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

Health and Wellbeing Board

The meeting will be held at **10.30am** on **21 September 2018**

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

Membership:

Councillors James Halden (Chair), Robert Gledhill, Susan Little, Barbara Rice and Tony Fish

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

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 20 July 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 Declaration of Interests

Every year members are asked to sign declaration of interest forms. These will be made available at the meeting for member's easy reference.

5 STP Update

A verbal update will be provided to members

6 SEND **13 - 130**

This item will be provided in three parts and cover:

- SEND Joint Strategic Needs Assessment
- Thurrock Local Area Special Educational Needs and Disability Strategy 2018-2020
- SEND Key Strategic Health priorities

Papers are included within member's packs for the meeting

7 Mental Health Peer Review follow up report - Adult mental health service transformation **131 - 174**

Papers are included in member's packs for this item.

8 Emotional wellbeing in schools - School Wellbeing Service Model

An update will be provided to members. A report will follow publication of Board papers.

9 Integrated Care Alliance Memorandum of Understanding and progress update

An update will be provided to members on the Integrated Care Alliance and the development of a Memorandum of Understanding for the Alliance

10 Report on visit to Basildon and Thurrock University Hospital on 24 August 2018 **175 - 182**

Members will be updated on the visit to BTUH approved by the Health and Wellbeing Board earlier this year. A report is provided within member's packs for the meeting

11 Cancer care report **183 - 188**

Members will be updated on action being taken to identify and treat cancer. A report is provided within member's packs for this meeting

12 Integrated Commissioning Executive minutes from meetings of May, June and July 2018 **189 - 200**

The Integrated Commissioning Executive is a sub-group of the Health and Wellbeing Board. Members are invited to consider minutes arising from meetings and comment.

13 Work Programme **201 - 206**

Members are invited to consider and comment on the emerging work plan for the Health and Wellbeing Board

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **13 September 2018**

This page is intentionally left blank

Information for members of the public and councillors

Access to Information and Meetings

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

Recording of meetings

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

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

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

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

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

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

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

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

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

Thurrock Council Wi-Fi

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

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

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

Evacuation Procedures

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

How to view this agenda on a tablet device

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

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

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

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

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

↓

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

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 Board held on 20 July 2018 at 1.30 pm

Present:	Councillors James Halden (Chair), Tony Fish and Susan Little Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group (Thurrock CCG) Roger Harris, Corporate Director of Adults, Housing and Health Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways Andrew Pike, Managing Director BTUH Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG Kristina Jackson, Chief Executive Thurrock CVS Kim James, Chief Operating Officer, Healthwatch Thurrock Rory Patterson, Corporate Director of Children's Services Jeanette Hucey, Director of Transformation, Thurrock CCG Ian Wake, Director of Public Health
Apologies:	Cllr Robert Gledhill and Barbara Rice Dr Anjan Bose, Clinical Representative, Thurrock CCG Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board David Archibald, Independent Chair of Local Safeguarding Children's Board Adrian Marr, NHS England Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust Gillian Ross, Laymember, Thurrock CCG Tom Abell, Deputy Chief Executive and Chief Transformation Officer Basildon and Thurrock University Hospitals Foundation Trust Steve Cox, Corporate Director for Place
Did not attend:	Dr Anand Deshpande, Chair of Thurrock CCG
In attendance:	Malcolm McCann was represented by Lynn Britt, Tania Sitch represented by Mark Haigh and Steve Cox represented by Leigh Nicholson.

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

1. Minutes

The minutes of the Health and Wellbeing Board meeting held on 8 June 2018 were approved as a correct record.

2. Urgent Items

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

3. Declaration of Interests

There were no declarations of interest.

4. STP Update

Mandy Ansell, Accountable Officer, Thurrock CCG provided members with a verbal update. The following points were made:

- All recommendations made in response to the STP consultation exercise had been passed by the CCG Joint Committee.
- A commitment has been provided that services continue to be provided in Orsett until they can be delivered elsewhere including within IMCs.
- A People's Panel is to be created to help inform the relocation of services and ensure continued community engagement.
- It has been agreed that services provided to Thurrock residents by Orsett will remain available in Thurrock.

RESOLVED: HWB members noted the update and provided comments.

5. Primary Care Strategy

Rahul Chaudari, Director of Primary Care, Thurrock CCG introduced this item. Key points included:

- Current high level modelling across the STP shows that there is an existing, and growing, demand and capacity gap for Primary Care services. This is more prominent in Thurrock as one of the most under-doctored boroughs nationally.
- 5 CCGs across the Mid and South Essex STP footprint have developed a collective Primary Care Strategy.
- A key part of the Strategy is to expand and change the primary care workforce so that there is a shift from a service that is GP delivered to one that is GP led. A key priority is to recruit more GPs and nurses, but also a wide range of other professionals to provide multi-disciplinary teams in general practice. Members were advised that a recruitment exercise was planned to Tilbury and Chadwell following workforce analysis that will create an additional 17 FTE posts, facilitating an additional 1500 additional appointments per week.
- The Strategy also aims to accelerate progress in practices coming together to form localities covering populations of roughly 30-50,000 people. Progress is being made with 8 practices having signed a MOU to collaborate.
- Positive feedback has been provided by NHS England on the Strategy

During discussions the following points were made:

- Members welcomed the Primary Care Strategy and would have welcomed additional references to Adult Social Care and interventions

such as social prescribing. It was also suggested that the Strategy could have been bolstered by referencing the management of Long Term Conditions and how treatment management of LTCs will provide cost savings for the system.
- Members welcomed the focus on the preventative approaches outlined in the Primary Care Strategy.

RESOLVED: Health and Wellbeing Board members:
- Noted and commented on Primary Care Strategy

6. Mental Health Peer Review Findings

Roger Harris, Corporate Director Adults Housing and Health introduced this item. Key points included:

- Thurrock invited the LGA to undertake the Peer Review and an expert team was assembled. The Peer Review team undertook extensive consultations with staff, members, users, carers and third sector groups as part of their on-site investigations.
- The review team identified following discussions with services users, third sector organisations and Thurrock Healthwatch that the demand for mental health support was growing but that people were finding it hard to access services when they wanted them.
- Recent initiatives such as Inclusion Thurrock, the Recovery College and Local Area Co-ordination (although not specifically a mental health focussed offer) were getting very good feedback from service users but it was felt that the whole pathway need an external check and challenge to ensure that it was fit for purpose.
- Some areas for consideration proposed by the Peer Review Team included:
    - Commissioners to develop an improvement plan in partnership with EPUT as a provider in Thurrock;
    - Develop joint commissioning arrangements between the Council and the CCG;
    - Commission for the “middle” of mental health needs; and
    - Create a Mental Health Programme Group, including children and transition, to ensure the elements of an improvement plan are coordinated to overcome current fragmentation of initiatives, including the JSNA recommendations.

During discussions the following points were made:

- Members acknowledged that more needs to be done to ensure that individuals who do not meet thresholds for more formal mental health support can access support that is necessary
- A Mental Health Operational Group has been established and there is merit in ensuring that Children’s Directorate are represented on the Group.
- It is important to ensure that adolescent services support children through the transition to adulthood. Members were informed that EPUT created a new protocol in January 2018 to support transition.

RESOLVED: Health and Wellbeing Board members provided comments on the Mental Health Peer Review findings and agreed to a further report being considered at the Health and Wellbeing Board meeting in September 2018.

7. Thurrock Dementia Local Action Plan

Catherine Wilson, Strategic Lead Adults Social Care Commissioning, introduced this item. Key points included:

- It is estimated that the number of people within Thurrock aged 65+ with dementia could increase by 75% between 2017 and 2030. The 85+ age group have the greatest prevalence of dementia. People in this age group with dementia more than doubles during this period from 660 to 1355
- This strategy is for everyone in Southend, Essex and Thurrock who is living with dementia or supporting someone who is. It describes what we want support for people with dementia to look like in the future and it describes nine priorities for action to make this happen.
- In order to deliver the Southend, Essex and Thurrock Dementia Strategy 2017 to 2021 it was agreed at the Essex wide implementation group that locality implementation plans should be developed. The Thurrock Implementation Plan identifies each priority area noted above; the outcome to be achieved against that priority and the success measures that will evidence the priority has been met. Within the Thurrock Implementation plan we have identified some positive areas of working including:
    - The Alzheimer's Society has developed our local Dementia Action Alliance.
    - The implementation of the Older Adult Wellbeing Service provided by North East London Foundation Trust (NELFT). This is a multi-disciplinary integrated approach to the care and support of older age adults including people living with dementia. The aim of the service is to support people to remain as independent as possible for as long as possible in their local communities and at home. This has proved to be very successful. The nurses within the team deliver Dementia Nursing support within our residential care homes and within the community.
    - Diagnostic services provided by Essex Partnership Trust (EPUT) and a clear pathway for referral post diagnosis to the Older Adult Well Being Service.
    - The Dementia Crisis Support Team has been extended so that the team can support individuals for longer at home in their own communities.

During discussions the following points were made:

- Members welcomed the local action plan and the increased profile of dementia across Thurrock, Essex and Southend
- Members welcomed the approach to considering individuals who fall through the net due to not meeting necessary thresholds to secure more formal support.

RESOLVED Health and Wellbeing Board members noted and agreed the Thurrock Implementation Plan for the Southend, Essex and Thurrock Dementia Strategy 2017 to 2021.

8. Thurrock Health and Wellbeing Strategy Annual Report 2017-2018

Ian Wake Director of Public Health introduced this item, supported by Goal Sponsors. Key points included:

- The annual report is a stand-alone document that:
  - Explains the Health and Wellbeing Board's function, membership and how it drives forward the development and implementation of the Health and Wellbeing Strategy;
  - Describes Thurrock's Health and Wellbeing Strategy and reports year two key achievements; and
  - Sets out progress made against Key Performance Indicators, approved by the Health and Wellbeing Board in November 2018
- All Early Years settings have achieved an Ofsted rating of good or outstanding.
- 76% of children achieved a good level of development at the end of the Early Years Foundation Stage, exceeding the trajectory target of 73% and the national average of 71%.
- 62% of children are achieved the national standard in Reading, Writing and Maths at the end of Key Stage 2, exceeding the trajectory target of 57%, consistent with the national average of 61%.
- 2.1% of 16/17 year olds are not in employment, education or training, achieving the trajectory target of 5%. This data is based on 16/17 year olds and therefore considerably exceeds the trajectory target that was set for 16-19 year olds.
- The under 18 conception rate in Thurrock continues to decline year on year and 2018 target for 2016 conceptions (23.2 per 1,000) was achieved.
- In 2015, 17.4 % of children are living in poverty (0-19 years) - exceeding our target of 19.28%.
- There were 3 Parks and Play sites improvement projects to encourage greater use during 2017/18.
- 52 % of adults aged 19+ are physical active achieving our target of 52%.
- The number of micro enterprises operating in Thurrock is 55, exceeding the trajectory target of 25.
- 61.6 % of parents achieving successful outcomes from early intervention prevention parenting programmes.
- At the of June 2018 there have been 1050 families attached to the Troubled Families Programme with the target of 2525 families supported by the TF programme when it ceases in March 2020.
- 71% of GP practices have a CQC rating of at least "good'' exceeding the trajectory target of 40%. Overall CQC Rating of good achieved for BTUH.
- The percentage of children in year 6 that are measured as being overweight or obese in year 6 at school was 36.9% for school year 2016/17. The target for 2017 was to achieve 37% and for 2018 to achieve 36.5%.

During discussions the following points were made

- Members welcomed that Thurrock has the 2nd fastest falling rate of teenage pregnancy across the country.

- The outcome framework appears to measure participation for children at sixth form. It was agreed that an additional Key Performance Indicator would be developed to measure attainment post sixteen for those students completing sixth form.

Action Children's Directorate

- It was agreed that Planning Directorate should consider planning for schools give due consideration to open spaces which can be utilised by schools and local communities
- Consideration should be provided to creating a Key Performance Indicator that is outcome focussed for Local Area Coordinators
- Members noted the performance on identification and treatment of cancer and agreed that a further paper on cancer treatment will be considered at the HWB meeting in September.

RESOLVED: HWB members agreed that the annual report can be published on the Council's website following amendments to the outcome framework, which have been agreed.

9. Health and Wellbeing Board Terms Of Reference Annual Refresh

Darren Kristiansen Business Manager Adults Housing and Health Directorate presented this item. Key points included:

- The revised Terms of Reference had:
  - Been subject to minor amendments to accurately reflect membership
  - Been amended to include the Board's subgroups and governance arrangements
- Members were asked to agree to delegate responsibility for responding to applications to consolidate pharmacies to Public Health on their behalf.

RESOLVED: HWB members approved the refreshed Terms of Reference

10. Housing and Planning Advisory Group Report and Terms of Reference

Leigh Nicholson, Strategic Lead, Development Services, Place Directorate will introduce the item as one of the joint Chairs of the Group. Key points included:

- The Health and Wellbeing Board's Housing & Planning Advisory Group is a multi-agency group which considers the health and well-being implications of major planning applications, and provides advice and guidance on the health, social care and community impacts of proposed new developments.
- The Advisory group comprises representatives from Thurrock Clinical Commissioning Group (CCG), NHS England (Essex Area Team), the Community and Voluntary Sector (Thurrock CVS), as well as Planning, Housing, Adults, Health and Commissioning, Public Health, Regeneration, Children's Services and Essex Police. It has a significant role in articulating the Health and Wellbeing Board's vision and priorities in relation to housing and the built environment.

RESOLVED: HWB Members:

- Noted the work that HPAG has undertaken in the last year and the proposed work-plan for 2018/19
- Agreed to the Terms of Reference and the proposal for an annual report to be provided to the Board in July of each year.

11. Integrated Commissioning Executive (ICE) Minutes

RESOLVED: Members considered and noted ICE minutes for meetings that took place in April 2018

12. Work Programme

RESOLVED: The Board noted the future work programme.

The meeting finished at 1540 hours

Approved as a true and correct record

CHAIR

DATE

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

This page is intentionally left blank

21st September 2018	**ITEM: 6**

Health and Wellbeing Board

Special Educational Needs and Disability Needs Assessment

Wards and communities affected:	**Key Decision:**
All	Key

Report of: Councillor James Halden – Portfolio Holder for Health and Education and Councillor Sue Little – Portfolio Holder for Children's Services

Accountable Head of Service: Andrea Clement – Assistant Director and Consultant of Public Health

Accountable Director: Rory Patterson – Corporate Director of Children's Services and Ian Wake – Director of Public Health

This report is Public

Executive Summary

Thurrock Council has a statutory duty to provide certain children and public health services to children and young people aged 0-19 living in the borough. This includes provision for children with Special Educational Needs and Disability (SEND) from age 0-25 years. To enable the council's Public Health team alongside Children's Services and the CCG to commission services effectively, a Joint Strategic Needs Assessment (JSNA) is required to identify level of need, characteristics of children and young people with SEND, their health and wellbeing needs as well as current and future demand for services. .

The Thurrock Public Health team has conducted a full needs assessment based on analysis of local health, education and social care data as well as incorporating a literature review, of children and young people with SEND in the borough. This document sets out a series of recommendations to improve the service offer, transformation and local provision for SEND children, young people and their families and is appended to this report.

This JSNA report has been completed in collaboration with a range of stakeholders; Children's Services and the CCG and were asked for feedback regarding this JSNA report. All feedback received was considered in the finalised JSNA report.

The number of children and young people aged 0 - 25 in Thurrock is set to increase over the next decade by approximately 10%. Alongside increases in the child population in Thurrock there is expected to be rapid economic and housing growth

over the same time period. It is expected that the population of children aged 0 – 25 will rapidly increase as a result. As such, it also highly likely that the SEND population in Thurrock will grow due to this population growth.

The main recommendations identified within the JSNA included greater collaborative work between education, health and social care, development of a SEND strategy, further improvement in local data to aid detailed modelling of expected demand on services, enhancement of the local offer, strengthening of transition between child and adult services and re-commissioning of short break provision. It is hoped that these recommendations will inform a SEND strategy and action plan for implementation.

1. Recommendation(s)

1.1 That the Board is appraised of this JSNA report, is invited to comment and subsequently agree to the recommendations made in the Special Educational Needs Assessment report

1.2 That the Board agrees to publication of the Special Educational Needs Assessment.

2. Introduction and Background

2.1 Every Health and Wellbeing Board holds the responsibility for producing JSNA's which will enable partner organisations to collaborative understand local needs, agree priorities and encourage organisations involved in health and care to work in a more joined up way.

2.2 The suite of Joint Strategic Needs Assessments (JSNAs) for Thurrock reports on the health and wellbeing needs of the people of Thurrock. It brings together detailed information on local health and wellbeing needs and looks ahead at emerging challenges and projected future needs.

2.3 The Special Educational Needs and Disability (SEND) JSNA is a product among this suite of publications in Thurrock which aims to establish a shared understanding and demonstrate the different considerations relevant to children and young people with SEND in Thurrock aged 0 – 25 by providing a comprehensive evidence and data analysis of the education, social care, health and wellbeing needs of this group of children.

2.4 Therefore, this JSNA will support the Thurrock Health and Wellbeing Strategy goal of creating 'Opportunity for All' for children and young people with SEND in Thurrock by ensuring children and young people with SEND flourish and achieve their full potential in life.

2.5 Following considerations of the needs relevant to this group of children, young people and their families, recommendations have been made to inform and

enhance any planned service transformation and work programmes for SEND children and their families.

3. Issues, Options and Analysis of Options

3.1 The SEND JSNA has been structured in three major areas;

1. What we know about our children and young people with SEND
2. How well they are doing with their health and wellbeing
3. What are we doing to support children, young people and their families with SEND.

3.2 Thurrock's population of children and young people aged 0 -25 years has been on the rise in the last decade. Of the total population of the borough **34.1% (56,959)** are children and young people aged 0 – 25 years. The population of children and young people is set to rise in the next decade ty approximately **10% to 62,427** children and young people by 2027.

3.3 There are **3882** children and young people on the school roll in Thurrock with SEND. The prevalence of SEND in Thurrock is rising in line with national rates. Therefore, Thurrock expects a rise in this number to **4619 (737)** and **5256 (1374)** in 2024 and 2037 respectively following population estimates and considerations of the planned growth within Thurrock.

.

3.4 Of those children with SEND 2899 (10.4%) qualify for SEN support and **983 (3.5%)** are on an Education, Health and Care Plan (EHC – Plan). SEND pupils on a statement/EHC plan achieved better educational outcomes than their peers nationally and in comparator local authorities.

3.5 There is a higher prevalence of SEND in males than females, with more boys more likely to be receiving SEN support than girls. Evidence suggests that certain types of primary need such as Autism are more prevalent in males than females.

3.6 Thurrock has a higher proportion of pupils with Moderate Learning Difficulty, in its primary, secondary and special schools than the national and Statistical Neighbours proportions. Moderate Learning Difficulty is the most common primary need in secondary schools, while ASD is the most common primary need within special schools. This finding will impact on special school provision.

3.7 The level of attainment at age 19 in Thurrock was below comparator areas for pupils on a statement/EHC plan. In addition, more than half of exclusions between 2013 and 2016 were of children with SEND.

3.8 Children with SEN are less likely to remain in Education, Employment or Training than those with no identified SEN in which only 5% were NEET. Conversely, 9% of pupils with a Statement/EHC plan were NEET and 8% of

pupils receiving SEN Support were NEET, highlighting the poorer outcomes for these pupils.

3.9 There is a range of offer for children, young people and their families with SEND in Thurrock spanning different age-groups – ranging from pre-school and school age to transition from childhood into adulthood services. Thurrock also has two outstanding special schools which are both sort after.

3.10 The literature review, data and consultation with stakeholders that informed this JSNA highlighted the need to make a strategic decision towards developing greater collaboration between the local authority, CCG, and schools through enhanced joint working practices. One example of where this is required is in the commissioning of Speech, Communication and Language therapies.

3.11 Furthermore, the report recommended a need to invest in provision of tailored short breaks which have been shown to prevent children and young people with SEND from entering the care system as well as producing significant cost savings. It also highlighted the need for enhanced inclusion of the voice of children, young people and their families in service design and provision.

3.12 The JSNA also reflected the importance of early intervention and prevention to ensure that children with SEND are identified early and as such can receive the right support at the right time, giving them the best early start in the life and the opportunity to live fulfilling and healthy lives.

3.13 Furthermore, it is important that early prevention is considered and enhanced for children and young people with SEND within the Brighter Futures Strategy.

4. Reasons for Recommendation

4.1 To appraise the Board on findings of the JSNA about children and young people with SEND.

4.2 To seek the Board's view and input on the needs assessment and subsequently grant approval for publication.

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

5.1 A number of stakeholders have been consulted in preparing this needs assessment. Partners across Children's Services, the CCG and Public Health were consulted and were involved in the development of this JSNA report.

5.2 It was vital to ensure input from members of the health and social care system as this has enabled a holistic picture of the SEND landscape in Thurrock to be captured and accurately reflected within the report, as well as the recommendations that have been developed from the findings.

5.3 Stakeholders will also continue to be consulted as these recommendations reach the implementation stage.

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

6.1 This JSNA report will support in delivering the Council's vision and priorities for People and Prosperity;

1. High quality, consistent and accessible public services which are right first time.
2. Vocational and academic education, skills and job opportunities for all.

6.2 More so, this JSNA will support and contribute to the development, consultation and implementation of the SEND strategy, thereby supporting Goals 1, 2,3,4,and 5 of the Health and Wellbeing Strategy and its associated objectives which are highlighted in the below table.

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

7. Implications

7.1 Financial

Implications verified by:

7.2 Legal

Implications verified by:

7.3 **Diversity and Equality**

Implications verified by:

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

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

- Special Educational Needs and Disabilities – Joint Strategic Needs Assessment
- Special Educational Needs and Disabilities – Joint Strategic Needs Assessment – Executive Summary.
- Thurrock Council's Health and Wellbeing Strategy 2016-2021.

9. Appendices to the report

- Special Educational Needs and Disabilities – Joint Strategic Needs Assessment
- Special Educational Needs and Disabilities – Joint Strategic Needs Assessment- Executive Summary.


Children with Special Educational Needs JS


SEND JSNA Exec Summary v3.pptx

Report Authors:

Elozona Umeh

Senior Public Health Programme Manager,

Thanks to co-author:

Karen Balthasar

Public Health Graduate Trainee Practitioner

Children and Young People with Special Educational Needs (SEND) and/or Disability

Joint Strategic Needs Assessment

Authors

Elozona Umeh – Senior Public Health Programme Manager – Children and Young People

Karen Balthasar – Public Health Graduate Trainee

Annelies Willerton – Public Health Graduate Trainee

Maria Payne - Senior Public Health Programme Manager – Health Intelligence

Contributors

Malcolm Taylor – Strategic Lead – Learning and Inclusion

Bianca Mills - Business Intelligence Analyst - Performance, Quality & Business Intelligence

Clare Moore – Strategic Lead -Brighter Futures – Prevention and Support Service

Helen Farmer –Senior Commissioning Officer; Thurrock CCG;

Nicola Smith – Public Health Intelligence Analyst

Kelly Clarke – Public Health Intelligence Officer

Please note

All data relating to EHCP/Statement pupils and those receiving SEN Support is based on information received during the January 2017 School Census and data extracted from the Thurrock Synergy Information System at the end of the 2016/17 academic year. All data will be updated following the January 2019 School Census and at the end of the 2018/19 academic year.

Contents

1 Executive Summary 5
1.1 Key Findings and Recommendations 5
2 List of Abbreviations 7
3 Background 8
3.1 National Picture 9
4 Local Strategic Picture - How many SEND Children and Young People are in Thurrock? 12
5 What are the characteristics of Children and Young People with Special Educational Need and/or Disability in Thurrock? 16
5.1 Prevalence of SEN in Thurrock 16
5.2 SEND and Gender 17
5.3 SEND and Socio-economic status 17
5.4 SEND and Ethnicity 19
5.5 Children in Social Care System 20
5.6 Prevalence by Types of Need 21
5.7 Prevalence of Disability in Thurrock 27
6 What factors put children at risk of SEND? 28
6.1 Infectious diseases 28
6.2 Smoking during pregnancy 28
6.3 Drug/alcohol use during pregnancy 29
6.4 Maternal diet 29
6.5 Maternal age 29
6.6 Low birth weight and pre-term birth 29
7 How well are Thurrock Children and Young People with SEND doing? 32
7.1 Educational Attainment of SEND Children 32
7.1.1 Early Years Foundation Stage 32
7.1.2 Key Stage 2 33
7.1.3 Key Stage 4 33
7.1.4 Post 16 – Attainment by age 19 35
7.2 Absence and Exclusions 37
8 Children with SEND and Youth Offending 39
9 Transition from children to adults services 40
10 What are we doing in Thurrock to support children and young people with SEND? 44
10.1 Local offer 45

10.1.1Early Years Support - Brighter Futures 45
10.1.3 Preschool Support Services 46
10.1.4 Portage and Early Support Service 46
10.2 School Age Support 46
10.2.1 Special Schools....46
10.2.2 Mainstream Schools/ Settings / Colleges 47
10.2.3 Special Educational Needs Coordinator....48
10.3 Preparing for Adulthood....48
10.4 Short Breaks for CYP and Families 48
10.4 Information, Advice and Support Services (IASS) 51
10.5 Health Services 52
10.5.1 Children and Adolescent Speech and Language Therapy (SALT)....52
10.5.2 Children's Dieticians 52
10.5.3Community Nursing Service 52
10.5.4 Specialist Health Visitors....52
10.6 Community Teams....53
10.6.1 Children's physiotherapy....53
10.6.2 Community paediatrics....53
10.6.3 Community children's nursing....54
10.6.4 Children's feeding and swallowing 54
10.6.5 Child and adolescent speech and language therapy (SALT) 54
11 Recommendations....58
12 References....61
12 Appendices 65
12.1 Appendix 1 – What works for Children and Young People with SEND -Evidence Review 65
12.2 Appendix 2- SEN High Needs Review....71
12.3 Appendix 3- Policy and Guidance 72

1 Executive Summary

1.1 Key Findings and Recommendations

Key Areas	Key Findings	Recommendation
What are the characteristics of CYP with SEND?	• The prevalence of SEND in Thurrock is rising in line with national rates. Thurrock expects a rise in the number of children with SEND from **3882** to **4619** and **5256** in 2024 and 2037 respectively. • SEND is more prevalent in males than females; more boys are likely to be on SEN support than girls. It is unclear why boys are more likely to have SEND than girls but some explanation include misdiagnosis in girls as a result of play styles e.g. autism potentially under-represented. However, some primary needs are more prevalent in girls; for example profound learning difficulty. • Thurrock has a higher proportion of pupils with Moderate Learning Difficulty, in its primary, secondary and special schools than the national and Statistical Neighbours proportions. Moderate Learning Difficulty is the most common primary need in secondary schools, while ASD is the most common primary need within special schools. This increase will impact on special school provision	• Make a strategic decision for greater collaboration between the local authority, the CCG and schools. • Develop and **implement a SEND strategy with** clear vision, themes and priorities. • **Improve local data collection and synchronisation of data systems**. Predicted increases in the number of children and young people with SEND included within this JSNA is an extremely simple estimate using national evidence. To begin to accurately predict the demand for SEND need and provision irregularities within existing Children's Services data need to be addressed by the lead for data and intelligence within Children's Services.
How well are SEND pupils in Thurrock doing to achieve a full potential?	• SEND pupils on a statement/EHC plan achieved better educational outcomes than their peers nationally and in comparator local authorities. This was noticed in early years, Key Stage 2 and Key Stage 4. Good educational attainment was not observed in pupils without a statement. • The level of attainment at age 19 in Thurrock was below other areas for pupil on a statement/EHC plan.	**Further develop and improve SEND operational areas of work;** • Continue to develop and improve Thurrock's Local Offer. This should be done in collaboration with children, young, parents and carers. This includes ensuring personalisation of the service offer for families to improve choice, ensuring EHC plans are co-produced within recommended timelines.

	• More than half of exclusions between 2013 and 2016 were of children with SEND. • Children with SEN are less likely to remain in Education, Employment or Training than those with no identified SEN in which 5% were NEET. However 9% of Statement/EHC pupils were NEET and 8% of SEN Support pupils in Thurrock were NEET, highlighting the poorer outcomes for these pupils	• A deep dive on SEND case files by the SEND team to explore whether transitional arrangements are being met according to guidance ie. conversion of statement EHC plans as well as transition between services for example, children to adult services. • Raise educational achievement of children and young people with SEND through early identification of need, appropriate intervention and effective monitoring of progress towards challenging target.
What are we doing for children young people with SEND and their families in Thurrock?	**There are a ranges of offers for children and young people with SEND and their families in Thurrock spanning different age-groups – ranging from pre-school and school age to transition from childhood into adulthood. Thurrock has two outstanding special schools which is quite sort after .** **Commissioning of offer in Thurrock is not as co-ordinated as it can be. An Integrated Commissioning Strategy for Children incorporating joint commissioning arrangements between different services for children most especially Speech and Language Therapy is a way of ensuring accountability, economies of scale and better outcomes for children with SEND are achieved.** **Short Break – Evidence suggest that short breaks consistently demonstrate positive impacts on carers, their children and the family as a whole. Most beneficial short breaks are those that offer something/benefit all family members. We calculated potential savings that could be made following evidence to account for all (66), half (33) and a third (22) of LAC children with SEN being prevented from entering into the care system.**	• A cross-cutting service review on transition from child to adult services to identify issues, challenges and areas of focus. • Invest in more sufficiently tailored short-break provision as part of a preventative service offer. Evidence suggests that personalised short-break provision has been effective in supporting children, young people and their families. • Develop a joint commissioning approach for SEND with a primary focus on therapies to address the increased demand. More specifically, an exercise to benchmark the Speech and Language Therapy provision against national guidance should be undertaken, alongside exploration of the current provision and a health equity audit.

***** Please see the recommendation section at the end of this report for further details.**

2 List of Abbreviations

ASD – Autism Spectrum Disorder
ADHD – Attention Deficit Hyperactive Disorder
CBT – Cognitive Behavioural Therapy
EYFS – Early Years Foundation Stage
EHCP – Education Health and Care Plan
DfE – Department for Education
DLA – Disability Living Allowance
GLD – Good level of development
JSNA – Joint Strategic Needs Assessment
MLD – Multiple Learning Disorder
SENCo – Special Educational Needs Coordinator
SEND – Special Educational Needs and Disabilities
SEND – Special Educational Needs
SHMA – Strategic Housing Market Assessment
YOS – Youth Offending Service

3 Background

In 2017 there were 1.24 million children living in England who had Special Educational Needs and Disability (SEND). This accounts for nearly a quarter (14.4%) of the total population of children and young people (CYP) (1). This has been a decrease in the percentage of children identified as having SEND reported in 2014 (17.9%) (2). This decrease may be due to continuously developing methods for identification and diagnosis of those with SEND from those who do not have SEND. Additionally, it may in part relate to the Ofsted review which identified that a ¼ of children identified as having SEN and half of the children at School Action did in fact not have SEN (3). SEND is quite a broad term that encompasses a range of disabilities, disorders and difficulties. Disabilities such as physical impairments may be relatively straightforward to identify while others are less obvious and sometimes are contested, making identification quite problematic in some cases.

The Joint Strategic Needs Assessment (JSNA) plays a significant role in enabling partners to understand and determine shared priorities for improving the health and wellbeing of a particular population through the Health and Wellbeing Board. This JSNA will support the Thurrock Health and Wellbeing Strategy goal of creating 'Opportunity for All' for children and young people with SEND in Thurrock by ensuring they flourish and achieve their full potential in life (4). It will look to understand and demonstrate the different considerations relevant to Children and Young People with SEND in Thurrock aged 0 – 25 by providing a comprehensive evidence and data analysis of the education, social care, health and wellbeing of this group of children. From this the intention is to inform and enhance any planned service transformation and work programme for SEND children and their families.

On the one hand, this JSNA is a key process to responding to some questions posed within this product and aims to fulfil the following objectives;

- Understand the health and wellbeing needs of children with SEND and/or disability;
- Understanding the current demand for services and project future need where possible;
- Provide an evidence base to inform service planning, commissioning processes and be a source of information for a SEND;
- Make recommendations to improve provision

On the other hand, in line with SEND reforms, joint local area inspections will take place across local authorities to evaluate the effectiveness of local areas in identifying children and young people who have special educational needs and/or disabilities. The inspection also intends to support and assist local areas in improving and developing their processes and support systems to effectively deliver better outcomes for children and young people. Thurrock is expecting an inspection imminently and this JSNA will support by providing some evidence needed to appropriately evaluate how Thurrock is fulfilling its statutory

SEND Definition

SEND is a broad term and covers a range of needs including behavioural, emotional and social difficulties, autism spectrum disorders and specific learning difficulties such as dyslexia. The Department for Education's definition in England encompasses all children or young people from birth up to the age of 25 who have;

> 'significantly greater difficulty in learning than the majority of others of the same age, or a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.' (Department for Education and Department for Health, 201, p16).

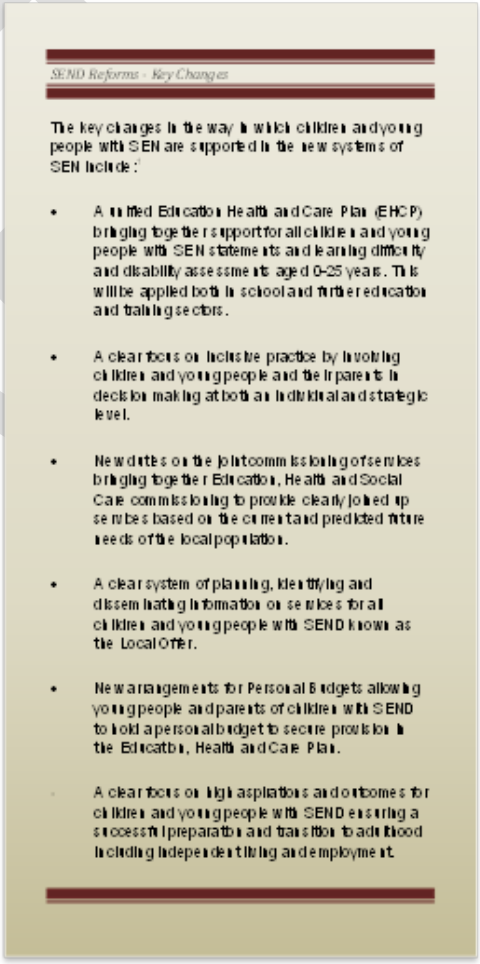
responsibilities for children and young people with SEND by providing an overall understanding of need, outcomes and service provision.

The scope of this JSNA provides a comprehensive analysis of data and evidence on SEND using current literature and statistics. Firstly, it will consider the characteristics of children with SEND – looking at prevalence and trends where possible. It will further explore the risk factors and outcomes experienced by children with SEND. The last section will consider what the local authority is doing to meet the needs of children and young people and their families. It will make both strategic and operational recommendations to influence and improve practice, inform the local offer and improve evidence-based planning and provision. Above all, these considerations will ensure improved educational, health and social care outcomes for children with SEND.

3.1 National Picture

In 2017, Pinney reported a one fifth decrease in the number of children with SEN in schools across England in 2016 (5). However, the 2017 school census has seen a rise in the number of SEND children nationally. In England, the number of children with SEND has increased from 1,228,785 in January 2016 to 1,244,255 in January 2017; however the rate remains stable at 14% (6).
Evidence suggests (5)there are 73,000 children of School-age (broadly 5 – 16 years) with complex needs which are made up of;

- 10,900 children with profound and multiple learning difficulties
- 32,300 children with severe learning difficulties
- 27,500 children with autistic spectrum disorders in special schools
- 2,300 children with multi-sensory impairments.


SEND Reforms - Key Changes

The key changes in the way in which children and young people with SEN are supported in the new systems of SEN include:

- A unified Education Health and Care Plan (EHCP) bringing together support for all children and young people with SEN statements and learning difficulty and disability assessments aged 0-25 years. This will be applied both in school and further education and training sectors.
- A clear focus on inclusive practice by involving children and young people and their parents in decision making at both an individual and strategic level.
- New duties on the joint commissioning of services bringing together Education, Health and Social Care commissioning to provide clearly joined up services based on the current and predicted future needs of the local population.
- A clear system of planning, identifying and disseminating information on services for all children and young people with SEND known as the Local Offer.
- New arrangements for Personal Budgets allowing young people and parents of children with SEND to hold a personal budget to secure provision in the Education, Health and Care Plan.
- A clear focus on high aspirations and outcomes for children and young people with SEND ensuring a successful preparation and transition to adulthood including independent living and employment.

The Children and Families Act 2014 (7) introduced major reforms to the way local authorities and its partners support children and young people with SEND. The national SEND reforms of 2014 created new legal requirements for local authorities, the NHS and others to consider SEND across the age range from birth to 25 years. It also required local authorities to provide all children with SEND access to integrated provision through Education, Health and Care (EHC) Plans. The Act was followed by a SEND Code of Practice published in 2015 (8)which focused on children, young people and carers driving the EHC plans, coupled with joined-up priorities between partners in achieving good outcomes for children and their families. A summary of the new arrangements can be found in the text box above.

Shaw et al (9) refers to SEND being identified and assessed in different ways, with some more easily identifiable than others. Disabilities are usually identified by a medical professional (possibly a

paediatrician), and involve 'a physical or mental impairment which has a substantial and long-term adverse effect on a child's ability to carry out normal day-to-day activities' (10).

In contrast, 'SEN' is quite a fluid concept and children may move in or out of categories of SEN over the course of their school lives. Accordingly, teacher perception plays an important role in determining whether a pupil is eligible for extra support. Some SEN are identified by medical experts (paediatrician) or child psychologists (for example, ADHD and dyslexia), while others are identified by teachers within the child's school (for example, SEN with some social, emotional and mental health aspects).

Consequently, a child or young person with SEND needs extra support if they find it harder to learn than the majority of their peers; hence they are currently categorised as needing some or all of the following interventions (11) , (2), (12), (13), (14), (15) .

Terminology

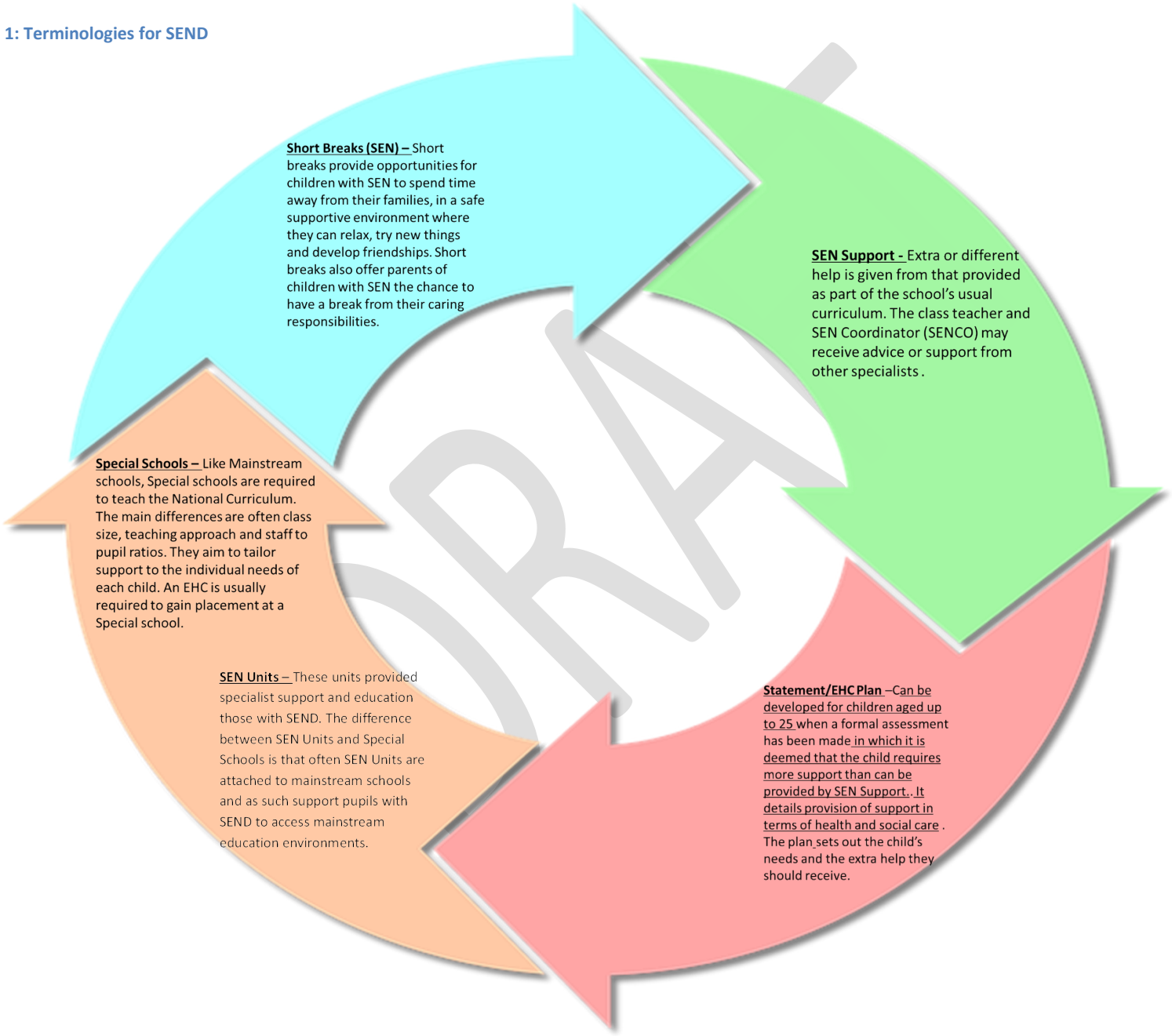
This JSNA document uses interchangeably the terms 'children', 'pupils' and 'young people' with SEN – because it is covering a wide age range from 0 – 25 and discussing educational and social care needs both within the school and in their lives outside of school. This JSNA document also refers to a range of sources which use different terms.

Likewise, this document may use 'parents' to include 'carers' and 'families'.

Sometimes children with SEN will also be disabled, which can be indicated with the acronym 'SEND'. This JSNA document refers to 'SEN' since this is the term used in National Statistics and data collection. Most of the issues identified in the document will apply equally to disabled children and it should be read as such. Where there is a difference it will clearly be indicated.

Finally, while data and analysis in this document may refer to 'children with SEN' or display general trends in data, there is no intention to claim that all children with SEN form one common group with exactly the same needs. There are national patterns outlined where necessary, but this document also seeks to highlight the wide spectrum of special educational needs, local variation in the identification of SEN and the fact that every child has certain needs to be met.

Figure 1: Terminologies for SEND



4 Local Strategic Picture - How many SEND Children and Young People are in Thurrock?

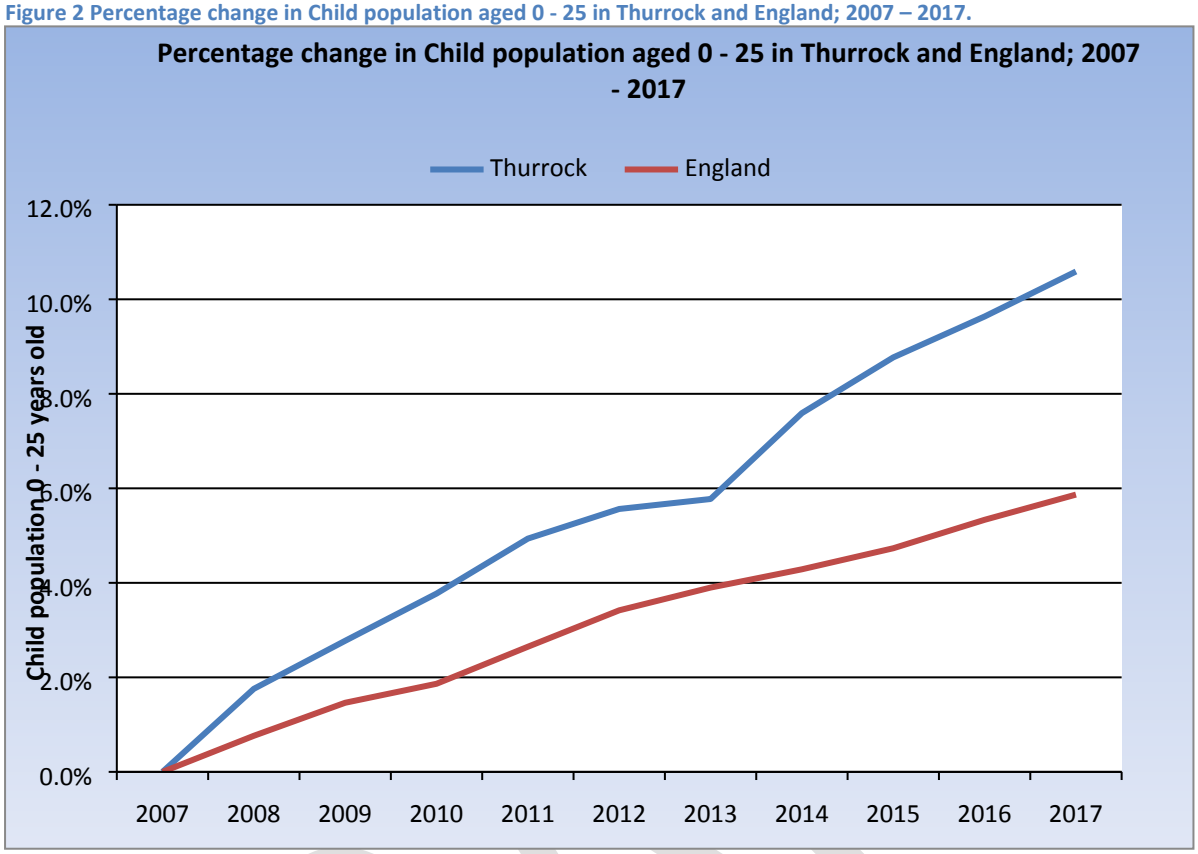
The Thurrock Health and Wellbeing Strategy set out goals and objectives which influence the health and wellbeing of all residents in Thurrock including children and young people with SEND.

There are **27,784** children on the school roll (School Census 2017 - he School Census is a statutory data collection for all maintained nursery, primary, secondary, middle-deemed primary, middle-deemed secondary, local authority maintained, special and non-maintained special schools, academies including free schools, studio schools and university technical colleges and city technology colleges in England.).

There are **3,882 (13.97%)** children and young on the school roll with SEND. Of those children with SEND **2899 (10.4%)** qualify for SEN support and **983 (3.5%)** are on an Education, Health and Care Plan (EHC – Plan).

Children and young people aged 0 - 25 make up **34.1% (56,959)** of the population of Thurrock. The child population aged 0 – 25 in Thurrock has been on the rise in the last decade (10.6% from 2007) which is double the rate of increase in England (5.9%). This trend is expected to continue over the next decade with the child population (0 – 25) projected to increase to 62,427 (9.2%) by 2027 from the 2016 mid-year estimate. Further details on the child population in Thurrock can be found in the Children and Young People's JSNA published in 2015 and updated annually to 2017 (16).

Figure 2 Percentage change in Child population aged 0 - 25 in Thurrock and England; 2007 – 2017.

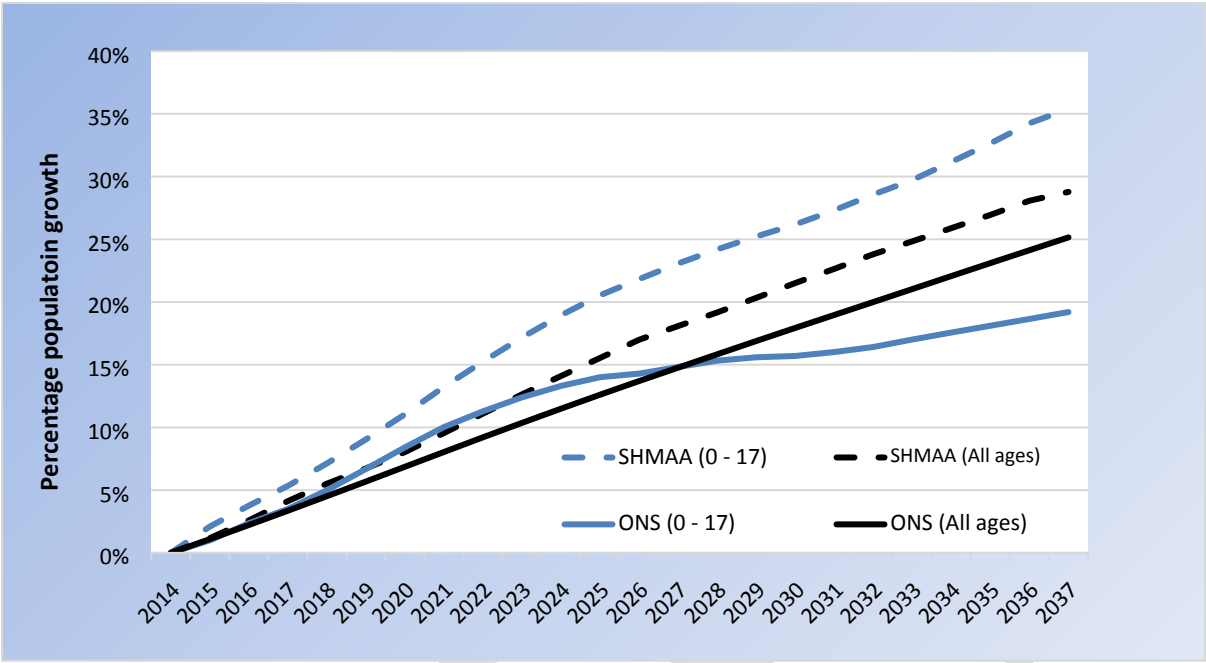


Source: ONS 2014 population projections

Alongside increases in the child population in Thurrock there is expected to be a rapid economic and housing growth over the next decade. It is expected that the population of children aged 0 – 25 will rapidly increase as a result. It is highly likely, therefore, that the SEND population in Thurrock will grow. In order to account for this expected population growth, the local Strategic Housing Market Assessment (SHMA) population projections take into account the high levels of job and housing growth expected to take place in Thurrock in the coming years to provide a more realistic forecast of population growth than the standard Office for National Statistics (ONS) forecasts.

Figure 2 above shows that the child (0-17) population has been increasing in Thurrock at a much faster rate compared to the national average. This higher rate of growth is expected to continue in the future in part due to the high level of economic and housing development currently taking place (17) – see Figure 3 below. There will therefore, be a proportionate increase in the numbers of SEND in Thurrock, even if the prevalence of SEND remains constant. This increase is also primarily driven by advances in healthcare, notable survival rate of preterm babies and increased life expectancy of children with congenital defects. Equally, children and young people with a range of disabilities, complex health needs and severe health problems are living longer, surviving into later childhood and even adulthood. Hence, this contributes to the expected rise in the prevalence of children and young people with SEND. Moreover, it is likely that the complexity of SEND needs will increase in the future, though this is hard to project accurately.

Figure 3 Strategic Housing Market Assessment Population Forecast - Percentage Population growth



These projections demonstrated that from the baseline year of 2014 the child population (0 – 17) will grow by 19 % by 2024 and 35.4% by 2037. By comparison, the child population of England is projected to grow by just 13.3% by 2024 and 19.2% by 2037 around half the rate of growth expected in Thurrock over the next 20 years.[1] Applying this to the SEND population (3,882) we expect to have an extra **737** and **1374** number of children with SEND by 2024 and 2037 respectively. To enhance this projection and accurately begin to estimate the number of children and young people with SEND further work is needed to begin to quantify the impact of the long term trend in the rising rates of SEND.

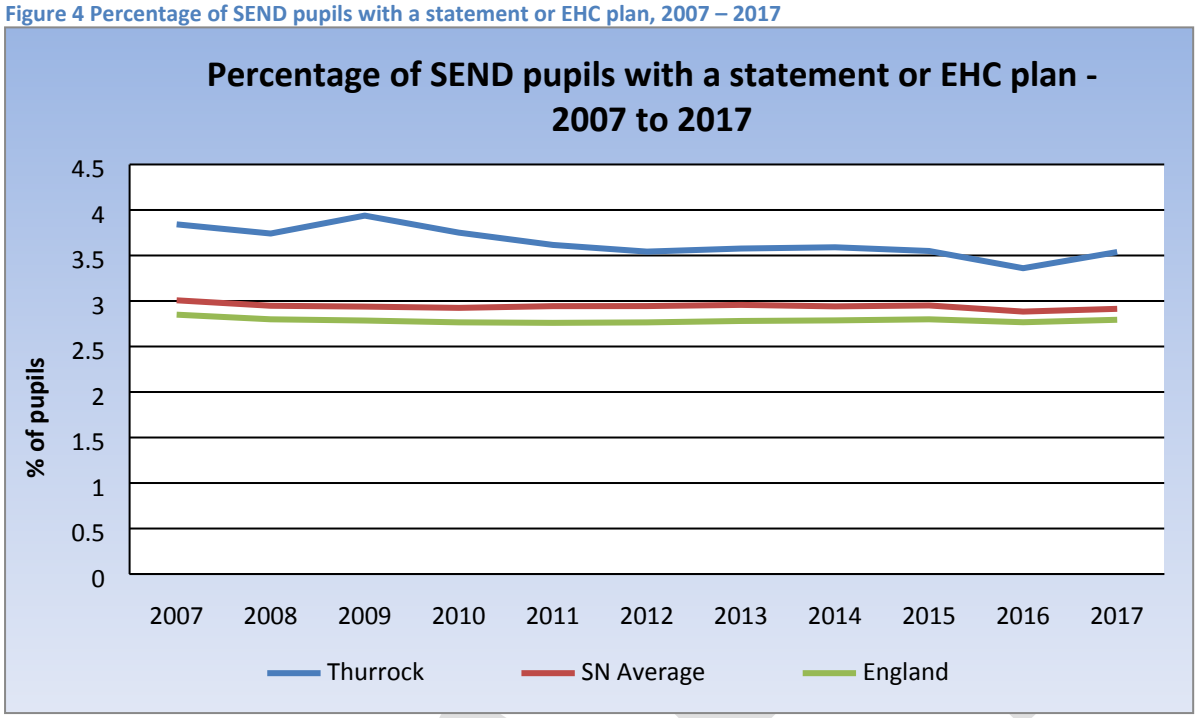
Data Warning!

The child population projections from SHMA covers children and young people from 0 – 17. The legal definition of SEND covers children and young people up to age 25. Therefore, the projected number of children expected to have SEND in 2024 and 2037 is likely to be under-estimated.

However, we know that the rate of SEND in the population is rising due to decreasing trend in mortality rate and advances in medical intervention meaning children are living longer with complex needs and as such are likely to need more support..

There are **2899** children with SEN support but without a statement in Thurrock. Overall, Thurrock has a higher proportion of pupils supported through a statement or EHC plan over the last decade than the SN and England averages. The proportion of Thurrock pupils with SEN requiring specialist support provided through a statement or an EHC plan as of January 2017 is **3.54% (983)** with a slight decrease in 2015/2016 which might be reflective of the major reforms introduced under the Children and Families Act 2014. This is higher than both the national average (2.8%) and statistical neighbours (2.91%) averages. Although the proportion of children supported through a statement of EHC plan is higher than comparator groups, Thurrock is expected to maintain **1,378** EHC plans by March 2018.

Figure 4 Percentage of SEND pupils with a statement or EHC plan, 2007 – 2017



Source: Department for Education, 2017

The increase is also reflected in the number of school children with a Statement or EHC plan although a slight decrease in numbers can be seen between 2015 and 2016. This slight decrease might have been driven by the SEND reforms (See section 3.1 - National Picture) and criticisms by Ofsted (Ofsted SEND Review, 2015) that schools were identifying more children as having SEND which reflected an over-representation of SEND.

Table 1: Number of children with a Statement/EHC Plan and of the % of annual change, 2007-2017.

	2007	2008	2009	2010	2011	2012	2013	2014	*2015	2016	2017
Number of children with a Statement/EHC Plan	887	866	917	876	857	863	895	918	934	908	983
% annual change		-2.4%	5.9%	-4.5%	-2.2%	0.7%	3.7%	2.6%	1.7%	-2.8%	8.3%

Source…….The * indicates the year that EHC Plans were introduced.

The number of children with SEND but without a Statement has decreased over time, from a peak of 5,054 in 2010 to 2,899 in 2017. The largest decrease when viewed as a proportion of pupils can be seen between 2014 and 2015 (17.5% decrease). This coincided with the SEND reforms which might in part explain this finding.

Table 2: Number of pupils with SEN without statements/with SEN support and the % annual change, 2009-2017.

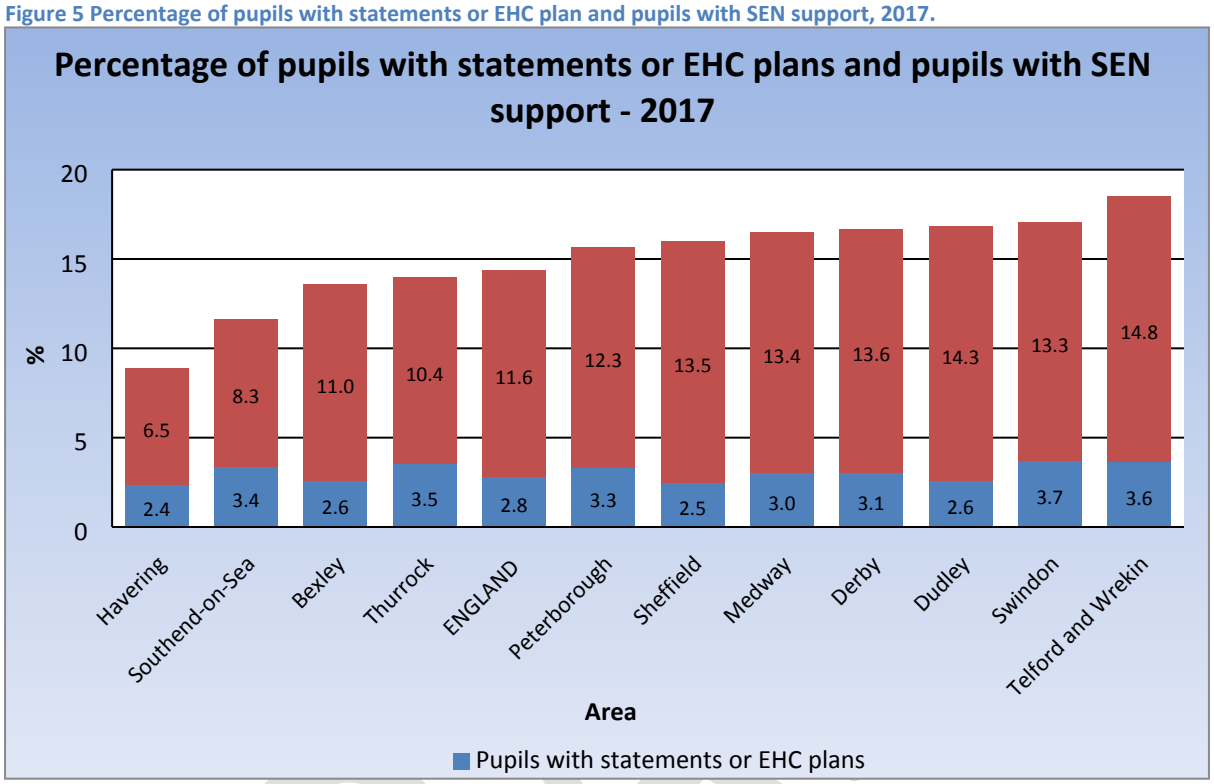
	2009	2010	2011	2012	2013	2014	*2015	2016	2017
Pupils with SEN without statements/with SEN Support	4996	5054	4828	4392	4006	3680	3037	2811	2899
% annual change	n/a	1.2%	-4.5%	-9.0%	-8.8%	-8.1%	-17.5%	-7.4%	3.1%

The * indicates the year SEN Support was introduced.

Whilst Thurrock's proportion of pupils with Statements or EHC Plans is higher than both England and the majority of its Statistical Neighbours, it can be seen from the figure below that the proportion of

pupils accessing SEN Support is in the middle of the group. This indicates that the proportion of pupils with Statements/EHC plans or SEN Support is comparable with other areas.

Figure 5 Percentage of pupils with statements or EHC plan and pupils with SEN support, 2017.



Source: Department for Education, 2017

5 What are the characteristics of Children and Young People with Special Educational Need and/or Disability in Thurrock?

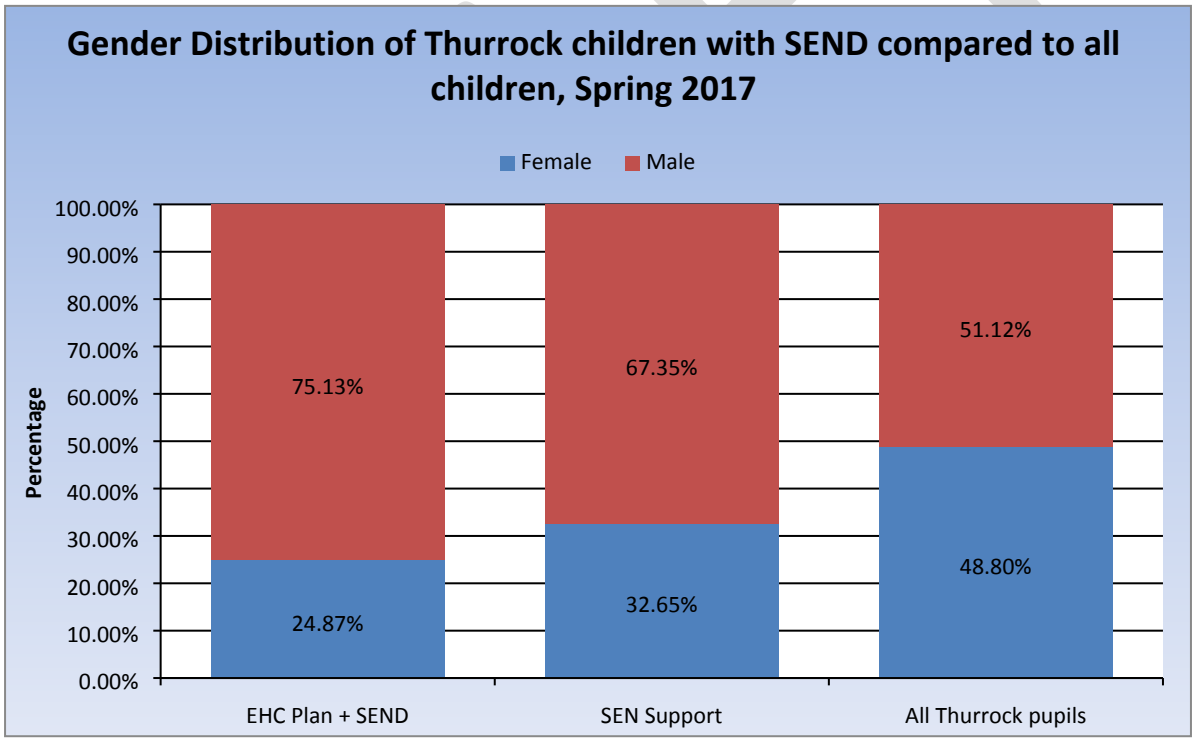
5.1 Prevalence of SEN in Thurrock

In Thurrock, of the 27,784 school-aged children, **3,882** (13.97%; January 2017) have SEND. This is in an increase from the number of children with SEND in January 2016 – 1960 (11.3%) out of a total of 17,332 pupils. The population increase during this year should be noted and taken into account in terms of the change in number of pupils with SEND. The sections below illustrate some of the characteristics of SEND children. The number of children and young people with SEND could be under-represented from the figures presented above. Gypsy, Romany and Traveller (GRT) children are more likely to have SEND than other pupils as well as being more likely to be excluded than the rest of the school population (18). Furthermore, in recent years more pupils with SEND, particularly those with Autism are home-schooled. One study that explored parent's views (27 in total) on their decision to home-school their children largely related to 'bad' experiences that their children had had whilst in school and where parents felt that their child's needs could not be met by the school. A large portion of the children were in mainstream school at the time the decision to home-school was made. Additionally, just under half (48%) of the children of the parent respondents were diagnosed with autism (19). In 2018 there are 158 children who either were Children in Need (CIN), (112), Children subject to child protection plans (CPP) (19) or children who are looked after (27).

5.2 SEND and Gender

Nationally SEND remains more prevalent in boys than girls (7). The School Census return provides a detailed breakdown of all pupils with SEND in Thurrock schools. These numbers include both children who reside in and out of Thurrock if they attend a Thurrock school. Of the 3882 school children with SEND, 75.5% are males and 24.5% are females. There are 67.4 % of boys receiving SEN support compared to 32.7 % of girls (Figure 6 below). It is unclear why boys are more likely to be receiving SEN support than girls but may relate to the number of genetic conditions which are more common in boys (20). There is also evidence to suggest that girls' needs may go unrecognised as they tend to exhibit less typical and intrusive behaviours in response to their difficulties (21). In addition, evidence suggests that there is an under-diagnosis of some primary types of need such as autism spectrum disorder in girls. Theories to explain the gender split include for the differences in terms of their special interests which are often more age appropriate e.g. dolls, make-up etc… and therefore, camouflage the autism. It may also relate to the fact that girls tend to find socialising easier than boys and more general exaggerations of gender differences (22).

Figure 6: Gender Distribution of Thurrock children with SEND compared to all children, Spring 2017.



Source: Department for Education, 2017

5.3 SEND and Socio-economic status

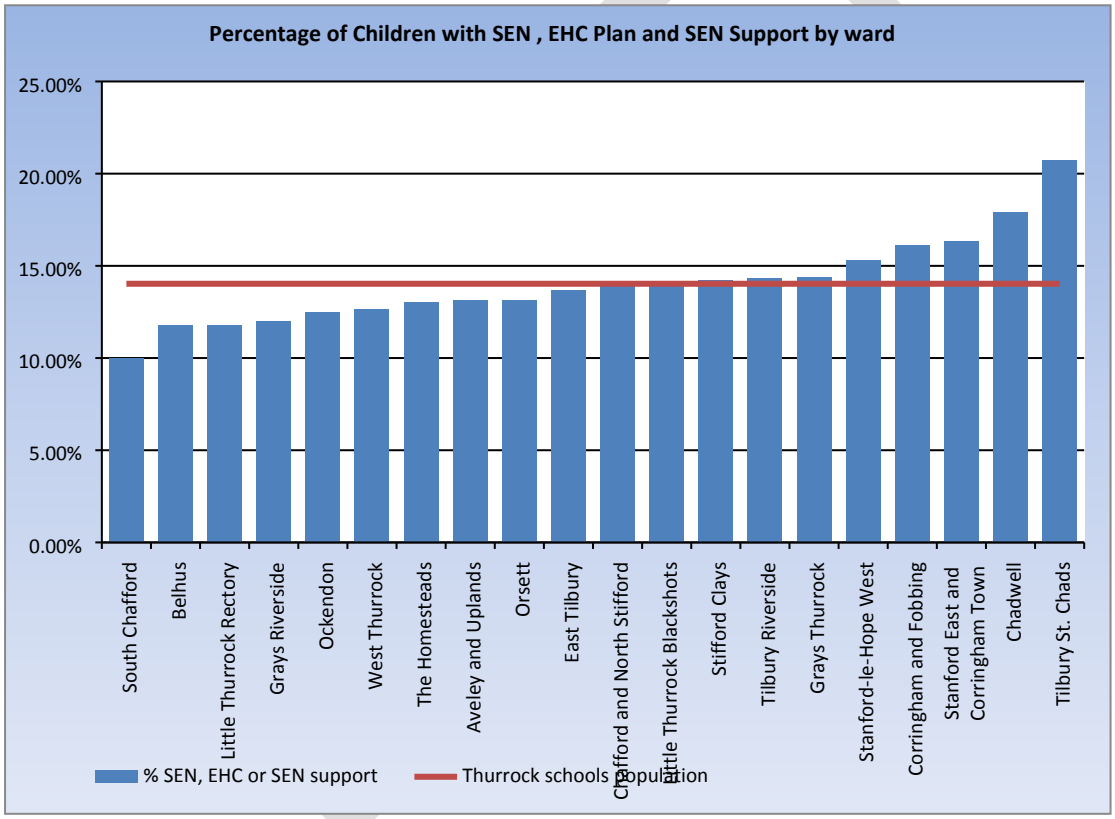
Across the United Kingdom (UK), Shaw et al (9) conclude that children with SEND from low-income families face particular barriers that prevent them from growing up into more affluent adults. A number of factors which may play a role, include:

- the outcomes they achieve and qualifications they gain as part of their education – they leave school with particularly low attainment

- their wellbeing as children
- access to support for their needs
- their diminished chances of finding well-paid work as an adult

Shaw et al (9) also suggest that a direct link might exist between pupils with SEN and children living in poverty, as either a cause of, or as a result of poverty. These social determinants contribute immensely to the prevalence of SEN and disabilities. The IDACI (Income Deprivation Affecting Children Index) score is a useful measure for child deprivation in a local area. It measures the proportion of children (age under 16) living in low income households in an area. Figure 7 below shows the percentage of SEN pupil with either a statement and/or EHC plan or who receive SEN support by ward. It depicts that the percentage of children with SEND ranges from 10% to 20.7%, with Tilbury St Chads having the highest proportion of children with SEND.

Figure 7 Percentage of Children with SEN, EHC Plan and SEN Support by ward

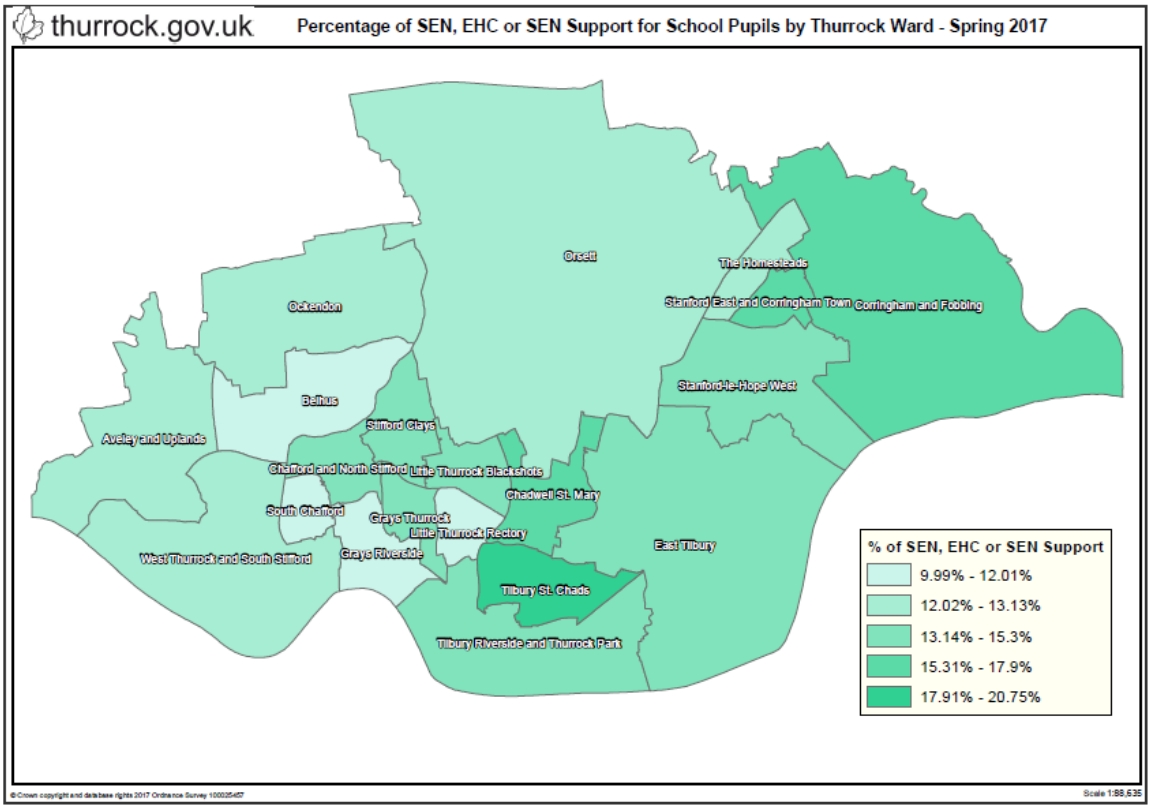


Source: School Census, 2017

Emerson (23)conducted a cross-sectional survey in a large sample of English children aged 7 – 15 years to estimate the independent association between household disadvantage, local area deprivation, ethnicity and the identification of intellectual and developmental disability. The author concluded that lower household socio-economic position was associated with increased rates of identification of intellectual and developmental disabilities especially milder forms of intellectual disability. Higher area deprivation was independently associated with increased rates of identification of less severe forms of intellectual disability but decreased rates of identification of profound multiple intellectual disability and autism spectrum disorder.

Figure 7 above and Figure 8 below illustrate where children and young people with SEND reside across the borough.

Figure 8 Percentage of SEN, EHC or SEN Support for School Pupils by Thurrock Ward - Spring 2017



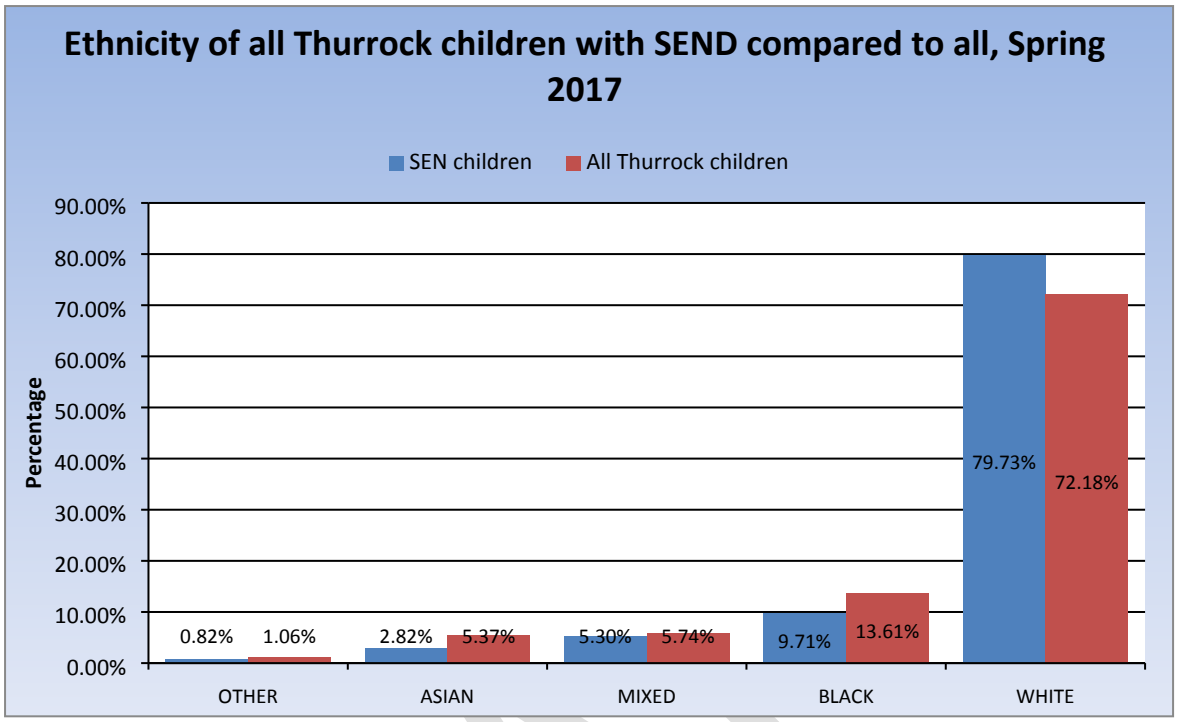
Source: School Census, spring 2017

5.4 SEND and Ethnicity

The relationship between ethnicity and SEND is complex, with many other variables such as socio-economic status, language and cultural barriers influencing children's outcomes. However, there is some evidence that ethnicity plays a part in the likelihood of some children being identified as having SEND. Emerson (23)concludes that minority ethnic status was, in general, associated with lower rates of identification of intellectual and developmental disabilities. However, the authors found some exceptions to this general pattern which included higher rates of identification of less severe forms of intellectual disability among Gypsy/Romany and Traveler children of Irish heritage, and higher rates of identification of more severe forms of intellectual disability among children of Pakistani and Bangladeshi heritage. One reason may be traditional preferences for consanguineous (cousin) marriages which increases the rate of some genetic disorders in this community.

In Thurrock, 32.7% of school pupils are from minority ethnic groups. Figure 9 below shows that 79.73% of SEN pupils were classified as White (School Census – January 2017). This covers a vast majority of pupils with SEND in Thurrock but without a statement. School pupils with SEND from a Black Ethnic background make up 9.71% of the SEND population.

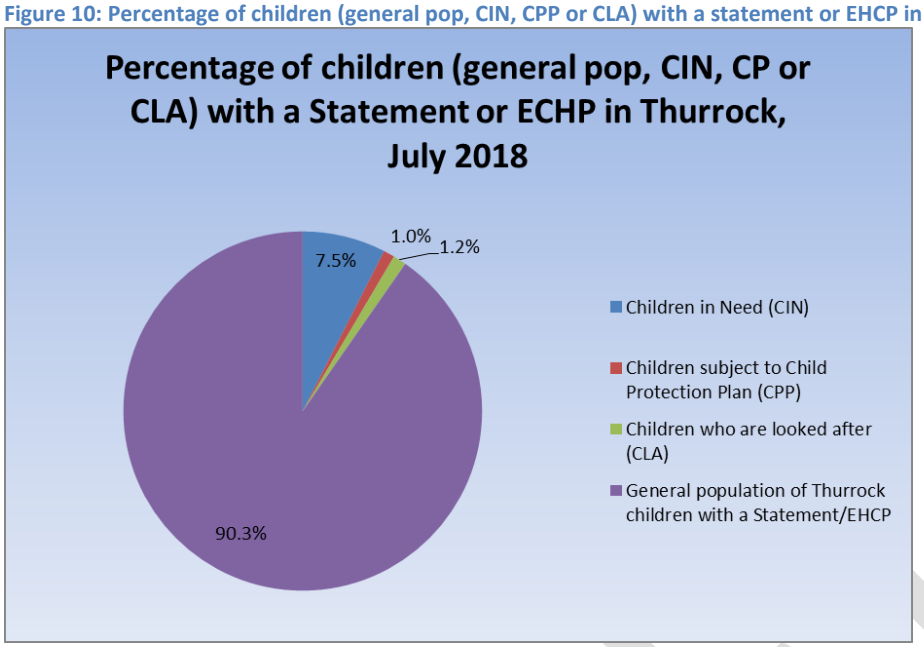
Figure 9 Ethnicity of all Thurrock children with SEND compared to all, Spring 2017



5.5 Children in Social Care System

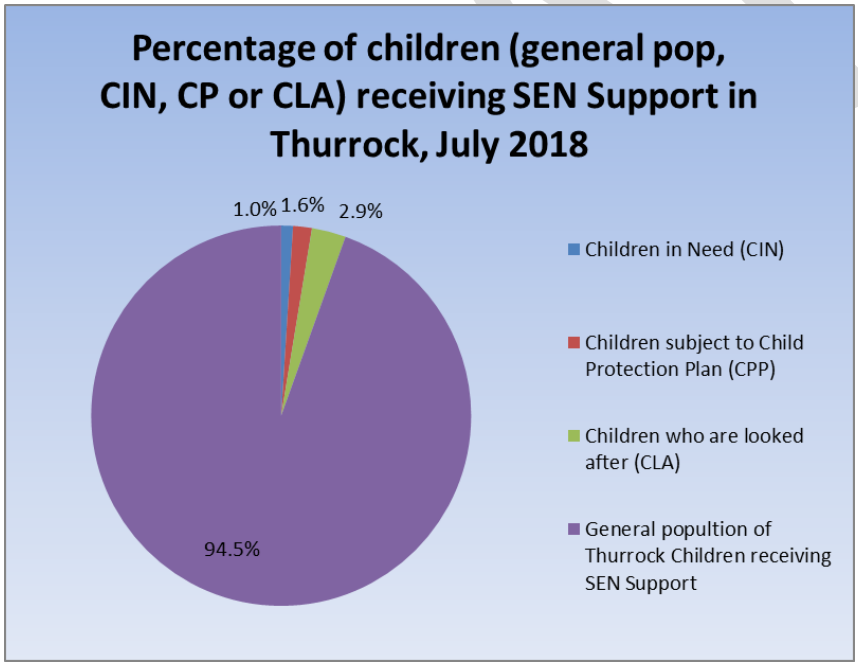
As highlighted above this year (2018) there are 112 children in Need, 19 Children subject to a Child Protection Plan and 27 children who are looked after. Of these children a total of 141 have a statement or EHCP; CIN (109, 7.5%), CPP (14, 1%) and CLA (18, 1.2%), (see figure 10 below). A further 17 are receiving SEN Support; CIN (3, 1%), CPP, (5, 1.6%) and CLA (see Figure 11 below for breakdown by circumstance). The two figures below (10 and 11) illustrate the number of children within the social care system who have SEN (supported via either a statement/EHCP or SEN Support) compared to the general population of SEN children. It should be noted that the data has been matched by UPN data as there is no current link between the Social Care database and SEN database. Therefore, caution should be taken when interpreting this data as it may be an over or under-representation of the true number of SEN children who are within the social care system.

Figure 10: Percentage of children (general pop, CIN, CPP or CLA) with a statement or EHCP in Thurrock, July 2018.



Source: Synergy SEN and LCS, 2018

Figure 11: Percentage of children (general pop, CIN, CPP,CLA) receiving SEN Support in Thurrock, July 2018.



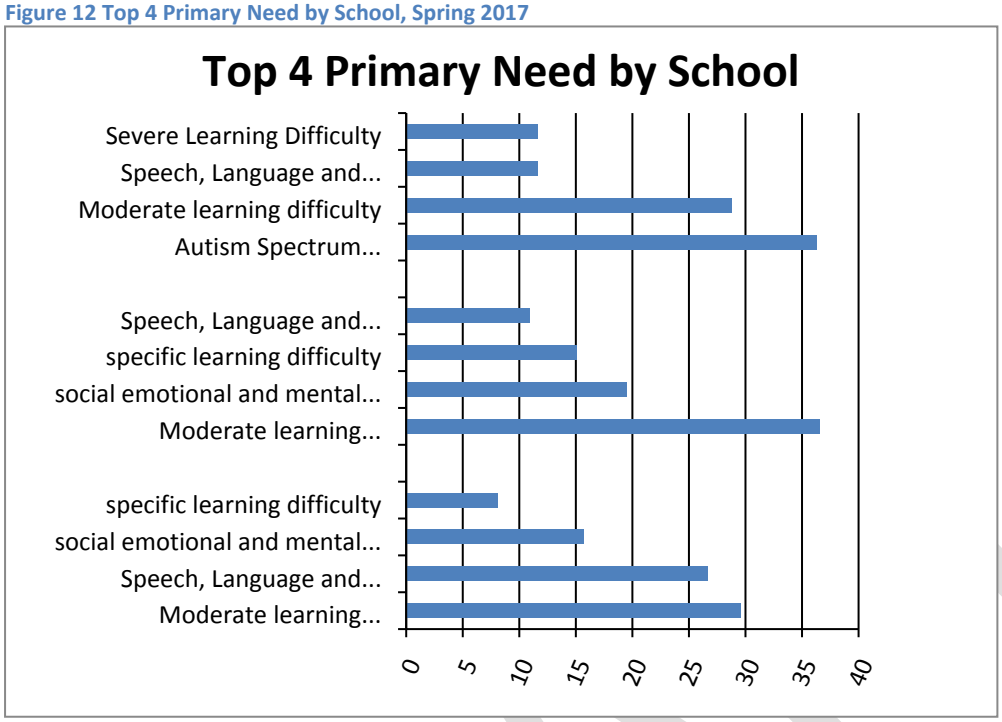
Source: Synergy SEN and LCS, 2018

5.6 Prevalence by Types of Need

Nationally, the most common type of need is Moderate Learning Difficulty (MLD) in both primary and secondary school pupils. Figure 10 show the top four primary needs in Thurrock within primary, secondary and special schools. Of its SEND pupils, Thurrock has a higher proportion of pupils with MLD, in its primary, secondary and special schools than the national and Statistical Neighbours

proportions. The proportion of SEND children with MLD in Thurrock is higher in secondary than in primary schools, but this pattern is not observed elsewhere (Figure 12).

Figure 12 Top 4 Primary Need by School, Spring 2017



Source – School Census, Spring , 2017

Autistic Spectrum Disorder (ASD) is the most common primary need among children with statements or EHC plans in special schools (1). The clearest trend from both the national and local education data is an increase in the number of children with ASD, apparent across both mainstream and specialist schools (24). This trend may impact on the number of children with diagnosed ASD, hence leading to an increase in demand for specialist provision including special school places as has been seen in Thurrock's outstanding special school provision.

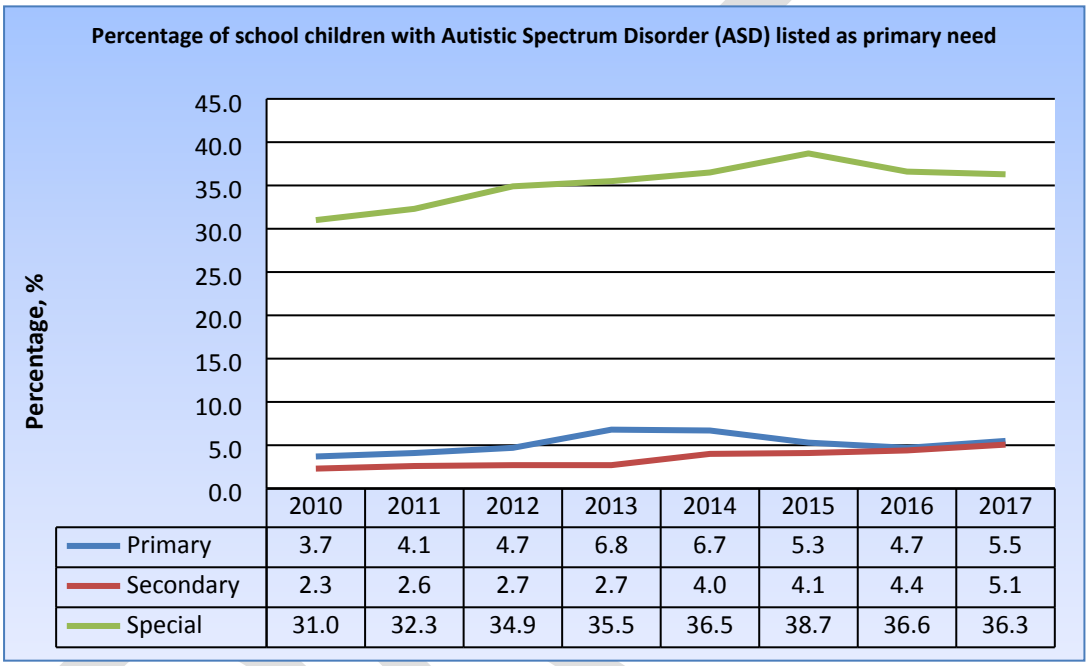
In Thurrock, 36% of pupils in special schools with SEN have ASD listed as their primary need. This is a greater proportion than the national or SN proportions (27% and 27% respectively) and has increased over the last 8 years most notably from 31% in 2010 to 36% of children in 2017 with SEN in Thurrock special schools. This is supported by a report commissioned by the Council for Disabled Children which found that the number of children with complex needs has increased over the last decade (5)The report highlights this increase as a result of two key trends;

- Increases in life expectancy for children with complex disabilities
- The increased survival rates among pre-term babies and children after severe trauma or illness.

A national estimate using school census data indicates an increase from 49,300 to 73,000 school-aged children (5-16) with complex needs from 2004 to 2016, including an estimated 219% increase in children with ASD in special schools, and 168% increase in children with multi-sensory impairments. Applying this to the population of children with ASD and multi-sensory impairments in Thurrock indicates an increase by xxx and xxx children respectively.

There is, the anticipation that this will continue to rise, and special schools will see an increase in the complexity of need and therefore, will need to support cohorts with a wide range of combined needs. However, it is much more difficult to evidence an increase in the severity and complexity of need (as opposed to simply an increase in numbers). ASD for example is a broad spectrum and there is no marker for identifying severity or complexity within the School Census data. The above estimated increase in need for ASD support relied on being in a special school as proxy for complexity which is not otherwise captured in the school census data. Mechanisms to depict this therefore, need to be explored to more accurately predict future service demand.

Figure 13 Trend in Percentage of school children with Autistic Spectrum Disorder (ASD) listed as primary need



	2010	2011	2012	2013	2014	2015	2016	2017
Primary	3.7	4.1	4.7	6.8	6.7	5.3	4.7	5.5
Secondary	2.3	2.6	2.7	2.7	4.0	4.1	4.4	5.1
Special	31.0	32.3	34.9	35.5	36.5	38.7	36.6	36.3

Source: School Census, 2017

Figure 13 shows that just over 5% of SEN children in primary and secondary schools have ASD in 2017. Whilst the primary school proportion is similar to other areas, the secondary proportion is half that of the statistical neighbours and national proportions (see pie charts below).

Thurrock has a very low proportion of SEN children in special schools with Social, Emotional and Mental Health (SEMH) issues, but this is not viewed nationally or elsewhere, as 13% of special school pupils nationally and 11% in the SNs have SEMH needs (see pie charts below).Thurrock's special school pupils have proportionally more (12%) SEN pupils with Speech, Language and Communication needs, which is double the proportion nationally and in the SN group (see bar charts below Figure 14, Figure 15 and Figure 16).

Figure 14 Percentage of Pupils with SEN by primary type of need- State Funded Primary Schools, Thurrock, Statistical Neighbours and England 2017.

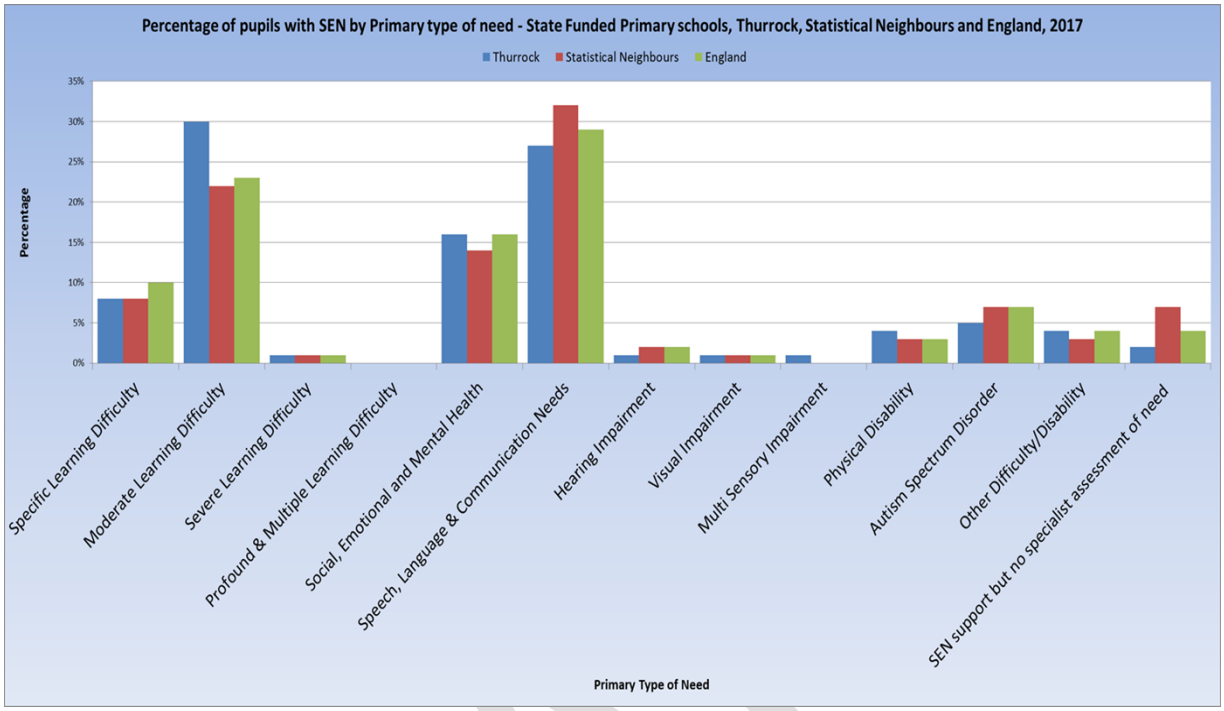


Figure 15: Percentage of pupils with SEN by Primary type of need - State funded Secondary Schools, Thurrock, Statistical Neighbours and England, 2017.

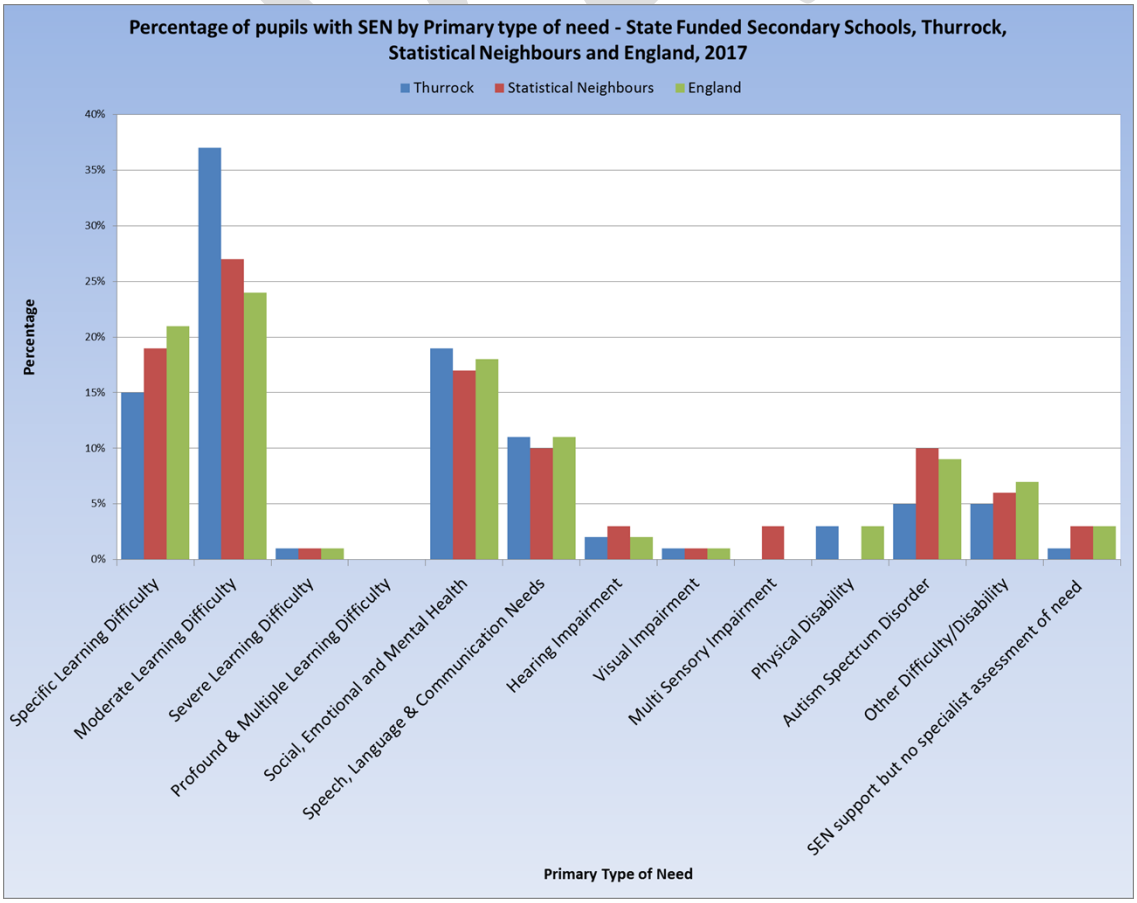
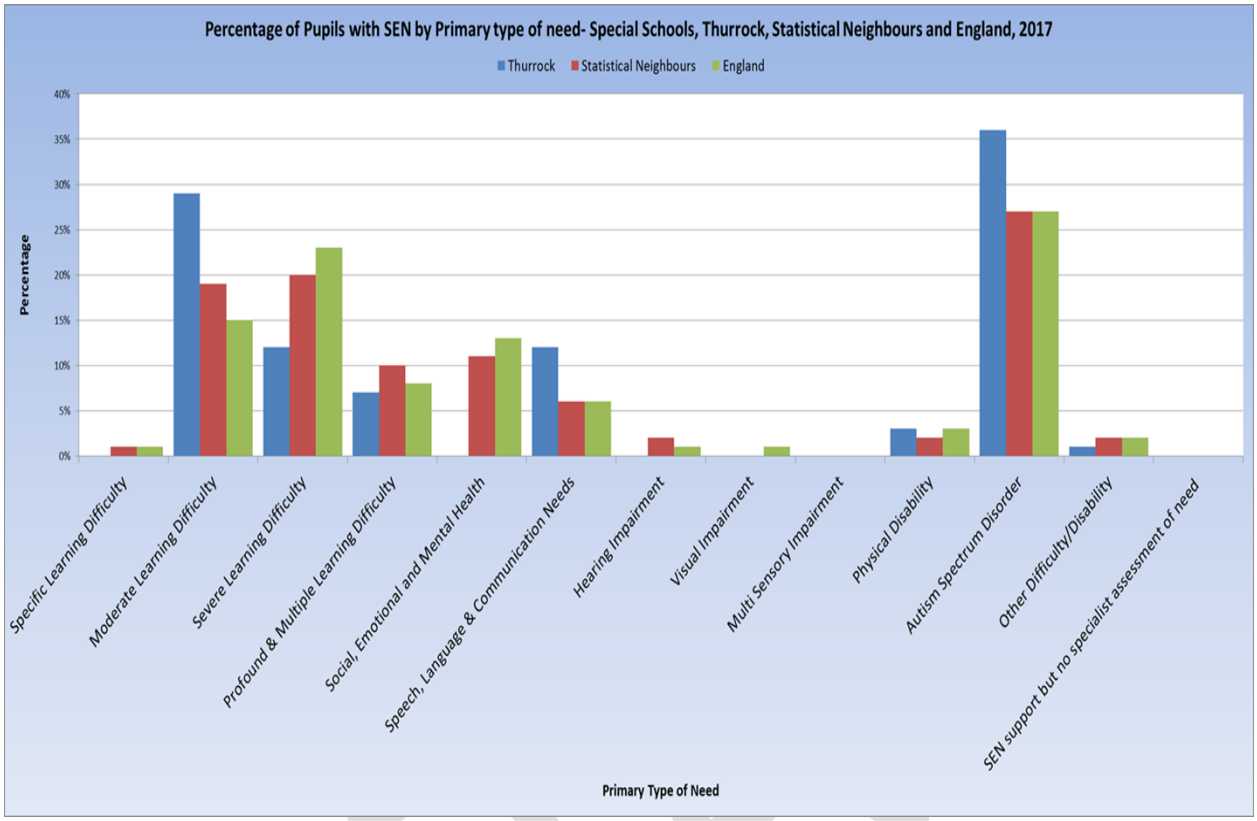
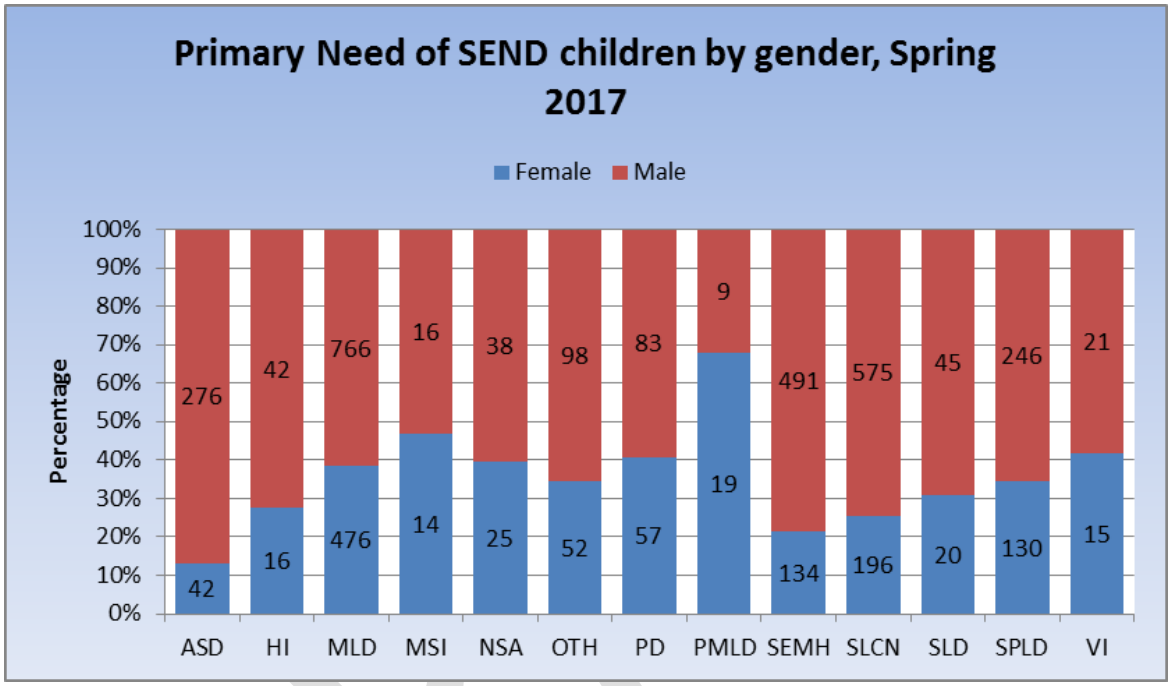


Figure 16: Percentage of Pupils with SEN by Primary type of need - Special schools, Thurrock, Statistical Neighbours and England, 2017.



The figure below shows some primary types of need which appear more prevalent in females than males in Thurrock (Spring 2017 Census). Although literature and earlier data (see section XXX above on 5.2 SEND and Gender) indicates that the majority of SEND pupils are males, some primary need are more prevalent in females. For example, there were 19 females with Profound & Multiple LD compared to 9 male as can be seen in the chart below.

Figure 17 Primary Need of SEND children by gender, Spring 2017



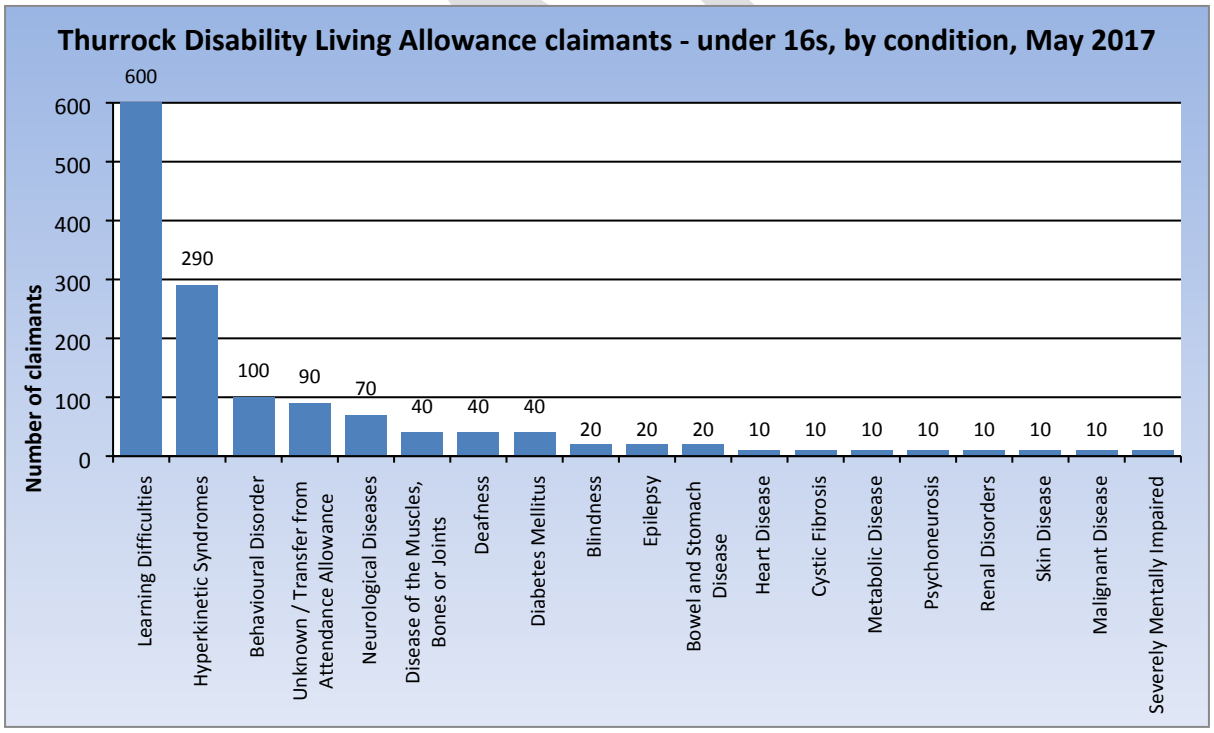
Source: Spring Census, 2017

5.7 Prevalence of Disability in Thurrock

There is a degree of overlap between children with SEN and those with a disability (25). Overall, the prevalence of disability is lower than the prevalence of SEN. There is however a rise in the number of disabled children with complex needs and/or life-limiting conditions, who, with their families, are likely to need support from health, education and social care continuously or at times throughout their life. For a better understanding of this cohort of children, the Disability Living Allowance data has been analysed to provide some context for Thurrock. Analysing historic data on those claiming Disability Living Allowance (DLA) can give an indication of those with the highest support needs. While this gives some indication of needs, recent data on Universal Credit claimants cannot be directly compared.

In May 2017 there were **1,420** children under the age of 16 claiming DLA in Thurrock. The most common reason for claiming was Learning Difficulties, which accounted for **600** (42.2%) of claims; followed by Hyperkinetic Syndromes for example (ADHA (290) and Behavioural Disorders (100). This distribution can be seen in the figure below.

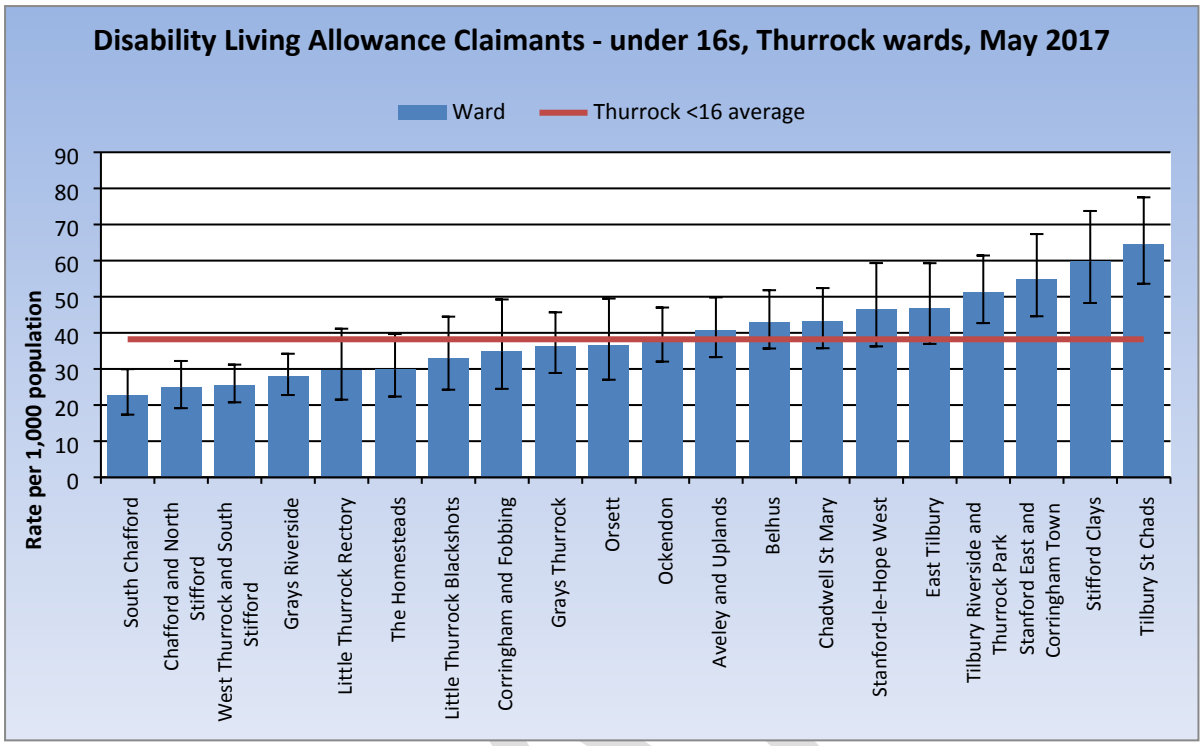
Figure 18 Thurrock Disability Living Allowance claimants - under 16s, by condition, May 2017



Source: NOMIS, May 2017

The rate of DLA claimants is not uniform across Thurrock. Converting the claimant counts per wards into rates per 1,000 population aged <16 in each ward, it can be seen that wards such as South Chafford and Chafford and North Stifford have low claimant rates, and Tilbury St Chads had the highest claimant rate in Thurrock. This corresponds with the wards with the highest proportion of SEN pupils – as well as linked to child poverty (see Figure 7 and Figure 8 above).

Figure 19 Disability Living Allowance Claimants - under 16s, Thurrock wards, May 2017



Source: NOMIS, May 2017

6 What factors put children at risk of SEND?

There are a range of risk factors which can impact on a child developing SEND, with some of the most important factors discussed below:

6.1 Infectious diseases

Measles, mumps and rubella are infectious conditions that can have serious complications in pregnancy and in children who have not been vaccinated, including meningitis, swelling of the brain (encephalitis) and deafness. Bacterial meningitis and septicaemia also can lead to health problems which may cause disability or lead to special educational needs including hearing or vision loss; problems with memory and concentration; epilepsy; co-ordination, movement and balance problems; and loss of limbs. Meningococcal meningitis produces severely disabling after-effects in about one in twelve survivors.

6.2 Smoking during pregnancy

Smoking during pregnancy is linked to complications during labour and a significant risk factor for premature birth and low birth-weight which can lead to disabilities. Trends for smoking during pregnancy in Thurrock have been steadily decreasing in recent years and currently the prevalence is significantly below the national average, with only 9% of women who were smoking at time of delivery during 2016/17. Thurrock Council runs a smoking cessation service which includes support for pregnant women.

6.3 Drug/alcohol use during pregnancy

Foetal Alcohol Spectrum Disorder (FASD) is an umbrella term for a series of preventable birth defects caused by alcohol exposure during pregnancy. It is the most common, non-genetic cause of learning disability in the UK. Children may have multiple difficulties (developmental, medical, learning, behavioural, social and/or emotional), some of which may not be evident from birth, may be misdiagnosed or diagnosed separately as ASD or ADHD which have similar symptoms or can be diagnosed as co-morbidity. A lack of intervention or suitable support can result in secondary difficulties such as poor mental health, disrupted school and criminal activity.

There is growing evidence to suggest that substance abuse can also lead to learning and behavioural difficulties as a result of perinatal complications and/or the postnatal environment i.e. interference with caretaking/parenting abilities. Parental substance misuse is a common factor in serious case reviews and child protection plans.

6.4 Maternal diet

A mother's diet during both the planning and actual stages of pregnancy has an influential role on foetal growth and development. Deficiencies in folic acid and vitamin D can increase the risk of neural tube defects (such as spina bifida) and impaired foetal growth and bone development respectively. Maternal obesity is also associated with an increased risk of birth defects such as spina bifida, heart defects and multiple anomalies.

6.5 Maternal age

Both maternal age extremes (young and old) carry higher risks for pre-term birth and low birth weight, which are associated with a range of disorders which can ultimately lead to a child being identified with SEND. The risk of congenital anomalies is more marked for women aged 40 and over

Teenage pregnancy rates in Thurrock have declined over the past 10 years and most recently have been measured at 18.4 under 18 conceptions/1000 which is similar to the national average (26).

6.6 Low birth weight and pre-term birth

Low birth weight (<2.5kg) is a major determinant of disability and/or special educational needs in infancy and childhood. Pre-term birth contributes substantially to the incidence of low birth weight. Children born pre-term (before 37 weeks) are at an increased risk of a vast array of developmental problems and disorders, including the following:

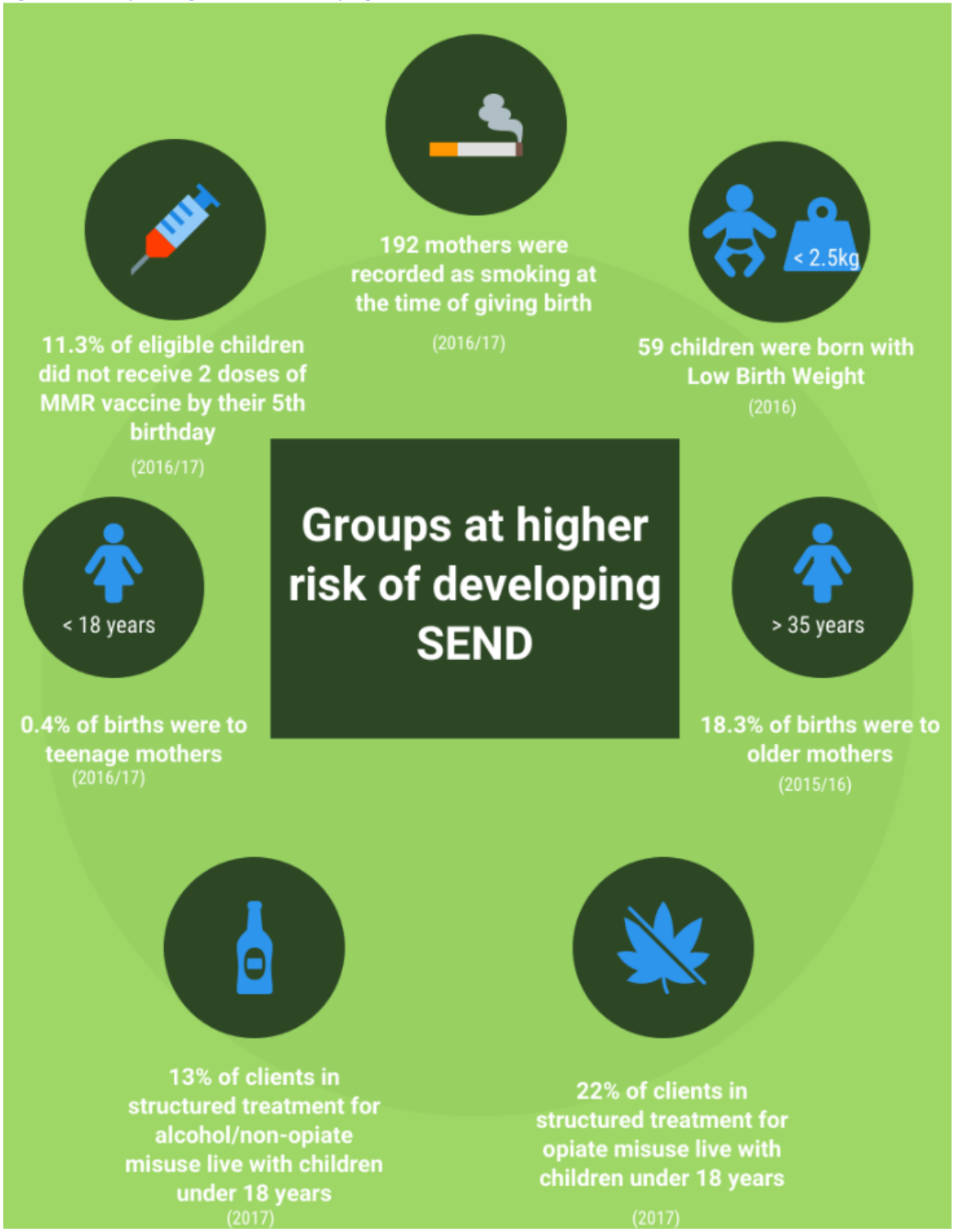
- Cerebral palsy
- Inattention, hyperactivity and impulsivity
- Motor function problems
- Autistic spectrum disorder
- Learning disabilities
- Emotional and behavioural problems
- Speech, language and communication problems
- Visual and hearing impairment

- Early-term birth (37 – 39 weeks)

A large population-based, retrospective study of 407,503 eligible school-aged children in Scotland found that gestation at delivery had a strong, dose-dependent relationship with SEN that was apparent across the whole range of gestation. Compared to children born at 40 weeks, early term children (born at 37–39 weeks of gestation) were 1.16 times as likely to have SEN (95% CI 1.12–1.20) (27). This has important implications as early term delivery is more common than preterm delivery (<37 weeks) and also contributes more to the overall SEN population than pre-term. Although there is currently no evidence in relation to this topic, it is possible that a bi-directional causal pathway exists, with SEN children being more likely to be born early than children who do not have SEN alongside children born early being more likely to have SEN.

The infographic below profiles some of these high risk groups in Thurrock.

Figure 20: Groups at higher risk of developing SEND



Source: Thurrock Council and Public Health England

7 How well are Thurrock Children and Young People with SEND doing?

It is widely known that children with special educational needs and disabilities are more likely to be at risk of poor outcomes in education and life in general which is likely to impact on their later life. It is however; also known that SEN and/or children with complex disabilities are surviving a lot longer and as such need specialist treatment for longer. This section looks at the outcomes experienced by this cohort of children drawing on some recommendations for making improvements.

7.1 Educational Attainment of SEND Children

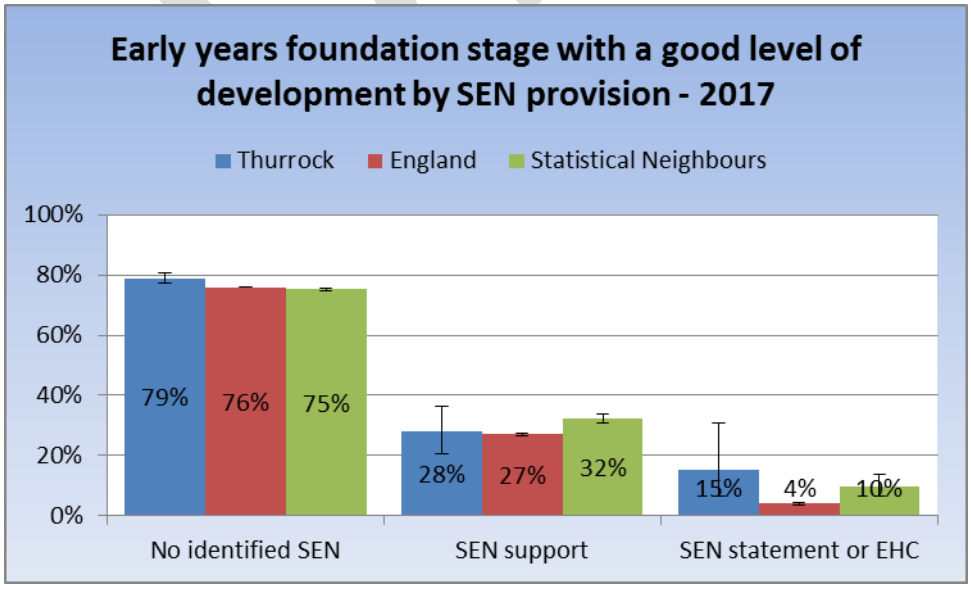
Evidence suggests that perhaps unsurprisingly, children with general or specific learning difficulties are among the groups of children on SEN support with the poorest academic attainments, with only 1/3 of those with SEN achieving national expectations at age 11 (28). Furthermore, only 32% of those with specific learning difficulties achieving GSCE English and Maths at A*-C, compared to the national average of 63% (24).The below sections present some information about educational attainment of Thurrock children with SEN at different stages.

7.1.1 Early Years Foundation Stage

Thurrock has historically had a higher proportion of children achieving a Good Level of Development (GLD) at Early Years Foundation Stage than the national average. This is not always the case for all SEN pupils.

Figure 21Figure 21 below shows GLD achievement for pupils on SEN Support, Statement/EHC and non-SEN pupils, and it can be seen that whilst GLD achievement for Statemented pupils is almost double that of our Statistical Neighbours and almost four times nationally, it is similar to other areas for SEN Support pupils.

Figure 21 Achievement of a GLD at Early Years Foundation Stage, 2017

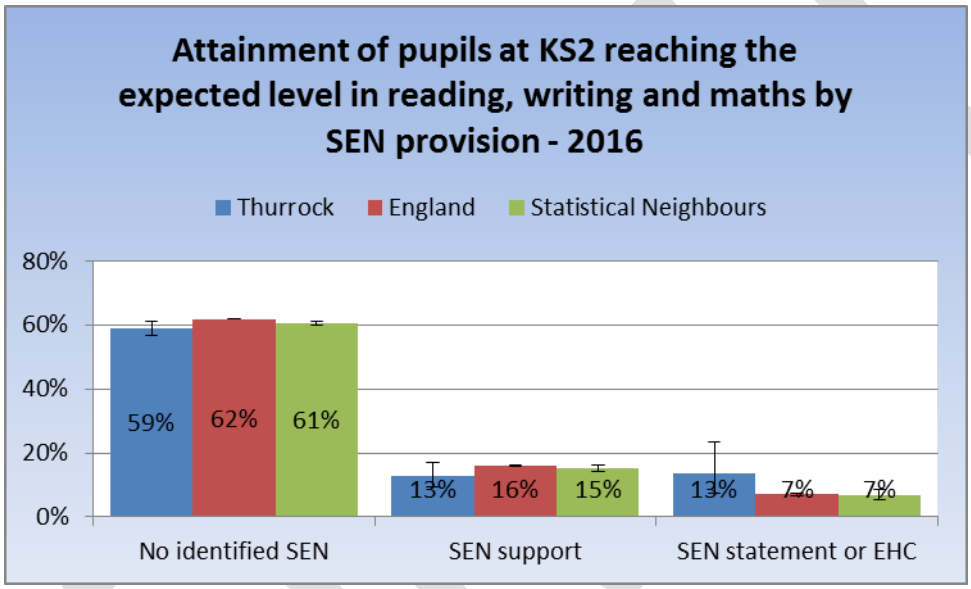


Source: Department for Education

7.1.2 Key Stage 2

Evidence has shown that children with SEN may experience a number of educational inequalities when compared with their peers; including lower levels of attainment, lower rates of sustained education, and higher rates of absence or exclusion (2). Thurrock has a higher proportion (13%) of KS2 SEN pupils with a statement/EHC plan achieving their expected level compared to 6.8% and 7% for its SNs and England. This pattern is not observed in the SEN pupils with no Statement, or non-SEN pupils – 59% of non-SEN pupils in Thurrock achieved their expected level, compared to 62% nationally.

Figure 22: KS2 attainment by SEND group type, 2016

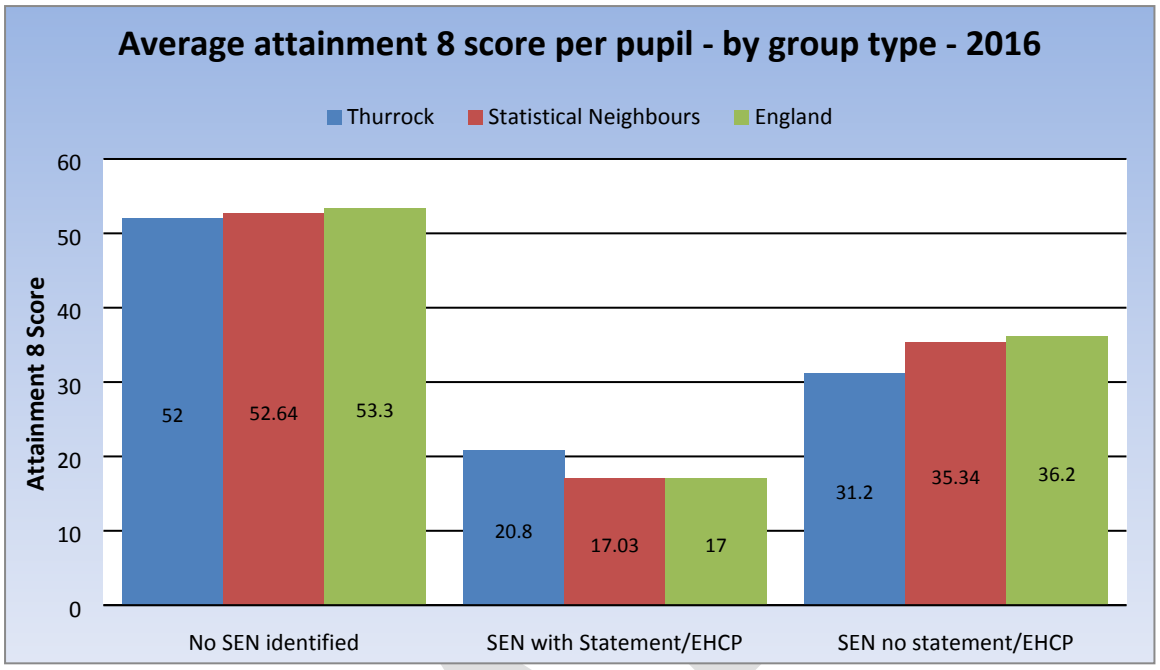


Source – Department of Education or LAIT 2017

7.1.3 Key Stage 4

In 2016, the average attainment 8 score (measures a child's average grade across 8 subjects) was higher for Thurrock's SEN pupils with a Statement; 20.8, compared to 17.9 and 17.0 for its SNs and England. The attainment 8 scores for SEN pupils with no Statement was below comparator areas (31.2 compared to 35.3 and 36.2).

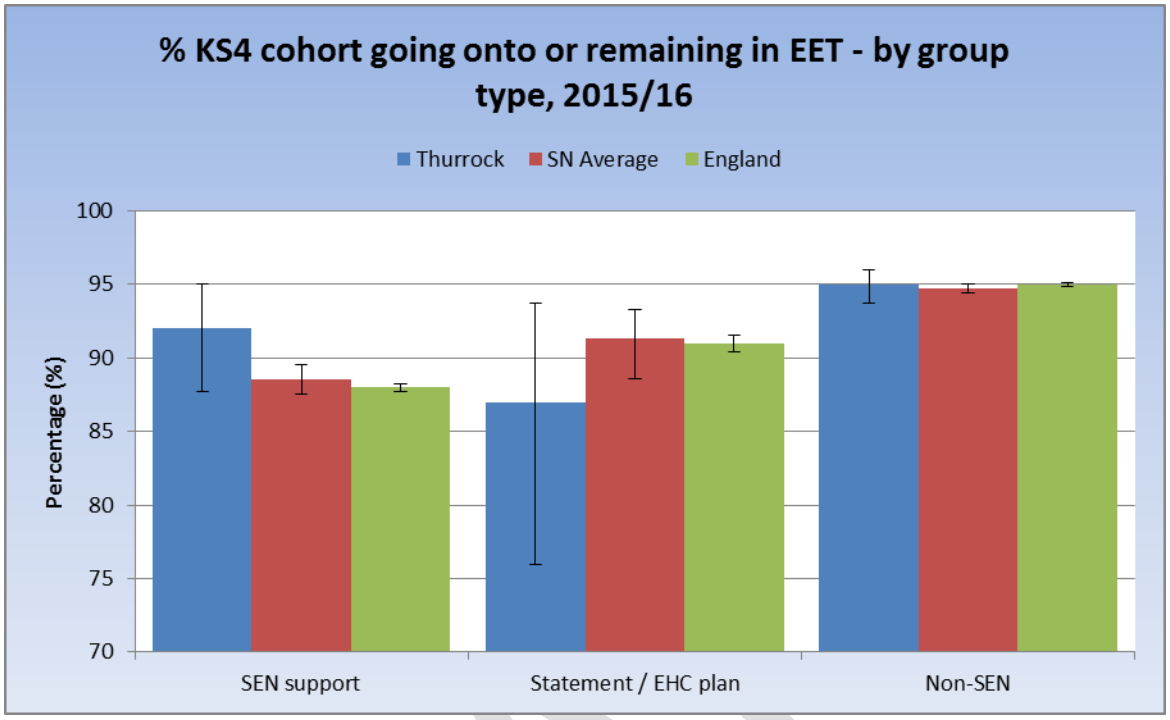
Figure 23: Attainment 8 score per pupil by SEND group type, 2016



Source: Department of Education, 2017

Children with SEN are less likely to remain in Education, Employment or Training than those with no identified SEN. Figure 24 below shows the rate of KS4 cohort children going onto education employment or training (EET). A slightly higher proportion of Thurrock's SEN pupils with no Statement remained EET compared to their peers nationally and comparator local authorities, although not significantly so. A similar proportion of children with a statement or EHC plan remained EET compared to other statistical neighbours. A similar proportion of non-SEN pupils in Thurrock's KS4 cohort remained in EET to other areas. The large confidence interval for Thurrock's Statement/EHCP children should be noted due to smaller numbers.

Figure 24: Percentage of KS4 cohort going on to or remaining EET by SEND group type, Spring 2017



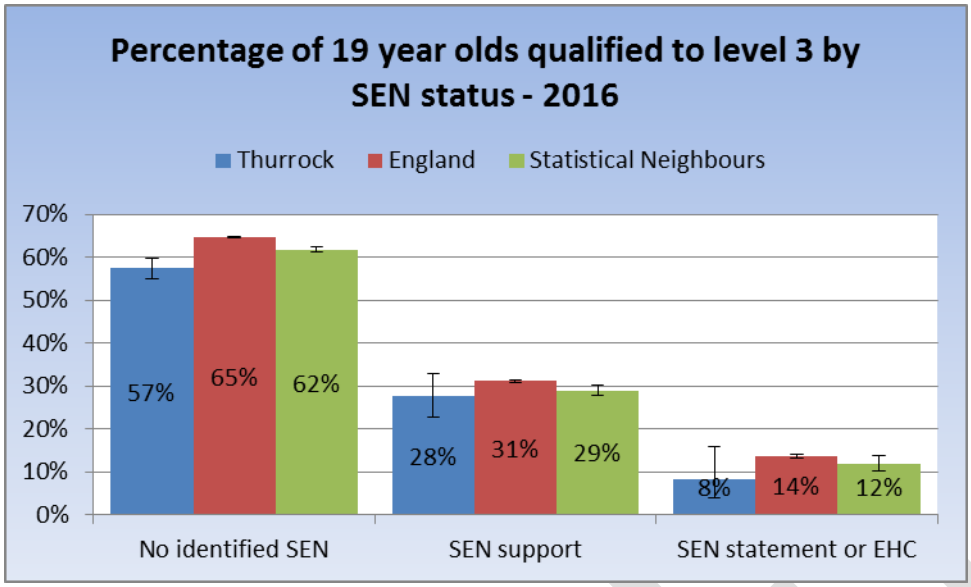
Source- Department for Education, 2017

7.1.4 Post 16 – Attainment by age 19

Students between the ages of 16 and 18 are expected to either be in education or undertaking an apprenticeship or traineeship. This, therefore, means that many more students with SEND require support with their education after the age of 16.

In Thurrock, the level of attainment at age 19 is below other areas for all pupil groups. There were 57.4% of all pupils achieving a level 3 qualifications which was higher at 62.3% and 64.8% in SNs and England respectively. SEN pupil with a statement achieved 8.4% level 3 qualifications which are lower than SNs and England proportions at 11.7% and 13.7% respectively. There were 27.7% of SEN pupils with no Statement qualifying at Level 3 in 2016 (30.3% and 31.2% in SNs and England).

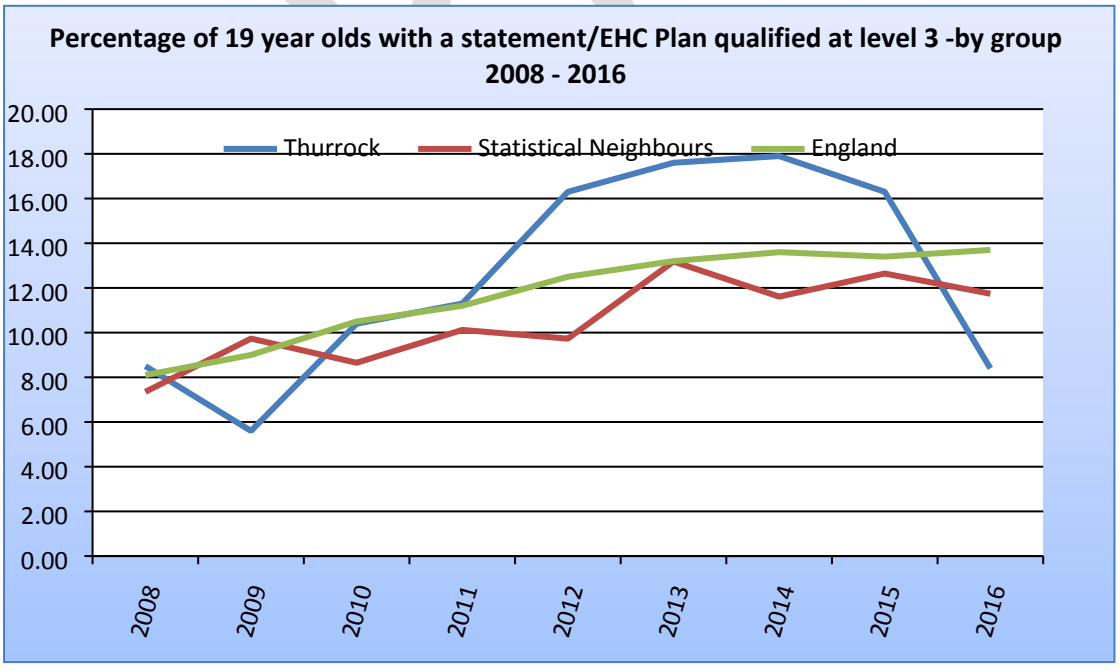
Figure 25 Percentage of 19 year olds qualified to Level 3 by SEND group type, Spring 2017



Source- Department for Education, 2017

Figure 26 below shows the trend in the proportion of 19 year olds with a statement/EHC plan qualified at level 3. Across the years (2008 – 2015), a higher proportion of SEN pupil with a statement/EHC plan have been achieving level 3 qualifications than their counterparts in SNs and England which has slightly reduced in 2016.

Figure 26 Percentage of 19 year olds with a statement/EHC Plan qualified at level 3 - by group, 2008 - 2016



Source- Department for Education, 2017

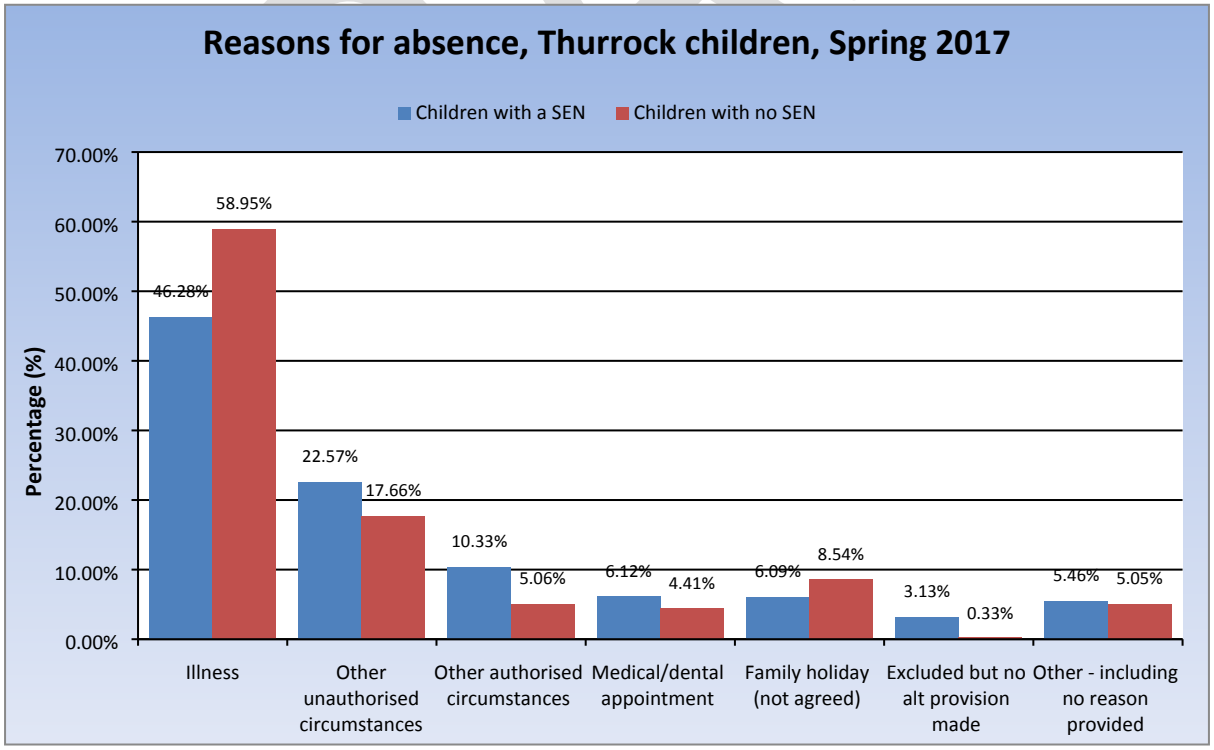
7.2 Absence and Exclusions

Across England, exclusion and absence rates are particularly high among children with SEND. In 2015/2016 the below summarise absence and exclusions in England:

- 7.7% of sessions were missed for pupils with statements or EHC plans when compared to 6.2% for pupils on SEN support and 4.2% for pupils without SEN.
- 22.6% of pupils with statements or EHC plans were persistent absentees when compared to 17.5% for pupils on SEN support and 8.8% for pupils without SEN
- Pupils with primary SEN type of Profound and Multiple Learning Difficulties were most likely to be absent from school in 2015/16, these pupils missed 14.0% of sessions.

Analysing the reasons given for absence in the Spring 2017 Census, it can be seen that the most common reason for absence for all Thurrock children is illness, which accounted for 56.4% of all absent sessions. However, looking at the reasons given by SEN compared to non-SEN pupils, it can be seen that children with SEN had a lower proportion of absences recorded for illness than non-SEN, but more for other unauthorised or authorised, and medical appointments. It is also notable that 3.13% of sessions missed by children with a SEN were because they were excluded but no alternative provision made available.

Figure 27 Reasons for absence, Thurrock children compared to Children with SEN, Spring 2017

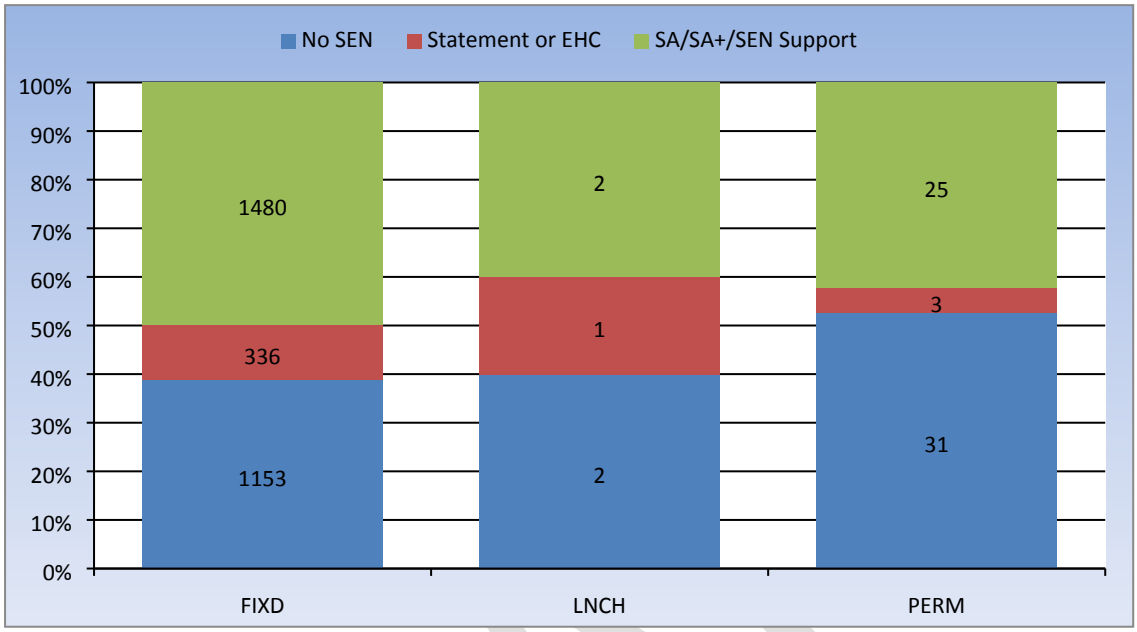


Source: Spring Census 2017

In Thurrock, between September 2013 and August 2016 there were 3,033 exclusions relating to 984 children. More than half of these (1,847; 61%) were to children with SEND (either

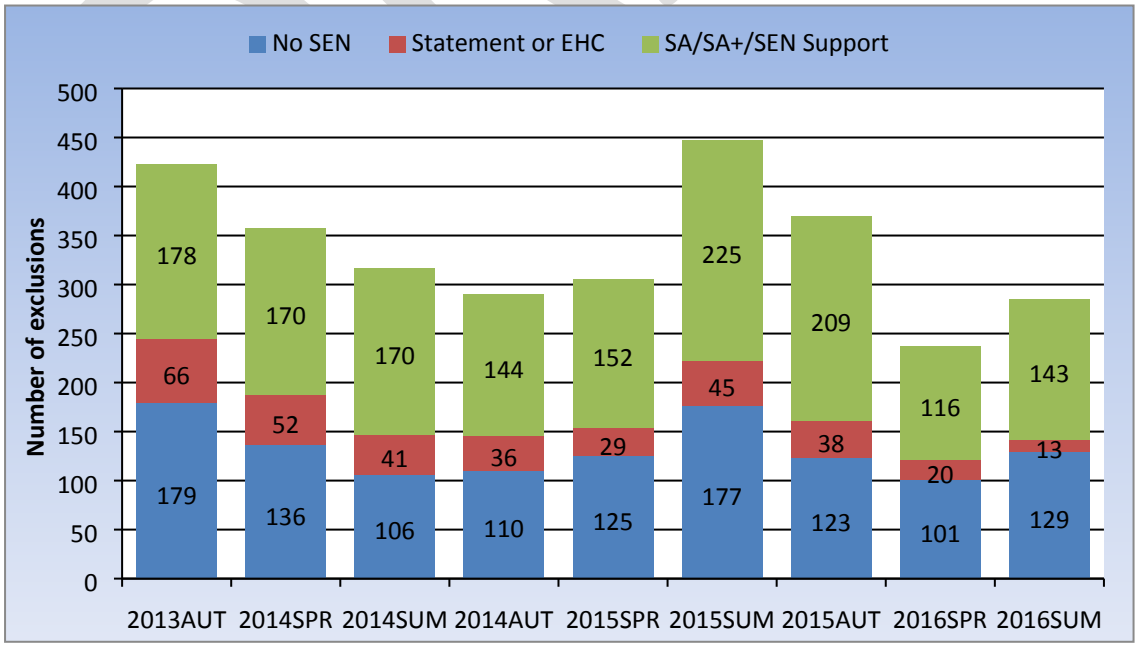
Statemented/EHCP or SA/SA+/SEN Support). The most common type of exclusion was Fixed Term, which accounted for 97.9% of exclusions seen.

Figure 28 Percentage of Exclusions by Type, 2017



Exclusions are recorded on every School Census return, and each term's data can be seen on the chart below Figure 29. There was a peak of 447 exclusions in the 2015 summer term but that this has halved to 237 by spring 2016. For all terms, the proportion of exclusions who were SEND was above the proportion who were not.

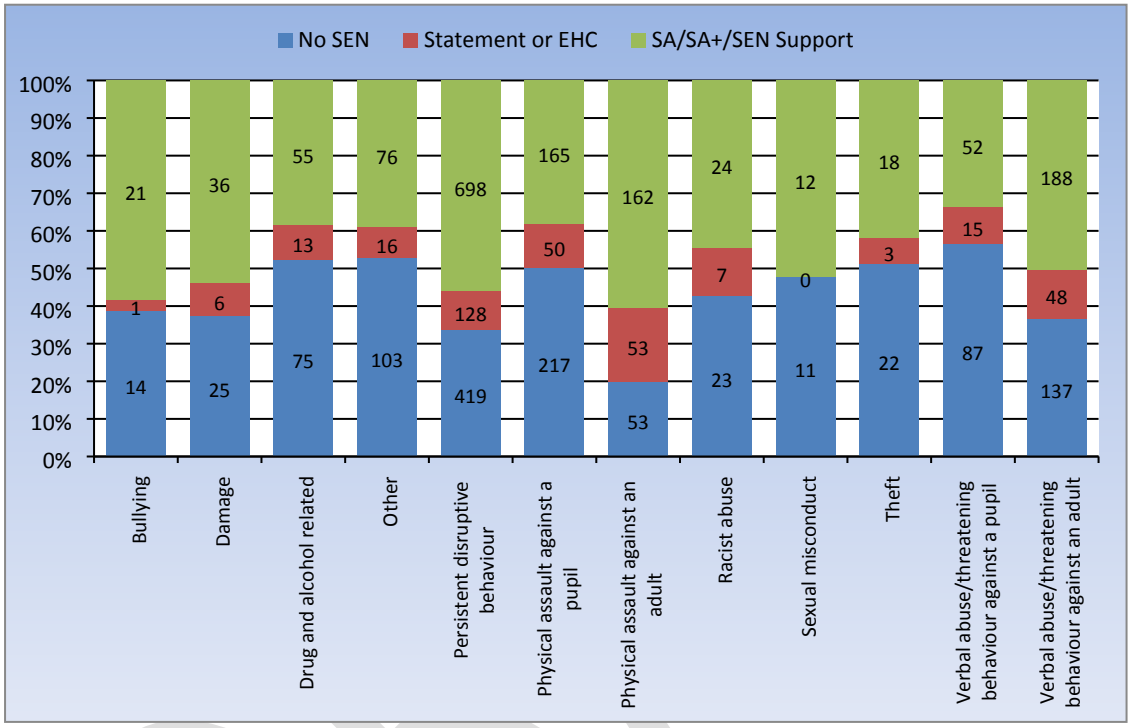
Figure 29: Number of exclusions by SEND group, 2013-2016



Source: ?????

Overall the most common reasons for exclusion were for Persistent Disruptive Behaviour (1,245 exclusions, or 41.1%), and Physical Assault against a pupil (432 exclusions, or 14.2%). When looking at the cohort excluded per category, SEND pupils made up 80.2% of those for Physical Assault against an Adult, 66.4% for Persistent Disruptive Behaviour and 63.3% of those for Verbal abuse/threatening behaviour against an adult.

Figure 30: Reasons for exclusion by SEND group, 2013-2016



Source: School Census, 2017

8 Children with SEND and Youth Offending

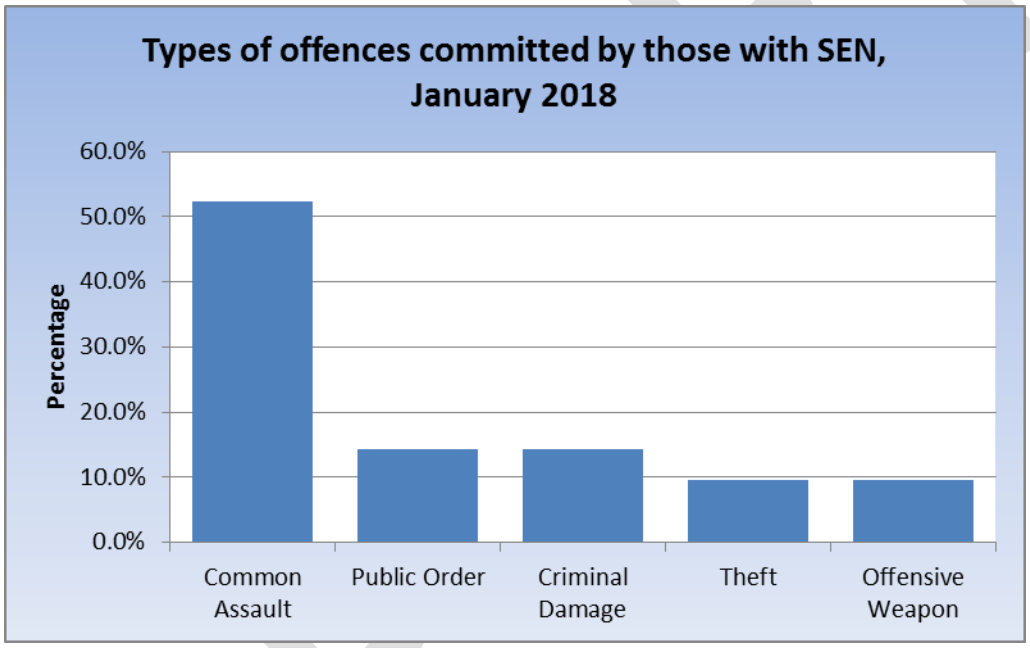
The Thurrock Youth Offending Service (YOS) looks after all young people subject to Court Orders (community and custody) and consequently under supervision to the YOS. (The caseload described below does not include young people subject to prevention interventions or out of Court disposals.)

At the point of analysis, 11 of the 54 cases on the YOS caseload had SEN recorded in their initial ASSET plus assessment (20%). Of these 11 cases, seven had Education, Care and Health plans (ECHP), two had Statements of special Educational Needs (SEN) and two had special needs identified but where not currently subject to an ECHP or SEN statement.

One key outcome measured by the YOS is the rate of reoffending 1 year post-conviction. Looking at all young people who offended in a six month period who are then tracked for a year, it was ascertained that 33% of them were identified as having special educational needs, which is proportionally higher than would be expected.

When considering the types of crimes committed by this cohort, it can be seen that the most prolific offence committed by young people with Special Educational Needs is common assault, followed by criminal damage and Public Order offences. The rate of common assaults committed by young people with special educational needs is higher than that of the general population, (52% as opposed to 39%) and the comparison is similar in respect of criminal damage and public offender order offences. It should be noted that these offences are often reactionary and directly linked to behaviour management, perhaps related to anxiety, frustration and communication problems. For example, although people with autism tend to be victims or witnesses to offences they can become involved in the criminal justice system due to changes or difficulties within the environment such as a change in the bus timetable which may lead them to become very anxious and distressed which in turns results in unintended aggressive behaviours (29). Nationally over 60% of CYP in the youth justice system have a speech, language and communication difficulty. A recent review suggests that the number of CYP with neurodevelopmental conditions such as dyslexia within the youth justice system is larger than the general youth population (30).

Figure 31 Types of offences committed by children with SEN, January 2018



Source: Thurrock Council Youth Offending Service, January 2018

9 Transition from children to adults services

Transition is seen as an important stage to consider for children with special educational need. Transition is a purposeful and planned process of supporting young people to move from children's to adult's services including health, education and social care services. There is a wealth of policy and guidance on agreed principles supporting good transitional care, but there is also evidence that these principles are often not reflected in practice allowing young people with on-going need to fall through the transition gap or disengage with services at this point. NICE asserts that outcomes of children due for transition become and remain unknown and are a serious cause for concern if

transition is not planned early enough (at school year 9; 13 – 14 years old) (31) . To support this, NICE published guidance to support with transition of children to adults services making a recommendation for co-production of transition plans, provision of a named worker to support from age 13 amongst others (31). Furthermore, the SEND Reforms outlined intentions to ensure that children and young people are better prepared for adulthood. This includes supporting them to develop ambitious and challenges goals for themselves as they become young adults, taking into account and respecting individual differences. In order to make transition into adulthood successful, and empowering young people to exert control and make choices in their lives, the 4 principle outcomes for 'preparing for adulthood' should be followed:-

1) Moving into paid employment and higher education
2) Living independantly
3) Having friends and relationships and being part of their local communities
4) Living as healthy lives as possible (32).

Continuation of EHC plans post-19 should be assessed on an individual basis and should not be discontinued based on chronological age alone.

In Thurrock, only the most complex children are assessed as eligible to receive Adult Social Care services and hence are eligible for a transition assessment. However, Section 36 of the Children and Families Act states that any young paged 19-25 years is entitled to request an EHC needs assessment excluding those who have had an assessment in the preceding 6 months (7). A decision should be made by the local authority within 6 weeks of the request and should take into account, whether the young person has SEND and/or whether special educational provision should be made to support the young person through continuing studies. Once an assessment has been undertaken the local authority need to determine whether an EHC is required and should consider whether the young person in question requires more time than peers without SEND to complete further education (32).

The table below shows the number of social care clients who were known to Adult Social Care from the age of 18, which is indicative of those who went through transition from Children's Social Care.

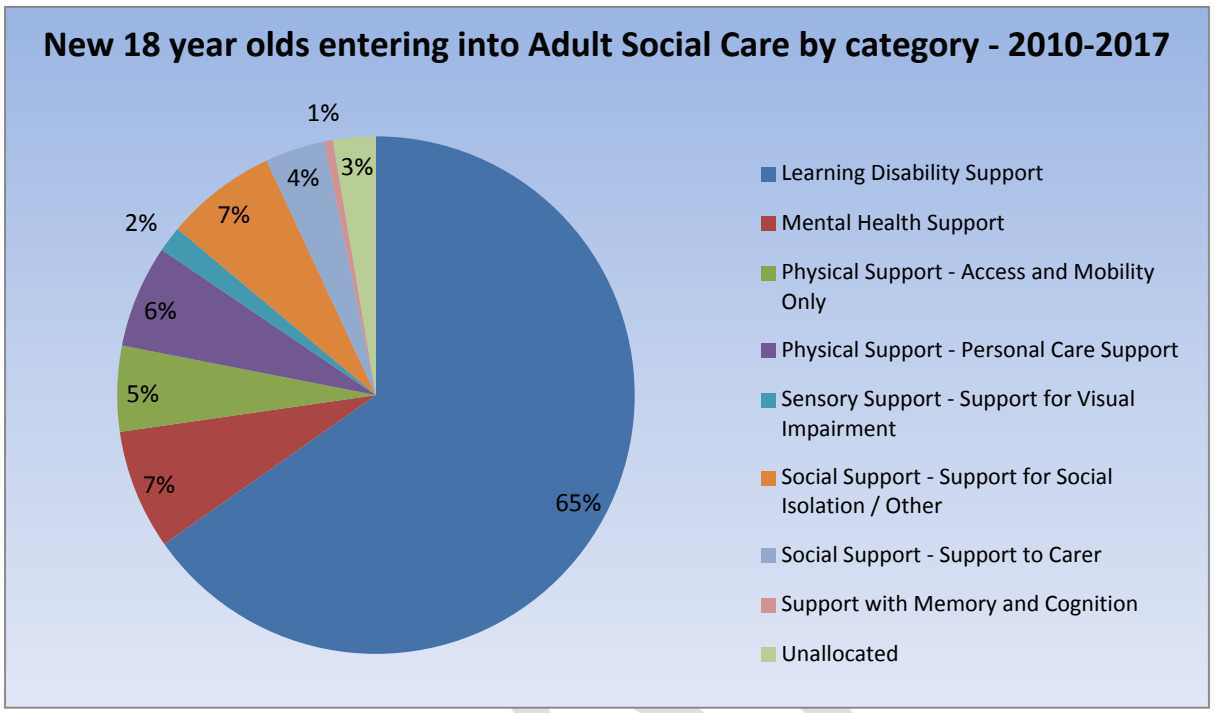
Table 3: Number of new 18 year olds known to Adult Social Care, 2010-2017

	2010	2011	2012	2013	2014	2015	2016	2017
Number of new 18 year olds	30	21	29	27	27	27	15	11

Source: Thurrock Council, 2018

The majority of 18 year olds coming through to Adult Social Care require Learning Disability support, with 65% of those over the last 7 years requiring this. The second most common reason for support is Mental Health. This can be seen in the figure below.

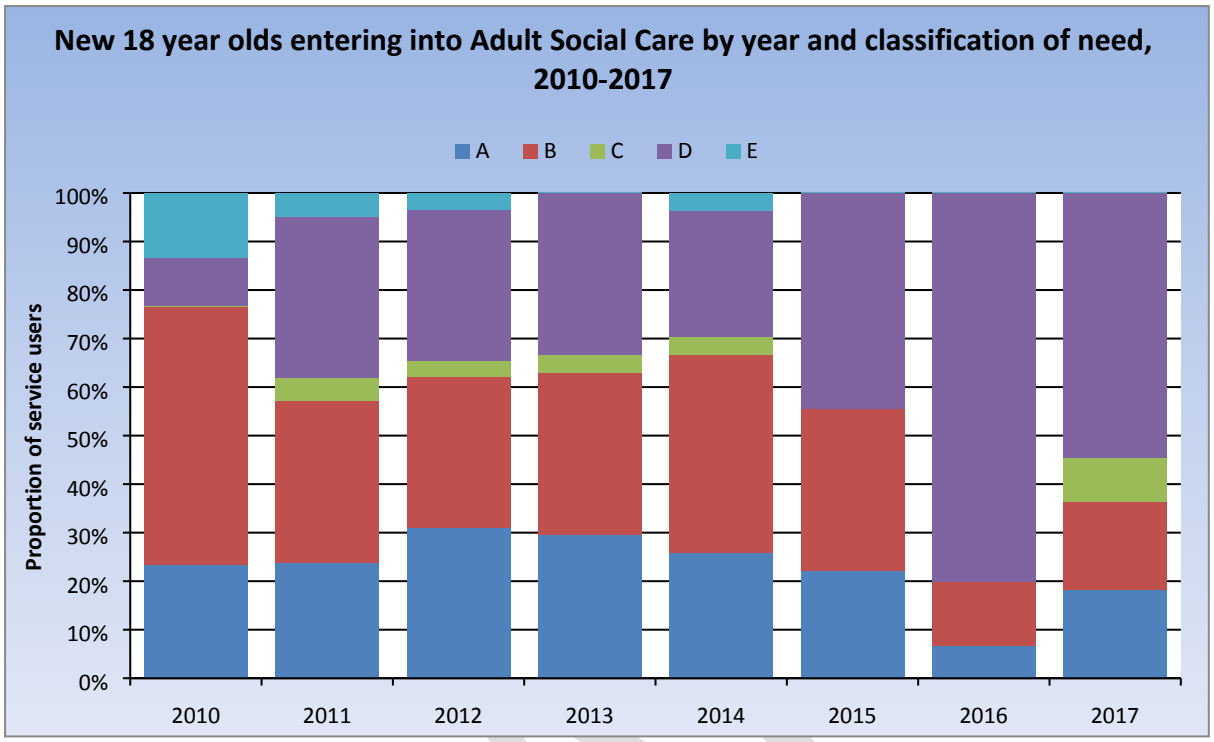
Figure 32 Category of need for new 18 year olds entering into Adult Social Care, 2010-17



Source: Thurrock Council, 2018

To get an indication of the complexity of these young people, internal work has been done to categorise them into one of five categories based on the type of support they are receiving. These are labelled A-E on the chart below (A indicates the most complex cases, E the least). Looking at the distribution over time, it can be seen that since the introduction of the Care Act in 2016 (33), there appears to have been a reduction in the proportion of cases in the most complex categories, and more particularly in category D – with 80% of cases in 2016 having this category assigned to them.

Figure 33 Classification of need for 18 year olds entering into Adult Social Care, 2010-17



Source: Thurrock Council, January 2018

It is clear data sources for SEND children are largely education based. Although some internal data has demonstrated knowledge of young people between the ages of 16 and 25 with SEND there are still gaps in our knowledge about the SEND population after they leave school. This is particularly true for young people without a formal EHC plan or statement in place and for young people past the age of 18 (i.e. once initial post-16 education or training has been completed).

After the age of 16, SEND data becomes more dispersed, as many young people start to attend colleges and training institutions rather than state-funded schools. Therefore, data on the post-16 SEND population is largely collated from a service-based perspective rather than a needs-based one, and we are less likely to know about the lower levels of need that are not being supported through formal statements or EHC plans. Furthermore, as young people begin the transition to adult services (or not), there is concern that their needs are being lost and potentially unmet from the perspective of young people's services and the 0–25 duty placed on local authorities by the Code of Practice. It is therefore recommended that a cross-cutting review on Preparing for Adulthood is undertaken to aid better understanding of need within this age-group.

10 What are we doing in Thurrock to support children and young people with SEND?

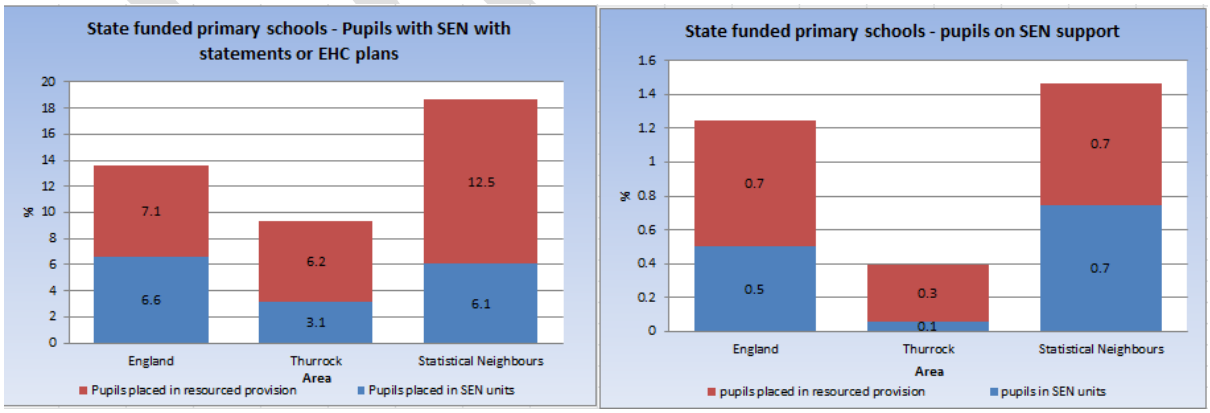
In accordance with the SEND Code of Practice (8), special educational provision should be matched to the child's identified SEND and unique need, which are generally thought of in the four broad areas of need and support which are: communication and interaction, cognition and learning, social, emotional and mental health, and sensory and/or physical need. However, individual children often have needs that cut across all four broad areas of need and their needs may change over time. It is recommended that special educational provision made for a child should always be based on an understanding of their individual strengths and needs and should seek to address them all appropriately.

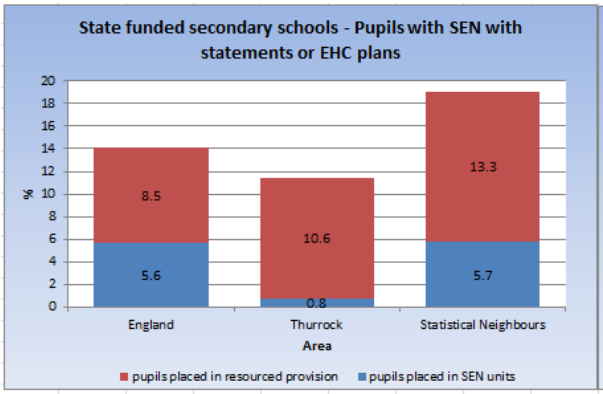
In 2017, Thurrock had lower proportions of its primary and secondary aged pupils with Statement/EHC plans and on SEN support placed in SEN units. There was 0.8% of Thurrock's secondary-aged pupils with Statements/EHC plans placed in SEN units which is 7 times less nationally (5.6%) and in the SN group (5.7%). It is worth noting that mainstream bases have been developed as a key component of the SEN work across the Authority. In other words the data supporting this work needs to be interpreted with caution due to the way data is collated and recorded.

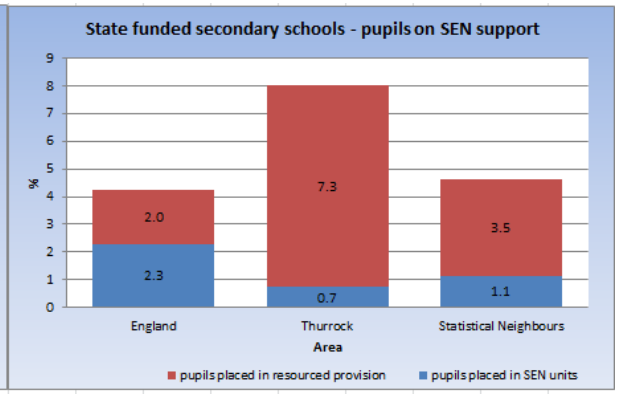
The total proportion of pupils attending SEN units and placed in resourced provision was lower, in both groups of Thurrock's primary aged pupils, than the national or SN averages.

A greater proportion of Thurrock's secondary-aged pupils with SEN support were placed in resourced provision than nationally or in the SN group (7.3% compared to 2.0% and 3.5% respectively). The total proportion of secondary-aged pupils with SEN support placed in either SEN units or resourced provision was higher than both national and SN averages.

Figure 34 Percentage of pupils with SEN placed in resourced provision, Spring 2017







10.1 Local offer

A key element of the SEND Code of Practice (8) is the provision of a local offer. The local offer aims to provide clear, comprehensive and accessible information about what services and provisions are available in Thurrock for children, young people and their families. It is collated centrally, showing information about services, support and activities for all children and young people with SEND from early years to transition into adulthood.

In Thurrock, all information regarding provision across education, health and social care for children and young people with SEND can be found in the Ask Thurrock online directory (a written version is also available for children and families who prefer this version). This includes both regional and national specialist provision.

Although the local offer does include information about all the areas specified in the SEND regulations 2014, it has been acknowledged that the information could be displayed in a way which is easier to use and more accessible to families. As such, a website refresh is ongoing with input from professionals, parents and relevant stakeholders.

10.1.1Early Years Support - Brighter Futures

Early years are a crucial stage for early intervention and family support. Children and their families have access to universal and preventative services in Thurrock through the Brighter Futures offer, including health provision, children's centres and Early Help services as well as through the third sector.

The Brighter Futures offer is an integrated and re-designed offer to support children, young people and their families under a single identity. Brighter Futures brings together all of Thurrock Council's universal and targeted prevention services for children and young people (ages 0 – 19). Core elements of Brighter Futures include:

- **Brighter Futures Children's Centres**: Children's Centres focus on improving outcomes in four main areas, namely child development and school readiness, parenting, parent aspirations and health and well-being.
- **Brighter Futures Healthy Families**: includes, among other things, Health Visitors who give advice and guidance to all new parents in Thurrock, and School Nurses who work to keep children healthy in schools;

- **Brighter Futures Prevention and Support Service**: provides targeted and Early help to families which have specific needs encompassing issues such as parenting support, domestic abuse, sexual violence and Troubled Families, who focus on accessing education, worklessness, ASB, Crime prevention, parental physical and mental health .Other targeted prevention services are available to families identified as needing them which includes support to Young Carers and short breaks for disabled children.

10.1.3 Preschool Support Services

The Early Years Team is a group of professionals that work together to provide a range of offers to children 0 – 5 years with SEND including language and communication difficulties, learning difficulties, physical and/or sensory impairment, difficulties affecting behaviour, severe and complex disabilities and children who have experienced disadvantage in their early years. Support should be given to Early Years and Pre-School providers who have lower identification rates to ensure early identification of SEND and to enable development of a care and support plan early on that can be carried forward, and amended as needed, as children progress through to school and then adulthood.

10.1.4 Portage and Early Support Service

Portage is a home visiting educational service operating out of Treetops school for preschool children (under 4 years old) with SEND and their families. It is offered as an early intervention service, supporting parents of children with SEND both at home and with support activities hosted through the two outstanding special schools. Eligible children are assessed as having a significant delay in two or more areas of their development through the EYFS assessment. The team is made up of specialist child development advisers who visit children and families in their own homes, helping them to learn new skills through play and giving them support and advice. Each child has a named adviser.The family receives regular weekly visits from a trained Portage home visitor, who will often link and undertake joint visits with other professionals, e.g. physiotherapists, speech and language therapists etc… to assess and provide needed support. Portage also supports the child's move from home into nursery/pre-school through a transition process.

The Early Support Programme also involves staff from both special schools in Thurrock and supports the identification and co-ordination of support for children with SEND and their parents. There are additional support services for pre-school children with Speech and Language difficulties through the ICAN Nursery at Harris Primary Academy and additional designated SEND nursery places at Stanford Le Hope Nursery. However, a significant number of pre-school children with SEND are supported in mainstream pre-school settings with additional support in place to meet their identified need.

10.2 School Age Support

Specialist education can take place in a number of mainstream schools or within special schools or units available for children with greater needs.

10.2.1 Special Schools

Thurrock has two special schools, both of which are rated as 'outstanding' and have strong regional and national reputations for their expertise in the education of pupils with particular SEND. Both special schools also provide a range of outreach services to support mainstream schools in meeting the needs of children and young people with SEND.

Treetops School is for pupils aged 3-19 with autism and/or moderate learning difficulties. There has been an exceptionally high demand for places in Treetops school for children with autism whose parents wish to access the Applied Behavioural Analysis /Verbal Behaviour department in the school. Treetop's ideology is one in which staff hold high expectations for pupil achievement regardless of SEND needs and level of disability. The curriculum on offer is innovative and personalised to the individual learning needs of each pupil with an emphasis on development of communication and personal and social skills. Specialist support that the school will offer as needed include:-

- Small groups to target things such as literacy and numeracy.
- In-class support across the curriculum.
- Social skills groups.
- Behaviour, emotional, social development projects; or support with homework.
- Staff training in communication includes Singalong and Elklan Speech and Language programmes.
- Staff are trained to manage health needs including epilepsy and the administration of Buccal Midazolam, gastronomy feeding and use of epipens.
- Specialist Sensory and Communication team, including 3 full time Speech and Language therapists and a part-time assistant.
- Health based teams within the school who offer physiotherapy, occupational therapy and nursing team.
- Access to and regular visits from Educational Psychologists (34).

Beacon Hill Academy is for pupils aged 2-19 with severe and complex learning difficulties. The school has experienced a significant change in the complexity and severity of needs of the pupil population. There is a significant increase in the number of children who have very complex health needs requiring a high level of nursing care, and exceptional vulnerability. Like Treetops Beacon Hill Academy has am ideology and motto that aspires to support pupils to full potential - 'Achievement knows no boundaries.'

Beacon Hill Academy is commissioned to offer outreach services to all schools across Thurrock to support pupils with physical, severe or complex learning disabilities. Additionally, Beacon Hill Academy is a qualified teaching school for both the Thurrock Teaching School Alliance and Dilkes Teaching Schools Alliance. As such they are able to offer bespoke training to other schools including communication skills training; Singalong, Intensive Interaction and Elklan. Furthermore, Beacon Hill Academy works closely with partners in Health and Social Care, and are a 'Trailblazer school' for the Royal Opera House workshop and work closely with the Jack Petchey Foundation (35). There is a need for increased specialist support for children and young people with ASD.

10.2.2 Mainstream Schools/ Settings / Colleges

The majority of children and young people with SEND attend mainstream schools, settings and colleges. Mainstream schools have identified particular challenges on ensuring that there is good communication and contact between health services and schools in relation to planning support for children and young people's SEND. Additionally, it is recommended that sharing of good practice in terms of SEN support is strengthened across the borough and that identification of individual school's training needs are addressed and enhanced. Improvements are also needed for EHCNAs in schools with high requests and waiting times. Furthermore, closer joint working practices between education and social care need to be established, particularly relating to EHCPs but also more generally via the LACs service. School's also need to be supported to boost parents/Carers confidence that they are able to sufficiently support children with SEND.

10.2.3 Special Educational Needs Coordinator

Every school and college in Thurrock should have a named Special Educational Needs Coordinator, who undertakes the statutory and non-statutory functions of the role. A SENCo's key strategic role is to ensure that children with special educational needs and disabilities within a school receive the support they need, by ensuring pupils with SEND are considered throughout the school. They achieve this by working to develop an inclusive ethos, analyse pupil's progress and co-ordinate liaison with parents and external agencies. In Thurrock and nationally there is a diminishing list of SENCo's across schools, and in the case of some mainstream schools this role is fulfilled by Inclusion Managers, who do not always have qualified teacher or SENCo status.

Thurrock commissions Resource Bases to meet a range of primary needs. Two of these resource bases are for pre-school children, 5 are for primary schools and four are secondary school resource bases which are located within mainstream schools across Thurrock for children with special educational needs.

Two mainstream colleges in Thurrock offer a specialist programme of learning and individual support arrangements for young people with SEND; Palmers and South Essex College (Thurrock Campus). Palmers have a team of communicators for students with hearing impairment as well as equipment and aids for some students with specific disabilities. There are a wide variety of strategies used within these colleges to support students with learning difficulties or disabilities. For example, South Essex College provides programmes and qualifications for learners with SEND. This programme is designed for students with severe learning difficulties which enable students to develop personal and social skills through a variety of modules.

10.3 Preparing for Adulthood

Thurrock aims to ensure that all young people transitioning into adulthood are able to access an appropriate education, employment or training route, which is considered to be a placement that supports the young person's aspirations and helps him or her to progress towards his or her adult destination - rather than providing participation and qualifications for their own sake. One recommendation of this JSNA would be to increase the number of businesses signed up to provide the MiNT programme, pending evaluation of this service.

10.4 Short Breaks for CYP and Families

One of the main reasons focussing on short break provision came from the Disabled Children's review in which highlighted the fact that children and their families viewed provision of reliable and regular short break as their biggest priority. This is echoed in the Aiming High for Disabled Children: Best Practice to Common Practice report (36). Furthermore, provision of short breaks acknowledges that parents, families and disabled children themselves require breaks to be able to cope and function as a family unit. It is a symbolic function of the short break programmes (37).

Additionally, the Children Act 1989 (38) contains Short Breaks Regulations which require local authorities to ensure the following are met (39);

- That short break provisions have regard to the needs of different types of carers, not just those who would be unable to continue to provide care without a break
- Provide a range of breaks, as appropriate, during the day, night, at weekends and during the school holidays
- Provide parents and carers with a short break service or duty statement detailing the range of available breaks and any eligibility criteria attached to them

The provision of short breaks has evolved since the Aiming High for Disabled Children review (40)and now encompasses a much wider range of support than out-of-home placement in specialist residential facilities. They also can vary in duration (from a few hours to several days), timing, and by funding (directly by local authorities or via direct payments or personal budgets) as well as a greater range of settings where short breaks can take place (41). The diversity in the short breaks offer as it has developed in terms of locations and activities/events provided are seen as valuable in being accessible, beneficial and meeting the needs of all children with SEND (37). Two of the main aims of short breaks are to provide fun activities that disabled children can participate in as well as offer a break in caring role for parents/carers and family.

Provision of short breaks should only be used if appropriate to meeting the needs of the child and family, be in the best interests of the child and take into account the child's and their family views and wishes and aim to safeguard their health and wellbeing. In order to support families t access short breaks there is a requirement of local authorities to ensure that assessment of need and careful planning of short breaks should be undertaken followed by continuous review of how short breaks are working/not working for individual children and their families (41).

Another important issue is ensuring that children are involved as much as possible in decision making relating to their lives and care. Feedback from children highlights the importance of including them in decision making relating to their care and in deciding whether short breaks will work for them. Children interviewed placed value on being involved in deciding who they attend short breaks with (need for a trusted adult), the types of activities they participate in. One of the children suggested that if children are asked for their opinion it might make adults between at what they do; including provision of services. Focus on treating children as experts in their own lives (41).

A systematic review of qualitative and quantitative literature assessing the impacts of short break provision for disabled children and their families concluded that short breaks consistently

demonstrate positive impacts on carers, their children and the family as a whole (42). Most beneficial short breaks are those that offer something/benefit all family members.

For disabled children short breaks provide social benefits in terms of making new friends as well as meeting up with friends that they perhaps don't see very often (perhaps due to going to different schools). Importantly provision of short breaks was also found to have raised expectations around disabled children being able to reach their full potential whilst also supporting families in their attempts to lead ordinary lives (37).

Parents potentially benefit from the opportunities to relax, spend time with their non-disabled children or for uninterrupted sleep. Parents have also reported improvements in the quality of their children's lives for example, being exposed to new experiences or receiving increased attention. Additionally such provision can support parents/carers to maintain employment. Employment is one of the most protective factors for mental health (43); it can support in terms of financial security, provide a break from caring responsibilities and for some families continuous monitoring of their child's health needs (37). Some parents feel that short breaks offer the opportunity for their child to participate in the same activities as their non-disabled peers.

For some parents it gives them space to 'themselves' or not to have to explain their child's behaviour all of the time as it can create opportunities to spend time with families in similar circumstances to themselves – peer support. Moreover, it can also provide them with time to spend with their non-disabled children as often parents are acutely aware that their attention is more focussed on their disabled child. This in turn can reduce stress and guilt associated with caring for a disabled child (37).

For siblings of disabled children evidence suggests that provision of short breaks are beneficial for these individuals also. For example, it provides opportunities for them to spend time with parents/ carers receive more attention, do activities that can't always do in the presence of disabled sibling e.g. Go on holiday. Although there is limited to no existing evidence of this, short breaks may also provide a break from caring responsibilities for sibling. Some Short break activities also give the opportunity for siblings to interact with their disabled sibling in a different context that is away from home and where they might meet other people in similar situations to themselves (37).

Furthermore, evidence was found among a report of 17 local authorities that the provision of short breaks as a preventative service has led to a reduction in the number of disabled children and young people becoming 'looked after'. This report elaborated on the potential cost savings identified to be around £1,851,550 for 22 children within case studies (scenario 1). Among the seven areas explored, identification of 35 disabled children who were prevented from entering care led to estimated savings between £1,820,000 and £7,000,000 (depending on the possible placement – family versus residential out of borough – scenario 2) (44)

The table below highlights potential savings for Thurrock, which are modelled on the two scenarios outlined above using data for Thurrock, in terms of the number of LAC with SEN in borough, as outlined earlier in this report (66 in total – Spring Census 2017).

Table 4: Potential savings to NHS and wider society in Thurrock if LAC with SEN are prevented from entering the care system.

	Scenario 1 based on evidence which explored identification of **22** disabled children who were prevented from entering care leading to an estimated savings of **£1,851,550**		**Scenario 2** based on evidence which explored identification of **35** disabled children who were prevented from entering care leading to an estimated savings of between **£1,820,000 and £7,000,000**	
	option A	**Potential total savings**	Option B	**Potential total savings**
No of SEN prevented from entering care as a fraction of all LAC with SEN in Thurrock	66	£5,554,650	66	£3,432,000 to £13,200,000 (depending on placement type
If Half of children with SEND is prevented from going into care	33	£2,777,325	33	£1,716,000 to £6,600,000 (depending on placement type)
If one thrid of children with SEND is prevented from going into care	22	£1,851,550	22	£1,144,000 to £4,400,000

It is worth noting that the calculated savings were based on average costs per LAC, although it is recognised that different children will have different levels of need and therefore, will cost children's social care, the NHS and wider society different amounts of money for their care.

It should also be noted that it is inevitable that some children will enter care due to the complexity of their disabilities which for some may require specialist support. Due to their high level of need support within the care system may represent the safest option in terms of supporting these individuals health and wellbeing and overall quality of life.

There is a range of respite or short break offer for children and young people with disabilities, aged up to 18 years-old, and their families in Thurrock. Detailed information on what is on offer for children, young people and their families can be found within the Short Break Duty Statement (**when this is published**). In summary the following short break offer is available for children, young people and their families in Thurrock;

1) Short Breaks available without a Social Work Assessment but with a Common Assessment:-

   a) Befriending Groups.
   b) Sunshine Centre- After School Clubs, weekend clubs and holiday clubs
   c) Hannah's Place- Afterschool clubs, weekend clubs and holiday clubs.

d) Summer Play-scheme

2) Short Breaks and Support that require additional Social Work assessments and referrals:-

a) Individual Day Time Care and support that is regular and frequent.
b) Support from specially trained support staff for a short length of time to help families support their child to achieve a special target such as being able to sleep better, behavior management strategies.
c) Overnight stays in a residential provision especially designed for children and young people with disabilities or complex health needs.
d) Overnight stays in child's home.
e) Shared Care (Care in another family home) during the day or at night.

The short break provision in Thurrock is due to be re-commissioned and it is recommended that the commissioning process and decision is informed by this JSNA using evidence on what works found in Appendix 1. Some further considerations when re-designing the short break provision include:-

- Ensuring that transport is integrated within the short breaks offer to remove barrier relating to accessibility for children and their families.
- There is a need for enhanced availability of qualified staff to provide the different programmes within the short break offer. Parents that were interviewed have highlighted this as something that concerns them in relation to short breaks.
- There is a need for enhanced flexibility in the short break provision e.g to respond to changing circumstances and needs of individual children and their family.
- Ensuring that there is a shared and common understanding of what short breaks are between families/parents/carers and the local authority. To date it has been reported by parents that there is different understanding of short breaks between themselves and the local authority. For example, one local authority removed direct payments for a family who were using direct payments for laundry, which would otherwise overwhelm them due to their child's needs and would not allow time for respite, as that time would be spent undertaking the laundry themselves.

10.4 Information, Advice and Support Services (IASS)

Independent information, advice and support services (IASS) are provided in Thurrock by the Parent Advisory Team Thurrock (PATT), replacing the previous Parent Partnership Service. PATT provides information and advice to parents and Carers of children and young people with SEND aged 0 to 25 years-old, supporting families through:

- the education, health and care plan (EHCP) assessment process
- the conversion of educational statements into an EHCP
- the appeals process
- mediation and tribunal
- working with schools and other educational professionals, offering support with school exclusions

10.5 Health Services

Most of the Health offer for children and young people with SEND is delivered by the North East Foundation Trust under its community services offer. These include but are not limited to; Therapies Occupational Therapy and Physiotherapy.

10.5.1 Children and Adolescent Speech and Language Therapy (SALT)

This service is commissioned by the Thurrock Clinical Commissioning group and delivered by NELFT NHS Foundation Trust. The service provides specialist assessment, diagnosis, treatment and management of delays or disorders in the areas of speech, language and communication to children and young people up to the age of 16, or 19 with an EHCP

. The team works with parents, carers, early year's practitioners, schools and other healthcare professionals to create a supportive environment for the development of communication skills. The service supports children and young people who are displaying

- Language difficulties in understanding and using words or sentences
- Speech sound difficulties
- Difficulties with social communication and social interaction
- Language that needs to be supported using alternative or augmentative communication
- Stammering
- Language difficulties as part of hearing impairment

10.5.2 Children's Dieticians

This specialist service, which is delivered by NELFT NHS Foundation Trust, aims to improve the wellbeing of children with clinically related special dietary needs or nutrition problems. It provides high quality patient and family focused care, supporting and empowering patients, families and carers to take control of their condition/s; and in doing so facilitate improved general health, well-being and independence. The service implements, monitors and evaluates the outcome of dietetic therapies.

10.5.3Community Nursing Service

This service is part of an integrated specialist community children's nursing service comprising of community children's nurses, specialist health visitors and specialist school nurses, epilepsy nurse specialists, sickle cell and thalassemia nurse specialists and the pediatric diabetes nursing team.. This service provides nursing care to children and young people between the ages 0 to 19 years in the community (e.g. at home or school), and empowers parents and carers to self-manage their child's condition. The service supports the national directives for the delivery of care closer to home by reducing hospital admissions and attendance and includes various specialisms including: Oncology, Epilepsy, Macmillan, Respiratory.

This team comprises of children's nurses and nursery nurses. Some nurses have a special interest in particular conditions such as premature babies, children with cancer, asthma and cystic fibrosis, and children with complex needs. The aim is to help prevent children being

admitted to hospital and enable early discharge if admitted. This service also offer support groups as well as supporting clinics within the hospital, for example, cystic fibrosis clinics.

10.5.4 Specialist Health Visitors

The Specialist Health Visiting service provides consultation to children and young people up to the age of 19 years old 5 , and their families, on all aspects of disability. This includes: specialist advice on conditions; observation and assessment; early support / one planning for Educational Health Care Planning; intervention from a team of nursery nurses; coordination of service provision; provision of information on education, social care, benefits and related issues; delivery of Specialist Developmental Playgroups; continence assessments; and training in Epipen/ Anaphylaxis and Epilepsy. The Specialist Health Visitors work jointly with the Specialist School Nursing team and school staff in special schools, supporting their role in attending core groups and completing LAC reviews.

.

BTUH Acute Care and specialist commissioning via NHS England (GOSH and Evelina)

10.6 Community Teams

10.6.1 Children's physiotherapy

The children's physiotherapy service provides treatment for children with a wide variety of conditions ranging from arthritis, cystic fibrosis, and musculoskeletal conditions to cerebral palsy and other neuromuscular conditions.

The service sees children in a variety of settings including clinics, children's centres, nurseries, schools and their own homes. Physiotherapy for children uses play, activities and exercise to help children reach their full physical potential.

Innovative practice includes Ponseti treatment for children with talipes (club foot), provision of supportive LYCRA® garments and therapeutic trampolining

10.6.2 Community paediatrics

Community paediatricians work in the community and see children with neurodevelopmental conditions. Professionals within this service provide the following

- Neuro-disability clinics
- social and communication assessment clinics
- assessment and management of complex needs
- neurodevelopmental assessment of preterm babies
- urgent medical assessments for children who may have been abused and initial health assessments of children taken into the care of the local authority

- Advice on health concerns relating to safeguarding, adoption and fostering.
- Behaviour concerns in 5 -11year olds where neurodevelopment conditions such as Social Communication difficulties / Autistic Spectrum Disorder is strongly suspected.

10.6.3 Community children's nursing

The community children's nursing team in Thurrock provides nursing care to children at home or in a community setting such as their school.

We care for all children with an identified nursing need between the ages 0 to 19 years. A child's condition/needs may be short or long-term. For example, wound care, administration of antibiotics, or treatment for cancer.

Our community children's nursing team comprises trained children's nurses and nursery nurses. Some nurses have a special interest in particular conditions such as premature babies, children with cancer, asthma and cystic fibrosis, and children with complex needs.

We work closely with other professionals to help prevent children being admitted to hospital, to enable early discharge.

Our nursery nurse in the team provides food play, baby massage, distraction and play therapy and other support roles for children and families.

We are continuing to develop our nurse-led clinics and support groups. We offer a premature baby support group an asthma clinic in addition to supporting clinics within the hospital, for example, oncology and cystic fibrosis clinics.

This service is part of an integrated specialist community children's nursing service comprising of community children's nurses, specialist health visitors and specialist school nurses, epilepsy nurse specialists, sickle cell and thalassemia nurse specialists and the paediatric diabetes nursing team.

10.6.4 Children's feeding and swallowing

The children's feeding and swallowing team provides a coordinated multidisciplinary service for babies and children with feeding and swallowing difficulties. The offer is of high quality, personalised and responsive by delivering assessment, diagnosis, support and management to children with feeding and swallowing difficulties.

The team consist of;

- speech and language therapists
- paediatric dieticians
- paediatric occupational therapist
- a specialist children's nurse
- a dietetic assistant
- an administrative assistant

10.6.5 Child and adolescent speech and language therapy (SALT)

Talking point is a national organisation that provides parents/carers of with information that can help them to support their child's speech and language development/needs. It works with CYP and their families from birth to 17 years. (45). Information provided includes:

- A guide to the skills children develop between birth and 17 years.
- Concerns to look out for
- Where to go for help
- Useful organisations
- Books and DVDs.

In Thurrock there are a variety of support services that can support CYP and their families with speech and language needs. These include children's centres, early year's settings, schools (including specialist support in schools) and through the NHS's Children's Speech and Language service which is run by NELFT.

Additionally, there are training opportunities for parents/carers. One of the training avenues is via ***Signature*** website (46) where information on training can be found. Training centres run courses on:-

- British and Irish Sign Language
- Lipspeaking
- Deafblind
- Deaf and Deafblind awareness
- Communication Support.

Other training for parents/carers includes Chatterbox as outlined Children's Centres section below and Signalong. Signalong is a manual communication system that supports alongside spoken language. Signalong helps to support communication and language development and is available to parents/carers, nurseries, pre-schools and schools (47).

Aladdin's Cave at Beacon Hill Academy allows parent/carers, support workers and teachers to join and borrow items to support and promote children's development of language, communication and the senses. Items that can be borrowed include:-

- Bubble tubes
- Sound beams
- projection equipment
- portable ball pools
- musical instruments
- fibre optics
- switch accessible toys
- sensory kits
- story sacks (48).

Afasic is a UK charity that supports CYP who have speech, language and communication needs. ***Afasic*** runs a club for young people aged 11 to 19 years-old with speech and language impairments. It meets at the Downshall Centre in Seven Kings, Redbridge every Friday evening in term time from 7pm to 9:30pm (49). Although this appears to be a useful support network for children with speech and language needs, for those in Thurrock this club may be difficult to access in terms of the distance to travel, as Redbridge is in Surrey as well as the time that the club runs from and to.

Ask Thurrock is an online directory of organisations for young people and families. It includes listings for organisations that support CYP with SEND and their families (50).

The Dyspraxia Society is a national society that supports people living with Dyspraxia. Dyspraxia is classified as a condition which affects both basic motor skills such as walking as well as fine motor skills such as holding a pen for writing. ***The Essex Dyspraxia Foundation*** offers; a monthly newsletter, a telephone helpline, a monthly parent's group meeting and family social activities (51).

The National Autistic Society provides useful information for parents/Carers and teachers who support children with autism spectrum disorders. Information is provided in relation to communication and how individuals with autism may be supported in this area. (52).

Children's Centres (CC's)

The Children's centres across Thurrock offer a variety of activities that either directly or in-directly support children's speech and language development. The types of activities provided differ across the children's centres and seem to be tailored to local need (e.g. by ward) in terms of demographics etc…

Chatterbox – aimed at children aged 18-60 months. A Booktrust programme to support families to develop a love of stories, books and rhymes to help their children's early reading skills. This activity is provided at Stanford, Ockendon, Tilbury and Thameside CC's.

Speech and Language drop-in's - For ages 0 to 60 months. Speech and language therapists will be available to provide advice and support to families who feel their child might be experiencing some delay in their speech and language development. Available at Tilbury, Stanford, Aveley and Thameside CC's.

Let's Talk with your baby - For ages 0 to 12 months. A programme to promote positive adult-child interaction and communication skills, attachment, stimulation in a rich environment through interactive, fun activities. This programme is available at Purfleet, Thameside, Chadwell and Ockendon CC's.

Language Focussed Play Therapy - An evidence-based therapy for children with expressive or receptive language delay for children aged 24-60 months. This course is provided by referral only. Available at Aveley, Tilbury and Thameside (although not therapy based at Thameside) CC's.

English for Speakers of Other Languages (ESOL) conversation club - A club for parents and carers to develop their English speaking and listening skills with friends. Available at Purfleet and Tilbury CC's.

Play and Learn - For ages 24 months to 60 months. A 6-week programme for families to support their child's learning through play. The sessions also provide ideas on how to support children's learning at home. This course is available at Ockendon, Purfleet and Thameside CC's.

Bookstart Corner - For ages 18 months to 60 months. A Booktrust programme to support families to develop a love of stories, books and rhymes to help their children's early reading skills. This programme is available at Purfleet, Ockendon, Chadwell and Tilbury CC's.

Stay and Play (various themes including messy play, rhyme time, story sack fun, worlds of discovery, little ones, little explorers, garden fun, play 2gethr plus, play babies, toddler talk, language focused and story and rhyme time) - age ranges vary dependant on theme but are usually 0-24 months. Stay and play involves fun activities for parent and their infant. The sessions promote social skills and stimulation to support children's development. Sessions available at Thameside, Ockendon, Stanford, Aveley, Chadwell, Tilbury and Purfleet CC's (53).

The sunshine centre in Tilbury offers a variety of activities and designed to support disabled children and young people. Its main objective is to provide practical support for CYP and their families. The offer includes family drop in's, toddler group, specialist groups alongside a regular programme of activities.

Early Years settings

All early years services employ a SENCo and offer inclusive education for all. This includes settings such as school nurseries, pre-schools, play-groups and child-minders (54).

Schools

Primary

All primary schools in Thurrock offer ***Speech Link*** an online assessment tool designed by Speech and Language Therapists. It assists school staff (teachers and teaching assistants and SENCo's) to identify, understand and learn how to support children's speech and language difficulties.

All Reception aged pupils are assessed initially using the ***Infant Language Link programme***. Those identified as having speech and language difficulties will additionally be assessed using ***Speech Link*** For children who either join a school at a later age or who still continue to experience difficulties can be assessed using either the ***Infant Language programme*** (4-8 year olds) or the ***Junior Language Link programme*** (7-11 year olds) (55).

Signature also offer SpellSign which aims to bring British Sign Language (BSL) into primary school classrooms using characters and stories to support children to learn about BSL, as well as improve their communication skills and literacy. In addition to stories, courses can also utilise resources such as digital stories, activities and flashcards. To extend this learning to the home environment, parents/carers can also sign up to receive resources (56).

Secondary

Some secondary schools in Thurrock have begun to use the ***Secondary Language Link programme*** to assess older children who may be experiencing speech and language difficulties (55).

Support in schools can be provided via specialist provision in schools as well as the NHS Children's Speech and Language therapy (see sections below).

Specialist Speech and Language Therapies

Specialist speech and language therapies are available for children who have communication difficulties relating to:-

- Autism
- Complex Special Needs, learning disability or physical disability
- Hearing impairment
- Specific language disorder or stammer.

NHS Speech and Language service (NELFT)

The speech and language therapy service provides specialist assessment, diagnosis, treatment and management of communications for children and young people up to the age of 16, or 19 with an EHCP. The team works with parents, carers, early year's practitioners, schools and other healthcare professionals to create a supportive environment for the development of communication skills.

The service supports children and young people who are displaying:

- Language difficulties in understanding and using words or sentences
- Speech sound difficulties
- Difficulties with social communication and social interaction
- Language that needs to be supported using alternative or augmentative communication
- Stammering
- Language difficulties as part of hearing impairment
- Voice disorders

Children's occupational therapy

Children and young people who have a specific functional concern which significantly impacts on their daily living skills, and are out of keeping with their general developmental profile.

The service is for Children with developmental delay, neurological impairment and difficulty with motor skills affecting function.

11 Recommendations

The sections within this JSNA have outlined the needs of children and young people as well as explored what we are doing to support SEND children, young people and their families. The key findings from this report indicate several areas in which Thurrock in which understanding of the

needs and SEND provision can be improved. Based on these, the following recommendations have been made.

- **Making a strategic decision for greater collaboration between education, health and social care services, and CYP and their families**

    - There is a need for a strategy which pulls together work for children and young people. Brighter Futures strategy is a great avenue to reinforce collaborative work between partner agencies and families. It might also be worth exploring further the ongoing Children and Young People Integrated commissioning strategy.

    - Within Thurrock children's therapy services particularly Speech and Language Therapy are currently commissioned by the CCG, schools and the Local Authority. This implies there is some form of duplication of services and use of resources resulting in lack of economies of scale as well as a confusing pathway for service users. This analysis have identified a significant increase in the need for Speech and Language therapy with high numbers of autistic children and other forms of SEND likely to need SALT. Therefore, it is recommended that a review and deep dive of these services is completed to develop and better understand the need and explore joint commissioning opportunities between education, social care and health. This will ensure better use of resources and possibly result in reduction in cost across partner organisations as well as ensure coordinated care provided to children and their families.

    - Following the detailed service review, make a strategic decision to invest in interventions for speech, language and communication needs that are evidence-based where possible by Thurrock CCG and the Local authority. The type of intervention chosen will depend on the range of SLCN identified across the borough and within schools.

    - Following this JSNA, it will be of benefit to develop and consult on an overarching SEND Strategy which will provide a strategic vision towards provision of support for children in their early years, at school, college and work. This will ensure that children, young people and their families are enabled to fully achieve their potential and have happy, healthy and fulfilling lives. The strategy should be co-produced with partners identifying key priorities for SEND in the next couple of years. There must be definite action plans to support achievement and monitoring of the vision and identified themes set out within the strategy. It is suggested that priorities could include early identification of and support for children with SEND and ensuring children with SEND are making good progress and have good outcomes. Further work is required on boosting parent's confidence in mainstream schools being able to sufficiently meet the needs of CYP with SEND.

    - Following recommendations highlighted in the SEND Self-Assessment that was conducted ensure that CYP and their families are given a meaningful voice in decision making, service design and provision and evaluation of services, so that service provision truly reflects the services that local residents desire and that meets their needs.

- **Continue to improve SEND operational areas of work**

    - The Local Offer is an essential part of the services available to SEND children and their families. It will be worthwhile to continue developing and improving the Local Offer, most importantly working to develop a better an enhanced comprehensive process of feedback and consulting with children, young people and their families. User feedback should be routinely collected and analysed to improve services and understand how effectively the local area meets the needs and improves the outcomes of children with SEND. This will ensure a robust and comprehensive offer in Thurrock; information is comprehensive, easily accessible and continuously updated. This is supported by the recognition by CaPa that despite parent participation in the SEND Strategic Group, more work is needed in terms of involving families in co-production during strategic planning activities and on deciding SEND services.
    - As part of the Local Offer, focus on re-commissioning of the short break provision offer in Thurrock, based on the evidence provided within this JSNA. Co-produce this element of the offer by consulting with CYP and their families to give them a voice, in decision making, service design and provision and evaluation of services, to truly provide services that local residents desire and that meet their needs.

    - Guidance in the code of practice recommended that all children and young people with SEND on a School Action or Action Plus plan be converted to SEN statements or EHPC plans by March, 2018. Thurrock is expected to ensure that 1,374 children are on an EHCP by 2018. The data within this JSNA identifies that 983 children are currently on a statement or EHC plan. An audit of case files of all children with SEND is recommended to ensure Thurrock is meeting this guideline. Consequently, if Thurrock has not transferred 1374 children to an EHC plan by March 2018, what actions need to be taken to achieve this and ensure all children with SEND are receiving the right support?

Further develop effective transition between education phases including preparing for adulthood pathways. Transition of children and young people with SEND to adult services must be refined in collaboration with Preparation for Adult services. It is unclear if all SEND children are assessed and prepared for a smooth transition to adulthood. This should incorporate higher education opportunities (16-25 years), employment and training prospects, social activity provision and increasing the offer in terms of independent living opportunities. In terms of employment this could be achieved by improving employer/businesses sign up and uptake in the MiNT programme once evaluation has been undertaken.

    - As recommended within the SEND Self-assessment conducted, improvements to EHCNA's in schools with high requests and waiting times should be sought.

    - Development of a School Wellbeing Service (SWS) should support and be the catalyst for reducing waiting times and demand on the EWMHS.

    - There is a need for increased specialist support for children and young people with ASD residing in the borough. Additionally, it would useful to develop a screening tool for use with CYP with SEN involved in the youth offending service (YOS).

- **Continue to improve local data collection**

    - Predicted increases in the number of children and young people with SEND included within this JSNA is an extremely simple estimate which is compounded by irregular CSC data and different data systems capturing different information and not matched to finance information. It will be useful to incorporate more robust projections to aid better understanding of need, ensure accurate spend as well as inform forward planning of children and health services for this cohort of children. To enhance this projection and accurately begin to estimate the number of children and young people with SEND further work is needed to begin to quantify the impact of the long term trend in the rising rates of SEND and some of the complexities that might arise. With increasing numbers of CYP with SEN who have an EHCP, a review of the thresholds for determining this should be undertaken, as figures suggest that the number of CYP with an EHCP's is the higher in Thurrock than the rest of the region, statistical neighbours and England as a whole.

    - The cost of provision as well as projected cost information has not been included within this JSNA and it is recommended that a dedicated piece of work is undertaken which is focused on synergies between finance and SEND data. For example adequate finance and activity data can be used to anticipate and plan for those children surviving longer with more complex needs. This can only be possible by ensuring information on finance and activity is improved. Further work needs to be done to produce an accurate SEND forecast through the Service Review board to provide a holistic and in-depth view. This can be supported by continuous monitoring of the demand and need for specific services, which will ensure that reducing budgets are used to invest in the right areas where need is highest.

12 References

1. **Department for Education.** *Special Educational Needs in England; 2017.* 2017.

2. —. *Special Educational Needs in England; 2014.* 2014.

3. **Ofsted.** *SEN Framework; 2010 Review.* 2010.

4. **Thurrock Council.** *Health and Wellbeing Strategy, 2016-2021.* 2016-2021.

5. **Pinney, A. - Council for Disabled Children and True Colours Trust.** *Understanding the needs of disabled children with complex needsor life-limiting conditions. What can we learn from national data? Exploratory Analysis.* 2017.

6. **Department of Children, Schools and Families.** *Designing for Disabled Children and Children with SEN; Guidance for Mainstream and Special Schools: Bulletin 102.* 2014.

7. **Government.** *The Children and Families Act.* 2014.

8. **Department for Health and Department for Health and Social Care.** *SEND Code of Practice - 0-25 Years.* 2015.

9. **Shaw, B. et al - John Rowntree Foundation.** *Special Educational Needs and their links to poverty.* 2016.

10. **Government.** *The Equality Act.* 2010.

11. **Department for Education.** *Special Educational Needs in England, SPR29, 2016.* 2016.

12. —. *SEND: Guide for Parents and Carers.* 2014.

13. —. *Children with Special Educational Needs and Disabilities (SEND).* 2018.

14. **Kent Independant Education Advice.** SEN Units. [Online] 2017. http://www.kentadvice.co.uk/special-education-needs/sen-units.html.

15. **Coventry City Council.** Coverntry's SEND Local Offer - Short Breaks. [Online] 2018. http://www.coventry.gov.uk/directory record/22660/short breaks.

16. **Thurrock Council.** *Thurrock Children and Young People JSNA.* 2017.

17. —. *A Sustainable Children's Social Care System for the future, Annual Report of the Director of Public Health, Thurrock.* 2017.

18. **Wilkin, A., Derrington, C., White, R., Martin, K., Foster,B., Kinder, K. & Rutt, S.** *Improving the Outcomes for Gypsy, Roma and Traveller Pupils: Final Report.* 2010.

19. *The Home-Education of children with special needs or disabilities in the UK: Views of parents from an online survey.* **Parsons, S. & Lewis, A.** 1, s.l. : International Journal of Inclusive Education, 2009, Vol. 14.

20. **National Fragile X Foundation.** Fragile X Syndrome. [Online] 2018. https://fragilex.org/learn/.

21. *Missed Diagnosis or misdiagnosis? Girls and women with austism spectrum disorder.* **Gould, J. & Ashton-Smith,J.** 1, s.l. : Good Autism Practice, 2011, Vol. 12.

22. **The National Autistic Society.** Gender and Autism. [Online] 2018. https://www.autism.org.uk/about/what-is/gender.aspx.

23. *Deprivation, Ethnicityand the prevalence of intellectual developmental disabilities. .* **Emerson, E.** s.l. : Journal of Epidemiology and Community Health, 2010.

24. **Department for Education.** *Statistics: Special Educational Needs (SEN).* 2010-2018.

25. **Parson, S., & Platt, P.** *Disability among young children's cognitive development in the early years.* s.l. : Department of Quantitative Social Science Working Paper no 14-15, London Institute of Education. University of London, 2013.

26. **Public Health England.** Public Health Profiles. *Public Health England Health Profiles.* [Online] 2016. https://fingertips.phe.org.uk/search/teenage%20pregnancy#page/0/gid/1/pat/6/par/E12000006/ati/102/are/E06000055 .

27. **MacKay, D.f. Smith, G.C.S, Dobbie, R., & Pell, J.P.** *Gestational age at delivery and Special Educational Need: Retrospective Cohort Study of 407,503 School Children.* 2010.

28. **Department of Children, Schools and Families.** *Breaking the link between Special Educational Needs and Low Attainment.* 2010.

29. **The National Autistic Society.** Criminal Justice: Why might autistic people become involved in the CJS? [Online] 2017. https://www.autism.org.uk/professionals/others/criminal-justice.aspx.

30. **Council for Disabled Children.** *Young Offenders with Special Educational Needs: a new legal framework.* 2014.

31. **NICE.** *Transition from Children's to Adults' Services for young people using health or social care services.* 2016.

32. **Department for Education.** SEND; 19-25 year olds' entitlement to EHC Plans. [Online] 2017. https://www.gov.uk/government/publications/send-19-to-25-year-olds-entitlement-to-ehc-plans/send-19-to-25-year-olds-entitlement-to-ehc-plans.

33. **Government.** *The Care Act.* 2016.

34. **Treetops School.** Local Offer. [Online] 2018. http://www.treetopsschool.org/local-offer.html.

35. **Beacon Hill Academy.** Beacon Hill Community Support. [Online] 2018. http://www.beaconhill.thurrock.sch.uk/community-support/.

36. **Department for Children, Schools and Families.** *Aiming Hgh for Disabled Children: Best Practice to Common Practice.* 2011.

37. **Langer, S., Collins, M., Welch, V., Wells, E., Hatton, C., Robertson, C. & Emerson, E.** *A Report on themes emerging from qualittative research into the impact of short break provisionon families with disabled children.* 2010.

38. **Department for Education.** *The Children Act - Short Break Regulations.* 1989.

39. —. *Short Breaks for Carers of disabled children.* 2011.

40. **HM Treasury and Department for Education and Skills.** *Aiming high for disabled children; better support for families.* 2007.

41. **Department for Children, Schools and Families & Department for Education.** *Statutory guidance on how to safeguard and promote the welfare of disabled children using short breaks.* 2010.

42. *The Impacts of short break provision on families with a disabled child: an international literature review/.* **Robertson, J., Hatton, C., Wells, E., Collins, M., Langer, S., Welch, V. & Emerson, E.** 4, s.l. : Health and Social Care in the Community, 2011, Vol. 19.

43. **Wadell, G.& Burton, A.K. for Department of Working Pensions.** *Is work good for your health and wellbeing?* 2006.

44. **Together for Disabled Children.** *Impact of the Short Programme on the prevention of disabled children entering the Looked after system.l.* 2011.

45. **Talking Point.** Speech and Language in Children. [Online] 2013. http://www.talkingpoint.org.uk/.

46. **Signature.** Welcome to Signature. [Online] 2018. https://www.signature.org.uk/index.php#.

47. **Thurrock Council.** Speech, Language and Communication Support - Training for Parents and Carers. [Online] 2018. https://www.thurrock.gov.uk/speech-language-and-communication-support/training-for-parents-and-carers.

48. —. Speech, Language and Communication Support - Specialist Local information. [Online] 2018. https://www.thurrock.gov.uk/speech-language-and-communication-support-at-school/specialist-local-information.

49. **Afasic.** Afasic - Voice for Life. [Online] 2018. https://www.afasic.org.uk/.

50. **Ask Thurrock.** Ask Thurrock - Young People and Families Directory. [Online] 2018. http://www.askthurrock.org.uk/kb5/thurrock/fis/home.page.

51. **The Dyspraxia Foundation.** Dyspraxia Foundation. [Online] 2018. https://dyspraxiafoundation.org.uk/.

52. **The National Autisitic Society.** National Autistic Society. [Online] 2018. https://www.autism.org.uk/.

53. **Thurrock Council.** Children's Centres. [Online] 2018. https://www.thurrock.gov.uk/childrens-centres.

54. —. Speech, Language and Communication Support - Pre-School Settings. [Online] 2018. https://www.thurrock.gov.uk/speech-language-and-communication-support-at-school/pre-school-support.

55. —. Speech, Language and Communication Support - School-aged Children. [Online] 2018. https://www.thurrock.gov.uk/speech-language-and-communication-support-at-school/school-aged-children.

56. **Signature.** Welcome to SignSpell. [Online] 2018. http://www.signspell.co.uk/?_ga=2.145187252.1602193614.1532678892-252969866.1532678892.

57. **Council for Disabled Children.** *Education, Health and Care Plans: Examples of good practice. .* 2017.

58. **Department for Education.** *Mapping user experience of the Education, Health and Care process: A Qualitative Study.* 2016.

59. **Council for Disabled Children.** *Securing good quality social care advice for Education, Health and Care (EHC) Plans.* 2017.

60. **Local Government and Social Care OMBUDSMAN.** *Education, Health and Care Plans: Our first 100 investigations.* 2017.

61. **Department for Education.** *'What Works:' Interventions for children and young people with speech, language and communication needs.* 2012.

62. **Royal College of Speech and Language Therapists.** *Resource Manual for Commissioning and Planning Services for SLCN.* 2009.

63. **NICE.** *Guidance CG170: Autism Spectrum Disorders in under 19s: Support and Management.* 2013.

64. —. *Guideline CG170 4-year surveillance- 2016 - Autism Spectrum Disorder in under 19s: Support and Management: Appendix A: Summary of new evidence.* 2013.

65. *Applied Behaviour Analytic Interventions for autism in early childhood; Meta-analysis, meta-regression and dose-response meta-analysis for multiple outcomes.* **Virues-Ortega, J.** s.l. : Clinical Psychology Review, 2010, Vol. 30.

66. *Effectiveness of the Picture Exchange Communication System (PECS) on communication and speech for children with autism spectrum disorders: a meta-analysis.* **Flippin, M. Reska, S & Watson, L.R.** s.l. : American Journal of Speech-Language Pathology, 2010, Vol. 19.

67. *A Review of the Efficacy of the Picture Exchange Communication System Intervention.* **Preston, D & Carter, M.** 10, s.l. : Journal of Autism and Developmental Disorders, 2009, Vol. 39.

68. **Lang, R., O'Reilly, M. & Healy, O et al.** *Sensory Integration Therapy for autism spectrum disorders: A systematic review.* 2012.

69. **NICE.** *Guidance CG72 - Attention Deficit Hyperactivity Disorder: Diagnosis and Management.* 2008.

70. *Parent Training Interventions for Attention Deficit Hyperactivity Disorder (ADHD) in children aged 5 to 18 years. .* **Zwi, M., Jones, H., Thorgaard, C et al.** s.l. : Cochrane Review, 2011.

71. *Nonpharmological interventions for ADHD: systematic review and meta-analyses of randomised controlled trials of dietary and psychological treatments.* **Sonuga-Barke, E.J., Brandeis, D., Cortese, S. et al.** 3, s.l. : American Journal of Psychiatry, 2013, Vol. 170.

12 Appendices

12.1 Appendix 1 – What works for Children and Young People with SEND - Evidence Review

Evidence of interventions that work for children and young people with SEND has been reviewed. It is expected that SEND professionals will refer to this to support their practice.

Education, Health and Care plans

The Council for Disabled Children have recently produced a document to support practitioners to write good quality Education Health and Care (EHC) plans (57). Some of the key features of high quality EHC plans have been listed below:

- Each special educational need is articulated separately to ensure that the correct provision of support can address and meet each child's holistic needs.
- Language describing the child or young person's health needs is simple and avoids jargon. Focus is on practical implications of health conditions or impairments on different areas of the child or young person's life
- When requesting social care advice, relevant information that has already been collected about the child or young person's social care needs and outcomes should be passed on to the social care professional providing the advice

- Joint outcomes across education, health and social care should be identified where appropriate and should relate to the child's aspirations

- When considering the special educational provision required by the child or the young person, the hours and activities need to be clearly outlined and related to the particular need and outcome they are intending to address.

- The required skills, qualifications and training for specialist education, health and social care provision need to be set out with a clear outline of when this will be made available and reviewed.

- The name and type of the school or other educational institution to be attended by the child or young person is clearly identified

- Where there is a Personal Budget, details of how it will support outcomes, the provision it will be used for and arrangements for any direct payments for education, health and social care should all be included.

A qualitative study published by the Department for Education (58) aimed to examine user satisfaction with the EHC process. Interviews were conducted with 77 parents and 15 young people with SEND as well as over 120 professionals from 4 local authorities.. Analysis found 10 factors which influence family satisfaction with their local EHC process:

- Accessible referral routes
- Holistic needs assessments driven by children, YP and families' needs and aspirations
- Suitable support to meet educational needs
- Consideration of longer-term ambitions and future implications
- Effectively actioned plans
- A monitoring and reviewing process in place
- Clear and transparent information
- Joined up working within and between the education, health and care sectors and families
- Parental and YP involvement
- Support (emotional, social and legal) provided to children, YP and families

There were several examples of issues being raised. For example, such as not having needs identified early enough, a lack of appropriate Health and Care input, plans not being SMART or outcome-focussed, panels overruling co-produced multi-agency needs assessments and also tensions around provision or placement issues.

Based on the research findings, the authors made several recommendations, including the following:

- User feedback should be routinely collected and analysed to improve services and understand how effectively the local area meets the needs and improves the outcomes of children with SEND. Local authorities need to consult with a wide range of families and not just the established parent forums.

- There is a need to draw up guidance on how best to effectively elicit and act upon the views of children and YP with SEND within the feedback process.

- Good practice for service delivery and feedback processes needs to be shared, as well as examples of innovative practice and ways to overcome barriers

Although the above findings may be applicable to Thurrock, the report recommended each authority to gather their own user feedback in order to identify their own priorities and this has been made clear for Thurrock within the recommendations.

Social care

In relation to social care advice for EHC plans, the Council for Disabled Children have identified the following key practices which need to be embedded throughout the process for EHC need assessments and planning (59):

1. **Clear thresholds for social care intervention-** The Local Threshold document should be clear on which children require statutory social care intervention, and there should also be a clear support pathway for those who do not.

2. **Professionals should ensure good communication with families about information that will be shared and with whom -** Children, young people and their families should be fully involved in evidence gathering, information sharing and decision making processes. The family should be made aware and asked for consent for information sharing.

3. **Quality assurance processes are in place to moderate the quality of social care advice and provide feedback to writers**

Issues and areas of good practice

The Local Government and Social Care Ombudsman recently produced a focus report 'EHC plans: our first 100 investigations' which identified common issues and complaints from families with the EHC process (60). The report highlighted that commons issues range from operational difficulties such as delays in issuing EHC plans within the recommended time limit to insufficient involvement of families in gathering evidence to inform EHC assessments. The report identified good practice themes to support councils. These include;

- Have a strategic plan for how the remaining transfers and new EHC requests will be managed giving priority to urgent cases and key transfer dates.
- Ensure high quality advice is obtained from professionals to inform EHC plans. Give professionals clear instructions about the advice required and that recommendations must be quantified and specified.
- Have a proper mechanism in place with NHS/CCG partners to address delays or problems receiving professional advice.
- Plan ahead for transfers – early discussion with families ahead of issuing the transfer notice can identify cases where significant changes in support are likely to be needed, or new assessments are required to inform the EHC plan
- Ensure social care needs are properly considered in every EHC assessment or transfer.
- Discuss possible education placements and their relative costs (including social care and transport) early, so families can make informed choices and have the opportunity to suggest alternatives.
- Consult possible education settings early to avoid unnecessary delay in reaching a decision
- Work closely with families throughout the EHC process and let families know if the council's views about needs or placement diverge from those of the family to avoid surprise conflicts.
- Ensure all involved in SEND are properly trained in the law

Interventions for children and young people with Speech, Language and Communication needs (SLCN)

A report from the Better Communication Research Programme drew together the relevant evidence about the effectiveness of interventions for children with speech, language and communication needs (SLCN) (61). Conclusions were drawn from a combination of a review of the research literature and qualitative interviews with experienced practitioners to investigate commonly used practices.

The review identified 57 interventions as being in use or published in literature. These were a mix of universal, targeted and specialist services. Only three interventions were found to have a strong level of evidence:

- Fast ForWord (although evidence was not in favour of the intervention)
- The Lidcombe Program (significantly positive outcomes for children who stammer)
- Milieu Teaching/Therapy (positive outcomes for early language learners)

Although the evidence was not strong for other interventions it does not necessarily indicate those interventions are ineffective. It simply implies that not enough is known about their effectiveness in supporting children with speech, language and communication difficulties.

The researchers noted that there have been too few large scale studies to draw firm conclusions about how services should be delivered. However, there were plenty of examples of individual techniques demonstrating positive impacts on outcomes which warrant larger studies to measure effectiveness, particularly in relation to the impact on the child's performance at school.

Speech and language therapy

Speech and Language Therapy (SLT) aims to identify the nature of the delay or disorder by assessing the pattern of the articulation and phonological template used by the child. Therapists will ascertain the effect any sound impairment will have on the individual's ability to access the curriculum and advise accordingly. The type of speech pattern will influence the type of intervention chosen.

The Royal College of Speech and Language Therapists (RCSLT) have produced several reports summarising the evidence of speech and language therapy in relation to various impairments and disabilities (including autism, learning disabilities and speech and language impairments) in order to inform service planning and commissioning for SLCN (62). Speech and language therapy has been found to be effective for children with a speech and language impairment, impacting on outcomes that extend beyond language gains to include social skills, peer relationships, self-confidence and literacy. Better outcomes are associated with earlier and more intensive therapy. Delivery has also been successful through the training of parents via speech and language therapists, but not for computer-based training.

There is also significant literature documenting the effectiveness of speech and language therapists providing training to professionals who work with individuals with learning disabilities. However, the methodological quality of most studies is poor.

Interventions for children and young people with Autistic Spectrum Disorder (ASD)

There are a range of communication-based, behavioural and educational approaches used to support people with autism to fulfil their potential. Children with ASD may have needs across all four broad areas of need and support. As for children with SEND, such interventions need to be adapted to the needs of the individual and monitored for impact.

Psychosocial interventions

NICE guidance for the support and management of ASD in under 19s recommends a specific social-communication intervention that includes play-based strategies with parents, carers and teachers to increase joint attention, engagement and reciprocal communication in the child or young person (63). This should include techniques of therapist modelling and video-interaction feedback.

A summary of more recent evidence suggests that other psychosocial interventions can result in targeted improvements in the core features of autism (joint attention, engagement and reciprocal communication) despite not being a specific social communication intervention. Randomised controlled trials have demonstrated effectiveness of Theory of Mind, comprehensive psychosocial interventions, parent training, social skills interventions (age 5 to 21), therapeutic horseback riding, music therapy, additional language instruction, and theatre-based interventions (64).

Verbal Behaviour Therapy and Applied Behaviour Analysis

Verbal Behaviour Therapy teaches communication using the principles of Applied Behaviour Analysis (ABA), motivating an individual to learn language by connecting words with their purpose.

A meta-analysis of ABA intervention trials for young children with autism found that long-term intervention leads to positive medium to large effects in terms of intellectual functioning, acquisition of daily living skills, social functioning and in particular language-related outcomes (IQ, receptive and expressive language, communication) (65).

Key features of this type of intervention include:

- Intensive intervention (20-40 weekly hours)
- Intervention is individualised and comprehensive targeting a wide range of skills
- Multiple behaviour analytic procedures are used to develop adaptive repertoires.
- Treatment is delivered in one-to-one format with gradual transition to group activities and natural contexts

The Picture Exchange Communication System (PECS) is a popular intervention based on ABA principles but unfortunately there is little evidence to support its efficacy. A meta-analysis of the intervention demonstrated small to moderate gains in communication but small to negative gains in speech (66). Another review indicates that there is preliminary evidence of a positive effect on social-communicative and challenging behaviours, but have requested more well-conducted RCTs (67).There is also insufficient evidence of effectiveness for sensory integration therapy for children with autism (68).

Speech and language therapy

A report by the RCSLT (62) concludes that speech and language therapy can be effective in improving communication which in turn has a positive impact on behaviour, social skills, peer relationships, and self-confidence. It also positively impacts on literacy, numeracy and skills for learning. A variety of different approaches were demonstrated to have a positive impact on social communication impairments and functioning, and as children with ASD may present in different ways and have varying profiles of skills and needs, it is therefore recommended that services should provide a range of interventions. This may include early intervention programmes (for pre-school children), computer-based interventions and therapists training family and staff involved in the care of those with ASD to deliver therapy.

Interventions for children and young people with social, emotional and mental health difficulties

Attention Deficit Hyperactivity Disorder

Current NICE Guidance (CG72) for the treatment of attention deficit hyperactivity disorder (ADHD) recommends parent-training/education programmes, which are also, recommended for parents/carers of children with conduct disorder. The main goals are to teach parents and carers to use behaviour therapy techniques with their child, with the aims of teaching the principles of child behaviour management, increase parental competence and confidence in raising children and to improve the parent/carer-child relationship by using good communication and positive attention to aid the child's development (69) Examples include the Webster–Stratton Incredible Years Programme and the Triple P (Positive Parenting Programme).

This recommendation is based on four small randomized controlled trials (RCTs) of psychological interventions (cognitive behavioural therapy (CBT) and social skills training) that resulted in parent-rated improvements in core symptoms of ADHD, social skills and self-efficacy. However, none of the teacher-rated scores were found to be statistically significant.

Two systematic reviews (70), (71) which have been conducted more recently indicate that parent and child training may benefit the parent but have little effect on reducing ADHD symptoms. Furthermore the included studies were of poor methodological quality, so conclusions about the effectiveness of these approaches cannot be fully drawn.

No evidence has been found for effective psychological interventions for young people aged 13 and over with ADHD, although it has been suggested that CBT and social skills training may still be applicable in adolescent years.

12.2 Appendix 2- SEN High Needs Review

Special provision funding was announced in March 2017. This fund aims to support local authorities to invest in provision for children and young people with SEN and disabilities aged 0-25 to improve the quality and range of provision available in the local authority. Thurrock is entitled to £1,071,283 over three years (2018 – 2021) and this is provided in addition to the basic need capital to support capital requirement for provision of new places or enhance existing facilities. Thurrock can invest this special provision capital in creating new (additional) places at good or outstanding provision or improve facilities or develop new facilities.

Premier has been recruited to effectively assess the need in line with the SEN High Needs criteria to identify how this fund will be effectively used to spport the need of children and young people

12.3 Appendix 3- Policy and Guidance

A range of policies and guidance support the local authority to exercise its statutory duty towards this children and young people with SEN and /or disability. These include;

Children and Families Act 2014 http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

Care Act 2014 - https://www.legislation.gov.uk/ukpga/**2014**/23/contents/en**act**ed

Education Act 1996 - https://www.legislation.gov.uk/ukpga/**1996**/56/contents

Equality Act 2010 - https://www.**legislation**.gov.uk/ukpga/**2010**/15/contents

Special Educational Needs and Disability Code of Practice: 0 to 25 Years (January 2015)

https://www.gov.uk/government/.../**sen**d-**code-of-practice**-0-to-25

Special Educational Needs (Personal Budgets) Regulations 2014

https://www.legislation.gov.uk/uksi/**2014**/1652/.../uksi_**2014**1652_en.pdf

Special Educational Needs and Disability Regulations 2014
https://www.legislation.gov.uk/uksi/**2014**/1530/.../uksi_**2014**1530_en.pdf

This page is intentionally left blank

Special Educational Needs and Disabilities

Joint Strategic Needs Assessment

Executive Summary

Elozona Umeh – Senior Public Health Programme Manager
Karen Balthasar- Public Health Graduate Trainee

Index

Summary of key findings and recommendations…… 2
Background…….... 4
National and regional policy context…… 6
Local Strategic Context – How many children and young people are with SEND ……. 7
Characteristics of children and young people with SEND ……. 8
Risk Factors …… 9
What works for children and young people with SEND?…….
How well are we doing in Thurrock?…… 11
CYP with SEND and Youth Offending
Transition from childhood to adulthood
What are we doing to support children and young people with SEND in Thurrock ……. ?
Acknowledgements…… 14

A copy of the full version of this report will be available on the Thurrock Council website at: thurrock.gov.uk/public-health-reports

Abbreviations

Abbreviation	Full form
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BF	Brighter Futures
CCG	Clinical Commissioning Group
CIPFA	Chartered Institute of Public Finance and Accountancy
CBT	Cognitive Behavioural Therapy
CYP	Children and Young People
EYFS	Early Years Foundation Stage
EHCP	Education Health and Care Plan
DfE	Department for Education
DLA	Disability Living Allowance
EWMHS	Emotional Wellbeing and Mental Health Service
GLD	Good level of development
JSNA	Joint Strategic Needs Assessment
MLD	Multiple Learning Disorder
NEET	Not in Employment Education or Training
NELFT	North East London Foundation Trust
ONS	Office for National Statistics
PHE	Public Health England
SEN	Special Educational Needs
SENCo	Special Educational Needs Coordinator
SEND	Special Educational Needs and Disabilities
YOS	Youth Offending Service

Summary of key findings and recommendations

Key Areas	Key Findings	Recommendation
What are the characteristics of CYP with SEND?	• The prevalence of SEND in Thurrock is rising in line with national rates. Thurrock expects a rise in the number of children with SEND from **3882** (2017**)** to **4619** and **5256** in 2024 and 2037 respectively. • SEND is more prevalent in males than females; more boys are likely to be on SEN support than girls. It is unclear why boys are more likely to have SEND than girls but some explanation include misdiagnosis in girls as a result of play styles e.g. autism potentially under-represented. However, some primary needs are more prevalent in girls; for example profound learning difficulties. • Thurrock has a higher proportion of pupils with Moderate Learning Difficulty, in its primary, secondary and special schools than the national and Statistical Neighbours proportions. ASD is the most common primary need within special schools. Moderate Learning Difficulty is the most common primary need in secondary schools, while This increase will likely impact on demand for special school provision. BK1	• Make a strategic decision for greater collaboration between the local authority, the CCG and schools. • Develop, implement and effectively monitor a SEND strategy with a clear vision, alongside themes and priorities informed by this JSNA and in consultation with children, young people and their families. • **Continue to improve local data** - To enhance this projection and accurately begin to estimate the number of children and young people with SEND. Predicted increases in the number of children and young people with SEND included within this JSNA is an extremely simple estimate which is compounded by irregular CSC data and different data systems It will be useful to incorporate more robust projections to aid better understanding of need, ensure accurate spend as well as inform forward planning of children and health services for this cohort of children.

Slide 3

BK1 What are you trying to say here? It seems like two sentences are being merged here?
Balthasar, Karen, 27/07/18

Summary of Key findings and recommendations

Key Area	Key Findings	Key Recommendation
How well are pupils in Thurrock performing?	• SEND pupils on a statement/EHC plan achieved better educational outcomes than their peers nationally and in comparator local authorities. This was noticed in early years (2017), Key Stage 2 (2016) and Key Stage 4 (2016). Good educational attainment was not observed in pupils without a statement. • The level of attainment at age 19 in Thurrock was below other areas for pupils who had a statement/EHC plan (2017). • More than half of exclusions between 2013 and 2016 were of children with SEND. • Children with SEN are less likely to remain in Education, Employment or Training than those with no identified SEN in which only 5% were NEET. However 9% of Statement/EHC pupils were NEET and 8% of SEN Support pupils in Thurrock were NEET, highlighting the poorer outcomes for these pupils	Further develop and improve SEND operational areas of work:- Continue to develop and improve Thurrock's Local Offer. This should be done in collaboration with children, young people, parents and carers. This includes ensuring personalisation of the service offer for families to improve choice and ensuring EHC plans are co-produced within recommended timelines. • A deep dive on SEND case files by the SEND team to explore whether transitional arrangements are being met according to guidance i.e. conversion of statement EHC plans as well as transition between services for example, children to adult services.. • Raise educational achievement of children and young people with SEND through early identification of need, appropriate intervention and effective monitoring of progress towards a challenging target.

Slide 4

BK2 perhaps needs re-wording as it is slightly confusing/misleading?
Balthasar, Karen, 27/07/18

Summary of Key findings and recommendations

Key Area	Key Findings	Key Recommendation
What are we doing for children young people with SEND and their families in Thurrock?	**There are a ranges of offers for children and young people with SEND and their families in Thurrock spanning different age-groups – ranging from pre-school and school age to transition from childhood into adulthood.** **Thurrock has two outstanding special schools which is quite sort after .** **Commissioning of offer in Thurrock is not as co-ordinated as it can be. The Integrated Commissioning Strategy for Children has been** **Short Break –** Evidence suggest that short breaks consistently demonstrate positive impacts on carers, their children and the family as a whole. Most beneficial short breaks are those that offer something/benefit all family members. We calculated potential savings that could be made following evidence to account for all (66), half (33) and a third (22) of LAC children with SEN being prevented from entering into the care system.	• A cross-cutting service review on transition from child to adult services to identify issues, challenges and areas of focus. • Invest in more sufficiently tailored short-break provision as part of a preventative service offer. Evidence suggests that personalised short-break provision has been effective in supporting children, young people and their families. • Develop a joint commissioning approach for SEND with a primary focus on therapies to address the increased demand. More specifically, an exercise to benchmark the Speech and Language Therapy provision against national guidance should be undertaken, alongside exploration of the current provision and a health equity audit.

Background

In 2014, the Government introduced wide-reaching changes to the SEND system, with the intention of offering simpler, improved and consistent help for children and young people with SEND.

Local areas were tasked with implementing most of these changes by the end of March 2018. This JSNA will hopefully look at what impact these changes are having different by Local Authority. In Thurrock,

Children and young people aged 0 - 25 make **34.1% (56,959)** of the population of Thurrock. The child population aged 0 – 25 in Thurrock has been on the rise in the last decade (10.6% from 2007) which is double the rate of increase in England (5.9%). This trend is expected to continue over the next decade.

There are **3,882 (13.97%)** children and young on the school roll with SEND. Of those children with SEND **2899 (10.4%)** qualify for SEN support and **983 (3.5%)** are on an Education, Health and Care Plan (EHC – Plan).

Purpose and Scope

This needs assessment is part of a response to the key changes to the SEND practice as well as in support of the joint SEND inspections. It considers the characteristics of children with SEND and presents comprehensive data and evidence on what we currently know about SEND in Thurrock.

Furthermore, this JSNA fulfils the following objectives

- Understand the health and wellbeing needs of children with SEND and/or disability;
- Understanding the current demand for services and project future need where possible;
- Provide an evidence base to inform service planning, commissioning processes and be a source of information for SEND;
- Make recommendations to improve provision and delivery

This needs assessment is intended to contribute to creating 'Opportunities for All' in Thurrock by assessing the strength of local arrangements for SEND need and provision through three broad strands.

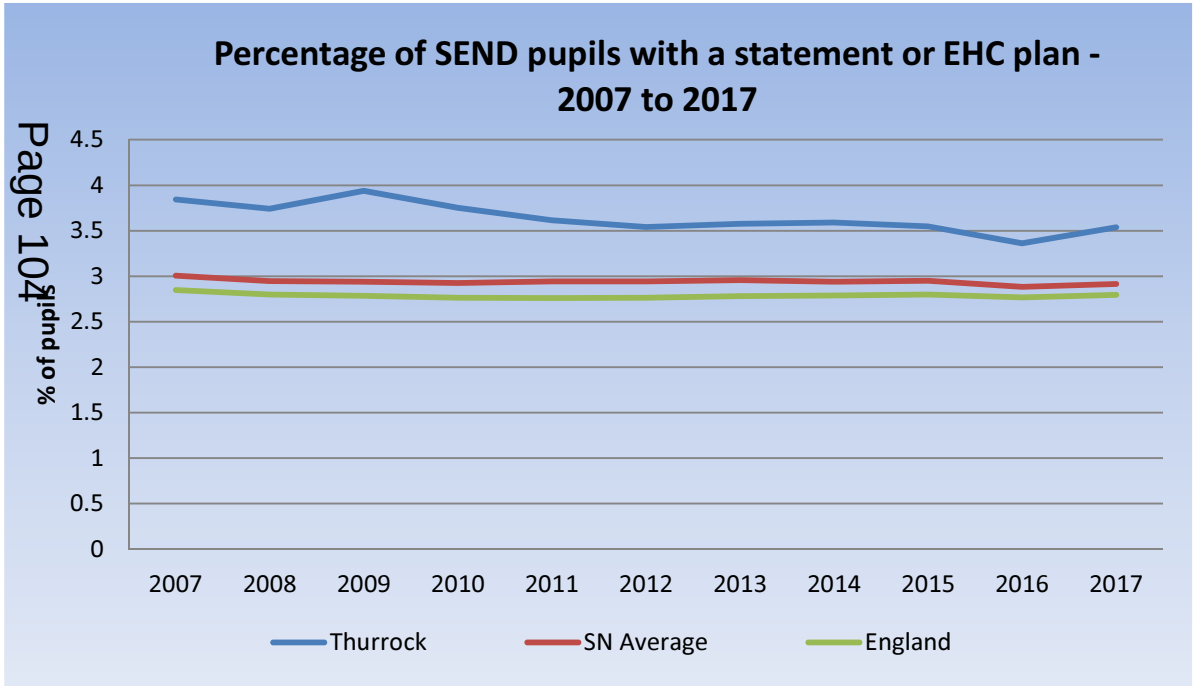
- Systems to identify need – what we know about children and young people with SEND?
- Assessing and meeting needs – what we are doing to supporting children and young people with SEND?
- Outcomes achieved – have our children and young people with SEND achieved their greatest potential?

National and Regional Policy Context

- In 2017 there were 1.24 million children living in England who had SEND, which accounts for nearly a ¼ of all children.
- Evidence suggests that 73,000 children of school age have complex needs made up of the following:-
  - 10,9000 children with profound and multiple learning difficulties.
  - 32,300 children with severe learning difficulties.
  - 27,5000 children with ASD
  - 2,300 children with multi-sensory impairments.

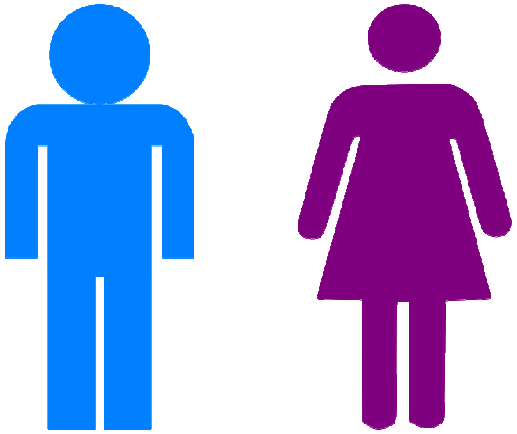
Local Strategic Context – How many children and Young People are living with SEND?

Figure 1. Percentage of SEND pupils with a statement or EHC plan

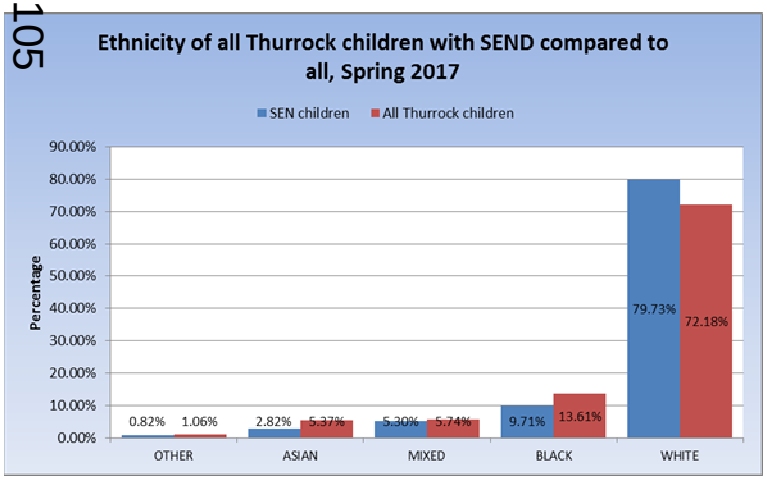


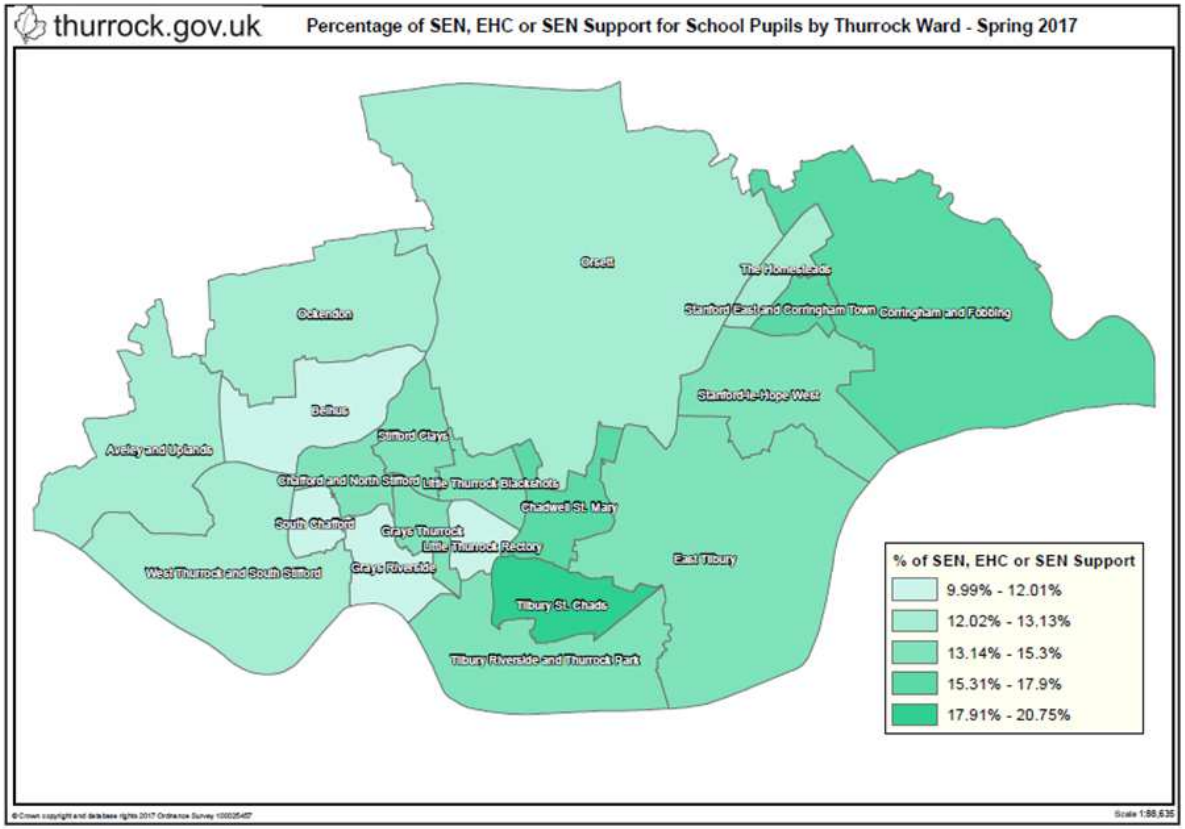
- The prevalence of SEND in Thurrock is rising in line with national rates. Thurrock expects a rise in the number of children with SEND from **3882** (2017**)** to **4619** and **5256** in 2024 and 2037 respectively.
- Thurrock has had a higher proportion of pupils supported through a statement or EHC plan over the last decade than the SN and England averages.
- The largest decrease when viewed as a proportion of pupils can be seen between 2015 and 2016 (17.5% decrease). This coincided with the SEND reforms which might in part explain this finding.
- The number of children with SEND but without a Statement has decreased over time, from a peak of 5,054 in 2010 to **2,899** in 2017
- The proportion of pupils with Statements/EHC plans or SEN Support is comparable with other areas.

Characteristics of Children and Young People with SEND.

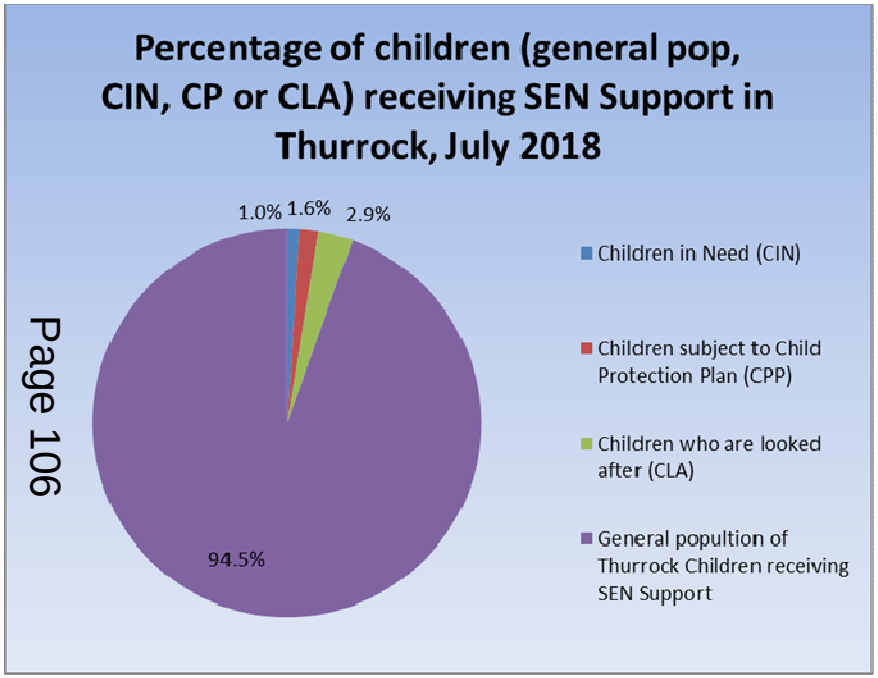


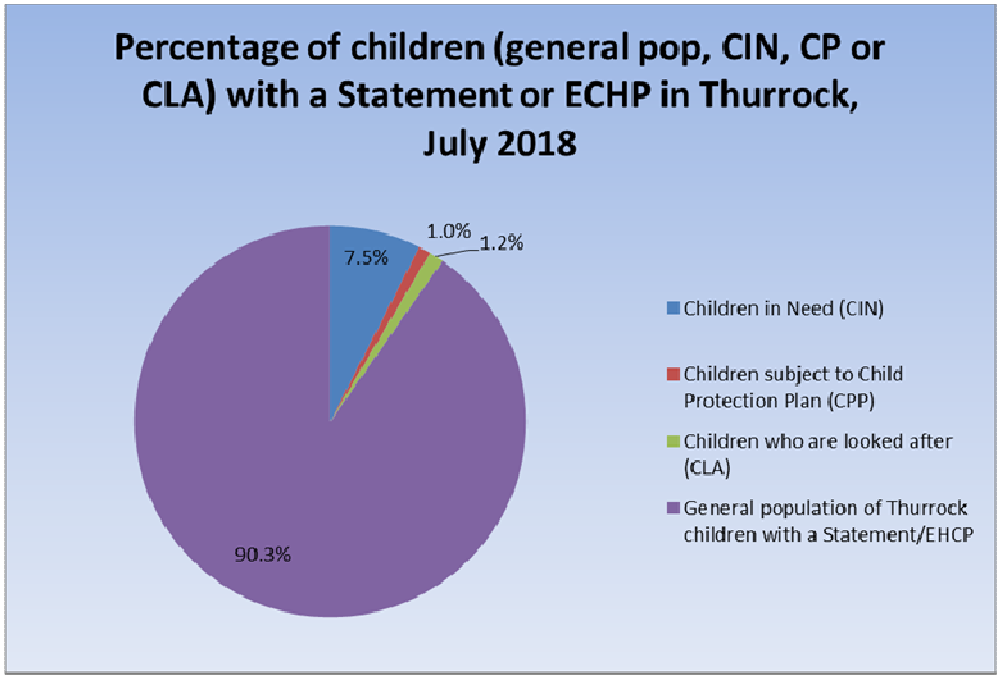
75.5% 24.5%





Characteristics of Children and Young People with SEND continued….

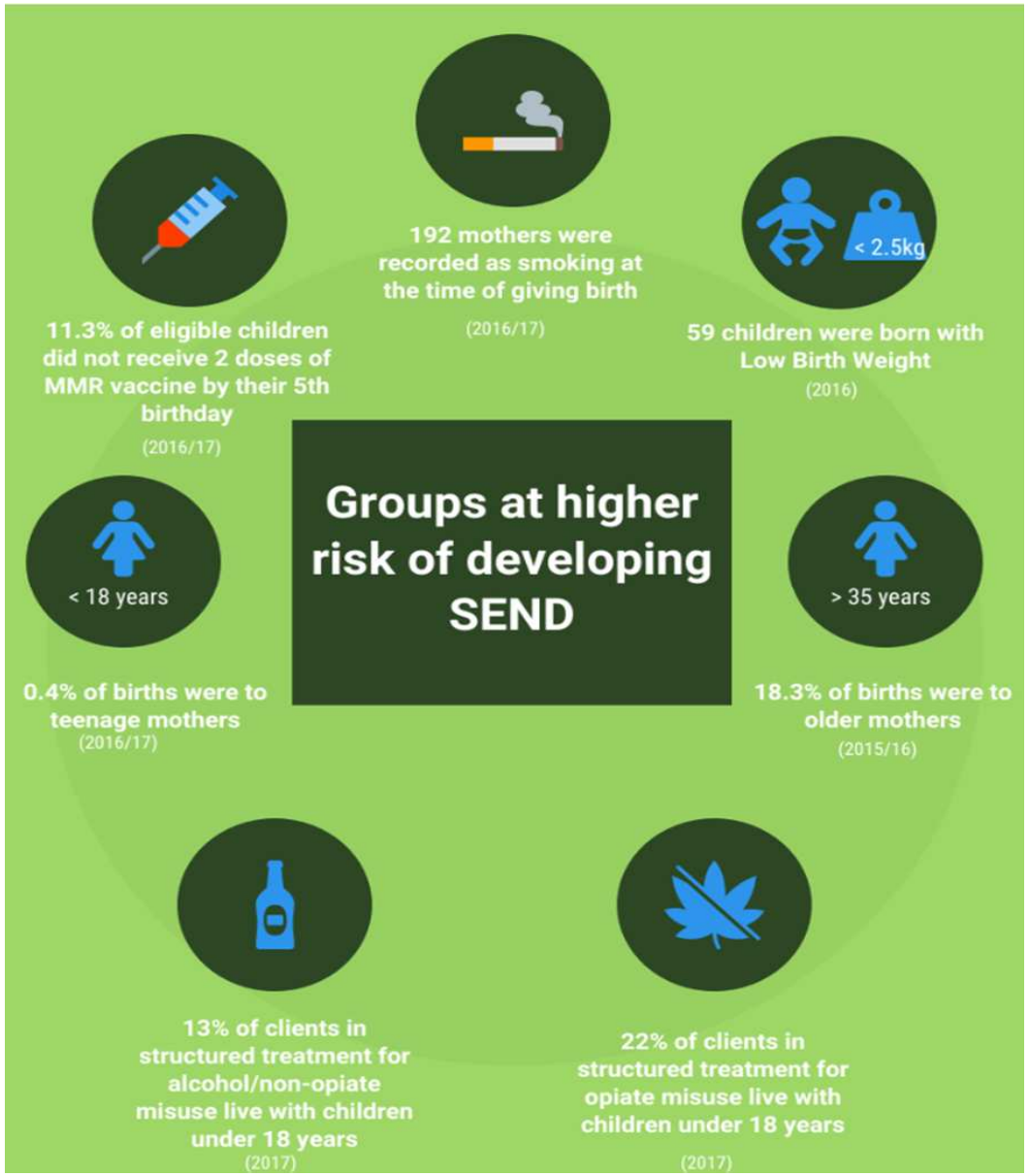




Risk factors

A range of factors are known to predispose children to developing special educational needs and disability. We have discussed some key risk factors which include;

- Infection or diseases such as complications in pregnancy as a result of measles, mumps and rubella, bacterial meningitis.
- Smoking in Pregnancy
- Drug and alcohol during pregnancy
- Maternal diet and age
- Low birth weight and pre-term birth



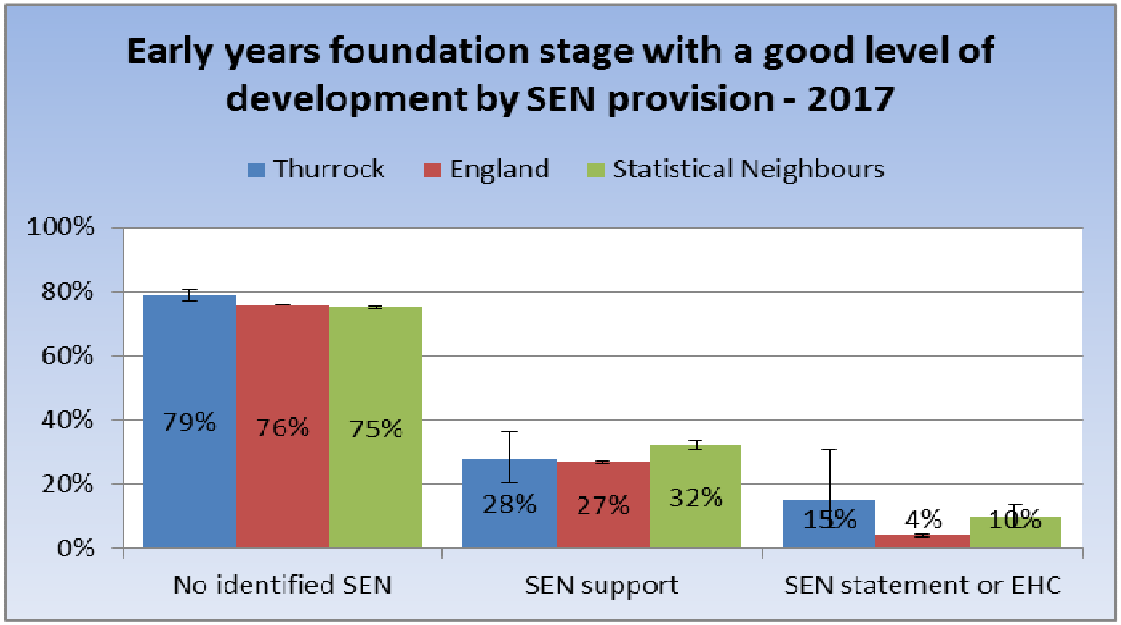
How well are children with SEND achieving their potential?

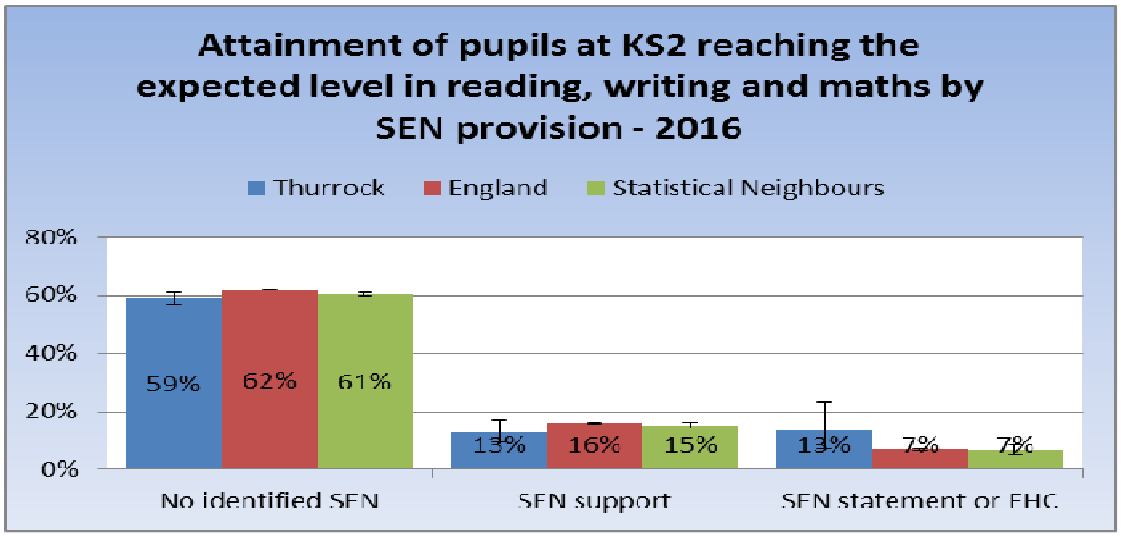
We know that children and young people with SEND are at risk of poorer outcomes in education and life in general which might impact on their later life. We also know that children with SEN and complex disabilities are now surviving for longer with some needing very specialised treatment.

Early Years - Although Thurrock has had a historically higher proportion of children achieving Good Level of Development (GLD) at Early Years Foundation Stage than the national average, this is not the case for children with SEND.

Key Stage 2 – Evidence has shown that children with SEN experience some educational inequalities when compared to their peers. These include inequalities in attainment, lower rates of sustained education and/or higher rate of absence or exclusions. In Thurrock;

- (13%) of KS2 SEN pupils with a statement/EHC plan achieved their expected level compared to 6.8% and 7% for its SNs and England. This is not observed in SEN pupils with no Statement, or non-SEN pupils.
- It is apparent that children and young people with SEN on a statement or EHC plan are doing far better and achieving expected levels of development compared to SEN children with no statement.

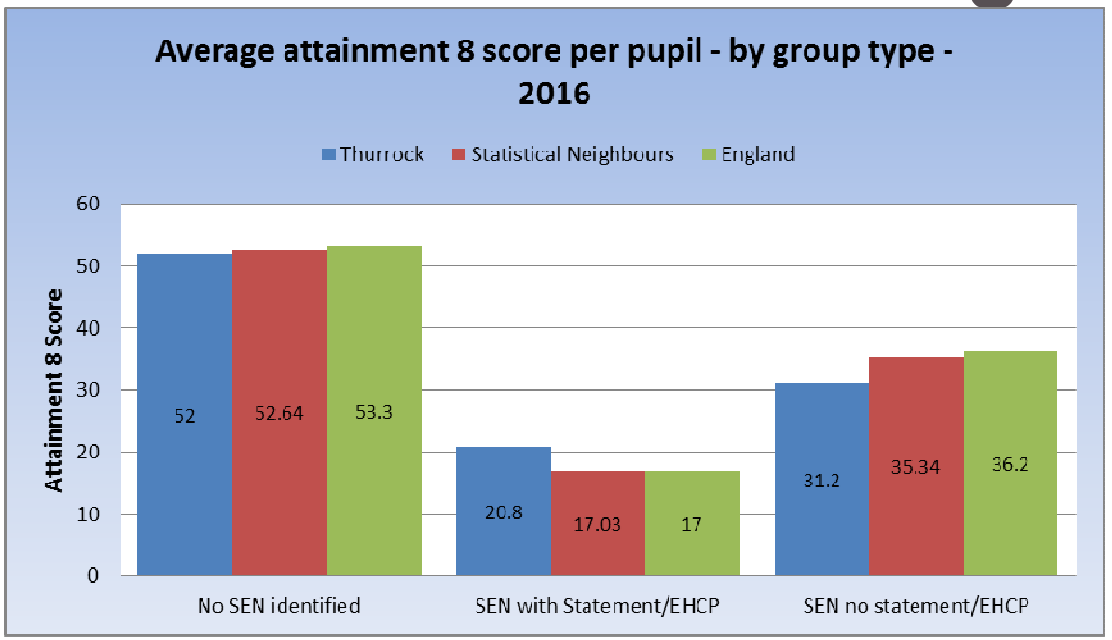


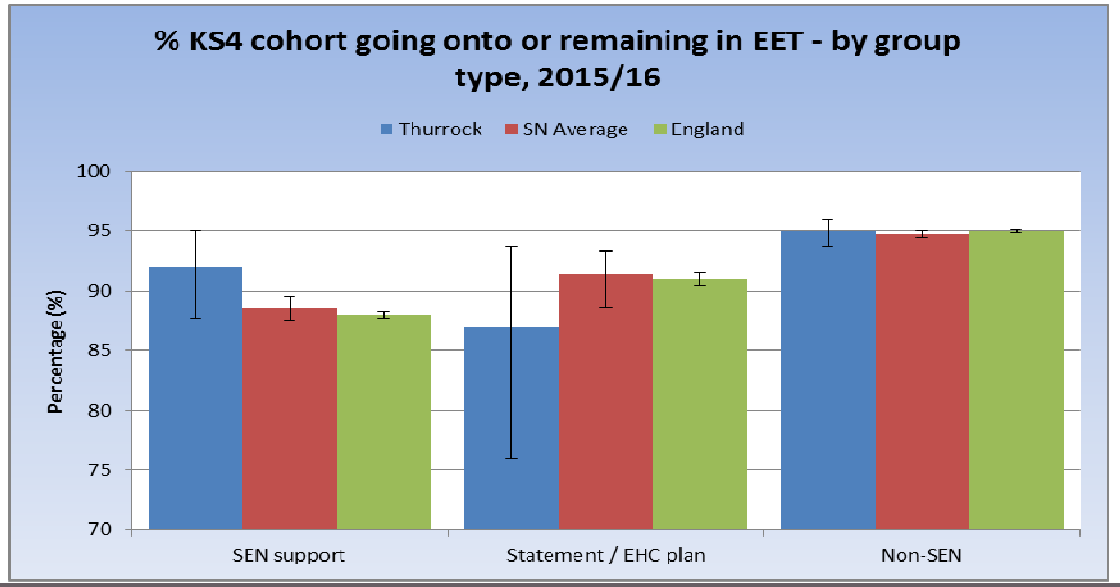


How well are children with SEND achieving their potential?

Key Stage 4 - The average attainment 8 score (measures a child's average grade across 8 subjects) was higher for Thurrock's SEN pupils with a Statement; 20.8, compared to 17.9 and 17.0 for its SNs and England. The attainment 8 scores for SEN pupils with no Statement was below comparator areas (31.2 compared to 35.3 SN and 36.2 and England).

Evidence tells us that young people with SEN are less likely to remain in Education, Employment or Training than those with no identified SEN. In Thurrock, there is no statistical difference between SEN young people remaining EET with a statement/EHCP and those without a statement. However, the percentage of CYP with SEND receiving SEN support who remain EET is significantly higher in Thurrock when compared to Statistical Neighbours and England averages.

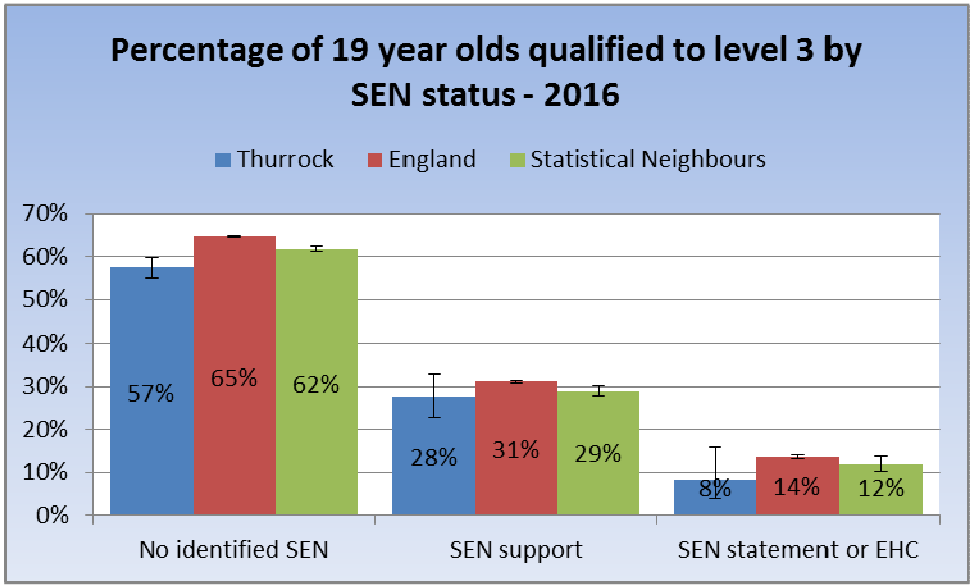


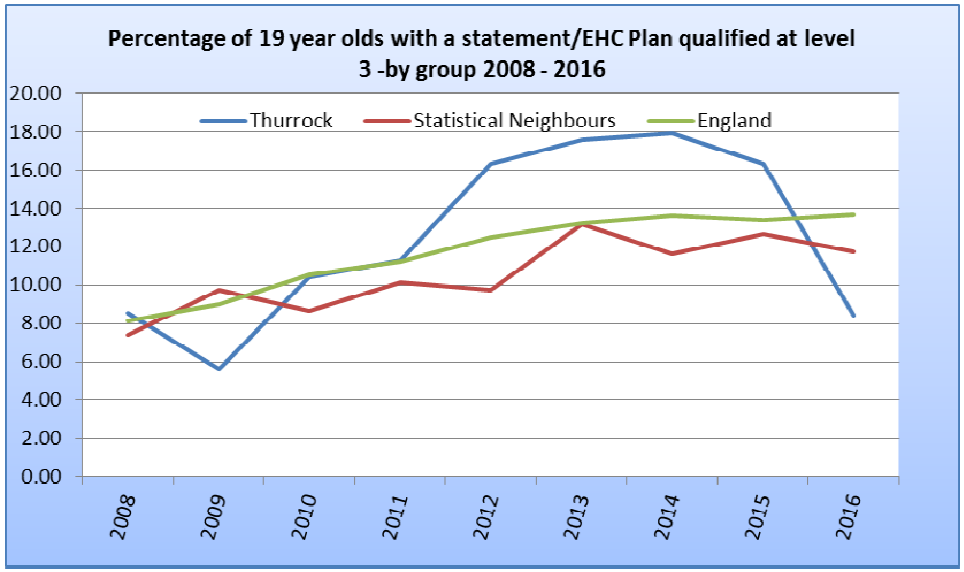


How well are children with SEND achieving their potential?

Post 16 - In Thurrock, the level of attainment at age 19 is below other areas for all pupil groups. In Thurrock,

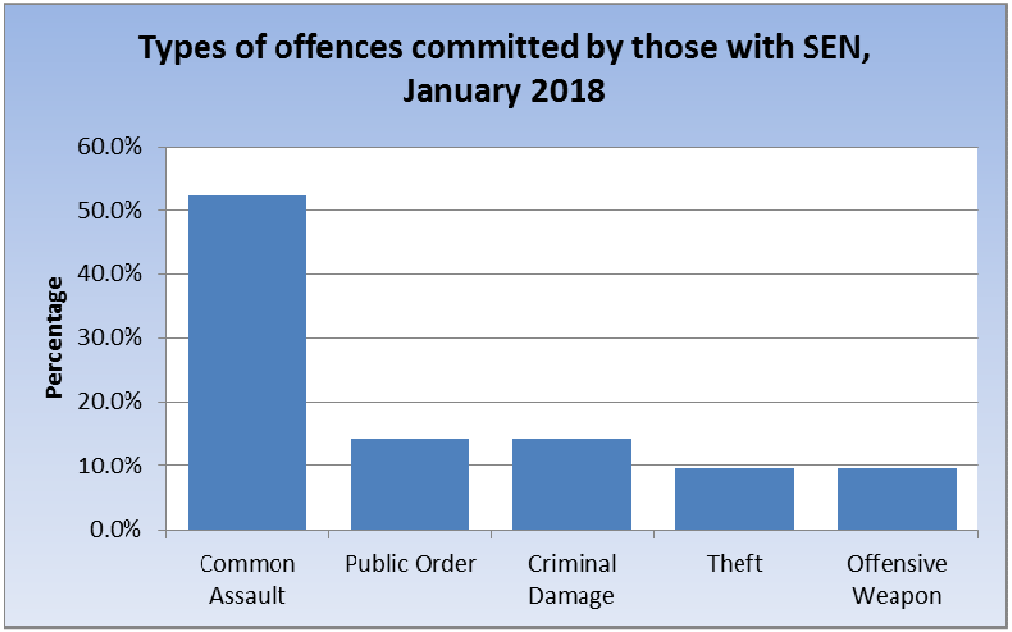
- SEN pupil with a statement achieved 8.4% level 3 qualifications which are lower than SNs and England proportions at 11.7% and 13.7% respectively.
- There were 27.7% of SEN pupils with no Statement qualifying at Level 3 in 2016 (30.3% and 31.2% in SNs and England).
- Across the years (2008 – 2015), a higher proportion of SEN pupil with a statement/EHC plan have been achieving level 3 qualifications than their counterparts in SNs and England which has slightly reduced in 2016.
- More than half of exclusions between 2013 and 2016 were of children with SEND.
- Children with SEN are less likely to remain in Education, Employment or Training than those with no identified SEN in which only 5% were NEET. There were 9% of Statement/EHC pupils who were NEET and 8% of SEN Support pupils in Thurrock who were NEET, highlighting the poorer outcomes for these pupils





How well are children with SEND achieving their potential?

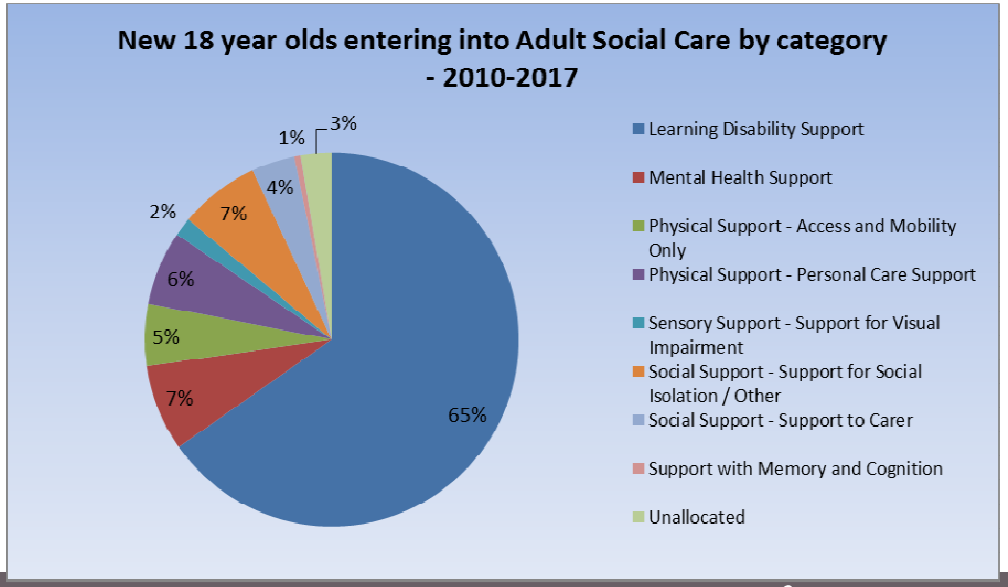
- Nationally 60% of CYP in Youth justice system have a speech, language and communication difficulty.
- In Thurrock, 11 of 54 cases on YOS caseload were recorded as having SEN (7 with EHCPs, 2 with statements and 2 with SEN but not subject to an SEN statement or EHCP.
- Common assault committed by CYP with SEN is higher than the general population (52% as opposed to 39%).
- Often reactionary and related to behaviour management e.g. anxiety.



Transition is an important life stage guided by four principle outcomes:

- Moving into paid employment and higher education
- Living independently
- Having friends and relationships and being part of their local community
- Living as healthy lives as possible

The majority of 18 year olds coming through to Adult Social Care require Learning Disability support, with 65% of those over the last 7 years requiring this. The second most common reason for support is Mental Health as show in Figure 2.



What are we doing in Thurrock to support children and young people with SEND?

- Local Offer

A key component of the SEN work across the borough is the provision of mainstream support and inclusive education..

- Brighter Futures

Healthy Families Service

Children's Centres

Prevention and Support services including Troubled Families.

Brighter Futures

A complimentary suite of Offers including;

- Early Years - for preschool support including home visiting and Portage
- School Aged – Main stream resources, Outstanding Special Schools, SENCo's
- Preparing for Adulthood - Transition to Short Breaks
- Health and Community Services – Community nursing, Therapies including Speech and Language Therapy etc.

Acknowledgements

Report Authors

- Elozona Umeh, Senior Public Health Programme Manager - Children
- Annelies Willerton – Public Health Graduate Trainee
- Maria Payne, Senior Public Health Programme Manager – Health Intelligence
- Karen Balthasar – Public Health Graduate Trainee

With thanks to all those who have helped us with this document. We particularly thank: Thurrock Council colleagues Malcolm Taylor, Bianca Peel, Nicola Smith; Thurrock CCG colleagues Helen Farmer; NELFT Colleagues – Sandra Bryan, Michael Smith.

This page is intentionally left blank

Health and Wellbeing Board Special Educational Needs and Disability

Malcolm W Taylor
Strategic Lead Inclusion / Principal Educational Psychologist

21st September 2018

Thurrock Local Area Special Educational Needs and Disability Strategy 2018-2020

SEND Strategic Vision

Our vision is that all that all children and young people with special educational needs and disabilities across the Local Area access outstanding support in their early years , school, college and at work that enables them to fully achieve their potential and have happy, healthy and fulfilling lives

Inclusion in Thurrock

Thurrock has a long standing commitment to an inclusive system of education health and care support that actively enables access and full participation to all aspects community life. This is in compliance with the Salamanca Statement and Framework for action on Special Education Needs (1994) , the UN Convention on the Rights of the Child and is embedded in the Equality Act 2010.

THURROCK SEND STRATEGY

Thurrock SEND Key Strategic Priority Areas

Developed through a process of co-production with partners in order to fulfil our shared vision for SEND .

1. Ensure that children and families are at the heart of an effective SEN system

2. Ensure every child and young person is making good progress and attends a good place to learn

3. Ensure children and families are well supported

4. Ensure an effective and responsive approach to assessing and meeting children and families' needs.

5. Ensure the early identification of and early support for children with SEND

6. Ensure young people are well prepared for adulthood

Peer Review 2017

Strengths :

Pre school SEND multi-agency systems ,

Post 16 work with Colleges

Areas for development :

SEN staffing capacity : Analysis and use of Data; Parental engagement in Local Offer; Governance structures ; Development of SEF and Strategic Plan

Peer Review Action Plan

11 main areas , Completed March 2018

Thurrock SEND Self Evaluation Headlines

Early Years

Identification and assessment of SEN in the Early Years is good, parental satisfaction with support is high and children are enabled to make progress.

SEN Support

Some schools are still developing their ability to make provision for pupils with SEN and this shortage of provision is reflected in a lack of parental confidence and high demand for statutory SEN assessments.

Joint Commissioning

Close working arrangements to ensure that Social Care, CCG and SEN services in Education work together to ensure a more effective and child/family centred approach across all aspect of SEND.

EHC Needs Assessments and Plans

EHCP School Population 3.5 % (Comparator 3.0 %)

Higher number statutory assessments in Early Years

2017 14% of EHC needs assessments completed within the 20 weeks statutory timescale.

2018 44% ytd , (August 67%), above national 61%)

Summary of percentage of school aged population with a statutory (Statement or EHC) plan (January 2017)	
England	2.8%
East Region	2.8%
Statistical Neighbours	3.0%
Thurrock	3.5%

1st May 2018 1375 Education Health and Care Plans

SEN Support 10.4% (comparator 12.1 %)

Increase in Staffing Capacity, New Performance Monitoring measures in place to ensure service improvement.

Regular quality assurance exercises in place with partners to ensure that our EHCPs are of a high quality.

Post 16

Percentage of Level 2 and Level 3 qualifications is good

Percentage point gap between young people with SEN and those with no SEN is smaller than national, regional and statistical neighbour comparators.

Parental Engagement and Co-Production

Strong and positive relationship between the local Parent Carer Forum and the Local Authority and CCG , regular meetings and co-production in all areas of SEND strategic development.

Improvements to pupil / parental feedback on school aged plans

Outcomes

EHC Plans achieving age expected levels in end of key stage assessments and tests is around twice that of national, regional and statistical neighbour comparators.

Young people identified at SEN Support are broadly in line with national averages for being in Education, Employment or Training at age 17.

Preparing for Adulthood

There are good opportunities for further education, employment and training for young people in Thurrock; and good support for independent living and engagement in a range of leisure activities.

Consultation on future SEND Provision and Resources

Community wide consultation December 2017-May 2018

To determine localised priorities for investment for high needs pupils with SEND.

Thurrock Capital fund allocation over three years £1,071,283

Structured survey questionnaire , face to face and telephone interviews.

KEY FINDINGS

- **Educational Establishment for SEMH**
- **SEMH expertise, outreach**
- **Priority to use existing buildings for SEMH**
- **Further resources required even with new Treetops Free school for ASC**

- **KEY FINDINGS (cont.)**

- **Educators Professionals SEMH priority**
- **Parents / Carers ASC priority**
- **Resource Hub to support SEND joint commissioned outreach and early intervention.**
- **Special School specific capital projects.**
- **Use of existing buildings at Local Primary schools for resource bases**
- **NEW Building**
- **Parents/ Carers 1) ASC 3-19 2) Post 19 ASC 3) post 19 SEMH**
- **Educators/professionals 1) SEMH Prim 2) ASC Prim, 3)SEMH Sec**
- **Primary PRU re-established**
- **Number of parents/carers who believed their SEND children's needs were addressed well, exceeded the number of parents /carers who believed the needs to an extent were not addressed well.**

Working together for better health and care

NHS
Thurrock
Clinical Commissioning Group

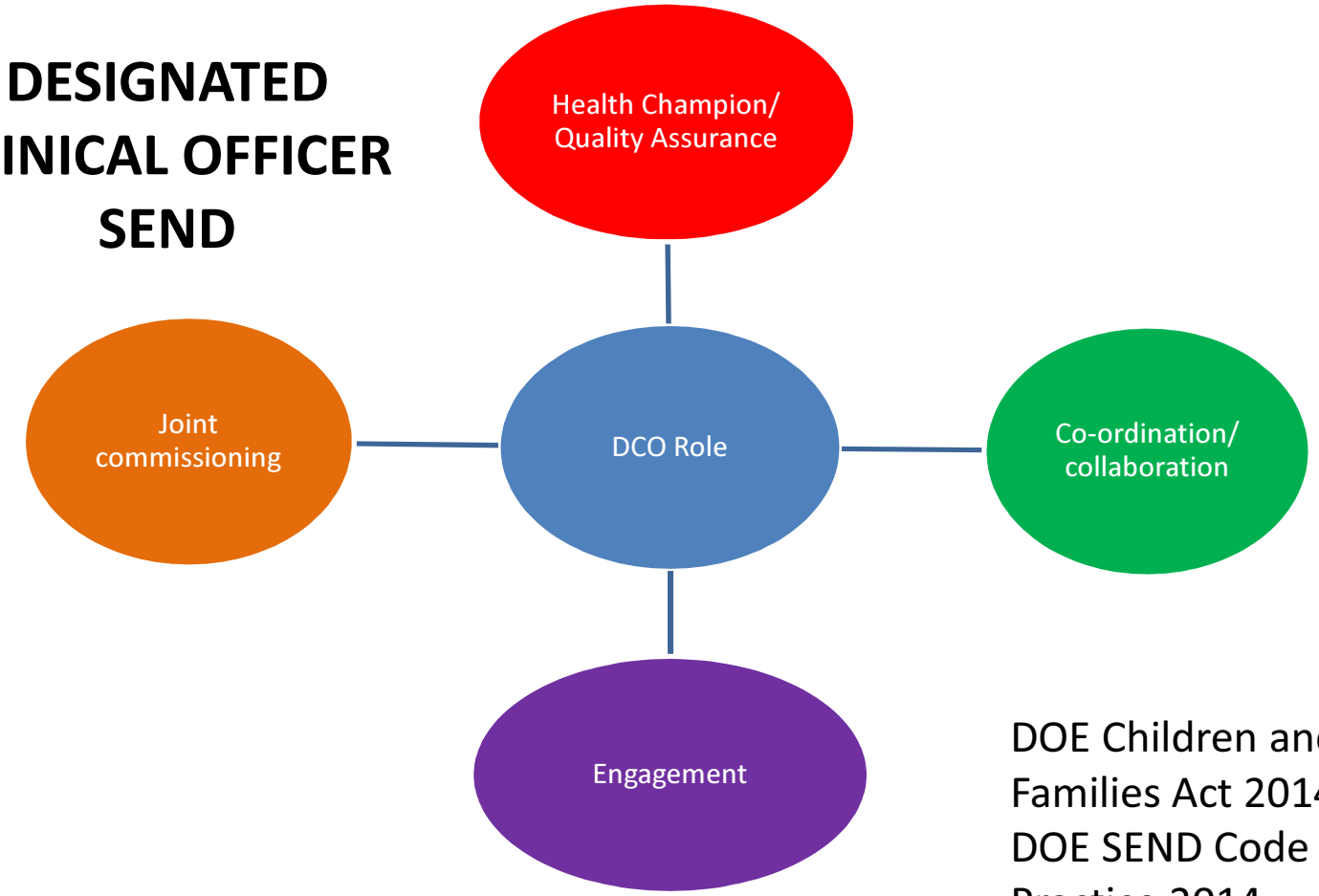
Key Strategic Health priorities – Next Steps…….

Presented to the Health and Wellbeing Board 21st September 2018

Working together for better health and care

NHS Thurrock Clinical Commissioning Group

DESIGNATED CLINICAL OFFICER SEND



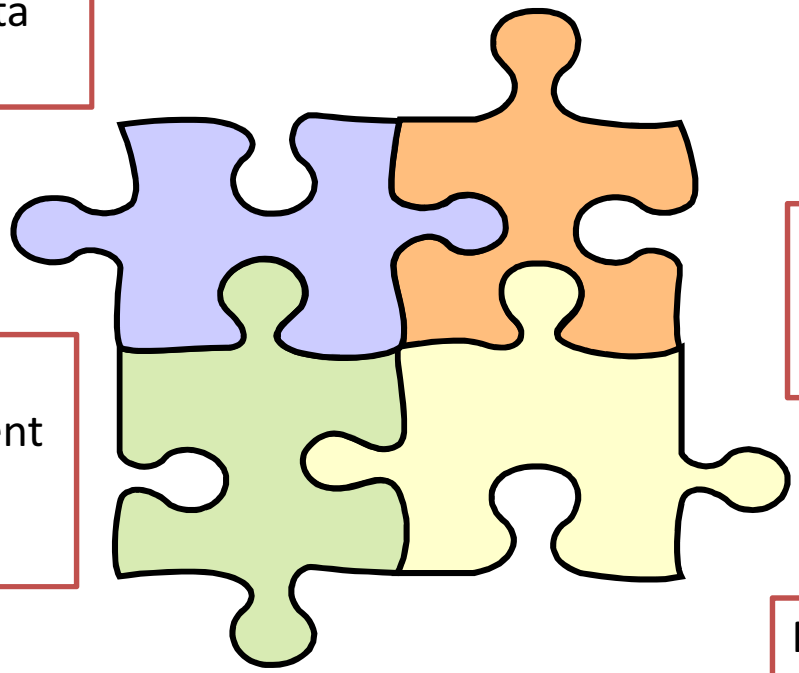
DOE Children and Families Act 2014
DOE SEND Code of Practice 2014

Time and Capacity, Clinical Knowledge, System Knowledge, data and information, professional skills (CDC, 2016)

Working together for better health and care

NHS Thurrock Clinical Commissioning Group

SEND Champions Health Forum



Child Centred planning

Engagement

Audit / Data reporting

Quality Assurance- EHCP

Thinking Environment / case studies

Partnership planning- strategic/ operational

Effective Communication

The Code of Practice 2014

Working together for better health and care

NHS Thurrock Clinical Commissioning Group

SEND AUDIT

- QUIPSOLUTIONS – CCG and Council are utilising an integrated audit tool which can align priorities and support coordination of action plans.
- NHS England East – Collating data and forming networks to support the health SEND agenda supported by the DFE regional advisor.
- Key areas identified : Multiagency outcome measures, joint commissioning intentions, co-production.

Working together for better health and care

Work programmes

NHS Thurrock Clinical Commissioning Group

Redesigned and commissioned an assessment service for CYP with ADHD age 11+

Extending the specialist mental health LD service for CYP.

Care, Education ,Treatment Reviews (CETR's), engagement with families and young people admitted to tier 4 mental health units.

Reviewed the current LD register in primary care and developing an action plan

Appointed a Designated Clinical Officer for SEND.

Developing an end of life model of care in partnership with Little Havens Hospice.

System wide review & development of a neurodevelopmental pathway

Equipment review and developing Personal Wheelchair Budgets

Integrated health teams for CYP with SEND.

This page is intentionally left blank

21st September, 2018	ITEM: 7
Health and Wellbeing Board	
Adult Mental Health Service Transformation in Thurrock	
Wards and communities affected: All	**Key Decision:** Key
Report of: Roger Harris, Corporate Director Adults Housing and Health	
Accountable Head of Service: Les Billingham – Assistant Director of Adult Social Care and Community Development Catherine Wilson – Strategic Lead Adult Social Care Commissioning	
Accountable Director: Ian Wake – Director of Public Health Roger Harris – Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

The attached paper discusses the need for adult mental health systems transformation in the context of three key recent pieces of work; the Adult Mental Health Joint Strategic Needs Assessment Product; The Local Government Association Peer Review in Adult Mental Health and; consultation work undertaken by Thurrock Healthwatch and other local partners with local residents and users of mental health services. It aims to triangulate the findings of this work with other local intelligence and the published evidence base in order to continue a discussion with all stakeholders as to what needs to change.

There has been considerable effort undertaken within Thurrock to transform local health and care services over the last three years including plans to create four new Integrated Medical Centres, a *New Model of Care* for Tilbury and Chadwell, the *Stronger Together* programme of community development and asset-based approaches, a Thurrock *Integrated Care Alliance,* the joint *For Thurrock in Thurrock* CCG-Adult Social Care programme and considerable efforts to transform Primary Care services. However mental health systems transformation has not perhaps featured as strongly as it should within these programmes to date.

In discussing local mental health service provision, the attached paper highlights a series of concerns and areas of practice that need improvement, based on the findings of the MH JSNA, LGA Peer Review and Healthwatch *User Voice* work. In

doing so, it seeks to criticise neither the hardworking front line professionals working with residents experiencing mental health difficulties, nor individual organisations that make up the mental health and care system, but the current configuration of the system itself, which it argues is not fit for purpose and needs urgent transformational reform. The paper proposes and discusses five key areas of transformation activity that emerge from the findings of the work to date around which this transformation should be concentrated. These are discussed in detail.

Further iterations of the paper will be developed following feedback from partners. The Health and Wellbeing Board and partner organisations may also wish to provide deeper consideration to issues such as how adult mental health transformation work may better integrate with both children and young people's mental health services in order to improve transition, and work to develop new models of care as part of the Integrated Medical Centres.

Public Health have committed to fund a new Strategic Lead post a key remit of working with all stakeholder organisations and local service users to develop a new Thurrock Mental Health Systems Transformation strategy and associated new models of care and commissioning arrangements. The attached paper makes a series of high level recommendations in each area, highlights current community and system assets related to the recommendations and poses a series of further questions that will hopefully guide development of this strategy, and which all stakeholders need to consider as part of our collective transformation journey.

1. Recommendation(s)

1.1 That the Board provides feedback on the high level recommendations made within the 'Next Steps' sections of the paper and on the questions posed within it.

2. Reasons for Recommendation

2.1 To update the Board on the proposed next steps to transform, integrate and improve adult mental health services in Thurrock and obtain buy in from all key stakeholders for a proposed strategic direction of travel.

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

3.1 All key stakeholders were consulted as part of the LGA Peer Review. The Healthwatch 'User Voice' has undertaken further extensive consultation with service users and their families.

3.2 The Discussion Paper has been shared with all key stakeholders and will be revised in response to further feedback from partners.

3.3 The Proposed Mental Health Strategic Transformation Group will afford all key stakeholders on-going input into future transformation activity.

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

4.1 The proposed Mental Health Transformation work will help deliver the following Thurrock Joint Health and Wellbeing Strategy 2016-2021 objectives:

3C: Reduce Social Isolation and Loneliness
3D: Improve the identification and treatment of depression, particularly in high risk groups
4B: When services are required, they are organised around the individual
4C: Put people in control of their own care
4D: Provide high quality GP and hospital care to Thurrock Council

5B: Reduce the proportion of people who smoke
5C: Significantly improve the identification and management of long term condition

5. Implications

5.1 Financial

The paper makes a series of high level recommendations, which if developed and implemented may require additional investment, but which will also seek to shift resources from the most expensive elements of the system (e.g. secondary mental healthcare and residential adult social care) and could act as 'invest to save' initiatives.

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

5.2 Legal

The paper in its current form has no legal implications.

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

5.3 Diversity and Equality

People with poor mental health face some of the greatest health inequalities. The high level recommendations in the paper, when further developed and implemented seek to reduce health inequalities faced by people suffering from poor mental health, by intervening earlier to prevent or reduce crisis, and providing new models of care to help people recover more quickly.

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

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

6. 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):

- LGA Peer Review into Adult Mental Health Services in Thurrock Council
- Thurrock Joint Strategic Needs Assessment into Adult Mental Health Services
- Healthwatch Consultation with Mental Health Service Users

Report Author:

Ian Wake

Director of Public Health

iwake@thurrock.gov.uk

Mental Health Service Transformation in Thurrock –

The Next Steps

A discussion Paper

Author: Ian Wake, Director of Public Health, September 2018

1 Introduction: the purpose of this paper.

This paper discusses the need for adult mental health systems transformation in the context of three key recent pieces of work; the Adult Mental Health Joint Strategic Needs Assessment Product; The Local Government Association Peer Review in Adult Mental Health and; consultation work undertaken by Thurrock Healthwatch and other local partners with local residents and users of mental health services. It aims to triangulate the findings of this work with other local intelligence and the published evidence base in order to continue a discussion with all stakeholders as to what needs to change.

There has been considerable effort undertaken within Thurrock to transform local health and care services over the last three years including plans to create four new Integrated Medical Centres, a *New Model of Care* for Tilbury and Chadwell, the *Stronger Together* programme of community development and asset-based approaches, a Thurrock *Integrated Care Alliance,* the joint *For Thurrock in Thurrock* CCG-Adult Social Care programme and considerable efforts to transform Primary Care services. However mental health systems transformation has not perhaps featured as strongly as it should within these programmes to date.

In discussing local mental health service provision, this paper highlights a series of concerns and areas of practice that need improvement, based on the findings of the MH JSNA, LGA Peer Review and Healthwatch *User Voice* work. In doing so, it seeks to criticise neither the hardworking front line professionals working with residents experiencing mental health difficulties, nor individual organisations that make up the mental health and care system, but the current configuration of the system itself, which it argues is not fit for purpose and needs urgent transformational reform. The paper proposes and discusses five key areas of transformation activity that emerge from the findings of the work to date around which this transformation should be concentrated. These are discussed in detail in section 3.

Public Health have committed to fund a new Strategic Lead post a key remit of working with all stakeholder organisations and local service users to develop a new Thurrock Mental Health Systems Transformation strategy and associated new models of care and commissioning arrangements. The paper makes a series of high level recommendations in each area, highlights current community and system assets related to the recommendations and poses a series of further questions that will hopefully guide development of this strategy, and which all stakeholders need to consider as part of our collective transformation journey.

2 Epidemiological Overview of Mental Health

Mental illness is the single largest cause of disability in the United Kingdom, contributing up to 22.8 per cent of the total burden, compared to 15.9 per cent for cancer and 16.2 per cent for cardiovascular disease[1]. 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. [2]

Among people under 65, mental illness accounts for nearly half of all instances of ill health[3]. Mental illness often begins early in life and affects people over a long period.[4] Estimates suggest that between a quarter to a half of mental health issues experienced in adulthood could be averted with effective early interventions in childhood.[5] Depression and anxiety disorders are by far the most common mental illnesses, affecting 11.66% of the adult population of Thurrock aged 16-74 in 2016.[6] A further 0.7% of the adult population of Thurrock has been diagnosed with a serious mental health disorder. [7]

Mental illness has a huge impact on population health. 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. People with serious mental ill health die on average 20 years before the general population.[8] . 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.[9]

Mental illness further affects the way individuals manage their health and interact with services. People with mental health problems are more likely to misuse substances[10] and less likely to be physically active[11]. Furthermore, they are less likely to attend medical appointments[12] and less likely to adhere to treatment and self-care regimens[13] [14] [15]

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.[4] This will put ever more pressure on an already overstretched NHS and Social Care system. Data held on Thurrock Council's LAS Adult Social Care record system suggests that the council spent £6.55M on social care packages due to mental ill health in 2015-16.

3 Background

Two major pieces of work on the Adults and Older People Mental Health agenda have recently been completed in Thurrock in response to anecdotal concerns raised by health and care professionals and *Thurrock Healthwatch* that the current system is not fit for purpose and is failing residents:

- Thurrock Joint Strategic Needs Assessment for Common Mental Health Disorders in Adults (recommendations agreed at the Joint Health and Wellbeing Board in March 2018)
- Local Government Association Peer Review into Mental Health (presented at the Joint Health and Wellbeing Board in July 2018)

The key findings of both of these reports are summarised below and overleaf and the findings/recommendations of both have been used in production of this paper.

3.1 Mental Health JSNA

Finding	Summary Recommendation
System Fragmentation The current mental healh prevention and treatment system is highly fragmented with a large number of services operating at different levels and commissioned in parallel	**Integration of commissioning** Pland for joing commissioning across health and social care in Thurrock should include integration of mental health commissioning between the local authority and CCG. Joint commissioning should be used as a platform to drive integration of services around the individual
	Integrated Service Delivery: The development of new models of care provides a huge opportunity to try doing thing differently. Mental health needs to be integrated into the delivery of new models of primary care and wellbeing teams delivering social care in the community. There are also important opportunities to integrate services addressing the social determinants of mental health such as housing and employment into these new models of care.
Under-diagnosis A large proportion of those with mental ill health are never diagnosed or treated. Depression is particularly poorly diagnosed and there is wide variation between GP practices in the extent of case finding.	**Reduce unwarranted variation between GP practices in case finding**. Building on the work of the GP practice profiles produced by the public health team there is an opportunity to reduce variation and find the 8000+ people estimated to have undiagnosed depression in Thurrock.
	Make better use of depression screening. There is a strong evidence base to support the use of depression screening amongst front-line staff working with high risk groups (e.g. use by social workers or health professionals in long term condition clinics). Current use of this tool appears to be minimal and is not consistently monitored. Joint work between the local authority and CCG is needed to promote this
Quality of Care Even when people are identified as having a mental illness they are often not referred for treatment or their treatment is not in line with the highest quality standards.	**Reducing unwarranted variation between GP practices.** Variation in referrals into IAPT services and reviews of newly diagnosed depression are examples of two quality standards which could be improved through joint working between GP practices and the public health team.
	Commissioners working to improve standards. Redesign of CCG-commissioned services of some existing services is underway and standards are expected to improve. This must be monitored closely by commissioners.
	Improve quality of service data. Commissioners in the local authority and CCG are working with providers to improve the quality of the service data they receive. New indicators need to be designed with are meaningful and focussed on patient outcomes, including wider social outcomes.
Risks Associated with Mental Health There are well-known wider health risks associated with mental health including high rates of smoking, obesity and long-term conditions (LTCs).	**Improve understanding of links between mental health and LTCs.** Feedback from residents with LTCs suggests that clinicians do not always appreciate these connections. Education of health professionals would be beneficial.
	Promote smoking cessation in those with serious mental illness. Work is ongoing between public health and mental health provider services to promote smoking cessation even in in-patient settings. This needs to be brought to completion and monitored.
	Promote referral of mental health patients into healthy lifestyles services commissioned by public health.

3.2 LGA Peer Review

	Area of investigation	Strengths	Areas for consideration
1	**THRESHOLDS** The extent to which he current servcie 'gate keeps' and the suitability of where 'thresholds' are set	· Thresholds are set and applied · Open referral for Local Area Coordinators · When high-level need is identified, the Grays Hall service received is perceived as good	· Crisis team perceived as gatekeepers and maintain high thresholds · GP referral system is seen as building delays; medical model · Opportunity to open up other referral routes but only as part of an holistic system change · Difference in perception of what "crisis" is and understanding of Threshold Criteria; for individual and service · Performance information not seen to evidence intervention impact on improvements in MH
2	**PERSON CENTRED-OUTCOME FOCUSSED** The extent that current arrangements and organisational culture delivers a person-centred, strengths based approach including a focus on delivering outcomes and a move away from "one size fits all"	· LACs person-centred approach widely acknowledged · MIND, Inclusion Thurrock (IAPT) and Recovery College services are well regarded · Once diagnosed, services are seen to be good · Cross-party political agreement for service improvement · Housing services reported that they worked well with Grays Hall on individual cases · Low numbers of rough sleepers	· Variable provision when thresholds are not met · Lack of a specialist housing plan for people with MH issues · Social workers should focus on the complex. Needs of the less complex should be met through other arrangements · Ensure that social work practice/values as a profession are asserted and owned within EPUT/Grays Hall team · Stretched but effective preventative provision for borderline homeless not consistent across the area, with rising demand from inner-London migration
3	**MARKET CAPACITY AND DEVELOPMENT** The extent that the current 'offer' needs to expand and the exent to which the market is robust enough to deliver against this	· Existing Market Position Statement and Joint Strategic Needs Assessment MH Product · Housing Investment and Regeneration Group recognises vulnerable people · Proactive in-house housing team deals with difficut supply issues · Innovation in terms of fragile social care market, e.g. Domicilary Care could be applied to MH · Community Hubs ad Strength Based conversations in ASC and 3rd sector; needs to be aligned and planned wih service model in nascent four IMCs	· Detailed analysis of MH market needs and specialist accommodation · Opportunity to Invest to Save to deliver accommodation, looking at external placements with the CCG · Build on personalisation approach and values in ASC and Housing
4	**A HOLISTIC SERVICE OFFER** The extent to which the current offer is holistic	· Thurrock First is seen as responsive and innovative · LACs development is sen as positive and well regarded · Joint commitment to development of IMCs · Joint funding of an Integrated Care Director · Opportunities to resolve operational housing issues through local housing group · Social prescribing in Primary Care	· Opportunity exists for EPUT to work jointly with NELFT, building on the NMC Pilot in Tilbury and Chadwell · Secondary MH care needs to benefit from a wider multi-disciplinary approach · IT incompatibilities between the council and EPUT · Ensure full engagement of seconded staff in all council initiatives · Grays Hall Crisis Line is not responsive · LACs have some inconsistency in approach, with skill variations
5	**PREVENTION** The extent to which the service is preventative	· LACs are responsive and can prevent crisis · Recovery College · Thurrock First · Improving out-reach reported in Purfleet and South Ockendon · MIND recognised as an asset · Thurrock Healthwatch providing useful feedback to prevent direct interventions	· Consider joint funding of prevention in MH with CCG as an invest to save initiative · Older People's MH service workload does not allow a focus on prevention · Thurrock First should consider interim measures to fill the gap in MH expertise and housing · Opportunities to agree a housing strategy and policy for people with MH issues - *"the same people float around the system "* · The Care Act is not well understood across partners
6	**WORKING WITH OTHER COMMUNITY PARTNERS** The interface between other key partners, e.g. housing and primary care	· Recent evidence of EPUT and Thurrock Coucnil wanting to improve their relationship · Robust evidence of good practice in the community, e.g. community enterprises, *Housing First, Shared Lives* · Shared care protocol · Positive relationships across partners witha 'can-do' attitude · Strong and valuable partnership with Thurrock coalition	· Recalibrate the relationship with EPUT and Thurrock Council, movnig on from legacy issues and past working · Make better use of resources across the Health and Social Care economy · Work in communities disparate and disjointed · Independent sector has expressed uncertainty about future funding, risking further integration
7	**SECTION 75** The extent to which the Section 75 is fit for purpose and possible areas of change	· Southend-on-Sea are open to working more closely on Performance Information · Thurrock Council is working more positively with EPUT post-reorganisation · Operations Group ready to take on a more engaged role; including provider and service user representation · BCF perceived as positive	· Need to develop and agree a single reporting and outcomes framework. · Assure that social care values and approaches are part of EPUT ways of working, including Executive Board level representation · Need to value social work practice including the availability of crisis team to support AMHPs and (for example), social workers being responsible for bed-finding, championed by Principle Social Worker. · No single point contact within Thurrock for Southend-on-Sea for developing commissioning issues · Section 75 staffing arrangements have a Health led culture that shapes practice
8	**COMMISSIONING ARRANGEMENTS** The extent to which current partnership arrangements are working both interms of providers and commissioning (CCG and Council)	· Public Health is an asset; has driven the Tilbury and Chadwell 'Case for Change' and through JSNA products and LTC management programme such as Stretched QOF · Opportunities to develop joint commissioning arrangements with CCG and others. · Council has recognised difficulties with EPUT and started to grip the situation · Council has a reputation for innovation and ability to deliver transformation - well regarded by partners.	· Consolidate new approach to management of EPUT; develop a plan that is set out and monitored · Need to commission for the *"Missing Middle"* e.g. with 24/7 crisis support, step-down, dual diagnosis. The current absence of services is seen as a clear gap by stakeholders · Consider how best to manage the development of the four IMCs in the context of NHS/STP · Ensure IMC development works to a realistic timeframe and service model · Joint commissioning with CCG-CCG currently focussed too narrowly on commissioning primary and secondary care. Need to develop a more holistic approach.

3.3 User Voice

Thurrock Healthwatch are currently undertaking a significant piece of research with service users of local mental health treatment services through both questionnaires and face to face engagement. Whilst this piece of work is not due to report until September 2018, the responses provided to *Thurrock Healthwatch* to date, together with intelligence gathered from workshops run by Th*urrock Coalition* with mental health service users have also been considered in the production of this paper.

4 Transforming Mental Health Services in Thurrock – Six Priority Areas

By triangulation of the intelligence, evidence and recommendations set out in the Mental Health JSNA, LGA Peer Review and User Voice, this paper proposes five *Key Themes* that warrant attention of local system leaders in order to improve and transform local mental health services for the benefit of Thurrock residents. These are summarised below and then discussed in turn in the context of the published evidence base, policy and other local intelligence.

1. Addressing Under-Diagnosis
2. Getting into the system
3. A new treatment offer for Common Mental Health Disorders
4. A new 'enhanced treatment' model including a greater focus on prevention and early intervention
5. Integrated Commissioning

These are discussed in detail in the proceeding sections

5 Addressing under-diagnosis

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. This has been repeatedly highlighted by the Thurrock Public Health Service in the Annual Public Health Report 2016[16], Tilbury and Chadwell New Model of Care *The Case for* Change[17], and Mental Health JSNA[7]. 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.[8]

The Mental 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.

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.

Case Study – The Good Thinking Project

Public Health England interrogated the commercial datasets held by Google and Facebook to identify people in London who used social media to post about a mental health issue, including a 'look back' exercise to see what this cohort of residents were posting one, two and three years prior to their post about mental health. This allowed them to identify social media posts and internet searches that best predicted future mental health problems, and then build an algorithm that accurately predicted those in the population most likely to experience future depression or anxiety.

By forward running this algorithm, PHE identified a potential 1M people with undiagnosed depression or anxiety in London, many of whom were unlikely or unwilling to discuss their symptoms with their GP.

The Good Thinking Project is a web based intervention aimed at this cohort of residents. It includes an online symptom checker that acts as a screening tool for anxiety and depression and includes a range of different on-line treatment tools including peer support, mindfulness training and sign posting to local community resources and assets.

5.1 Next Steps: Addressing Under-diagnosis

High Level Recommendations	• Expedite roll out of PHQ2/9 depression screening tool prompt template in SystmOne for patients that are being reviewed for physical long-term health conditions • Improve uptake of the NHS Healthchecks programme to a minimum of 60% of those offered a healthcheck, as a systematic way to screen for undiagnosed depression • Embed depression screening into the practice of wider front line professionals and new models of care including front line housing, social care and community workers • Improve access to depression screening for the general population with the use of online screening tools linked to self-referral mechanisms
Key Questions for further Metal Health Transformation	• How can we best embed depression screening practice into the day job of a wider cohort of resident facing staff across the public sector? • Are there opportunities to embed depression screening into the work of community volunteers and at community hubs? • Can we capitalise on the proposed new models of care in Tilbury and Chadwell including Community Led Support Teams and Wellbeing Teams to systematise depression screening? • How can we use commercial datasets held by social media companies and search engines to better target depression screening at the general population at risk through on-line portals? • How can we better increase the up take of NHS Healthchecks in practice populations where this is currently low?
Existing Assets to build on	• *Better Care Together Thurrock* Long Term Conditions Working Group / Project Plan • Tilbury and Chadwell new models of care including Wellbeing Teams and Community Led Support Teams • Thurrock Council Public Health Social Marketing Research on Health checks • Local Area Coordinators • Community hubs • Analysis within the MH JSNA about other key 'at risk' groups that could benefit from a tailored approach.

6 Getting into the system

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 (featuring in 100% of all survey responses received to date) and The Thurrock Coalition. This is true of both services to treat Common Mental Health Disorders and more serious mental ill-health.

The issue encompasses variation in referral behaviour across different GP practices, unacceptably long waiting times following referral, complexity of referral pathways, current clinical thresholds for referral acceptance and inadequate coverage of the provision of crisis care services. These are discussed in turn.

"I have suffered for over 20 years with mental health problems, have been referred to MIND and a psychologist under Inclusion. I have been waiting months for an appointment, and would like to see a walk in centre"

The DH has stated a national ambition to have 25% of patients estimated to have depression or anxiety being treated by an IAPT service by 2020/21. The Mental Health Disorders JSNA highlighted significant variation in entry to IAPT services between different GP practice populations diagnosed with depression and anxiety in 2016/17, ranging from 8% to 46%. This could be partly a function of poorer levels of access to IAPT provision in certain localities across the borough (it is interesting to note that four of the seven practice populations with the lowest percentage of diagnosed patients with depression are in Tilbury), although is likely to also reflect variation in referral behaviour of GP surgeries and self-referral behaviour of their patients. Variation in knowledge and clinical practice of different GPs is highlighted in the user voice work, particularly in terms of serious mental ill health, with several responders highlighting the need for better training of GPs and other Primary Care clinicians in serious mental ill health.

Action to address this variation needs to be part of future Mental Health Service Transformation.

Waiting times for IAPT treatment also appears to be deteriorating and needs to be addressed. In March 2017, the Mental Health JSNA reported that 98.5% of patients waited fewer than six weeks for treatment by IAPT, however latest reports provided at the *Better Care Together Thurrock Long Term Conditions Programme Board* suggest that access has deteriorated to waiting times of typically 14 weeks. Waiting times for services provided by MIND have also been highlighted by some residents as too long. Further action (and possibly additional resource) needs to be considered to address this situation and reduce waiting times to 2016/17 levels.

Accessing secondary mental health treatment services is equally problematic and is highlighted in both the LGA Peer Review and User Voice work. EPUT currently only accept new referrals from a GP surgery. This causes an immediate problem to residents in mental health crisis 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.*"

Whilst Primary Care Transformation work including the mixed skill workforce that is being implemented in Tilbury and Chadwell as part of *Better Care Together Thurrock* should ameliorate Primary Care access issues, roll out borough wide is likely to take several years and urgent action is required now to provide timely access to mental health assessment and treatment for those with conditions too complex to be treated by IAPT. There may be opportunities to open up other referral routes into EPUT as part of holistic systems

A lack of 24/7 crisis care is repeatedly referenced in the user voice and LGA peer review. The current Grays Hall Crisis line is seen as not sufficiently responsive and doesn't operate out of hours or over the weekend leaving few choices of residents in crisis over and above attendance at A&E. *Thurrock First* is also seen by users as inadequate, reflecting the current lack of provision of 24-7 crisis services and simply signposting back to the limited access options of A&E or the GP surgery.

Front line clinicians have also highlighted difficulties in accessing assessment for patients experiencing mental health crisis, citing complexity and fragmentation within EPUT care pathways and the fact that Community Psychiatry won't take community referrals unless the patient is already known to EPUT and that new patients are only assessed as an emergency if they come via Acute Care. The quote opposite from a local Tilbury GP is an example of some of the current problems.

"One of my care home patients who has chronic schizophrenia was becoming aggressive and needed urgent assessment. I called the Crisis Team at EPUT and was told to contact First Response. I called them but was told they couldn't help and sign posted me to the Grays Hall Duty Team. They told me that they could only accept acute referrals and told me to take the patient to A&E. It was only when I lost my temper and refused to do this and eventually the Crisis Team undertook the assessment.

Thurrock GP

"My husband is suffering with severe anxiety and depression and was 'eventually' referred to Inclusion Thurrock by this GP but has been waiting for 20 weeks. This is not acceptable. He had a second breakdown this weekend and was so bad he ended up at A&E for the second time. Our GP surgery won't speak to me and my husband is finding it difficult to deal with. We now have to wait for a GP telephone appointment as we can't get a face to face appointment"

Thurrock resident telephone response to Healthwatch User Voice survey

A RAID (Rapid Access, Interface and Discharge) team is operating at Basildon Hospital. However anecdotal evidence provided by the hospital's Managing Director suggests that a lack of access to community mental assessment is driving patients in mental health crisis to A&E unnecessarily and causing avoidable system-wide treatment costs. The hospital operates a Clinical Decision Unit (CDU) where patients with high levels of need presenting at A&E can be seen and assessed/diagnosed with a view to preventing four hour A&E wait breeches and avoiding unnecessary hospital admissions. However the Hospital's Managing Director reports that capacity in the CDU is increasingly being monopolised by patients in mental health crisis, demand from whom is increasing at an unsustainable rate and now averages 10 per day. This in turn is resulting in inadequate assessment capacity within the CDU for patients with physical health needs and in turn,

avoidable hospital admissions to avoid A&E four-hour wait breeches, placing operational stress on the hospital and avoidable cost on the system.

The LGA Peer Review report a difference in perception of what "crisis" means between individuals and services. The LGA Peer Review and User Voice work also highlight that current 'thresholds' are currently set too high. This is resulting in what the LGA Review deem *The Missing Middle* – a cohort of patients with complex needs deemed too ill to be treated by IAPT but with a level of mental ill-health complexity below the threshold for treatment by EPUT without a service. This cohort of patients often ends up back in Primary Care who report having inadequate support or expertise to provide treatment, and/or is being picked up by Local Area Coordinators.

Work has already commenced at STP level to develop and commission a 24/7 Crisis Care model, and work has already begun as part of the Urgent and Emergency Mental Health Work Stream across the STP.

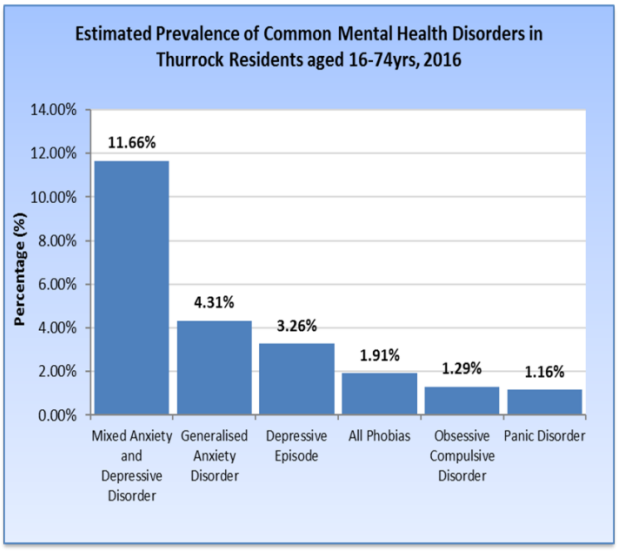
6.1 Next Steps: Getting into the System

High Level Recommendations	• Reduce waiting times to IAPT and MIND Services to an agreed maximum standard of no more than the six week national standard • Develop and implement a new model of 24-7 Rapid Direct Access Crisis Care Assessment within the community to reduce supply side demand on A&E and negates the need for a GP referral into secondary mental health care • Agree system wide *thresholds* for treatment into secondary mental healthcare services that are recognised by all stakeholders and ensure that all patients above the threshold for IAPT services receive prompt assessment and treatment
Key Questions for further Metal Health Transformation	• To what extent do we need to increase capacity of IAPT to meet demand and reduce waiting times, what will this cost, how do we fund it and what will be the Return on Investment and population health gain on avoided excess treatment costs in other parts of the system? • What does an effective model of 24-7 assessment/crisis care within the community look like, what will it cost, how do we fund it, and what will be the return on investment and population health gain in avoided excess healthcare costs elsewhere in the system (for example through releasing capacity in? • What changes need to be made to current treatment threshold levels across Primary, Community and Secondary Care to ensure that all residents with mental health needs receive a service, and how do we develop a single shared understanding of thresholds across all treatment providers? • How can work on a 24/7 Crisis response model commenced at STP level best be applied to Thurrock?
Existing Assets to build on	• Thurrock First • Local Area Coordinators • Community Hubs • Primary Care Locality Mixed Skill Workforce Team • IAPT • Thurrock MIND • Hospital based RAID Team • EPUT Assessment Services • Work already started at STP level of 24/7 Crisis Response

7 A New Model of Care for Common Mental Health Disorders

Figure 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). Figure 1 shows the estimated prevalence of CMHDs in Thurrock residents aged 16-74 in 2016.



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.

Evidence in the Mental Health JSNA, LGA, Peer Review and other local intelligence suggests that the current offer is inadequate and subject to unwarranted levels of variation between different practice populations. Three key issues are identified which will be discussed in turn:

1) Unacceptable levels of variation of treatment between different GP practice populations and different population groups
2) The need to integrate mental health treatment services with physical health services
3) The need to broaden the treatment offer to encompass a strengths based approach, community assets and mentally protective factors such as employment and exercise.

7.1 Unacceptable variation in treatment between different GP practice populations and population groups.

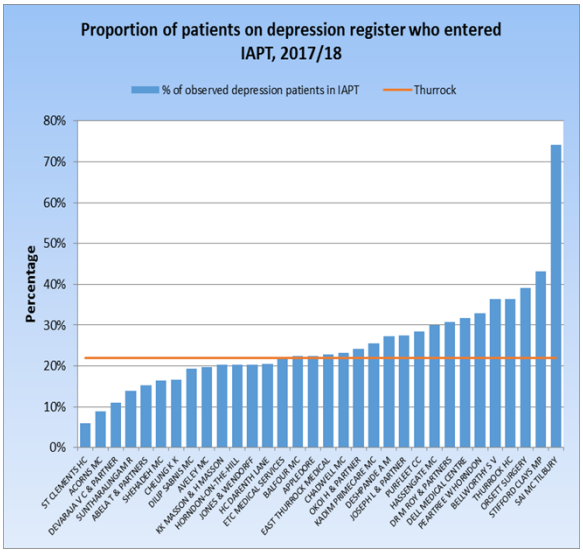
The most common treatment options for CMHDs in Thurrock are prescription of antidepressant medication (most typically Serotonin Selective Re-uptake Inhibitors [SSRIs]). Prescription of anti-depressant drugs has increased year on year between 2013/14 and 2016/17 for Thurrock patients, and there are 20% more anti-depressant items prescribed in 2016/17 compared to the 2013/14 baseline, although significant variation in growth of anti-depressant prescribing exists at GP practice level (from -18% to +70% between 2013/14 and 2016/17). This could partly be a function of variations in increase of need between different practice populations, but also suggests significantly different levels of prescribing behaviour between different surgeries.

Referral to talking therapies (IAPT provided by Inclusion Thurrock) is the second most common treatment option. Latest data from Inclusion, shown in figure 2 suggests that IAPT is treating approximately 20% of patients on QOF depression registers (assuming that all patients treated in IAPT are also diagnosed with depression and recorded on QOF registers). This figure has reduced from 25% in 2016/17.

However, the Mental Health JSNA also highlights that access to IAPT amongst residents with a diagnosis of depression is not uniform across different population groups.

Two thirds of those referred to IAPT are female, which is a greater proportion than would be expected from CMHD prevalence data even after adjusting for the higher prevalence of CMHDs in women compared to men. Only 7% of entrants are aged over 65, despite the fact that this age group makes up 18.4% of the Thurrock population aged 18+ and is at significantly greater risk than the general population of CMHDs. Furthermore, extreme variation exists (a 14-fold difference) between different practice populations which is likely to be (at least in part) due to variation in referral behaviour between surgeries.

Figure 2



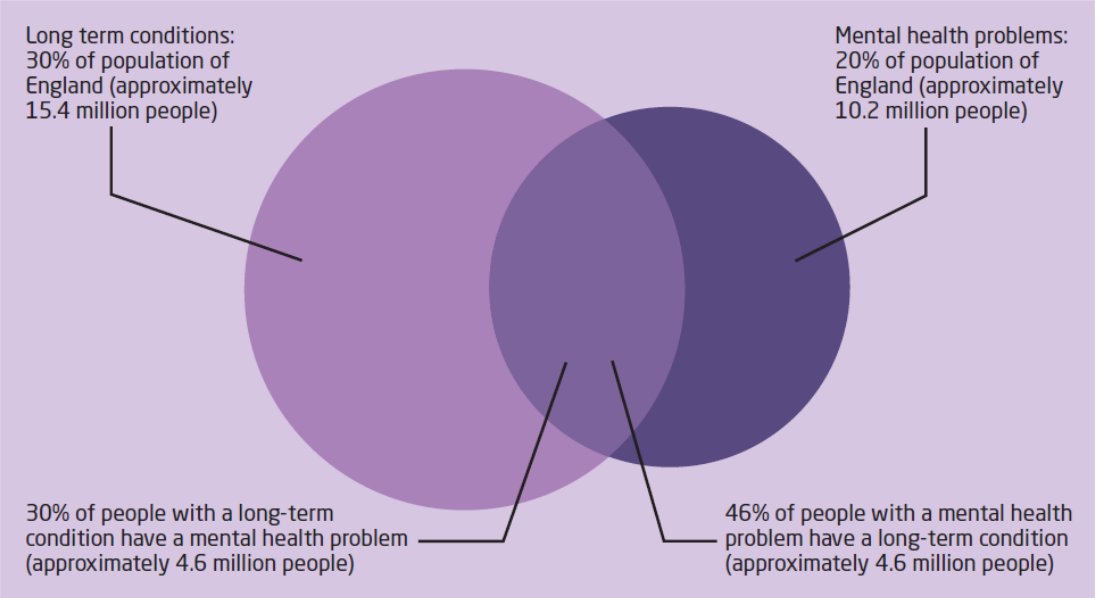
The Mental Health JSNA also highlights variation in management of patients on depression QOF registers between GP practices. The NICE clinical guideline on depression in adults states that patients with mild depression or sub-threshold symptoms be reviewed and re-assessed after initial presentation, normally within two weeks. CG90 recommends that patients with mild or moderate depression who start antidepressants are reviewed after one week if they are considered to present an increased risk of suicide or after two weeks if they are not considered at increased risk of suicide[18]. Patients are then re-assessed at regular intervals determined by their response to treatment and whether or not they are considered to be at an increased risk of suicide. As such QOF states that patients with a new diagnosis of depression should have a 'depression review' between 10 and 56 days after diagnosis. This review should encompass a review of depressive symptoms, social support, alternative treatment options, follow up on progress of external referrals, a medication review (where relevant) and an enquiry of suicidal ideation.

The Mental Health JSNA identified that only 60% number of patients with newly diagnosed depression in Thurrock who are not receiving this appropriate review 10-56 days after diagnosis. Once again there is unacceptable variation between different GP practice populations ranging from 6% to 90% of patients who receive this review.

7.2 The need to integrate CMHD treatment services with physical health services

The evidence base identifies an unequivocal link between CMHDs and long term physical health conditions. The DH estimates that long term health conditions account for 70% of all NHS spending and that between 12% and 18% of this expenditure is attributable to poor mental health. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.[8] Putting this in terms of individual patient costs, the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year.

Figure 3: The overlap between LTCs and MH problems in England, 2012.



Source: Naylor et al, 2012[9]

Co-morbid mental health problems are particularly common among people with multiple long-term conditions. Data from the World Health Surveys indicate that people with two or more long-term conditions are seven times more likely to have depression than people without a long-term condition.[19]A 2012 report by The King's Fund found that 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. A significant part of the explanation for poorer clinical outcomes is that co-morbid mental health problems can reduce a person's ability to manage their own physical condition actively, leading to poorer adherence to treatment plans and greater association with unhealthy behaviours such as smoking[20].

The strong relationship between mental health and LTCs suggests that care for large numbers of people with LTCs could be improved by the better integration of MH support with primary care LTC management programmes. The challenge is to integrate interventions for MH within physical health management protocols rather than merely overlaying MH interventions on top of existing protocols. Estimates in the Mental Health JSNA suggest that for Thurrock this would require integrating services for between 15,600 and 16,000 patients. Using the DH figures quoted earlier in terms of **average excess treatment costs attributable to untreated depression/anxiety with co-morbid physical long term health conditions**, **this would suggest a potential additional cost to the Thurrock local health economy of £28.16M**

The Tilbury and Chadwell *Case for Change* set out proposals to create a more integrated Long Term Conditions service within a locality network of GP surgeries that would be able to provide clinical management for multiple long term conditions and include IAPT services, providing a 'one-stop-shop' for residents. Implementation of this concept has been slow, hampered in part by fragmentation of current services for physical long term conditions between Primary and Community Care, and across different disease specialities. Further needs assessment work to

understand the scope for integration is on-going. Similarly IAPT have been resourced via an external funding stream obtained by Thurrock CCG to develop a programme of psychological support for patients with physical long term health conditions, although this is also in its early stages.

There is also an opportunity to embed case finding for physical long term health conditions, for example hypertension into IAPT and other mental health treatment service pathways, and conversely to screen for depression/anxiety within care pathways relating to physical long term health conditions. Work to embed this best practice has already commenced as part of the *Tilbury and Chadwell New Model of Care* Long Term Conditions Management Work Stream.

There is an urgent need to accelerate progress and integrate these two work streams to create a single long term conditions offer that addresses psychological and physical health needs of circa 16,000 Thurrock residents who are living with physical long term health conditions and co-morbid depression and anxiety.

In the medium term, there is further opportunity to provide significantly greater integration of long term physical and mental health condition treatment services through re-modelled workforce operating from the Integrated Medical Centres.

7.3 The need to broaden and integrate the current offer

Treatment options for those with CMHDs managed within Primary Care remain relatively narrow and almost exclusively clinical, with the offer for the vast majority of patients comprising of anti-depressant medication and/or talking therapy via IAPT. As such, the approach to date has been tailored at an individual level and almost exclusively deficit based.

However, there is clear evidence that CMHDs do not occur 'in a vacuum' and are 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*[21] 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.[22,23] 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.

7.3.1 Enhancing social capital – leveraging an assets based approach

A new model of care for treating CMHDs needs to 'join the dots', triangulating pharmaceutical interventions and the offer of talking therapies with action to connect residents with mentally protective community assets that improve social capital, and where appropriate interventions that help address wider determinants of help including access to employment and training.

> *"Working at Hardie Park as a volunteer has helped me manage my mental health due to being part of a community and not being isolated."*
>
> **67 year old female Thurrock resident**

Significant opportunity 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. Systematising of exercise on prescription as another valid treatment option also has to potential to improve population based mental health.

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 services 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. In the short term, other potential mechanisms to achieve this could include standardising a referral template on SystmOne with a broader range of treatment options, systematising social prescribing into the CMHD care pathways and integrating employment support services with Primary Care and IAPT

Social Prescribing is one mechanism through which to achieve the above and is currently being piloted in Thurrock. The service, currently managed by CVS employs 3.0WTE social prescribers that aim to work as part of GP surgery teams and see patients who have issues in their lives that may not have an underlying clinical cause. CVS report that 60% of patients seen by social prescribers have some level of mental ill-health problem. By providing space for clients to work through problems with a social prescriber, empowers them to identify positive solutions. The social prescribers are also able to connect their clients with other assets within the community that may help them address their own problems.

The Social Prescribing Service is currently running as a pilot and is available to 21 of the 29 GP practices in Thurrock. As such there is currently insufficient capacity within the service to provide a systematic and uniform 'offer' to all patients with a CMHD being treated in primary care, and contact with this cohort is at present somewhat opportunistic. A new model of care for CMHD needs to expand and embed social prescribing into clinical practice of all GP surgeries in treating patients with depression or anxiety.

7.3.2 Work as a health outcome

Integrating employment support services with CMHD treatment services within a new model of care could also be a 'quick win'. Local intelligence suggests that 46% of Thurrock residents (2,160 people) claiming Employment and Support Allowance are doing so because of a mental health problem. Providing *Employment Advisors/Coaches* as part of an expanded offer within IAPT has been trialled successfully in other parts of the UK. Supporting this with an outcomes framework that promotes 'being in work' as a health outcome for treatment should also be considered in any new model of care.

Individual Placement Support (IPS) is a new programme of support offered to patients with SMI that seeks to enable them to get tailored employment support. Thurrock was unsuccessful in a bid for Wave 1 funding of IPS, but wishes to apply for IPS resource in the wave 2 funding round. There may be additional opportunities to embed employment support programmes as part of the Recovery College.

7.3.3 Physical Activity as a treatment option

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. A recent meta-analysis of the effects of exercise on depression/depressive symptoms in 58 randomized controlled trials (n = 2982) indicated that participants in the exercise treatment had significantly lower depression scores than those receiving the control treatment or no-treatment. The meta-analysis also showed that clinically depressed individuals receiving exercise as an intervention showed greater improvement that non-clinically depressed individuals, and that within the clinically depressed population exercise treatment was as at least equally effective to antidepressant medication and psychotherapy. Within clinically depressed populations, interventions lasting 10 – 16 weeks result in larger effects than interventions lasting 4 – 9 weeks; and exercise bouts of 45 – 59 minutes produce larger effects than bouts of 30 – 44 minutes and of ≥ 60 minutes. [24]

The same meta-analysis concluded similar positive results when considering the impact of exercise as a treatment for anxiety. 46 studies examined concluded a positive treatment effect of exercise on anxiety. Exercise was shown to be more effective than stress management education, slightly more effective than group therapy, stretching and yoga, relaxation and meditation, and as effective as cognitive behavioural therapy. Only psychopharmacotherapy produced a very small greater anxiety reducing effect than exercise.[23]

An *Exercise on Referral* intervention is currently commissioned by Public Health (partly via the Better Care Fund). This allows GP practices and Inclusion Thurrock to refer patients with a diagnosis of a range of long term health conditions (including depression and anxiety) to a structured exercise programme provided by Impulse Leisure. However, of the 111 referrals to the programme in Q1 of 2018/19, only five were placed into the mental health stream of which four from GPs and one directly from Inclusion. This would suggest that like social prescribing, prescribing exercise as a treatment intervention needs to be expanded.

7.4 A New Model of Care for CMHDs: Next Steps

High Level Recommendations	• Address the variation in referral to IAPT for CMHDs amongst GP practices such that a minimum of 25% of patients estimated to have a CMHD receive treatment each year, and age and sex variation is also reduced. • 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 and future Stretched QOF interations. • Expedite integration of IAPT Services with other Long Term Physical Health conditions to create single integrated 'on-stop-shops' where all LTCs can be dealt with at the same time, as part of *Better Care Together Thurrock* transformation • Increase the capacity of the current Social Prescribing Service and embed it within clinical teams of all GP Practices, through the roll out of Locality Based Shared Mixed Skill Workfce Teams • Design and implement a *New Model of Care* for CMHDs that encompasses programmes that support residents to address worklessess, increase physical activity and increase social capital and community connectivness, building on existing community assets.
Key Questions for further Metal Health Transformation	• What are the key causes of variation in current referral patterns across local GP practice populations into IAPT and what needs to happen to reduce this variation? • What other actions need to occur to support individual practices and localities to reduce variation in clinical management of patients with CMHDs? • What does an integrated model of physical and mental long term conditions management look like, and how is this best delivered through Primary Care Transformation work at locality level? • What additional resource is required to expand the current Social Prescribing service to all GP surgeries and how can this be funded? • What does a new model of care for CMHDs look like that encompasses a broader strengths/asset based approach and how do we design, implement and resource this?
Existing Assets to build on	• Primary Care Locality Mixed Skill Workforce Team • Tilbury and Chadwell Long Term Conditions Working Group Programme • Primary Care/PH Development Team • Stretched QOF Programme and Practice Based Profile Card • Thurrock MIND • Existing Social Prescribing Programme • Community Hubs • Local Area Coordinators • Wider third sector community assets • Existing Employment Support Programmes • Exercise on referral programme • Recovery College

8 A New 'Enhanced Treatment' Model with a greater focus on prevention and early intervention

This paper defines *Enhanced Treatment* as any service aimed to assist the cohort of patients with mental ill-health that is more complex than Common Mental Health Disorders (as discussed in section 7). As such, *Enhanced Treatment* encompasses the needs of patients with disorders deemed too complex to be treated by IAPT or in Primary Care alone.

NHS England has defined a series of 12 *Mental Health Treatment Clusters;* groups of patients with similar clinical characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool.[25] A description the 12 clusters together with likely primary diagnoses relating to each is given in Appendix A. Inclusion Thurrock generally accept referrals from patients falling into clusters 1-3 (and possibly cluster 4). As such, this paper defines 'Enhanced Treatment' as interventions required for patients in clusters 4 and above. This would include a wide spectrum of patients from those with 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.

Evidence from the Mental Health JSNA, LGA Peer Review and User Voice suggests that the current health and care system is not adequately addressing the needs of this broad cohort of patients. The following issues have been identified and will be discussed in turn:

1) Inadequate provision of the current service offer to patients at the lower end of Enhanced Treatment spectrum of clusters *("The Missing Middle")*

2) A need to address fragmentation in current care pathways and broaden the focus of the current offer in terms of:
    a. Primary and Secondary Care
    b. Pathways within Secondary Care including continuity of care relationships
    c. Physical and Mental Health
    d. Social and community support
    e. Housing
    f. Employment

3) Inadequate focus on prevention and recovery

8.1 Inadequate provision of the current service offer to patients in lower end of the Enhanced Treatment spectrum - the *"Missing Middle"*

The LGA Peer Review concludes that when patients meet the EPUT crisis team criteria threshold and receive a service from EPUT, the service they receive is generally perceived as good. However the LGA Peer Review, user voice and other local intelligence suggest that there is a cohort of patients too mentally unwell to be treated by IAPT but who are not considered unwell enough to meet current EPUT thresholds for treatment. The Peer Review team referred to these as *The Missing Middle*. This suggests that the current threshold for accessing EPUT services is set too high.

EPUT referral criteria state that they accept all patients with needs that place them in Cluster 5 and above. Given that IAPT accept patients up to cluster four, the current referral criteria thresholds are

reported struggle to explain a lack of service provision for *The Missing Middle* unless they all fall into cluster 4 and are not accepted by IAPT. As such, this raises the question of whether stated referral thresholds are being applied correctly and warrants further investigation.

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. What they require is a coordinated response from multiple agencies.

The LGA Peer Review concluded that commissioning for *The Missing Middle* needs to include step-down, personality disorders and dual diagnosis and that it needs to integrate with Primary Care

8.2 The need to 'broaden' and integrate the current offer

Whilst the service provided by EPUT is perceived as positive in clinical terms, the LGA Peer Review, MH JSNA and user voice intelligence suggests that there is a need to broaden the current treatment offer to better integrated with other services that can assist in the recovery of mental ill health commenting that *"Secondary Mental Healthcare needs to benefit from a wider multi-disciplinary team approach".* This paper argues that a radically different approach to treating patients with serious mental ill-health is required locally that triangulates a clinical treatment offer with wider socio-environmental factors including family and community support, employment and housing.

Half of the current workforce at Grays Hall consist of Mental Health Social Workers seconded from Thurrock Council under current section 75 arrangements. This workforce should have a key role in addressing the wider determinants of health in clients with complex needs. The LGA Peer Review commented that "*social work values and practice as a profession were not adequately asserted and owned within the Grays Hall Team"*, and that there was a need for the current social work profession *to focus more on the most complex cases, leaving the needs of less complex cases to be met by other arrangements".*

Early Intervention in Psychosis has been shown to be highly effective in treating and preventing relapse of patients experiencing their first episode of psychosis (FEP). EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes. NICE states that from 1 April 2016 more than 50% of people experiencing first episode psychosis (FEP) should be treated with a NICE-approved care package within two weeks of referral and that 8 NICE Quality Standards shown in figure 3 should be followed as a measure of quality for EIP services:

Figure 3: NICE Quality Standards for Early Intervention in Psychosis (NICE QS80).

Quality Statements	Action (in adults)
Maximum waiting time from referral to treatment	Adults with FEP start treatment in EIP services within 2 weeks of referral
Psychological therapy	Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp)
Psychological therapy	Family members of adults with psychosis are offered family intervention
Medicines management	Adults with schizophrenia that has not responded adequately to treatment with at least two antipsychotic drugs are offered clozapine.
Education, Employment and Training	Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.
Support for Carers and families	Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

Source: NICE Psychosis and Schizophrenia in Adults, Feb 2015

The MH JSNA reported that as of February 2018 no patient with First Episode Psychosis (FEP) began treatment in an Early Intervention for Psychosis service provided by EPUT against a national target of 50% and that there was no evidence that the eight quality standards above were being adhered to as EPUT was not commissioned to collect or provide this data. This suggests that the current service offer is not as broad as it should be and may not be triangulating other key elements of wellbeing including the physical health and lifestyles of their patients, assistance with employment and support for carers and families. Since the MH JSNA was published, Public Health staff have met with EPUT, Inclusion and Social Care to discuss EIP going forward, and developed a new service specification which stipulates adherence and data recording against the NICE quality standards. EPUT are currently modifying their systems to enable this and supplying better monitoring data.

8.2.1 Fragmented healthcare pathways and a lack of continuity of care relationships

Local intelligence suggests fragmentation of current healthcare pathways for patients with serious mental ill-health. This includes a disconnect between Primary and Secondary Mental Healthcare, fragmented pathways within secondary mental healthcare including multiple teams being involved in a patient journey and a silo'd working in terms of the physical and mental healthcare needs of individuals.

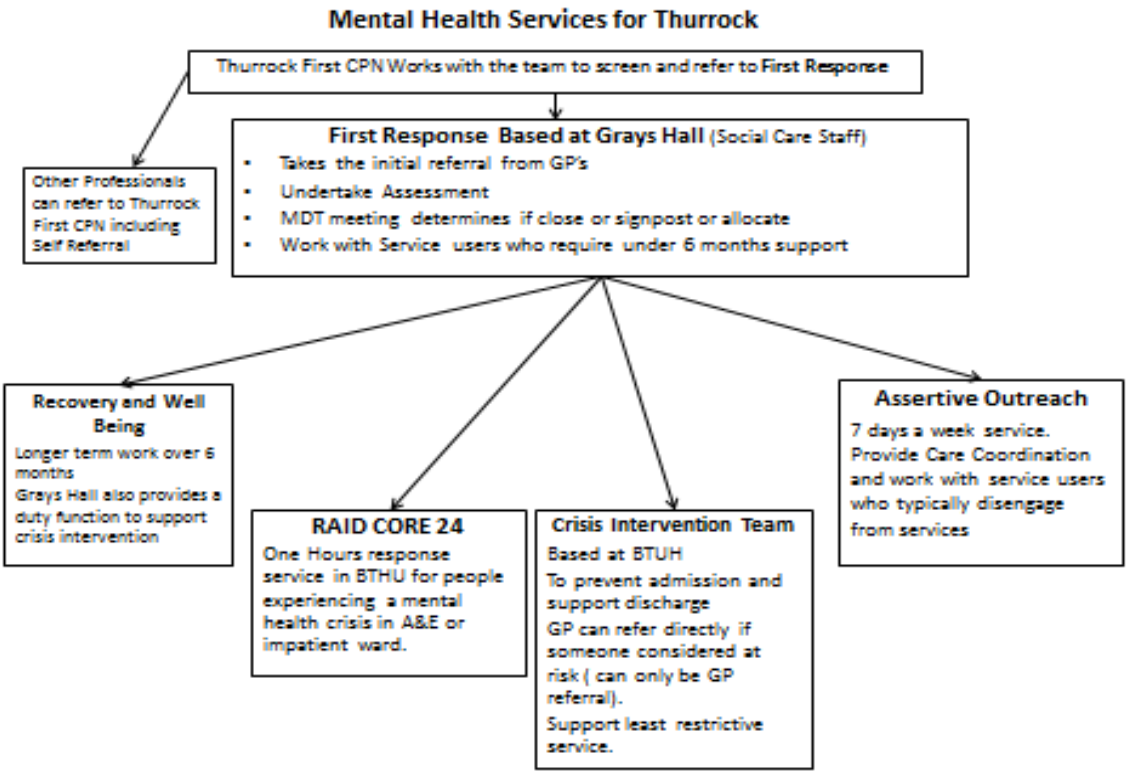
Provision of mental health care at Grays Hall is not adequately integrated within Primary Care and Thurrock Council has an ambition to move current provision at Grays Hall into the four Integrated Medical Centres when built to provide a more integrated treatment offer. However, given that it is unlikely that the first IMC will be open prior to 2020/21 there is a more urgent need to improve the

interface between Grays Hall and current Primary Care provision as part of new treatment models in *Thurrock Better Care Together* including provision of Psychiatric Nursing Support as part of the new Primary Care Mixed Skilled Workforce teams and within a wider offer of support to Community Wellbeing Teams.

EPUT provide the services outlined in figure 4 below. Thurrock Council delegate its statutory duty to provide adult social care assessment and care management services under the Care Act 2014 to EPUT through a Section 75 Agreement. A Community Psychiatric Nurse 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 six months of support or less. 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. The Crisis Intervention Team is based at 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 on inpatient wards.

Inpatient assessment and treatment across working age adults and older age adults is provided through a CCG block contract.

Figure 4: Secondary Mental Healthcare Services in Thurrock



"I'm fed up with the change of workers and high turn-over of staff within the Mental Health Service. Mental health workers are not informing people correctly that they are leaving and the patient will have to change worker. Grays Hall is not offering enough support"

The user voice work undertaken by Healthwatch and The Thurrock Coalition highlights concerns relating to lack of continuity of care relationships, and patients being passed from one individual to another.

8.2.2 Fragmentation between Physical and Mental Health Needs of Patients with SMI.

People with severe mental illnesses such as bipolar disorder or psychosis are at particularly high risk of physical ill health as a result of medication side effects, lifestyle-related risk factors and socioeconomic determinants[26] For example, smoking rates among people with a mental health condition are three times higher than among the general UK population (Public Health England 2015).

The high prevalence of co-morbid drug and alcohol addiction in people with mental health disorders has been well documented since the 1980s with data showing that people diagnosed with mood or anxiety disorders are twice as likely as the general population to also suffer from drug or alcohol misuse or dependence.[27]Despite this, evidence shows that people with SMI are less likely than the general population to receive health improvement interventions such as smoking cessation support, and most mental health professionals do not feel that reducing smoking is within their remit. [28]People with severe mental illnesses are also less likely to receive many other forms of preventive care, such as routine cancer screening[29]

Certain psychotropic medications are known to cause weight gain and obesity, leaving people at greater risk of developing diabetes or cardiovascular diseases, and contributing to low quality of life[30] The high prevalence of smoking, alcohol abuse and other lifestyle-related risk factors also contributes to this, and is one of the main factors responsible for the dramatic 15–20-year gap in life expectancy among people with severe mental illnesses.[31]

Contrary to some assumptions, people with severe mental illnesses who smoke are just as likely to want to quit as the general population, but are more likely to be heavily addicted and to anticipate difficulty quitting[32]. Smoking cessation in this group is associated with improved mental health and reduced levels of medication, illustrating that quality of life as well as longevity is affected [33]

The MH JSNA highlighted the need to address physical as well as mental health needs of patients in secondary mental health care and broaden the current narrow focus of treatment to include lifestyle assessment and improvement programmes. Lifestyle modification services are currently provided by the Thurrock Healthy Lifestyles Team within the council's Public Health Service either directly or through sub-contracted services provided by Impulse Leisure, Weightwatchers, Slimming World and some community providers.

Some good partnership working between Public Health's Healthy Lifestyle Service and EPUT and other providers treating patients with serious mental ill-health:

- All EPUT staff have been trained to Level 1 smoking cessation and two staff are 'level 2' smoking cessation trained and able to provide direct smoking cessation interventions to patients. Level 2 smoking cessation is also available within Inclusions Thurrock's drug and alcohol treatment services.

- NHS Health Checks are beginning to be offered at Grays Hall.
- Wellbeing clinics have recently commenced with Thurrock MIND offering mini NHS Health Checks and have generated referrals into stop smoking, weight management and hypertension treatment services.

There is a need to build upon this and systematise lifestyle assessment and referral into health improvement services as part of transformation work on care pathways.

Drug and Alcohol Treatment Services are currently commissioned by Public Health and provided by *Inclusion Thurrock.* There is also anecdotal evidence from the user voice work, that patients with dual diagnosis are being refused mental health treatment until they have addressed their drug and alcohol problem rather than being treated in parallel for issues that are likely to be strongly linked. There is an urgent need to investigate and address this.

There is some evidence in the Healthwatch user voice work that physical and mental health needs of EPUT patients are being silo'd due to the current system configuration. Some EPUT patients have reported being referred back to EPUT when they have contacted Thurrock First with non-mental health problems.

8.2.3 Interface with social support and community assets

Positive social networks have been linked to good mental health whilst social isolation and loneliness have been linked to poor mental health outcomes. Feelings of loneliness are worse and social network size is smaller among mental health service users than in the general population.[34,35]Previou s studies report loneliness to be related to personality disorders and psychoses[36 37], suicide[38], and more severe depressive symptoms.[39 40 41] Similarly, a systematic review[42] identified that poor social support and quality of relations, and lack of confidants were significantly associated with depression. In the context of severe mental illness, social isolation has been linked to higher levels of delusions[43], lack of insight[44], and higher hospital usage. [45]Conversely, people with stronger social networks were most likely to recover from psychotic symptoms[46]

Thurrock has a positive story to tell in terms of transformation of health and care services in the context of a 'strengths based, community assets approach', both in terms of the success of Local Area Coordination and more widely the *Stronger Together, For Thurrock In Thurrock,* and *Better Care Together Thurrock* programmes. Unfortunately mental health services have not been adequately reflected in strengths/community assets based transformation journey to date. Like housing, providing clinical treatment interventions in isolation to the social context that the patient finds themselves in is unlikely to result in optimum outcomes and recovery.

Opportunities exist in terms of the new Integrated Wellbeing Teams and *Better Care Together Thurrock* to begin to have radically different strength based conversations with mental health service users in terms of treatment and recovery plans set in the context of wider family and community support and social prescribing. However this work is currently in its infancy and certainly not mainstreamed into the EPUT clinical treatment offer. For example, the Social Prescribing Service reports inadequate collaboration between social prescribers and Grays Hall staff.

The User Voice work undertaken by Thurrock Coalition highlight the value of social and peer support from mental health service users. The need of a drop in centre where people with mental health difficulties can go when needing support, more coffee mornings, more peer support opportunities were all highlighted. There may be further opportunities to use the current capacity within the six Community Hubs in Thurrock as a base from which to build further peer support to this cohort.

8.2.4 Interface with housing

There is a significant body of evidence associating housing to mental health. Studies suggest that the overall quality of the housing environment including dampness, overcrowding, noise, poor neighbourhood and levels of infestations is positively correlated with poor mental health outcomes.[47] [48] [49] [50] Research has suggested that concepts of *personal identity* that housing provides[51]; *insecurity of tenure* [52]; *levels of social support* linked to housing design [53]; *parenting practices* in response to inadequate housing including ability for outdoor play [54]and; *perceptions of self-efficacy and life control* in terms of housing type and stress caused by having to deal with faceless bureaucracies [55] [56]ca n explain the interaction between housing and mental health outcome.

> *"My increase in banding level for housing based on medical priority has not been confirmed and I've had no response to my calls from the homelessness team".*
>
> **Thurrock Diversity Network member**

The link between homelessness and poor mental health is particularly strong. Up to 80% of homeless people report some form of mental health issue with 45% having a mental health disorder that has been diagnosed.[57] A considerable proportion of homeless people have a dual diagnosis, with both one or more mental health problems and a problem with drugs and/ or alcohol. Estimates of the prevalence of dual diagnosis among the homeless population vary from 10 to 50 per cent. [58] [59]R ecent research by the former National Mental Health Development Unit and the Department for Communities and Local Government, cited by Homeless Link, suggests that up to 60 per cent of individuals living in hostel accommodation and accessing homelessness services have experienced complex trauma or have an undiagnosed form of personality disorder.[60] [61]

Providing clinical treatment interventions for patients suffering from SMI in an environment where housing/homelessness issues remain unresolved are unlikely to deliver optimum outcomes for residents. As such, the treatment offer for serious mental ill-health needs to occur in the context of ensuring that patients' housing needs are also adequately addressed. Evidence from the LGA Peer Review, user voice work and other local intelligence suggests that this is not happening adequately in Thurrock, with stakeholders not working in a sufficiently integrated and holistic way. Whilst the Peer Review found evidence of *"Housing Services reporting working well with Grays Hall on individual cases",* there is evidence that this is not happening universally or part of a systematic and integrated offer. The Peer Review highlighted *a lack of specialist housing plans* for patients being treated by EPUT, the need for "*Thurrock First to consider interim measures to fill the gap in housing expertise",* and a *"Stretched but effective preventative provision for borderline homelessness is not consistent across the borough, with rising demand from inner-London Migration".*

> *"No, the organisations don't work well together. The Housing Department at the Council doesn't work with mental health services. Housing sees physical impairments but not mental health. Housing are really bad at assisting people with mental health conditions – providing inappropriate housing in the wrong areas and being away from carers/family pushes people back into crisis"*
>
> **Thurrock Diversity Network member**

Conversely, Thurrock Council Housing Team staff report issues with tenants with unmet mental health needs. In addition, the council's current housing allocation policy doesn't take into consideration mental health issues when assigning residents into priority bandings. The LGA Peer Review highlights "*Opportunities to agree a housing strategy and policy for people with Mental*

Health Issues – the same people float around the system". It also highlighted opportunities to *invest to* save to deliver an integrated supported accommodation offer for people with serious mental ill-health *'in*-borough' rather than relying on potentially more expensive out of areas placements. As such, there is considerable scope to provide a more integrated offer between housing and mental health services.
There is the opportunity to develop further work on housing as part of the Market Position Statement Specialist product on MH accommodation, and possibly through revision of the council's Housing Allocation Policies.

8.2.5 Interface with Employment

Being in employment has been shown to be one of the most mentally health protective factors. The workplace provides important opportunities for building resilience, self-esteem and development of social networks. Unemployed people may feel a lack of purpose as well a lack of social opportunities for development of self-esteem.

The Employment and Support Allowance (ESA) is a benefit for people who are unable to work due to illness or disability. The Mental Health JSNA highlighted the high proportion of claims for Employment Support Allowance for Mental Health problems in some wards, with almost 3.5% of the working age population of Tilbury St. Chads claiming ESA because of mental ill health.

Thurrock Council commission *Thurrock World of Work*, a third sector organisation to provide support to people with mental health difficulties to access employment including identification of goals and aspirations, training, work experience and volunteering opportunities. However it is unclear how well integrated this service is into the current EPUT treatment offer and what outcomes it is delivering as we do not currently collect outcome statistics on employment for patients with serious mental ill health. However, these metrics would form part of the IPS offer discussed in section 7.3.2.

Thurrock Council coordinates a Micro-Enterprises programme as part of *Stronger-Together. Micro-enterprises* are delivered by eight or fewer full time equivalent paid or unpaid workers and are completely independent of any larger organisation. They offer a diverse range of flexible and individually tailored community based services that aim to bring real choice to the local care and support market. There is considerable scope to better target and integrate support to people with mental health issues who may be interested in setting up new micro-enterprises and/or participating in/working/volunteering with existing programmes as part of a more holistic employment offer.

Future treatment models need to better integrate support to access employment within them.

Case Study – Open Dialogue, Western Lapland, Finland

'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.

The approach is humanistic and non-hierarchical. Patients are treated in their own homes where possible 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.

Outcomes for patients using the 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.

8.3 Inadequate focus on recovery and relapse prevention

The LGA Peer Review and user voice work highlight the need to strengthen the offer around recovery and relapse prevention. The work of the Recovery College in supporting people to develop the capacity to cope with their mental health problems is seen as positive, and the diverse range of programmes provided by Thurrock MIND as a local asset. However, the user voice work highlight long waiting lists for both services which suggests that they is not operating as part of a single integrated pathway but as discrete services. The issue of clients being discharged from secondary care mental health services following treatment for a mental health crisis, but without adequate on-going care is also highlighted repeatedly in the user voice intelligence.

The Peer Review team also highlighted reports from front line staff and providers that there are a cohort of patients who although not presently in crisis, are at risk of escalating to require higher level support and who were unable to access a service until this happened. The need to invest in lower level mental health prevention services as part of an integrated offer was highlighted by the Peer Review, as was the need to shift the focus of the current service offer from one that deals only with complex patients and those in crisis to one aimed to prevent people reaching crisis in the first

place. The Peer Review highlighted opportunities for 'invest to save' if a more preventative programme of work could be commissioned jointly by Thurrock Council and CCG.

8.4 A new Enhanced Treatment Model of Care: Next Steps

High Level Recommendations

- Further investigate the needs and clinical characteristics of *The Missing*
- Review current referral criteria thresholds across IAPT and secondary care and agree new common standards to ensure service provision is available for *The Missing*
- Develop a new 'enhanced treatment' that model of care that:
  - Reduces fragmentation in current care pathways within EPUT and improves continuity of care
  - Reduces fragmentation between Primary and Secondary Care services
  - Seeks to reduce unnecessary in-patient stays and re-admissions
  - Embeds physical health assessment, health improvement and lifestyle modification into secondary care pathways
  - Provides an integrated treatment offer for patients will dual diagnosis including the ability to have mental ill-heath and drug/alcohol misuse problems being treated in paralell.
  - Better leverages the professional skill set of social care staff
  - Encompasses a 'strengths-based' community asset focus that promotes peer support and increases service users' social capital in the context of their families and community
  - Addresses housing and employment needs of service users as an integral part of their treatment and on-going recovery
  - Shifts the current balance of treatment from one of reactive intervention in crisis to one of proactive crisis and relapse prevention

Key Questions for further Metal Health Transformation

- What are the key needs characteristics of *The Missing Middle* and how does current service commissioning / delivery need to change to meet those needs
- How can we improve communication and shared care between Primary and Secondary healthcare providers?
- Why do current reported threshold criteria for IAPT and EPUT not match the lived experience of service users and how do they need to change to ensure that no service user 'falls between the gap' of IAPT and secondary care?
- How can we re-assert and leverage the professional skill-set of current social workers in transformed services?
- What does an enhanced, integrated and more holistic model of care look like and how do we bring together clinical treatment with community assets, third sector provision, housing and employment support in a single model that wraps around service users, rather than expecting them to access multiple single services?
- How do we best integrated the current service offer at Grays Hall into new clinical models being developed for the four Integrated Medical Centres
- How does commissioning/service delivery models need to change to move to a proactive preventative and relapse-prevention approach, and what will be the impact in terms of population health gain and system-wide return on investment?
- How can we leverage learning from the new *Wellbeing Team* approach about to be piloted in Tilbury and Chadwell and apply it to people with serious mental ill-health?

Existing Assets to build on

- Strong engagement of mental health service users and their voice through *Healthwatch* and Thurrock coalition, and the opportuity for co-design of services
- Primary Care Locality Mixed Skill Workforce Team
- Perceived quality within EPUT and Thurrock MIND
- Existing Social Prescribing Programme
- Community Hubs
- Proposed new models of care of *Community Liaison and Support Teams* and *Wellbeing Teams*
- Local Area Coordinators
- Wider third sector community assets
- Micro-enterprises programme
- Existing Employment Support Programmes
- Exercise on referral programme
- Inclusion Thurrock
- Thurrock Healthy Lifestyles Service

9 A new integrated commissioning and outcomes framework

Commissioning arrangements for the local mental health system in Thurrock as currently fragments, perhaps explaining in part why the provision of service models are also fragmented. NHS Thurrock CCG currently commissions IAPT and healthcare treatment elements of EPUT, although this is increasingly being done in collaboration with other local CCGs on a Mid and South-Essex STP footprint. Thurrock Council commissions social care elements of EPUT through a section 75 agreement.

Third sector provision in terms of mental health is commissioned by both Thurrock CCG and Council separately, and within the council services are commissioned from both Public Health and Adult Social Care and Communities divisions of the Adults Health and Housing Directorate. Supported Accommodation is commissioned by Adult Social Care with homeless and housing fieldwork services being provided directly by Thurrock Council.

GP provision is commissioned by NHS England with additional contracts for lifestyle improvement services and the mental health elements of Stretched QOF being commissioned independently by the Public Health Team. The CCG and Public Health also work together as part of a joint Primary Care Development Team to provide additional support and encourage transformation and service improvement within Primary Care. The Public Health Team also commissions Drug and Alcohol Treatment from *Inclusion Thurrock,* who also provide IAPT services, but through a different contractual route.

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 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.

There is a clear need to rationalise and integrate the current disparate and fragmented commissioning arrangements relating to the local mental health service, 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. 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 7 and 8. It is really important that new arrangements integrate with wider work on systems wide commissioning transformation as part of the new *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.

9.1 Improving Commissioning Intelligence

The Mental Health JSNA highlights a number of key areas where informatics intelligence to support commissioning is inadequate and need to be addressed. These include:

- The need to understand at patient level the issue of re-admission rates at Basildon Hospital and identify interventions to reduce the numbers of high intensity users accessing beds (the 'revolving door' patients).
- The need to better code patients who self-harm, particularly in A&E
- The need to collect and report Early Intervention in Psychosis outcome measures standardised against NICE Guidance.
- The extent of depression screening throughout the system and opportunities to improve it
- The need to develop predictive modelling and risk stratification tools to better describe the risk factors for the cohort of patients attending A&E with mental health crises in order to design interventions and look for opportunities for earlier intervention
- The need to work with adult social care commissioners to determine the cost of services per package as these are currently unavailable
- The need for all service providers, particularly emergency services to code and flag para-suicides so that these can be followed up promptly with appropriate interventions

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 SystmOne data by autumn 2018. There is a need to expedite linking of EPUT held data as part of this programme moving forward.

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

9.2 Commissioning Arrangements: Next Steps

High Level Recommendations	• Create a single shared commissioning function between Thurrock Council and Thurrock Clinical Commissioning Group to undertake all Mental Health commissioning including all commissioning of third sector and public health provision related to mental health as part of the transformation journey • Agree a single strategic commissioning plan for mental health in Thurrock • Agree a single shared outcomes framework for mental health that encompasses Primary and Secondary Care outcomes, and wider determinants of health and wellbeing including prevention and recovery,physical health of the service users, housing, employment and social capital • Undertake further informatics work to support commissioing intelligence as set out in section 9.1
Key Questions for further Metal Health Transformation	• How do we bring together existing commissioning capacity across Thurrock Council and Thurrock CCG? • How do we manage the interface between what is commissioned at Thurrock level and what is commissioned by the CCG Joint Committee at Mid and South Essex STP level, and where do we need to involve STP partners? • What are the key shared outcomes that we want a newly transformed mental health system in Thurrock to be delivered and how do we agree and measure them? • How do we best involve user voice and the co-design of outcomes? • How can we quantify the impact of a newly transformed mental health service on system wide budgets in order to make the financial case for 'invest to save' initiatives? • How can we rationalise the number of process KPIs from existing contracts to free up front line provider staff to innovate? • How does a new outcomes framework and commissioning arrangements play into wider work in its infancy around the *Thurrock Integrated Care Alliance* and what does it mean for providers in terms of length of future contracts and financial risk-reward share? • What does the new outcomes framework and commissioning arrangements mean for the current section 75 agreement between EPUT and Thurrock Council and how do we best review this? • How can we better strengthen commissioning intelligence and how do we best expedite inclusion of EPUT data sets into the MedeAnalytics integrated patient data lake?
Existing Assets to build on	• Existing commissioning expertise held within the council, CCG and at STP level • Strong informatics expertise held within the Healthcare Public Health function • Mede-analytics integrated data set development • User voice engagement • Thurrock Integrated Care Alliance and work to develop an MoU and Alliance Agreement • Goodwill and strong partnership working commitment from all local partners

10 Conclusions and Next Steps

This paper has aimed to triangulate learning from the Peer Review, Mental Health JSNA Product and Healthwatch User Voice work with other local intelligence and the published evidence base around the five key themes that emerged from this work, as discussed in sections 5 to 9.

The issue of mental health and mental health service transformation is highly complex, and the no one person nor stakeholder organisation within Thurrock can have an adequate view of the system to know all the answers. As such, this paper perhaps highlights more problems than it proposes solutions, and has sought to set out a series of questions that the author hopes are a helpful starting point for further discussion from all stakeholders as to the next steps. The author encourages all stakeholders to review, comment and add to the proposals set out within this paper.

As stated in the introduction, Public Health have identified resource for a full time Strategic Lead for Mental Health Transformation to be recruited as a resource to coordinate and lead further work on mental health transformation in Thurrock, taking a 'whole systems' approach across all stakeholder organisations and working in partnership with respective commissioners and providers in both health and care to develop and agree a single, shared narrative for future mental health provision locally. It is proposed that the first key deliverable from this post will be an agreed Mental Health Transformation Strategy encompassing new models of care for CMHD and Serious Mental Ill-Health and associated outcomes framework and commissioning arrangements. Specific objectives of this work programme could include (but may not be limited to) the following:

- Map out Adult Mental Health as a whole system, incorporating relevant community and wider determinants services, to include referral mechanisms, patient flows, the specifics around the s75 etc.
- Undertake a comprehensive review of the literature to better understand best-practice models of delivering crisis care in Mental Health
- Maintain an influential presence within the existing Essex / Mid & South Essex STP work streams to ensure Thurrock transformational programmes are incorporated into the work agenda
- Review existing specialist accommodation for those with Serious Mental Health needs in Thurrock, and undertake a deep dive incorporating best practice from other areas, and model expected impacts for Thurrock if applied locally
- Work with relevant stakeholders to redesign the performance reporting requirements across all MH programmes (EIP, Crisis, Primary Care Mental Health, Dementia etc.), standardising against agreed Outcomes
- To unpick the true picture around demand on the Grays Hall Crisis line, and support redesign where required to ensure patients can receive quality care in a timely manner (in conjunction with literature review outcomes as mentioned above)
- Work with the third sector to better understand perceived barriers to accessing MH services and look at implementing solutions to address these
- Prioritise the identification of 'dual-diagnosis' in SMI patients, and working with stakeholders to streamline referral pathways where required
- Supporting implementation and establishing effectiveness of existing programmes such as Physical Health Checks for SMI patients in collaboration with EPUT staff
- To maximise opportunities to embed prevention within MH services

- To support monitoring of the reporting around the SALT return (in conjunction with Council PQBI team –
- To develop mechanisms to allow service user voice and co-design of future models of care
- To support the wider Communications around the transformation of mental health services, feeding into relevant stakeholder meetings, public events etc.

It is proposed that a Mental Health Transformation Steering Group be formed, containing appropriate representation from all key partner organisations to oversee the strategic work programme of this post. It may be possible to expand the existing membership and Terms of Reference of the Mental Health Operation Group to fulfil this function.

References

[1] World Health Organization. *The global burden of disease: 2004 update.* Geneva: World Health Organization; 2008. Available at: www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf

[2] Friedli L, Parsonage M. *Promoting mental health and preventing mental illness: the economic case for investment in Wales*. Cardiff: All Wales Mental Health Promotion Network; 2009. Available at: www.centreformentalhealth.org.uk/publications/promoting_mental_health_Wales.aspx?ID=614

[3] Centre for Economic Performance Mental Health Group. *How mental illness loses out in the NHS*. London: London School of Economics and Political Science; 2012. http://cep.lse.ac.uk/_new/research/mentalhealth/

[4] Royal College of Psychiatrists. *No health without public mental health: the case for action*. London: Royal College of Psychiatrists; 2010. Available at: www.rcpsych.ac.uk/mediacentre/pressreleasearchives/2010/publicmentalhealth.aspx

[5] COI; 2011. MH JSNA. Cited in Thurrock Mental Health JSNA 2018

[6] Public Health England Fingertips – Common Mental Health Disorders Prevalence Profile; 2016.

[7] Thurrock Joint Strategic Needs Assessment for Mental Health Disorders. Thurrock Council Public Health Service; 2018. https://www.thurrock.gov.uk/sites/default/files/assets/documents/jsna-adult-mental-health-201802-v01.pdf

[8] Brown S, Kim M, Mitchell C, Inskip H. 'Twenty-five year mortality of a community cohort with schizophrenia'. *British Journal of Psychiatry*, 2010;vol 196, pp 116–21. Available at: http://bjp.rcpsych.org/content/196/2/116.long

[9] Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. *Long-term conditions and mental health: the cost of co-morbidities*. London: The King's Fund; 2012. Available at: www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health

[10] Coulthard M, Farrell M, Singleton N, Meltzer H. T*obacco, alcohol and drug use and mental health*. London: Her Majesty's Stationery Office; 2002. Available at: www.ons.gov.uk/ons/rel/psychiatric-morbidity/tobacco--alcohol-and-drug-use-and-mental-health/index.html

[11] Osborn DPJ, King MB, Nazareth I. 'Physical activity, dietary habits and coronary heart disease risk factor knowledge amongst people with severe mental illness. A cross sectional comparative study in primary care'. *Social Psychiatry and Psychiatric Epidemiology.* 2007;vol 42, no 10, pp 787–93.

[12] Mitchell AJ, Selmes T. 'Why don't patients attend their appointments? Maintaining engagement with psychiatric services'. *Advances in Psychiatric Treatment.* 2007;vol 13, pp 423–34. Available at: http://apt.rcpsych.org/content/13/6/423.full (accessed on 1 August 2014)

[13] Conley RR, Kelly DL.. 'Management of treatment resistance in schizophrenia'. *Biological Psychiatry*, 2001;50(11):898–911.

[14] Benton T, Staab J, Evans DL. 'Medical co-morbidity in depressive disorders'. *Annals of Clinical Psychiatry*. 2007;19(4):289–303.

[15] DiMatteo MR, Lepper HS, Croghan TW. 'Depression is a risk factor for noncompliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence'. *Archives of Internal Medicine*. 2000;160(4):2101–07. Available at: http://archinte.jamanetwork.com/article.aspx?articleid=485411

[16] Wake I.R, Sanford E, and Payne M. *A Sustainable Health and Care System.* Annual Report of The Director of Public Health 2016. Thurrock Public Health Service, December 2016. https://www.thurrock.gov.uk/sites/default/files/assets/documents/annual_health_report_2016_summary.pdf

[17] Wake I.R, *The Case for Change: A New Model of Care for Tilbury and Chadwell*,. Thurrock Public Health Service, September 2017. https://democracy.thurrock.gov.uk/documents/s13765/The%20Case%20for%20Change.pdf

[18] NICE CG90. Depression in adults: recognition and management. 2009. https://www.nice.org.uk/guidance/CG90

[19] Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet*, 370: (**9590)**, pp 851–8.

[20] DiMatteo MR, Lepper HS, Croghan TW 'Depression is a risk factor for noncompliance with medical treatment: Meta-analysis of the effects of anxiety and depression on patient adherence'. *Archives of Internal Medicine*. 2000; 160,**(14):** 2101–7.

[21] 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

[22] 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.

[23] 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

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

[25] NHS England, Mental Health Clustering Booklet V5.0. NHS England Publications Gateway Reference 04421. 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf

[26] Joint Commissioning Panel for Mental Health 2013 *Guidance for commissioners of liaison mental health services to acute hospitals*. London: Joint Commissioning Panel for Mental Health. Available at: www.jcpmh.info/good-services/liaison-mental-health-services/ (accessed on 2 February 2016).

[27] National Institute on Drug Abuse. *Comorbidity, Addiction and Other Mental Illness*. September 2010. https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf

[28] Kulkarni M, Huddlestone L, Taylor A, Sayal K, Ratschen E. 'A cross-sectional survey of mental health clinicians' knowledge, attitudes, and practice relating to tobacco dependence among young people with mental disorders'. *BMC Health Services Research*. 2014;14:618. Available at: http://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-014-0618-x (accessed on

19 February 2016)

[29] Lawrence D, Kisely S. 'Inequalities in healthcare provision for people with severe mental illness'. Journal of Psychopharmacology. 2010; 24(4):61–8.

[30] Gatineau M, Dent M. *Obesity and mental health*. Oxford: National Obesity Observatory. 2010; Available at: www.noo.org.uk/uploads/doc/vid_10266_Obesity%20and%20mental%20health_FINAL_070311_MG.pdf (accessed on 3 December 2015).

[31] De Hert M, Dekker JM, Wood D, Kahl KG, Holt RIG, Möller H-J. 'Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC)'. *European Psychiatry: The Journal of the Association of European Psychiatrists*. 2009;24(6):412–24.

[32] Royal College of Physicians, Royal College of Psychiatrists. *Smoking and mental health*. London: Royal College of Physicians and the Royal College of Psychiatrists; 2013. Available at: www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr178.aspx (accessed on 3 December 2015).

[33] Campion J, Checinski K, Nurse J, McNeill A. 'Smoking by people with mental illness and benefits of smoke-free mental health services'. *Advances in Psychiatric Treatment*. 2008;14:217–28.

[34] 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.

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

[36] Neeleman J, Power MJ.Social support and depression in three groups of psychiatric patients and a group of medical controls, *Social Psychiatry and Psychiatric Epidemiology*. 1994;29(1)46–51.

[37] DeNiro DA. Perceived alienation in individuals with residual-type schizophrenia, *Issues in Mental Health Nursing.* 1994,16(3):185–200, DOI: 10.3109/01612849509006934

[38] Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press; 2002,

[39] Segrin C. Social skills, stressful life events, and the development of psychosocial problems, *Journal of Social and Clinical Psychology*. 1999;18(1):14–34, DOI: 10.1521/jscp.1999.18.1.14.

[40] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA. Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses, *Psychology and Aging*. 2006;21(1):140–51, DOI: 10.1037/0882-7974.21.1.140.

[41] Luanaigh CO, Lawlor BA. Loneliness and the health of older people, *International Journal of Geriatric Psychiatry*. 2008;23(12):1213–1221

[42] Schwarzbach M, Luppa M, Forstmeier S, Konig HH, Riedel-Heller SG. Social relations and depression in late life – a systematic review, *International Journal of Geriatric Psychiatry*. 2014;29(1): 1–21.

[43] Garety PA, Kuipers E, Fowler D, Freeman D, Bebbington PE. A cognitive model of the positive symptoms of psychosis, *Psychological Medicine*. 2001;31(2):189–195.

[44] White R, Bebbington P, Pearson J, Johnson S, Ellis D. The social context of insight in

schizophrenia, *Social Psychiatry and Psychiatric Epidemiology*. 2000;35(11):500–507.

[45] Mgutshini T. Risk factors for psychiatric re-hospitalization: an exploration, *International Journal of Mental Health Nursing*. 2010;19(4):257–267

[46] Calsyn RJ, Winter JP. Social support, psychiatric symptoms, and housing: a causal analysis, *Journal of Community Psychology.* 2002;30(3):247–259.

[47] Brown, G. W., Brolch´ain, M. N., & Harris, T. Social class and psychiatric disturbance among women in an urban population. *Sociology,* 1975;*9*:225–254.

[48] Kasl, S. W., Will, J., White, M., & Marcuse, P. Quality of the residential environment and mental health. In A. Baum & J. E. Singer (Eds.), Advances in environmental psychology (pp. 1–30). Hillsdale, NJ: Erlbaum; 1982

[49] Zahner, G. E. P., Kasl, S. V., White, M., & Will, J. Psychological consequences of infestation of the dwelling unit. *American Journal of Public Health.* 1985; *75*: 1303–1307.

[50] Byrne, D. S., Harrison, S., Keithley, J., & McCarthy, P. *Housing and health.* London: Gower; 1986.

[51] Halpern, D. *Mental health and the built environment*. London: Taylor & Francis; 1995.

[52] Macintyre, S., Ellaway, A., Der, G., Ford, G., & Hunt, K. Do housing tenure and car access predict health because they are simply markers of income and self-esteem? A Scottish study *Journal of Epidemiology and Community Health.* 1988;*52*:657–664

[53] Baum, A., Gatchel, R., Aiello, J., & Thompson, D. Cognitive mediation of environmental stress. In J. H. Harvey (Ed.), *cognition, social behavior, and the environment* (pp. 513–533). Hillsdale, NJ: Erlbaum; 1981

[54] Bartlett, S. Does inadequate housing perpetuate children's poverty? *Childhood.* 1988;*5*: 403–420.

[55] Rosenbaum, J. E., Reynolds, L., & Deluca, S. How do places matter? The geography of opportunity, self-efficacy and a look inside the black box of residential mobility. *Housing Studies.* 2002; *17*: 71–82.

[56] Evans, G. W., Saltzman, H., & Cooperman, J. Housing quality and children's socioemotional health. *Environment and Behavior.* 2001; *33*: 389–399.

[57] https://www.homeless.org.uk/facts/our-research/all-research-reports/homelessness-and-health-research, 2018.

[58] St Mungo's. *Happiness matters: homeless people's views about breaking the link between homelessness and mental ill health*; 2009

[59] Rees S. *Mental ill health in the adult single homeless population: a review of the literature*. London: Crisis; 2009

[60] Homeless Link (2011) op.cit.

Appendix A – Mental Health Care Clusters

	Care Cluster Name	Description	Likely Primary Diagnoses
1	**Common Mental Health Problems (Low Severity)**	This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms	F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F50 Eating Disorder.
2	**Common Mental Health Problems (Low Severity with Greater Need)**	This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms	As cluster 1
3	**Non-Psychotic (Moderate Severity)**	Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)	As cluster 1
4	**Non-Psychotic (Severe)**	The group is characterised by severe mood disturbance and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks	As cluster 1 plus F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders
5	**Non-Psychotic Disorders (Very Severe)**	This group will be experiencing severe mood disturbance and/or anxiety and/or other symptoms. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk of non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living	As cluster 1 plus F33 Recurrent Depressive Episode (non-psychotic), F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders
6	**Non-Psychotic Disorder of Over-Valued Ideas**	Moderate to very severe disorders that are difficult to treat. This may include mood disturbance treatment resistant eating disorder, OCD etc. where extreme beliefs are strongly held, some personality disorders and enduring depression	F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31.2&31.5 Bipolar Disorder with psychosis
7	**Enduring Non-Psychotic Disorders (High disability)**	This group suffers from moderate to severe disorders that are very disabling. They will have received treatment from a number of years and although they may have improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways	Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60.
8	**Non-Psychotic Chaotic and Challenging Disorders**	This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.	F60 Personality disorder.
9	**Blank Cluster**		
10	**First Episode Psychosis (with/without manic features)**	This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have mood disturbance and/or anxiety or other behaviours. Drinking or drug-taking may be present but will not be the only problem	(F20-F29) Schizophrenia, schizotypal and delusional disorders, F31 Bi-polar disorder.
11	**Ongoing Recurrent Psychosis (low symptoms)**	This group has a history of psychotic symptoms that are currently controlled and causing minor problems if at all. They are currently experiencing a sustained period of recovery where they are capable of full or near functioning. However there may be impairment in self-esteem and efficacy and vulnerability to life	Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

12	**Ongoing or Recurrent Psychosis (High Disability)**	This group has a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation	(F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

This page is intentionally left blank

Friday 21 September 2018	ITEM: 10
Thurrock Health and Wellbeing Board	
Visit to Basildon and Thurrock University Hospital Trust	
Wards and communities affected: All	**Key Decision:** Yes
Report of: Councillor James Halden – Portfolio Holder, Education and Health	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris: Corporate Director Adults Housing and Health	
This report is Public	

Executive Summary

Health and Wellbeing Board members visited BTUH on Friday 24 August 2018 to consider the impact of interventions introduced within the hospital to effectively manage an increase in demand experienced by the A&E department.

This report sets out key points raised during the visit and key outcomes and further areas for consideration resulting from the visit.

1. Recommendations:

1.1 HWB members are asked to consider and comment on key findings of the visit, set out at paragraph 3

2. Introduction and Background

2.1 Health and Wellbeing Board members considered BTUH's end of year position in 2017/18 in June 2018 at which members learned about a substantial increase in A&E attendances and the measures that had been introduced to effectively manage additional demand.

2.2 Board members welcomed an opportunity to visit BTUH as part of understanding how measures taken were impacting on the patient's experience in A&E and to explore how previous issues considered by the HWB are managed at BTUH. These included:

- The potential increase in Sepsis and the work that has been done so that people can identify early signs of Sepsis.
- A&E waiting times and performance
- The work that the BTUH had undertaken to stream patients to the most appropriate service

- The impact of providing a GP service based at BTUH whose role is to divert patients that can be seen by the GP away from A&E
- Work of the Social Care discharge team
- Creating of space within A&E to effectively manage patients experiencing mental ill health
- Cllr Fish's experience when he visited A&E during a particularly busy time

3. Key Outcomes

3.1 Consideration could be given to providing GPs with access to local appointment systems enabling them to book appointments for patients at their own GPs when it is the most appropriate support required for the patient.

3.2 Members learned that further consideration is to be provided to continuing to provide financial resources to continue offering a GP service in A&E.

3.3 Members learned that BTUH has experienced a 30% increase in patients requiring mental health support since April when police stations could no longer be used as a place of safety for individuals detained by police under S135/136 of the Mental Health Act. It was agreed that support should be made available for individuals who do not meet necessary thresholds to access more formal mental health services.

3.4 Members acknowledged the substantial progress that has been made to support the early identification and treatment of Sepsis. It was agreed that providing additional guidance to GPs and other professionals on the early identification and treatment of Sepsis will improve outcomes. It was also agreed that BTUH would provide examples of practice that can be shared with GP surgeries.

3.5 Consideration should be given to how to improve crisis response service availability in the community. It was agreed that an operational / Commissioner meeting will be arranged to consider the provision of mental health services in the Community and at BTUH.

4. Summary of visit / Key highlights

<u>A&E waiting room</u>

4.1 Members learned about a streaming process comprising nursing staff providing an initial assessment of a patient's needs prior to registration at A&E. This intervention enables patients to be streamed to the most appropriate service areas. Risk for patients are minimised due to being provided with an initial assessment upon arrival at A&E.

4.2 The provision of a GP service that is accessible for visitors to A&E facilitates the provision of immediate GP treatment where needed, reducing the number of patients remaining in A&E and reducing A&E waiting times. Members were advised about plans to pilot NELFT services within the streaming process as part providing patients with access to mental health support.

Minors Unit

4.3 Members learned that the Minors Area is used for patients not requiring admission to hospital and is supported by a nurse practitioner team and senior doctors when necessary. Effective operation of the Minors Unit reduces demand placed upon the Majors Unit. As part of providing resilience employees are rotated between the Minors and Majors Units.

4.4 Members noted that the provision of an additional GP service in the Minors Unit would provide further support the streaming of patients. It is recognised that provision of GP services at BTUH facilitates the provision of a fast and effective service for patients. As part of enhancing the service it was agreed that consideration could be given to providing GPs with access to local appointment systems enabling them to book appointments for patients at their own GPs when it is the most appropriate support required for the patient.

Majors Unit

4.5 Members learned that BTUH have utilised a specific bay in Majors Unit to effectively manage and treat Sepsis, identified as part of the initial assessment stage upon visiting the hospital. 'Bay 12' provides a space within which treatment can be administered to patients outside of A&E. Members were reassured that BTUH assess the management of Sepsis and suspected Sepsis on a monthly basis.

4.6 Members were advised that the Majors Unit is used to support people waiting to be admitted to hospital, effectively reducing the number of patients waiting in A&E. Additional options available to support the effective management of patients include escalation beds and a short stay ward when necessary. The A&E Delivery Board can also open an additional ward in Brentwood providing additional capacity of 28 beds when required.

Clinical Decisions Unit (CDU)

4.7 Members were advised that CDU provides support to patients that require additional treatment but do not require admission to hospital. It was acknowledged that redesigning the department to increase the number of beds from 4 to approximately 12 would have a positive impact on the management of patients. Members learned that the current capacity of 4 beds is almost always used for patients that require mental health support.

4.8 Members learned that BTUH has experienced a 30% increase in patients requiring mental health support since April since police stations have not been used as a place of safety for individuals detained by police under S135/136 of the Mental Health Act.

Acute Medical Unit (AMU)

4.9 Members were advised that patients visit AMU via a GP referral. The new AMU in BTUH was opened in April 2018 and aims to minimise follow up treatment being required and enable patients to access additional and subsequent treatment elsewhere.

4.10 The location of AMU within BTUH facilitates prompt and effective admission to hospital when necessary.

Part 2 – Meeting

4.11 Members were provided with a presentation on how BTUH manages and regularly assesses the management of SEPSIS which includes reviewing all cardiac arrests and reviewing the effectiveness of separate pathways provided for children and pregnant women.

4.12 Members were informed about an electronic observations system that provides guidance on options for treatment based on information fed into the system about a patient's condition. Members learned that this system has already improved treatment pathways and outcomes for patients.

4.13 Data on Sepsis is shared with CCGs on a monthly basis and considered by A&E Delivery Board. Members acknowledged the importance of ensuring Sepsis is addressed at the earliest stage possible including encouraging referrals from GPs, residential care homes and wider care professionals. It was recognised that providing additional guidance to GPs and other professionals on the early identification and treatment of Sepsis will improve outcomes.

4.14 Members learned that Tom Abell had met with EPUT to consider how to effectively manage an increase of approximately 30% of patients requiring mental health support attending A&E.

4.15 It was acknowledged that consideration should be given to how to improve crisis response service availability in the community. It was agreed that a operational / Commissioner meeting will be arranged to consider the provision of mental health services in the Community and at BTUH.

5. Issues, Options and Analysis of Options

5.1 Not applicable as specific further action has not been agreed.

6. Reasons for Recommendation

6.1 The recommendation within this report is for Board members to consider and comment upon outcomes arising from the visit

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

6.1 N/A

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

7.1 Not applicable

8. Implications

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

There are no financial implications at this stage as no specific recommendations are being made that will create cost implications

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

No legal implications have been identified.

8.3 **Diversity and Equality**
Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

No diversity or equality implications have been identified

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

- N/A

10. Appendices to the report

- Appendix 1 – BTUH visit itinerary

Report Author:
Darren Kristiansen
Business Manager Adults Housing and Health

Appendix 1

BTUH visit itinerary
Thurrock Health and Wellbeing Board
Timetable

TIME	ACTIVITY	DETAILS
9:30am	Delegate arrival to BTUH Main Reception **Cllr James Halden** **Cllr Tony Fish** **Roger Harris** Corporate Director Adults Housing & Health **Ian Wake** Director for Public Health **Darren Kristiansen** Adults Housing and Health Business Manager **Stephen Mayo** Deputy Chief Nurse STP, Mid & South Essex STP Joint Committee	Delegates to be met by: **Tom Abell** Deputy Chief Executive/Chief Transformation Officer (msb group) **Andrew Pike** Managing Director **Dawn Patience** Director of Nursing
9.45 – 10:30	**45 minutes tour of A&E, meeting with staff** AS & AH to walk the patient pathway: • Streaming • Triage • Minors/GP • Mental Health • Majors/Ambulance / Discharge • Resus • CDU During the tour of these areas we will be able to discuss: • Wait times/performance against KPI's. • Ambulance offloads • Mental health • Sepsis/deteriorating patient pathways and the use of cubicle 12 • Relationship with Social Care/NELFT Passing through the department there will be opportunity to talk to: • ENP (Pauline Carney) Nurse in Charge/Matron (Emma Mckenzie & Emma Nicholls) • Consultant in Charge (Mr Edward Lamuren and Mr Kahn) Other members of staff would be happy to be spoken to if approached by the team.	Meet in A&E reception: **Anthony Schirn** Head of Nursing for Acute Medicine **Andrea Holloway** Service Unit Manager for Acute Medicine

10.30 – 11:15	Meeting in A&E Seminar Room to include: • SEPSIS: Brief presentation by Dawn Patience, Director of Nursing • Cllr Fish's experience when he visited A&E during a particularly busy time • **Any questions?**	

This page is intentionally left blank

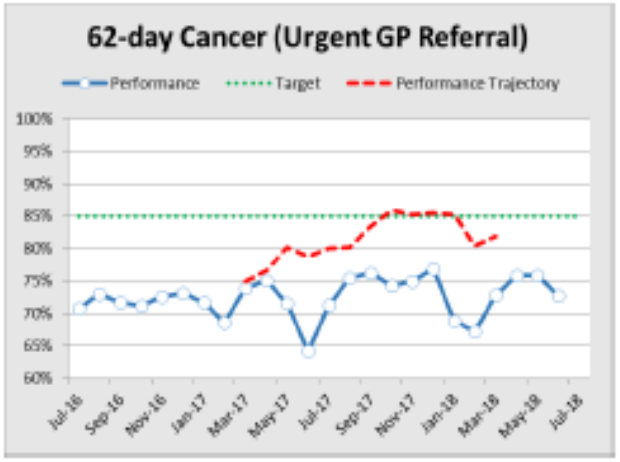
Thurrock Health and Wellbeing Board

21st September 2018
Civic Offices, Grays
Committee Room 1

Andrew Pike
Managing Director

September 2018

62 Day Standard



Key issues across the group:

- Priority tumour sites for improvement across the group are Skin and Urology. Additional local priorities are GI in BTUH and Breast in MEHT.
- Achieving national average performance in these priority tumour sites would deliver compliant performance in aggregate across the group.
- Diagnostic challenge across the group in endoscopy, histopathology and cross sectional imaging.
- Significant focus on achieving first appointment / straight to test within 7 days.

Key recovery actions across the group:

- NHSi elective care lead supporting assessment of recovery plans and trajectories. Initial reviews undertaken w/c 13th August focus recovery actions on high impact areas and highlighted need for further data analysis
- New weekly dashboards developed at BTUH being rolled out across group to improve oversight of position and earlier identification of risks facilitating course correction
- Planned recovery of specialist surgery waiting times in Urology (SUHFT) and Breast (MEHT) still carry a number of risks related to specialist workforce. Mitigations being pursued include insourcing and outsourcing

		SUHFT			MEHT			BTUH			msb Hospitals		
		Apr-18	May-18	Jun-18	Apr-18	May-18	Jun-18	Apr-18	May-18	Jun-18	Apr-18	May-18	Jun-18
62-day Cancer (urgent GP referral)	62- day performance	76.8%	74.1%	68.0%	69.8%	76.1%	73.3%	83.4%	77.4%	74.5%	75.8%	75.9%	72.8%
	Treatment Points	77.5	100.5	87.5	116.0	111.0	110.5	81.5	93.0	184.0	275.0	304.5	382.0
	Treatment Points over 62	18.0	26.0	28.0	35.0	26.5	29.5	13.5	21.0	47.0	66.5	73.5	104.0
	Treatment Points over 104	7.0	5.0	6.0	5.5	4.0	6.0	2.5	3.0	6.0	15.0	12.0	18.0
	National performance	82.3%	81.1%	79.2%	82.3%	81.1%	79.2%	82.3%	81.1%	79.2%	82.3%	81.1%	79.2%
2ww Cancer (GP referral)	2ww performance	87.0%	94.8%	89.7%	82.9%	81.7%	76.9%	91.2%	93.4%	91.7%	87.5%	89.9%	87.8%
	Referrals	791	920	825	1,213	1,331	1,332	1,647	1,872	3,310	3,651	4,123	5,467
	Referrals seen after more	103	48	85	208	244	308	145	123	274	456	415	667
	National performance	90.8%	92.1%	91.1%	90.8%	92.1%	91.1%	90.8%	92.1%	91.1%	90.8%	92.1%	91.1%

Cancer – Control Documents

Weekly dashboard at tumour site level

Daily exception reporting at tumour site level
Measures against key stages of pathway:

- 1st appointment 7 days
- Focus on STT pathways
- Diagnosis 28 days

2WW and 62 Day First Daily Position (Excluding Breast Sympto)

Tumour site	No Diagnosis After 28 Days	Number of Patients Without An OPA	Number Of Patients Dated After 1WW That Are Saveable	Number Of Patients Dated After 2WW That Are Saveable	Total PTL Size	Referrals Received (15/08/2018)
Brain/Central Nervous System	4	0	0	0	13	0
Breast	6	0	25	3	155	18
Childrens	1	0	0	0	5	0
Gynaecological	15	0	3	0	104	7
Haematological	5	2	3	0	16	2
Head and Neck	29	1	9	1	98	2
Lower Gastrointestinal	60	25	31	3	265	12
Lung	13	11	0	0	59	4
Other	3	0	0	0	7	0
Sarcoma	13	0	1	0	26	1
Skin	154	2	87	2	647	30
Testicular	1	0	0	0	6	0
Upper Gastrointestinal	17	1	5	0	88	0
Urological	28	5	6	2	141	9
	349	47	170	11	1630	85

Tumour Site	Number of Patients Without An OPA	Number Of Patients Dated After 1WW That Are Saveable	Number Of Patients Dated After 2WW That Are Saveable
Lower GI - Colon	13	0	1
Lower GI - OPA	12	31	2
Upper GI - OGD	1	1	0
Upper GI - OPA	0	4	0
Urology - Cysto	5	0	0
Urology - OPA	0	6	2

Cancer Unify Trend

3rd September 2018

	01-Apr	09-Apr	16-Apr	23-Apr	30-Apr	09-May	14-May	21-May	29-May	04-Jun	10-Jun	18-Jun	25-Jun	02-Jul	09-Jul	16-Jul	23-Jul	30-Jul	06-Aug	13-Aug	13-Aug	28-Aug	03-Sep
35-48 Days	206	192	201	264	238	145	119	168	182	164	132	167	164	165	187	182	163	149	163	171	158	151	127
49-55 Days	56	41	52	57	44	46	49	20	35	35	48	34	29	42	48	37	47	44	35	32	37	36	37
56-62 Days	24	31	26	35	38	35	44	34	18	24	26	30	24	16	28	22	22	35	30	27	18	30	25
63-69 Days	17	19	21	12	21	24	18	23	18	12	19	20	19	16	7	15	13	12	23	18	11	18	15
63+	62	63	63	62	61	64	54	61	67	63	67	74	75	77	61	52	48	43	53	54	51	52	45
104+	14	11	8	8	7	6	4	5	4	4	9	14	13	16	14	8	7	8	10	8	7	3	6
Total	**348**	**327**	**342**	**418**	**381**	**290**	**266**	**283**	**302**	**286**	**273**	**305**	**292**	**300**	**324**	**293**	**280**	**271**	**281**	**284**	**264**	**269**	**234**

62+ Day by tumour site

Tumour Site	02-Jul	09-Jul	16-Jul	23-Jul	30-Jul	06-Aug	13-Aug	20-Aug	28-Aug	03-Sep
Brain/CNS	0	0	0	0	0	1	1	2	0	1
Breast	3	3	1	3	3	2	2	2	2	2
Childrens	1	1	1	0	0	0	0	0	0	0
Gynaecological	5	3	2	5	4	5	4	4	3	4
Haematological (Exc AML)	5	2	2	2	2	3	1	1	1	1
Head and Neck	7	9	7	5	4	5	4	5	10	10
Lower Gastrointestinal	14	12	9	9	7	6	7	9	13	12
Lung	10	5	5	4	2	3	2	3	2	3
Other	1	1	0	1	0	0	1	1	2	1
Sarcoma	2	2	3	2	1	2	3	2	2	2
Skin	10	8	7	6	4	14	11	10	10	7
Testicular	1	1	0	0	0	0	0	0	0	0
Upper Gastrointestinal	8	7	7	6	7	4	9	7	3	1
Urological (Exc Testes)	10	7	8	5	9	8	9	5	4	1
Grand Total	77	61	52	48	43	53	54	51	52	45

PTL Back Log Summary

30th August 2018

62 Day First Backlog Summary

Tumour Site	Basildon			Broomfield			Southend			Guys		Barts	Royal Free	Royal London	UCLH	Stanmore	Grand Total
	Treated	Treatment Booked	Treatment Date Pending	Treated	Treatment Booked	Treatment Date Pending	Treated	Treatment Booked	Treatment Date Pending	Treated	Treatment Date Pending	Treatment Date Pending	Treatment Date Pending	Treatment Date Pending	Treatment Date Pending	Treated	
Breast	1		2		1												4
Gynecological			4					1	4								9
Haematological		1															1
Head and Neck	4	2	6														12
Lower Gastrointestinal	7		10						1						1		14
Lung	1		2														3
Other			1						1								2
Sarcoma			2													1	3
Skin	2	1	4	8	4	9											28
Upper Gastrointestinal			2	1		5			1				1	1			9
Urological			1				1	1	12	1	1	1					16
Grand Total	10	4	34	9	5	12	1	2	19	1	1	1	1	1	1	1	103

Dtd/Undtd	Basildon	Broomfield	Southend	Guys	Barts	Royal Free	Royal London	UCLH	Stanmore	Grand Total
Treated	10	9	1	1					1	22
Treatment Booked	4	5	2							11
Treatment Date Pending	34	12	19	1	1	1	1	1		70
Grand Total	48	26	22	2	1	1	1	1	1	103
Percent at Trust	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

Treated - Treatment date has passed as waiting Histology confirmation if took place
Treatment booked - Treatment date is in the future
Treatment Date Pending - No treatment date in Somerset

Diagnosis Code	(Multiple Items)

Tumour Site	Basildon	Broomfield			Southend			Guys		Barts	Royal Free	Royal London	Grand Total
		Treated	Treatment Booked	Treatment Date Pending	Treated	Treatment Booked	Treatment Date Pending	Treated	Treatment Date Pending	Treatment Date Pending	Treatment Date Pending	Treatment Date Pending	
Breast	3		1										4
Gynecological	1					1	4						6
Haematological	1												1
Head and Neck	1												1
Lower Gastrointestinal	1						1						2
Lung	2												2
Other							1						1
Skin		5	4	4									13
Upper Gastrointestinal		1		5			1				1	1	7
Urological	1				1	1	11	1	1	1			17
Grand Total	10	6	5	7	1	2	18	1	1	1	1	1	54

Patients over 28 days with no diagnosis

3rd September 2018

2WW and 62 Day First Daily Position (Excluding Breast Sympto)

Tumour site	No Diagnosis After 28 Days	Number of Patients Without An OPA	Number Of Patients Dated After 1WW That Are Saveable	Total PTL Size	Referrals Received (23/07/2018)
Brain/Central Nervous System	8	0	1	17	1
Breast	4	0	17	203	1
Childrens	3	0	7	17	3
Gynaecological	21	5	0	130	11
Haematological	2	0	0	22	0
Head and Neck	27	0	8	97	2
Lower Gastrointestinal	85	2	13	281	6
Lung	11	13	0	62	3
Other	1	0	0	7	0
Sarcoma	10	0	2	28	2
Skin	132	8	65	642	9
Testicular	1	9	12	9	3
Upper Gastrointestinal	35	0	2	114	7
Urological	34	8	8	142	8
	374	**45**	**135**	**1771**	56

NHS
Thurrock
Clinical Commissioning Group

MINUTES
Integrated Commissioning Executive (ICE)
31 May 2018

Attendees

Roger Harris – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Ian Wake – Director of Public Health, Thurrock Council
Les Billingham – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Mark Tebbs – Director of Commissioning, NHS Thurrock CCG
Maria Wheeler - Interim Chief Finance Officer, NHS Thurrock CCG
Tendai Mnangagwa - Head of Finance, NHS Thurrock CCG
Jeanette Hucey – Director of Transformation, NHS Thurrock CCG
Jo Freeman – Management Accountant, Thurrock Council
Jane Foster-Taylor – Chief Nurse, NHS Thurrock CCG
Catherine Wilson – Strategic Lead for Commissioning and Procurement, Thurrock Council
Ann Laing - Quality Assurance Officer, Thurrock Council
Darren Kristiansen – Business Manager Health and Wellbeing Board, Thurrock Council
Emma Sanford – Strategic Lead Adult Social Care and Health, Public Health, Thurrock Council

Apologies

Mandy Ansell – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Mike Jones – Strategic Resources Accountant, Thurrock Council
Allison Hall – Commissioning Officer, Thurrock Council
Philip Clark – Continuing Health Care Transformation Lead
Ceri Armstrong - Senior Health and Social Care Development Manager, Thurrock Council
Christopher Smith – Programme Manager Health and Social Care Transformation, Thurrock Council
Iqbal Vaza – Strategic Lead for Performance, Quality and Information, Thurrock Council

1. **Minutes of the last meeting**

An editorial amendment was required on the 26 April minutes whereby the Accountable Care Alliance should be referred to as the Integrated Care Alliance.

Action HWB Business Manager (Complete)

On the basis of the amendment being made the minutes were approved as an accurate record. Members considered the action log and agreed which actions could now be closed. These are reflected in the updated action log, circulated with these minutes.

2. **BCF Plan 2017-19 – Performance DTOC Report and the BCF scorecard**

Ann Laing introduced the item. Key points included:

- In March there were 260 delayed transfers of care (delayed days), which is a decrease of 57 compared to the previous month (317).
- There have been 17,164 non-elective admissions overall in the year, 4,813 over target. If changes had not been made to the recording of non-elective admissions, the outturn would have been 13,143, which would have been 792 over target.

- In Quarter 4, 52 out of 61 service users that were discharged from hospital into reablement/rehabilitation were still at home 91 days later, which equates to 85.3%. Of the 9 individuals who were not at home 91 days later, 5 had passed away, 1 was in hospital, 2 were in residential care and 1 was in extra care. With 5 individuals deceased the maximum percentage that could have been attained (if everyone else was at home) would be 93.4%.

During discussions the following points were made:

- Members considered whether ICE should be considering how action taken is addressing the target not being achieved.
- It was agreed that the CCG Quip Plan for non-elective admissions will be shared with members and discussed at the next ICE

Action Mark Tebbs

- Members were advised that the A&E Delivery Board acknowledged efforts made in Thurrock to reduce DTOCs.

3. Proposed methodology for DToC targets 18/19

Members noted the proposed methodology set out within the briefing note which focussed on the BCF– DTOC ambitions for 18/19, which included setting out that:

- The national expectation for 2018-19 is that the number of hospital beds occupied by people whose transfer has been delayed should not average more than 4,000 by end September.
- DTOC ambitions have been calculated:
    - Using a 3 month baseline based on Quarter 3, 2017-18 data (instead of 1 month as was used in the previous year)
    - To deliver the mandate ambition of fewer than 4,000 daily delays and the reductions from the baseline to be nationally split 50:50 between NHS and ASC delays – but locally, the degree of reductions expected will not be equal
    - Based on three bands for social care and NHS delays. These bands are based on the level of DToCs in each HWB per 100,000 18+ population.

4. BCF Plan 2017 – 2019 Finance Report

Jo Freeman provided confirmation that:

- The BCF pool, following LA's adjustments for pay award and increments, is £42,488,011
- The BCF carry forward total is £1,345,682

5. Internal Audit Report

Members noted that an audit of the Better Care Fund (BCF) had been undertaken as part of the approved internal audit periodic plan for 2017-18. The audit was designed to assess controls that seek to ensure the Council accurately records and accounts for all cash income and that banking arrangements are secure.

The internal audit concluded that the council can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

The internal audit report made the following recommendations:

- A signed copy of the Annual Governance Statement should be retained on file. The annual review process within the section 75 agreement needs to be revisited to determine how reporting should be measured. This ensures compliance with the agreement.

- Risk management should be a standing agenda item at ICE meetings and any discussions and decisions minuted. This ensures compliance with the agreement.

Action HWB Business Manager

- Minutes of ICE meetings should be formally noted by HWBB on a regular basis to evidence that they have been presented and discussed if appropriate.

Action HWB Manager

6. Mede Analytics

Emma Sanford provided members with an overview and update on the Mede Analytics Project, which included:

- Proof of concept was approved by the ICE in November 2017
- NEL CSU, the CCG's current provider had previously (during procurement) agreed to transfer data to whatever provider we chose providing a valid DSA had been obtained from NHS Digital. However they gave notice to the CCG in December 2017 for provision of this service. Public Health colleagues have contacted Arden GEM (the CCG's new provider) to develop a separate contract to run to the same term as the Mede analytics contract.
- Progress is also being made towards Primary Care data sets being transmitted into Mede analytics
- Progress has also been made towards obtaining IAPT data. A field list and data sharing agreement has been agreed with the provider and Mede Analytics will be installing the Pseudo-anonymisation at source imminently.
- Progress is being made with obtaining the NELFT community data.
- Due to delays of implementation this results in an additional, unbudgeted for, cost pressure of
    - 2018/19 - £10,375
    - 2019/20 – £10,800
    - 2020/21 - £10,800

During discussions the following points were made:

- ICE members approved the additional budget requested, set out above
- Mede Analytics will not provide live updates but data will be transferred on a monthly basis. However, once live Mede Analytics will support professionals by enabling them to access all relevant data about an individual.

7. Thurrock First System Integration Project

Members noted the short paper providing an overview of the Thurrock First System Integration Project and acknowledged that the evaluation of Thurrock First is scheduled for September. It was agreed that the merits of the system integration project should be considered at that time.

Action HWB Manager

8. AOB

No other business was raised or considered by members.

This page is intentionally left blank

NHS
Thurrock
Clinical Commissioning Group

MINUTES
Integrated Commissioning Executive (ICE)
28 June 2018

Attendees

Roger Harris – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Allison Hall – Commissioning Officer, Thurrock Council
Maria Wheeler - Interim Chief Finance Officer, NHS Thurrock CCG
Tendai Mnangagwa - Head of Finance, NHS Thurrock CCG
Jo Freeman – Management Accountant, Thurrock Council
Iqbal Vaza – Strategic Lead for Performance, Quality and Information, Thurrock Council
Jane Foster-Taylor – Chief Nurse, NHS Thurrock CCG
Catherine Wilson – Strategic Lead for Commissioning and Procurement, Thurrock Council
Darren Kristiansen – Business Manager Health and Wellbeing Board, Thurrock Council
Christopher Smith – Programme Manager Health and Social Care Transformation, Thurrock Council

Apologies

Mandy Ansell – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Jeanette Hucey – Director of Transformation, NHS Thurrock CCG
Les Billingham – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Mike Jones – Strategic Resources Accountant, Thurrock Council
Ian Wake – Director of Public Health, Thurrock Council
Mark Tebbs – Director of Commissioning, NHS Thurrock CCG
Philip Clark – Continuing Health Care Transformation Lead
Ceri Armstrong - Senior Health and Social Care Development Manager, Thurrock Council

Representatives

Emma Sanford – Strategic Lead Adult Social Care and Health, Public Health, Thurrock Council, representing Ian Wake.

Guests

Faith Stow - Public Health Programme Manager
Ann Laing - Quality Assurance Officer, Thurrock Council
Abdul Ahad - Head of Financial Strategy, NHS Thurrock CCG

1. **Minutes of the last meeting (31 May)**

   The minutes of 31 May were approved as an accurate record.

   Members considered the action log and agreed which actions could now be closed. These are reflected in the updated action log, circulated with these minutes.

2. BCF Plan 2017-19 – Finance

Jo Freeman advised members about the month two position. No financial pressures have been identified. During discussions it was agreed that:

- Hypertension detection funding would be considered at the next meeting

Action Emma Sanford

- Homecare funding should be considered at the next meeting

Action Catherine Wilson

3. BCF Plan 2017-19 – Performance DTOC Report and the BCF scorecard

Ann Laing introduced the item. Key points included:

- Total non-elective admissions in to hospital (general & acute), all age. There were 1,554 non-elective admissions in April. This is 511 over the BCF target. The CCG agreed a new target trajectory with NHS England which equates to a target of 1,517 for April. If this target can be used for the BCF the non-elective admissions would be only 37 over target.
- Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+). In April there have been 76 delayed days which is 228 days under the target (green). Thurrock is the best performing local authority of both the region and CIPFA comparator groups.

Members welcomed the delayed transfers of care performance and acknowledged that hard work across the NHS and that of key partners that has had a positive impact on improving performance.

4. NHS England letter about DTOC targets and ambitions

Ann Laing explained that the letter issued by NHS England:

- . Sets out national plans to introduce targets for reducing long stays in hospital consisting 21+days.

- Excess bed days are currently monitored by the Clinical Commissioning Group (CCG) which suggests that the CCG will be best placed to monitor and report against proposed new targets.

Members agreed that a whole system response would be required to achieve the target. It was agreed that CCG colleagues would consider the proposed new targets further in conjunction with the Hospital Group and will report back to ICE at July's meeting.

Action Abdul Ahad

5. CCG QIPP plan for non-elective admissions

Abdul Ahad introduced the item. Key points included:

- The CCG QIPP plan comprising £8m total budget of which £1,048,647 is provided for unplanned care. The QIPP business case was agreed in April. A review will be undertaken to evidence how QIPP financial support is improving outcomes.

During discussions the following points were made:

- It can be a challenge compiling evidence that unequivocally demonstrates cause and effect and the impact of some interventions on improving outcomes. However, as part of the Tilbury and Chadwell pilot project the availability of more appointments for patients is likely to impact on A&E activity.
- It is important to establish links between QIPP and BCF funding to ensure activities can be aligned, coordinated and not duplicated.
- Dashboards will be created to monitor QIPP funding activities. It was agreed that an update would be provided at August ICE.

Action Abdul Ahad

6. Exercise and referral programme business case

Faith Stow introduced the item. Key points included:

- The Exercise on Referral (EoR) Programme is an additional clinical pathway for patients with conditions such as stroke, diabetes, cardiovascular disease and cancer and focuses on tertiary prevention, so preventing serious illness, rehabilitation and preventing relapse. It is provided by Impulse Leisure
- An individual programme for the participant is devised with the agreement of the person being referred and they will be placed in the appropriate pathway within the overall programme lasting up to 12 weeks, with twice weekly session lasting one hour. All sessions are led by a suitably qualified instructor (Level 3/4) and there is a maximum cost of £3.00 per session to the participant.
- The programme is contracted from May 2018 for 2 years, plus optional 1 year. The contract value is £80,000 per year/ £240,000 in total. ICE have already agreed funding of £33,000 from the Better Care Fund (BCF) for 2018-19. Approval was being sought in principle for funding into 2019-20 and 2020-21.

Funding breakdown			
	2018/19	**2019/20**	**2020/21 (optional)**
Public Health	£42,335	£37,667.5	£37,667.5
Better Care Fund	£33,000	£37,667.5 (TBC)	£37,667.5 (TBC)
Total Programme costs	£75,335	£75,335	£75,335

During discussions the following points were made:

- Members welcomed the impact of the exercise on referral scheme and agreed in principle to the funding proposed.
- Members agreed that some users may not like or prefer the gym environment and welcomed guidance on the flexibility and creativity that can be provided, such as purchasing exercise equipment such as bikes for individuals.

Action Faith Stow

- Members welcomed the age profile of users particularly with regard to the BCF focus on the cohort aged 65+. Members also welcomed sight of the evaluation report

Action Faith Stow

- Members noted that social prescribers, of which the Mayor is one, are often the best referrers to exercise on referral schemes.

7. BCF National Guidance

Members noted that national guidance has not been published. The BCF leads teleconference scheduled for 26 June 2018 had been cancelled.

8. Collins House performance analysis – services funded through BCF

Ann Laing introduced the item. Key points included:

- Collins House provides 45 beds in total of which 28 are permanent, 5 are reablement and 12 are interim beds.
- It is important to note that interim beds were previously referred to as 'step up, step down'.
- The beds are used for permanent residential patients, step down and reablement support.
- Interim beds appear to be used more for including discharge to assess, awaiting suitable placement following reablement support in the health funded beds, and emergency placements. Reablement is provided through the health funded reablement beds and individuals are moved back to interim beds when reablement has been completed and the individual is awaiting suitable accommodation.

During discussions the following points were made:

- Considerable financial support is provided to Collins House and members noted that if patients were not being supported at Collins House that it is likely that they would remain in hospital

- The target currently set for the average length of stay of interim beds (in days) (based on service users supported in the period, including departures) is 42 days. ICE members previously agreed the target and given the change in focus of interim beds it was agreed that the target should be reviewed. It was agreed that further consideration would be provided outside of the meeting and a report would be provided to ICE members at the July meeting.

Action CCG and Council Commissioning

9. How GP provision at Collins House should be funded in future

This item was considered in part within agenda item 8

10. Risk management

Recommendations made by internal audit of the BCF recommended a standing agenda item at ICE meetings. Members agreed that the BCF risk register will be reviewed on a quarterly basis, commencing in July.

Action Christopher Smith

11.AOB

Allison Hall advised members the BCF quarterly template has been circulated and will be circulated to members on 16 July for approval. Members were advised that the BCF and iBCF reporting arrangements have now been combined into a single template.

NHS Thurrock Clinical Commissioning Group

MINUTES

Integrated Commissioning Executive (ICE)

26 July 2018

Attendees

Mandy Ansell – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Jeanette Hucey – Director of Transformation, NHS Thurrock CCG
Mark Tebbs – Director of Commissioning, NHS Thurrock CCG
Maria Wheeler - Interim Chief Finance Officer, NHS Thurrock CCG
Tendai Mnangagwa - Head of Finance, NHS Thurrock CCG
Jane Foster-Taylor – Chief Nurse, NHS Thurrock CCG
Philip Clark – Continuing Health Care Transformation Lead (for AOB), Thurrock CCG
Jo Freeman – Management Accountant, Thurrock Council
Catherine Wilson – Strategic Lead for Commissioning and Procurement, Thurrock Council
Jackie Groom - Strategic Lead – Performance, Quality and Business Intelligence, Thurrock Council
Ann Laing - Quality Assurance Officer, Thurrock Council
Emma Sanford – Strategic Lead Adult Social Care and Health, Public Health, Thurrock Council, representing Ian Wake.
Christopher Smith – Programme Manager Health and Social Care Transformation, Thurrock Council

Apologies

Roger Harris – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Les Billingham – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Mike Jones – Strategic Resources Accountant, Thurrock Council
Ian Wake – Director of Public Health, Thurrock Council
Ceri Armstrong - Senior Health and Social Care Development Manager, Thurrock Council
Allison Hall – Commissioning Officer, Thurrock Council

1. Minutes of the last meeting (28 June 2018)

The minutes of 31 May were approved as an accurate record.

Members considered the action log and agreed which actions could now be closed. These are reflected in the updated action log, circulated with these minutes.

2. BCF Plan 2017-19 – Finance

Jo Freeman presented a detailed spreadsheet which showed the 3 month position for the BCF Pooled Fund.

- It was noted that this showed a £270k underspend which could be attributed in the main to lower than forecast expenditure on Care Homes, the Joint Re-ablement Team and the Bridging Service.
- Approximately £300k was shown as a currently un-allocated, non-recurring, carry forward fund, and it was agreed to reserve this against future winter pressures.

It was noted that the Bridging Service may need to be expanded during the summer holidays if carer availability reduces further as a result of leave being taken. CW is

liaising with providers regarding this cost pressure and will advise when the position is clearer.
There was a discussion about the process and criteria for committing underspends and un-allocated funds, and it was agreed that in the face of the current cost and demand pressures it would not be appropriate to invite business cases for new projects at this stage.

3. BCF Plan 2017-19 – Performance DTOC Report and the BCF scorecard

Ann Laing presented the Better Care Fund Scorecard to May 2018. Key points included:

- In relation to Indicator 5.1, there has been a change in the way Non Elective Admissions are recorded, and a change to the NHS England target itself. However, these are not recognised in the Better Care Fund reporting arrangements. Nor can the issue be resolved under the terms of the new Operating Guidance. The position is explained in the commentary for each Better Care Fund quarterly return submitted.
- In relation to indicator 5.3, Green has been achieved for the first time – although it was noted that the snapshot relates only to quarter 4.
- In relation to indicator 5.4, it was noted that the 7.9 value changes to 6.6 from September. Generally it was noted that performance was good with a Year to Date value of 2.7 being achieved against a 10.6 value nationally.

The meeting again welcomed the good performance in relation to delayed transfers of care and acknowledged that hard work across the Council, NHS and partners that has had a positive impact on improving performance.

It was noted that the national plans to introduce targets for reducing long stays in hospital (21+days) is not to be reported as part of the Better Care Fund this year.
Mark observed that the data may give us a richer picture of the nature of the pressure on hospital beds and so it may be helpful to consider this in future DTOCs reports.
Ann agreed to include the figure in the Scorecard report in future.
Mark also suggested DTOC for mental health beds requires equal focus.
Ann noted that this features in Care Home placement figures where currently 31 of the 38 beds relate to mental health beds.

There was a short discussion about the report on the use of Interim Beds at Collins House. It was noted that the Interim Beds are not being used for re-ablement although the length of stay target is based on the target for re-ablement.
Catherine felt more work was needed to arrive at an appropriate target for stays in the interim beds.
Emma and Irene were asked to investigate the current pattern of use and to advise on an appropriate basis for measurement.
It was agreed that the matter would be discussed again in September.

Action Emma Sanford and Irene Lewsey

4. Better Care Fund Quarter 1 2018/19 Return

It was noted that this had been signed off and submitted on Monday 23 July 2018.

5. Operating Guidance

Christopher explained that the Operating Guidance for the year 2018/19 has now been published. It was noted that:

- Any challenge to the DTOC baseline target must be submitted to NHS England by 3 August 2018.
- Any change to the Better Care Fund Plan must be submitted by 24 August 2018.
- As noted above there is no requirement to report long hospital stays this year.
- The Departments of Health, and Communities and Local Government are working on the 2019/20 Policy Framework which will cover a single year and minimal changes can be expected.
- The Better Care Fund Plan for 2019/20 is expected to be a "roll over" of the previous year's plan.
- In the longer term, with the ambition to publish a Green Paper as well as the Spending Review, larger scale changes may be expected.

6.GP Provision at Collins House

- Catherine explained that the Council funded interim GP cover for residents at Collins House was established to meet an urgent need in Christmas 2017. The arrangements need to be resolved and it was agreed that going forward College Health would provide GP services for those using Interim Beds but that otherwise the residents would be expected to receive the service from their existing GP under the terms of the APMS contract. It is anticipated that this College Health contract will cost £10k per year, which will be met from resources within the Better Care Fund. This is to be a time limited arrangements and the longer term solution may be informed by the review of the length of stays in Interim Beds to be considered in September.

7. Hypertension – Update Report

Emma presented a number of slides drawing on the evaluation of the programme to gain a better understanding of the impact and cost-effectiveness of the Pharmacy Hypertension Detection Programme in Tilbury, which has been operating for over 11 months - since June 2017. The evaluation report covers the activity of the programme over a nine month period of June 2017 - March 2018.

The report was noted and following discussion of the low activity, poor data recording, and high drop-out rate it was agreed no decision on the future funding of the programme would be agreed. Emma was asked to review the current Service Level Agreements to determine whether the programme could be halted prior to the end of the contract term. Jane Foster-Taylor, Phillip Clarke, Rahul Choundry and Jeanette Hucey were asked to review the report and to advise the Executive of the future of the programme.

8. Risk – related to the BCF Schemes, and to the Better Care Fund Pland and Section 75 Agreement

- It was noted that the Risk Register in the 2017/19 Better Care Fund Plan now appeared somewhat negative, especially in relation to the highly successful partnership which has been forged between the Council and the CCG, and the improving performance of the Better Care Fund Schemes, especially in relation to Delayed Transfers of Care.

- Christopher and Ceri Armstrong were asked to review the Risk Register, and risks associated with the Better Care Fund more generally, and to come back to the Executive with an updated assessment.

Action Ceri Armstrong and Christopher Smith

9.Any Other Business

Phillip joined the meeting and there was a discussion about the need for beds for complex, and palliative, and end of life care. He explained that the CCG has spoken with a Care Home provider wishing to exit the residential market who may be in a position to meet this need.
Catherine suggested it would be helpful to know more about the type of need being presented, as well as the deficiencies in the existing residential provision.
Christopher noted that the Market Position Statement, which is intended to be a signal to the market of future commissioning intensions, is currently being revised.
It was agreed that Phillip would come back to the Executive with a proposal addressing these issues.

Action Philip Clarke

Meeting Planner

Health and Wellbeing Board

Health and Wellbeing Board Executive Committee

HWB Membership

Leader of the Council* (Cllr Robert Gledhill) Portfolio Holder for Education and Health (Chair) (Cllr James Halden), Portfolio Holder for Children's and Adult Social Care (Cllr Sue Little), Cllr Barbara Rice, Cllr Tony Fish, Corporate Director of Adults, Housing and Health * (Roger Harris), Corporate Director of Children's Services * (Rory Patterson), Director of Public Health* (Ian Wake), Accountable Officer: Thurrock NHS Clinical Commissioning Group* (Mandy Ansell), Chief Operating Officer HealthWatch Thurrock * (Kim James), Clinical Representative: Thurrock NHS Clinical Commissioning Group (Dr Anjan Bose), Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board (Dr Deshpande), Executive Nurse: Thurrock NHS Clinical Commissioning Group (Jane Foster-Taylor), Lay Member Patient Participation: Thurrock NHS Clinical Commissioning Group (Gillian Ross), Corporate Director – Place (Steve Cox), Director level Executive, NHS England Midlands and East of England Region (Adrian Marr) Chair Thurrock Community Safety Partnership Board / Director – Environment and Highways (Julie Rogers), Chair of the Adult Safeguarding Board or their senior representative (Graham Carey, Independent Chair or Jane Foster-Taylor, Thurrock CCG), Chair Thurrock Local Safeguarding Children's Board or their senior representative (David Archibald), Integrated Care Director Thurrock, North East London Foundation Trust (NELFT) (Tania Sitch), Executive member, Basildon and Thurrock Hospitals University Foundation Trust (Andrew Pike), Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Malcolm McCann), Chief Executive Thurrock CVS (Kristina Jackson)

HWB Executive Committee membership

Roger Harris (Chair), Ceri Armstrong, Les Billingham, Jane Foster-Taylor, Jeanette Hucey, Kim James, Mandy Ansell, Rory Patterson, Malcolm Taylor, Ian Wake, Richard Birchett, Julie Rogers

Meeting	Meeting date and time		Meeting	Meeting date and time
Exec Committee	24/5/18 (2-3:30pm)		Exec Committee	29/11/18 (2:30-4pm)
HWB	8/6/18 (10:30-1pm)		Exec Committee	Dec 18 To be arranged
HWB	20/7/18 (1:30-4pm)		**HWB**	25/1/18 (10:30-1pm)
Exec Committee	16/8/18 (2-3:30pm)			
HWB	21/9/18 (10:30-1pm)			
Exec Committee	27/9/18 (2-3:30)			
Exec Committee	18/10/18 (2-3:30)			
HWB	23/11/18 (10:30-1pm)			

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	**Fri 21 September 2018** **10.30 – 1pm**	1. Adult Mental Health Peer Review findings Local Action Plan 2. SEND Disabilities local area self-assessment 3. Emotional wellbeing in schools (building on Mental Health Summit) 4. BTUH Performance and operational update and update on visit 5. Cancer care (Andrew Pike) 6. Thurrock Integrated Care Alliance MOU and TOR 7. STP update	Implications and papers ready to brief Cllr Halden: Friday 31 Aug Publishing date Thurs 13 Sept	

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Exec Meeting	Thurs 27 September 2.00 – 3.30 3rd floor room 4			

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Exec Meeting	Thurs 18 October 2018 2.00-3.30 3rd floor room 4			
Health and Wellbeing Board meeting	**Friday 23 November 2018** **10.30 – 1.00pm** **Committee Room 1**	1. Plan on a page and Education attainment results (Michele Lucas) 2. Reflects agenda item being included on Nov 17 HWB 3. Open Up Reach Out Year Four Sign Off emotional wellbeing and mental health services for young people. Paula McCullough 4. Whole Systems Obesity Strategy for Approval Faith Stow 5. Air Quality (Requested by Cllr Halden) 6. Whole systems obesity Strategy Faith Stow 7. Air Quality 8. The East of England Ambulance Service	Implications and papers ready to brief Cllr Halden: Fri 2 Nov Publishing date Thurs 15 Nov	Request sent to room hire on Mon 26 March – Invitations sent to members
Exec Meeting	Thursday 29 November 2018 2.30-4.00pm. 3rd floor room 5			Room reserved, invitations sent to members
Exec Meeting	December 2018			
Health and Wellbeing Board meeting	**Friday 25 January 2019** **10.30 – 1:00pm CR1**		Implications Fri 4 Jan Final papers to me: Monday 14 Jan Publishing date 18/1/19	Request sent to room hire on Mon 26 March – Invitations to be sent to members Papers to be sent to Ceri as I will be on AL

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Exec Meeting	January 2019			
Exec Meeting	February 2019			
Health and Wellbeing Board meeting	March 2019		Implications and papers ready to brief Cllr Halden: Publishing date	
Exec Meeting	March 2019			