 61%)	67%	73%	79%	85% National Target	TBC	Primary accountability measures have changed for 2016. Levels no longer exist and have been replaced by a scaled score outcome. The new headline measure for attainment is the percentage of pupils achieving the 'expected standard' in English reading, English writing and mathematics at the end of Key Stage 2.	Report progress
				% of children achieving 5 good GCSEs at A*-C including English and Maths									Progress 8 will replace 5+ A*-C including English and Maths (GCSE) in the 2016 Department for Education performance tables. This is a value added measure that aims to capture the progress a pupil makes from the end of primary school to the end of secondary school. As such, it is not possible to quantify a target for this indicator until it is changed.	Indicator to be deleted and replaced by (i) % of children achieving combined level 4 in English and Maths at GCSE (ii) New progress 8 scores. Targets to be established
				% of children achieving combined level 4 in English and Maths at GCSE	**YES**		60% achieved (national 63.5%)	TBC	TBC	TBC	TBC	TBC		**Targets and Trajectories to be set if HWB approve new indicator**
				New progress 8 scores	**YES**		Current data - 0.03 aligned with national progress of -0.03	TBC	TBC	TBC	TBC	TBC		**Targets and Trajectories to be set if HWB approve new indicator**

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	1B. More Thurrock residents in employment, education and training	Corporate Director for Corporate Services (Rory Patterson)	Michele Lucas / Tim Rignall	% of working age population who are economically active		78.30%	78.64%	78.98%	79.32%	79.66%	80% (Draft target)		This indicator quantifies the proportion of working aged people (16-64 years currently) who are economically active – that is to say, they are either employed or unemployed.	Remove as indicator will be duplicating the evidence provided by universal credit rplacement 1B2
				% of the population of working age claiming Employment Support Allowance and incapacity benefits – will be replaced by indicator regarding Universal Credit.		5.0% (August 2015)					Unable to produce target as indicator will change		This indicator quantifies the proportion of working aged people (16-64 years currently) who are claiming Employment Support Allowance and incapacity benefits. The age at which women reach State Pension age is gradually increasing from 60 to 65 between April 2010 and April 2020. Throughout this period, only women below State Pension age are counted as working age benefit claimants. However, the national roll out of Universal Credit means that claimants will be required to move onto that, so this indicator will require revising in the near future.	Indicator to be amended to % of population claiming Universal Credit
				% of the population of working age claiming JSA – will be replaced by indicator regarding Universal Credit.		1.6% (August 2015)					Unable to produce target as indicator will change		This indicator quantifies the proportion of working aged people (16-64 years currently) who are claiming Job Seekers Allowance. The age at which women reach State Pension age is gradually increasing from 60 to 65 between April 2010 and April 2020. Throughout this period, only women below State Pension age are counted as working age benefit claimants. However, the national roll out of Universal Credit means that claimants will be required to move onto that, so this indicator will require revising in the near future.	Remove indicator as will measure the same thing as new indicator proposed to replace 1B2
				% of people claiming universal credit	YES	N/A indicator developed in 2017	Baseline to be confirmed	TBC	TBC	TBC	TBC	TBC		**Targets and Trajectories to be set if HWB approve new indicator**
				% of 16 – 19 year olds not in Employment, Education or Training (See column T for suggested amendments)		5.2% (2014)	5% (Target exceeded latest data shows 3.8%)	2%	2%	2%	2%	March each year	This indicator quantifies the proportion of those **aged 16-19 years** who are not in employment, education or training (NEET). There is national legislation in place known as Raising the Participation Age which requires all young people to remain in education or training until their 18th birthday, so this is likely to result in a decrease in this figure. The impact this will have on 18-24 year olds who are not in employment or training is unknown.	Amend age of target group within indicator from 16-19 to 16/17 year olds to national changes made by Government on the reporting framework

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	1C. Fewer Teenage Pregnancies in Thurrock	Corporate Director for Corporate Services (Rory Patterson)	Tim Elwell-Sutton /Sareena Gill	Under 18 conception crude rate per 1,000		25.5 (2014)	24.5 (24.5 target achieved)	23.3	22.2	21.1	20	March each year	This indicator quantifies the rate per 1,000 females aged 15-17 years who have had a conception. Most teenage pregnancies are unplanned and approximately half end in an abortion. Research evidence shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. This is also an indicator on the Public Health Outcomes Framework.	
				Possible creation of new KPI that measures the number of teenage parents that are supported through a multi-agency approach. This will reflect a new service being developed by NELFT as part of Brighter Futures.	**YES**	**N/A indicator developed in 2017**	**Baseline to be confirmed**	**TBC**	**TBC**	**TBC**	**TBC**	TBC		**Targets and Trajectories to be set if HWB approve new indicator** (Ian Wake)
	1D. Fewer children and adults in poverty	Corporate Director for Corporate Services (Rory Patterson)	Dave Petrie / Michele Lucas (Copy in Tim Rignal)	% of children in poverty (all dependent children).		19.6% (2013)	19.28%	18.96%	18.64%	18.32%	18.0% (Draft Target)	TBC	This indicator quantifies the percentage of all dependent children under 20 years of age in "relative poverty" – where the household income is less than 60% of median household income before housing costs. There is a large body of evidence to suggest that poverty in childhood leads to a number of poor health outcomes in both children and adults. Reducing the numbers of children who experience poverty should improve health outcomes and increase healthy life expectancy. This is also an indicator on the Public Health Outcomes Framework.	
				Number of homeless households supported by Thurrock Council.		472 (2015)	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	TBC	This quantifies the number of homeless households supported by Thurrock Council Housing service – i.e. those where a homeless application was processed for them because homelessness could not be prevented. There is a large amount of evidence to show that those who are homeless are at risk of experiencing poorer outcomes than those who live in stable accommodation – these include worse physical and mental health, unhealthier lifestyles and increased hospital use.	
				Increase in number of HMOs available for young people across Thurrock		0	2	**TBC**	**TBC**	**TBC**	**TBC**	TBC		New indicator proposed re increasing the number of houses of multiple occupation across Thurrock for young people. Increasing HMOs will help to reduce poverty and ensure that young people can be housed . **Subject to HOSC Decisions**
				Number of places given out for the 2 year old offer - Definition to be agreed	Not in existence yet								Definition and data to be agreed	Indicator to be deleted as free places offerred to 2 year olds do not necessary help to identify children and adults in poverty

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
2. Healthy Environments	2A. Create Outdoor Spaces that make is easier to exercise and be active	Corporate Director for Environment and Place (Steve Cox)	Grant Greatrex and Andy Millard	% Physical Active adults 16+ (150 mins per week)			52.00%	52.50%	53.00%	53.50%	54%	Annually	This indicator quantifies the proportion of adults aged 16+ achieving at least 150 minutes a week of physical activity in accordance with the Chief Medical Officer's recommended guidelines. This is also an indicator on the Public Health Outcomes Framework.	
				% of physically active children		**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	TBC		
				% of new developments that conform to the minimum Design Standards as produced by the Council's Planning Team.	Standards not in place yet								The Planning Team have produced draft Design Standards guidance to be referred to by all developers submitting future planning applications. These will contain guidance on criteria for 'best-practice' developments, which include recommendations on developing spaces to encourage exercise and activity. The full suite of standards documents are currently under development.	It is proposed that this indicator is deleted. This is because there is not currently a mechanism in place to record or evaluate the % of new developments that conform to the minimum design standards as produced by the Council's Planning Team indicator. To establish and report against this indicator a way to record and assess it would need to be determined and would be several months in the making. Following this, a 6 or 12-month recording and assessment period would be required to enable accurate statistical reporting.
				Residents very or fairly satisfied with council owned sports and leisure facilities.		39%	NA	45%	NA	50%		Bi Yearly	It is proposed that a future indicator might come from the forthcoming Thurrock Residents Survey that launch in the summer of 2016 and that gives an understanding of residents' views. This still needs to be fine tuned for appropriate and relevant use.	**Targets and Trajectories to be set if HWB approve new indicator**
				Residents who think that the Council make it easy to exercise in parks and open spaces (Bi yearly survey)		69%	NA	71%	NA	73%		Bi Yearly		New indicator proposed by Grant Greatrex.
				Based on needs assesment, the number of Parks and Play sites improvement projects to encourage greater use			3	3	3	3	14	TBC		**Targets and Trajectories to be set if HWB approve new indicator**

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	2B. Develop homes that keep people well and independent	Corporate Director for Environment and Place (Steve Cox)	Sean Nethercoat, Keith Andrews, Les Billingham and Andy Millard	% of all major housing developments that have an approved Health Impact Assessment.		TBC	TBC	TBC	TBC	TBC	TBC	July	This indicator quantifies the proportion of all major (in this instance, defined as those with more than 25 dwellings) planned housing developments that have an approved Health Impact Assessment completed. A Health Impact Assessment is a means of assessing the health impacts of policies, plans and projects using a range of techniques. These should be conducted in line with the Department of Health guidance (2010). Including this as an indicator will ensure developers are mindful of the positive and negative impacts their schemes can have to population health, meaning more proposals that are received will be able to evidence positive benefits to health	Sean Nethercoat, Helen Horrocks and Robert Cotter will need a further discussion. Sean made the valid point that major schemes will be subject to an EIA that will already have a HIA as part of it, so truly major schemes will already be covered. That then leaves the range between 25 units and EIA-triggering major schemes. We need to discuss whether it is prudent to ask developers to supply a HIA that the Council would then have to assess but ONLY by way of understanding the scheme i.e. a full assessment. In my view it makes sense that we undertake this work (and eliminate having to assess their HIA) and based on our own suggest changes to the proposal to meet and HIA requirements. In short, the indicator will stay there in some form, but we have to determine what that form resolve in advance of Sep 14.
				% of all major planning applications that have been assessed by the Health and Wellbeing Housing and Planning Advisory Group			100%	100%	100%	100%	100%		This indicator quantifies the proportion of major (in this instance, defined as those with more than 25 dwellings) planning applications and pre applications that have been provided to the Thurrock Health and Wellbeing Housing and Planning Advisory Group for review and assessment. The Health and Wellbeing Housing and Planning Advisory Group is a multi-agency group which considers the health and well-being implications of major planning applications, and provides advice and guidance on the health, social care and community impacts of proposed new developments.	We can easily achieve 100% of majors going to this group, but what does that achieve? I would suggest that there needs to be some kind of monitoring of percentage of schemes going to HPAG and percentage of those schemes that have been recommended for alteration to address health issues. Further detail could then be recorded on what these changes were and perhaps even costed to indicate an uplift in quality and/or usability of certain aspects of a scheme. Otherwise we are just acknowledging that schemes are regularly going to a group that is neither minuted nor has any kind of follow up. There are is validity in asking what's the point of this indicator and **potentially removing it**?
				Number of Right Size Schemes developed in Thurrock (Dawn Shepherd)			0	5	5	5	20	September each year. Scheme being launched Sept 17	Right Size Schemes enable older occupiers to downsize into sheltered housing accomodation while leasing their property to the council for use for homeless households	New indicator to reflect action being taken on establishing right size scheme in Thurrock
				Number of people who are supported by the Housing First Scheme (Dawn Shepherd)			0	5	5	5	20	November of each year	The project is funded, as a pilot, jointly between Housing, Adult Social care and health. One year's funding was initially provided but the report will obviously recommend that this continues, and possibly even increases based on the success of the scheme. The Housing first concept is to provide housing first and then start supporting the person – unlike the usual model of expecting a client to engage with support before being housed. So 5 spaces would involve 5 separate flats – unlike most schemes we offer full secure tenancies. Clients will be the most difficult and complex cases – often described as those for whom nothing else has worked – therefore success would probably be measured in terms of how long they are keeping their accommodation, engaging with services etc. We have managed to set up a graph system which shows the level of needs of the individual and how they go up and down but for the long term, decreasing. Happy to share as anonymous info.	New indicator to reflect pilot housing first scheme

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	2C. Build strong, well connected communities	Corporate Director for Environment and Place (Steve Cox)	Les Billingham / Kristina Jackson	Number of weekly hours of volunteering time.		19069 (Annual) (2014/15) = 366.71 hours per week	40,000 annual = 769 hours per week (Target exceeded currently achieved 131,500 hours (Annual) = 6,838 per week	10% increase	10% increase	10% increase		TBC	This indicator quantifies the total number of hours that volunteers working in Thurrock's voluntary sector workforce give per week. Volunteering can yield benefits both for the person volunteering and the people/organisations they support. These include benefits to mental health and wellbeing, improved relationships and better social opportunities, as well as reduced burdens to carers and other formal services. The source for this indicator is the State of the Sector Survey produced by CVS.	It is recommended that this indicator is amended so that the source is transferred to VSDF reporting. This is because the State of the Sector Survey does not collect data consistently. The indicator should be amended from number of weekly hours to numbres of annual hours of volunteering time provided
				Number of micro-enterprises operating in the area.		0	25 (30 achieved)	Programme scheduled to conclude March 18				TBC	Micro-services or enterprises provide support or care to people in their community. To be a micro -service provider they must have eight or fewer paid or unpaid workers and be totally independent of any larger organisation. This is a new initiative being rolled out in Adult Social Care and as such there is no baseline yet.	Report against trajectory
				Estimated Dementia Diagnosis Rate for people aged 65+		66.40%	66.52%	66.64%	66.76%	66.88%	67%	TBC	This indicator quantifies the proportion of those aged 65+ estimated to have dementia who have been formally diagnosed by their GP. This indicator is included as it provides a guide to the effective recognition and diagnosis of dementia patients in Thurrock. The national target has been set at 67%.	It is proposed that the indicator is removed as they do not measure 'build strong, well connected communities' and are not an effective measure of impact or outcome.
				% of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months.	Proposed amendments following HWB Exec Committee meeting	70.70%	71.96%	73.22%	74.48%	75.74%	77.00% (was national average in 2014/15)	TBC	This indicator quantifies the proportion of those diagnosed with dementia who have a care plan that has been reviewed in the last 12 months. This review should address four key issues: an appropriate physical and mental health review for the patient if applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs if applicable, the impact of caring on the care-giver communication and co-ordination arrangements with secondary care (if applicable). This indicator is measured as part of the Quality Outcomes Framework for Mental Health (DEM002) and is also a measure on the CCG Outcomes Framework.	It is proposed that the indicator is removed as they do not measure 'build strong, well connected communities' and are not an effective measure of impact or outcome.
				Corporate Volunteering. Number of businesses across Thurrock that facilitate volunteering for staff		**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	TBC		New indicator proposed (Kristina Jackson)
	2D. Improve air quality in Thurrock	Corporate Director for Environment and Place (Steve Cox)	Ann Osola / Fred Raphael	Number of AQMAs declared in Thurrock.		18 (2016)	**TBC**	**TBC**	**TBC**	**TBC**	8	TBC	The Local Air Quality Management regime (Part IV of the Environment Act, 1995) requires all local authorities to review and assess the quality of their local air quality. Should this confirm that an objective will not be met within the required timescale, the local authority must designate Air Quality Management Areas (AQMAs). Thurrock currently (2016/17) has 18 declared AQMAs for exceeding threshold annual average limit values for nitrogen dioxide (NO_2). Evidence associating NO_2 with health effects has strengthened substantially in recent years; it is estimated that the effects of NO_2 on mortality are equivalent to 23,500 deaths annually in the UK	**Targets and Trajectories to be set if HWB approve new indicator**

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
3. Better Emotional Health and Wellbeing	3A. Give parents the support they need	Corporate Director of Adults, Housing and Health (Roger Harris)	Sue Green	% of parents achieving successful outcomes from early intervention prevention parenting programmes.		72% (2015/16)	61.6% **(next update due March 2018)**	73.20%	73.80%	74.40%	75%	Annually	This indicator quantifies the proportion of parents who successfully complete 10 or more out of 12 sessions of the 'Strengthening Families' targeted parenting programme and evidence improvements in 3 or more of the 8 outcome areas. In general, there is evidence to indicate that certain parenting programs can reduce problem behaviour in children and improve parental mental health and wellbeing. It should be noted that the indicator definition may be subject to change if the commissioned offer changes between 2016 and 2021	
				Number of families known to Troubled Families Service		370 (2016/17)	567 **(Data of Oct 17 shows 613, exceeding the trajectory target)**	686	844	1002	1160 (by May 2020, Nationally Set Target)	quarterly	This quantifies the number of families that the Troubled Families team have provided support to. The headline criteria, underpinned by the DCLG Financial Framework 2015 for identifying families is as follows: • Parents and children involved in crime or anti-social behaviour / Children who have not been attending school regularly / Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan/ Adults out of work or at risk of financial exclusion or young people at risk of worklessness/ Families affected by domestic violence and abuse / Parents and children with a range of health problems	
				Increasing the proportion of children who achieve a 'Good Level of Development'1 (GLD is at 75% in 2016) and reducing the gap between the most and least deprived groups by supporting child development and school readiness		75%	76% **(Sept 17 data shows trajectory target achieved)**	77%	78%	79%	80%	Annually September	This indicator supports a child's ongoing development and is one of the key outcomes being supported through the development of the 0-19 Wellbeing Programme. It also provides a good indication of work to reduce inequalities across the Borough, this is a key indicator for children's centres. The baseline performance is above the national level of 69% (2016) and the target performance aims to remain at least 2% above national levels	
	3B. Improve children's emotional health and wellbeing	Corporate Director of Adults, Housing and Health (Roger Harris)	Malcolm Taylor / Helen Farmer	% of children and young people reporting that they are able to cope with the emotional difficulties they experience.	Yes		**TBC**	**TBC**	**TBC**	**TBC**		TBC	This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.	A school survey has been undertaken which captures data about children's mental health. The survey is currently being finalised. Public Health will use the results of the survey to inform the development of baselines, annual trajectory targets and an overall target for 2021 for this KPI.
				% of children and young people reporting that they know how to seek help when experiencing difficulties with emotional health and wellbeing.	Yes		**TBC**	**TBC**	**TBC**	**TBC**		TBC	% of children reporting being bullied in the last 12 months. This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.	A school survey has been undertaken which captures data about children's mental health. The survey is currently being finalised. Public Health will use the results of the survey to inform the development of baselines, annual trajectory targets and an overall target for 2021 for this KPI.
				% of children reporting being bullied in the last 12 months.	Yes		**TBC**	**TBC**	**TBC**	**TBC**		TBC	% of children reporting being bullied in the last 12 months. This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.	A school survey has been undertaken which captures data about children's mental health. The survey is currently being finalised. Public Health will use the results of the survey to inform the development of baselines, annual trajectory targets and an overall target for 2021 for this KPI.

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	3C. Reduce isolation and loneliness	Corporate Director of Adults, Housing and Health (Roger Harris)	Les Billingham	Number of people who are supported by a Local Area Coordinator.		558 (Jan-Dec 15)	576 - achieved 841	595	613	632	650	Jan - Dec of previous year. So 2016 baseline informed by data of Jan - Dec 15	This is the number of people recorded by Thurrock Council as being in receipt of support from a Local Area Coordinator. Local Area Coordinators are based in their communities and their role is to help people, who may be isolated or excluded due to disability, mental health needs, age/frailty, to re-connect with their communities. They focus on helping to reduce isolation and offering earlier support to those who otherwise may end up requiring statutory support.	
				% of people whose self-reported wellbeing happiness score is low		10.7% (2014/15)	10.16% (Latest data 9.3%)	9.62%	9.08%	8.54%	8.00%	TBC	This indicator quantifies the proportion of adults who rated their happiness as of the preceding day to have a score of 4 or below (maximum = 10) in the Annual Population Survey. Perceived poor wellbeing has been linked to depression and suicide risk. This is also an indicator on the Public Health Outcomes Framework	
				The directly standardised average health status (EQ-5D) for individuals reporting that they are carers		0.798 (2014/15)	0.799 (For 2015/16 the figure for Thurrock is 0.78. The England mean average is 0.80)	0.8	0.0802	8.03	0.804 (was the national average in 2014/15)	TBC	This indicator quantifies the directly standardised average health status score for those who report that they are carers from their responses to the annual GP Patient Survey. The health status is derived from the responses to question 34 of the GP Patient Survey, which asks respondents to describe their health status using the five dimensions of the EuroQol 5D (EQ-5D™) survey instrument: Mobility, Self-care, Usual activities, Pain/discomfort, Anxiety/depression. People who are carers may have a lower quality of life than those who are not, and those that care for more hours may have a lower quality of life than those who care for fewer hours. This is also an indicator on the CCG Outcomes Framework	It is proposed that the indicator 'the directly standardised average health status (EQ-5D) for individuals reporting that they are carers' is removed as it does not help to monitor the objective 'reduce social isolation and loneliness'
				Proportion of caers who reported that they had as much social connection as they would like			29.67% (16/17 survey results) - Baseline	**TBC**	**TBC**	**TBC**	**TBC**	TBC	Indicator reflects national survey outcomes 'The personal social services survey of adult carers (SAC).	Targets and Trajectories to be set if HWB approve new indicator
				Officials are currently considering the development of a new key performance indicator that measures on the amount of people living in sheltered accommodation that are supported through assistive technology. This indicator would measure the number of people who are being supported to remain in their own home.				**TBC**	**TBC**	**TBC**	**TBC**		Subject to HWB Approval in Principle	Targets and Trajectories to be set if HWB approve new indicator (Tina Mitchell)
	3D. Improve the identification and treatment of depression, particularly in high risk groups **AMENDED TO** improve the identification and treatment of mental ill-health, particularly in high-risk groups. Approved by Board at July 17 Health and Wellbeing Board meeting	Corporate Director of Adults, Housing and Health (Roger Harris)	Ian Wake/ Les Billingham	People entering IAPT as a % of those estimated to have anxiety / depression.		15% (Sept 15)	17% Latest Data 16.6%	19.00%	21.00%	23.00%	25%	January of each year	This indicator captures the number of people entering Improving Access to Psychological Therapy (IAPT) services as a proportion of all those estimated to have anxiety and/or depression. The ambition for increasing IAPT access for those with a common mental health disorder was set out in the Five Year Forward View for Mental Health report in February 2016, setting a national target of 25% by 2020/21.	
				% of people who have completed IAPT treatment who are "moving to recovery".		39.00%	41% Latest data 50.8%	44.00%	46.00%	48.00%	50.0% (Current national target)	Jan each year	This indicator is a measure of IAPT patient outcome, as it shows the proportion of people that were above the clinical threshold for anxiety/depression before treatment but below following treatment.	
				% of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool.	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	95%	TBC	The indicator looks to quantify the proportion of patients known to long term conditions services who have been screened for depression using a validated tool (PHQ9) within the last 24 months. This has been included as there is evidence to indicate that those with an existing long term condition are at high risk of depression. This has only recently been added into the service contract as a requirement and as a result, baseline data is difficult to obtain at this stage.	
				% of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff	50%	52%	54%	56%	58%	60%		TBC	This is a new indicator aiming to quantify the proportion of clients known to adult social care services who have been screened for depression. Work is in progress to start this as a pilot programme from 1st July 2016.	

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
				With the development of the Southend, Essex and Thurrock Mental Health Strategy and the Mental Health JSNA, some time is spent reviewing what indicators are used to measure the impact of the strategy in improving the identification and treatment of mental ill-health. This will be reported back to the Board when the Mental Health Strategy and JSNA are reported.		66.40%	66.52%	66.64%	66.76%	66.88%	67%	TBC	This indicator quantifies the proportion of those aged 65+ estimated to have dementia who have been formally diagnosed by their GP. This indicator is included as it provides a guide to the effective recognition and diagnosis of dementia patients in Thurrock. The national target has been set at 67%.	Possible new indicator to capture action and outcomes on wider mental health

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
4. Quality Care Centred Around the Person	4A. Create four integrated healthy living centres	Accountable Officer Thurrock CCG (Mandy Ansell)	Rahul Chaudhari	Identify localities for IMCs	N/A	N/A	4	N/A	N/A	N/A	N/A	TBC		Targets and Trajectories to be set if HWB approve new indicator. New indicator proposed that reflects stage of establising IMC. Can report that target has been achieved of identifying all 4 localities in 2017
				Develop business case for IMCs	N/A	N/A	N/A	4	N/A	N/A	N/A	TBC		New indicator proposed that reflects stage of establising IMC
				Number of IMCs that are operational		0	0		2	2	4	TBC	The future vision for Thurrock is that there will be four "integrated healthy living centres", one in each of the four locality areas. Work to detail the requirements for two of the centres (Tilbury and Purfleet) has already begun, with the other two to follow in the near future. It is the intention that these centres will incorporate a range of different health, social care and wider community services which will enable some of the root causes of ill-health to be addressed alongside treatment of more serious conditions via primary care and some secondary care services.	Yes can report final ambitions
				% of A&E attendances that are coded as no investigation with no significant treatment.		40.93%	Progress on target will partly depend on other system changes happening later (i.e. IMCs). IMCs will be being developed during this period				38.8% (draft target)	TBC	This quantifies the proportion of A&E attendances by Thurrock patients that are given the HRG code of VB11Z – defined as 'no investigation with no significant treatment'. Attendances with this HRG code are generally considered to be those that could have had their needs met elsewhere. Attending A&E for clinical conditions that are could have been treated in a more local clinical setting are both inconvenient for patients and put additional unsustainable pressure and cost on the Thurrock health economy. It is the intention that establishment of the IHLCs will result in a reduction of these patients attending A&E.	

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	4B. When services are required they are organised around the individual	Accountable Officer Thurrock CCG (Mandy Ansell)	Mark Tebbs	% of the 2% highest risk frail elderly in Thurrock with a care plan and named accountable professional.	New Indicator	Baseline not available yet	**TBC**	**TBC**	**TBC**	**TBC**	95%	TBC	This quantifies the proportion of people registered with identified GP practices, which have been classified as living with 'moderate' or 'severe' frailty, following screening using the Electronic Frailty Index (eFI), to have a Comprehensive Care Plan (CCP) and a Named Accountable Community Professional identified. We are aiming to identify the most vulnerable frail elderly in Thurrock through a standardised tool (currently the electronic frailty index). This will enable us to ensure that each patient has a CCP, a comprehensive escalation plan to manage worsening conditions and a named accountable community professional. Our aim is that we will be able to reduce non elective attendances by better managing people in the community. This is a new indicator.	
				Establish a data system linking records from primary, secondary, community, mental health and adult social care		System in place	**TBC**	**TBC**	**TBC**	**TBC**		TBC	Currently, there are a number of different information systems that hold patient-level health and social care data, but there is no easy way to link records, meaning it is difficult and often impossible to see who is accessing multiple services. This means it is difficult to identify residents who are at risk of becoming future users of expensive services, and therefore makes future service planning very complex. Approval has been given for the procurement of a solution that will enable Thurrock to maintain a Population Health solution, enabling population segmentation (i.e. being able to identify sub-populations who share similar characteristics to better target interventions), risk stratification across services, and predictive/scenario modelling to be carried out (enabling forecasting of future service use in line with population projection information to aid future planning).	
				% of Early Offer of Help episodes completed within 6 months.		76.5% 2015/16	95% (2016/17) Can we report against trajectory target?				Target to be confirmed	TBC	This indicator quantifies the proportion of all Early Offer of Help episodes that were completed within 180 days. Services provided under the Early Offer of Help aim to support families and children at the edge of statutory intervention or, where statutory intervention is already in place, to prevent this escalating to care proceedings. Reducing the risk of poorer outcomes by providing support at an earlier stage prevents more costly later intervention from both a health and social care perspective.	
	4C. Put people in control of their own care	Acting Interim Accountable Officer Thurrock CCG (Mandy Ansell)	Catherine Wilson	% of people who have control over their daily life.		74.2% (2014/15)	76.36%	78.52%	80.68%	82.84%	85%	TBC	This indicator shows the proportion of adult social care service users aged 18+ who feel that they have control over their daily life, and is calculated from data collected in the Adult Social Care Survey. Part of the intention of personalised services is to design and deliver services more closely matching the needs and wishes of the individual, putting them in control of their care and support. This measure is one means of determining whether the desired outcome is being achieved. This is also an indicator on the Adult Social Care Outcomes Framework	
				% of people receiving self-directed support.		70.3% (2014/15)	76.24% (Year to date in Sept 17: 74%)	82.18%	88.12%	94.06%	100%	2017 outcomes available on 31 March 18	This indicator shows the proportion of adult social care users aged 18+ who are receiving self-directed support. Self-directed support allows people to choose how their support is provided, and gives them control of their individual budget. This measure supports the drive towards personalisation of care, and is also an indicator on the Adult Social Care Outcomes Framework.	

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	4D. Provide high quality GP and hospital care to Thurrock	Acting Interim Accountable Officer Thurrock CCG (Mandy Ansell)	Rahul Chaudhari	The number of GPs per 1,000 patients.		0.47 (2015)		1 locality	1 locality	2 localities	0.27 (National Average in 2015) in all 4 localities	**TBC**	This indicator quantifies the number of full time equivalent GPs including GP Providers, Salaried/Other GPs, Registrars, Retainers and Locums per 1,000 weighted patients. Under-doctoring is a significant factor in provision of high quality care. NHS England is expected to ensure everyone has easier and more convenient access to GP services, including appointments at evenings and weekends where this is more convenient for them, and effective access to urgent care 24 hours a day, seven days a week. This is also an indicator in the CCG Outcomes Framework.	Indicator to be expanded to become The number of GPs per 1,000 patients **to reach national average in all four localities** Indicators contained in years 2018 - 2021 relate to localities
				The number of nurses per 1,000 patients.		0.22		1 locality	1 locality	2 localities	England average was 0.27 in 2015 to be achieved in all 4 localities	**TBC**	This indicator quantifies the number of full time equivalent nurses including Practice Nurses, Advanced Nurse Practitioners, Nurse Specialists, Trainee and district Nurses per 1,000 weighted patients. Under-nursing is a significant factor in provision of high quality care. NHS England is expected to ensure everyone has easier and more convenient access to GP services, including appointments at evenings and weekends where this is more convenient for them, and effective access to urgent care 24 hours a day, seven days a week. This is also an indicator in the CCG Outcomes Framework	Indicator to be expanded to become The number of nursies per 1,000 patients **to reach national average in all four localities** Indicators contained in years 2018 - 2021 relate to localities
				% of GP practices with a CQC rating of at least "requires improvement".							100%	**TBC**	The Care Quality Commission (CQC) inspects and regulates health and social care services under 5 domains: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led? Providers can receive one of four ratings for each domain: outstanding, good, requires improvement and inadequate. This measure quantifies the proportion of GP practices that achieved an overall CQC rating of "requires improvement" or above across all domains	Indicator to be removed as supersueded by indicator 4D4
				% of GP practices with a CQC rating of at least "good".		2 practice rated as good from 32 practices	40% (Latest data)	90%	100%	All practices rated as good and 2 practices rated as outstanding	50%	**TBC**	This measure quantifies the proportion of GP practices that achieved an overall CQC rating of "good" or above across all domains.	Can report that we have exceed 2017 target of 40%. Have now achieved 71% of practices being rated as good in 2017
				% of patients who had a good experience of GP services.	Proposed amendment following HWB Exec Committee meeting of July	80% (2015/16)	81% Latest data 77%	82%	83%	84%	England average was 85% in 2015/16	**TBC**	This indicator quantifies the weighted proportion of patients who reported that their overall experience of GP services was 'fairly good' or 'very good', when asked as part of the GP Patient Survey. A high proportion would indicate high levels of satisfaction with the care being provided by Thurrock GPs, and can be used as one indicator for quality of care	Report progress
				% of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge.	Description indicates there is another agreed trajectory	91.11% (2015/16)	91.88% Can we report progress? If not when will we expect to be in a position to do so?	92.67%	93.44%	94.22%	95%	**TBC**	The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated and then admitted or discharged in under four hours. This is commonly known as the four-hour standard. The clock starts from the time that the patient arrives in A&E and stops when the patient leaves the department on admission, transfer from the hospital or discharge. Thurrock has an agreed recovery plan and trajectory for sustained recovery from May 2016.	Data not available to report progress
				Overall CQC Rating – BTUH		Good (Maternity Dept rated as outstanding)	Will not be subject to inspection	Will not be subject to inspection	Will not be subject to inspection	Retain good overall rating	Retain good overall rating	**TBC**	This measure quantifies the overall CQC rating across all domains for Basildon and Thurrock University Hospital.	Waiting for steer from Rahul following advice that after an inspection rating of good BTUH would not be inspected again for four years is there merit in suggesting removing this indicator as I am not sure what added value it provides. **Rahul suggested removal**
				Overall CQC Rating - NELFT		Formal result expected Sept 16	Requires Improvement				Good or be working towards good	**TBC**	This measure quantifies the overall CQC rating across all domains for North East London Foundation Trust.	Report progress
				Overall CQC Rating - SEPT		Good (Nov 15)	Will not be subject to inspection	Will not be subject to inspection	Will not be subject to inspection	Retain good overall rating	Retain good overall rating	**TBC**	This measure quantifies the overall CQC rating across all domains for South Essex Partnership Trust.	
				Overall CQC Rating - East of England Ambulance Service		Formal result expected Sept 16	Requires Improvement				Good or be working towards good	**TBC**	This measure quantifies the overall CQC rating across all domains for the East of England Ambulance Service.	Waiting for steer from Rahul who suggested removing but agreed to consider further - do we have the result of the inspection? Did we achieve the rating?

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
5. Healthier for Longer	5A. Reduce Obesity / Increase the number of people in Thurrock who are a healthy weight	Director of Public Health - Ian Wake	Helen Horrocks	% of children overweight or obese in year 6		36.7% 2014/15 37.8% 2015/16	37% Latest data will be available in December 2017	36.50%	36%	35.50%	35% of statistically similar to national average	**December each year**	This indicator quantifies the proportion of children aged 10-11 years classified as overweight or obese in the National Child Measurement Programme. There is concern about the rise of childhood obesity and the implications of obesity continuing into adulthood. Evidence has shown that children who are overweight or obese have higher risks of developing long term conditions such as diabetes and hypertension, exacerbation of conditions such as asthma, and poor mental health and wellbeing. This is also an indicator on the Public Health Outcomes Framework.	
				% of physically inactive adults		N/A	31% or 37,890 adults	30% or 37,174 adults	29% or 36,313 adults	28% ir 35,455 adults	27% or 34,548 adults	PHOF Active lives survey - proposed reporting every six months Most recent data Jan 17. Sept data not available	The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing less than 30 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16 and over. This is also an indicator on the Public Health Outcomes Framework.	Targets and Trajectories to be set if HWB approve new indicator
				% of adults overweight or obese		70.4% (2012/14) 70.3% (2013-2015)	70.30%	70%	69.50%	69%	68%	Latest data in column 1	This indicator quantifies the percentage of adults classified as overweight or obese calculated from self-reported height and weight data in the Active People Survey. Reducing the levels of obesity is a key priority for both national and local organisations, as it is known that excess weight and obesity are a major determinant of premature mortality and avoidable ill-health. This is also an indicator on the Public Health Outcomes Framework.	
	5B. Reduce the proportion of people who smoke	Director of Public Health - Ian Wake	Kevin Malone	Smoking prevalence in those aged 18+.		20.3% Integrated Household Survey 21.3% Annual Population Survey	19.3% Actual Data result: 20.8% (Annual Population Survey)	18.30%	17.30%	16.30%	Below 16%	Every June	This indicator quantifies the percentage of adults aged 18+ who smoke. Smoking is the most important cause of preventable ill-health and premature mortality in the UK, and is a risk factor for a number of other diseases. This is also an indicator on the Public Health Outcomes Framework.	Trajectory for 2017 not achieved as latest data shows 20.8%
				Smoking prevalence in those aged 15-17 years. (Beth Capps)		4.70%	4.50%	4.30%	4.10%	3.90%	3.70%			It is proposed that this key performance indicator is removed. Smoking prevalence among young people cannot be updated because the What About Youth Survey 2014 was a one off survey and the Smoking, Drinking and Drug (SDD) Survey 2014 has not been repeated since 2014. The young people's health survey undertaken in Thurrock across some schools and canvassed young people up to the age of 15. Public Health are currently considering the merits of developing an indicator based on the young people's survey.
				% of mothers smoking at time of delivery.	Proposed amendment following HWB Exec Committee meeting of July	9.9% (2015)	9.45% Data shows trajectory exceeded as 9.0% achieved	9.00%	8.54%	8.09%	Trajectory suggests 7.64% should be achievable	**TBC**	This indicator quantifies the percentage of women who were smokers at the time of delivery, out of the number of maternities. Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. This is also an indicator on the CCG Outcomes Framework.	Trajectory for 2017 Exceeded as latest data shows 9.0%

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	5C. Significantly improve the idenification and management of long term conditions	Director of Public Health Ian Wake	Emma Sanford / Mark Tebbs	Mean score on an agreed GP practice-based LTC management scorecard.	New Indicator								This is a new indicator and no baseline data exists for this as yet. However plans are in place to produce this scorecard on a monthly basis from December 2016. It is proposed that two indicators on the scorecard will become future indicators for this objective: 1) % of diabetes patients that have achieved all three of the NICE recommended treatment targets [Adults: HbA1C<=55mmol/mol (7.5%), Cholesterol <5mmol/L and BP <=140/80mmHg. Children: HbA1c <=58mmol/mol (7.5%)] 2) Absolute gradient of the relationship at LSOA level between unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population and deprivation measured by the IMD 2015 score.	Indicator replaced by 5C2 due to development of progile card not having a final mean score
				Outcome Framework Indicator 1 New recommended indicators: a) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Hypertension. b) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Stroke. c) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Coronary Heart Disease. d) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Peripheral Arterial Disease. e) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of Depression. f) The percentage of GP practices that meet the recommended parameters for diagnosis and treatment of COPD.		A) 25% B)26% C) 26% D)26% E)25% F) 26%	A) 28% B) 27% C) 29% D) 29% E)25% F) 39%	A) 31% B) 29% C) 33% D) 33% E) 25% F) 48%	A) 35% B) 31% C) 36% D) 36% E) 28% F) 56%	A) 40% B) 35% C) 40% D) 40% E) 30% F) 65%		Autumn 2018 to report against 2017 targets	The new LTC profile card contains indicators on progress of case-finding and treating patients with a number of long term conditions. It is hoped that the use of these practice-level profile cards will increase both detection and management of long term conditions. The above indicators are recommended to replace the previously suggested ones which were suggested before the development of the profile card. If accepted, work will be done to calculate the baseline and targets for these. Each indicator includes a combination of diagnosis rates and treatment levels as per the QOF indicator . i.e. increasing the green portion of the bars in the "LTC Management" portion of the profile card below. QOF payment thresholds may be used as either the 2021 target or a target for one of the preceding years.	New indicator which will better reflect quality of care and management of long term conditions. The 2017 target will be measured against in autumn 2018
				Unplanned care admission rate for conditions amenable to healthcare		1940.6 (2015)	1931.7	1922.76	1913.84	1904.92	1896 (Draft target)		This quantifies the rate of emergency admissions for conditions that could have been avoided if good quality healthcare had been in place. These are defined using a standard list of ICD-10 codes provided by the ONS. Rates are shown by 100,000 population.	Indicator to be replaced by 5C4

Goal	Objective	Sponsor	Lead official	Key Performance Indicators	New Indicator	2016 Baseline	2017	2018	2019	2020	2021 Target	When data becomes available for reporting purposes	Description	Amends and decisions taken on indicator
	5D. Prevent and treat cancer better	Director of Public Health – Ian Wake	Funmi Worrell / Mark Tebbs	% of cancer admissions diagnosed for the first time via emergency presentation.		25%	24% Can we report progress?	23%	22%	21%	20%	**TBC**	About a quarter of people with cancer are diagnosed via emergency routes. Survival rates for people diagnosed via emergency routes are considerably lower than for people diagnosed via other routes. Identifying the proportion of people who first present as an emergency is likely to prompt investigation into how to increase earlier presentation, leading to improved outcomes.	
				Cancer diagnosis at stage 1 and 2									This quantifies the proportion of all new cancer diagnoses that were diagnosed at stages 1 and 2, as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour: invasive malignancies of the breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of the skin). Diagnosis at an early stage of the cancer's development leads to dramatically improved survival chances. Specific interventions, such as screening programmes, information/education campaigns and greater GP access to diagnostic services all aim to improve rates of early diagnosis. This is also an indicator on the Public Health Outcomes Framework and the CCG Outcomes Framework.	Indicator to be deleted as by achieving indicator 5D1 will mean that we are also achieving this indicator
				% of patients treated within 62 days of receipt of urgent GP referral for suspected cancer to first treatment		56% (February 2016)	62% **Target not achieved)**	68.00%	73.00%	79.00%	Working toward national standard of 85%	**TBC**	This measures the proportion of people with an urgent GP referral for suspected cancer that began their first definitive treatment within 62 days. This indicator is one of the national cancer waiting times standards. Achievement of these standards is considered to be an indicator of the quality of cancer diagnosis, treatment and care. The operational standard specifies that 85% of patients should be treated within this time. This is also an indicator on the CCG Outcomes Framework.	Target missed in Trajectory for 2017. Board to be given option to amend Trajectory - at the moment it is ambitious and not necessarily achieveble
				1 year survivorship after breast cancer.		95% (2013)	96% (Value for 2014 = 95.7%)	96.25%	96.50%	96.75%	Working towards 97%	**TBC**	This indicator quantifies the one year net survival rate for people diagnosed with breast cancer (after adjustment for other causes of death). Survival rates give an indication of successful service provision and can help identify differing practice requiring further investigation	
				Bowel cancer screening coverage		54% (2015)	55.00%	56.00%	57.00%	58.00%	60% (Current national target)	**TBC**	This indicator quantifies the percentage of people aged 60-69 years who were eligible for bowel screening who had a screening test result recorded in the last 2.5 years. The bowel cancer screening programme plays an important part in supporting early detection of cancer, and increasing screening coverage would mean more cancers are detected at earlier, more treatable stages. This is also included as an indicator on the Public Health Outcomes Framework.	

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NHS Thurrock Clinical Commissioning Group

MINUTES
Integrated Commissioning Executive
17th August 2017

Attendees
Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Ian Wake (IW) – Director of Public Health, Thurrock Council
Ade Olarinde (AO) – Chief Finance Officer, NHS Thurrock CCG
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
Ann Laing (AL) - Quality Assurance Officer – Adults Social Care, Thurrock Council
Les Billingham (LB) – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement, Thurrock Council
Ceri Armstrong (CA) – Senior Health and Social Care Development Manager , Thurrock Council
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council

Apologies
Mandy Ansell (MA) – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Jane Foster-Taylor (JFT) – Chief Nurse, NHS Thurrock CCG
Sean Clark (SC) – Director of Finance and IT, Thurrock Council
Allison Hall (AH) – Commissioning Officer, Thurrock Council
Iqbal Vaza (IV) – Strategic Lead for Performance, Quality and Information, Thurrock Council

Item No.	Subject	Action Owner and Deadlines
1.	**Welcome and Introductions**	
	RH Chaired the meeting and introductions were made. No conflicts of interest were declared.	
2.	**Notes of the last meeting**	
	The minutes of the meeting on 22nd of June were agreed subject to the deletion of the 2nd paragraph in item 8 which was incorrectly reported. There were no matters arising not on the agenda.	CS to amend minutes.
3.	**Better Care Fund 2017-19**	

Expression of Interest in Graduation and the delayed publication of the guidance for the 2017-19 Plan
The email dated 14 August 2017 confirming Thurrock has not been agreed as one of the seven programmes put forward for graduation nationally was noted. Some feedback by letter is awaited.

CS reported that the 2017-19 BCF Guidance was finally published by NHS England on 4 July 2017 despite concerns from the Local Government Association and the Association of Directors of Adult Social Services about the requirement regarding spending on reducing delayed discharge from hospitals to be prioritised over other social care needs. The deadline for submission of the plan, to be agreed by the Health and Well-Being Board on 8th September, is 11 September 2017.

Narrative Plan
CA outlined the direction of travel for the 2017-19 Plan which continues to be on whole system redesign including the contribution of non-clinical inputs. It was suggested that the focus of scheme 3 – Intermediate Care - needs to change because of the guidance and the emphasis required on Delayed Transfers of Care. The linkages to the Sustainability and Transformation Plan will also be highlighted. The structure of the plan will again follow the Key Lines of Enquiry published along with the guidance.

JH suggested there may also be pointers for the content of the Plan in the feedback regarding graduation

Financial Plan
MJ introduced that table showing the additional funding for 2017-19 including the Improved Better Care Fund (IBCF) allocations. He highlighted that £823,000 still needed to be allocated to existing or new initiatives.
The combination of incoming grant and the Social Care precept has resulted in a net increase of circa £1m for the Health and Well-Being Board total for 2017/18.

AO noted the closing position for the Better Care Fund's total expenditure for 2016/17 which resulted in a carry forward of funds of £389k. Also, by way of context, he explained the BCF funding nationally and locally, including the iBCF and shared a schedule identifying the funding streams comprising the minimum BCF values. He noted that the uplift for the community provider in 2017/18 needed to be incorporated in the relevant service lines. Inflation of 1.79% has been applied to the CCG minimum contribution in line with guidance.
AO pointed out that in terms of governance the guidance requires the agreement of both parties to the application of iBCF funds. The financial plan, including the application of the iBCF funding, was agreed in principle, pending the allocation of the £823k to specific projects. Final agreement would be sought at the next meeting as part of the BCF

	Plan being brought for approval. MT asked whether the increase in the home care rate included in the plan should be extended from adult social care to include Continuing Health Care funded placements. RH agreed this was an option for the use of new monies. CW suggested as a first step to quantify the potential requirement and to judge the likely financial impact. **Proposal for unallocated iBCF funds** CW explained that proposals were being put forward for each of the 3 BCF schemes: Prevention and Early Intervention; Out of Hospital Community Integration; Intermediate Care. IW noted that the Integrated Commissioning Executive had agreed criteria for prioritising new investment, derived from the high level population outcomes, and the objectives of For Thurrock in Thurrock. RH noted that the publication of the BCF guidance since the last meeting meant that some refinement of the criteria was now required, particularly because of the requirements regarding Delayed Transfers of Care. In terms of the Business Cases presented for new investment IW noted not all currently provide sufficient detail regarding need, cost, evidence base of effectiveness, number of service users who would benefit, and return on investment. RH said that deliverability within reasonable time frames was also an important factor. He also felt it was important to progress without further delay and to avoid significant underspends. Each of the proposals was discussed in detail and agreement reached as set out in the table appended below. **Performance report** Ann Laing attended the meeting in place of IV and the Planning Template giving performance targets over the 2 year period for the BCF was discussed. It was noted that a number of fields were pre-populated. In relation to table 4.2 Residential Admissions, the expectation was for a 5% reduction by 2018/19. It was agreed a further discussion of the targets was required prior to submission. **Arrangements for finalising the BCF** It was noted that the Integrated Commissioning Executive meeting scheduled for 31st August will need to sign off the Plan prior to publication of the Health and Well-Being Board papers for the (8th September) later that day. RH has a meeting with Portfolio Holders on 28th August and can use that as an opportunity to obtain Council sign off of the Plan under delegated powers agreed by Cabinet on 5th April. AO confirmed CCG sign off would be at its Finance and Performance Committee on 5th September. It was agreed to share the draft Plan with NHS providers	MT to provide information on quantum. IV/AL to arrange CA to share with Providers and VCS

	and the voluntary and community sector as soon as possible. AO asked for the opportunity to review the template with a subgroup prior to the meeting on the 31st. **Governance and reporting arrangements** AO said it would be helpful for the CCG Board to have greater visibility, and so understanding of the BCF. It was agreed that Adult Social Care representatives would attend the Finance and Performance Committee to report on progress and to answer questions from Committee members.	AO to arrange AO to arrange/invite
4.	**For Thurrock in Thurrock**	
	It was noted that the Executive of the Accountable Care Partnership is due to meet next week (commencing 21st August). An update on its plans will be available after that meeting Highlight reports from the CCG and Adult Social Care were presented.	IW to report at next
6.	**Any Other Business**	
	JH explained that an initiative has been established to support transformational change through improved system leadership. It will involve three, two day events for a team representing the Thurrock system. She felt it was an important opportunity to focus collectively on the operation of the system in Thurrock, and also to influence the Sustainability and Transformation Plan. IW agreed to represent the Council.	IW/IH to arrange

Thurrock BCF – Development Fund schemes 2017/18

Scheme	Recurrent	One Off
Implement a "Stretched QOF" in Tilbury and Chadwell		**£ 68,000 for 1 year pilot**
Increase the uptake of flu vaccination		**£ 6,000 for 1 year pilot**
Implement a depression screening and referral programme for patients on LTC registers and ASC clients aged 65+	**Business case not ready yet**	
Improve case finding of Hypertension and AF		**N/A (£ 100k already carried forward)**
Implement e-consults in Tilbury and Chadwell	**No funding required**	
Extend Provision of Social Prescribing	**£ 100k (plus £ 37,500 already in budget) – dependent upon agreement of business case**	
Alzheimer's Society	**£ 19,000**	
Exercise on Referral		**N/A (£ 33,000 already in budget)**
St. Luke's Hospice	**Not BCF priority**	
Micro-enterprises	**Not BCF priority**	
Home from Hospital		**£75k one-year funding for pilot**
Red Bag initiative	**£ 2,000**	
RRAS	**£ 49,000 to be hosted by the LA**	
Hospital Social Work Team	**£ 80,000 agreed on the basis that this will give us 7 day service.**	
Community based Social Work	**£ 60,000**	
A night service – enhancing John Stanley's current service	**£ 50,000 – on the basis that this was also available to CHC clients**	
Transform Homecare/Community Nursing/Buurtzorg	**Need Business case**	
Bridging Service – short term domicilary care post discharge		**£ 64,000 agreed for 1 year only.**

Discharge to assess beds (linked to Pickwick)	**Agreed to establish £ 200k Winter Pressures fund that could go towards this. Further business case required for Discharge to Assess scheme.**	
Total	**£ 560k**	**£ 138k**

MINUTES
Integrated Commissioning Executive
31st August 2017

Attendees
Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Mandy Ansell (MA) – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Ian Wake (IW) – Director of Public Health, Thurrock Council
Jane Foster-Taylor (JFT) – Chief Nurse, NHS Thurrock CCG
Ade Olarinde (AO) – Chief Finance Officer, NHS Thurrock CCG
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
Irene Lewsey, Head of Transformation, NHS Thurrock CCG
Allison Hall (AH) – Commissioning Officer, Thurrock Council
Ann Laing (AL) - Quality Assurance Officer – Adults Social Care, Thurrock Council
Les Billingham (LB) – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement, Thurrock Council
Ceri Armstrong (CA) – Senior Health and Social Care Development Manager , Thurrock Council
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council

Apologies
Sean Clark (SC) – Director of Finance and IT, Thurrock Council
Iqbal Vaza (IV) – Strategic Lead for Performance, Quality and Information, Thurrock Council

Item No.	Subject	Action Owner and Deadlines
1.	**Welcome and Introductions**	
	RH agreed to Chair the meeting and introductions were made. No conflicts of interest were declared.	
2.	**The Pickwick Model**	
	RH explained the purpose of the Integrated Commissioning Group and its interest in proposed use of Pickwick Court for out of hospital care. He invited IL together with Linda King from the Hospital Social Work Team and Karen Scott and Sharon Shelley from BTUH to describe the proposals in detail.	

Karen explained that Pickwick Court comprises two former 8-10 bedroom care homes owned by EPUT in Laindon. The proposal is to facilitate the timely transfer of medically stable patients from BTUH to a setting more suited to assessment and rehabilitation. This would free up capacity in acute and intermediate care settings. Refurbishment of the two care homes would take 2-3 months at which point recruitment (including that of a full time geriatrician) could begin. It is envisaged that stays of up to 10 days would enable patients time for recovery, and the facility would be a resource for all of south west Essex.
Karen felt that in comparison to the interim beds at Collins House, and Mayfield Ward which focus on rehabilitation, this facility would allow time for convalescence. She also felt that it would allow more specialist assessment to be undertaken, which were necessary because of the age of the patients and their multiple long terms conditions.

MT clarified that the scheme would not have a payment by results tariff and that instead the costs would be shared between NHS Basildon & Brentwood CCG (BB CCG) and Thurrock on a 60/40 basis. IL suggested there would be a quarterly review of usage to ensure the split remains proportionate. The proposal has already been agreed by BB CCG and features in the Better Care Fund Plan for the area.

RH thanked those presenting and invited the Executive to discuss the proposal.

AO said that the key challenge would be to ensure Thurrock gets its share. The cost of running the two units is £1,065k per year and so Thurrock's share would be £426k. He proposed a formal discussion with BB CCG to ensure there is clear agreement.

IL said that the requirement for convalescence beds had been identified in the Intermediate Care Review undertaken in 2015/16 and that at present there was no capacity in the system to meet this need. It was noted that the costs of a bed in the facility was lower than Intermediate Care.

CW said she would like to see evidence that there was a need for these beds for Thurrock residents.

JFT said having heard about the re-admissions of older adults over the weekend it would be helpful to know more about why discharges were failing.

MT said in view of the ambition to get the scheme operational in 6 months there was no time to undertake due diligence but that evidence could be collected over the course of the next year.

RH said he felt that more work was needed to clarify the

	pathways, demand and costs. IW said that it would be helpful to compare the costs to the costs of Delayed Transfers of Care. He took the view that a return on investment of 2-1 should be expected. It was agreed that CW and MT should review the proposals in detail and come back with recommendations regarding funding.	
3.	**Notes of the last meeting**	
	RH said that following the meeting he had drafted a schedule containing what he felt to be the agreed development fund schemes for 2017/18 (these were then appended to the minutes) and asked in there were any corrections or comments. AO said he would confirm his agreement to the schemes after the meeting. MT asked that the Home from Hospital scheme be funded as a 1 year pilot for £75k. The minutes of the meeting on 17th of August were otherwise agreed. There were no matters arising not on the agenda.	
4.	**Better Care Fund 2017-19**	
	Graduation MA noted that no feedback has been received to date. **Narrative Plan** CA confirmed that phone calls with NHS Providers have been scheduled to allow them to comment on the plan in advance of the Health and Well-Being Board meeting on 8 September. There has been a request that the plan should show more of the impact of BCF schemes over the past two years. Comments from the voluntary and community sector are awaited. Comments received from the Portfolio Holder have been incorporated. It was noted that a DTOC target for Thurrock of 8.4 days had been approved by NHS England but that this value has now been queried by them. IW suggested doing detailed work to explain the costs and effects of this on the CCG finances. It was noted that the MediAnalytics software will not necessarily illustrate this and a clinical audit approach may be needed. It was agreed that the Performance and Data Group should be re-convened by IW and asked to address these issues. The plan will have a final review against the Key Lines of Enquiry after this meeting. However, it was agreed that, in view of the publication deadline for the Health and Well-Being Board, the current version should be circulated for	All were asked to make suggestions/

	approval at that meeting. **Financial Plan** AO highlighted some of the detail to be included in the Financial Template to be submitted with the Narrative Plan on 11 September. This includes updating the contract values for NHS Providers. The Health and Well-Being Board total has been adjusted because not all elements attract an inflation uplift. The net change is £31k. The closing position for last year's Plan has now been agreed. A minor adjustment has also been made to the IBCF value to bring it in line with the NHS England figures. The new total for 2017/18 is therefore £40,251,387. It was noted that the values in the plan for Winter Pressures will need to be adjusted to take account of the Home from Hospital investment agreed earlier in the meeting. AO confirmed NHS Provider payments will be brought up to date from October – not including CQINN payments. Subject to the points above the Financial Plan was agreed. In terms of completing the Financial Template AO suggested a small group to include CA/MT/CW/CS should meet to agree the scheme descriptions. **Performance Plan** The performance targets set out in the Plan were agreed. **Arrangements for finalising the BCF** The Plan is to be considered by the CCG's Finance and Performance Committee on Tuesday. CA agreed to attend to present the narrative Plan. RH said the Council's Directors Board will meet to consider the Plan on Tuesday. Delegated Authority for approval of the Plan by the Portfolio Holder and Corporate Director was agreed by Cabinet at its meeting on 5 April 2017.	
5.	**Continuing Healthcare Funding**	
	JFT presented a paper showing the cost pressures which would result in any attempt to stabilise the market by aligning rates. AO noted that slippage in the BCF schemes and carried over sums may allow some flexibility going forward. CW proposed that in future rates should be negotiated jointly. It was agreed that including CHC funding in the BCF was not a possibility at present but that the proposition should be kept under review.	

6	**For Thurrock in Thurrock**	
	It was noted that the Accountable Care Partnership is on track. The Executives met last week but it seems there is a clash with future meeting dates.	
7	**Winter Plan**	
	The Winter Plan was noted.	
8.	**Any Other Business**	
	The next meeting will be held on 28 September 2017.	

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Thurrock Health and Wellbeing Board Work Programme

Meeting	Date	Agenda	Key Deadlines
Health and Wellbeing Board	Amended to Tuesday 30 January 3:00 – 5:30pm Committee Room 1	1. STP Update 2. Annual Public Health Report (Ian Wake) 3. Pharmaceutical Needs Assessment (Maria Payne) 4. Mental Health JSNA (Funmi Worrell) (Deferred from Sept meeting) 5. Essex Southend and Thurrock Mental Health Strategy – Local Plan (Catherine Wilson) 6. Pan-Essex suicide strategy report (Ian Wake)l 7. Children's mental health (Malcolm Taylor) 8. NELF Strategy Update (Malcolm Taylor / Sue Green) a. Suicide prevention toolkit b. Self-harm toolkit c. Online portal	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	16 March 2018 CR1	1. Matters Arising ○ 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. 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 6. Southend, Essex and Thurrock Dementia Strategy – Local Implementation Plan (Mark Tebbs and Catherine Wilson) Agreed at July 17 meeting that local plan would be developed and presented to HWB in future **<u>Items deferred from previous meetings</u>** 1. Teenage pregnancy work (Sareena Gill) 2. Employment support (Michele Lucas) 3. Housing support (Michele Lucas) 4. Active Places Item Grant Greatrex 40 mins a. Paper General Overview (focus on one element indoor built facilities) (10 minutes paper and 20 minutes Sport England Presentation) Grant needs to check they are available, subject to Sport England availability Defer to November as Grant on leave in September. 5. Local Plan (Sean Nethercoat) 6. Action Plan 4C Living Well at Home progress report November 2017 (Catherine Wilson) 7. Action Plan 4C Personal Budgets progress report and evaluation of the pilot for Individual Service Funds November 2017 (Catherine Wilson) 8. .5A Ensure people of Thurrock are of a healthy weight. update against the action plan and progress (Helen Horrocks) 9. Action Plan 5D (Ian Wake) Emergency Prevention Audit (Previously proposed for Aug meeting) 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)	Implications and papers ready to brief Cllr Halden: Wed 14 March Publishing date Thurs 22 March

		11. 4C Transforming Care for people with Learning Disabilities progress report January 2018 (Catherine Wilson) 12. Annual Report from the Housing and Planning Advisory Group (Christopher Smith) – Previously considered by HWB July 16 13. 21st Century Strategy for residential accommodation (Christopher Smith) 14. Transforming Care Programme (Mark Tebbs and Catherine Wilson) As agreed at July HWB **Additional agenda item for HWB (Timing TBD)** 1. Health of looked after children (suggested by Rory Patterson at September HWB Exec Committee meeting)	

Meeting	Date	Agenda	Key Deadlines
Health and Wellbeing Board meeting	Fri 18 May 2018 10.30 – 1.00 Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September Invitations sent to members	1. March 2018. An update on targeted health checks and preliminary results. Suggested time slot – 10-15mins	Implications and papers ready to brief Cllr Halden: Wed 2 May Publishing date Thurs 10 May

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	Friday 13 July 2018 10.30 – 1.00 Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September Invitations sent to members		Implications and papers ready to brief Cllr Halden: Wed 27 June Publishing date: Thurs 5 July	
Exec Meeting	Thurs 19 July 2018 2.00 – 3.30 3rd floor room 4			

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	Fri 21 September 2018 Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September Invitations sent to members		Implications and papers ready to brief Cllr Halden: Wed 5 Sept Publishing date Thurs 13 Sept	

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	Friday 23 November 2018 10.30 – 1.00pm		Implications and papers ready to brief Cllr Halden: Wed 7 Nov Publishing date Thurs 15 Nov	
Health and Wellbeing Board meeting	January 2019		Implications and papers ready to brief Cllr Halden: Publishing date	
Health and Wellbeing Board meeting	March 2019		Implications and papers ready to brief Cllr Halden: Publishing date	