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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00pm** on **24 January 2019**

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

Membership:

Councillors Victoria Holloway (Chair), John Allen (Vice-Chair), Tom Kelly, Cathy Kent, Elizabeth Rigby and Joycelyn Redsell

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

Substitutes:

Councillors Alex Anderson, Sue Sammons and Sue Shinnick

Agenda

Open to Public and Press

Page

1. Apologies for Absence

2. Minutes **5 - 20**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 8 November 2018.

To approve as a correct record the minutes of the Extraordinary Health and Wellbeing Overview and Scrutiny Committee meeting held on 5 December 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**	
5.	**HealthWatch**	
6.	**Briefing Note - Referral to the Secretary of State : Orsett Hospital**	**21 - 40**
7.	**Briefing Note - NHS Long Term Plan**	**41 - 48**
8.	**Adult Mental Health Service Transformation**	**49 - 76**
9.	**Verbal Update - SERICC**	
10.	**Work Programme**	**77 - 80**

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: **16 January 2019**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

Does the business to be transacted at the meeting
- **relate to; or**
- **likely to affect**

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:
- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

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

Non- pecuniary

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

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 8 November 2018 at 7.00 pm

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Present:	Councillors Victoria Holloway (Chair), Cathy Kent, Elizabeth Rigby and Joycelyn Redsell
	Kim James, Healthwatch Thurrock Representative
Apologies:	Councillors John Allen (Vice-Chair), Tom Kelly and Ian Evans
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Tom Abell, Deputy Chief Executive and Chief Transformation Officer, Basildon & Thurrock Hospital Trusts Mandy Ansell - Accountable Officer Thurrock CCG Les Billingham, Assistant Director of Adult Social Care and Community Development Jeanette Hucey, Director of Transformation, Clinical Commissioning Group Mark Tebbs, Director of Commissioning, NHS Thurrock CCG Jenny Shade, Senior Democratic Services Officer

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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.

23. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 6 September 2018 were approved as a correct record.

24. Urgent Items

Roger Harris, Corporate Director of Adults, Housing and Health, informed members that the Care Quality Commission had notified the Council that Allied Healthcare was likely to be unable to provide regulated activities because of a business failure. It was confirmed that only 15 packages were provided by Allied in Thurrock and that alternative provider could be sourced if required.

Councillor Holloway informed members that due to the continued concerns with the Sustainability and Transformation Plan (STP) she proposed that a call in be made to refer the STP to the Secretary of State on the consultation process and the proposed closure of Orsett Hospital. Members agreed to refer to the Secretary of state which will be formalised in a report to be presented at the extraordinary Health and Wellbeing Overview and Committee outlining the reasons for the referral.

25. Declarations of Interests

No interests were declared.

26. HealthWatch

Kim James, Healthwatch Thurrock Representative, stated some concern around the removal of funding by the Clinical Commissioning Group for specific counselling with SERICC for Sexual Abuse Counselling. Kim James continued to state that it did not seem logical to commission these services to provide an interim arrangement when they were not specialists in the subject, and the eventual outcome may be that it went back to SERICC. Kim James had attended a workshop on the 7 November and had raised concerns and asked the Committee to look at how the removal of the service could take place before an alternative pathway had been set up.

Mandy Ansell, Accountable Officer, Clinical Commissioning Group (CCG), stated her disappointment that this matter had been brought to the committee rather than directly to her. At the workshop held yesterday it was agreed that resources would be allocated to the relevant pathway and the CCG were committed to get the service right and deliver as soon as possible. Mandy Ansell agreed that a report would be brought back to committee to update Members.

27. Improving Cancer Waiting Times

Tom Abell, Deputy Chief Executive and Chief Transformation Officer, Basildon and Thurrock Hospital Trusts presented the update report on behalf of Andrew Pike who was unable to attend. Tom Abell stated that since the last update the focus had continued on the pathway transformation, operational control and the investment in additional capacity and capability. It was also recognised that improvement must be made to deliver sustainable waiting times. Members were taken through the report slides where the pathway transformation, the snapshots and comparisons of waiting times and performance were discussed.

Tom Abell stated that the next steps would be to recruit and to increase the endoscopy capacity to support cancer treatments and to continue to focus on the challenged tumour sites and improve the surgery pathway.

Councillor Holloway thanked Tom Abell for the report and the good work undertaken.

Councillor C Kent questioned why cancer was being picked up at Accident and Emergency. Tom Abell stated that Thurrock had a high emergency presentation at accident and emergency particularly for lung cancer which was hard to diagnose. That work continued with general practitioners and will take part of a pilot of the proposed national lung cancer screening.

Councillor Redsell questioned what other advice could be given to residents.

Mandy Ansell stated that lung cancer was hard to diagnose and anyone who had a cough for more than three weeks should seek medical advice. With obesity and smoking being the main factors of concern in Thurrock and residents should be aware of their general life styles. It was noted that Ian Wake, Director of Public Health, had continued to do some good work with the recent report on Cancer Deep Dive.

Councillor Redsell stated more should be done to stop people smoking outside the Civic Offices and places such as Thurrock Hospital.

Councillor Holloway acknowledged that numbers had been reduced but the numbers were still far too high and needed to be lower and requested that an update report be presented to committee which demonstrated the next steps.

Members agreed that an update report be presented at the 7 March 2019 committee.

Tom Abel left the Committee Room at 7.30pm.

28. Mental Health Urgent and Emergency Care

Mark Tebbs, Director of Commissioning, Thurrock Clinical Commissioning Group, presented the report that highlighting that the demand for adult acute mental health had increased and as a result the system was under pressure. That over the last 18 months commissioners had focused on developing and delivering an urgent and emergency care transformation programme. This focused on the S136 pathways and the development of street triage services; psychiatric liaison at Basildon & Thurrock University Hospital NHS Foundation Trust which provided expert assessment, treatment and developing 24/7 community crisis care. Mark Tebbs stated that the focus was on the winter plan to improve the operational efficiency of the current service and plans to merge two dementia wards to form an adult inpatient ward with 16 beds.

Councillor Holloway thanked Mark Tebbs for the report.

Councillor Redsell questioned whether children and young people formed part of the plan. Mark Tebbs stated they were not in the scope of this plan but the opportunity to integrate this will happen going forward and stated that early intervention was critical which would start as young as the age of 14.

Councillor Redsell questioned why Thurrock Hospital wards had been empty and when were they planning to be re-opened. Mark Tebbs stated that the empty wards were being refurbished to take on the new requirements.

Councillor C Kent welcomed the new beds but had concerns over the small rise of unexpected deaths. Mark Tebbs stated a Zero National Ambitions which was part of the National Suicide Prevention Alliance would focus on suicide prevention. Mark Tebbs stated that it was important to do more with funding coming from the STP.

Councillor Holloway questioned whether there were sufficient investments being made to recruit staff into mental health services. Mark Tebbs stated that recruitment was one of the biggest challenges in health but Thurrock were ahead of the national timetable and would look at models being used in other local authorities.

Councillor Holloway stated that education played a vital part in this and with great college facilities in the borough this was a great opportunity for training to be undertaken and to keep those skills in the borough.

Councillor Redsell agreed with Councillor Holloway's comments that educating the young and to steer young people in the right direction was vital.

Councillor Rigby asked for clarification on the predicted increase in winter. Mark Tebbs stated that peak demands coincide with school holidays with the peak demand being the second week in January. .

Roger Harris stated that Adult Social Care broadly supported the proposals but wanted further work undertaken to understand the reasons behind the increase in demand and ensure services in the community were better co-ordinated and more integrated.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted the content of the report and proposed urgent and emergency care plan.

Mark Tebbs left the Committee Room at 8.05pm.

29. Thurrock Safeguarding Adults Board Annual Report 2017-18

Les Billingham, Assistant Director of Adult Social Care and Community Development, presented the annual report that had set out the profile of adult safeguarding activity within Thurrock for the period 2017/18. The report described the strategic objectives, achievements and challenges. Les Billingham stated that during this period Thurrock had no cause to commission a Safeguarding Adult Review and welcomed the incoming chair of the Thurrock Safeguarding Board as Jim Nicholson.

Councillor Redsell questioned the contingency underspend from 2016/17 of £38,000. Les Billingham stated that this money would be used sensibly and appropriately and forecasted that this figure would come down following the planned funded events and training programmes.

Councillor Holloway referred to the Deprivation of Liberty Safeguards (DoLS) and asked what changes and issues would come about and what impact these may have. Les Billingham stated that an analysis of the proposed changes for the future had taken place and that additional challenges were likely but the government was looking to change the law and get greater

clarity. Every local authority had waiting lists for DoLS with Thurrock having only a small list.

Councillor Redsell questioned how data collection would change. Les Billingham stated that data collection was a national issue problem on the data set and that data was collected differently. In Thurrock the data set had been agreed which included some data for performance. It was planned to have a complete data set in January 2019.

RESOLVED

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

30. Adult Social Care - Fees & Charges Pricing Strategy 2019-20

Roger Harris, Corporate Director Adults, Housing and Health presented the report that set out the charges in relation to services within the remit of the Health and Wellbeing Overview and Scrutiny Committee with any new charges taking effect from 1 April 2019.

Councillor Holloway thanked Roger Harris for the report.

Councillor Redsell questioned whether meals on wheels were still being used. Roger Harris stated the contract with RVS was due to expire at the end of 2018/19 financial year and that options would be reviewed on how the service should be run following this date.

Councillor Redsell stated that the on-line application for Blue Badges was not working well. Roger Harris stated that the Blue Badge application was a national online form that Thurrock Council could not change but agreed to take back and look at how support could be provided where required.

Councillor Holloway stated her concern for domicilary care workforce and questioned whether charging more would generate more funds to pay the workforce more. Roger Harris stated that the rates paid to providers were favourable.

Councillor C Kent referred to the £1.4 million target to be secured through the demand increases from residents and ask whether this would be profit to the Council. Roger Harris stated that no profit would be made as services were heavy subsidised.

Councillor Holloway questioned whether a wide budget report would be presented to the committee. Roger Harris agreed to let the chair know of any planned reports and timescales.

Councillor Redsell questioned the Transport fees. Roger Harris explained that these were the core permanent in house service at Elizabeth Gardens

provided by Care Watch at £40 per week to which the Council subsidised a further £40.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee noted the revised fees and that Health and Wellbeing Overview and Scrutiny Committee commented on the proposals currently being considered with the remit of the committee.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee noted that Director delegated authority will be sought via Cabinet to allow Fees and Charges to be varied within a financial year in response to commercial and legal requirements.**

31. Communities First - A Strategy for developing Libraries as Community Hubs in Thurrock

Roger Harris, Corporate Director of Adults, Housing and Health, presented the first comprehensive strategy for Thurrock's Library Service and Community Hubs. The strategy provided a strong foundation to deliver the Council's vision for a vibrant service, to meet the needs of the growing population in Thurrock within modern buildings that would run alongside local community activities. Roger Harris stated a consultation had taken place to which 800 residents had responded. The expansion of the library service, the demand for Saturday afternoon opening and extended evening opening where just some of the comments made. Roger Harris was also pleased to confirm that there would be no library closures.

Councillor C Kent stated how pleased she was that there would be no library closure and asked for assurance on behalf of the volunteers that staffed the hubs. Roger Harris stated that the Council would be expanding the number of volunteers but there would be no proposal to have a volunteer only service.

Councillor C Kent questioned whether the Book Fund was still up and running. Roger Harris stated that it still existed but the budget had been cut and now stood at only £50,000.

Councillor Redsell raised some concern over the size and the future of the Blackshots library and questioned where the consultation process had taken place. Roger Harris stated that the consultation had been on-line, copies had been placed in libraries, schools and as part of the summer reading. Roger Harris agreed to send a copy of the consultation responses to Members.

Councillor Holloway stated that the fundamental purpose of libraries was about the books which linked to education and for skills to be developed for the future. Councillor Holloway asked how much of the consultation in producing the strategy had been discussed with staff as they were the professionals.

Councillor Rigby stated that each library may be slight different and that the community should be involved in the development of them.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee commented on the draft strategy.

32. Developing a new residential care facility and a new model of primary care in South Ockendon

Les Billingham, Assistant Director Adult Social Care and Community Development presented the update report on the proposed development of a new residential facility in South Ockendon which would make a significant contribution to meeting the demand and set new standards in terms of facilities and services. The development would consist of a new residential facility for older people, an interim care facility and the potential for a new medical centre with community facilities. Approval had now been sought to progress with the design and development stages.

Councillor Redsell asked whether the facilities would be for Thurrock residents. Les Billingham stated that almost certainly for Thurrock residents who had a very high degree of need.

Councillor Redsell stated it would be good to see some data on the number of Thurrock elderly residents who still lived at home and received care.

Councillor C Kent raised the concern that parking should be addressed as part of the design stages of any new development.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee noted the request to be made to Cabinet for delegated authority for the Corporate Director Adults, Housing and Health, the Director of Finance and IT, and the Portfolio For Children and Adult Social Care, to tender for and award the building contract for the development of housing and associated facilities for older people requiring residential care, subject to tender returns being in line with an agreed business plan based on the principles within this report.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee noted the negotiations being undertaken with health partners concerning the development of a phase 2 Integrated Medical Centre to replace the current South Ockendon Health Centre.**

33. Further Transformation to Continue Improving Standards in Primary Care

Roger Harris, Corporate Director of Adults, Housing and Health, presented the report that provided Members with an update on the Long Term Condition Case Finding and Management Programme which had been led by Public Health as part of a systematic programme of Primary Care Transformation. Mandy Ansell, Accountable Officer Clinical Commissioning Group, stated that the report had been prepared from a public health view of primary care and the programme had been recognised nationally.

Councillor Holloway thanked Officers for the fantastic report.

Councillor Rigby questioned Flash Glucose Monitoring. Mandy Ansell stated that there was no evidence based for this and was being studied in micro-optic detail. A report would be presented to committee when findings had been made.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee commented on the programme and approved progress, changes and additions to the programme of performance and improvement and support for primary care with linked demand management for hospital and adult social care services.

34. Work Programme

The Chair asked Members if there were any items to be added or discussed for the work programme for the 2018-19 municipal year.

Members agreed that the Update on Mental Health Urgent report to be added to the 7 March 2019 committee.

Members agreed that the SERICC (for Sexual Abuse Counselling) to be added to the 7 March 2019 committee.

Members agreed that the Update on Cancer Waiting Times report to be added to the work programme for the 2019-20 municipal year.

Members agreed that the Flash Glucose Monitoring Report to be added to the work programme when information was readily available.

The meeting finished at 9.20 pm

Approved as a true and correct record

CHAIR

DATE

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Minutes of the Meeting of the Extraordinary Health and Wellbeing Overview and Scrutiny Committee held on 5 December 2018 at 7.00 pm

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Present:	Councillors Victoria Holloway (Chair), John Allen (Vice-Chair), Cathy Kent, Elizabeth Rigby (arrived at 7.06pm), Joycelyn Redsell and Alex Anderson (substitute for Tom Kelly) Kim James, Healthwatch Thurrock Representative Neil Woodbridge, Chief Executive Officer, Thurrock Lifestyle Solutions
Apologies:	Councillor Tom Kelly and Ian Evans, Thurrock Coalition
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Ian Wake, Director of Public Health Tom Abell, Deputy Chief Executive and Chief Transformation Officer, Basildon & Thurrock Hospital Trusts Jo Cripps, Mid & South Essex STP Claire Hankey, Mid & South Essex STP Jeanette Hucey, Director of Transformation, Clinical Commissioning Group Jenny Shade, Senior Democratic Services Officer

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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.

35. Urgent Items

No matters of urgent business were received.

36. Declarations of Interests

No interests were declared.

37. Sustainability and Transformation Partnership (STP) - Orsett Hospital

The Chair read out the following statement:

"One item on the agenda this evening which was to formalise the decision from the committee's last meeting to refer the STP plan to the Secretary of State on two grounds. The closure of Orsett Hospital was not in the interests of health services in Thurrock and the consultation process which resulted in the decision to close the hospital was not adequate.

As a committee we have continued to worry about these issues in particular. Having discussed the plan over many months it had become inevitable that in

order to properly ensure the interests of Thurrock residents and the future of the right health services we should refer the decision for further scrutiny to the Secretary of State.

I believe it was important that as a committee, indeed cross party as a Council we wholeheartedly support four new Integrated Medical Centres. We want new health centres and facilities to support the health needs of our residents. This was not a question.

We know both Councillors and Officers however that at the moment these centres do not exist. We know that building these centres involve a number of partners to agree, a number of planning issues to be resolved, ultimately many elements falling into place all at the same time. It may be that every single element of the very long to do list that needs to be in place to ensure four centres come through. But it would be irresponsible of us as Councillors not to think about what happens if all of these centres are not built. This was not explained to residents in the consultation. They believe all of them will be built without question however sadly we have experienced here in Thurrock of promises of new health facilities which progress well until they are pulled at the last minute. In the meantime, Orsett Hospital will slowly be shutting down and what happens to services in the hospital when there are not four centres to put them in.

The decision to close Orsett Hospital was one not only based on the consideration of the development of health facilities in the area. The underlying reason was a lack of investment which meant Orsett Hospital was not up to the standards we want in a hospital. The Deputy Chief Executive of BTUH had acknowledged the lack of money to this committee when he explained the hospital must close. How can a decision be based on this reason be to the benefit of health services for Thurrock residents.

Over the years, for some Councillors and months for others, the concerns about the consultation have been raised regularly. There have been a number of minutes reflecting these concerns. Sadly they have not all been included in the pack. Councillor Redsell I remember you particularly raising concern regarding a meeting in your ward that you did not know about. You were rightly concerned about how widely the notice the meeting had been circulated. In additional HealthWatch raised serious reservations which had not been included in the pack provided to Members from a meeting held on the 18 January this year.

On page 17 of tonight's report it states that 276 submitted a specific consultation questionnaire distributed in Thurrock. The specific questionnaire was only received mid-February. What might that number have been if we had that questionnaire throughout the whole consultation period?

Therefore this decision requires referral. I am aware that we have all already agreed to take this forward and ask Members for their comments before formally voting".

Councillor C Kent stated her support to the referral to the Secretary of State by stating the consultation process had been inadequate with late notice being given of consultation events, those questions raised by residents appeared to be unwelcomed, the on-line consultation was unavailable to many Thurrock residents and had been excluded from the consultation as they had no access to this facility. Councillor C Kent stated that the forecasted increase in Thurrock population with new homes and infrastructure being built in Thurrock there was no confidence the four Integrated Medical Centres could support all the services currently at Orsett Hospital.

Councillor Redsell stated she was not in agreement with the referral to the Secretary of State as this would delay the process of opening the four Integrated Medical Centres. The need for the four Integrated Medical Centres was vital so the services currently at Orsett Hospital could be spread out making it easier for residents as currently the hospital was not close to everyone. Councillor Redsell stated the current services would not cope with the future demand and planned developments in the borough.

The Chair stated her disappointment in the choice to not refer this matter bearing in mind the concerns raised up to this point.

Councillor Rigby echoed Councillor Redsell's comments that the referral to the Secretary of State would only delay the opening of the four Integrated Medical Centres.

Councillor Allen stated the four Integrated Medical Centres were a good idea providing services closer to residents and stated he was not in agreement that Orsett Hospital should close. Councillor Allen stated the borough needed its own hospital and questioned whether the opening of hubs by 2021 was now ambitious.

Roger Harris stated it was ambitious and increasingly unlikely the hubs would open by 2021. The referral recently made by Southend on Sea Council had already added a further six months onto the process. Roger Harris reassured Members that although health partners would not be agreeing or signing any agreements the planning work would continue.

Ian Wake stated that the current design and specification for the four Integrated Medical Centres had been based on the assumption that Orsett Hospital would close and that services provided from it would be migrated into the Integrated Medical Centres. It was stated could not have both the Integrated Medical Centres and Orsett Hospital. In response to Councillor Allen question on whether Thurrock should have its own hospital; Ian Wake stated that the optimum way of delivering future health services for Thurrock residents should include the integration of hospital diagnostic and outpatient services within the new Integrated Medical Centres and the rationalisation of specialist services such as cardio-vascular, stroke and cancer services on fewer sites in order to create specialist centres of excellence that could provide 24/7 specialist care.

Councillor Anderson also echoed Councillor Redsell's comments that the referral to the Secretary of State would delay the opening of the four Integrated Medical Centres.

The Chair questioned why following the undertaking of more financial investigation that having both the Orsett Hospital and the four Integrated Medical Centres was now not an option, the Integrated Medical Centres were planned to happen with no dependence on the other and asked if this was not now the case.

Ian Wake stated since the clinical model was proposed more time had allowed for a further detailed financial analysis and it was clear that it was more affordable to have the services in the four Integrated Medical Centres.

The Chair stated this was brand new information to Members and very upsetting to hear.

Councillor Allen stated he was in favour of the referral to the Secretary of State.

The Chair asked Members to vote on recommendation 1.1 with three Members voting in favour and three Members abstaining.

The Chair asked Members to vote on recommendations 1.2 and 1.3 with Members voting in favour.

The Chair announced that the STP will now be referred to the Secretary of State and stated a formal letter be prepared by officers outlining the basis of the referral. This letter would then need to be shared with STP colleagues to comment and that the IRP would also be asked to comment. All Members agreed the letter should be signed off by the Chair of the Health and Wellbeing Overview and Scrutiny Committee. The Chair asked the letter be available as soon as possible.

RESOLVED:

1. **Health and Wellbeing Overview and Scrutiny Members considered whether there was sufficient evidence to refer the decision of the CCG Joint Committee to transfer services out of Orsett Hospital, to the Secretary of State on the following grounds:**

    - **That they consider the consultation exercise inadequate.**
    - **That they consider the proposal not in the interests of health services in Thurrock.**

2. **Health and Wellbeing Overview and Scrutiny Members noted the timetable detailed within the report.**

3. Health and Wellbeing Overview and Scrutiny Members agreed that a copy of the final response was shared with the STP before final submission.

The meeting finished at 7.23 pm

Approved as a true and correct record

CHAIR

DATE

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Health and Wellbeing Overview and Scrutiny Committee : 24 January 2019

Briefing Note: Referral to the Secretary of State : Orsett Hospital

Purpose of the briefing note: To provide a short update to the Committee on the current situation with the referral following the HOSC decision in December.

1.1 Following the HOSC decision in December officers worked with the Chair to agree the wording of the referral based on the report submitted to the December HOSC (copy of the referral letter attached).

1.2 The draft letter was sent to the STP / CCG Joint Committee for their comments and a response was received from them (copy attached).

1.3 The final letter was sent to the Secretary of State on the 8 January and a letter requesting further information was received back from the DHSC on the 10 January (copy attached).

1.4 Officers are currently considering the letter and drafting a further response, providing the additional information requested. A further update will be provided to the HOSC meeting on the 24 January.

For any questions regarding this briefing note, please contact:

Name: Roger Harris, Corporate Director, Adults, Housing and Health

E-mail: rharris@thurrock.gov.uk

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Civic Offices, New Road, Grays
Essex RM17 6SL
8 January 2019

The Rt Hon Matthew Hancock MP
Secretary of State for Health and Social Care
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

Dear Secretary of State,

Referral of Mid and South Essex Sustainability and Transformation Partnership – Orsett Hospital proposals

As Chair of Thurrock's Health and Wellbeing Overview and Scrutiny Committee (HOSC) I am writing to advise you that on 5 December 2018 members of HOSC agreed to refer for reconsideration the:

- Mid and South Essex Sustainability and Transformation Partnership's (STP) public consultation exercise 'Your Care in the Best Place' as it relates to proposals for Orsett Hospital; and

- The decision taken by the Mid and South Essex CCG Joint Committee to approve the relocation of services currently provided at Orsett Hospital to a range of locations within Thurrock for those services provided to Thurrock residents and Basildon and Brentwood for those services provided to Basildon and Brentwood residents, enabling the closure of Orsett Hospital.

There has been limited clarity on what those services are, when they might be relocated and where they may be relocated to or the impact on those services that will still be provided at Orsett Hospital until they are relocated elsewhere.

Thurrock HOSC wishes to submit a referral on 2 of the 4 grounds for referral as set out in the Local Authority Health and Scrutiny Regulations: June 2014 and Regulation 23 (Local Authority Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations 2013). The referral is being submitted on the basis of HOSC not being satisfied with the adequacy of the consultation and that the proposal to relocate services currently provided by Orsett Hospital are not in the best interest of health services in Thurrock.

This referral meets the conditions of referral as set out in regulation 23 parts (5)(a)(b)(c) (Local Authority Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations 2013) the STP team were invited to the Thurrock HOSC meeting of September 2018 where our concerns, as described in this referral were explained. However, the CCG Joint Committee decision to relocate services currently provided by Orsett Hospital remain.

I can confirm that as a Unitary Authority Thurrock Council formed a Joint HOSC (JHOSC) with Southend-on-Sea Borough Council and Essex County Council on 20 February 2018 as required by 'Guidance to Support Local Authorities and their partners to deliver effective health scrutiny', published by the Department of Health in June 2014. While the guidance permitted Local Authorities to delegate the power of referral to the JHOSC I can confirm that the power of referral has been retained by each of the Local Authorities.

INVESTORS IN PEOPLE | Gold

Attached to this letter is detailed supporting documentation outlining HOSC's grounds for this referral, a summary of its reasons and evidence to support the referral, as per the expectation set out in the Local Authority Health and Scrutiny Regulations: June 2014.

We have sent a copy of this referral to the STP / Joint Committee for their comments. Attached is the response from the Chair of the CCG Joint Committee which I have considered but do not feel it changes the substance of our referral

As Chair of Thurrock HOSC I request that you provide full consideration to the issues outlined in the attached referral. Should you require any further information, please do not hesitate to contact Darren Kristiansen, Business Manager on 01375 659739.

Yours sincerely

Cllr Victoria Holloway
Chair
Health & Wellbeing Overview and Scrutiny Committee
Thurrock Council

Referral to the Secretary of State for Health and Social Care

1. Grounds for Referral

1.1 Thurrock Council's HOSC request that the Secretary of State for Health and Social Care considers our concerns regarding Mid and South Essex STP (The STP) formal public consultation 'Your Care in the Best Place', particularly regarding proposals for services currently provided at Orsett Hospital

1.2 The grounds for this referral are that we are not satisfied that:

- The consultation exercise in relation to proposals to relocate services currently provided by Orsett Hospital were adequate.
- The decision taken by the Mid and South Essex CCG Joint Committee to approve the relocation of services currently provided at Orsett Hospital to a range of locations within Thurrock for those services provided to Thurrock residents and Basildon and Brentwood for those services provided to Basildon and Brentwood residents, enabling the closure of Orsett Hospital. There has been limited clarity on what those services are, when they might be relocated and where they may be relocated to or the impact on those services that will still be provided at Orsett Hospital until they are relocated elsewhere.

2. Context

2.1 Thurrock is situated south of Essex and lies to the east of London on the north bank of the River Thames with an area of 165 square kilometres. It has a very diverse and growing population.

2.2 In June 2018, the Office of National Statistics (ONS) published new estimates which show the population of Thurrock (as of June 2017) had risen to 170,394, an increase of 1,966 people since the previous year, representing a percentage rise of 1.2%. The most significant increases from the previous year are in some of the older age groups, with the number of 50-54 year olds increasing by 3.82% and those aged 70-74 years increasing by 11.33%. Thurrock currently has a significantly greater proportion of young people than the England average and this trend is likely to continue into the future. Thurrock's older population is lower as a percentage of total population than the England average.

2.3 This 1.2% increase in Thurrock's population is approximately double the national population increase (0.6%), and can be attributed to two factors – "natural change" (which is the number of births minus the number of deaths) and migration. In 2017, there were 2,463 births and 1,290 deaths, representing a natural change of 1,173 residents. Internal migration (residents moving into Thurrock from other parts of the country) resulted in an extra 8,898 residents moving in and 8,650 moving out. A total of 1,109 people moved into the borough from areas outside England and Wales and 571 moved out.

3. Consultation exercise – particularly in relation to Orsett supplement

3.1 The STP launched a consultation exercise on 30 November 2017 "Your Care in the Best Place" which was originally scheduled to close on 9 March 2018 but was extended until 23 March 2018. HOSC do not consider the extension of the consultation exercise adequate, as outlined at section 6.

3.2 It was proposed that clinical services would transfer from Orsett Hospital to one of the four Integrated Medical Centres (IMC) being developed in Thurrock for Thurrock residents or in facilities in Basildon and Brentwood for residents from those areas. This means that for Basildon and Brentwood patients, there is a potential to offer services that are currently offered at Orsett Hospital to facilities within Basildon and Brentwood. The underlying key principle behind this was to deliver care closer to home in settings that allowed stronger integration between primary, community and social care. Orsett was a valued service but was difficult to access from some parts of

Thurrock and as an ageing building, required significant investment to bring it up to modern standards.

3.3 An external consultancy company commissioned by Thurrock CCG met with service leads from Basildon and Thurrock University Hospital (BTUH), Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT) and Southend NHS Hospital Foundation Trust (SUHFT) to discuss and analyse both the provider and patient's requirements for services at Orsett presently, and incorporating projections to account for expected population growth. A Strategic Outline Programme was produced which detailed what services would transfer out of Orsett to align with the proposed development of the IMCs which had already started as a project to improve primary and community care.

3.4 STP proposals were based on seeking feedback from the public and professionals on several broad principles. In terms of Orsett consultation respondents were invited to provide views on proposals to transfer services from Orsett to a number of new centres closer to where people live in Thurrock (for Thurrock residents) and to Basildon, Brentwood and Billericay (for residents of those areas), as previously described. A commitment was provided in the consultation document that only when new services were up and running, would it would be possible to close Orsett Hospital.

3.5 As part of preparing and informing the consultation process we recognise and acknowledge that the STP programme team engaged partners in Thurrock by providing regular updates to Thurrock Health and Wellbeing Board, Thurrock HOSC and a joint HOSC comprising elected members representing Thurrock, Southend and Essex.

3.6 Thurrock HOSC has been provided with updates on the STP across 9 meetings held between the periods of 1 December 2015 to 14 June 2018. However, our view is that Orsett changes were so significant that they should have been part of a separate consultation and not part of the wider discussion over acute hospital reconfiguration.

4. Consultation outcomes

4.1 The consultation responses were analysed independently and a comprehensive report published. Key findings included:

- There is broad agreement with the overall approach, outlined in the consultation, to provide care in the best place in the home and community settings and in hospitals. The principle of care provided closer to home was particularly appreciated by many.
- However, there are concerns raised consistently across all the responses about the feasibility of delivering such a plan given current staffing issues - including the difficulty in recruiting GPs, community nurses and the shortage of specialist hospital staff - and given the resource challenges that the NHS is facing.
- There are strong views expressed from groups and areas who feel they are most impacted by the proposals. These were mainly:
    - patients and residents from Thurrock who are concerned about the potential impact on the community if the proposals for Orsett Hospital go ahead.
    - patients and residents from Southend who are concerned that services currently being provided at Southend Hospital are being downgraded and that patient outcomes will be impacted if current specialisms, in particular stroke services, are located elsewhere.
    - older, more isolated and less mobile groups of patients who are concerned they will have to travel further to access hospital services.

4.2 In response to the supplementary consultation document focussed on relocating services currently provided by Orsett Hospital feedback received included:

- People who regularly used Orsett Hospital praised its services, the staff and the quality of care received. There were a number of anecdotal stories about the assistance they or their families had received from the Hospital and how much of a loss it would be if it did not exist anymore.
- Many of the respondents also queried the claim in the consultation documentation that Orsett Hospital was difficult to access via public transport. There had been recent improvements in bus services from a range of nearby providers and many felt it was as easy to get to as some of the other centres and hospitals mentioned in areas such as Basildon, Billericay, Chafford Hundred and Brentwood. Others felt that if transport had been cited as a key reason for closing the hospital then more should have been done to address this, for example providing shuttle buses to and from neighbouring areas.
- A number of respondents were also concerned about the loss of services that only Orsett Hospital provided in the Thurrock area if the hospital were to close. The key service mentioned was renal dialysis but others such as orthopaedic care, eye care and minor injuries unit were also mentioned. Patients receiving dialysis were particularly concerned by the proposals with some stating that the nearest current alternative, Basildon Hospital, was quite difficult to get to for them.
- There was also a case made by some that since Thurrock was a growing borough, with a possible 30,000 new homes due to be built, including additional homes in the nearby Dunton Hills estate, that there was a case for keeping services at Orsett Hospital to be able to meet future need.
- Many respondents felt that one of Orsett Hospital's strengths was its good parking provision – a feature which was not available at some of the other centres.
- A small number of people also felt that the decision to close Orsett Hospital was driven by the financial benefit that could be made by selling the land off to developers since it was in a valuable location.
- There were some respondents who agreed that Orsett Hospital was becoming difficult to maintain and that it was no longer fit for purpose and that investing in the new approach was the way forward.
- There were a number who also felt that it was quite difficult to access from other areas so it would make since to transfer its services to a number of new centres closer to where people lived.

5. CCG Joint Committee Decisions

5.1 On 6 July 2018 the five CCG's across mid and south Essex, meeting as a CCG Joint Committee, met to consider the recommendations from the STP.

5.2 Recommendation 15 of the decision making business case focussed on Orsett Hospital and was agreed:

- Approved the relocation of services currently provided at Orsett Hospital to a range of locations within Thurrock, Basildon and Brentwood, enabling the closure of Orsett Hospital.
- Noted that there will be a period of co-production with the local community through the establishment of a "People's Panel" supported by Healthwatch organisations in Thurrock and Essex to determine the best site(s) to relocate these services to.
- Noted that, alongside the period of co-production, further detailed assessments will be undertaken on equality and health inequality impacts, and the quality impact of proposed service relocations.
- Noted that once the period of co-production is complete, and with the detailed work on impact assessment, the CCG Joint Committee will be asked to make a decision on which sites will provide the relocated services.
- Noted that, in accordance with the agreement between Thurrock CCG, Thurrock Council and the three mid and south Essex hospitals, the Orsett

Hospital site will not be closed until the new services are in place at the agreed new locations.

6. Reasons for referral and supporting evidence

Criteria One: Consultation in relation to Orsett Hospital was inadequate

6.1 On 9 January 2018 Thurrock Health Watch raised concerns about the availability and accessibility of the STP consultation exercise, which was supported by HOSC members. Primarily:

- The consultation was inaccessible for some groups within Thurrock.
- That the consultation was hard to access with only an on-line option available at that time.
- Requests made for hard copies, were not being made available for Thurrock residents.
- Given the complexity of the consultation exercise easy read versions were not available and it is the view of HOSC that residents with learning disabilities should be given every opportunity to engage and be involved.
- Versions printed in different languages were not being made available to residents.

6.2 While we accept that some of these points were addressed by the STP team this should have all been in place before the consultation started.

6.3 This section of the referral sets out evidence that reflect the points raised above and additional concerns about the consultation exercise.

The overarching STP consultation document provided limited information about proposals to relocate services currently provided at Orsett Hospital and the Orsett supplement did not present information consistently

6.4 Page 25 of the overarching STP consultation document set out some broad principles for relocating services currently provided at Orsett Hospital but did not provide sufficient details for Thurrock residents to consider and respond to.

6.5 The Orsett supplement provided as part of the overarching STP consultation material did not present proposals in a consistent manner to support residents with understanding them. Page 7 of the Orsett Hospital consultation supplement set out services currently provided at Orsett Hospital. Page 9 set out a list of potential locations for services in the future. The language used was inconsistent and residents would not have been able to easily identify whether the services currently provided at Orsett Hospital were to be relocated to all or indeed any of the IMCs.

6.6 HOSC noted that the proposals on future locations for services did not include treatment facilities being made available at either Corringham or Tilbury Integrated Medical Centres. This provides an inconsistent offer for residents and could result in some patients being required to travel further for treatment, contrary to the aim of providing services closer to local residents' homes, as described at paragraph 3.2.

The consultation document was inaccessible for some groups within Thurrock

6.7 Given the complexity of the wider STP consultation exercise we are concerned about reports suggesting that easy read versions were not available for either the overarching consultation documentation or the Orsett Hospital supplement at the commencement of the consultation exercise. It is the view of HOSC that residents who require some form of easy read version should be given every opportunity to engage and be involved at the start of a consultation exercise.

6.8 The consultation was initially hard to access and it has been reported to us that only an on-line option was available in January 2018 for both the overarching consultation documentation and the Orsett Hospital supplement, approximately two months after the consultation exercise commenced. Evidence in Thurrock suggests a proportion

of residents do not have access to the internet so would have been restricted from responding to the consultation exercise until it was already substantially underway.

6.9 Versions of the Orsett Hospital supplement were not made easily available to Thurrock residents in different languages, potentially excluding a proportion of Thurrock's population who are affected by the proposed changes. Residents that have English as a second language would have been required to contact the STP team to request copies of the consultation material in different languages if they wished to engage with the process.

6.10 Hard copies of the supplementary consultation document setting out proposals to relocate services being provided by Orsett Hospital were made available in February 2018, three months following the launch of the consultation. While HOSC acknowledges that the consultation exercise was extended from 9 March until 23 March 2018 we do not believe that the extension sufficiently addresses the delay in providing hard copies of the Orsett supplement.

Limited consultation responses and consultation outcomes not being addressed

6.11 HOSC recognises that the STP consultation exercise was wide ranging and included an independent telephone survey, 16 large scale public meetings and 40 deliberative workshops and specific events for people who were most likely to be affected by the proposals. There was also an online presence which reportedly reached in excess of 350,000 people. It is disappointing that only an estimated circa 3,500 people took the opportunity to participate. Given the population of the Mid and South Essex footprint comprises circa 1.2 million people this equates to 0.3% of the population. This suggests that the residents of Thurrock did not engage in as great a number as you would expect for a change of this significance. We believe that the issues outlined at paragraphs 6.4 to 6.10 could have adversely impacted on the response rate.

6.12 The decision making business case makes clear that further detailed assessments will be undertaken on equality and health inequality impacts, and the quality impact of proposed service relocations. There will be a period of co-production with Thurrock residents via a newly established People's Panel which, once completed, the CCG Joint Committee will be asked to make a decision on which sites will provide the relocated services. This evidence shows that Thurrock residents could not have been invited to provide their feedback on how services currently provided at Orsett Hospital will be relocated elsewhere as part of the consultation exercise, due to those decisions not having been taken at that stage.

6.13 The STP reports that strong views were provided by patients and residents from Thurrock who are concerned about the potential impact on the community if the proposals for Orsett Hospital go ahead. The decision making business case provides a review against national tests for service reconfiguration for Orsett Hospital. It makes clear that patient and public support for proposals, provided through evidence collected through the consultation exercise, had less support.

6.14 Thurrock HOSC acknowledges that the purpose of the consultation was to understand issues and concerns that residents might have about a service change the decision to relocate services currently provided at Orsett Hospital does not reflect feedback provided by Thurrock residents, contrary to information set out in the Orsett Supplement, as set out in paragraph 4.2.

Criteria Two: The decision taken by the CCG Joint Committee to relocate services provided at Orsett Hospital to a range of locations within Thurrock, Brentwood and Basildon are not in the best interest of health services in Thurrock.

6.15 The proposals are dependent on the need for more detailed and costed plans for patients, NHS staff and public to better understand how this vision will work in practice. However, there are a number of important associated matters about the deliverability of the IMC programme and important factors around transport and travel requirements that clearly the STP consultation exercise was unable to answer. Relocating services currently provided at Orsett Hospital without clarity being provided on the transport infrastructure is not in the best interest of health services in Thurrock.

6.16 The Decision making business case makes clear that neither the Clinical Senate nor Clinical Cabinet have been asked to review the proposals for the relocation of services from Orsett Hospital. It is suggested that this is because proposals do not involve a significant redesign of the existing services, rather a relocation of these services to new locations. Thurrock HOSC suggests that the proposals create a serious enough change to local health services in Thurrock that the Clinical Senate and Clinical Cabinet should have been asked to review the proposals in this case.

6.17 The STP consultation material explains that Orsett Hospital is an ageing building and it is estimated that it would cost in the region of £10m to bring the facilities up to date. The documentation suggests that the system needs to make the best use of all resources and to improve access to services for existing and future patients and that closing an older building allows the NHS to free up funds for newer, purpose built facilities. The decision making business case did not consider upgrading Orsett Hospital and the benefits of continuing to use an existing site, valued by the local population, to provide services.

6.18 We are concerned that there is a lack of certainty over IMCs and a lack of clarity on when IMCs will be in place, how they are to be funded, how services will transfer, whether all services will be transferred to all IMCs and the impact on Orsett Hospital while the services are being relocated. The decision making business case sets out some implementation considerations and explains that the Trusts have committed not to close the Orsett Hospital site unless and until services are satisfactorily re-provided in agreed alternative locations. It is acknowledged that this is reliant on the delivery of new integrated medical centres in Thurrock, and the development of existing premises across Basildon and Brentwood – for patients from those areas.

6.19There is also no available information to explain contingency plans should an IMC development be delayed or not take place. We suggest that the lack of clarity on proposals for Orsett Hospital are not in the best interest of health services in Thurrock.

6.20 According to latest available data, a total of 20,913 patients visited Orsett Hospital either for planned care or minor injuries and 19,973 patients attended Orsett Minor Injuries Unit.in one year. There is no detailed implementation plan on how any decant of services will be managed. This will cause uncertainty for thousands of patients that use Orsett Hospital on where the service they access will be provided in future, when that service may be relocated elsewhere in future and where it might be relocated.

Mid and South Essex Sustainability and Transformation Partnership
CCG Joint Committee

Sent via email

Cllr Victoria Holloway
Chair, Thurrock HOSC

Wren House
Hedgerows Business Park
Colchester Road
Chelmsford
Essex, CM2 5PF

Tel: 01245 398760

3 January 2019

Dear Cllr Holloway

Referral of Mid and South Essex Sustainability and Transformation Partnership – Orsett Hospital proposals

Thank you for your email of 21 December 2018 which outlined your intention to refer the decisions relating to Orsett Hospital, made by the Mid and South Essex STP CCG Joint Committee in July 2018, to the Secretary of State for Health and Social Care. This follows the public consultation *Your Care in the Best Place*. The draft referral letter has been passed to me as chair of the CCG Joint Committee, the decision-making body.

In your covering email you asked for comments on the draft referral, and inquired whether there had been any changes to the CCG Joint Committee's decision that might affect the content of the referral. You requested a response by 4 January 2019. You did not provide an indication as to when the referral would be submitted to the Secretary of State.

I must begin by stating that the CCG Joint Committee fully respects the right of the Council to refer our decisions for independent examination. On behalf of the CCG Joint Committee however, I must express my disappointment with this outcome, particularly as it comes almost six months after decisions were made.

I can confirm that there have been no changes to the decisions made by the CCG Joint Committee.

Having studied the draft referral letter, I am unable to comprehend the basis of your referral. I outline below a number of factors for your consideration.

Engagement with Thurrock Health & Wellbeing Board and Thurrock HOSC

As you have outlined in your letter, the STP team met with both the Thurrock Health and Wellbeing Board and Thurrock HOSC on a number of occasions in the lead up to the consultation launch. The team provided information on emerging plans and shared draft consultation materials with both committees for comment. This follows

a lengthy engagement process, run by Thurrock Council and Thurrock CCG (*For Thurrock in Thurrock*), where residents were asked about their priorities for the Integrated Medical Centres (IMCs), and the services they would like to see provided locally.

As part of our engagement with Thurrock HOSC, we clarified a number of questions about the proposals as they affected Orsett Hospital, these included the commitment that clinical services at the Hospital would not close prior to them being re-provided within the IMCs.

Given the background in Thurrock, and the fact that both the Health and Wellbeing Board and the HOSC were heavily involved in the *For Thurrock in Thurrock* work, and had the opportunity to comment on the broader STP plans and consultation materials, I do not understand why referral suggests that consultation was inadequate. I trust you and your officers appreciate that referral under the Regulations relates to our consultation with the relevant local authority and not the public. With respect I would invite you to reconsider this proposed basis for referral as it would appear to be based on your view of the public consultation rather than our consultation directly with the individual HOSCs and the Joint HOSC.

Availability & Dissemination of Materials

The consultation was launched on 30th November 2017, with the immediate availability of on-line resources including:

- Full consultation document
- Summary consultation document
- Consultation survey
- Supplementary information about Orsett Hospital proposals.
- Supplementary survey for Thurrock residents

Printed copies of the above materials were disseminated by each of the 5 CCGs in mid and south Essex. Thurrock CCGs engagement log shows that the CCG disseminated hard copy information between 12-14 December 2017 to:

- All 31 GP practices
- Council offices
- Libraries
- Community hubs

On 4 January 2018, materials were sent to 83 pharmacies across Thurrock; on 9th January, GP practice materials were replenished. This in addition to circulation of materials of public events, meetings, forums and at Orsett Hospital.

In response to feedback, the STP made a specific on-line video regarding the changes proposed at Orsett Hospital – this was released on 6 February 2018. During the consultation, the video appeared on the Facebook newsfeed of over 20,000 people, and had over 5,000 views.

Like all public organisations, the NHS must to use its resources wisely. Significant dedicated funds were made available by the CCGs to undertake the public consultation; this covered the cost of consultation materials, consultation events, focus groups, meetings, promotional activities, website development, digital materials (including videos and animation), a telephone survey and the independent analysis of consultation responses.

All consultation materials contained information on how to request the material in a different language, large print, audio format, braille, and easy-read version.

An easy-read version of the consultation document was made publicly available on 17 January 2018.

During the consultation we received two requests for language translation which were fulfilled.

As independent consumer champions, Healthwatch organisations play a vital role in engaging with patients and service users. The STP engaged with all three Healthwatch organisations in mid and south Essex and each played a positive role in the consultation process.

Healthwatch Thurrock were extremely helpful in supporting the STP engagement and consultation process. I attach their consultation exercise report (appendix 1) which very specifically states that "Healthwatch Thurrock is a key partner and member of Thurrock's Health and Wellbeing Board and Thurrock Council's Health and Wellbeing Overview and Scrutiny Committee. As such, Healthwatch Thurrock has informed the development of the STP proposals and helped to ensure that subsequent consultation exercise is accessible to Thurrock residents".

I am confused by your assertion that Thurrock residents did not have timely access to consultation materials - I have outlined above how materials were disseminated in Thurrock. The minutes of the Thurrock HOSC meeting (18th January) contain reference to concerns from Thurrock Healthwatch on the availability of materials, yet by 8th February 2018, Healthwatch Thurrock, in an email to the consultation team, state that they had spoken with over 2,000 people, and had booked many visits and meetings with specific groups. Healthwatch reported that they had disseminated 5,000 copies of the simplified questionnaire for Thurrock residents.

Through all channels of engagement and consultation, the CCGs strongly encouraged members of the public to complete the survey questionnaire, including having CCG and Healthwatch colleagues attending Orsett Hospital on several occasions throughout the consultation to provide materials directly to patients using the facility, and also supporting meetings and forums where Thurrock residents met, including older people, younger people and specific patient groups. This in addition to the two large public meetings held to discuss the Orsett proposals. Healthwatch also collected the views of individuals as they engaged with them and the report provided to the STP sought to theme the responses received. These were largely consistent with the themes arising from completed questionnaires that were independently analysed (relating to accessibility, funding and finance, workforce and quality of services).

It is disappointing that your draft referral also makes reference to inconsistencies in the materials provided relating to proposed changes at Orsett. Both the HOSC and Health and Wellbeing Board in Thurrock were provided with drafts of the suite of consultation materials – if there were inconsistencies, these could have helpfully been highlighted in the drafting phase, rather than now, almost six months after decision-making.

Since decision-making, we have also maintained engagement with Thurrock residents, through Thurrock CCG's newsletter, local media, and through the development of post-decision materials including "10 facts about the Orsett Hospital closure" leaflet and further circulation of the Orsett hospital on-line video, which reached over 13,000 people. We have also worked with Healthwatch Thurrock to establish the People's Panel.

Best Interests of Health Services in Thurrock

I am struggling to understand the HOSCs position that the proposals are not in the best interests of Thurrock residents, citing concerns that the IMCs would not emerge (particularly given that the development of the IMCs is a joint Council and CCG initiative), and that Orsett Hospital would close without services being made available in Thurrock. As you will be aware, on 17 May 2017, Thurrock Council was a co-signatory, along with Thurrock CCG, Basildon & Thurrock University Hospitals NHS Foundation Trust, Essex Partnership University NHS Foundation Trust and North East London NHS Foundation Trust, to a memorandum of understanding (attached at Appendix 2), which undertook that the partners would (subject to the results of the public consultation):

- not cease provision of services at Orsett Hospital prior to the construction and opening of the integrated medical centres; and
- undertake a comprehensive review of health and care services provided at Orsett to inform the appropriate clinical services which may be migrated to each IMC or other

appropriate location, taking account of the specific care needs of the population of each of the four localities in Thurrock.

The STP echoed the principles of this signed MoU throughout all of its consultation materials and in public events and meetings.

It would be of interest to us and partner NHS organisations if you could clarify in detail how providing care closer to a person's home is not in the best interests of health services in Thurrock.

Consultation Response

The primary purpose of consultation is to understand any issues and concerns that people, and in particular those most likely to be affected, might have had about service change so that decision-makers can consider these and seek to mitigate any risks or negative impact as far as possible. Whilst it is disappointing that higher numbers did not formally respond to the consultation, the reach of the consultation was significantly beyond the response rate – in Thurrock alone, there were 26 meetings and group sessions that were supported by Healthwatch; across the wider STP our social media marketing reached in excess of 350,000 people.

In the decision-making business case we fully acknowledge that there was less support for the proposal to close Orsett Hospital from residents of Thurrock, and the concerns reflected in the consultation responses were taken into account when decisions were taken.

Clarity on Services

The supplementary information on the Orsett proposals outlined specifically the services currently provided from the Orsett site and outlined where those services might be provided in future across the four IMCs in Thurrock and the centres being considered for Basildon and Brentwood patients. We asked specifically for feedback on the location of renal dialysis, musculoskeletal, ophthalmology and minor injury services. The documentation was clear that not all services would need to be provided in all four of the planned IMCs and that detailed planning would be required to work out the best location.

At the suggestion of Healthwatch Thurrock, the decision-making business case included a specific recommendation to create a "People's Panel" to enable residents of Thurrock to not only continue to have a voice about the changes that were being made, but also to help shape the future provision of services and have a role in overseeing implementation.

As outlined in the decision-making business case, the CCGs undertook detailed equality and health inequality impact assessments on each of the proposed

changes. For the Orsett Hospital changes, the assessments found an overarching positive impact on quality, outcomes and accessibility for Thurrock residents.

A key area of concern in feedback to the consultation across all areas was that of access to services. You will be aware that Thurrock Council and Thurrock CCG have already commenced discussions with transport providers regarding access to the IMCs to mitigate these concerns.

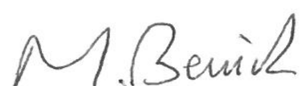
The recommendation made to, and supported by the CCG Joint Committee was that, once the work with the People's Panel had concluded and the best site(s) for relocation had been considered, the CCG Joint Committee would be asked to make a final decision on service location. This decision would be supported by further detailed equality and health inequality assessments.

All of this means that detailed future arrangements on service location have not yet been set in stone. However, I am surprised that the HOSC consider it a reason for referral to the Secretary of State, particularly given that we have made provision for the people of Thurrock to have a strong say in service provision and implementation.

In summary, I am disappointed that you have reached the decision to refer to the Secretary of State for Health and Social Care. I believe that the prior work of Thurrock Council and Thurrock CCG, coupled with the agreed memorandum of understanding between all parties, and the work the STP has done with Healthwatch Thurrock, should give the HOSC assurance that we are doing all we can to make the right decisions about service provision in Thurrock.

I sincerely hope that the outcome of any independent review will enable us to move forward and deliver on our obligations to our local communities to secure much needed improvements in the provision and sustainability of health services.

Yours sincerely



Professor Mike Bewick
Independent Chair
Mid & South Essex CCG Joint Committee

Encs. Appendix 1 – Healthwatch Thurrock report
Appendix 2 – Memorandum of Understanding

Department
of Health &
Social Care

Acute Care and Provider Policy
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

10th January 2019

Dear Councillor Holloway,

Referral of Mid and South Essex Sustainability and Transformation Partnership – Orsett Hospital proposals

Thank you for your letter of 8th January 2019 in which you refer the above matter to the Secretary of State for his consideration, in accordance with Regulation 23 of The Local Authority *(Public Health, Health and Wellbeing Boards and Health Scrutiny)* Regulations 2013.

It would help us in determining whether this referral is legitimate, if you could set out clearly how your written submission conforms to the requirements of these Regulations.

Your letter states that *"This referral meets the conditions of referral as set out in regulation 23 parts (5)(a)(b)(c) (Local Authority Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations 2013)"*. It would be helpful if you could provide evidence of this; for example, the recommendations made to the CCG Joint Committee and the steps taking to reach agreement in relation to the subject of the recommendation. If you believe you did not make a recommendation to the CCG Joint Committee, please refer to Paragraphs (6), (7) and (8) of the Regulations.

To meet the requirements set out in Paragraphs (10) and (11), it would be helpful if you could explain how you have attempted to reach agreement on the proposals. This could include, for example, providing a summary of the evidence considered, copies of (or website links to) the minutes of Council, Thurrock HOSC or JHOSC meetings, and copies of communication with the CCG Joint Committee.

For ease of reference, I have attached Regulation 23 as an Annex to this letter.

Yours sincerely,

Lauren Ging
Acute Care and Provider Policy team
020 7210 2739
Lauren.ging@dhsc.gov.uk

23.— Consultation by responsible persons

(1) Subject to paragraphs (2) and (12) and regulation 24, where a responsible person ("R") has under consideration any proposal for a substantial development of the health service in the area of a local authority ("the authority"), or for a substantial variation in the provision of such service, R must—

(a) consult the authority;

(b) when consulting, provide the authority with—

(i) the proposed date by which R intends to make a decision as to whether to proceed with the proposal; and

(ii) the date by which R requires the authority to provide any comments under paragraph (4);

(c) inform the authority of any change to the dates provided under paragraph (b); and

(d) publish those dates, including any change to those dates.

(2) Paragraph (1) does not apply to any proposals on which R is satisfied that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff.

(3) In a case such as is referred to in paragraph (2), R must notify the authority immediately of the decision taken and the reason why no consultation has taken place.

(4) Subject to regulation 30(5) (joint committees) and any directions under regulation 32 (directions as to arrangements for discharge of health scrutiny functions), the authority may make comments on the proposal consulted on by the date or changed date provided by R under paragraph (1)(b)(ii) or (c).

(5) Where the authority's comments under paragraph (4) include a recommendation to R and R disagrees with that recommendation—

(a) R must notify the authority of the disagreement;

(b) R and the authority must take such steps as are reasonably practicable to try to reach agreement in relation to the subject of the recommendation; and

(c) in a case where the duties of R under this regulation are being discharged by the responsible commissioner pursuant to paragraph (12), the authority and the responsible commissioner must involve R in the steps specified in sub-paragraph (b).

(6) This paragraph applies where—

(a) the authority has not exercised the power in paragraph (4); or

(b) the authority's comments under paragraph (4) do not include a recommendation.

(7) Where paragraph (6) applies, the authority must inform R of—

(a) its decision as to whether to exercise its power under paragraph (9) and, if applicable, the date by which it proposes to exercise that power; or

(b) the date by which it proposes to make a decision as to whether to exercise that power.

(8) Where the authority has informed R of a date under paragraph (7)(b), the authority must, by that date, make the decision referred to in that paragraph and inform R of that decision.

(9) Subject to paragraph (10), the authority may report to the Secretary of State in writing where—

(a) the authority is not satisfied that consultation on any proposal referred to in paragraph (1) has been adequate in relation to content or time allowed;

(b) in a case where paragraph (2) applies, the authority is not satisfied that the reasons given by R are adequate; or

(c) the authority considers that the proposal would not be in the interests of the health service in its area.

(10) The authority may not make a report under paragraph (9)—

(a) in a case falling within paragraph (5), unless the authority is satisfied that—

(i) the steps specified in paragraph (5)(a) to (c) have been taken, but agreement has not been reached in relation to the subject of the recommendation within a reasonable period of time;

(ii) R has failed to comply with its duty under paragraph (5)(b) within a reasonable period of time; or

(b) in a case to which paragraph (6) applies, unless the authority has complied with the duty in paragraph (7) and, where applicable, paragraph (8).

(11) A report made under paragraph (9) must include—

(a) an explanation of the proposal to which the report relates;

(b) in the case of a report under paragraph (9)(a) or (b), the reasons why the authority is not satisfied of the matters set out in paragraph (9)(a) or (b);

(c) in the case of a report under paragraph (9)(c), a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the authority;

(d) an explanation of any steps the authority has taken to try to reach agreement with R in relation to the proposal or the matters set out in paragraph (9)(a) or (b);

(e) in a case falling within paragraph (10), evidence to demonstrate that the authority has complied with the applicable condition in that paragraph;

(f) an explanation of the reasons for the making of the report; and

(g) any evidence in support of those reasons.

(12) In a case where R is a service provider and the proposal relates to services which a clinical commissioning group or the Board is responsible for arranging the provision of—

(a) the functions of R under this regulation must be discharged by the responsible commissioner on behalf of R; and

(b) references to R in this regulation (other than in paragraph (5)(c)) are to be treated as references to the responsible commissioner.

(13) Where the functions of R under this regulation fall to be discharged by more than one body under paragraph (12)(a), the duties of those bodies under that paragraph may be discharged by those bodies jointly or by one or more of those bodies on behalf of those bodies.

(14) In this regulation—

"service provider" means an NHS trust, an NHS foundation trust or a relevant health service provider;

"the responsible commissioner" means the clinical commissioning group or groups or the Board, as the case may be, responsible for arranging the provision of the services to which the proposal relates.

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Health and Wellbeing Overview and Scrutiny Committee : 24 January 2019

Briefing Note: NHS Long Term Plan

Purpose of the briefing note: To bring to the attention of HOSC the publication of the NHS LTP on 7 January 2019.

1.1 The NHS Long Term Plan was published on 7 January 2019 and is a comprehensive long term vision for the NHS.

1.2 Attached is a copy of the Executive Summary and officers from the CCG and the Council will give a further verbal summary and update at the meeting.

1.3 It is proposed that a more detailed report comes back to the March meeting of HOSC when the implications for Thurrock can be more fully considered.

1.4 Members are asked to comment on the NHS Long Term Plan.

For any questions regarding this briefing note, please contact:

Name: Roger Harris, Corporate Director, Adults, Housing and Health

E-mail: rharris@thurrock.gov.uk

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Overview and summary

The NHS has been marking its 70th anniversary, and the national debate this has unleashed has centred on three big truths. There's been pride in our Health Service's enduring success, and in the shared social commitment it represents. There's been concern – about funding, staffing, increasing inequalities and pressures from a growing and ageing population. But there's also been optimism – about the possibilities for continuing medical advance and better outcomes of care.

In looking ahead to the Health Service's 80th birthday, this NHS Long Term Plan takes all three of these realities as its starting point. So to succeed, we must keep all that's good about our health service and its place in our national life. But we must tackle head-on the pressures our staff face, while making our extra funding go as far as possible. And as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. This Plan sets out how we will do that. We are now able to because:

- first, we now have a secure and improved funding path for the NHS, averaging 3.4% a year over the next five years, compared with 2.2% over the past five years;
- second, because there is wide consensus about the changes now needed. This has been confirmed by patients' groups, professional bodies and frontline NHS leaders who since July have all helped shape this plan – through over 200 separate events, over 2,500 separate responses, through insights offered by 85,000 members of the public and from organisations representing over 3.5 million people;
- and third, because work that kicked-off after the *NHS Five Year Forward View* is now beginning to bear fruit, providing practical experience of how to bring about the changes set out in this Plan. Almost everything in this Plan is already being implemented successfully somewhere in the NHS. Now as this Plan is implemented right across the NHS, here are the big changes it will bring:

Chapter One sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. GP practices and hospital outpatients currently provide around 400 million face-to-face appointments each year. Over the next five years, every patient will have the right to online 'digital' GP consultations, and redesigned hospital support will be able to avoid up to a third of outpatient appointments - saving patients 30 million trips to hospital, and saving the NHS over £1 billion a year in new expenditure averted. GP practices - typically covering 30-50,000 people - will be funded to work together to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff. Now expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes. Within five years over 2.5 million more people will benefit from 'social prescribing', a personal health budget, and new support for managing their own health in partnership with patients' groups and the voluntary sector.

These reforms will be backed by a new guarantee that over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget. This commitment – an NHS 'first' - creates a ringfenced local fund worth at least an extra £4.5 billion a year in real terms by 2023/24.

We have an emergency care system under real pressure, but also one in the midst of profound change. The Long Term Plan sets out action to ensure patients get the care they need, fast, and to relieve pressure on A&Es. New service channels such as urgent treatment centres are now growing far faster than hospital A&E attendances, and UTCs are being designated across England. For those that do need hospital care, emergency 'admissions' are increasingly being treated through 'same day emergency care' without need for an overnight stay. This model will be rolled out across all acute hospitals, increasing the proportion of acute admissions typically discharged on day of attendance from a fifth to a third. Building on hospitals' success in improving outcomes for major trauma, stroke and other critical illnesses conditions, new clinical standards will ensure patients with the most serious emergencies get the best possible care. And building on recent gains, in partnership with local councils further action to cut delayed hospital discharges will help free up pressure on hospital beds.

Chapter Two sets out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities. Wider action on prevention will help people stay healthy and also moderate demand on the NHS. Action by the NHS is a complement to - not a substitute for - the important role of individuals, communities, government, and businesses in shaping the health of the nation. Nevertheless, every 24 hours the NHS comes into contact with more than a million people at moments in their lives that bring home the personal impact of ill health. The Long Term Plan therefore funds specific new evidence-based NHS prevention programmes, including to cut smoking; to reduce obesity, partly by doubling enrolment in the successful Type 2 NHS Diabetes Prevention Programme; to limit alcohol-related A&E admissions; and to lower air pollution.

To help tackle health inequalities, NHS England will base its five year funding allocations to local areas on more accurate assessment of health inequalities and unmet need. As a condition of receiving Long Term Plan funding, all major national programmes and every local area across England will be required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years. The Plan also sets out specific action, for example to: cut smoking in pregnancy, and by people with long term mental health problems; ensure people with learning disability and/or autism get better support; provide outreach services to people experiencing homelessness; help people with severe mental illness find and keep a job; and improve uptake of screening and early cancer diagnosis for people who currently miss out.

Chapter Three sets the NHS's priorities for care quality and outcomes improvement for the decade ahead. For all major conditions, results for patients are now measurably better than a decade ago. Childbirth is the safest it has ever been, cancer survival is at an all-time high, deaths from cardiovascular disease have halved since 1990, and male suicide is at a 31-year low. But for the biggest killers and disablers of our population, we still have unmet need, unexplained local variation, and undoubted opportunities for further medical advance. These facts, together with patients' and the public's views on priorities, mean that the Plan goes further on the NHS Five Year Forward View's focus on cancer, mental health, diabetes, multimorbidity and healthy ageing including dementia. But it also extends its focus to children's health, cardiovascular and respiratory conditions, and learning disability and autism, amongst others.

Some improvements in these areas are necessarily framed as 10 year goals, given the timelines needed to expand capacity and grow the workforce. So by 2028 the Plan commits to dramatically improving cancer survival, partly by increasing the proportion of cancers diagnosed early, from a half to three quarters. Other gains can happen sooner, such as halving maternity-related deaths by 2025. The Plan also allocates sufficient funds on a phased basis over the next five years to increase the number of planned operations and cut long waits. It makes a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24. This will enable further service expansion and faster access to community and crisis mental health services for both adults and particulary children and young people. The Plan also recognises the critical importance of research and innovation to drive future medical advance, with the NHS committing to play its full part in the benefits these bring both to patients and the UK economy.

To enable these changes to the service model, to prevention, and to major clinical improvements, the Long Term Plan sets out how they will be backed by action on workforce, technology, innovation and efficiency, as well as the NHS' overall 'system architecture'.

Chapter Four sets out how current workforce pressures will be tackled, and staff supported. The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. But our staff are feeling the strain. That's partly because over the past decade workforce growth has not kept up with the increasing demands on the NHS. And it's partly because the NHS hasn't been a sufficiently flexible and responsive employer, especially in the light of changing staff expectations for their working lives and careers. However there are practical opportunities to put this right. University places for entry into nursing and medicine are oversubscribed, education and training places are being expanded, and many of those leaving the NHS would remain if employers can reduce workload pressures and offer improved flexibility and professional development. This Long Term Plan therefore sets out a number of specific workforce actions which will be overseen by NHS Improvement that can have a positive impact now. It also sets out wider reforms which will be finalised in 2019 when the workforce education and training budget for HEE is set by government. These will be included in the comprehensive NHS workforce implementation plan published later this year, overseen by the new cross-sector national workforce group, and underpinned by a new compact between frontline NHS leaders and the national NHS leadership bodies.

In the meantime the Long Term Plan sets out action to expand the number of nursing and other undergraduate places, ensuring that well-qualified candidates are not turned away as happens now. Funding is being guaranteed for an expansion of clinical placements of up to 25% from 2019/20 and up to 50% from 2020/21. New routes into nursing and other disciplines, including apprenticeships, nursing associates, online qualification, and 'earn and learn' support, are all being backed, together with a new post-qualification employment guarantee. International recruitment will be significantly expanded over the next three years, and the workforce implementation plan will also set out new incentives for shortage specialties and hard-to-recruit to geographies.

To support current staff, more flexible rostering will become mandatory across all trusts, funding for continuing professional development will increase each year, and action will be taken to support diversity and a culture of respect and fair treatment. New roles and inter-disciplinary credentialing programmes will enable more workforce flexibility across an individual's NHS career and between individual staff groups. The new primary care networks will provide flexible options for GPs and wider primary care teams. Staff and patients alike will benefit from a doubling of the number of volunteers also helping across the NHS.

Chapter Five sets out a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS. These investments enable many of the wider service changes set out in this Long Term Plan. Over the next ten years they will result in an NHS where digital access to services is widespread. Where patients and their carers can better manage their health and condition. Where clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support and AI, and without the administrative hassle of today. Where predictive techniques support local Integrated Care Systems to plan and optimise care for their populations. And where secure linked clinical, genomic and other data support new medical breakthroughs and consistent quality of care. Chapter Five identifies costed building blocks and milestones for these developments.

Chapter Six sets out how the 3.4% five year NHS funding settlement will help put the NHS back onto a sustainable financial path. In ensuring the affordability of the phased commitments in this Long Term Plan we have taken account of the current financial pressures across the NHS, which are a first call on extra funds. We have also been realistic about inevitable continuing demand growth from our growing and aging population, increasing concern about areas of longstanding unmet need, and the expanding frontiers of medical science and innovation. In the modelling underpinning this Long Term Plan we have therefore not locked-in an assumption that its increased investment in community and primary care will necessarily reduce the need for hospital beds. Instead, taking a prudent approach, we have provided for hospital funding as if trends over the past three years continue. But in practice we expect that if local areas implement the Long Term Plan effectively, they will benefit from a financial and hospital capacity 'dividend'.

In order to deliver for taxpayers, the NHS will continue to drive efficiencies - all of which are then available to local areas to reinvest in frontline care. The Plan lays out major reforms to the NHS' financial architecture, payment systems and incentives. It establishes a new Financial Recovery Fund and 'turnaround' process, so that on a phased basis over the next five years not only the NHS as a whole, but also the trust sector, local systems and individual organisations progressively return to financial balance. And it shows how we will save taxpayers a further £700 million in reduced administrative costs across providers and commissioners both nationally and locally.

Chapter Seven explains next steps in implementing the Long Term Plan. We will build on the open and consultative process used to develop this Plan and strengthen the ability of patients, professionals and the public to contribute by establishing the new NHS Assembly in early 2019. 2019/20 will be a transitional year, as the local NHS and its partners have the opportunity to shape local implementation for their populations, taking account of the Clinical Standards Review and the national implementation framework being published in the spring, as well as their differential local starting points in securing the major national improvements set out in this Long Term Plan. These will be brought together in a detailed national implementation programme by the autumn so that we can also properly take account of Government Spending Review decisions on workforce education and training budgets, social care, councils' public health services and NHS capital investment.

Parliament and the Government have both asked the NHS to make consensus proposals for how primary legislation might be adjusted to better support delivery of the agreed changes set out in this LTP. This Plan does not require changes to the law in order to be implemented. But our view is that amendment to the primary legislation would significantly accelerate progress on service integration, on administrative efficiency, and on public accountability. We recommend changes to: create publicly-accountable integrated care locally; to streamline the national administrative structures of the NHS; and remove the overly rigid competition and procurement regime applied to the NHS.

In the meantime, within the current legal framework, the NHS and our partners will be moving to create Integrated Care Systems everywhere by April 2021, building on the progress already made. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

Our National Health Service was founded in 1948 in place of fear - the fear that many people had of being unable to afford care for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war. At its best our National Health Service is the practical expression of a shared commitment by the British people: over the past seven decades, there when we need it, at the most profound moments in our lives. But as medicine advances, health needs change, and society develops, the Health Service continually has to move forward. This Long Term Plan shows how we will do so. So that looking forward to the NHS' 80th Birthday, in a decade's time, we have a service that is fit for the future.

24 January 2019	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
Adult Mental Health Service Transformation	
Wards and communities affected: All	**Key Decision:** Key
Report of: Ian Wake, Director of Public Health	
Accountable Officers: Mark Tebbs, Director of Commissioning NHS Thurrock Clinical Commissioning Group (CCG) Catherine Wilson, Strategic Lead Commissioning, Adults Housing and Health	
Accountable Director: Ian Wake, Director of Public Health Roger Harris, Corporate Director, Adults, Housing and Health Mandy Ansell, Accountable Officer, NHS Thurrock Clinical Commissioning Group	
This report is Public	

Executive Summary

Mental illness is the single largest cause of disability in the UK and a major driver of health inequalities. Whilst there are many examples of good practice amongst health and care providers, the current adult mental health treatment system in Thurrock as a whole is not fit for purpose and needs fundamental system wide reform. The recent Adult Mental Health Joint Strategic Needs Assessment and Local Government Association Peer Review identified some strong assets within our local system on which to build, including a good service provided by our main mental health provider - Essex University Mental Health Partnership Trust (EPUT), Thurrock MIND and *Inclusion* Thurrock to patients being treated, Local Area Coordination, Public Health Intelligence and Thurrock First. However both also highlighted a number of systemic failures, many of which were also echoed in the Thurrock Healthwatch report – which found that 88% of mental health service users were dissatisfied with the current service offer.

Collation of the key issues raised in the three pieces of work have been grouped into five priority areas for action to improve local mental health services – each of which is discussed in more detail in this report:

1. Address the issue of under-diagnosis of mental health problems
2. Improve access to timely treatment

3. Develop a new model for Common Mental Health Disorders
4. Develop a new *Enhanced Treatment and Recovery Model* for people with serious mental ill-health conditions
5. Integrate commissioning and develop a single common outcomes framework supported with improved commissioning intelligence.

This report sets out work to date to address problems in the local mental health and care system in Thurrock and sets out plans with NHS Thurrock CCG and NHS and third sector provider partners to transform mental health services moving forward. The report also discusses the issue of suicide prevention and how best to integrate commissioning of services between the council and NHS.

The report seeks HOSC support for the new programme of transformation, and for proposals to reform the section 75 agreement between the Council and EPUT.

Recommendation(s)

1. That Health and Wellbeing Overview and Scrutiny Committee notes the contents of this report and comments on the direction of travel in terms of adult mental health system transformation

2. That Health and Wellbeing Overview and Scrutiny Committee comments on and supports the proposals as set out in section 7.14 to 7.15 of this report to develop a new Section 75 Agreement with EPUT from 1 April 2019 based on a longer term contract, with a revised performance and budget framework

3. That Health and Wellbeing Overview and Scrutiny Committee comments on and supports and approves the proposals set out in section 10 of this report in relation to suicide prevention.

1. Introduction

1.1 Mental illness is the single largest cause of disability in the United Kingdom, contributing up to 22.8 per cent of the total burden of morbidity, compared to 15.9 per cent for cancer and 16.2 per cent for cardiovascular disease. Current figures suggest that one in four people will experience a mental health problem during their lifetime. No other set of health conditions match the combined extent of prevalence, persistence and breadth of impact of mental ill-health.

1.2 Mental illness has a huge impact on population health and is a major driver of health inequalities. There is a bi-directional relationship between poor mental health and poor physical health. People with mental health problems are at higher risk of experiencing significant physical health problems; they are more likely to develop preventable conditions such as diabetes, heart disease, bowel cancer and breast cancer, and do so at a younger age. Conversely, people with long-term physical health conditions are at greater risk of mental health problems, particularly depression and anxiety.

1.3 Mental illness further affects the way individuals manage their health and interact with services. People with mental health problems are more likely to

smoke, misuse substances and less likely to be physically active. Furthermore, they are less likely to attend medical appointments and less likely to adhere to treatment and self-care regimens.

1.4 People with serious mental ill health die on average 20 years before the general population. Conversely, rates of mental illness, particularly depression, are between two and three times more common in those with long-term conditions compared to the general population including coronary heart disease, cancer, diabetes, osteoporosis, multiple sclerosis, immunological problems and arthritis. Mental health co-morbidities in those with physical long term conditions contribute significantly to poor physical health outcomes and higher treatment costs; it is estimated that £1 in every £8 spent on treating a long-term condition is linked to a co-morbid mental illness.

1.5 The cost of mental ill-health in England has been estimated to be £105 billion of which £30 million is allocated to work related sickness. This is due to increase and double over the next 20 years. The costs to Social Care for people with mental health collates to £2 billion annually and is also likely to continue to increase if mental health services are not re-organised and managed more effectively. This will put ever more pressure on an already overstretched NHS and Social Care system. In 2018/19 Thurrock Council is forecast to spend £3.259m on care packages.

2. Background – Current Provider and Commissioning Landscape

2.1 The Adult Mental Health Service Provider landscape in Thurrock is currently complex and fragmented, and is characterised with a lack of continuity of care relationships, i.e. there is the potential for many different health and care professionals are involved in an individual’s care, increasingly the likelihood that they will need to tell their story multiple times.

2.2 Common Mental Health Disorders (depression, anxiety, phobias and obsessive compulsive disorder) make up the vast majority of mental health problems amongst Thurrock residents, and are mainly dealt with in Primary Care. The current treatment offer is limited to prescription of anti-depressant medication, referral to a social prescriber (in practices were this service is operating), or referral to IAPT (Increasing Access to Psychological Therapies) which is provided by *Inclusion Thurrock* who also deliver drug and alcohol treatment services to Thurrock residents. Patients known to EPUT services have access to a telephone line 24/7 where they can contact services and seek advice. Service users who are discharged from secondary care to primary care are supported through a shared care protocol. This enables a comprehensive handover of care and rapid access back into services in the event that the patient deteriorates.

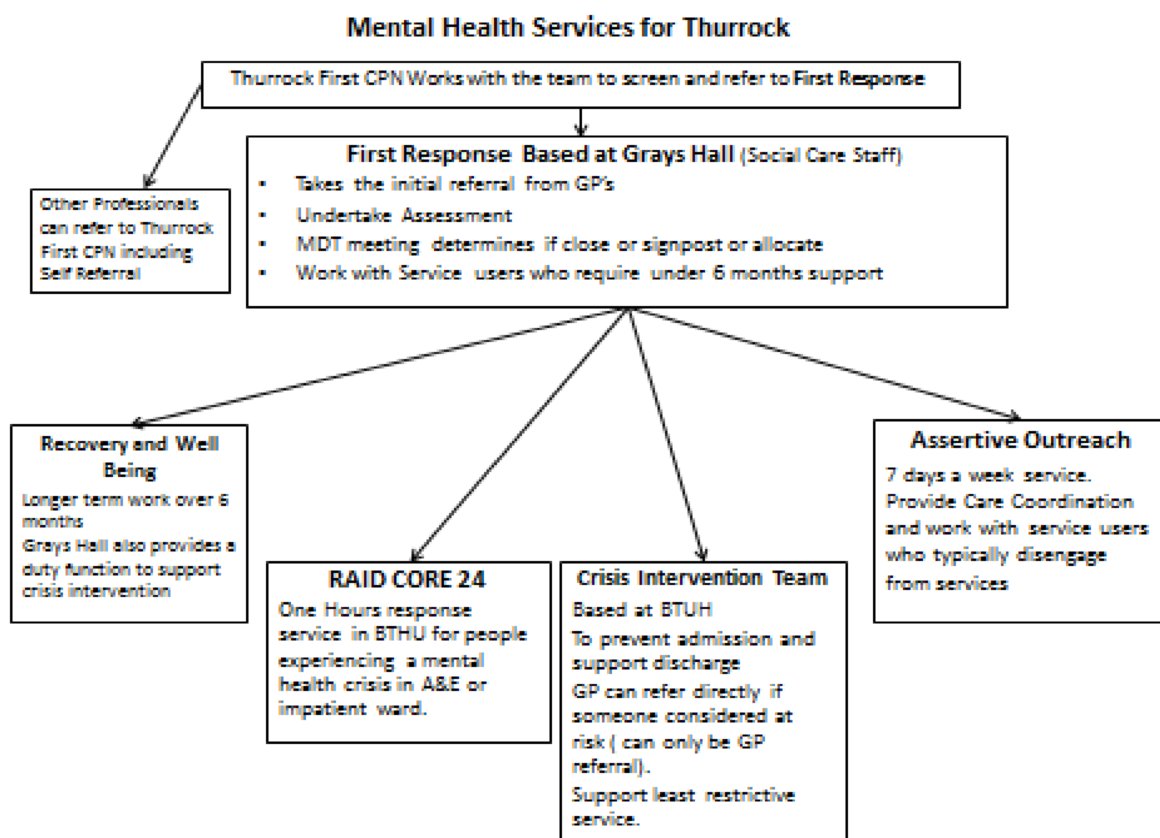
2.3 *Inclusion Thurrock* provide a *Recovery College* consisting of suites of courses which help people recovering from mental health problems self-manage their conditions. This includes programmes on mindfulness, understanding anxiety and food and mood.

2.4 A range of third sector organisations provide support to people with mental ill health. The largest provider of these services is Thurrock MIND, who provides

a range of interventions including talking therapies, supported housing, peer mentoring, positive pathways and advocacy. They are also active participants in a ‘shared care protocol’ which supports clients discharged from EPUT services to stay well and reduce re-admissions to secondary care. The Emotional Well Being Forum supported by Thurrock Coalition and MIND is an opportunity for those with lived experiences of services and mental health and carers to meet together for support, to gain information and to influence service developments. *The World of Work* provides support and training to enable people to become work ready through CV writing interview practice support with volunteering and support into paid employment.

2.5 More serious mental ill-health treatment services, for example for psychotic illness such as schizophrenia and bi-polar disorder, are provided by Essex Partnership University Foundation Trust (EPUT) at Grays Hall. Early Intervention in Psychosis, including Individual Placement Support (employment service) and Personality Disorders services are collaboratively delivered by EPUT and Inclusion Thurrock. This service offer can currently only be accessed through a referral from a GP. Figure 1 summarises the current treatment model.

Figure 1



2.6 Thurrock Council delegates to EPUT its statutory duty to provide adult social care assessment and care management services under the Care Act 2014 through a Section 75 Agreement. A Community Psychiatric Nurse (CPN) works within Thurrock First taking initial referrals and supporting the Thurrock First Advisors. The CPN can offer support information and advice and can also refer

directly to the First Response Team. The First Response Team works with people who require 6 months of support or less. The Team consists of social workers and community nurses together with psychiatrists and therapists offering a range of supports, including individual therapy, case management, and medication monitoring and risk management. The referral route into the team is via GP's and other professionals, not self-referral.

2.7 Within Grays Hall the Recovery and Well Being Team and the Assertive Outreach Team provide longer term support from both health and social care practitioners.

2.8 The Crisis Intervention Team is based at Basildon and Thurrock University Hospital (BTUH) and works with individuals to prevent admission and facilitate discharge. The RAID CORE 24 Team offers a one hour response to patients presenting with mental health challenges at BTUH accessing A&E or for inpatients. Street Triage based in the Police Force Control Room (FCR) supports the police and with a crisis response option to ensure appropriate application of their powers under s136.

2.9 Inpatient assessment and treatment across working age adults and older age adults is provided through the wider CCG block contract across Essex. Patients within Thurrock have access to an assessment unit, adult acute inpatient beds, older people functional beds and psychiatric intensive care beds. These beds operate across a South Essex footprint.

2.10 Thurrock has a number of services funded by the CCG and Adult Social Care to support early intervention and prevention within Mental Health and provide therapeutic self-management support.

2.11 There are a range of specialist teams which provide care for particular conditions including people with eating disorders, personality disorders, Asbergers and specialist perinatal mental health care.

2.12 The current Crisis Resolution Home Treatment (CRHT) operates 12 hours per day, 7 days per week. The team 'gate-keeps' admissions to inpatient services and facilitates early discharge. A business case is being developed to develop a 24/7 direct access mental health crisis service.

2.13 A range of universal services are accessed by service users with mental health problems. This includes social prescribing (estimated 66% of all clients have an underlying mental health issue), Local Area Coordination, Housing Operations, Healthy Lifestyles Services including NHS Health Checks operating in EPUT and MIND, drug and alcohol treatment services, and community and third sector groups.

2.14 Commissioning of the current mental health system is also fragmented. NHS Thurrock CCG lead commissioning Inclusion Thurrock to provide IAPT services, the secondary healthcare treatment services provided by EPUT on behalf of the Mid and South Essex CCG Joint Committee and commission some third sector provision. Similarly Thurrock Council Adult Social Care also commission EPUT through the section 75 arrangement for social care staff, and commission a range of third sector and community social care support. The Council's Public Health Team commission drug and alcohol and healthy

lifestyles service provision. NHS England commission Primary Care services. Basildon and Brentwood CCG lead commissioning of A&E services on behalf of the Mid and South Essex Joint Committee. NHS England, via specialist commissioning, commission low and medium secure services. West Essex CCG commission children's mental health and emotional wellbeing services.

2.15 Some work has already commenced to integrate commissioned care pathways. This includes improved collaboration between *Inclusion Thurrock* and NELFT; *Inclusion Thurrock* and EPUT; and within *Inclusion Thurrock* for clients receiving both IAPT services and Drug and Alcohol Treatment (dual diagnosis).

3. Background – Transformation of Mental Health Services work to date

3.1 Thurrock Council, Thurrock CCG and local NHS healthcare provider organisations and the third sector have embarked on a major programme of health and social care transformation over the past three years. This has included the *Stronger Together* programme of community development using a strengths and asset based approach, new models of integrated primary, community and social care set out in *Better Care Together Thurrock,* proposals to build for new Integrated Medical Centres, and a new Integrated Care Alliance and MOU which seeks to integrate commissioning and delivery of a single health and care system around a new outcomes framework.

3.2 Thurrock CCG has developed an STP wide service mental health transformation group. The group has initially focussed upon delivering the core mental health targets identified within the Mental Health Five Year Forward View (MHFYFV). This has overseen the significant additional local funding into Perinatal Services, Early Intervention in Psychosis Service, and Psychiatric Liaison in BTUH and Employment services.

3.3 The CCG GP clinical lead has established a clinical forum with consultants from EPUT, Inclusion and other partners to improve relationships and co-ordination of care. The group has significantly improved engagement and created an environment within Thurrock which promotes innovation and trust.

3.4 However, historically the issue of mental health and mental health treatment services has not featured as strongly as perhaps it could within wider system transformation plans. As a result, three major pieces of work have been undertaken in 2018 considering the issue of adult mental health transformation in Thurrock:

- An Adult Mental Health Joint Strategic Needs Assessment was undertaken by Public Health and agreed at the March 2018 Joint Health and Wellbeing Board.

- A Local Government Peer Review was undertaken in June 2018 which considered eight issues: current thresholds to access treatment; the extent to which services were person centred and outcome focussed; market capacity and development needs; the extent to which the current service offer was holistic; prevention and early intervention; partnership working; the section 75 arrangements between the council and EPUT, and; the suitability of current commissioning arrangements.

- Healthwatch Thurrock undertook research with residents who were users of local mental health treatment services to better understand patient experience of existing local services. It concluded that 88% of respondents felt unsupported in their mental health issue and made a series of recommendations for system wide transformation.

3.5 A report by the Director of Public Health which aimed to triangulate learning from the JSNA, LGA Peer Review and Healthwatch Research and propose strategic action on transforming the local adult mental health treatment system was agreed at the September 2018 Thurrock Joint Health and Wellbeing Board. The report set out five priority areas for action to improve local mental health services which are discussed in more detail in sections 5 to 8 and made a series of recommendations. These are included in the action plan in section 10.

1. Address the issue of under-diagnosis of mental health problems
2. Improve access to timely treatment
3. Develop a new model for Common Mental Health Disorders
4. Develop a new *Enhanced Treatment Model* for people with serious mental ill-health conditions
5. Integrate commissioning and develop a single common outcomes framework supported with improved commissioning intelligence.

4. Address the issue of under-diagnosis of mental health problems

4.1 As with many other long-term conditions in Thurrock, there are a significant cohort of the population living with Common Mental Health Disorders who remain undiagnosed and are therefore not receiving support treatment. The latest modelled estimates from Public Health England (2016) found there are likely to be as many as 21,317 residents who have depression in Thurrock, of which 8,628 remain undiagnosed. The size of this cohort is a significant public health issue in itself and also will likely be compounding poorer health outcomes in patients with other co-morbid long term conditions.

4.2 The Mental Health JSNA shows an approximate four-fold variation in GP Practice Depression QOF register completeness ranging from 24% through to fully complete. A number of programmes are already being implemented to *find the missing thousands* of residents with undiagnosed depression. These include:

- Including the PHQ-9 depression screening tool as part of the Thurrock NHS Health Check Programme
- Commissioning ICS to interrogate SystmOne in GP practices to identify patients' medical records that have entries that may suggest depression (for example prescription of an SSRI) but who are not on depression QOF registers
- Piloting proactive template prompts in SystmOne that highlight the need for a GP to undertake a PHQ-2/9 depression screen with patients being reviewed/newly diagnosed with physical long term conditions (starting with diabetes with a view to rolling out across all LTCs if successful).

- Piloting embedding electronic IAPT referral into SystmOne in response to a positive screen on a PHQ-9.

4.3 There are further opportunities to embed depression screening across the health and care system locally, particularly by front line professionals such as community nursing and social care staff working with older people (who are at significantly greater risk of having undiagnosed depression), other community workers for example Local Area Coordinators and Social Prescribers, and moving forward the new *Wellbeing Teams* about to be piloted in Tilbury and Chadwell. Future mental health transformation plans need to consider these and other opportunities for embedding depression screening into the role of the wider workforce, and for widening access to symptom checkers for the general population. For example, there may be further opportunities to embed depression screening tools into existing E-Consult/Web-GP and NHS Choices software.

5. Improve timely access to treatment

5.1 Difficulty in accessing current local mental health treatment services is a recurrent theme running through the JSNA, LGA Peer Review and 'User Voice' work undertaken by Healthwatch This is true of both services to treat Common Mental Health Disorders and more serious mental ill-health.

5.2 The DH has a national ambition to have 25% of patients estimated to have depression or anxiety treated by an IAPT service by 2020/21. Thurrock is on track to deliver against this target. However, the Thurrock average hides significant variation between practices. The figure in Thurrock varies from 8% to 46% across different GP practice populations. Further work is required to understand and address variation in access to IAPT services. Furthermore, we need to understand why only 50% of people recover following treatment and to understand how to provide more responsive care.

5.3 Accessing secondary mental health treatment services is equally problematic and is highlighted in both the LGA Peer Review and User Voice work. Historically, EPUT only accepted new referrals from a GP surgery. This caused an immediate problem to residents in need of urgent mental health support who are unable to access a GP appointment quickly, leaving them without access to timely assessment and treatment and risking further deterioration in their mental health. The LGA Peer Review commented that "*GP referral is building unnecessary delays into the system.*" However, recent improvements to the care pathway now mean that referrals can be made directly from Thurrock First into EPUT.

5.4 A lack of direct open access 24/7 crisis care is repeatedly referenced in the user voice and LGA peer review as an issue, and is likely to be a key contributory factor to avoidable demand on A&E, currently the only part of the system offering direct access to services for residents in mental health crisis. A RAID (Rapid Access, Interface and Discharge) team is operating at Basildon Hospital.

5.5 Thurrock CCG is leading the work to develop an open access 24/7 community crisis service in EPUT. The model will enable people to access specialist crisis

care via 111. EPUT will provide both the triage and the specialist teams to assess and treatment teams. The ambition is that the funding will be approved to enable the service to begin mobilisation in the new financial year and be operational for the winter 2019.

6. A new treatment model for Common Mental Health Disorders

6.1 Common Mental Health Disorders (CMHDs) include depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). CMHDs account for the vast majority of mental health problems in the population and moreover, the vast majority these cohorts of patients will be treated in Primary and Community Care. The most prevalent CMHD in Thurrock is *Mixed Anxiety and Depressive Disorder*, affecting just under 12% of residents aged 16-74.

6.2 There is an unacceptable level of variation in the clinical management of CMHD between different GP surgeries with many surgeries failing to review newly diagnosed residents with depression in a timely manner. The CCG's Primary Care Development Team in conjunction with Healthcare Public Health staff need to address this variation and improve performance on this indicator through the ongoing work of continuous quality improvement based around the GP Profile Card and GP Practice visits.

6.3 The current treatment offer for CMHDs is too narrow. Currently patients typically are offered anti-depressant medication and/or referral to talking therapies provided by IAPT. However CMHD risk is strongly associated with socio-economic and psycho-social factors. As such, CMHDs are not evenly distributed amongst the population and are dependent at least in part by the environment in which the individual lives. CMHDs are more likely to persist in people in lower socioeconomic groups such as people who are on low incomes, long-term sick or unemployed. The Marmot report*, Fair Society, healthy lives*[i] showed that, among other factors, poor housing and unemployment increase the likelihood that people will experience mental health disorders and affect the course of any subsequent recovery. Feelings of loneliness are worse and social network size is smaller among mental health service users than in the general population.[ii,iii] Conversely, there is a wide body of evidence that demonstrates the highly mentally health protective effect of having strong positive social connections and being employed.

6.4 There is a strong and growing evidence base demonstrating exercise to be an effective intervention for treatment of mild to moderate depression a valuable complementary therapy to the traditional treatments for severe depression. Physical activity has been shown to be as effective as anti-depressant medication and psychotherapy in reducing both depression and anxiety with the greatest gain observed in those who already have clinical symptoms. [iv] However at present, very few patients with CMHD are referred by GPs into Public Health commissioned physical activity programmes and action needs to occur to ensure exercise on prescription becomes a common treatment offer to local residents who have been diagnosed with depression or anxiety. Further

work is required to understand this issue and increase referral rates from GP surgeries into this treatment option.

6.5 There is an unequivocal link between CMHDs and long term physical health conditions. 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health problem. Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively and this translates to considerable excess treatment costs to the NHS.

6.6 There is an urgent need to expedite recommendations set out in the *Tilbury and Chadwell New Model of Care Case for Change,* to integrate treatment on mental ill-health with that of physical long term conditions in a single one stop shop.

6.7 Significant opportunity also exists to design a new model of care for treatment of CMHD that broadens the offer to encompass a 'strengths based' approach to mental health, having a different 'strengths based' conversation with residents suffering from CMHDs, connecting them with community assets to increase social capital and helping them to address wider determinants of health where appropriate, particularly employment.

6.8 In the medium term, the new Integrated Medical Centres provide an opportunity to create new models of care that integrate mental health treatment provision with physical long term condition services, and those that address wider determinants of health such as employment support and wider 'community wellbeing' approaches through flexible space for third sector groups and Local Area Coordination.

7. Developing a new 'Enhanced Treatment and Recovery' Model for Serious Mental Ill-Health

7.1 Serious Mental Ill-health (SMI) is defined by this report as psychiatric conditions too complex to be treated in Primary Care or by IAPT. It encompasses a wide spectrum on conditions that would include very severe non-psychotic disorders, personality disorders through to patients with severe and enduring psychotic illness including schizophrenia, schizotypal and delusional disorders and Bipolar Affective Disorders.

7.2 Current clinical interpretation of thresholds for access to treatment across the mental health systems is resulting in inadequate service provision for patients in the lower end of the enhanced treatment spectrum. The LGA Peer Review team termed these residents *The Missing Middle*; a cohort of patients too mentally unwell to receive an appropriate treatment offer in Primary Care or IAPT but not unwell enough to meet EPUT thresholds for access to services.

7.3 Anecdotal evidence on the characteristics of The Missing Middle suggests that they often return to Primary Care, Thurrock Healthwatch and Local Area Coordinators looking to access services from parts of the system that are not best skilled or equipped to provide it. Local GPs and Healthwatch report that

many people within the Missing Middle have personality disorders, and often have chaotic lifestyles with multiple issues including housing and drug/alcohol problems. A multi-agency project group has been established to focus on improving outcomes for those with personality disorders. The group is working on:

- Understanding the profile of those with personality disorders, including where in the system they present.
- Designing an evidence-based assessment and treatment pathway which will comprise of a partnership approach.
- Developing a training package to relevant professionals to improve confidence with identifying and treating these individuals.

7.4 Like CMHDs the current offer is too clinical and not sufficiently person centred or holistic. There is clear evidence the wider determinants of health including housing, employment and social isolation can have a major influence on relapse and recovery rates of SMI, yet at present these are commissioned and provided by other parts of the health and local government system largely in isolation of secondary clinical services. Furthermore, the current service offer is seen as too reactive, waiting for patients to hit mental health crisis before services are available and with insufficient focus on early identification and intervention to prevent patients with SMI entering crisis.

7.5 Some progress is being made to broaden the current treatment offer. *Inclusion* Thurrock is increasing its staffing resource to provide Individual Placement Support (IPS) to patients being treated by the Early Intervention in Psychosis team. This new service will aim to facilitate clients back into employment. IPS will also soon become fully operational within EPUT's Community Mental Health Teams. A review of care coordination by EPUT is underway to ensure a more holistic approach to care is delivered within EIP and CMHT teams.

7.6 People with serious mental health problems face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15-20 years lower than the general population. 40% of people with SMI still smoke. National guidance was released in February 2018 to improve the physical healthcare of people with SMI in primary care. The guidance sets out that good quality physical health care is based on the completion of the physical health assessments, follow up referrals and ongoing personalised care planning. There have been parallel work to improve the physical health of individuals in secondary care. This has focussed on improving cardio-metabolic assessments.

7.7 Despite these improvements a radically new model of Enhanced Treatment and Recovery is required that:

- Enhances specialist mental health support within primary care to improve timely access to care.
- Reduces fragmentation in current care pathways within EPUT and provides a stronger continuity of care relationship.

- Reduces fragmentation between Primary and Secondary care including access to Psychiatric Nursing as part of Primary Care mixed skill workforce teams.
- Seeks to reduce un-necessary inpatient stays and re-admissions through focusing on prevention and early intervention activity.
- Embeds physical health assessment, health improvement and lifestyle modification into secondary care pathways.
- Provides an integrated treatment offer for patients with dual diagnosis including the ability to have SMI and drug and alcohol misuse issues treated in parallel.
- Better leverages the skill set of specialist social care field work staff in addressing the wider determinants of health.
- Encompasses a ‘strengths-based’ community asset focus that promotes per support and increases service users social connectivity in the context of their families and wider communities.
- Shifts the current balance of treatment from one of reactive intervention in crisis to one of proactive crisis and relapse prevention.

7.8 Delivering a new model of care that encompasses the above requires a whole system change across the whole mid and South Essex STP. It is not going to be possible to change one part of the system in isolation. Addressing the ‘missing middle’ will require a whole system change. It will require co-ordinated changes in prevention, social care, primary care, secondary care and crisis care across the whole STP footprint. To this end, partners across the STP have embarked upon an exercise to develop a ‘costed’ strategy. Partners are aiming to work rapidly to articulate a clear case for change, high level care model, workforce plan, estates plan, and digital plan and associated finances. The aim will be to produce a radically different model of care which is deliverable within our current workforce and financial constraints. In effect, the STP plan will ‘unpick’ the block contract to facilitate, enable and empower our Thurrock locality working.

7.9 ***Open Dialogue*** is a Finish holistic, strengths based approach to treating people with psychosis that is currently being piloted in the UK. Unlike traditional medical models treatment, it conceptualises psychosis as a problem occurring between individuals and in relationships rather than a problem that occurs in the brains of patients with SMI. It rejects traditional medical model paradigms of expert assessment and diagnosis plus pharmacological interventions and hospitalisation treatment with a community based approach that seeks to repair the relationships in the lives of patients and help them generate their own solutions.

7.10 The *Open Dialogue* approach is humanistic and non-hierarchical. Patients are treated in their own homes (where possible) within 24 hours of reporting mental health crisis and therapy occurs between up to three therapists, the patient with psychosis and their family working together in the same session. The purpose of therapy sessions is to generate dialogue between therapists, patients and their families, and all parties reflect openly about their feelings towards one another and discuss ideas about the situation. The primary purpose of therapy is dialogue and “meaning making” and as a product of this dialogue solutions

begin to emerge and relationships begin to be repaired. Medication is kept to an absolute minimum and used for the shortest period of time possible, and only to help patients get over the worst symptoms. Sedatives to help patients sleep are favoured over neuroleptic medication which is seen as preventing "meaning making". Hospitalisation of patients is also avoided in all circumstances possible, with community nurses staying overnight in patients' own homes when they are very seriously unwell. Treatment is continued in terms of 'open dialogue' until medication is ceased.

7.11 Outcomes for patients using the *Open Dialogue* approach have been highly positive in Finland. Two thirds of patients with psychosis never used anti-psychotic medication and of the third that did, 50% ceased using during treatment meaning only one in six patients with psychosis continued on long term anti-psychotic medication. In patient bed use has almost completely ceased. More impressively, the approach claims that 85% of patients with First Episode Psychosis (FEP) recover within six months meaning that schizophrenia prevalence has dropped in Western Lapland from one of the highest in the world to one of the lowest. (This compares to the gold standard target for NICE recommended Early Intervention in Psychosis interventions in the UK of 50% recovery. Furthermore, background unemployment rates of FEP patients who recover using Open Dialogue are lower than in the general population in Finland, suggesting the treatment produces productive individuals who integrate well back into general society.

7.12 Following a workshop led by Public Health and NELFT (who are piloting the Open Dialogue approach in localities outside Thurrock), EPUT, Thurrock Council and NHS Thurrock CCG committed to participation in a national Randomised Control Trial that is assessing the impact of the *Open Dialogue* approach in the UK. A multi-professional team of EPUT clinical and Thurrock Council Adult Social Care staff will be trained to in delivering *Open Dialogue* during 2019, and will aim to implement the approach in Thurrock in late 2019 / early 2020. The approach has the potential to radically improve both timely access and outcomes for patients in mental health crisis, provide a continuity of care relationship throughout a patient's treatment journey, reduce demand on secondary mental health care in-patient beds and deliver significantly more holistic and family centred approach to treating serious mental ill-health. It has the potential to address many of the key criteria set out in section 7.9 in terms of a new and improved treatment offer for patients in mental health crisis. The approach also integrates well with the wider asset/strengths based transformation programme as set out in section 3.1.

7.13 **Section 75 Agreement.** The Section 75 Agreement between Thurrock Council and EPUT allows the Local Authority to delegate its statutory duties under the Care Act 2014 to deliver social work and social care services. The current model is embedded in an existing medical model of GP referral (or referral by other professionals via Thurrock First) and the threshold for access to services is very high and not fully compliant with the principles of the Care Act. For a number of years we have tried to address this but this has not progressed as fast as we would like. The performance framework within the Section 75 Agreement is not outcome focused and as stated above a considerable amount of joint work between EPUT and the three local authorities is taking place to

address this. We are clear that the current Section 75 Agreement is now not fit for purpose however what we have learnt from the development of the Southend, Essex and Thurrock Mental Health Strategy, the outcomes for the Thurrock Health and Well-being Strategy, the recommendations of the Mental Health Joint Strategic Needs Assessment and the Peer Review is that a partnership approach is required to develop a new model for the provision of mental health services.

7.14 The Council will therefore work in partnership with EPUT and the CCG to ensure that Section 75 approach is aligned with our CCG colleagues. The council will develop a new Section 75 Agreement with EPUT from the 1st April 2019 with a revised performance and budget framework. The Section 75 Agreement will also focus on the social work role and the work around social work for better mental health to ensure a more robust approach to Care Act delivery. We propose offering EPUT a longer term agreement, in line with CCG commissioning intentions. The first year of the new agreement will enable all partners to engage with the work to develop a costed strategy that will then be reflected in the four year longer contract. Within the first year, we will seek to agree the following:

- A new Performance and Outcomes Framework
- Enhanced data sharing between EPUT and commissioners to support the Performance and Outcomes Framework
- A new workforce strategy that supports social care staff
- Transparency around finance
- A new operating model

7.15 The successful completion of the work and the development of a care model which addresses Care Act compliance, the missing middle and the move towards prevention will then be the basis for the longer term contractual arrangement. It will enable CCG and council colleagues to develop a more integrated approach to this work. The revised performance framework will be key to the delivery of an outcomes approach and the transformation of mental health approaches in Thurrock. The framework will be based on extensive work currently being undertaken across the three Local Authorities in partnership with EPUT ensuring that high level strategic information is available supported by the outcomes achieved with individuals. It will be important to support the joint commissioning approach that performance can be monitored jointly with the CCG. The initial framework will be in place by 1 April 2019 and the first year of the new section 75 agreement will allow for further development alongside the new and innovative approaches for mental health transformation. If Thurrock Council is not satisfied with the rate of progress in establishing a long-term section 75 framework it reserves the right to withdraw from the agreement and end the secondment arrangement for its social care staff. A review meeting will be held before the end of September 2019 to assess whether sufficient progress has been made.

8. **Integrate Commissioning and develop a single common outcomes framework supported with improved commissioning intelligence**

8.1 Commissioning arrangements in mental health are complex and dispersed. Thurrock CCG leads mental health commissioning across the Mid and South Essex STP geography. The role focusses on three aspects; leading the EPUT contracting and performance management, commissioning urgent and emergency care and co-ordinating work across the STP.

8.2 This is based on the principle of 'do it once' where CCG's and EPUT avoid duplication of effort to maximise efficiency and reduce bureaucracy. This is particularly important in relation to services which are delivered at scale. For example, there is only one assessment unit or PICU unit for the population of South Essex. The CCG ensures that there is good financial governance and performance management. This is particularly important for quality monitoring where it is important to look at trends over a larger footprint. For example, over the contract, we monitor is there an increase in serious incidents in particular service areas.

8.3 However, it is also fair to say that there are occasions where the 'do it once' approach causes local frustrations. As local economies develop locality based integrated care models there is a need for developing local flexibilities to reflect local needs. This is felt strongly within Thurrock where our alliance work is well progressed. There is therefore a tension between local and system.

8.4 We are therefore working towards developing a three tiered governance structure which co-ordinates STP system executive leadership, a focussed EPUT transformation board and a Thurrock Mental Health Transformation Board. This will ensure that there is system oversight, EPUT delivery and local integrated delivery.

8.5 Reporting arrangements against these contracts happen at individual contract level and are inadequately focussed on outcomes, tending instead to concentrate on process inputs such as numbers of patients seen and interventions delivered. Furthermore, their focus is almost completely clinical and many fail to capture wider wellbeing metrics and those focused on the wider determinants of health such as employment and housing. Primary Care performance is not triangulated with secondary performance, reinforcing the fragmentation of care between these two settings.

8.6 There is a clear need to rationalise and integrate the current disparate and fragmented commissioning arrangements relating to the local mental health service into a single shared CCG and Local Authority function, and to agree a single systems wide performance framework focused on outcomes which underpins a transformed provider landscape and new integrated treatment models. The LGA Peer Review Team highlighted the lack of integrated commissioning and lack of evidence of a single reporting and outcomes framework as a *significant shortfall* in current arrangements and also suggested that the current section 75 agreement between the local authority and EPUT needed to be considered as part of a wider commissioning review.

8.7 Future commissioning arrangements need to broaden the current focus and be more holistic and wider than current clinical services, encompassing the key issues of social support, housing and employment highlighted in sections 6.3 to 6.11 and 7.8. A Thurrock Mental Health Partnership Board will be established to

drive the local mental health agenda. The Board will bring together CCG, local authority and public health commissioning arrangements. This Board will be the first step towards developing more formal joint commissioning arrangements. The board will provide a specific mental health focus to the work of the *Thurrock Integrated Care Alliance* including a shift from individual contract and provider process/input KPIs to single system wide outcome KPIs with agreed financial risk and reward mechanisms.

8.8 Much NHS Commissioning of secondary mental health services now occurs through the CCG Joint Committee at an STP rather than Thurrock footprint. This includes secondary care inpatient services, Crisis Resolution and Home Treatment Teams and Rapid Assessment, Interface and Discharge services in A&E. The Thurrock Mental Health Partnership Board will need to align to the STP Partnership Board so that there is co-ordination between system wide services and integrated locality working.

8.9 The Integrated Dataset work being led by Public Health through MedeAnalytics has the potential to improve commissioning intelligence moving forward, and it is expected that IAPT data will be linked to SUS, Adult Social Care and about 25% of GP Practice System One data by spring 2019.

8.10 The Mental Health Service Data Set has been specified by Public Health in their contract with Arden GEM (the DSCRO that flows SUS data into Mede Analytics. As such, secondary mental healthcare data will form part of the integrated dataset moving forward.

9. Joint Work between Mental Health Commissioning and Housing

9.1 The connection between positive mental health outcomes for individuals and settled accommodation is well documented and researched. Shelter's Report – The impact of housing problems on mental health, published in April 2017 highlights that of 3,509 interviewed for the research adults experiencing mental ill health 69% of them said that housing problems such as poor conditions, struggling to pay rent or being threatened with eviction had a negative effect on their mental health.

9.2 The LGA Peer Review also highlighted that in Thurrock there was evidence of good practice in the community concerning housing support and that the Housing and Mental Health operational group supported the resolution of operational issues.

9.3 However there is no clearly defined specific Housing and Mental Health Strategy and it is recommended through the LGA Peer Review and agreed that across Mental Health Commissioning and Housing there needs to be a joint Strategy and Policy. This is identified in the action plan and will be developed and co-produced through 2019.

10. Suicide Prevention

10.1 In a recent speech to the Global Ministerial Mental Health Summit on World Mental Health Day, the Prime Minister announced that Thurrock M.P. Jackie Doyle-Price would become the UK's first Minister for Suicide Prevention, with a remit to reduce the current 4,500 people who take their own lives each year in

England, and overcome the stigma that prevents people from seeking help. Suicide is the biggest killer of men under the age of 45. She also announced that every local authority area should have a suicide prevention plan in place. In the Autumn Budget, the Chancellor announced an additional investment of £250 million in new mental health crisis services including money for suicide prevention activity, which can be accessed via Sustainability and Transformation Partnerships.

10.2 Many areas have signed up to a Zero Suicide ambition. Whilst the evidence base for achieving a Zero Suicide ambition is limited, the concept aims to challenge the prevailing wisdom that suicide is inevitable for some people when they hit rock bottom. The idea of 'zero suicide' provokes debate about how much more we might be able to do in the future to avoid such tragedies.

10.3 In Thurrock in 2017 there were five recorded deaths by suicide. Whilst tragic for the individuals and their family/friends, this represents 0.0031% of the population and is a very low number. However, evidence suggests that for every successful suicide there are at least 10 para-suicides (failed suicide attempts), and possibly thousands of residents with suicide ideation or in mental health crisis. **As such, effective action to prevent suicide must be set in a context of improving wider mental health services set out in sections 6 and 7, and a broader approach to improving community mental resilience in schools and workplaces, rather than direct action that focus on a very rare population outcome.**

10.4 A recent literature review of the published evidence base on suicide prevention undertaken by the Public Health Service, identified the following as being effective in reducing the risk of suicide

- School Based preventative approaches based on working with young people to identify risk factors for poor mental health and self-harm attempts
- 'Gate keeper' training of relevant health professionals including teachers and the police. There is no evidence that training of GPs specifically has any impact.
- Psycho-social assessment and on-going CBT for those presenting with a self-harm attempt.

10.5 Thurrock has agreed the following actions on suicide prevention based on guidance from Public Health England and the published evidence base. These include:

- Establishing and participation in multi-agency partnership at Mid and South Essex Level to take action on suicide prevention across all key stakeholders
- Participation in on-going suicide audit work at Essex level to improve understanding and intelligence on suicide. Because of the very small numbers involved, we propose undertaking a suicide audit across Essex based on the last ten years' data
- Development of a new Suicide Prevention Strategy at Essex level, against which new government funding can be accessed based on the findings of the Suicide Audit

- Implementation of the Mental Health Schools Based Wellbeing Service and well-being teams to boost capacity and capability in schools to prevent suicide and identify and intervene early with those young people at risk
- Implementing a training programme of suicide awareness with front line professionals at Essex level in line with the published evidence base
- Develop a local information-sharing system to ensure that information on para-suicides (and other people at very high risk of suicide) is cascaded to relevant agencies.
- Develop protocol for multi-agency action to provide support to prevent further attempts in cases of para-suicide
- Transformation of mental health crisis services as set out in section 7 of this report including improving access to 24/7 crisis care.
- Review of self-harm care pathways and improvement in line with recommendations in the published evidence base.

11. Next Steps and Action Plan

11.1 At its October 2018 meeting The Thurrock Joint Health and Wellbeing Board agreed appointment of a Strategic Lead for Public Mental Health and Mental Health Transformation, to coordinate action across all stakeholders to transform and improve the adult mental health system in Thurrock in line with actions set out in this report. The post will be accountable to a new Mental Health Transformation Board that will be a sub-group of the Health and Wellbeing Board.

11.2 The key deliverable of the post will be a Mental Health Transformation Strategy Case for Change encompassing the priority areas set out in sections 4 to 10 of this report. We would envisage this being complete towards the end of 2019.

11.3 A high level action plan, developed from the recommendations from transformation work to date, set out in this report is supplied below as an appendix.

12. Reasons for Recommendation

12.1 The current mental health and care treatment offer is failing residents and is need of urgent reform to improve outcomes, provide a more seamless and holistic care offer and strengthen prevention and early intervention approaches.

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

13.1 This report is based on work that has included a significant amount of consultation between other stakeholder organisations and residents including the Adult Mental Health Joint Strategic Needs Assessment, Local Government Association Peer Review and Healthwatch Thurrock research with service users of local mental health and care services. It is based on a report produced by The Director of Public Health that triangulated the findings of these previous pieces of work, and which was presented and agreed at the October 2018 meeting of the Thurrock Joint Health and Wellbeing Board.

14. Implications

14.1 Financial

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

The recommendations as set out in this report do not have any immediate direct financial implications on the council in the sense that the work programme will be funded from existing allocated resources.

Implementation of recommendations made in the new *Mental Health Case for Change* (when produced as a result of the work of the new Strategic Lead for Mental Health Transformation) in consultation with partners may identify the need for future investment across the health and care system to address the current issue of poor access and long waiting times.

14.2 Legal

Implications verified by: **Roger Harris**
Corporate Director AH&H

The Transformation of Mental Health Services in Thurrock will ensured the continued delivery of the duties outlined in the Mental Health Act 1983 (Amended 2007) and the Care Act 2014.

14.3 Diversity and Equality

Implications verified by: **Natalie Warren**
Strategic Lead Communities and Diversity

Residents with mental ill health are at significantly greater risk of experiencing health inequalities. The programme of transformation work set out in this report will help to address this issue.

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

- Thurrock Joint Strategic Needs Assessment on Adult Mental Services. Thurrock Public Health Team (2018)
- Local Government Association Peer Review (2018) into Adult Mental Health Services in Thurrock
- Thurrock Healthwatch Mental Health Consultation Report (July-August 2018)

16. Appendices

Appendix A – Mental Health Transformation Action Plan

Report Authors:

Ian Wake, Director of Public Health
Catherine Wilson, Strategic Lead Commissioning, Adults Housing and Health
Mark Tebbs, Director of Commissioning, NHS Thurrock Clinical Commissioning Group

References

[i] The Marmot report, *Fair Society, healthy lives.* London: Institute of Health Equity. 2010. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

[ii] Lauder W, Sharkey S, Mummery K. A community survey of loneliness, *Journal of Advanced Nursing*. 2004;46(1): 88–94, DOI: 10.1111/j.1365-2648.2003.02968.x.

[iii] Palumbo C, Volpe U, Matanov A, Priebe S, Giacco D. Social networks of patients with psychosis: a systematic review, *BMC Research Notes*. 2015; 8: 560–560

[iv] Rethorst, C., Wipfli, B., & Landers, D. The antidepressive effects of exercise: A meta-analysis of randomized trials. *Sports Medicine*. 2009; *39*: 491– 511.

Recommendation	Key Objective	Lead	Other Key Stakeholders	Timescales
1) Improve the diagnosis of residents with undiagnosed depression and anxiety	a) Expedite roll out of the PHQ2/9 depression screening tool prompt template in SystmOne for patients that are being reviewed for physical Long Term Health Conditions	Healthcare Public Health Team	GPs, Primary Care Development Team	By June 2019
	b) Improve the uptake of NHS Health Checks Programme such that a minimum of 60% of those offered a health check receive one, as a systematic way of screening for depression through implementation of the Health Checks Strategic Plan	Thurrock Healthy Lifestyles Team Manager	GP surgeries, Pharmacies	By March 2019
	c) Embed depression screening into the practice of wider front line professionals including front line house, social care and community workers	Strategic Lead, MH Transformation	Principal Social Worker AD Housing Operations NELFT LTC Management Teams Strategic Lead Community Development	By June 2019
	d) Improve access to depression screening for the general population with the use of online screening tools linked to self-referral mechanisms	Strategic Lead, MH Transformation	Council and CCG Communications Leads	By December 2019
2) Improve Access to timely mental health treatment	a) Undertake capacity modelling to understand and implement actions to reduce IAPT waiting times to the six week minimum	CCG Mental Health Commissioning Lead	Inclusion Thurrock	By March 2019

	b) Develop and commission a new model of 24-7 direct access crisis care	CCG Mental Health Commissioning Lead	EPUT Strategic Lead, MH Transformation	*By Winter 2019
	c) Examine current and agree new system wide thresholds for treatment access for all MH clusters to ensure that *Missing Middle* are able to access timely and appropriate secondary MH services	CCG Mental Health Commissioning Lead Strategic Lead, MH Transformation Strategic Lead – ASC Commissioning	EPUT	By December 2019
3) Develop and commission a New Model of Care for Common Mental Health Disorders	a) Address the variation in referral to IAPT for CMHD amongst GP practices such that a minimum of 25% of patients estimated to have a CMHD receive treatment each year, and that age and sex variation is also reduced	Strategic Lead, MH Transformation Strategic Lead – Healthcare PH	GPs, Inclusion Thurrock	From April 2019 through rolling programme of GP surgery visits
	b) Address variation in clinical management of depression in Primary Care including inclusion of QOF indicators relating to depression review on the GP Practice Profile Card/Practice visits and future Stretched QOF iterations	Strategic Lead MH Transformation Strategic Lead – Healthcare PH	GPs	From April 2019 through rolling programme of GP surgery visits
	c) Expedite integration of IAPT Services with other LTC Physical Health Conditions to create single 'one stop shops' where all LTCs can be dealt with at the same time, as part of *Better Care Together* Transformation Programme building on the new pathway that is now in place between Inclusion Thurrock and NELFT	Strategic Lead – MH Transformation	NELFT LTC services Inclusion Thurrock CCG Mental Health Commissioning Lead	From April 2019

	d) Increase the Capacity of current Social Prescribing Service and embed within clinical teams of all GP practices, through roll out of Locality Based Mixed Skill Workforce Teams	Director of Primary Care, CCG Director of Transformation, CCG	CVS, GPs	Proposals by April 2019
	e) Design and implement a *New Model of Care for CMHDs* that encompasses programmes that support residents to address worklessness, increase physical activity and increase social capital and community connectivity, building on existing community assets	Strategic Lead MH Transformation	CCG Mental Health Commissioning Lead AD and Consultant in PH AD ASC and Community Development Community Hubs CVS	Proposals by December 2019
4) Develop and commission a New *Enhanced Treatment and Recovery* model	a) Further investigate and understand the needs of *The Missing Middle*	Strategic Lead – MH Transformation		Initial proposals by September 2019
	b) Review current referral criteria thresholds across IAPT and secondary care and agree new common standards to ensure service provision for *The Missing Middle*	Strategic Lead – MH Transformation	CCG MH Commissioning Lead Strategic Lead, ASC Commissioning Inclusion Thurrock, EPUT	Initial proposals by September 2019

	c) Reduce current fragmentation in care pathways within EPUT to improve continuity of care	Strategic Lead – MH Transformation CCG MH Commissioning Lead Strategic Lead, ASC Commissioning EPUT Operations Leads		Initial proposals by December 2019
	d) Reduce current fragmentation in care pathways between Primary and Secondary Care including basing Psychiatric Nursing Capacity within Primary Care Mixed Skill Workforce Teams	Strategic Lead – MH Transformation CCG MH Commissioning Lead Director of Primary Care, CCG Director of Transformation CCG		Initial proposals by December 2019

	e) To understand the current use of the available Bed base under the current Health Contract, particularly the increase in demand to then reduce this demand in line with increased community resources	Strategic Lead – MH Transformation CCG MH Commissioning Lead Director of Primary Care, CCG Director of Transformation CCG	EPUT	April 2019 Reduction on going through 2019 aligned to development of community resources.
	f) Embed physical health assessment, health improvement and lifestyle modification into secondary care clinical pathways to address the physical health needs of patients with SMI and improve life expectancy, integrating the current CQUIN into 'business as usual'.	Strategic Lead – MH Transformation AD and Consultant in PH	Inclusion Thurrock, Thurrock MIND, EPUT CCG Primary Care team	On-going
	g) Develop an integrated treatment offer for patients with SMI and drug and alcohol misuse problems, that treats both issues in parallel	Strategic Lead – MH Transformation AD and Consultant in PH CCG MH Commissioning Lead	Inclusion Thurrock EPUT	Pathway redesign from April 2019

	h) Leverage the professional skill set of social care staff in addressing the wider determinants of health of patients with SMI	Strategic Lead – ASC Commissioning Principal Social Worker, ASC.	EPUT	On-going through 2019 to be in place by April 2020
	i) Encompass a 'strengths-based' community asset focus that promotes peer support and increases service users' social capital within the new treatment model	Strategic Lead – MH Transformation	AD – ASC and Community Development EPUT Thurrock MIND Inclusion Thurrock (Recovery College)	Initial Proposals December 2019
	j) Integrate employment and housing support as an integral part of the new *Enhanced Treatment Model* and on-going recovery	Strategic Lead – MH Transformation	AD – Housing Operations, TBC Strategic Lead, ASC Commissioning	By March 2020
	k) Commission programmes that seek to identify and intervene at an earlier stage in the patient journey, shifting the current focus from crisis support to prevention and recovery	Strategic Lead – MH Transformation Strategic Lead – ASC Commissioning CCG MH Commissioning Lead		Initial Proposals December 2019
5) Integrate Mental Health Commissioning across council and CCG	a) Create a single shared commissioning function and strategy between TBC and NHS Thurrock CCG to undertake all commissioning across the current and future provider landscape	Director of Commissioning TCCG Strategic Lead - ASC Commissioning		Initial model by May 2019 further development ongoing through 2019

	b) Develop a single shared commissioning outcomes framework	Director of Commissioning, TCCG Strategic Lead - ASC Commissioning	Strategic Lead – MH Transformation CCG MH Commissioning Lead	Initial framework by May 2019 with ongoing development through 2019

To note – other actions relating to suicide prevention are outlined in the main body of the report.

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Health Overview & Scrutiny Committee
Work Programme
2018/19

Dates of Meetings: 14 June 2018, 6 September 2018, 8 November 2018, 24 January 2019 and 7 March 2019
Dates of Joint HOSC Meetings: 6 June 2018, 19 June 2018, 30 August 2018

Topic	Lead Officer	Requested by Officer/Member
6 June 2018		
Joint HOSC - Mid and South Essex STP @ Southend	Thurrock/Southend and Essex	Officers
14 June 2018		
HealthWatch	Kim James	Officers
For Thurrock in Thurrock - New Models of Care across health and social care	Roger Harris / Tania Sitch	Officers
Verbal Update on Learning Disability Health Checks	Mandy Ansell / CCG	Officers
STP Consultation Verbal Update	Mandy Ansell / CCG	Officers
Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership (STP) for Mid and South Essex	Roger Harris	Officers
19 June 2018		
Joint HOSC - Mid and South Essex STP @ TBC	Thurrock/Southend and Essex	Officers
30 August 2018		
Joint HOSC - Mid and South Essex STP @ TBC	Thurrock/Southend and Essex	Officers
6 September 2018		

HealthWatch	Kim James	Officers
STP Consultation Outcome	Roger Harris	Officers
Young Person's Misuse Treatment Service Re-Procurement	Kevin Malone	Officers
Primary Care Strategy - Thurrock Clinical Commissioning Group	Andy Vowles / Rahul Chaudhari	Officers
Integrated Medical Centres : Delivering high quality health provision for Thurrock	Christopher Smith	Officers
Market Development Strategy - Commissioning a Diverse Market	Sarah Turner	Officers
2017/18 Annual Complaints and Representations Report	Tina Martin	Officers
Adult Social Care : Mental Health Peer Review	Roger Harris	Officers
Establishment of a Task and Finish Group in relation to Orsett Hospital	Roger Harris	Cllr Holloway
8 November 2018		
HealthWatch	Kim James	Officers
Adult Social Care - Fees & Charges Pricing Strategy 2019/20	Andrew Austin / appropriate finance officer	Officers
Thurrock Safeguarding Adults Board Annual Report 2017/18	Roger Harris	Officers
Improving Cancer Waiting Times	Andrew Pike	Officers
Communities First – A Strategy for developing Libraries as Community Hubs in Thurrock	Natalie Warren	Officers
Developing a new residential care facility and a new model of primary care in South Ockendon	Christopher Smith	Officers
Further Transformation to Continue Improving Standards in Primary Care	Ian Wake	Officers
Mental Health Urgent and Emergency Care	Mark Tebbs	Officers

24 January 2019		
HealthWatch	Kim James	Officers
Adult Mental Health Service Transformation	Roger Harris	Officers
Briefing Note - Referral to the Secretary of State – Orsett Hospital	Roger Harris	Officer
Verbal Update - SERICC	Mandy Ansell / Jane Itangata	Members
Briefing Note - NHS Long Term Plan	Roger Harris	Officers
7 March 2019		
HealthWatch	Kim James	Officers
SERICC (Sexual Abuse Counselling)	Mandy Ansell	Members
Update on Mental Health Urgent	Mark Tebbs	Members
Whole System's Obesity Strategy	Faith Stow	Officers

Reports for 2019/20:

- Update on Cancer Waiting Times
- Flash Glucose Monitoring Report

Clerk: Jenny Shade
Last Updated: November 2018

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