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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **12 March 2018**

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

Membership:

Councillors Graham Snell (Chair), Victoria Holloway (Vice-Chair), Gary Collins, Jack Duffin, Joycelyn Redsell and Gerard Rice

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

Substitutes:

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

Agenda

Open to Public and Press

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1. Apologies for Absence

2. Minutes **5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held 18 January 2018.

3. Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4. Declarations of Interests

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **2 March 2018**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 18 January 2018 at 7.00 pm

Present:	Councillors Graham Snell (Chair), Victoria Holloway (Vice-Chair), Gary Collins, Jack Duffin, Clifford Holloway and Joycelyn Redsell Kim James, Healthwatch Thurrock Representative Neil Woodbridge, Chief Executive Officer, Thurrock Lifestyle Solutions
Apologies:	Ian Evans, Thurrock Coalition Representative
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Ian Wake, Director of Public Health Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group Jeanette Hucey, Director of Transformation, Thurrock NHS Clinical Commissioning Group Tom Abell, Chief Transformation Officer, Basildon & Thurrock University Hospitals Andy Vowles, Programme Director, STP Jenny Shade, Senior Democratic Services Officer

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

33. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 16 November 2017 were approved as a correct record.

34. Urgent Items

There were no items of urgent business.

35. Declarations of Interests

No interests were declared.

36. HealthWatch

Kim James stated that HealthWatch had received concerns from advisory groups, the HealthWatch board and organisations within Thurrock on how the Sustainability and Transformation Partnership Consultation was being run and

how it was failing the people of Thurrock. Kim James stated that this was an unfair consultation which had become inaccessible for some groups within Thurrock. That the consultation was hard to access with only an on-line option available and requests made for hard copies, easy read versions and versions printed in different languages were not being made available to residents. That hard copies of the consultation document should have been more readily available for residents to access. Kim James also stated that the lack of reference to Orsett Hospital was disappointing.

Andy Vowles, Programme Director for the Sustainability and Transformation Programme, stated that the consultation had been shared with HealthWatch on the 30 November 2017 and an agreed approach was defined. That the consultation had been launched widely which had explained how documents could be accessed. Andy Vowles stated that a huge number of downloads had already been recorded. Printed copies and easy read versions of the complex consultation were available. That focus and interaction groups could also be set up for residents that would give them the opportunity to comment and participate.

Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group (CCG) confirmed that conversations had taken place with HealthWatch and had agreed that CCG would now print off copies of the consultation. Mandy Ansell drew Members attention to the CCG Insight magazine that included published articles on the STP.

Councillor Redsell stated that a large proportion of Thurrock residents did not have access to the internet and those residents were being excluded and forgotten about. Councillor Snell echoed Councillor Redsell's comments and concerns.

Councillor V Holloway stated that she was appalled that no easy read version of this consultation was available due to the complexity of the report. Those residents with learning disabilities should be given every opportunity to engage and be involved. Councillor V Holloway also stated that Members of the Health and Wellbeing Overview and Scrutiny Committee had previously been given reassurance that Orsett Hospital would not be buried within the STP consultation but yet again hardly any references had been made to Orsett Hospital.

Andy Vowles stated that Essex County Council had advised that an easy read version of the complex report would be difficult to prepare but this had been undertaken and versions were available. That no disregard to any resident had been made and that the remainder of the 14 week consultation period presented an opportunity to learn more from focus groups. Andy Vowles confirmed that Orsett Hospital formed part of the STP and this had been shared with HealthWatch and was included in the five principles for the proposed future hospital services and reassured Members that Orsett Hospital had not been buried within the consultation documentation.

Neil Woodbridge, Thurrock Lifestyle Solutions, stated that reasonable adjustments should be made to the consultation for those with learning disabilities and that HealthWatch and Thurrock Lifestyle Solutions now had the hard task of working with those groups to get them involved and to reassure them that there had been no conspiracy against them.

Councillor Redsell stated that discussion events should have been advertised earlier to enable resident participation.

Councillor Snell stated that there had clearly been some communication issues with the publishing of the consultation and having not been passed through the correct channels. That future consultations should ensure that easy read versions were available.

37. Mid and South Essex Sustainability and Transformation Partnership (STP) (Presentation and Q&A)

Andy Vowles, the Programme Director for the Sustainability and Transformation (STP) Partnership, presented the report to Members that covered a small range of services that formed part of the large STP and stated that the consultation was half way through with more discussion event focus groups being organised. Andy Vowles went through the five principles for the future hospital services which included:

1. The majority of hospital care will remain local.
2. Certain more specialist services which need a hospital stay are concentrated in one place.
3. Access to specialist emergency services, such as stroke care, should be via your local (or nearest) Accident & Emergency.
4. Planned operations should, where possible, be separate from patients who are coming into hospital in an emergency.
5. Some hospital services should be provided closer to residents.

The figure of those that would be affected in emergency were based on currently 960 attendees per day on average across the three Accident & Emergency departments, around 300 patients per day on average are currently admitted to hospital from Accident & Emergency; under the proposals for reorganising some specialist emergency services, an estimate of around 15 people per day would require a transfer from their local Accident & Emergency to a specialist team in another hospital.

The figure of those that would be affected in planned treatment were based on around 3,300 patients per day on average visiting the three hospital for an outpatient appointment, around 380 patients per day on average visiting the three hospitals for a planned operation; under the proposals for separating planned operations from emergency care, it would be estimated around 14 people per day would be referred to a hospital that was not their local hospital for a planned operation.

A summary of the proposed changes at Basildon Hospital was presented to Members and that the following services would remain the same: Accident and Emergency and urgent care, maternity services, intensive care, short stays in hospital, children's care, care for older people, day case treatments and operations, tests, scans and outpatient appointments. The proposed service changes to emergency services could include: specialist stroke unit, improve stroke care and rehabilitation; specialist teams for complex lung problems, complex vascular problems, complex heart problems, more complex orthopaedic trauma surgery and specialist team for complex kidney problems.

The proposed changes that would affect Thurrock population were:

- All outpatients and majority of operations will stay local.
- Transfer of services from Orsett to the four new Integrated Medical Centres.
- Specialist stroke unit proposed in Basildon.
- Specialist teams in Basildon proposed for complex lung, vascular, heart and kidney problems.
- Planned orthopaedic operations proposed in Braintree and Southend.
- Specialist teams in Chelmsford proposed for complex urology, abdominal surgery and gastroenterology.
- Specialist gynaecology including cancer proposed in Southend.

Those views from the consultation on the proposed transfer of services from Orsett into the Integrated Medical Centres would be considered.

Andy Vowles updated Members on the proposed clinical transfer of patients between hospitals to ensure that discussions between clinical teams and patient/families were undertaken and clinical support was available throughout any transfer. That a free bus service between hospitals would be provided.

Andy Vowles finished the presentation by providing Members with an update on the next steps of the consultation with implementation planned for autumn 2018 and onwards. That implementation would not be imminent after this date as this was reliant on successful bids for funding to make infrastructure changes to hospitals.

Tom Abell, Chief Transformation Officer, Basildon & Thurrock University Hospitals, stated that conversations with Orsett Hospital were ongoing looking around the configuration of services into the Integrated Medical Centres and that input from local communities was vital to ensure a good service and the right accessibilities were provided.

That focus would be put on community services and where these services should be located to ensure they were fit for purpose and would work well for residents.

That the process may take up to five to seven years to be implemented to ensure that lessons can be learnt and those changes can be adopted.

Tom Abell reiterated the commitment that the relocation of services from Orsett Hospital would not be made until those services were available in the Integrated Medical Centres.

Councillor Snell thanked Andy Vowles and Tom Abell for the report.

Councillor Redsell stated that the proposed five to seven year implementation plan seemed a long way off and questioned where the Dialysis Unit, currently at Orsett hospital, would be located and who would provide and pay for the proposed bus services. Tom Abell stated that the implementation would be carried out as fast as possible but time would clearly need to be made to undertake the proposed infrastructure to the hospitals. That plans were in place to specifically engage with dialysis users on where services would be best located and arrange suitable dates with HealthWatch. Tom Abell confirmed that allowances had been made for operating the bus services but no decision had been made as to who the supplier would be yet.

Councillor V Holloway pressed Tom Abell on the funding of the transportation proposal following pressures from elderly residents. Tom Abell confirmed that residents should now take part in the consultation stating what transport would be good for them, to get local views on the best configuration and asked Members to encourage their constituents to feedback on this item. That many more services are already provided and would remain local for the frail and elderly.

Councillor Snell stated that it was really important that patient information was kept updated so that relatives and visitors were aware of any ward or hospital transfers. Tom Abell stated that investments to IT infrastructure were being pushed forward to use the TeleTracking system that would be used for patient flow logistics across the three hospitals with implementation into Southend in June 2018. The system would then be rolled out into the other two hospitals. Tom Abell stated that good quality conservations would be undertaken with patients and relatives about what hospital would be best to treat that person.

Councillor Redsell stated that the consultation had not covered residents over the age of 65. Andy Vowles stated that the wider agenda of the STP would cover this to look at right locations that had the right integrated services available. Roger Harris stated that the local authority would play a part in this process and was being addressed with Integrated Medical Centres becoming community hubs with local resources being made available.

Councillor V Holloway thanked Andy Vowles for the report and stated that it was readable for residents. Councillor V Holloway stated that the summary of the STP consultation was vague on certain services such as mental health and social care and where could details of the wider range of care and funding be found. Andy Vowles thanked Councillor V Holloway for her comments and questions and stated that a wider story and information on the STP were available through a range of different documents on the web site. Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning

Group, stated that the consultation relied on resident's preferences and this would be undertaken by talking to local people. Mandy Ansell referred Members to "For Thurrock, In Thurrock" where the commitment between the NHS, Thurrock Clinical Commissioning Group, Thurrock Council and HealthWatch Thurrock to radically change the way health and social care services are commissioned and provided for within Thurrock.

Councillor V Holloway asked that following consultation with the right groups would a further consultation be required. Tom Abell hoped that no further consultation would be required following the events being organised by the Clinical Commissioning Group which would highlight to residents the timescales involved.

Councillor V Holloway asked whether some services would be relocated outside of Thurrock or would these be moved to the Integrated Medical Centres for Thurrock residents. Tom Abell stated that services would not be relocated outside of Thurrock unless feedback received stated otherwise. Tom Abell stated that getting the balance would be crucial where feedback might identify that residents would prefer all services under one roof rather than having to travel to different locations for different services.

Councillor V Holloway asked would the Capital Receipts for Orsett Hospital once sold be reinvested into Thurrock for Thurrock residents. Tom Abell stated that the selling of Orsett Hospital was some way off but the plan would be to reinvest into Thurrock with the purchase of equipment or other facilities for the Integrated Medical Centres.

Councillor Redsell stated her concerns over parking at Thurrock Hospital. Mandy Ansell stated that this was being addressed as part of the planning application.

Councillor Snell asked whether staff at Orsett hospital would transfer to the Integrated Medical Centres. Tom Abell stated that yes this would be the case apart from two principles areas, the sterile service unit and the medical record office, where this would be a good opportunity to bring services together and work differently.

Roger Harris stated that the Integrated Medical Centres were absolutely fundamental in delivering the STP Project and provided Members with the following updates:

- The Tilbury Integrated Medical Centre was most advanced with a design team being commissioned and that a business case would be taken to Cabinet in late summer/early autumn.
- A site had been identified for the location of the Purfleet Integrated Medical Centre.
- North East London NHS Foundation Trust (NELFT) had purchased the building for Corringham Integrated Medical Centre and a business case will go through the board in the summer.

- The Grays site would be slightly different as some components were already in place.
- That no contracts have been signed as yet with an enormous amount of work still had to be done to make this happen.

Councillor Snell stated that the travel of the STP was going in the right direction and that communication had possibly not been clear enough in the early stages. Councillor Snell stated that the Thurrock Plan was a good one and awaited the consultation responses.

38. Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Programme for Mid and South Essex

Roger Harris, Director of Adults, Housing and Health, presented the report and stated that following the establishment of a Joint Health and Wellbeing Overview and Scrutiny Committee with Essex and Southend the consultation papers had now been formally issued for consultation. Members were being asked to comment and agree to the draft terms of reference and to appoint four members to represent the Thurrock Health and Wellbeing Overview and Scrutiny Committee. Roger Harris stated that following guidance from the Department of Health on Joint Scrutiny Committees it was clear that local authorities are required to appoint joint committees where a relevant NHS body or health service provider consults with more than one local authority's health scrutiny function. Members were being advised to reserve its right over any potential referrals to the Secretary of State.

Councillor Snell stated that the majority of Members were initially against this Joint Health and Wellbeing Overview and Scrutiny Committee but understood the legal position and regulations for this to proceed. Councillor Snell stated that recommendation 2 should be amended to demand that meetings must be held in the evening to give all Thurrock full time working Members the opportunity to attend. That a formal request be made to the Chair of the Joint Health and Wellbeing Overview and Scrutiny Committee requesting that future timings are held no earlier than 7.00pm to ensure that Thurrock Members are given the opportunity to attend.

Councillor C Holloway requested some clarification on the terms of reference item 2.5. Roger Harris confirmed that individual local authorities, local Clinical Commissioning Group and local HealthWatch would continue to participate in the wider STP in their own right. Councillor Holloway requested clarification on item 6.2 of the terms of reference with regards to powers of the Joint Health and Wellbeing Overview and Scrutiny Committee. Roger Harris confirmed that all powers will fall to the Joint Committee apart from the power of referral to the Secretary of State.

Andy Vowles confirmed that discussions will take place at the informal committee on the 22 January 2018 with regards to the Joint Health and Wellbeing Overview and Scrutiny Committee functions and that comments received from the three Health and Wellbeing Overview and Scrutiny

Committees would be analysed and shared and that any reflections, observations or recommendations made would be put forward.

Councillors Snell, Collins, V Holloway and Redsell agreed that their views previously minuted with regards to Thurrock joining the Joint Health and Wellbeing Overview and Scrutiny Committee had not changed.

Councillor V Holloway asked how the three local authorities weighted with regards to the practicalities of comments. Roger Harris stated that a formal written response would be provided by the Joint Health and Wellbeing Overview and Scrutiny Committee delegation apart from the referral to the Secretary of State which would come from the Thurrock Health and Wellbeing Overview and Scrutiny Committee.

Councillor V Holloway asked whether the STP report would be presented again at Thurrock Health and Wellbeing Overview and Scrutiny committees. Roger Harris stated that this would be a twin track process where Thurrock Members could express further views on the consultation but a formal response would need to be made through the Joint Committee.

Councillor V Holloway agreed with Councillor Snell that a formal letter should be sent to the Chair of the Joint Health and Wellbeing Overview and Scrutiny Committee requesting that future timings be changed.

Councillor Snell reiterated that Members could not attend day time meetings as many Members worked full time. Councillor Snell stated that the proposed formal committee had been scheduled for the 28 February 2018 at 5.00pm in Southend which clashed with the Thurrock's Budget Full Council. Therefore no Thurrock Members would be able to attend and that put a question over the quorum of that meeting.

Councillor Snell asked Democratic Services to work with Southend and Essex to have the formal committee rescheduled and whether video conferencing or conference calling could be used.

The following Members nominated themselves to sit on the Joint Committee:

- Councillor Graham Snell (Chair of HOSC), UKIP
- Councillor Victoria Holloway (Vice-Chair of HOSC), Labour
- Councillor Gary Collins (Member of HOSC), Conservative.

The fourth member, due to political balance in Thurrock would need to be filled by an administration (Conservative) Member – this will be taken back to group for a further nomination.

RESOLVED:

1. That the Health and Wellbeing Overview and Scrutiny Committee comment on the proposed terms of reference for the Joint Health

and Wellbeing Overview and Scrutiny Committee with Essex and Southend.

2. **That the Health and Wellbeing Overview and Scrutiny Committee agreed to appoint four Members to represent Thurrock Health and Wellbeing Overview and Scrutiny Committee at the Joint Health and Wellbeing Overview and Scrutiny Committee meetings but can only attend meetings that commence from 7.00pm due to work commitments.**

3. **That the Health and Wellbeing Overview and Scrutiny Committee not delegate its power of referral to the Secretary of State to the joint Health and Wellbeing Overview and Scrutiny Committee.**

39. Work Programme

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

Members agreed that the report on Business Case for Tilbury Integrated Medical Centre/Tilbury Accountable Care Partnership be added to the next municipal year work programme.

Members agreed that the report on General Practitioner 5 Year Forward Review be added to the next municipal year work programme.

RESOLVED:

1. **That the item Business Case for Tilbury Integrated Medical Centre/Tilbury Accountable Care Partnership be added to the 2018/19 work programme.**

2. **That the item General Practitioner 5 Year Forward Review be added to the 2018/19 work programme.**

The meeting finished at 8.50 pm

Approved as a true and correct record

CHAIR

DATE

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

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12 March 2018	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
Thurrock First – Health and Social Care Single Point of Access	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Tania Sitch – Integrated Care Director : Thurrock Council and NELFT	
Accountable Assistant Director: Les Billingham – Assistant Director Adult Social Care and Community Development	
Accountable Director: Roger Harris – Corporate Director Adults, Housing and Health	
This report is public	

Executive Summary

This report is to update members on the Thurrock First Service which was launched in November 2017. Thurrock First is an exciting collaboration between health and social care partners and provides a single access point for information, professional advice, referral, assessment and access to services across health and social care for residents of Thurrock. Thurrock First aims to reduce duplication and brings together the previous separate initial points of contact for the Council, our NHS community provider North East London Foundation Trust (NELFT) and our local Mental health Trust (EPUT). This report provides detail of the service and successes to date.

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1. Recommendation(s)

1.1 That the progress in the development of Thurrock First be noted and commented on.

2. Introduction and Background

2.1 Feedback from customers and stakeholders indicated the need for improved access to fragmented health and social care support and advice - especially at the initial point of access. People do not know if they have health or social care needs, that are chronic, acute or are in crisis – they just want advice and assistance. They need one access point for people to obtain timely, effective information, advice and access to services. The service was set up to improve the customer experience whether a patient, GP or community member, including reducing the need for people to tell their story numerous times. By using a strength based approach and giving people advice and

solutions in their community, this service hopefully will reduce demands on health and social care resources while promoting self-management. Integrated team working has enabled earlier identification of individuals reaching crisis by providing support as a preventative measure.

2.2 The service was set up by creating a steering group and working groups involving the three key social care, community and mental health providers who currently run access points and services in Thurrock. They are NELFT (North East London Foundation Trust), Essex Partnership University Trust (EPUT) and Thurrock Council. It, importantly, included key stakeholders especially customer representatives and staff. A shared vision/understanding of the objectives and roles/responsibilities were designed from the start. In addition to bringing service access points together, this integrated service would develop a new offer that was strength based, promoted self-management and recognised the community and voluntary sector assets. This development required a change in culture that needed developing and challenging throughout. Willingness and commitment to work and share information and resources enabled the set-up of the service. A memorandum of understanding that set out the ethos was adopted in that the all organisations agreed to focus on what was right for the system and not individual organisations. This meant a commitment to overcome organisational sovereignty. As such, all organisations contributed time and funds without questioning their exact pro-rata share.

2.3 The Team which came together initially in July 2017 is made up of call handlers and clinicians/professionals and provides a service from 7am to 7pm seven days a week, with weekends and evenings for emergency contacts at present. The team are now based at Thurrock Community Hospital and co-location is key to the success of multi-agency working. The initiative works because all of the advisors have been cross agency trained to provide, or signpost to, appropriate support. This includes access to early support for mental health issues. All staff are to be trained as Motivational Interviewers and are able to screen for depression.

The team have access to multiple databases allowing an overview of an individual's needs and support already being provided, this information, along with what the caller is saying, helps inform the most effective outcome to a request. The team also has access to a broad range of community information, to help signpost individuals, therefore building on solutions not services.

They have an Integrated Team Manager (jointly funded across the three agencies) who brings staff from all organisations together. The service has access to social work, clinical nurse and community psychiatric nurse specialist support. The service has access to social work, clinical nurse and community psychiatric nurse specialist support. Regular multi-disciplinary meetings have been arranged with a view to identifying individuals who need support earlier (to prevent crisis/admission) and ensure multi-organisational input is co-ordinated, efficient and effective.

2.4 The weekly average calls the team manage is now 880 per week compared to 770 in September 2017. 8% of calls are at weekends. The team have had great success with reducing the number of abandoned calls due to a high volume of calls at certain times. The Performance Scorecard is now agreed for this service, will be presented to all three main partners and will include data on calls and when received and outcomes for people including which support, advice or services they received. In November 2017 3664 calls were received alone. Calls are coming from a variety of sources including individuals themselves, family, GP's and other professionals.

2.5 One outcome for this service is they can make one call and get an enhanced offer. Some examples of improved outcomes for people are as follows:

- A family member phoned to request contact from a nurse for her terminally ill sister, during that call concerns were raised with how the daughter was treating her mother, the patient, this triggered a Safeguarding Concern.
- An individual phoning to request a social care assessment was happy when we were able to chase the provision of their Occupational Therapy equipment (assessed prior to discharge from hospital) within the same call
- We were able to expedite a safeguarding investigation by providing appropriate contact details of those actively involved in providing care from the NELFT perspective.
- A family member phoning to request a nurse visit was supported through the provision of a social care assessment as the conversation identified that the daughter was struggling to continue to support the mother's health needs.
- Collated community asset information used by Stronger Together, for their Google map, and Local Area Co-ordinators into one user friendly spreadsheet and made this available to Adult Social Care
- The team have had lots of compliments with the themes being how helpful the team are, and how they managed to get a number of things resolved.

There is scope for further efficiencies and added value with the transfer of additional services into Thurrock First going forward, including possibly housing and public health functions. The links to the children's service Multi Agency Safeguarding Hub (MASH) and out of hours services offered by the Emergency Duty Team (EDT) will also be reviewed. A full evaluation of the service will be carried out in Autumn 2018 and any recommendations will be taken forward as appropriate.

3. Issues, Options and Analysis of Options

3.1 The concept of an integrated service came from feedback from service users themselves who very much wanted to tell their story only once. The Local Authority and the NHS locally have a strong record of working together and Thurrock First is another example of this working in practice.

4. Reasons for Recommendation

4.1 This report updates the Committee on the progress made so far, a full evaluation will be undertaken after a year's full operation of the service.

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

5.1 No formal consultation has taken place regarding this service, but patient/service user groups' feedback was used to identify the key areas and outcomes that should be achieved. Customers helped form the principles and objectives of the service.

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

6.1 This service will impact positively on Health and Wellbeing of residents and is one of the delivery objectives of the Joint Health and Well-Being strategy.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care

An initial three way budget was set up with each partner (NELFT, EPUT and Thurrock Council) contributing equally towards set-up costs (accommodation, IT and other costs) and each partner funding their existing staff. Ongoing costs for the team will be funded equally. An MOU has been signed by all partners to confirm equal funding. The team comprises of approximately 20 FTE. There are no financial risks or implications arising from this report.

7.2 Legal

Implications verified by: **David Lawson**

Monitoring Officer

An MOU has been signed to confirm how partners will manage the service going forward in an equal partnership. This covers financial contributions, sharing performance data etc. There are no legal implications.

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

This project will ensure an improved service for all vulnerable people in Thurrock across all wards. An improved access point will support vulnerable people and people from all protected characteristics, as it will avoid people having to access multiple points and will give improved information about support groups and services in their community.

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

N/A

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

- N/A

9. Appendices to the report

- N/A

Report Author:

Tania Sitch
Integrated Care Director
Adults, Housing and Health

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12 March 2018	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Living Well in Thurrock: Adult Social Care Transformation Programme Update	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Roger Harris, Corporate Director of Adults, Housing and Health	
Accountable Assistant Director: Les Billingham, Assistant Director for Adult Social Care and Community Development	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health	
This report is public	

Executive Summary

Adult Social Care faces a number of significant and sustained challenges. Transformation of the existing health and care system is a must in order to ensure sustainability by using available resource to greatest effect.

The Adult Social Care transformation journey began in 2012 with a programme called Building Positive Futures. The programme recognised the vital role of the built environment and of community resilience. Instigating the Programme resulted in the development of the Stronger Together Thurrock Partnership and also attracted a significant amount of grant money with which to develop a greater choice of accommodation for both older people and adults of working age. The Programme achieved a great many things including Local Area Coordination, HAPPI housing schemes, growth in supported accommodation, and community hubs.

Living Well in Thurrock was launched as phase 2 of Thurrock's transformation programme and was a collaboration with local Health partners and the voluntary and community sector. Living Well in Thurrock built on the work developed by Building Positive Futures – for example expanding Local Area Coordination, introducing Social Prescribing, developing independent living accommodation, and scoping the development of a 21st century residential care facility.

Phase 3 of the Adult Social Care transformation programme consolidates and expands the approach further still – with a focus on place and on system redesign.

This report reflects on what has been achieved through the delivery of the Living Well in Thurrock Programme and set out next steps and future plans.

1. Recommendation(s)

1.1 For the Committee to note and comment on the Adult Social Care Transformation Programme: Living Well in Thurrock

2. Introduction and Background

2.1 Thurrock Council's Adult Social Care transformation journey started back in 2012 following a Commission of Enquiry in to Housing, Health and Social Care across South Essex in 2011. The three key areas of interest identified by the Commission remain the focus of our transformation today:

- The significance of place and housing in terms of improved health and wellbeing;
- The crucial roles that communities play in providing nurture and support for all, and therefore the need to build resilient communities; and
- The importance of professional services providing a safety net for people – so long as they are delivered in a whole system way and only when a 'service' is the right option.

2.2 Thurrock's initial Adult Social Care transformation programme was called Building Positive Futures and had a number of key successes under each of the three strands identified in 2.1. Much of the success achieved was as a result of collaboration with key partners – with the voluntary and community sector having a significant role. The successes included:

- The introduction of Local Area Coordination;
- Asset-Based Community Development – leading to the instigation of the Stronger Together Partnership and Programme;
- Successful bids totalling £2.6 million of capital funding used to develop HAPPI housing schemes – 28 specialist flats in South Ockendon (Bruyn's Court), supported-living flats for working age adults (Medina Road), and funding to transform 8 sheltered housing flats in Aveley (Chichester Close);
- A Rapid Response and Assessment Service (RRAS) – operating in partnership with community health provider (NELFT);
- A Joint Reablement Team (JRT); and
- The establishment of a joint post across Adult Social Care and Community Health (NELFT) – Director of Integrated Care.

2.3 In January 2017 a report was presented to the Committee which outlined the next phase of the Department's transformation programme - Living Well in Thurrock. Living Well in Thurrock is designed to respond to the key challenges facing adult social care and to build on the success of Building Positive Futures. Recognising that a collaborative approach was vital to success, Living Well in Thurrock became a joint programme with Thurrock Clinical Commissioning Group and incorporated the Stronger Together Thurrock Programme as part of its approach.

2.4 The purpose of this report is to detail the achievements of the Living Well in Thurrock programme to date and to outline future transformation plans.

3. Issues, Options and Analysis of Options

Why do we need to transform?

3.1 There are a number of factors driving the need for transformation across the health and care system. These include:

- An ageing population – with people living for more years but with a greater number of years in poorer health;
- Increased complexity of cases for both older people and working age adults;
- Insufficient capacity across the system;
- An extremely fragile provider market – particularly domiciliary care;
- A health and care system designed to react to rather than prevent ill-health; and
- Difficulty retaining and recruiting social care staff – carers in particular.

3.2 The factors driving the need for health and social care transformation require a very different approach to be taken – one that focuses on prevention and early intervention and more generally on promoting wellbeing. The current system has predominantly focused on responding to need and waiting until individuals reach crisis point. To successfully overcome current challenges, transformation must redesign the foundations upon which the health and care system is based – for example:

- A focus on strengths not on need – reducing dependency;
- Empowering individuals to take control of their own lives;
- Targeting interventions so that they prevent crisis;
- The importance of outcomes as opposed to process;
- The need to reduce duplication, bureaucracy and process to ensure the majority of resource is focused on providing support;
- The importance of technology to enable improved outcomes; and
- The importance of a solution and outcome focus not of a service and prescription model.

3.3 Whilst the transformation of the health and care system is extremely complex and constantly evolving, there is already evidence that the approach being taken in Thurrock is having an impact. In addition to a number of case studies captured to demonstrate impact, the 2016 Annual Director of Public Health report stated that data *'suggests prevention and early intervention programmes such as Local Area Coordination, Stronger Together and Living Well in Thurrock are having a positive impact on reducing demand for statutory care packages….'* Whilst this is positive and evidence that the Transformation Programme is shifting the system towards prevention and early intervention, there is a need to acknowledge that when individuals do enter the system, they often have a greater degree of complexity and therefore cost.

What's been achieved?

3.4 Living Well in Thurrock has continued to build and expand on the successes achieved during the first phase of transformation – against the programme's three key strands: stronger communities, built environment, and health and social care system infrastructure. As already stated, a significant amount has been achieved in collaboration with partners – namely local NHS partners and the voluntary and community sector (through the Stronger Together Programme). Much of the expansion has been made possible by Better Care Fund investment – a pooled fund between the Council and CCG. Some of these were reported in the January 2017 report, so the examples mentioned below are in addition to those already reported:

- **Local Area Coordination** – starting with 3 Local Area Coordinators (LACs) and a manager, the success of the approach has resulted in a Borough-wide service consisting of 14 LACs and a manager. The service is funded by the Better Care Fund.
- **Social Prescribing** – starting with 2 Social Prescribers funded by the Better Care Fund, social prescribing has been expanded to provide greater coverage across the Borough. Social Prescribing's purpose is to reduce service demand (particularly primary care) and to enable individuals to find solutions to non-clinical issues – e.g. via effective signposting and through improved resilience. This might include referral to a Local Area Coordinator.
- **Thurrock First** – Thurrock's integrated single point of access across Adult Social Care, Mental Health and Community Health was launched in July 2017. The service aims to reduce duplication and bureaucracy and improve the customer's experience. There are case studies that demonstrate the impact of the service to date and further work will be carried out that will consider how the service can expand and improve.
- **Micro-Enterprises** – Thurrock's micro-enterprise programme has resulted in over 80 micro enterprises now being in place. The approach has enabled greater market choice and focuses on helping people to live independently at home, live a full life and keep well, maintain or make new relationships, and to get around in their community. The approach also enables a greater proportion of investment to be retained within the local economy.
- **Chichester Close** – 8 refurbished ex-sheltered housing flats were made available for people with a learning disability as a result of a successful bid to the Housing and Technology for People with Learning Disabilities Local Authority Capital Fund. The aim of the flats is that individuals are able to live as independently as possible within the community and that where possible, residential placements are avoided or reduced. All 8 flats have now been let.
- **21st Century Care Home** – in November, the Committee noted and supported the strategy for the development of a new residential facility for the 21st century on the Whiteacre and Dilkes Wood sites in conjunction with Health partners. The purpose of the strategy is to be able to support people who are very frail and who would usually be

supported in residential care to be supported in a new way – one that maintains privacy, independence and dignity.

3.5 Thurrock is seen as being at the forefront of innovation in transformation and as such the Council's approach is attracting significant interest and recognition. For example, the Chief Social Worker for England (Lyn Romeo) visited Thurrock during 2017 and then wrote about Thurrock's strength-based approach to social work in her annual report; a report following a facilitated workshop hosted by health and social care think tank the King's Fund entitled 'six innovations in social care' mentioned Thurrock as one of a small number of authorities to adopt five of the six innovations; and in January a number of national organisations at the forefront of innovation in social care made Thurrock the focus of a workshop hosted by Birmingham University. The workshop reviewed Thurrock's use of innovation (particularly through strength-based approaches) in its transformation journey to date and discussed how the approach might need to evolve to move system redesign further forward – including how best to evaluate the impact of the changes being made.

3.6 The recognition received by the Council for its work to date has enabled Thurrock to be in a position to inform national policy. This has included the forthcoming Green Paper for Older People's Social Care.

3.7 Due to the interest in Thurrock's approach and regular contact received from local authority colleagues requesting information, in February the Council hosted a successful Adult Social Care 'showcase' event. The event was attended by over 100 people and showcased the Council's approach and future plans. Whilst the Council does not profess to have all of the answers, it does appear that Thurrock is at the forefront in terms of its thinking and progress to date.

What's next?

3.8 Whilst the Council, in conjunction with partners, has successfully implemented a number of new and innovative approaches aimed at transforming adult social care, it is important that these initiatives do not operate in isolation and it is also important that Adult Social Care continues to consolidate and build on what is already in place.

3.9 During 2017, the Director of Public Health developed a 'case for change' that helped to define the next phase of Thurrock's transformation journey. The work focused on shifting resource away from the most expensive part of the system (acute) and to the community where it would have the greatest impact – in terms of prevention, early intervention, and management of long-term conditions. To be successful, the existing health and care system would have to be redesigned to focus on the principles underpinning prevention and early intervention.

3.10 As a result of the work carried out by the Director of Public Health, work has commenced through a New Models of Care programme to deliver the recommended action identified by the Case for Change. The work has attracted recognition from Public Health England. A report was presented to the Committee in November. In short, the work provides Thurrock with an opportunity to redesign the health and care system around a place (Tilbury and Chadwell) to the benefit of people within that 'place'. The programme is consistent with the direction of travel set by Adult Social Care – including recognising the importance of strengths, prevention, early intervention, and outcomes over process. The approach is one based on collaboration and includes a range of partners.

3.11 As part of the New Models of Care work and the next phase of transformation, Adult Social Care is to pilot two alternative delivery models – based in the Tilbury and Chadwell locality. This followed an options appraisal that explored and evaluated alternative options for the delivery of current in-house Adult Social Care provision. As well as piloting the individual approaches, the new pilot teams will explore the advantages of working alongside other innovations. The pilot approaches are:

Wellbeing Teams – two staff-led teams will be piloted. The teams will provide an alternative delivery model for domiciliary care. The aim is to enable staff to spend a greater amount of time with individuals being supported; work closer with individuals to identify and meet personal outcomes; and to help professionalise the carer role. With the domiciliary care market so stretched, developing a new approach is vital. Whilst being tested, there are also opportunities to have greater connectivity with community activities and to identify how teams could work alongside Health – e.g. community health. The aim is to have the pilot teams in place by the end of the summer.

Care and Assessment Team – one team will be piloted. The team will carry out social work functions in the Tilbury and Chadwell locality and will be based in that community. The benefit of the approach is that staff themselves lead the team's approach and are able to change how the team and function operates to achieve the best method of working. The approach was first piloted in Shropshire and has numerous benefits – for example a streamlined assessment process, increasing the amount of time spent within individuals by reducing bureaucracy and unnecessary process, and changing the location of assessments – e.g. not always carried out in the home but in a community setting.

The pilot approaches will be evaluated to identify impact and will be governed by through the New Models of Care programme.

4. Reasons for Recommendation

4.1 To update the Committee and ensure its input on progress made to date and on future Adult Social Care transformation plans.

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

5.1 Thurrock residents were consulted on and informed a set of principles that underpin any health and care transformation activity. Additionally, Thurrock residents – including users of services, carers, and representative organisations – are involved in shaping many of the pieces of work incorporated within the transformation programme. As part of this, the Council works with user-led organisation Thurrock Coalition to ensure plans are developed in conjunction with users of services and their representatives.

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

6.1 The Adult Social Care transformation programme will contribute to the delivery of the Council's vision and priorities in particular:

People – a borough where people of all ages are proud to work and play, live and stay

- High quality, consistent and accessible public services which are right first time
- Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
- Communities are empowered to make choices and be safer and stronger together

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care & Commissioning

The Adult Social Care Transformation Programme is delivered within existing budgets and through the successful bidding of government funding grants. The Programme is designed to help to meet the challenges faced by Adult Social Care and to therefore ensure as best as possible that the Department is able to meet demand and operate within its budget.

7.2 **Legal**

Implications verified by: **Sarah Okafor**

Barrister (Consultant)

On behalf of the Assistant Director of Law I have read in full the contents of this report, and there appears to be no external legal implications arising from it. The aims and objectives of the Transformation will operate within the range of legislative statutory frameworks that govern Adult Social Care and Local Government functions.

7.3 **Diversity and Equality**

Implications verified by: **Becky Price**

Community Development Officer

Service users and residents across all protected groups may be impacted by the Living Well at Home programme. Positive implications include increased choice and control over the type of solution individuals receive along with how and where they access them leading to an increase in the scale of independent living within service users' and residents' own homes and communities across the Borough. Positive implications also relate to preventing and delaying service need and a focus on delivering outcomes. Failure to fully implement the programme could have negative impacts – for example a reduction in services offered or how they are offered and restrictions about the type and accessibility of services available. This could lead to higher levels of dependency and complexity of cases. Implementation of the Living Well in Thurrock Programme aims to address inequality in service provision and increase the scale and the scope of the positive benefits outlined.

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):

- Living Well in Thurrock: Adult Social Care Transformation Programme, Health and Wellbeing Overview and Scrutiny Committee, 17 January 2017
- New Model of Care for Tilbury and Chadwell, Health and Wellbeing Overview and Scrutiny Committee, 16 November 2017

9. Appendices to the report

- None

Report Author:

Ceri Armstrong
Senior Health and Social Care Development Manager
Adult Social Care

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12 March 2018	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
Dementia Strategy – Implementation Progress	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Catherine Wilson - Strategic Lead Commissioning and Procurement	
Accountable Assistant Director: Les Billingham - Assistant Director Adult Social Care and Community Development	
Accountable Director: Roger Harris - Corporate Director Adults, Housing and Health	
This report is Public	

Executive Summary

The purpose of this report is to update Health Overview and Scrutiny Committee regarding the progress within Thurrock of the implementation of the Southend, Essex and Thurrock Dementia Strategy 2017 – 2021 and to inform Members of future events to ensure an inclusive approach to the strategy implementation in Thurrock.

1. Recommendation(s)

1.1 For Health Overview and Scrutiny Committee to comment on the current position regarding the Southend, Essex and Thurrock Dementia Strategy in Thurrock.

2. Introduction and Background

2.1 This strategy is for everyone in Southend, Essex and Thurrock who is living with dementia or supporting someone who is. It describes what we want support for people with dementia to look like in the future and it describes nine priorities for action to make this happen.

2.2 The purpose of the new strategy is to reduce fragmentation in service delivery and accessibility to information support and advice across Greater Essex for people with lived experience of dementia and for organisations offering support. The strategy aspires to deliver its vision that:

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

Within the strategy there are nine priorities these are:

- **Prevention** – to ensure that people in Thurrock have good health and wellbeing enabling them to live full and independent lives for longer.

- **Finding Information and advice** – Everyone with dementia will have access to the right information at the right time.

- **Diagnosis and support** – all people with dementia will receive appropriate and timely diagnosis and integrated support.

- **Living well with dementia in the community** – all people with dementia are supported by their communities to remain independent for as long as possible.

- **Supporting Carers** – carers are supported to enable people with dementia to remain as independent as possible.

- **Reducing risk of crisis** – all people with dementia receive support to reduce the risks and manage crisis.

- **Living well in long term care** – all people with dementia live well when they are supported in long term care.

- **End of life** – people with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their own wishes.

- **To have a knowledgeable and skilled workforce** – all people with dementia receive support from knowledgeable and skilled professionals where needed.

2.3 Living Well with Dementia: A National Dementia Strategy published by the Department of Health on the 3rd February 2009 laid the foundation for significant changes across Health and Social Care for the support of people living with dementia.

Dementia continues to be a growing challenge. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. In England it is estimated that around 676,000 people have dementia. In the whole of the UK, the number of people with dementia is estimated at 850,000.

Dementia is a key priority for both NHS England and the Government. In February 2015 the Challenge on Dementia 2020, was launched. It sets out NHS England's aim that by 2020 we are:

- The best country in the world for dementia care and support for individuals with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases.

Some of the key aspirations of this vision are:

- Equal access to diagnosis for everyone
- GPs playing a lead role in ensuring coordination and continuity of care for people with dementia
- Every person diagnosed with dementia having meaningful care following their diagnosis
- All NHS staff having received training on dementia appropriate to their role.

One of the priorities identified by NHS England as part of the Five Year Forward View is to improve the quality of care and access to mental health and dementia services.

2.4 In Thurrock we are moving forward very positively with the delivery of the nine priorities within the Southend, Essex and Thurrock Dementia Strategy.

- The Alzheimer's Society will be leading the development of our local Dementia Alliance. This will start in the first quarter of 2018-2019 and the Dementia Alliance will continue the work around the further development of Dementia Friendly communities throughout Thurrock.
- The Better Care Fund has funded an Older Adult Wellbeing Service provided by North East London Foundation Trust (NELFT). This is a multi-disciplinary integrated approach to the care and support of older age adults including people living with dementia. The aim of the service is to support people to remain as independent as possible for as long as possible in their local communities and at home. This has proved to be very successful. The nurses within the team deliver Dementia Nursing support within our residential care homes and within the community.
- Diagnostic services are provided by Essex Partnership Trust (EPUT) and the pathway is now clear for referral post diagnosis to the Older Adult Well Being Service.
- The Dementia Crisis Support Team has been extended so that the team can support individuals for longer at home in their own communities.

- Further funding has been agreed through the Better Care Fund for the Alzheimer's Society to deliver information, advice and community support together with their memory service.
- St. Luke's are working with care homes regarding end of life planning to support people living with dementia to remain within the care home wherever possible.
- The Alzheimer's Society has undertaken a programme of Dementia Friends training across the Council and in local communities which has been well attended.
- Adult Social Care and EPUT's Older People Mental Health Team provide specialist support for people living with dementia and their carers together with a duty response to urgent situations.

3. Issues, Options and Analysis of Options

3.1 It is key that we retain the local focus to the delivery of the wider strategy to ensure good quality service and community responses in Thurrock.

4. Reasons for Recommendation

4.1 This report is to give an update to members regarding support for people with lived experience of dementia and their carers living in Thurrock and to ensure that members are aware that the priorities within the Southend, Essex and Thurrock Mental Health Strategy are being delivered and addressed.

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

5.1 As the detailed work progresses we plan to hold a series of consultation and engagement events in partnership with the voluntary sector and local communities to listen to the experience of those receiving services and to help shape and develop further community and care supports.

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

6.1 Dementia services and the programme of work the Dementia Alliance will deliver will support and enhance the well-being of individuals with lived experience of dementia and their carers and this will benefit our wider communities. The work will also ensure that we adhere to the Council's Charter for Older People which echoes many of the priorities within the Strategy to support independence, choice and ensure that people are treated with dignity and respect. The strategic approach is to highlight and ensure that support and care is fair and equitable and that people living with dementia have a voice in shaping their own services and support networks.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care

There are no current financial implications to the delivery of the strategy however there may need to be consideration of further investment. This will be done in collaboration with our Health colleagues and with the intention of allocation of funds through the Better Care Fund. Detailed business cases would need to be presented to the Integrated Commissioning Executives committee and adhere to the usual governance arrangements.

7.2 Legal

Implications verified by: **David Lawson**

Monitoring Officer

There are no direct legal implications at this stage but as the strategy continues to be implemented Legal Services is available to provide any necessary legal advice

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The delivery of the strategy will support wider communities within Thurrock to embrace and support people with lived experience of dementia to live well in their local community.

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

N/A

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

- N/A

9. Appendices to the report

- Southend, Essex and Thurrock Dementia Strategy 2017- 2021

Report Author:

Catherine Wilson Strategic Lead Commissioning and Procurement

Southend, Essex and Thurrock Dementia Strategy (DRAFT)

2017-2021

Version 5.5

7th February 2017

Southend, Essex and Thurrock Dementia Strategy

Table of Contents

Living well with dementia in Southend, Essex and Thurrock,

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

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

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

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

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

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

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

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

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

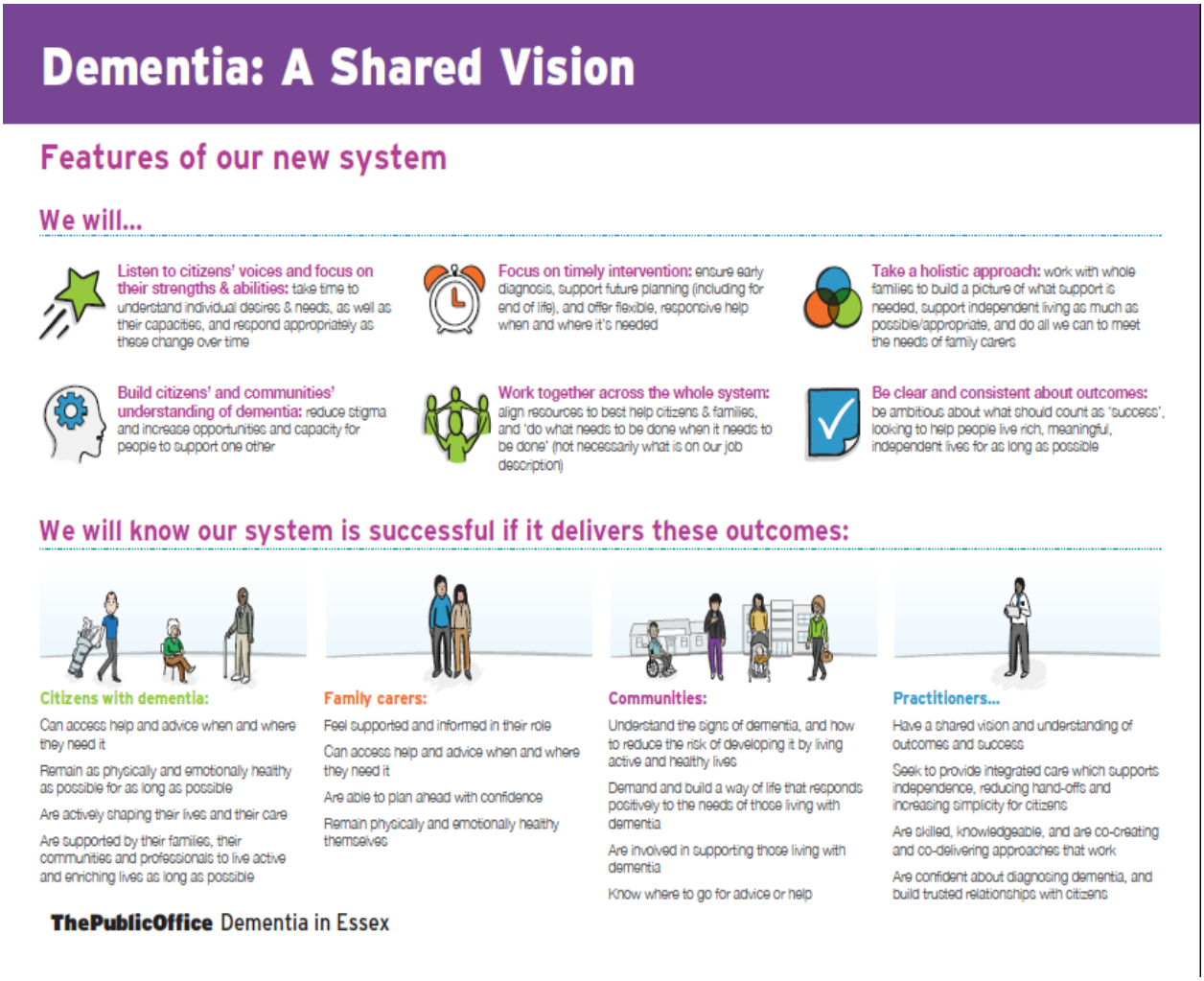
Rethinking dementia: A collaborative enquiry

Vision

Our vision for the future is one in which:

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

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



1. A joint strategic approach to dementia in Greater Essex

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

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

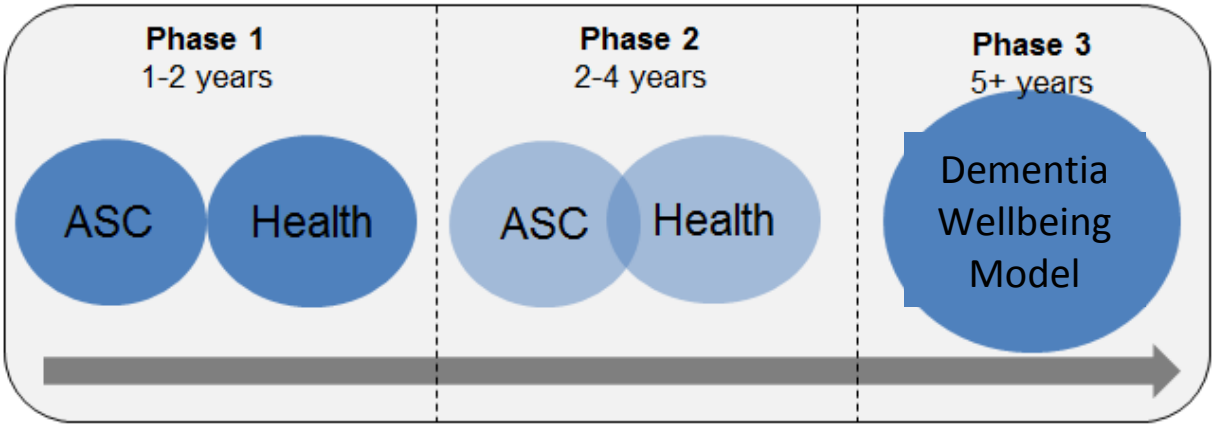
We aim to design systems that reflect the unique local and demographic needs of communities across Greater Essex but are able to;

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

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

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

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



2. A new model of specialist support

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

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

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

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

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

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

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

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

4. Maximise the use of technology

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

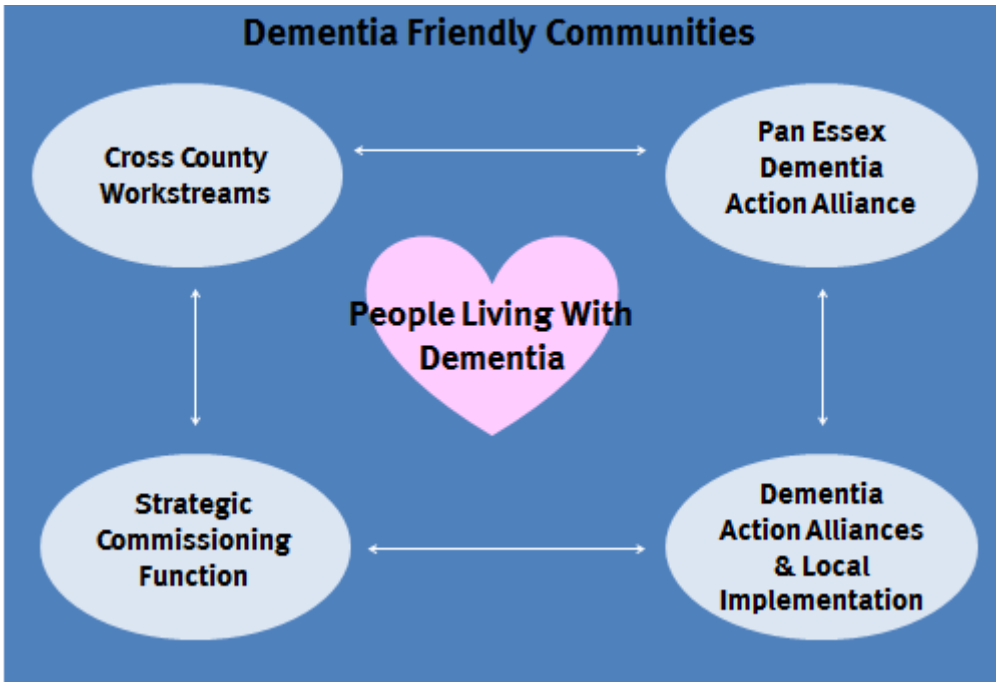
5. The voice of lived experience

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

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

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

Future partnership model:



Priorities

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

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

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

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

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

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

The stages of dementia

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

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

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

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

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

Ethnicity

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

Early onset dementia

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

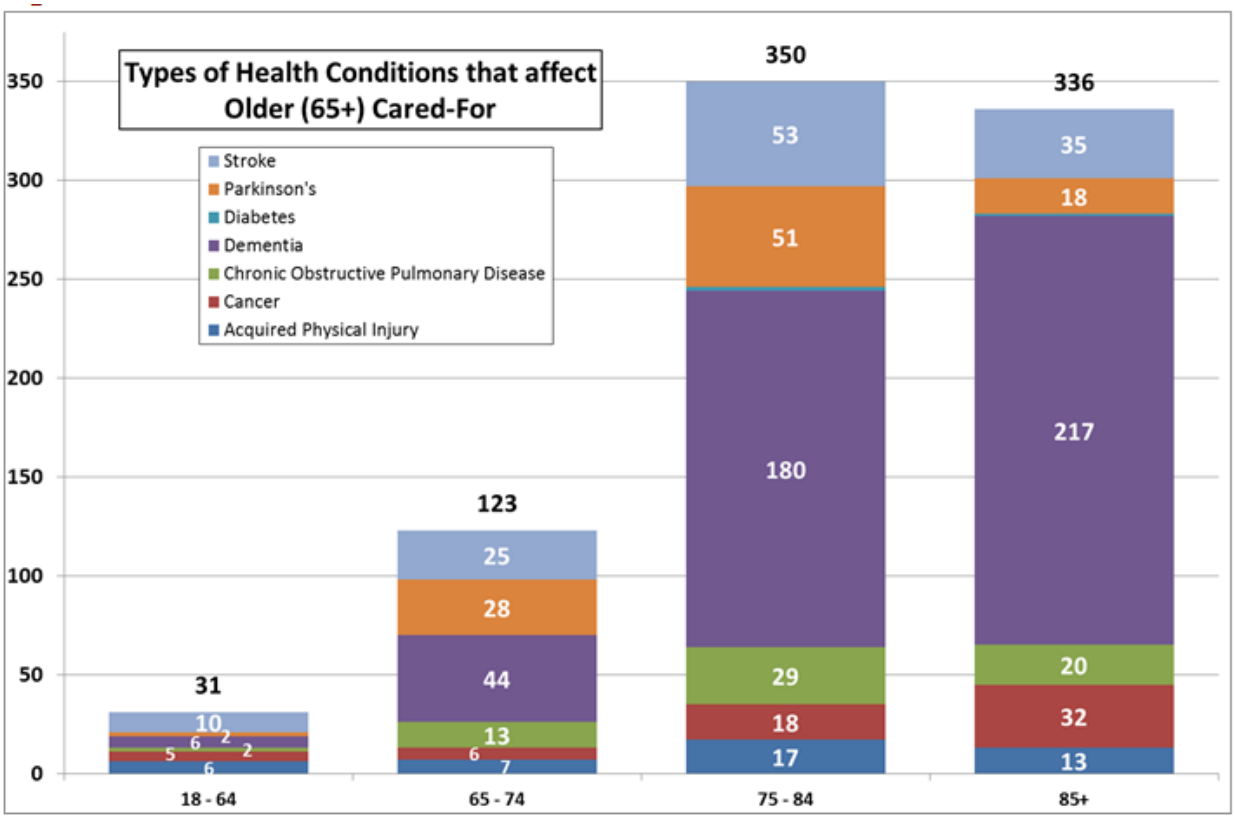
Learning disability and dementia

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

Carers

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

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



Priority 1: Prevention

The issue

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

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

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

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

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

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

Success measures

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

Priority 2: Finding information and advice

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

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

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

The issue

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

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

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

Success measures

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

Priority 3: Diagnosis and assessment

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

imagining it. We could start to make plans."

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

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

The issue

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

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

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

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

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

Success measures

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

Priority 4: Living well with dementia in the community

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

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

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

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

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

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

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

The issue

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

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

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

We want to promote a more inclusive approach to help people live independently in their community, maintaining the relationships and activities that matter to them. We will do this by helping people and their families to use their existing strengths and resources and connect to things that will help them get on with their lives. Where people need more intensive support we will make sure this is tailored to their individual needs and preferences, with the option of a personal budget to give them maximum control over the kind of help they receive.

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

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

Success measures

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

Priority 5: Supporting Carers

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

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

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

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

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

The issue

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

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

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

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

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

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

Success Measures

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

Priority 6: Reducing the risk of Crisis

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

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

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

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

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

The issue

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

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

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

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

Success Measures

- All hospitals to aspire to being dementia friendly care settings
- People living with dementia, with complex needs such as co-morbidities are offered specialist information and support
- Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively
- Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments
- Primary Care are able to respond to episodes of crisis in care homes appropriately

Priority 7: Living well in long term care

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

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

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

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

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

The issue

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

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

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

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

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

Success Measures

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

Priority 8: End of life

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

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

The issue

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

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

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

Success Measures

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

Priority 9: A knowledgeable and skilled workforce

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

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

The issue

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

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

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

Success Measures

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

Key Documents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Glossary

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

Appendix – Implementation Plan

Dementia Implementation Plan.:

Business as Usual Delivery

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

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

	the right information at the right time.	guidance offer is available.	Who is accessing it?	Development of Offer	X	X			X	X	X		X	X	X	X	L
				Linking in with Technology Enabled Care	X	X			X	X	X		X	X	X	X	H
		People living with dementia will feel supported to navigate the system and access information and support that is relevant to them		As above	X	X			X	X	X		X	X	X	X	L
Living well with Dementia in the community	All people with Dementia are supported by their communities to remain independent for as long as possible	There is a whole community response to living well with dementia	Number of Dementia Friendly Communities Coverage of DAA across Essex	Delivery of the DAA across Essex	X						X					X	L
				Commissioning a Dementia Friendly Co-ordinator to drive the demential friendly network	X						X					X	L
				Promotion of Dementia Friends in the communities of Essex	X						X					X	L
		Environments and physical settings in the community are dementia friendly	As above	As above	X						X					X	L
		People living with dementia are able to take advantage of open space and nature	Number of "green" commmunities with Dementia Friendly Number of people engagin with green spaces as part of their dementia support	Green prescription project focused on enabling communities to do this	X						X					X	L
		The voice of lived experience helps to shape how communities respond to dementia	Number of Lived Experience conversations to support shaping community action	Delivery of Lived Experience training	X						X					X	L
				Process by which commissioned services use this type of conversation to shape support	X						X					X	L
				Ongoing development of Healthwatch sustainable process for engaging with people with Dementia to shape their support and offer	X						X					X	L

		People living with dementia are encouraged to access information and support to help themselves	Number of people accessing the service that received low level support/signposting	Family Navigation and Information Support service delivery	X						X					X	L
		The lives of people living with dementia in the community are transformed through the DAA activity	Reduction in admission to hospital Reduction in admissions to long term care Number of people who feel their lives have improved since becoming involved with their communities	As above	X						X					X	L
		Young people are part of the community support for people living with dementia	Number of under 18's involved in community dementia support Number of under 18 dementia friendly	As above	X						X					X	L
		The market is able to respond to people living with dementia and support them to live well	Number of dementia champions within each provider setting Number of dementia Friendly Care settings	Delivery of Residential and Domicillary Provider forums	X						X					X	L
		People with dementia have awareness of alternative accommodation options	Number of people with Dementia accessing alternative accomodation options	Family Navigation and Information Support service delivery	X						X					X	L
Supporting Carers	Carers are supported to enable people with dementia to remain as independent as possible	Carers are a driving force behind shaping the response to dementia in Essex	Number of carers engaging in Dementia quality assurance Number of carers on design forum	Development of Dementia Carers network to assess all settings where Dementia support is offered	X				X		X				X		L
				Development of Dementia Carers service design forum for developing support where needed	X				X		X				X		L

		Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy	Number of crisis for carers Number of carers who have accessed support networks following our intervention	Family information and support network developed to provide them with relevant information and timely appropriate support	X				X		X				X		M
				Development of community neighbourhood model	X				X		X				X		M
				Development of DAA to support carers	X				X		X				X		L
Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	All hospitals to aspire to being dementia friendly care settings	Number of dementia friendly hospitals	Collectively share best practise around supporting people with Dementia in an acute setting	X				X		X				X		L
				Explore contractual changes with acute settings	X				X		X				X		L
		People living with dementia, with complex needs such as co-morbidities are offered specialist information and support	Number of family group conferences carried out Number of hospital/long term care admissions	Identification of "high risk" people and working together to co-ordinate a care plan to support them	X				X		X				X		L
				Development of process for linking multiple condition systems	X				X		X				X		L
		Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively	Number of crisis plans developed Number of crisis Acute Admissions	Support Good Lives centres to support individuals to plan for and manage crisis	X				X		X				X		L
				An all age dementia offer developed for those who required their complex needs managed	X				X		X				X		H
				Develop Care Home response to Crisis and approaches for managing times of crisis	X				X		X				X		M
		Emergency planning is addressed as part of all carer's assessments	Number of carers assessment that incllludes emergency planning	As above	X				X		X				X		L

Living well in Long Term Care	All people with dementia live well when in long term care	All care homes for people with dementia in Essex to be dementia friendly by 2020	Number of Dementia Friendly Care Homes	Comms exercise to promote Dementia Friends programme and local alliance	X				X		X		X		X		M
				Explore contractual changes with Care Homes	X				X		X		X		X		L
		People living with dementia, their families and carers understand what high quality care looks like and where to find it	Number of people who are aware of the varying options they have for care	How we can work with carers to understand how their voice can support the quality of care	X				X		X		X		X		L
				Development of a best practise guide for Carers to use when researching long term Dementia Care in Essex as part of IAG offer	X				X		X		X		X		L
		People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings	Number of people with Learning Disabilities who have a holistic assessment of need	Ensure that Care settings are able to "Identify how best to meet individuals needs" especially for those considering "high risk" of developing dementia	X				X		X		X		X		L
				Developing a pathway link that supports people with learning disabilities to obtain a timely diagnosis	X				X		X		X		X		L
				Dementia Champions within LD care settings	X				X		X		X		X		M
		People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting	Number of People with Dementia accessing the Dementia Friendly network in Essex	Dementia friendly network in Essex developed to be inclusive	X				X		X		X		X		:L
				Support the care workforce to link with the dementia friendly network and to look outside of their setting to provide support	X				X		X		X		X		M
				Carers knowledge and confidence increased to allow them to become part of the network outside of the care setting	X				X		X		X		X		L

		People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate	Increase No. of MCA referrals	Process and guidance change/communication	X				X		X		X		X		L
End of Life	People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes	People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate	Increase No. of MCA referrals	Process and guidance change/communication	X				X		X		X		X		L
		People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose	Number of people who "feel informed" about EOL options Number of people completing EOL Advanced Care Plans Number of people who die in their place of choice	Delivery of the above	X				X		X		X		X		-
		Carers and families receive bereavement support	Number of people who are offered berevement support following the death of a relative with Dementia	Determining current market offer for berevement support and forging links to sign post people to	X				X		X		X		X		
A Knowledgeable and Skilled Workforce	All people with dementia receive support from knowledgeable and skilled professionals where needed	There is a framework for dementia training across Essex to ensure all people receive training relevant to their role	Framework in place for training	Link in with Health Education England to see if there is an existing framework we can use	X				X				X				-
				Identify whether a national framework is useful for Essex	X				X				X				-
				Link Health and ECC Training programmes to map how what is currently delivered sits against the framework	X				X				X				-
				Task and finish group to identify gaps and solutions to improve this	X				X				X				L

		To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so.		Development of the above framework	X				X				X				-

Additional Delivery

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

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

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

		There is a clear referral pathway to diagnosis with appropriate information and support offered	Number of people using appropriate pathway	Development of Customer Journeys	X	X			X	X	X				X		H
				Investment in primary care to support timely diagnosis	X	X			X	X	X				X		H
				IAG with communities to understand the process for delivery	X	X			X	X	X				X		H
				Community Agent + resource within GP surgeries	X	X			X	X	X				X		H
		BAME communities are accessing assessment and diagnostic services	Number of BAME accessing services	Development of visible services that are communicated sensitively for those who wish to access it	X	X			X	X	X				X		L
				Development of DAA to support BAME communities	X	X			X	X	X				X		L
		There is appropriate screening for people who are considered to be at high risk of dementia	Number of people diagnosis from a high risk categeory	Identification of "high risk" people and working together to co-ordinate a care plan to support them	X	X			X	X	X				X		H
				Development of an All Age Dementia response service	X	X			X	X	X				X		H
		People with dementia have access to post diagnostic support that is relevant and personalised	Range of post-diagnosis support linked to the system	Range of tools developed to support people to access the level of support that is appropriate to them post diagnosis	X	X			X	X	X				X		M
				Agree an affordable implementation plan for the prime minister's challenge on dementia 2020, including to improve the quality of post diagnosis treatment and support	X	X			X	X	X				X		M

		People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia, and plan for the future	Number of Family group conferences carried out Number of collaborative care plans	As above	X	X			X	X	X				X		L
		People are offered a direct payment upon diagnosis of dementia	Number of people with a direct payment following Diagnosis	As above	X	X			X	X	X				X		L
Supporting Carers	Carers are supported to enable people with dementia to remain as independent as possible	Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia	Number of referrals for carers assessments Number of carers offered support and guidance Number of carers on Carers registers	Family information and support model developed to take Carers views in to account and identifying opportunities to empower them to remain healthy	X				X		X				X		L
				Development of carers specific IAG offer	X				X		X				X		L
				Identifying how Primary Care currently support and record carers	X				X		X				X		M
				Working with primary care to develop carers registers	X				X		X				X		H
		Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges	Number of carers who feel informed and equipped	Access to relevant information and timely appropriate support from the point of concern developed and communicated to Essex	X				X		X				X		M
		Carers are able to access a range of opportunities to take a break from their role as a Carer	Number of opportunities available for Carers Number of carers actively taking a break from their role Number of carer breakdowns	Working with carer programme to identify an action plan to support carers of people living with Dementia	X				X		X				X		L

Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	Primary Care are able to respond to episodes of crisis in care homes appropriately	Number of acute admissions from Care Homes following Primary Care involvement	Development of response teams with GPs and the community to avoid hospital admissions from Care Homes because of crisis (Community Models)		X			X				X		X		H
End of Life	People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes	People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP	Number of advanced care plans completed Number of advanced care plans completed in consultation with people living with dementia	Agree a central system of recording Care plans	X				X		X				X		H
				Review existing care plans in localities and ensure that people with Dementia have had input	X				X		X				X		M
				Work with GPs to define requirements for system	X				X		X				X		M
				Define "end of life" champion approach to drive support where identified	X				X		X				X		L
				Improve Care Homes ability to respond to EOL	X				X		X				X		L
				Working with Advocacy network to ensure that best interest decisions take in to account the views of the most vulnerable	X				X		X				X		L
				Link in with EOL programmes to define best approach for Dementia	X				X		X				X		
				Link Dementia care in to hospice network to ensure advanced care plans are being adhered to	X				X		X				X		L
		People are not delayed in being discharged from hospital	Reduction in delayed discharge for people with dementia	Specialist Market Capacity developed that is responsive to need	X				X		X				X		M

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

12 March 2018	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
Supporting People with Personality Disorders and Behaviours that Challenge	
Wards and communities affected: All	**Key Decision:** Non Key
Report of: Fran Leddra - Principal Social Worker and Strategic Lead Safeguarding and Complex Care	
Accountable Assistant Director: Les Billingham Assistant Director Adult Social Care and Community Development	
Accountable Director: Roger Harris Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

The purpose of this report is to inform Health Overview and Scrutiny Committee of the latest position with regards to supporting people with Personality Disorders and behaviours that challenge. This follows the request of the Chief Executive Officer of Healthwatch, to formally raise this as an agenda item owing to the growing concern that there are limited services available.

1. Recommendation(s)

1.1 For Health Overview and Scrutiny Committee to comment on the current position regarding services for people who have a personality disorder.

2. Introduction and Background

2.1 At the November meeting of this Scrutiny Committee, Healthwatch raised their concerns about services available for people who are considered to have a personality disorder. This was after a number of cases locally where service users were receiving multiple interventions. These cases were proving extremely difficult to resolve owing to their complex situations.

It is estimated that 1 in 20 people live with some kind of personality disorder. Whilst individuals with personality disorders are all unique and can possess very different personality disturbances, their condition is unlikely to improve without professional intervention. (Coid, J. et al. (2006) Prevalence and

correlates of personality disorder in Great Britain. *British Journal of Psychiatry*, 188, 423-431.)

2.2 Whilst there are a lot of people living in our communities with personality disorders, and many different classifications of the condition, a few people will live chaotic, anti-social and difficult lives because of it. They pose a real challenge in how best to support and respond, especially when there are other associated mental health issues and in some cases substance misuse.

2.3 A case which received a high profile nationally and illustrated the difficulties of working with people with personality disorders was 'Carol'. On the 13th June 2017 Teeswide Adult Safeguarding Board published a serious case review into the death of 'Carol' a 39 year old woman who was murdered by two teenage girls aged 13 and 14 in her own home. Whilst the review concluded that professionals could not have predicted the murder, Carol's life was chaotic as a result of a long history of alcohol addiction and personality disorder.

Carol was primarily under the care of an integrated mental health team. The support she received was highlighted as positive in respect of the commitment of professionals to try and support her; she had fluctuating mental capacity to make decisions. However, a lack of specialist services available for her did mean that opportunities to intervene and provide treatment were missed.

Carol's complex condition and needs posed many challenges to those agencies and professionals who came into contact with her. The first finding from this review was:

Finding 1: The care pathway in Hartlepool for people with a dual diagnosis, including personality disorder, has insufficient appropriate senior clinical oversight, early specialist input; close clinical case management and multi-agency understanding.

As lessons learned from serious case reviews are disseminated through our Safeguarding Board a forum to discuss this case was held in August 2017 and it was acknowledged that this was an area that needed further development. Thurrock does not have a specialist local offer for those with challenging behaviour associated with personality disorder.

2.4 Specialist services however, are not the only solution to managing challenging behaviours within our communities. People with personality disorders are likely to have capacity to make unwise life choices and decisions regarding their support. They may refuse clinical treatment and intervention and this makes arriving at a satisfactory outcome very difficult if people are unwilling to engage with existing services.

In such cases it is important that front line workers from all agencies have a knowledge and understanding of personality disorder, and that agencies, whilst not able to directly intervene, can have a strategy discussion and plan

that supports the individual from a distance. This can provide a safety net for when they are in crisis and may be more receptive to help.

2.5 Over recent years we have developed more flexible services that can meet the needs of people locally who do not engage with existing mainstream services. These are:

- Assertive Outreach Team, with Social Workers and Community Psychiatric Nurses, for people who require intensive support
- Housing First, where people's accommodation needs are addressed first, before their lifestyle and health issues
- Local Area Co-ordinators to reconnect people back into their communities.

Unfortunately for a small number of people who do not wish to engage in any of the above services, a more co-ordinated and specialist support is required.

2.6 In Thurrock it is recognised that front line staff sometimes lack skills in understanding and supporting people with personality disorders and therefore a broader training programme is required

3. Issues, Options and Analysis of Options

Current initiatives that will support this agenda

3.1 Following the matter being raised by Healthwatch, a meeting was held with our local mental health trust, Essex Partnership University Trust, Healthwatch, Adult Social Care and the Police on 2nd February to discuss a local response to those people who have challenging behaviour and personality disorder. Below are three areas which provide an update on initiatives that will support this agenda.

3.2 Essex Partnership University Trust is leading a clinical transformation of personality disorder services. A presentation was given at the Thurrock Consultants and Primary Care Group in January 2018 highlighting the ambitions of the project which includes both specialist services and a training and cultural shift framework. The presentation recognised the need for a clear pathway to support the clinical transformation and that this approach must be multi-disciplinary, encompassing all partners.

3.3 Adult Social Care has set up a new high risk self-neglect and hoarding panel which may help support some individuals with personality disorders. The panel will be multi agency and will discuss cases where people self-neglect to the point of causing themselves harm, and where the practitioner is 'stuck' and change is difficult. Whilst this Panel will discuss cases much broader than just personality disorders it can be another avenue for support.

3.4 Adult Social Care is delivering a number of workshops in May 2018 to front line practitioners regarding understanding and supporting people with

personality disorders. The training is facilitated by a specialist in this area will be available for front line workers across agencies.

3.5 Corporately, the Council recognises that it can improve its collective response to individuals within Thurrock who are considered to be vulnerable but do not necessarily meet an existing eligibility criteria and sometimes don't get a fully co-ordinated response by all the different parts of the Council. Currently one part of the Council may take enforcement action without realising that someone may be vulnerable where earlier intervention may have prevented a situation deteriorating. As a result the Transformation Board will be looking at how the Council can better define what is meant by vulnerability and how we can better co-ordinate our response.

4. Reasons for Recommendation

4.1 This report provides a position statement on addressing the issues associated with services for people who have personality disorder and challenging behaviour. This is an early update and work in this area will be continuing.

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

5.1 Any future work and development of this area will be in partnership with health partners and other agencies such as Health Watch. A further more detailed update can be provided when more progress is made.

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

6.1 Future development of services for those people who have a personality disorder in Thurrock aims to enhance the well-being of the individual and where behaviours challenge, will be of benefit to our communities.

7. Implications

7.1 Financial

Implications verified by: **Joanne Freeman**

Management Accountant, Social Care and Commissioning

There are currently no additional financial implications. Any requirement for additional future funding will be sought through the Better Care Fund which is a shared arrangement between the Local Authority and Thurrock CCG. There are strict governance arrangements in place and business cases will need to be presented to the Integrated Commissioning Executive Committee.

7.2 **Legal**

Implications verified by: **Sarah Okafor**

Barrister (Consultant)

On behalf of the Assistant Director of Law I have read in full the contents of this report, and note there appears to be no external legal implications arising from it. The aims and objectives are consistent with the exercise of statutory powers and the statutory duties across Health and Social Care.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

Community Development Officer, Community Development and Equalities Team

Service development must ensure delivery across all protected characteristics, and that reasonable adjustments are made to ensure all communities and groups are served. Any service implementation will be monitored closely to ensure access and equality.

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

- N/A

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

Reference: Coid, J. et al. (2006) Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry*, 188, 423-431

9. Appendices to the report

- None

Report Author:

Fran Leddra

Principal Social Worker and Strategic Lead Safeguarding and Complex Care

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Health Overview & Scrutiny Committee
Work Programme
2017/18

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

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

Last Updated: August 2017

2016/17 Adult Annual Complaints and Representations Report	Tina Martin	Officers
Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Plan/ Success Regime for Mid and South Essex	Roger Harris	Officers
HealthWatch	Kim James	Officers
16 November 2017		
Fees & Charges Pricing Strategy 2018/19 (Adults) / Non-Residential Charging Options	Carl Tomlinson / Ian Kennard	Officers
Basildon Hospital – Update on number of complaints	Clare Culpin, Basildon Hospital	Members
Developing a new model of residential care for older people in Thurrock, fit for the 21st Century	Roger Harris	Members
Cancer – 62 Days Wait Standard	Clare Culpin, Basildon Hospital	Officers
Model of Care – Tilbury & Chadwell	Ian Wake	Officers
Update on Mid and South Essex STP	Andy Vowles, Programme Director, Mid and South Essex Success Regime	Officers
HealthWatch	Kim James	Officers
18 January 2018		
Mid and South Essex Sustainability and Transformation Partnership (STP) (Presentation and Q&A)	Andy Vowles, Programme Director for Health Care	Officers
Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Programme for Mid and South Essex	Roger Harris	Officers

HealthWatch	Kim James	Officers
12 March 2018		
Thurrock First	Tania Sitch	Members
Living Well in Thurrock	Ceri Armstrong	Members
Update – Action Plan for Dementia	Catherine Wilson / Mark Tebbs	Members
Mental Health Services, Personality Disorders	Fran Leddra	Members
Verbal Update on the Joint STP / Orsett Hospital Consultation	Roger Harris	Members
HealthWatch	Kim James	Officers

Future reports for 2018/19

- Formal consultation on Orsett Hospital
- Learning Disability Health Check
- Basildon Hospital
- Business Case for Tilbury Integrated Medical Centre / Tilbury Accountable Care Partnership
- General Practitioner 5 Year Forward Review – Mandy Ansell, CCG

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