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 **1.30pm** on **15 February 2019**

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
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 - 10**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 23 November 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

5 STP Update

This item will be presented by Mandy Ansell, Accountable Officer, Thurrock CCG. Members will receive a verbal update

6 Cancer Wait Times

A PowerPoint presentation will be provided by Andrew Pike, Managing Director BTUH

7 Children's Safeguarding Arrangements **11 - 16**

This item will be presented by Rory Patterson, Corporate Director, Children's Services. A report is provided in member's papers

8 The NHS Long Term Plan **17 - 52**

This item will be presented by Ian Wake, Director for Public Health and Mandy Ansell, Accountable Officer, Thurrock CCG.

An Executive Summary of the long term plan and a covering report summarising the plan and the impact for Thurrock is included in member's papers

9 Proposals to amend Health and Wellbeing Strategy Goal 2 'Healthier Environments' **53 - 60**

This item will be presented by Julie Rogers, Chair of Thurrock Community Safety Partnership and Director for Environment and Highways.

A report is included in member's papers

10 Ward Profiles **61 - 72**

This item will be presented by Ian Wake, Director for Public Health.

A report is provided in member's papers

11 Mental Health Transformation **73 - 102**

This item will be presented by Ian Wake, Director for Public Health.

A report is provided in member's papers

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: **7 February 2019**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

Minutes of the Meeting of the Health and Wellbeing Board held on 23 November 2018 at 10.30am

Present:	Councillors James Halden (Chair) and Cllr Robert Gledhill, Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group (Thurrock CCG) Roger Harris, Corporate Director of Adults, Housing and Health Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG Kim James, Chief Operating Officer, Healthwatch Thurrock Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust Andrew Pike, Managing Director BTUH Jeanette Hucey, Director of Transformation, Thurrock CCG Ian Wake, Director of Public Health Rory Patterson, Corporate Director of Children's Services Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust Jeanette Hucey, Director of Transformation, Thurrock CCG
Apologies:	Councillors Susan Little, Barbara Rice and Tony Fish 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 Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways Kristina Jackson, Chief Executive Thurrock CVS 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:	Andrea Winstone (Thurrock Council, Assistant Director, Public Health) Michelle Cunningham (Thurrock Council, Community Safety Partnership Manager)

1. Minutes

The minutes of the Health and Wellbeing Board meeting held on 21 September 2018 were approved as a correct record.

2. Urgent Items

There were no urgent items raised in advance or at the meeting 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:

- The STP, Orsett Hospital proposals had been referred to the Secretary of State for the Department of Health and Social Care. HOSC agreed in principle to refer the Orsett Hospital Closure on 8 November 2018. A special HOSC had been arranged for 5 December at which a formal referral would be considered.

During discussions the following points were made:

- Cllr Halden and Cllr Gledhill expressed concerns about the time taken to refer decisions taken by the Mid and South Essex CCG Joint Committee in July 2018 to the Secretary of State.
- The impact on delaying plans within Thurrock on progressing the development of Integrated Medical Centres and wider transformation work was acknowledged by members.

RESOLVED: HWB members noted the update and provided comments.

5. Plan on a Page and Educational Attainment Outcomes (Provisional)

This item was presented to members by Andrea Winstone, School Improvement Manager, Children's Directorate. Key points included:

- There has been a three year improving trend in all subjects at key stage 1 for the percentage of pupils achieving the expected standard.
- Whilst the percentage of pupils achieving the greater depth is lower than the national, Thurrock has seen a marked improvement on the previous year.
- This is as a result of greater teacher confidence in the revised curriculum and a focus on ensuring more pupils achieve greater depth.

- Early GCSE data suggests that 72% of the pupils in Thurrock achieved a grade 4+ in English and 67% achieved a grade 4+ in mathematics (standard pass).
- In Thurrock provisional data shows that 62% of pupils achieved the combined English and mathematics grade 4+ measure, compared to 61% in 2017. The proportion of pupils who achieved the 'strong' combined English and mathematics grade 5+ increased by 1 percentage point in 2018.
- The plan on a page, although not statutorily required, captures information and that includes plans for reviewing termly performance data on a quarterly basis as well as brokering support and guidance.

During discussions the following points were made:

- The data on educational attainment was welcomed and progress made with improving.
- The narrowing of the attainment gap between disadvantaged and more affluent pupils was welcomed by members.
- The plans to provide mental health support in schools through school based teams was welcomed.

RESOLVED: Health and Wellbeing Board members noted improved educational attainment outcomes across a range of indicators.

6. Whole Systems Obesity Strategy

This item was presented by Faith Stow, Public Health Programme Manager. Key points included:

- Obesity is one of the most serious and complex public health challenges of the 21st century. On a simplistic individual level, it is caused by consuming more calories than are burned off over a sustained time period. However, the evidence base highlights a huge array of factors that drive this equation related to physiology, biology, individual psychology, parenting, community, daily activity, food production and marketing, food consumption, transport and the physical built environment.
- Obesity is associated with significantly increased incidence of hypertension, heart disease, stroke, 13 types of cancer, asthma, musculoskeletal conditions including osteoarthritis, liver disease, reproductive complications and mental ill health including depression and anxiety, placing potentially avoidable demand on health and care services.
- In Thurrock:
    - more than 1 in 5 children (22.6%) at age 5 are overweight or obese
    - More than 1 in 3 children (39.3%) at age 10 and 11 are overweight or obese (2017/18)
    - 7 in 10 adults are overweight or obese (2016/17)
    - Just over half of adults in Thurrock are physically active (2016/17)
- The financial cost of obesity nationally and in Thurrock is substantial

During discussions the following points were made:

- The merit of creating allotments was considered and members noted that a high proportion of allotments in Thurrock remain vacant. Queries were raised about the contribution that creating allotments in Thurrock may have on tackling obesity.
- Members acknowledged the importance of considering the hidden costs of obesity including, for example, bariatric bathroom conversions. Members also noted that financial resources allocated to tier two treatment and bariatric surgery had increased substantially. It was agreed that calculations on financial losses caused by obesity would be provided to Cllr Gledhill for information

Action Faith Stow

- It was suggested that consideration should be provided to funding school sports facilities including for example, building all weather pitches that can be shared between neighbouring schools. Travel to schools through creating safe walking and cycling routes should also be considered.

- Members acknowledged the complexities of tackling obesity and welcomed the whole system approach being adopted to tackle obesity in Thurrock. Members welcomed further information at a future meeting on how the action plan will link with other key strategies.

RESOLVED:

- The Health and Wellbeing Board approved the WSOS, subject to issues raised by members being considered and the proposed governance arrangements were approved.
- The Health and Wellbeing Board noted the work of the WSOS as being pivotal in contributing to outcomes within the overarching Health and Wellbeing Strategy 2016-2021.

7. Annual Report of the Director of Public Health - Healthy Housing for the Third Age: Improving Older People's Health through Housing

Andrea Clement, Assistant Director Public Health, presented this item. Key points included:

- There is a wide body of evidence that shows the link between good housing and health. Housing is widely accepted to be a key determinant of health and can impact positively and negatively on an individual's physical and mental health, in turn affecting the demand for and use of health and social care resources.
- Thurrock has a growing and ageing population. Nationally the population is living longer, albeit not necessarily healthier, lives. Within Thurrock, the over 65yrs+ population is estimated at 23,700 (2017) and is projected to grow by 5% by 2020, and potentially by 46% by 2035. As a result, it is anticipated that there will be a significant increase in the number of older people requiring health and social care services. Housing can contribute positively or negatively to the prevalence and management of health conditions.
- The report makes the case for focus on four key areas for older people's housing: the need to build a bespoke range of specialist homes, the need to build mainstream homes which are suitable across the life-course, the need to ensure existing housing is suitable

for older people, and a need to develop healthy places which incorporate age friendly features.

During discussions the following points were made:

- Members welcomed the report and the substantial evidence base used to inform how older people's health could be improved through housing.
- It was acknowledged that residential and nursing care was outside of the scope of this report.
- The need to support people in their own homes to remain in the community and encouraging people to consider when to move, particularly to consider downsizing was recognised
- The work of the Housing and Planning Advisory Group, a sub-group of the Board which considers the health impact of major developments was acknowledged by members.
- It was suggested that consideration should be given to how to ensure that training is provided to young people with a view to creating a labour workforce within Thurrock to support the building of houses.

RESOLVED: The Health and Wellbeing Board:

- Noted and commented on the content and recommendations contained within the report.
- Considered how the findings of the report can best be used to influence strategy relating to older people's housing and The Local Plan

8. Integrated Care Alliance Memorandum of Understanding

Roger Harris advised members that Thurrock Integrated Care Alliance comprising key partner agencies had continued to develop a MOU to support the alignment and integration for planning and delivering health and care services.

Board members acknowledged the importance of ensuring that the MOU is right and shows how partners will work together as a single system. The Health and Wellbeing Board agreed the MOU and delegated authority to the Chair to approve minor amendments to the MOU which may be suggested by Boards of partners involved in the MOU.

9. Integrated Commissioning Executive Minutes

RESOLVED: Members considered and noted ICE minutes for the meeting of August 2018

10. Work Programme

RESOLVED: The Board noted the future work programme.

The meeting finished at 13.20

Approved as a true and correct record

CHAIR

DATE

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

15 February 2019	ITEM: 7
Health & Well Being Board	
Thurrock New Multi- Agency Children's Safeguarding Arrangements	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Manager Thurrock Local Safeguarding Children Board (LSCB)	
Accountable Assistant Director: Sheila Murphy, Assistant Director, Children's Services	
Accountable Director: Rory Patterson, Corporate Director, Children's Services	
This report is Public	

Executive Summary

The Children and Social Work Act 2017 and Working Together 2018 dissolves the requirement for Local Safeguarding Children's Boards and requires new arrangements to be put into place. It is the responsibility of Local Authorities to ensure that the new safeguarding arrangements meet the statutory requirements of these new arrangements.

Government Guidance has been published to assist in the transitional process during 2018.

The three Strategic Partners, determined under the Children and Social Work Act 2017, comprise Thurrock Council, Essex Police and Thurrock Clinical Commissioning Group (CCG). The three Partners are required to publish an Implementation Document setting out the new Multi-Agency Safeguarding Arrangements (MASA) three months prior to its implementation.

The document has to be published no later than June 2019 and implemented no later than September 2019. Thurrock's new arrangements will be published in February 2019 and come into effect on 1st May 2019

A Strategic Group of the three Partners was set up in November 2017 and have been developing the new arrangements during 2018 to ensure they meet the statutory requirements. The new arrangements will be referred to as Thurrock Local Safeguarding Childrens Partnership (Thurrock LSCP). The Implementation Plan (see appendix) sets out the changes for Thurrock.

1. Recommendation(s)

1.1 The Health & Well Being Board consider and provide comment on the new safeguarding arrangements.

2. Introduction and Background

2.1 The Thurrock Local Safeguarding Children Board (Thurrock LSCB) was introduced following requirements set out in The Children Act 2004 and has been supporting multi-agency safeguarding arrangement and their statutory responsibilities for Thurrock.

2.2 The Children and Social Work Act 2017 Bill received Royal Assent on 27 April 2017 and requires changes to the current local safeguarding arrangements.

2.3 The Government (DfE) has provided guidance to support partners during the transitional arrangements and Working Together 2018 was published in April 2018 setting out the final details expected of the new arrangements

2.4 Thurrock LSCB set up a Strategic Group of the three Partners in December 2017 to develop the new safeguarding requirements as Government guidance became available during 2018

2.5 The current Child Death Review process moves from the responsibility of the LSCB to separate arrangements between the Local Authority and the CCG and are not subject of this plan.

2.6 The new arrangements will be referred to as Thurrock Local Safeguarding Children partnership (Thurrock LSCP)

2.7 Summit meetings were held with Essex and Southend Safeguarding Children Board during 2018, where it was agreed to adopt three new safeguarding arrangements covering Essex, coterminous with the exiting Authority boundaries. A joint partnership approach was also agreed for strategic areas of safeguarding across Essex in line with existing safeguarding procedures for Southend, Essex and Thurrock. (SET Procedures)

2.8 The main areas of change under the new arrangements are:

- The name changes to Thurrock Local Safeguarding Children Partnership (Thurrock LSCP)
- Statutory Partners change from five to three, removing CAFCASS and Probation as Statutory Partners of the LSCB. They will become two of the “Relevant Agencies” identified to be a part of the new arrangements. Relevant agencies are those agencies the Safeguarding Partners consider are required to be a part of the new arrangements to safeguard and promote the welfare of children. (Relevant Agencies) Regulations 2018.

- Serious Case Reviews change to become Local or National Practice Reviews. Under the new process a National Child Safeguarding Practice Review Panel will assess if a review is likely to be of national importance and if agreed they will oversee or conduct the review process. The process for a review changes with new timescales and a slight change to the criteria that determines a review.
- The Child Death Review process is now separate and does not form part of the new arrangements.
- An independent Chair is no longer required, however the safeguarding partners must ensure that independent scrutiny arrangements are in place.
- A Multi-function independent scrutiny process will be introduced. This will include an Annual Report and also comprise peer reviews, audits and individual scrutineers, including the voice of children, young people, families and communities, to ensure the new arrangements are working effectively.
- Some structure changes to the existing LSCB will take place to meet the new arrangements, this will include changes to the sub-group structure and function.

3. Issues, Options and Analysis of Options

3.1 This is a statutory requirement

4. Reasons for Recommendation

4.1 To ensure the Council meets its statutory duties with regard to Childrens Safeguarding

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

5.1 A consultation process with agencies involved in safeguarding children in Thurrock has been taking place during the transitional arrangements

5.2 Two safeguarding summits have taken place with Essex and Southend Safeguarding Children Board to agree working across Essex arrangements

5.3 The plan is also being presented to the LA Directors Board and Childrens Overview and Scrutiny Committee.

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

6.1 This report impacts on the following corporate priorities:
- People: a place where people of all ages are proud to work and play, live and stay;
- Place: a heritage rich Borough which is ambitious for its future;
- Prosperity: a Borough which enables everyone to achieve their aspirations.

6.2 There are no Local Authority policy changes proposed as part of the new arrangements

7. Implications

7.1 Financial

Implications verified by: Michelle Hall

Management Accountant

There are no additional financial implications for the new safeguarding arrangement. The Local Authority contribution currently to the safeguarding arrangements remain in place and will be reviewed during the next financial year.

7.2 Legal

Implications verified by: Stephen Smith

Team Leader (Social Care)

Law and Governance

The Council are required to ensure that the new safeguarding arrangements meet the statutory requirements. No other legal implications have been identified. The document is owned collectively by the newly formed Local safeguarding Childrens Partnership. (Thurrock LSCP)

7.3 Diversity and Equality

Implications verified by: Roxanne Scanlon

Community Engagement and Project Monitoring Officer I Adults, Housing & Health

The new safeguarding arrangements and implementation Plan applies to all Children and families. There are no known negative implications arising for groups or individuals with protected characteristics.

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

None relevant

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):

- Working Together 2015 (Government Document)
- The Children and Social Work Act 2017 (Legislation)
- Child Death Review – Statutory guidance October 2017 (Government Document)

- Changes to Statutory Guidance: Working Together to Safeguard Children and new Regulations February 2018 (Government Document)
- Local Safeguarding Transitional Arrangements April 2018(Government Document)
- Working Together 2018(Government Document)
- Local Safeguarding Partner (Relevant Agencies) (England) Regulations 2018 (Government Document)
- SET Procedures

9. Appendices to the report

- LSCP Implementation Plan - 2019

Report Author:

Alan Cotgrove
LSCB Manager
Thurrock Local Safeguarding Children Board

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Overview and summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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15 February 2019	ITEM: 8
Health and Wellbeing Board	
NHS Long Term Plan: An Overview and Critique for Thurrock	
Wards and communities affected: All wards	
Accountable Director: Ian Wake, Director of Public Health Roger Harris, Corporate Director, Adults, Housing and Health	
Report Authors: Ian Wake, Director of Public Health	

1. RECOMMENDATIONS

- **That the Health and Wellbeing Board consider and comment on the report and the themes that it addresses.**
- **That the Health and Wellbeing Board consider and comment on how the NHS Long Term Plan may be implemented in the context of the needs of the population of Thurrock and our existing system transformation agenda.**
- **That Health and Wellbeing Board members comment on the risks and opportunities associated with the wider proposed changes to the commissioning arrangements across Mid and South Essex STP.**
- **That the Health and Wellbeing Board members receive further information about how the new funding will be invested in Thurrock.**

2. Introduction and Background

2.1 Despite budgets increasing in real terms by circa 2% per annum over the past 8 years this is less than compared to an average of 3.7% per annum since the NHS was funded. During the same period, adult social care has seen a considerable increase in demand and public health budgets have reduced whilst demographic pressures have increased demand for health and care services.

2.2 In June 2018, the Prime Minister announced a new five-year funding settlement for the NHS; a 3.4% average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24, totalling a £20.5 billion increase over this period. To unlock this funding, the Department of Health and Social Care and NHS England were asked to develop a long-term plan. This document was published on 7 January 2019 and can be found here: www.longtermplan.nhs.uk

2.3 It is important to note that the funding settlement applies only to NHS England's budget. This means that some important areas of NHS spending including in the Department of Health and Social Care's budget; such as capital and education and training are not covered by it. Local authority public health spending and social care spending are also excluded. Consequently the plan is for the NHS only, and not the entire health and care system. It had been hoped that the Green Paper on long term funding options for Adult Social Care would also be published at the same time but that did not happen.

2.4 The NHS Long Term Plan is certainly long (comprising of over 120 pages!) and contains a plethora of eye catching commitments. These can be summarised around five key themes:

- Finance and Resources
- Prevention and Health Inequalities
- New models of integrated care
- Action to improve care quality and outcomes in different clinical specialities
- Workforce

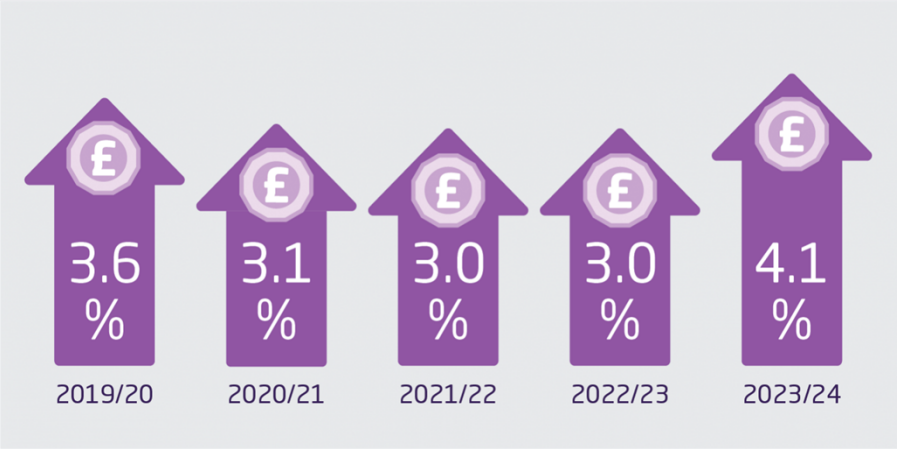
The digital agenda also features heavily throughout each of these themes.

2.5 There is much to welcome within the new NHS Long Term Plan, together with a few proposals that raise potential concerns. This paper discusses each of these five themes in turn and critiques what they may mean for Thurrock in the context of the needs of our population and our existing strategic transformation plans. A full summary of every commitment within the plan can be found in Appendix A

3 Finance and Resources

3.1 The plan sets out considerable real terms cash increases to NHS budgets in England of £20.5Bn over the next five years (figure 1). **This extra spending will need to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities.**

Figure 1 Real Terms Growth in NHS England Funding 2019/20 to 2023/24

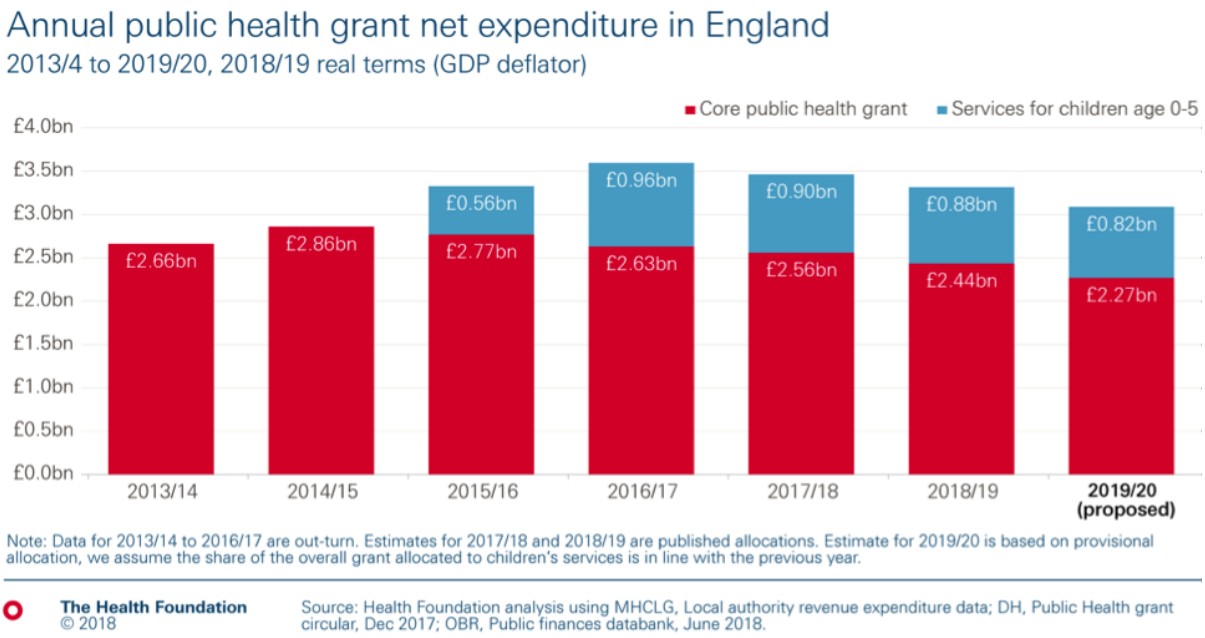


3.2 However future funding for Adult Social Care is not included within the plan and will be subject to a delayed Green Paper now due later in 2019 and possibly considered as part of the Government's Comprehensive Spending Review. Some commentators have labelled this decision a missed opportunity to tackle the issues faced by health and social care in a joined up way.

3.3 Despite being strong on prevention (see section 4), the plan also does not address Public Health Grant funding to local authorities, and the Government confirmed further reductions to the Public Health Grant in

2019/20 at the very end of 2018 (Figure 2), again drawing criticism from some for not thinking 'in a joined up way'.

Figure 2



3.4 When the Prime Minister announced the new funding settlement, she was clear that all NHS organisations must get back into financial balance by 2023/24. The plan gives further commitment to return the provider sector within the NHS to financial balance by 2020/21. To achieve this, NHS Improvement will deploy an accelerated turnaround process in the 30 worst financially performing trusts and a new financial recover fund of £1.05 billion will be created for trusts in deficit who sign up to their control totals

3.5 Part of the financial issues faced by NHS Providers centre around the flawed way in which the NHS financial regime operates. By rewarding activity in secondary care on a cost per case basis, whilst commissioning community providers on block contract the system both financially dis-incentivises community prevention activity that keeps patients out of hospital, and makes it difficult of secondary care providers to control costs when faced with difficult to predict and costly levels of unplanned activity. The measures in the plan seek to address this through changing the payment system from activity based payments to population based payments. There is also a further move away from individual to system control targets centred on new Integrated Care Systems (ICSs) that will operate at STP level – in our case this is Mid and South Essex.

3.6 ICSs will become the level of the system where commissioners and providers (for both the NHS and local authorities) make shared decisions

about financial planning, and prioritisation. The plan states that beyond 2019/20 Government will introduce further financial reforms that will support ICSs to deliver integrated care. Through a process of earned financial autonomy NHS England will give local health systems greater control over resources on the basis of a track record of strong financial and performance delivery, assessed in part through the new ICS accountability and performance framework.

3.7 The plan requires the NHS to deliver savings from administrative costs of more than £700 million, with £290 million to be delivered from savings in commissioning – CCG's have been told that they need to reduce their running costs by 20% by 1st April 2020. There is also focus on improved productivity through 10 priority areas which largely expand on existing schemes such as centralised procurement, e-rostering, e-prescribing, stopping procedures of limited clinical value and improving access to information.

What this means for Thurrock

3.8 Historically, the south and mid Essex health economy has been one of the most financially challenged in England, and so new resources are always welcome. It is however possible that Trusts within our own STP may be subject to further centralised 'Turn Around' processes referenced within the plan. The projected deficits for BTUH, Mid Essex Hospital Trust and Southend Hospital University Hospital Trust for 2018/19 are £27M, £60.7M and £10.9M respectively. Without system reform, there is a danger that 'more of the same' will result in growth monies being used to plug secondary care deficits.

3.9 The financial reforms in terms of a move away from activity based reward and towards population health outcomes are a welcome reform that seeks to address flaws in the current system that result in Trusts acting only in their own financial interest without regard to system wide impact. It also signals a move away from transactional commissioning towards population health that closely mirrors our own ambitions for a Thurrock Integrated Alliance Contract with system wide targets and financial risk and reward mechanisms. However, there is a clear direction of travel to set system level targets at STP and not CCG level which adds a potential level of complexity into local plans and moves system wide commissioning away from other Thurrock local authority level place based initiatives. Setting population and system outcomes at STP rather than borough level also risks making them less meaningful and relevant to the needs of the Thurrock population.

3.10 Government announcement of further reductions in the Public Health Grant (PHG) for 2019/20 only days before the publication of an NHS Long Term Plan that places increasing prevention and addressing health inequalities at its heart, drew much criticism from sections of the public health profession on social media. Whilst public health should be seen as far more than commissioning of programmes from the PHG, obvious conclusions about a lack of joined up Government strategic thinking could be drawn. A combination of successful re-procurement of contracts funded from the PHG in Thurrock and three year financial planning by the DPH has mitigated the risk of substantial PHG decommissioning in 2019-20. However, it is clear that additional prevention ambitions set out in the Long Term NHS Plan will need to be funded through accessing a part of the additional £20.5Bn NHS growth monies rather than by relying on existing PHG resources. The commissioning mechanisms by which this is done, and how these new prevention services interface within those commissioned and delivered by Thurrock Council remains unclear in the plan and will perhaps need to be determined at a local level.

4 Prevention and Health Inequalities

4.1 The plan commits to a ‘more concerted and systematic approach to reducing health inequalities’, with a promise that action on inequalities will be central to everything that the NHS does. To support this ambition and to ensure that local plans are focused on reducing inequalities, specific, measurable goals will be set. Local areas will need to set out how they will achieve this in 2019, drawing on a menu of evidence based interventions developed by Public Health England. Changes to commissioning allocations for CCGs will ensure that a higher share of funding is targeted at areas with high inequalities and a review of inequalities adjustment to funding formulae will be undertaken.

4.2 The Plan specifically recognises that there are two major sets of work which need to progress in parallel:

- Population Health Management approaches – which requires action by everyone, including the NHS
- Place Based Approaches – including action on wider determinants such as planning, housing, education and employment outcomes and many other aspects the NHS is not set up to deliver on

4.3 We will not see improvements in health of the population without both. The NHS Plan itself explicitly acknowledges this where is says:

Action by the NHS is a complement to, but cannot be a substitute for, the important role for local government. In addition to its wider responsibilities for planning, education, housing, social care and economic development, in recent years it has also become responsible for funding and commissioning preventive health services, including smoking cessation, drug and alcohol services, sexual health, and early years support for children such as school nursing and health visitors. These services are funded by central government from the public health grant, and funding and availability of these services over the next five years which will be decided in the next Spending Review directly affects demand for NHS services.

4.1 The plan goes on to state that:

As many of these services are closely linked to NHS care, and in many case provided by NHS trusts, the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be.

4.2 The plan sets out a series of health improvement initiatives aimed at embedding prevention firmly within the 'day job' of NHS providers as opposed to being something commissioned from afar by local government. Trusts will gain increased responsibility for smoking cessation including implementation of 'The Ottawa model' which prescribes that all patients should have smoking status recorded and smokers offered specialist support to quit including Nicotine Replacement Therapy of other pharmacological interventions. The model will include a new smoke-free pathway for maternity services including focussed sessions and smoking cessation treatment for pregnant women who smoke. A new universal smoking cessation offer is also to be included as part of all specialist mental health services, including the option for patients admitted to in-patient mental health facilities to use e-cigarettes.

4.3 New weight management services are to become part of Primary Care for people with hypertension, a BMI of 30+ or type II diabetes.

4.4 The plan also talks about increased provision of Hospital Alcohol Care Teams to reduce significantly the number of A&E attendances, hospital bed-days and ambulance call outs that are alcohol related.

4.5 The NHS Diabetes Prevention Programme that seeks to identify those most at risk of developing diabetes and intervene with lifestyle modification programmes is set to receive double its current funding. The plan also sets out ambition to address inequality in access to foot care teams for patients with diabetes, and trial a programme of diabetes referral through the prescription of very low calorie diets to those who are newly diagnosed.

4.6 Immunisation and screening programmes are given prominence in the plan with a new responsibility for CCGs to ensure that they are reducing health inequalities. At present responsibility for commissioning and monitoring immunisation and screening rests with NHS/Public Health England specialist teams.

4.7 By 2023/24 the plan sets out an ambition to increase the number of patients with serious mental ill-health receiving a health check by 110,000 a year to 390,000 a year.

What this means for Thurrock

4.1 The shift in focus for the NHS from an illness treatment service to (at least in part) one that focuses on preventing disease is hugely welcome. Every day in the NHS in England there are circa 1M contacts between patients and clinicians, and these present a tremendous opportunity for the health service to engage the population in a conversation about improving their health and wellbeing. Perhaps for too long, many clinicians have seen health improvement as someone else's responsibility and any move to change this is positive.

4.2 The plan sets out clear action on health inequality with a higher share of growth monies being targeted towards geographies with high levels of health inequity. What is less clear moving forward, is the geographical foot print on which this funding i.e. CCG vs STP will be rewarded or whether health inequality will be calculated as differences in health outcome *between* or *within* the geographical area. A funding formula based on the levels of health inequality within Thurrock is likely to be more generous than a funding formula

that compared the level of health inequality within Mid and South Essex to England.

4.3 Smoking cessation services are currently commissioned and directly provided by the Thurrock Public Health Service. The focus this year has been on targeted support to smokers with other long term health conditions as the APHR 2016 identified that reducing smoking prevalence in this cohort will have the biggest impact on secondary care demand in the shortest possible time (however a universal offer is also available to any smoker who requests it). Performance against target has been significantly below the planned trajectory and the stop smoking core team have struggled to engage Primary and Secondary Care clinicians in activity to funnel smokers into cessation services. Embedding and integrating stop smoking support within existing long term condition pathways in both primary, secondary and mental health trusts is highly desirable if as a system, we are going to act in a coordinate way to reduce smoking prevalence through cessation activity, and the strategic direction in the long term plan supports this approach. A paper with specific proposals as to the best mechanism to achieve this will be brought back to the Thurrock Integrated Care Alliance.

4.4 Public Health also already commission Alcohol Liaison Teams in hospital settings jointly with Essex and Southend Councils. Identifying and treating patients with underlying alcohol addiction is highly cost effective and returns system savings within year. Similarly weight management programmes including Sliming World, Weight Watchers and community weight management including exercise on referral are commissioned from the Thurrock PHG. The NHS Plan provides further scope and potential resources to expand these services.

4.5 Thurrock was one of the first wave adopters of the NHS Diabetes Prevention Programme. Additional resources through the NHS Long Term Plan to expand this programme are welcome.

4.6 National evidence suggests that people with serious mental ill-health experience some of the worst health inequalities of any group in England dying on average 15-20 years earlier than the general population. Action to address this has been set out in the recent papers to Health and Wellbeing Board and HOSC as part of a wider approach to transforming mental health services. A new Public Mental Health working group will bring forward new models of care over the next 12 months and expansion of new local approaches to embed cardio-vascular health checks in EPUT care pathways is welcome. However, although the NHS Plan has ambitions to increase the number of checks, population health gain will be limited unless this is

undertaken in conjunction with lifestyle modification (and where appropriate) pharmacological interventions to reduce risk in those highlighted through this programme.

4.7 Focus on improving the coverage of immunisation and screening programmes set out in the plan is also welcome. These are currently the responsibility of the teams of dedicated Public Health England staff based in NHS England regional offices. They have generally felt remote and disconnected from both the wider Public Health Local Authority based system and CCG Primary Care transformation, despite GP practices being responsible for many of the programmes. Moving forward, if CCG's are given specific responsibilities for improving coverage rates there is an opportunity to integrate with our local Primary Care development work and team.

4.8 The proposals in the plan for the Government and NHS to consider a greater role in commissioning of Public Health services including sexual health, health visiting and school nursing came somewhat 'left-field' and has not to date been discussed with the public health professional body through usual channels such as the Association of Directors of Public Health or Faculty of Public Health. It is worth noting that currently the single public health commissioning function retained by the NHS – immunisation and screening programmes is the worst performing of all commissioned functions. Whilst there is perhaps some merit for re-integrating sexual health services into NHS commissioning functions (commissioning responsibilities are currently split with local authorities commissioning contraception and GU medicine services and the NHS commissioning HIV treatment), the case for the NHS commissioning school nursing and health visiting is less clear. These are clear public health functions that in Thurrock have been successfully integrated into our Brighter Futures Programme and align well with other local authority functions within children's services. A move to the NHS potentially adds an additional level of complexity and moves public health functions away from the Director of Public Health and specialist public health staff, for little obvious gain.

4.9 In conclusion, there is much to like within the NHS Long Term Plan in terms of a move to embed prevention within the work of the NHS and strengthen responsibilities of CCGs in reducing health inequalities. The Thurrock Public Health Team will need to work with senior officers in the CCG and NHS providers through the Thurrock Integrated Care Alliance to develop and agree plans to implement the proposals on prevention set out in plan locally.

5. New Models of Integrated Care

5.1 The plan confirms the shift towards integrated care and place-based systems which has been a defining feature of recent NHS policy. Integrated Care Systems (ICSs) will be the main mechanism for achieving this – the plan says that ICSs will cover all areas of England by April 2021 – and will increasingly focus on population health.

5.2 The plan outlines several core requirements for ICSs (such as the establishment of a partnership board comprising representatives from across the system) but stops short of setting out a detailed blueprint for their size or structure. Systems will be required to 'streamline' commissioning arrangements, which will 'typically involve' a single CCG across each ICS. It also recognises that NHS organisations will need to work in partnership with local authorities, the voluntary sector and other local partners to improve population health. A new NHS Integrated Provider Contract, Alliance Agreement will be available in 2019 which will allow the contractual integration of Primary and Community Care, and support funding flows and collaboration between providers across the health and care system.

5.3 From 2019, population health management tools will be rolled out, enabling ICSs to identify groups at risk of adverse health outcomes and inequalities and to plan services accordingly. Existing approaches to bringing together health and social care budgets are also encouraged, with an expectation that the social care Green Paper will set out further proposals. Recent funding through the BCF and IBCF has been very important and extremely welcome – however these are only short term and what is required is a long term, publically acceptable way of funding the growing demand for Adult Social Care. There will also be a review of the Better Care Fund. It is dis-appointing that the LTP does not recognize the important role that the BCF has played in both drawing extra resources into the health and care system but also how it has facilitated better joint working – especially in Thurrock.

5.4 The move towards a more interconnected NHS will be supported by a 'duty to collaborate' on providers and commissioners, while NHS England and NHS Improvement will continue efforts to streamline their functions. The plan suggests that progress can continue to be made within the current legislative framework but also puts forward a list of potential legislative changes that would accelerate progress, in response to requests from the Health and Social Care Select Committee and the government. The proposed changes include allowing joint decision-making between providers and commissioners and reducing the role of competition in the NHS.

5.5 In line with the Forward View and the *General practice forward view*, improving care outside hospitals is one of the headline commitments in the

plan. Encouragingly, the plan backs this goal with money: by 2023/24, funding for primary and community care will be at least £4.5 billion higher than in 2019/20 – ensuring that their share of NHS spending increases over the period.

5.6 The plan confirms that general practices will join together to form primary care networks – groups of neighbouring practices typically covering 30–50,000 people. Practices will enter network contracts, alongside their existing contracts, which will include a single fund through which network resources will flow. Primary care networks will be expected to take a proactive approach to managing population health and from 2020/21, will assess the needs of their local population to identify people who would benefit from targeted, proactive support. To incentivise this, a 'shared savings' scheme is proposed, under which networks will benefit financially from reductions in accident and emergency (A&E) attendances and hospital admissions. The existing incentive scheme for GPs – the Quality and Outcomes Framework (QOF) – will also see 'significant changes' to encourage more personalised care.

5.7 Alongside primary care networks, the plan commits to developing 'fully integrated community-based health care', ending the current fragmentation of primary and community health care. This will involve developing multidisciplinary teams, including GPs, pharmacists, district nurses, community psychiatric nurses, reablement teams, community geriatricians, adult social care staff, allied health professionals and staff from the third sector working across primary care and hospital sites. Over the next five years, all parts of the country will be required to increase capacity in these teams so that crisis response services can meet response times set out in guidelines by the National Institute for Health and Care Excellence (NICE). Access to social prescribing will be extended, with more than 1,000 trained link workers in place by the end of 2020/21.

5.8 There is also a strong emphasis on developing digital services so that within five years, all patients will have the right to access GP consultations via telephone or online. Primary care networks will also roll out the successful approach pioneered by the enhanced health in care homes vanguards so that by 2023/24, all care homes are supported by teams of health care professionals (including named GPs) to provide care to residents and advice to staff.

What this means for Thurrock

5.9 The move to integrate primary and community health care around mixed skill workforce teams serving populations of 40-50K is welcome and replicates the

model set out in the Tilbury and Chadwell Case for Change document already being rolled out locally including our mixed skill Primary Care workforce and Community Led Solutions teams, whilst building on it to encompass some new posts including Community Geriatricians. The LT Plan references the role of promoting self-care of these new teams and this is perhaps an area which is underdeveloped in Thurrock and which we need to focus on in 2019/20. The Public Health Team will bring forward proposals for self-care in our 2019/20 Service Plan.

5.10 The commitment to expand social prescribing with 1000 new social prescribers nationally by 2021 is also welcome and dove tails into the need to increase capacity locally. Perhaps one criticism that could be made is that 1000 new social prescribers nationally is under-ambitious given the scale of demand on Primary Care.

5.11 The focus on in-reach services to care homes also mirrors best practice already happening in part of Thurrock, where paramedics, GPs and pharmacists undertake weekly proactive review of residents and provides additional resources to ensure this occurs borough wide.

5.12 The move the population based health again links well with existing work locally, where Thurrock has plans that are significantly more developed than other localities in our STP area. The Better Care Together Thurrock programme forms the strong basis of a Population Health Management Programme, and the new Mede-analytics data lake will provide functionality to develop the risk stratification tools referenced in the plan, together with opportunities for identification and early proactive management of cohorts of patients at risk of serious adverse health events in 2019/20.

5.13 The proposals on Integrated Care Systems leave further questions, largely around geographical footprint. Better Care Together Thurrock forms the basis of a local ICS, triangulating population with place, community and integrated data, and delivering new models of integrated care. Although the plan stops short of specifying new geographical footprints for ICSs, it does talk about a single CCG for each ICS. There is a strong likelihood that locally, this will be at STP footprint. This geography makes little sense to Thurrock in terms of place base initiatives and builds an additional level of complexity in terms of boundaries crossing multiple local authorities. It presents a danger in terms of slowing down local transformation work if Thurrock is forced to operate in a wider system with other localities that have less developed integrated plans.

5.14 The LT Plan references new Alliance agreements and integrated provider contracts which may allow us to short cut proposals to develop something

similar through the Thurrock Integrated Care Alliance. However, the LT Plan also raises questions relating to top down control from NHS England. It states that each ICS will need to agree system wide objectives with their relevant NHSE Locality Director and these will be a mixture of national and local priorities. More ominously it talks about ICSs needing to "earn" greater authority from NHSE to develop local initiatives, raising the Spector of centralised top down command and control. It is unclear how this will work in practice.

5.15 Finally, as referenced in section 3 there is little detail on Adult Social Care or integrated funding over and above some negative commentary on the Better Care Fund and talk that NHS funding being used to 'prop up' councils. If the plan is serious about integration of health and care, this separation of funding streams seems counter-intuitive.

6. Action to improve care quality and outcomes in different clinical specialities

6.1 Perhaps the most striking part of the plan is the sheer number of commitments relating to a group of clinical specialities where outcomes in the UK have sometimes lagged behind other similar western health systems. Priorities include cardio-vascular disease, cancer, mental health, maternity and neonatal health, diabetes and respiratory care.

6.2 **Cardio-vascular health.** The plan references an ambition to prevent up to 150,000 heart attacks, strokes and vascular dementia cases by 2029. Initiatives to achieve this will include improving the effectiveness of the NHS Health Check programme, hypertension case finding, expanding testing for Familial Hypercholesterolaemia, a national primary care audit on CVD prevention, rapid access to Heart Failure Nurses in hospital, improved access to echocardiography in Primary Care and scaled up cardio rehabilitation.

6.3 Specific ambitions for stroke care include implementation of more HASU units, implementation of high intensity stroke rehabilitation lasting six months or more, and a ten-fold increase in the proportion of patients who receive thrombectomy after stroke leading to 1600 more people being independent after their stroke by 2022.

What this means for Thurrock

6.4 Thurrock already has robust plans for Cardio-vascular disease prevention though the Long Term Conditions Working Group that match many of the ambitions set out above including hypertension case finding, improving the

management of cardio-vascular disease in Primary Care through stretched QOF, improving the effectiveness of NHS Health Checks and upskilling of the Primary Care workforce in CVD management. The move to Integrated Medical Centres provides opportunities for increasing access to ECGs in Primary and Community Care, and the MSB hospital reconfiguration provides for creating a new HASU. There are however opportunities to use LT Plan investment to expand cardiac rehabilitation programmes for patients with Heart Failure.

6.5 **Cancer.** The LT Plan has a bold ambition to increase the proportion of cancers diagnosed at stage 1 and 2 from the current 50% to 75% by 2028. It aims to achieve this by increasing knowledge of GPs to recognise the early stages of cancer, accelerate diagnosis and treatment and maximising early diagnosis by identifying more cancers through screening.

6.6 A new Faecal Immunochemical screening test will be rolled out as part of the Bowel Cancer screening programme that has shown to increase uptake by 7% and the age at which screening starts will be lowered from 60 to 50. Similarly a new HPV Primary Screening test for cervical cancer will be implemented across England by 2020. Lung health checks to identify lung cancer earlier implemented together with mobile lung CT scanners in supermarket car parks.

6.7 A new 28 day maximum cancer definitive diagnosis standard will be implemented from 2020 together with a radical overhaul of the way diagnostic services are delivered for patients with suspected cancer including a roll out of Rapid Diagnostic Centres across the country equipped with the latest kit and expertise. There will be new capital investment in MRIs and CT scanners to address the fact that the NHS has the third lowest number of scanners per head of population in the OECD34 group of countries. Finally there will be investment in advanced radio-therapy and immunotherapy techniques including proton beam therapy and a routine offer of genomic testing to everyone with cancer who would benefit clinically, from 2023

What this means for Thurrock

6.8 Cancer is the single biggest cause of death in Thurrock and historically our outcomes have been poorer than England's both in terms of cancer waiting time standards, fragmented diagnostic pathways, screening programme up take and early diagnosis. As such, the new investment set out in the plan is welcome. Perhaps the challenge will be implementation on the ground; we do not have a good track record on meeting existing cancer wait standards and have populations within the borough who have often not taken up the offer of

cancer screening programmes. As a local health and care system we will need to bring forward plans to address these challenges.

6.9 **Mental Health.** The Plan references a huge range of ambitions to improve the treatment (and to some extent the prevention) of mental ill-health in both adults and children and young people. The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years. NHS England's renewed pledge means mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24. Children and Young People's Mental Health service funding will grown faster than over-all mental health funding with 70,000 more children and young people being able to access mental ill-health treatment services by 2020/21.

6.10 There will be new waiting time standards for children's eating disorder and crisis services. Plans already set out in an earlier government response paper to a consultation on children's mental health are repeated including expanded CAMHS services and new Schools Based Mental Health Support Teams. There will also be a new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood based around the 'iThrive' model.

6.11 A new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood will extend current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults. The new model will deliver an integrated approach across health, social care, education and the voluntary sector, such as the evidenced-based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25 year olds.

6.12 For adults, the plan talks about an expansion of IAPT services for treatment of Common Mental Health Disorders with 380,000 additional adults being treated by 2023/24, together with an integration of provision with other physical long term condition treatment programmes. For those with Serious Mental Ill-Health, the plan references "New and Integrated models of Primary and Community Mental Health Care" with "access to psychological therapies, improved physical health care, employment support, personalised ad trauma-informed care, medicines management and support for self-harm and co-exiting substance misuse"

6.13 Expanding crisis care features strongly in the LT Plan including a commitment to 24/7 community based crisis care by 2020/21 including home treatment,

integration with NHS 111, RAID services in A&E and alternative provision for those in crisis including Sanctuaries, Save Havens and Crisis Cafes.

What this means for Thurrock

6.14 New investment in mental health services should be broadly welcomed. The 2018 Children's and Adults Mental Health JSNAs together with LGA Peer Review and Thurrock Healthwatch research identified structural problems with children and adults local mental health systems. The proposals within the NHS LT plan fit well with transformation work already underway in Thurrock. There is a potential opportunity to main stream the three-year funding for our Schools Based Mental Health Wellbeing Service, and for the development of new models of care for Common Mental Health Disorders and SMI set out in the January 2019 HOSC Paper on Mental Health Transformation. A new 24-7 Crisis Care pathway has already been developed with plans for roll out in 2019/20 which will meet the commitments set out in NHS LT Plan ahead of schedule. However perhaps one criticism of the NHS LT Plan commitments is that they remain largely clinical and perhaps do not match local ambitions to create a more holistic offer better integrated with community and place based initiatives.

6.15 **Neo-natal, maternity and child health.** The plan sets out a wide range of initiatives to improve clinical outcomes in this area, together with an ambition to reduce still birth, maternity mortality, neonatal mortality and serious brain injury by 50% by 2025.

6.16 There are commitments to implement the *Saving Babies Lives Care Bundle* by 2020 which has shown a 20% reduction in still births at maternity units where it has been piloted. Continuity of care for pregnant women and new mothers will also be improved with an ambition that 20% of all pregnant women will have the opportunity to have the same midwife caring for them throughout their pregnancy, birth and post-natally by March 2021. There will be increased access to evidence based care for women with post-natal depression and Personality Disorder diagnosis with an extension of help from 12 to 24 months after giving birth. This will include an expansion of access to psychological therapies with specialist perinatal mental health input and will include parent-infant, couple, co-parenting and family interventions including support for fathers.

6.17 A physio-therapy offer for women in the post-natal period who suffer faecal incontinence and pelvic organ prolapse will be expanded. There is a commitment to deliver an accredited infant feeding programme like the UNICEF Baby Friendly initiative in all maternity services. More broadly, there

is a commitment to expansion of the neonatal workforce including allied health professionals supporting neonatal nurses.

6.18 The plan prioritises improvements in childhood immunisation coverage to the base level standards in the NHS PH function agreement. It also recognises that children and young people are most likely to attend A&E inappropriately and recommends developing new models of urgent care as part of a Community Multi-speciality Provider approach. Perhaps most significantly it recommends creation of a new 0 to 25 year old service model for young people that offers person-centred age appropriate care for children and young people and integrates physical and mental health.

What this means for Thurrock.

6.19 Again there is much to be welcomed in the plan although Maternity Service Planning in south Essex is notoriously complex, not least because of significant migration of expectant mothers from areas outside Essex into local units. As such, planning for delivery on the ground is likely to be challenging. Strategic Partnership arrangements for children and young people in Thurrock need to be strengthened and new delivery plans will need to be developed as part of this process. It is unclear whether proposals to address inappropriate A&E attendances by children by creating new community provision will be successful. Evidence on creation of Minor Injuries Clinics in the community suggests that they had little to no impact on A&E use, and simply created additional supply-side demand.

6.20 **Acute and emergency Care.** The plan includes a significant package of measures aimed at reducing pressures on A&E departments. Many of the measures build on previous initiatives, including the introduction of clinical streaming at the front door to A&E and the roll-out of NHS 111 services across the country.

6.21 The plan commits to rolling out urgent treatment centres (UTCs) across the country by 2020 so that urgent care outside hospitals becomes more consistent for patients. UTCs will be GP-led facilities and will include access to some simple diagnostics and offer appointments bookable via NHS 111 for patients who do not need the expertise available at A&E departments. Alongside this, the plan aims to improve the advice available to patients over the phone and extend support for staff in the community by introducing a multidisciplinary clinical assessment service (CAS) as part of the NHS 111 service in 2019/20.

6.22 Over the same timeframe, all major A&E departments will introduce same day emergency care (also known as ambulatory emergency care). This will see some patients admitted from A&E undergo diagnosis and treatment in quick succession so that they can be discharged on the same day, rather than staying in hospital overnight. The plan estimates that up to one-third of all people admitted to hospital in an emergency could be discharged on the same day by rolling out this model. Despite ongoing concerns about operational performance in emergency care, the plan does not make any commitment on the four-hour A&E target, postponing any decision to restore performance standards until the Clinical Review of Standards reports in the spring.

6.23 Unlike some previous NHS strategies, the long-term plan does not assume that moves to strengthen primary and community care will reduce demand for inpatient hospital care. Instead, its plans for hospital bed numbers and staffing assume that acute care will grow broadly in line with the past three years (although the plan does not specify what figure it is using for this).

6.24 The plan includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert up to a third of face-to-face consultations in order to provide a more convenient service for patients, free up staff time and save £1.1 billion a year if appointments were to continue growing at the current rate. It is not yet clear what this redesign will involve.

6.25 Although the plan notes that these changes will have implications for how waiting-times performance is calculated, there is no commitment to meet the 92 per cent target for 18-week waits. Instead, over five years, the volume of planned activity will increase year-on-year to reduce long waits and cut the number of people on the waiting list (currently more than 4 million). The commitment to reduce long waits is given teeth by the reintroduction of fines for providers and commissioners where patients wait 12 months or more.

What this means for Thurrock

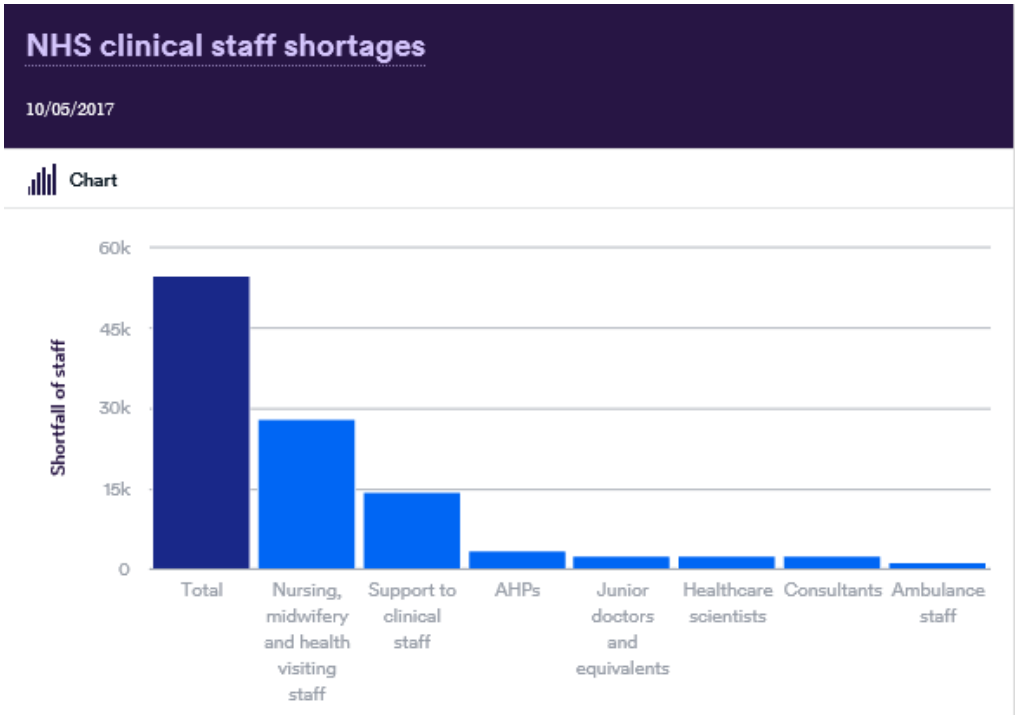
6.26 Some measures set out in the plan are already in place at Basildon Hospital including new approaches to ambulatory care and ‘same day’ wards. A lack of reform of the four-hour A&E waiting target is perhaps disappointing as it could be argued that treating patients who attend A&E with non-urgent or emergency conditions creates perverse clinical priorities and encourages misuse of the system. However, this was perhaps filed in the ‘politically too difficult’ box when the plan was developed.

6.27 Referencing DTOCs without considering Adult Social Care funding or transformation within the plan is perhaps short-sighted, although it is worth remembering that Thurrock benchmarks extremely well against CIPFA comparators on DTOC suggesting existing arrangements are largely effective. It remains to be seen whether the proposals that rely on deploying new technology can be delivered or whether or whether or not they will be effective in enabling providers to improve performance. We will need to wait for the publication of the clinical review of standards to better understand government expectations.

7. Workforce

7.1 Workforce shortages are currently one of the biggest challenges facing the health service. There were approximately 50,000 vacancies across all types of clinical staff in 2017 according to the National Audit Office. (Figure 3)

Figure 3



7.2 The plan recognises the scale of the challenge and sets out a range of specific measures to address it, although many will not be finalised until after the 2019 Spending Review which sets the budget for training, education and professional development. NHS Improvement, Health Education England and

NHS England are tasked within the plan to form a cross sector National Workforce Group and publish a workforce implementation plan later in 2019.

7.3 The plan does set ambitions to reduce the nursing vacancy rate from 11.6% to 5% by 2028 by increasing the number of undergraduate nursing placements by 25% by 19/20 and offering new routes to nursing qualification including a new online nursing degrees and expansion of the nursing apprenticeship programme. It also reiterates the DH commitment to increase medical school places by 1,500 per year and suggests that this figure could increase further subject to the Spending Review. There is also ambition to increase numbers of paramedics and physio-therapists, podiatrists, speech and language therapists and radiographers working in Primary and Community Care, although again the plan is light on detail, stating that the Chief Allied Health Professions Officer will bring forward further proposals as part of a new national strategy on AHPs.

What this means for Thurrock

7.4 Workforce remains a major challenge in Thurrock. We are the second most under-GP'd area in England and have significant shortages of all clinical staff. Our proximity to both London and more affluent areas of Essex make attracting and retaining staff to the borough challenging. Our local transformation programmes including Integrated Medical Centres and New Models of Care aim to address this by making Thurrock an attractive place to operate as a clinician and our links to both the new Anglia Ruskin University Medical School and proposals for a new London Southbank School of Health and Social Care campus at Purfleet may also assist in the medium term.

7.5 The NHS LT Plan makes multiple commitments throughout that are dependent on successful increases in the clinical workforce, yet firm proposals to address the current shortfall are limited. Until these are brought forward following the forthcoming government spending review, this remains a major risk for us.

8. Final reflections and conclusions

8.1 There is much to feel optimistic about within the NHS Long Term Plan, and many proposals that mirror local transformation work already underway in Thurrock. New models of care for a mixed skill integrated community and primary care workforce match our own ambitions for Better Care Together Thurrock, and similarly new integrated alliance contracts, collaboration between NHS providers and commissioners and population health management approaches fit will with the local direction of travel set by the

Thurrock Integrated Care Alliance. Similarly ambitions on mental health transformation, cardio-vascular disease management, diabetes, and integrated data.

8.2 What is less clear is the impact of organisational reform set out in plan. Whilst the plan stops short of specifying that the new ICSs will operate at STP level, this remains a strong possibility locally. Slimmed down CCGs (likely also to operate locally to operate at our STP level) risk slowing down transformation plans in Thurrock on Population Health and integrated care that are more advanced than some of our neighbours, and also risk moving focus away from Thurrock as a place, and resources away from local Primary Care transformation which has been so successful. There is an urgent need to agree with STP colleagues the different logical footprints for various aspects of NHS commissioning and transformation to take place over. We have benefited from being co-terminous with our local CCG and we don't want to lose that essential ingredient to good, close, local working.

8.3 The focus on shifting the NHS from a treatment to (at least in part) preventative service is hugely welcome, particularly at a time of reducing funding to other preventative services in the local health and care system, perhaps most obviously the Public Health Grant. Delivering this will however require significant organisational development activity if we are going to shift the attitudes of many in an NHS workforce that have historically not seen prevention as part of their job. It will also require leadership at a local level to move funding in CCG baselines from treatment to prevention initiatives if the ambitions in the NHS plan are to be realised. The NHS does not have a great history on funding prevention and public health budgets were often the first to be plundered in PCT days when acute services overspent.

8.4 Moves to consider a greater role for the NHS in commissioning of sexual health, health visiting and school nursing services came somewhat 'left field', with little further explanation. It is worth noting that the poorest performing Public Health services since the 2012 reforms have been those immunisation and screening services commissioned from the NHS. Further fragmentation in commissioning of particularly school nursing and health visiting locally risks adding additional complexity to our local Brighter Futures model.

8.5 Perhaps one of the greatest criticisms of the NHS LT Plan is that it is largely inward looking. The new funding will remain more or less entirely within the NHS itself and proposals for the long term funding of adult social care or wider prevention remain subject to future government strategy. Prevention is almost entirely focused on individuals without setting this in the context of wider determinants of health or community; settings that evidence suggests have

much greater impact on over-all health outcome than individual care management or lifestyle modification approaches.

8.6 Finally, much of the plan is dependent on successful expansion of the NHS workforce. Again the strategic ambition is positive but the plan is light on detail and this is perhaps the biggest risk to successful implementation locally.

9 Implications

9.1 Financial

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

The NHS Plan sets out a considerable new investment into the NHS locally with year on year increases in CCG baseline budgets totally £20.5Bn nationally. Funding will come down into CCG baselines and local plans will need to be developed to meet the ambitions set out in the plan including a new significant role in prevention that will not be able to be funded from the Public Health Grant.

9.2 Legal

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

This paper is a summary of the NHS Long Term Plan. There are therefore no legal implications for this report.

9.3 Diversity and Equality

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

The initiatives outlined in this report will assist in future strategic planning to address health inequalities, placing a requirement on the local NHS to bring forward detailed plans to address variation in health outcome between different populations and linking future funding partly on success in reducing health inequalities. It is not clear at this stage between which geographical footprints reduction in health inequalities will be assessed.

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Appendix 1: The NHS Long Term Plan: Commitments

This document itemises the commitments in the plan.

Chapter 1: A new service model for the 21st Century

Section	Commitment
1.8	Within 5 years expected to improve the responsiveness of community health crisis response services within two hours of the referral in line with National Institute for Health and Care excellence (NICE) guidelines where clinically judged appropriate
1.8	All parts of the country should be delivering reablement care within two days of referral
1.9	Practices enter into network contract
1.10	From 2019 NHS111 will start direct booking into GP practices across the country, as well as referring onto community pharmacists. Clinical Commissioning Groups (CCG) develop pharmacy connection schemes for patients who don't need primary medical services
1.15	We will upgrade NHS support to all care home residents who would benefit by 2023/24, with an Enhanced Health Care (EHCH) model rolled out across the whole country
1.17	From 2020/21 Primary Care Networks will assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed.
1.25	From 2019/20 embed single multi-disciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP Out of Hours services
1.26	By Autumn 2020 fully implement Urgent Treatment Centre model
1.30	Every acute trust with a "Type 1 Accident and Emergency" department (ie fully staffed with Consultant Physicians) will: • move to a comprehensive model of Same Day Emergency Care (SDEC). The SDEC model should be embedded in every hospital, medical and surgical specialities during 2019/20 • provide an acute frailty service for a least 70 hours a week. Work towards clinical frailty assessment within 30 mins of arrival • test and begin implementing new emergency and urgent care standards
1.33	From 2020, embed Emergency Care Depts into UTCs and SDEC services.
1.34	By 2023 Clinical Assessment Service will typically act as single point of access for patients
1.39	Rolle out NHS personalised Care Model reaching 2.5m people by 2023/2024 and aiming to double that within the decade.
1.40	Over 1,000 trained social prescribing link workers will be in place by end of 2020/21 rising further by 2023/24 (no mention of how the actual interventions will be funded in plan, a major concern for local authorities and voluntary sector.)
1.41	Accelerate roll out of Personal Health Budgets (PHB). By 2023/24 up to 200,000 people will benefit form PHB
1.44	Over next five years every patient in England will have the right to choose telephone or online consultations from their GP
1.47	Re-designing out patient services over the next five ears
1.51	By April 2021 Integrated Care Systems (ICS) will cover the whole country

Chapter 2: More NHS action on prevention and health inequalities

Section	Commitment
2.9	By 2023/24 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services
2.10	Adapted model available for expectant mothers and their partners
2.11	New universal smoking cessation offer be available as part of the specialist mental health services for long-term users of specialist mental health, and learning disability services
2.14	Target support offer and access to weight management series in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+
2.20	Over next five years, hospital with highest rate of alcohol dependence-related admissions will be supported to fully establish specialist Alcohol Care Teams
2.21	By 2023/24 NHs will cut business mileage and fleet air pollution emissions by 20%.
2.26	During 2019 all local systems expected to set out how they will specifically reduce health inequalities by 2020/24 and 2028/29
2.26	Expect all CCGs to ensure that all screening and vaccination programmes are designed to support a narrowing of health inequalities
2.28	By 2024 75% women from Black and Minority Ethnic communities and similar percentage of women from the most deprive groups will receive continuity of care from their midwife, throughout out their pregnancy, labour and post natal period.
2.30	By 2020/21 will ensure that at least 280,000 people living with Severe Mental Illness (SMI) have their physical health need met.
2.30	By 2023/24 increase the number of people with SMI problems receiving physical health checks to an additional 110,000 people per year
2.31	Over five years we will invest to ensure that children with Learning Disabilities have their needs met by eyesight, hearing and dental services.

Chapter 3: Further progress on care quality and outcomes

Section	Commitment
3.9	NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury.
3.10	In 2019 aim to roll out the care bundle across every maternity unit in England.
3.12	Spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative.
3.13	By 2021 most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.
3.15	Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by the end of 2019/20.
3.15	By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices.
3.39	We will actively support children and young people to take part in clinical trials, so that participation among children remains high, and among teenagers and young adults rises to 50% by 2025.
3.40	From September 2019, all boys aged 12 and 13 will be offered vaccination against Human Papilloma Virus-related diseases, such as oral, throat and anal cancer.

3.45	From 2019/20 clinical networks will be rolled out to ensure we improve the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes. (How these will differ from the Networks which the NHS rolled out between 2005 – 2010 remains to be seen)
Milestones for Cancer	• From 2019 NHS will start to roll out new Rapid Diagnostic Centres across the country. • In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days. • By 2020 HPV primary screening for cervical cancer will be in place across England. • By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. • By 2022 the lung health check model will be extended. • By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers. • By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.
Milestones for cardiovascular disease	• The NHS will help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years. • We will work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest. • By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.
Milestones for stroke care	• In 2019 we will, working with the Royal Colleges, pilot a new credentialing programme for hospital consultants to be trained to offer mechanical thrombectomy. • By 2020 we will begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of this Long-Term Plan. • By 2022 we will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke. • By 2025 we will have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit.
3.80	From April 2019 will ensure that, in line with clinical guidelines, patients with type 1 diabetes benefit from life changing flash glucose monitors.
3.80	By 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes.
3.89	Mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24.
3.91	The Five Year Forward View for Mental Health set out plans for expanding IAPT services so at least 1.5 million people can access care each year by 2020/21. We will continue to expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long-term conditions. By 2023/24, an additional 380,000 adults and older adults will be able to access NICE-approved IAPT services.

Milestones for mental health services for adults	• New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24. • By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post-crisis support. • By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis. • Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.
3.108	The local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list.
3.114	We will work to increase the number of people registering to participate in health research to one million by 2023/24.
3.115	By 2023/24 the new NHS Genomic Medicine Service will sequence 500,000 whole genomes.
3.117	From 2020/21 we will expand the current NHS England 'Test Beds' through regional Test Bed Clusters.
3.119	**We will invest in spreading innovation between organisations. Funding for AHSNs, subject to their success in being able to spread proven innovations across England, will be guaranteed until April 2023**

Chapter 4: NHS staff will get the backing they need

Section	Commitment
4.12	Improve nursing vacancy rate to 5% by 2028
4.15	Extra 5,000 nursing undergraduate places funded from 2019/20
4.18	Continue investment in growth of nursing apprenticeships with 7,500 new nursing associates starting in 2019
4.19	Grow wider apprenticeships in clinical and non-clinical jobs in the NHS with the expectation that employers will offer all entry-level jobs as apprenticeships before considering other recruitment options.
4.36	Improve staff retention by at least "% by 2025
4.42	Each NHS organisation will set is own target for BAME representation across its leadership team and broader workforce by 2021/22.
4.48	By 2021 NHSI will support NHS trust and FTs to deploy electronic rosters or e-job plans
4.54	Double the number of NHS volunteers over the next three years.

Chapter 5: Digitally-enabled care will go mainstream across the NHS

Section	Commitment
5.12	In 2019/20, 100,000 women will be able to access their maternity record digitally with coverage extended to the whole country by 2023/24.
5.13	We will work with the wider NHS, the voluntary sector, developers, and individuals in creating a range of apps to support particular conditions
5.13	By 2020, we aim to endorse a number of technologies that deliver digitally-enabled models of therapy for depression and anxiety disorders for use in IAPT services across the NHS.
5.14	Support for people with long-term conditions will be improved by interoperability of data, mobile monitoring devices and the use of connected home technologies over the next few years
5.14	By 2023, the Summary Care Record functionality will be moved to the PHR held within the LHCR systems, which will be able to send reminders and alerts directly to the patient.
5.17	Supporting moves towards prevention and support, we will go faster for community-based staff.
5.21	Over the next five years, every patient will be able to access a GP digitally, and where appropriate, opt for a 'virtual' outpatient appointment.
5.22	By 2024 all providers, across acute, community and mental health settings, will be expected to advance to a core level of digitisation.
5.25	By 2022, technology will better support clinicians to improve the safety of and reduce the health risks faced by children and adults.
5.26	During 2019, we will deploy population health management solutions to support ICSs to understand the areas of greatest health need and match NHS services to meet them.
5.28	By 2021, pathology networks will mean quicker test turnaround times, improved access to more complex tests and better career opportunities for healthcare scientists at less overall cost.
5.28	By 2023, diagnostic imaging networks will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret
Milestones for digital technology	• During 2019 we will introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in *The Future of Healthcare*. • By 2020, five geographies will deliver a longitudinal health and care record platform linking NHS and local authority organisations, three additional areas will follow in 2021. • In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's LHCR across the country over the next five years. • By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system. • In 2021/22, we will have systems that support population health management in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation. • By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices. • By 2023/24 every patient in England will be able to access a digital first

	primary care offer (see 1.44). • By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and LHCRs will cover the whole country

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15 February 2019	ITEM: 9
Thurrock Health and Wellbeing Board	
Thurrock Health and Wellbeing Strategy Goal 2 'Healthier Environments' proposal	
Wards and communities affected: All	**Key Decision:** To approve an amendment to Thurrock Health and Wellbeing Strategy Goal B, Healthier Environments
Report of: Councillor James Halden, Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board	
Accountable Head of Service: N/A	
Accountable Director: Steve Cox, Corporate Director Place Julie Rogers, Corporate Director of Environment and Highways	
This report is Public	

Executive Summary

The Health and Wellbeing Strategy 2016-2021 was approved by the Health and Wellbeing Board in February 2016 and the CCG Board and Council in March 2016. The Health and Wellbeing Board monitors and scrutinises progress being made in achieving Strategy outcomes by way of an annual report.

Board members have also previously agreed to consider reports by exception. This helps to ensure that the Health and Wellbeing Strategy remains focussed on the right areas to improve health and wellbeing outcomes for the population of Thurrock, remains fit for purpose and addresses emerging priorities and challenges.

This paper sets out proposals for amending Goal 2 of the Health and Wellbeing Strategy, Healthier Environments to help ensure that consideration is given to providing healthier and safer environments.

1. Recommendation(s)

1.1 The Board is asked to approve amendments to Goal 2 of the Health and Wellbeing Strategy to help ensure that we are creating healthier environments that are safe for Thurrock residents and that the perception of those environments amongst Thurrock residents is that they are safe.

2. Introduction and Background

2.1. Thurrock's Health and Wellbeing Strategy comprises five strategic goals which make the most difference to the health and wellbeing of the people of Thurrock. Each of the Goals is defined by four objectives.

2.2 The Health and Wellbeing Strategy is not static and is regularly reviewed to ensure it continues to address the wider determinants of people's health and wellbeing. This is demonstrated by the Board previously approving proposed amendments to two of the objectives that underpin the Strategic Goals.

- Objective 2A was previously amended from Create outdoor places that make it easy to exercise and to be active to 'Create Spaces that make it easy to exercise and be active'. This facilitated reporting action being taken to improve indoor health and leisure activities.
- Objective 3D has been amended from 'Improve the identification and treatment of depression, particularly in high risk groups' to 'Improve the Identification and treatment of mental ill-health, particularly in high risk groups'. This helped to ensure that the Strategy is not solely focussed on depression and captures activities, policies and programmes that support individuals with a wider range of mental health issues.

2.3 A snapshot of the Health and Wellbeing Strategy's Goals and Objectives is provided on the following page for member's easy reference.

GOALS →	1 OPPORTUNITY FOR ALL	2 HEALTHIER ENVIRONEMENTS	3 BETTER EMOTIONAL HEALTH AND WELLBEING	4 QUALITY CARE CENTRED AROUND THE PERSON	5 HEALTHIER FOR LONGER
Objectives	1A All children in Thurrock making good educational progress	2A. Create Spaces that make it easy to exercise and be active. Amended from: 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	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 groups. Amended from: Improve the identification and treatment of depression, particularly in high risk groups	4D. Provide high quality GP and hospital care to Thurrock	5D. Prevent and treat cancer better

3. Issues, Options and Analysis of Options

3.1 The statutory duty for working with partners to reduce crime and promote public safety in Thurrock falls to Thurrock Community Safety Partnership (CSP). Thurrock Council is a statutory member of the CSP, as are the Clinical Commissioning Group (CCG) and the Chair of the CSP is a member of the Health and Wellbeing Board.

3.2 The relationship between health and crime is well documented and evidenced. Offenders are more likely to experience multiple inequalities when compared with the general population. The potential to become a victim of crime will affect the public's behaviour and impact on their health and

wellbeing and there can be long lasting consequences on a victim's mental and /or physical health. Crime rates and the perception of crime impacts on the public's likelihood of utilising local facilities, in particular, outdoor open spaces.

3.3 The built environment plays an important role in crime and disorder. Situational and environmental crime prevention approaches aim to design and manage the built environment to make crime more difficult and less rewarding. It is not only concerned with reducing physical opportunities to commit crime, but also about influencing perceptions about an area and reassuring people that the area is safe.

3.4 Amending Goal 2 to include safety will reinforce existing links between the two Strategic Partnerships by ensuring activities undertaken as part of improving health and wellbeing outcomes for the population of Thurrock consider the impact of crime and anti-social behaviour as appropriate. For example:

- As part of creating healthier spaces exercise equipment is provided in local parks. However, if the equipment is vandalised or the park is perceived to experience Anti-Social Behaviour it is less likely that residents will use the facilities available to them. Increasing the number of cycle paths and walkways will only be effective if members of the public feel safe to use them.
- As part of developing homes that keep people well and independent it is important for developers to reflect guidance provided within the National Planning Policy Framework which states that planning policies and decisions should aim to achieve healthy, inclusive and safe places which:
    - (a) promote social interaction, including opportunities for meetings between people who might not otherwise come into contact with each other – for example through mixed-use developments, strong neighbourhood centres, street layouts that allow for easy pedestrian and cycle connections within and between neighbourhoods, and active street frontages;
    - (b) are safe and accessible, so that crime and disorder, and the fear of crime, do not undermine the quality of life or community cohesion – for example through the use of clear and legible pedestrian routes, and high quality public space, which encourage the active and continual use of public areas; and
    - (c) enable and support healthy lifestyles, especially where this would address identified local health and well-being needs – for example through the provision of safe and accessible green infrastructure, sports facilities, local shops, access to healthier food, allotments and layouts that encourage walking and cycling.

- Thurrock has suffered an increasing rise in reports of drugs and the associated gang related activity. There is an emerging picture of the activity and there has been considerable focus on the C17 gang, which was impacting on people using Grays High Street and park.
- The consequences of an increase in violent crime, particularly where offensive weapons are involved, also has an adverse impact on our emergency health services, although as yet BTUH are reporting low numbers of A & E admissions: 200 recorded assaults to A & E between Jan and September (inclusive) 2018, a decrease of 7% on previous year and 8% involved a blade.
- The Thurrock Housing ASB Team has seen an increase in the reports of young people misusing communal areas and smoking 'skunk cannabis'. Emerging issues include those of individuals, often known to the police, gaining access to vulnerable tenant's properties often by coercion but also misplaced 'friendships'. Widely known as 'cuckooing' the result is often criminal activity including drug dealing and gang-related aggressive behaviour on estates. It is likely that this would have had an adverse impact on residents' mental health and wellbeing.
- Violence Against Women and Girls is another high priority for the CSP and the cost to victim's health is well researched and documented.
- Latest data from the Community Rehabilitation Company who supervise 299 offenders in Thurrock indicate that 36% have alcohol problem, 32% use drugs and 16% have a mental health issue.

4. Reasons for Recommendation

4.1 Health and Wellbeing Board members are responsible for driving forward Thurrock's Health and Wellbeing Strategy and ensuring it remains fit for purpose while having a positive impact on health and wellbeing outcomes. Given the evidence provided at paragraph 3.4 it makes sense to incorporate safety and security into the Health and Wellbeing Strategy as part of Goal 2, Healthier Environments.

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

5.1 Not applicable.

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

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

6.2 An increased focus and awareness through the Health and Wellbeing Board will contribute to the CSP priorities.

7. Implications

7.1 Financial

Implications verified by: Jo Freeman, Management Accountant Social Care & Commissioning, Corporate Finance

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

7.2 Legal

Implications verified by: Sarah Okafor - Barrister (Consultant)

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

7.3 Diversity and Equality

Implications verified by: Roxanne Scanlon, Community Engagement and Project Monitoring Officer, Adults, Housing & Health

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

The Community Safety Equality Impact Assessment has highlighted:

1. There is a need to focus on the vulnerable within our communities as they are at greater risk of serious harm
2. Older people are at greater risk of distraction burglary and rogue traders
3. Young people are at greater risk of sexual exploitation, cyber bullying and gang related violence.
4. Hate crime within the disabled, transgender, and sexual orientation communities continues to have low rates of reporting.
5. Learning disabled are at risk of being "cuckooed" in relation to gang violence.
6. Females are more likely to be a victim of domestic and sexual violence/abuse
7. There is a gap around information with regards to same sex domestic abuse victims
8. Hot spot areas for crime are West Thurrock and South Stifford, Grays Riverside, Ockendon and Aveley and Uplands wards.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)
The proposals in this paper facilitate closer working relationships between Thurrock Health and Wellbeing Board and Thurrock Community Safety Partnership and contribute to the council's statutory duties with regards to S17 of the Crime and Disorder Act and to reduce re-offending.

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

- Thurrock Community Safety Partnership Delivery Plan 2018/19

9. Appendices to the report

- None

Report Author:

Darren Kristiansen, Business Manager, Adults Housing and Health Directorate, Thurrock Council in conjunction with Michelle Cunningham (Community Safety Partnership Manager) and Joanne Davies (Anti-Social Behaviour Services and Strategy Manager)

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Health and Wellbeing Board	ITEM: 10
Thurrock Health and Wellbeing Board	
2018 Ward Profiles	
Wards and communities affected: All wards	
Accountable Director: Ian Wake, Director of Public Health	
Report Authors: Ian Wake, Director of Public Health	

1. RECOMMENDATIONS

- **That Health and Wellbeing Board approve the Ward Profiles such that Public Health such that they can be shared with partners.**

- **That Health and Wellbeing Board members discusses how best to promote and publicise the Ward Profiles within their respective organisations and to wider stakeholders and the community**

2. Introduction and Background

2.1 This paper seeks approval from Health and Wellbeing Board to approve 20 ward profiles for each of the wards in Thurrock using the format set out in PDF attachment that accompanies this report. It also invites comment from members of Health and Wellbeing Board as to how best to promote the ward profiles within their respective organisations and to the wider community and other key stakeholders.

2.2 The Director of Public Health is keen to improve engagement of all elected members in the Public Health agenda. Elected members are key stakeholders for public health. In representing their constituents and through casework and surgeries, ward councillors should have a good understanding of the needs and concerns of their constituents, providing a unique source of community intelligence that can be fed into wider policy and strategy work. Similarly, if ward councillors understand the public health issues within their wards, they can assist in communicating positive public health messages to their residents, and sign posting residents to existing commissioned services and wider community assets.

2.3 In order to improve members' understanding of the health issues faced by residents, and as a mechanism for engaging councillors in the health and wellbeing agenda, the public health team has developed ward profiles for each of Thurrock's 20 wards.

2.4 More widely, a detailed understanding of the health issues faced by residents in different wards could be useful to a range of stakeholder organisations when planning services, or developing external funding applications. The Public Health service are therefore keen that the ward profiles are promoted as widely as possible within individual Board member stakeholder organisation and to the third sector and community.

3. Discussion

3.1 The PDF attachment that accompanies this report sets out the proposed format for each ward profile, and has used the data from the The Homestead ward as an example. Our vision was to create a high level ward profile, presented in an infographic style booklet that presents a summary of the key health and wellbeing issues within their ward in a visually appealing and engaging way.

3.2 The proposed indicators that we have included within the current draft were initially selected by the public health team, with the 'Your Voice, Your Place' and community assets information being added following discussions with colleagues in Adults, Housing and Health. As such, the profile highlights both issues and assets. The latest available datasets have been used for each indicator, and where data as available, comment is provided as to whether these a statistically better, worse or similar to England mean averages. The final box provides a helpful summary of the data contained within the profile.

3.3 The current profile format has been discussed and approved by the Adults, Housing and Health Directorate Management Team, and Director of Strategy. It has also been discussed with the Cabinet Portfolio Holder for Education and Health, and more widely with The Cabinet.

3.4 The Health and Social Care Public Health Team has developed the other 19 profiles, and will publish these once final approval is provided by Health and Wellbeing Board. The Public Health Service and propose running an event to launch the profiles with invitations extended to all ward members and more widely to Health and Wellbeing Board stakeholders and the third sector. The profiles could have further applications as useful resource on local health issues, assets and data for other key stakeholders including the third sector and community, and Directors Board may also wish to consider publishing them on the council's website.

3.5 Following feedback from The Cabinet Portfolio Holder for Education and Health, and more widely from Cabinet, GP and schools information that fall within a two mile radius of the ward boundary have also been included for wards that have few or none of these facilities within the ward boundary. For example, in The Homestead ward, information on The Hassengate Surgery has been included, as the majority of residents access this GP practice, despite the fact it is located slightly over the ward boundary.

3.6 Public Health will review and where possible update the information contained within the ward profiles on an annual basis.

4. Implications

4.1 Financial

Implications verified by: Jo Freeman, Management Accountant Social Care & Commissioning, Corporate Finance

There are no direct additional financial costs arising from this report. All costs of the programme will be met from use of existing Public Health staffing resources.

4.2 **Legal**

Implications verified by: Sarah Okafor - Barrister (Consultant)

On behalf of the Director of Law, I have read the report in full. The recommendations are consistent with the duties upon Thurrock Council under the various Social Care and Health legislative frameworks to joint fund and pool resources to facilitate improved public health objectives across all residents within the area. Accordingly, there appears to be no external legal implications arising from the recommendations at this stage of the process.

4.3 **Diversity and Equality**

Implications verified by: Becky Price, Team Manager – Community Development & Equalities

The initiatives outlined in this report will assist in future strategic planning to address health inequalities, by highlighting variation in health outcome between different wards, and the assets and health and wellbeing challenges faced by residents within wards. In doing so they will have a positive impact on health inequalities and overall population health

Report Author:

Ian Wake, Director of Public Health. iwake@thurrock.gov.uk

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The Homesteads Ward
(E05002245)

Published by Thurrock Public Health
October 2018

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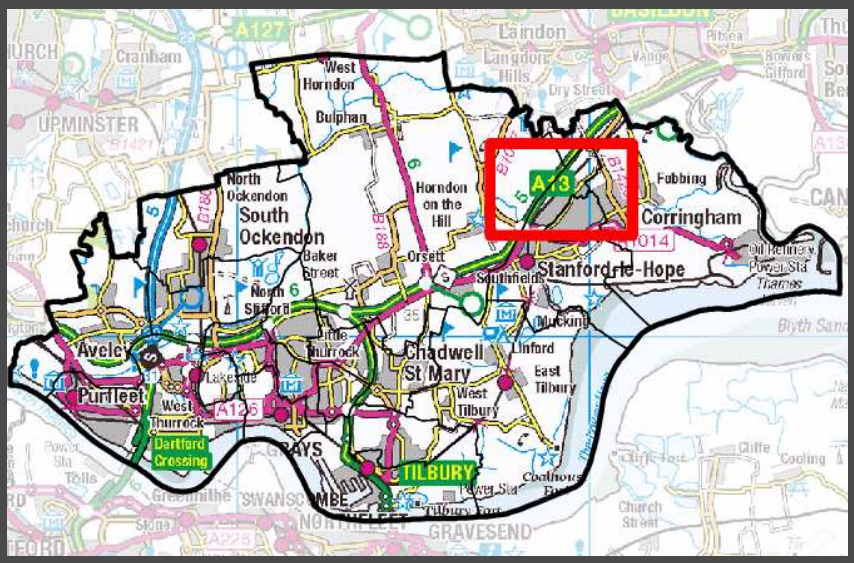
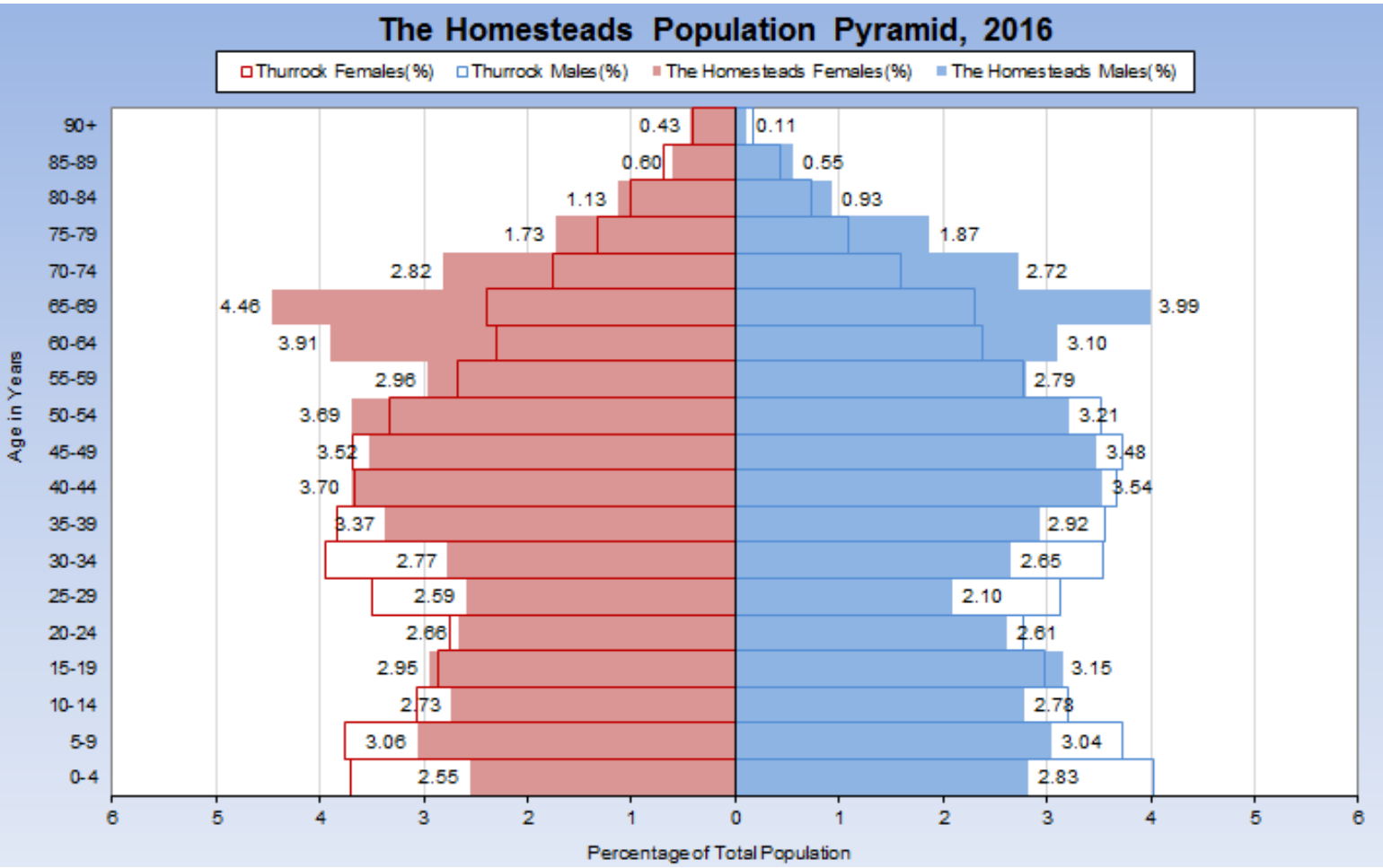


Population Pyramid



The Homesteads Ward has a greater percentage of adults aged 60-74yrs compared to Thurrock.

Conversely, there is a smaller proportion of children aged 0-14yrs and adults 25-39yrs.

Source: ONS Mid-Year Estimates 2016

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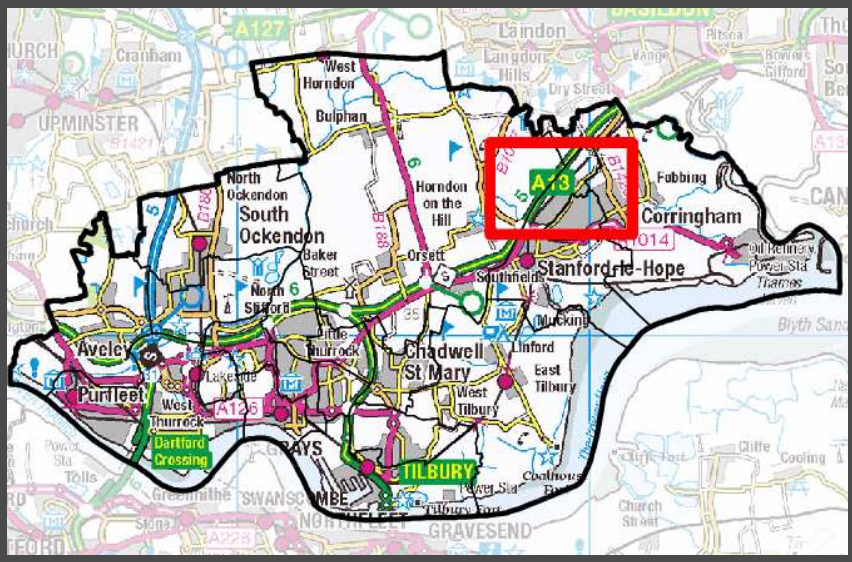
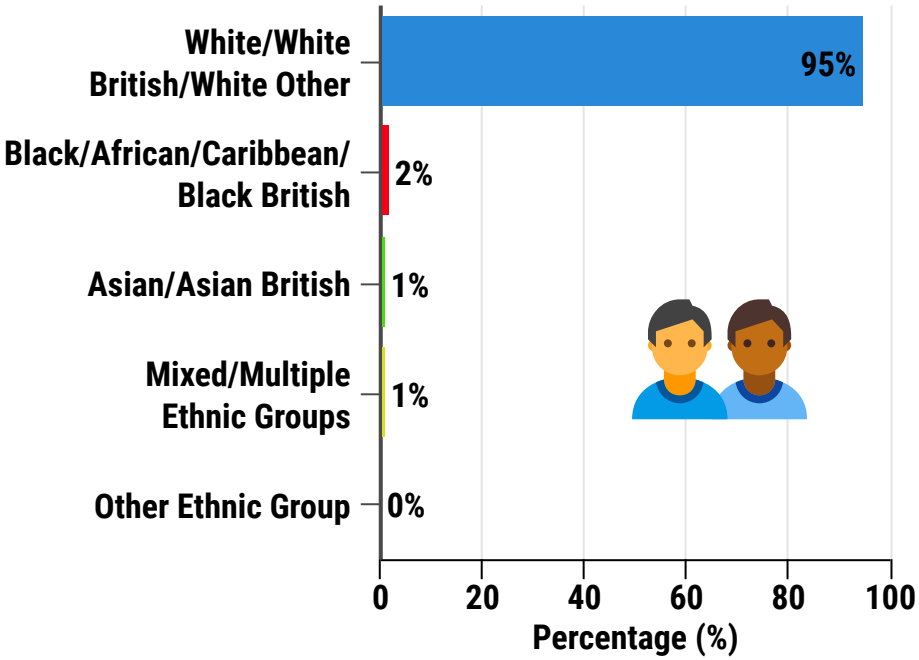


Ethnicity Groups (%)



Deprivation

The Homesteads is ranked 18th out of the 20 Thurrock wards

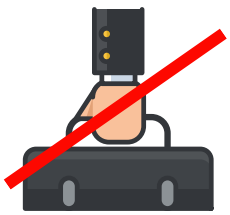
1 = Most Deprived
20 = Least Deprived

Deprivation is strongly associated with poor physical and mental health

Source: DCLG (Department of Communities and Local Government)

Employment

Employment Status	The Homesteads Ward (%)	Thurrock (%)
Employee: Full-time	41.4	42.3
Employee: Part-time	17.0	14.5
Self-employed	9.0	9.0
Unemployed	3.3	5.2
Retired	17.0	12.2
Looking after home or family	3.8	5.1
Long-term sick or disabled	1.9	3.4
Student (inc. full-time students)	2.9	3.5



Being in employment has been shown to be highly protective to one's health.

Conversely, evidence shows that being unemployed is linked to poor physical and mental health outcomes.

(Source for all data in this profile is Census 2011 unless otherwise stated)

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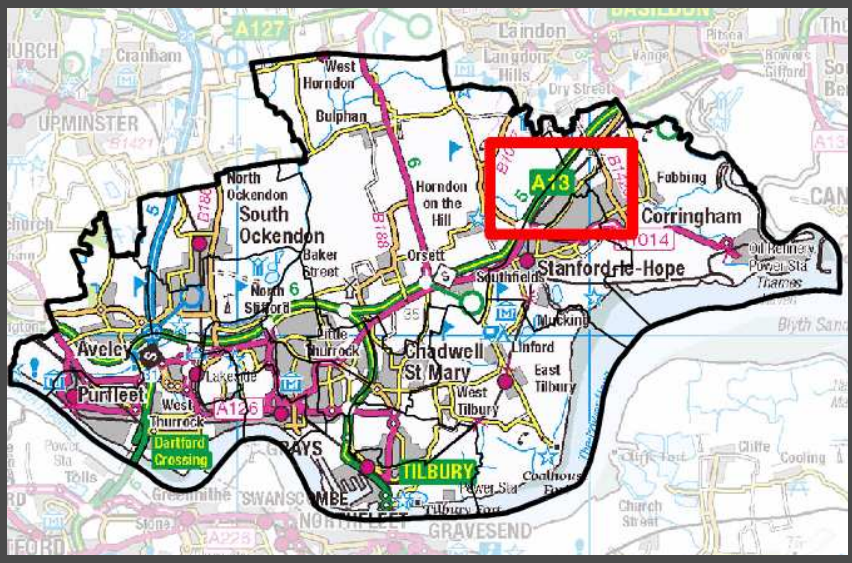


Primary Schools
(No secondary schools within this ward)

Abbots Hall Primary

Approx pupils - 218
Ofsted rating - Good

Graham James Primary Academy

Approx pupils - 435
Ofsted rating - Good

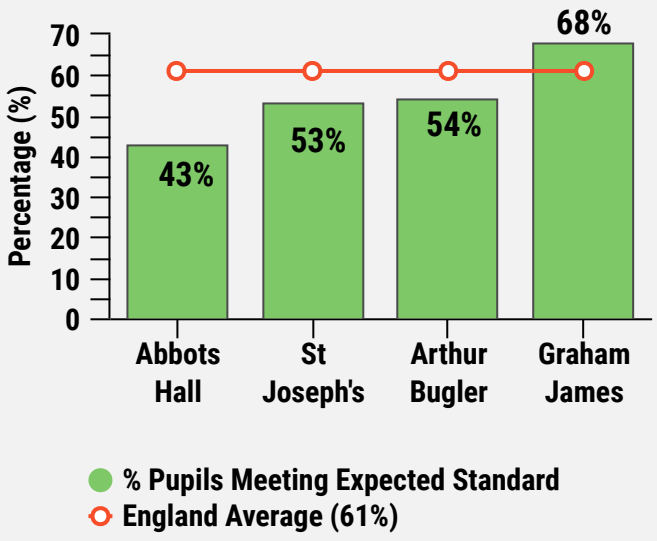
Arthur Bugler Primary

Approx pupils - 419
Ofsted rating - Good

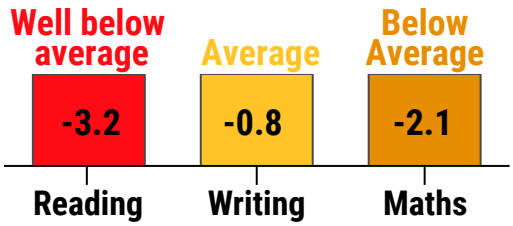
St Josephs Catholic

Approx pupils - 256
Ofsted rating - Good

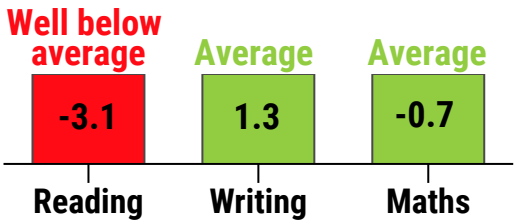
SATs Results 2017



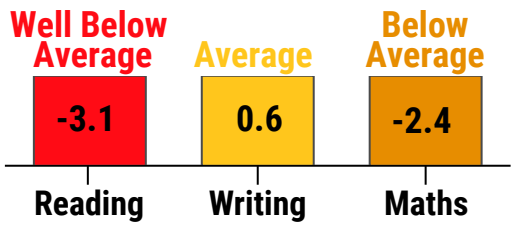
Government pupil progress score, comprises of key stage 1 assessments & key stage 2 tests, compared to pupils across England. Scoring range is -5 & +5, 0.0 being the average.



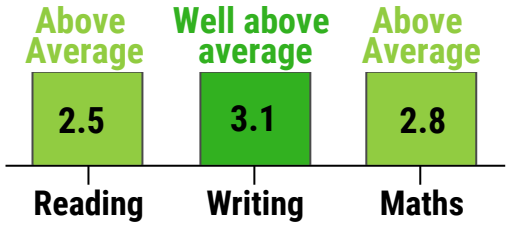
Abbots Hall Primary



Graham James Primary Academy



Arthur Bugler Primary



St Josephs Catholic

Educational achievement is strongly correlated with good health. Research demonstrates that people with high level educational achievement live longer and spend a smaller percentage of their life living with poor health.

Source: www.compare-school-performance.service.gov.uk

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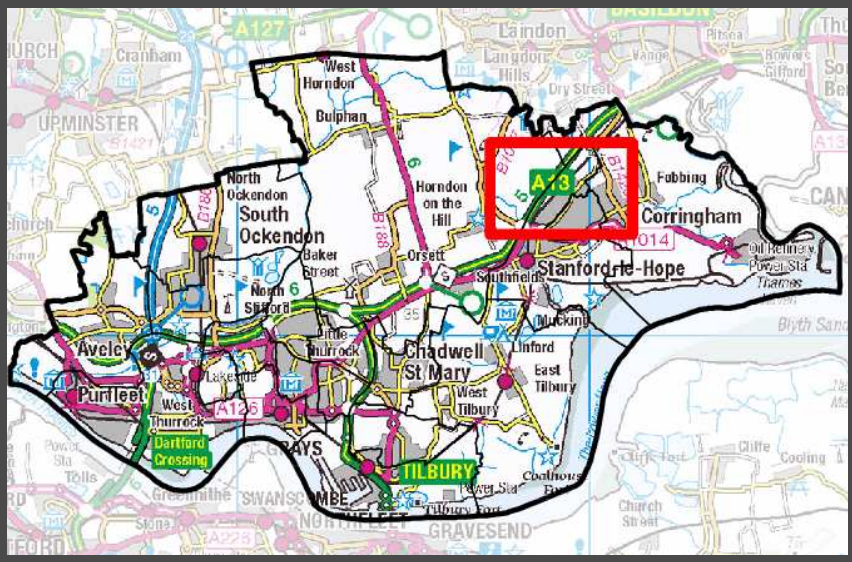

Reported Crime 2016

Count of crimes Oct'16 to Sep'17 - 213

Crime rate per 1,000 persons - 15.2

Thurrock crime rate per 1,000 persons - 47.62

England crime rate per 1,000 persons- 149.58

Reported crime rates in The Homesteads ward are statistically significantly lower than England's. Compared to Thurrock there is a lower crime rate within this Ward.

Source: www.ukcrimestats.com

Residents Views

82% of The Homesteads residents are satisfied with their local area where they live.

81% of The Homesteads residents feel safe going outside in their local area after dark.

Persons feeling unsafe and less satisfied within their area could lead to social isolation and impact negatively on physical/mental health.

Source: Thurrock Council Residents Survey 2016

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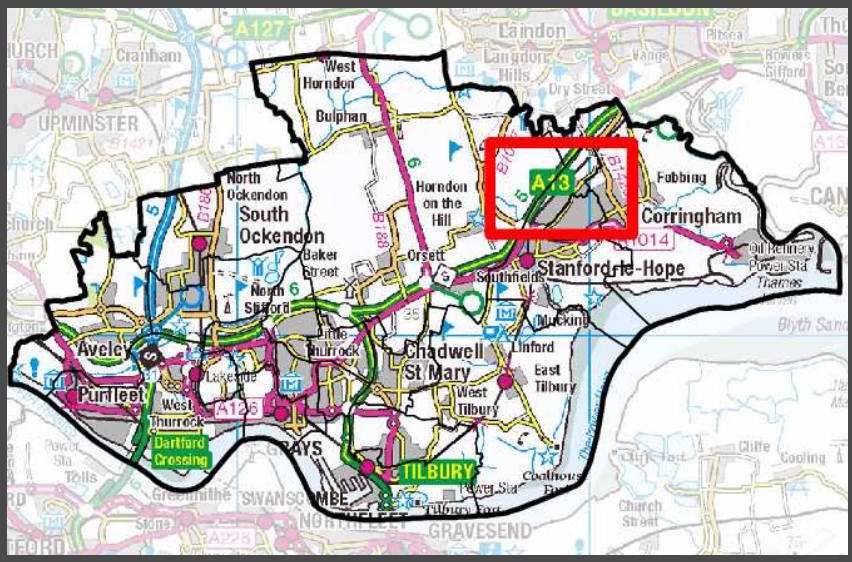


● = Not statistically different ● = Statistically significantly different

Binge Drinking

The Homesteads Ward - 17.9%

England - 20.0%

(% of population 16+ that binge drink)

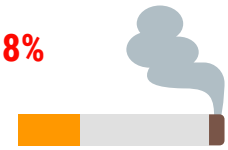
Binge drinking can increase blood pressure, affect mood and memory & longer term, can lead to mental and physical health issues.

Source - PHE Local Health (2006/08)

Smoking

The Homesteads Ward - 19.8%

England - 18%



(Prevalence of 18yrs+ self-reported smokers)

Smoking causes 84% of deaths from lung cancer & 83% of deaths from chronic obstructive pulmonary disease (COPD)

Source - ASH Ready Reckoner (2016)

Obesity (Adult)

The Homesteads Ward- 29.7%

England - 24.1%

(% of population aged 16+ with a BMI 30+)

Obesity causes high blood pressure, leading to strokes, high cholesterol, high blood sugar, and heart disease.

Source - PHE Local Health (2006/08)

Obesity (Child)

The Homesteads Ward - 17.3%

England - 19.3%

(% of children Yr 6 - overweight or obese)

Childhood obesity can lead to adult obesity & serious health issues including heart disease, type 2 diabetes, asthma, social discrimination and depression.

Source - PHE Local Health (2013/14-2015/16)

General Health

3.2% of persons reported that their general health was bad / very bad.

Conversely 86.2% of persons reported their general health as good / very good.

Life Expectancy at Birth

Male - 82yrs
(England 79yrs)

Female - 85yrs
(England 83yrs)

Life expectancy is a function of multiple elements including poor diet/lifestyle (excessive alcohol/drugs), environmental factors such as housing and air quality, educational attainment, deprivation and access to high quality of health services.

Source - PHE Local Health (2015/16)

(Source for all data in this profile is Census 2011 unless otherwise stated)

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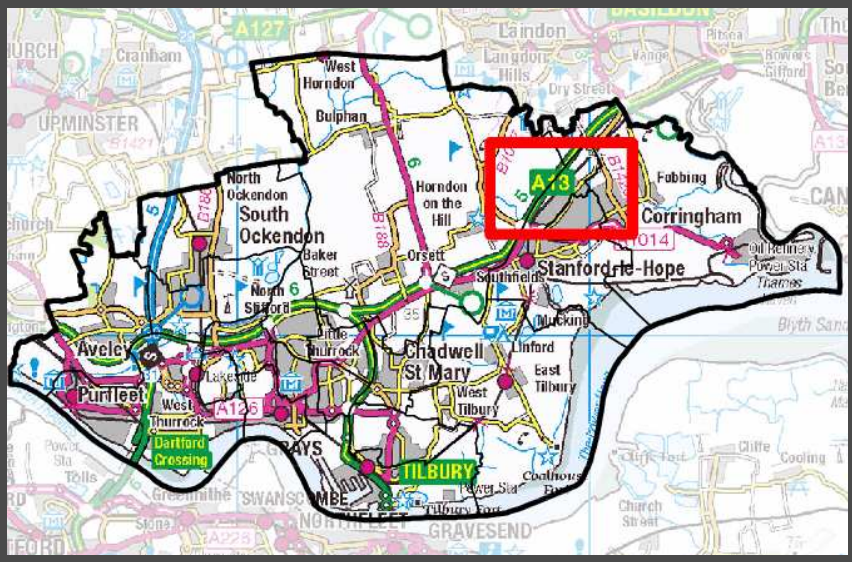
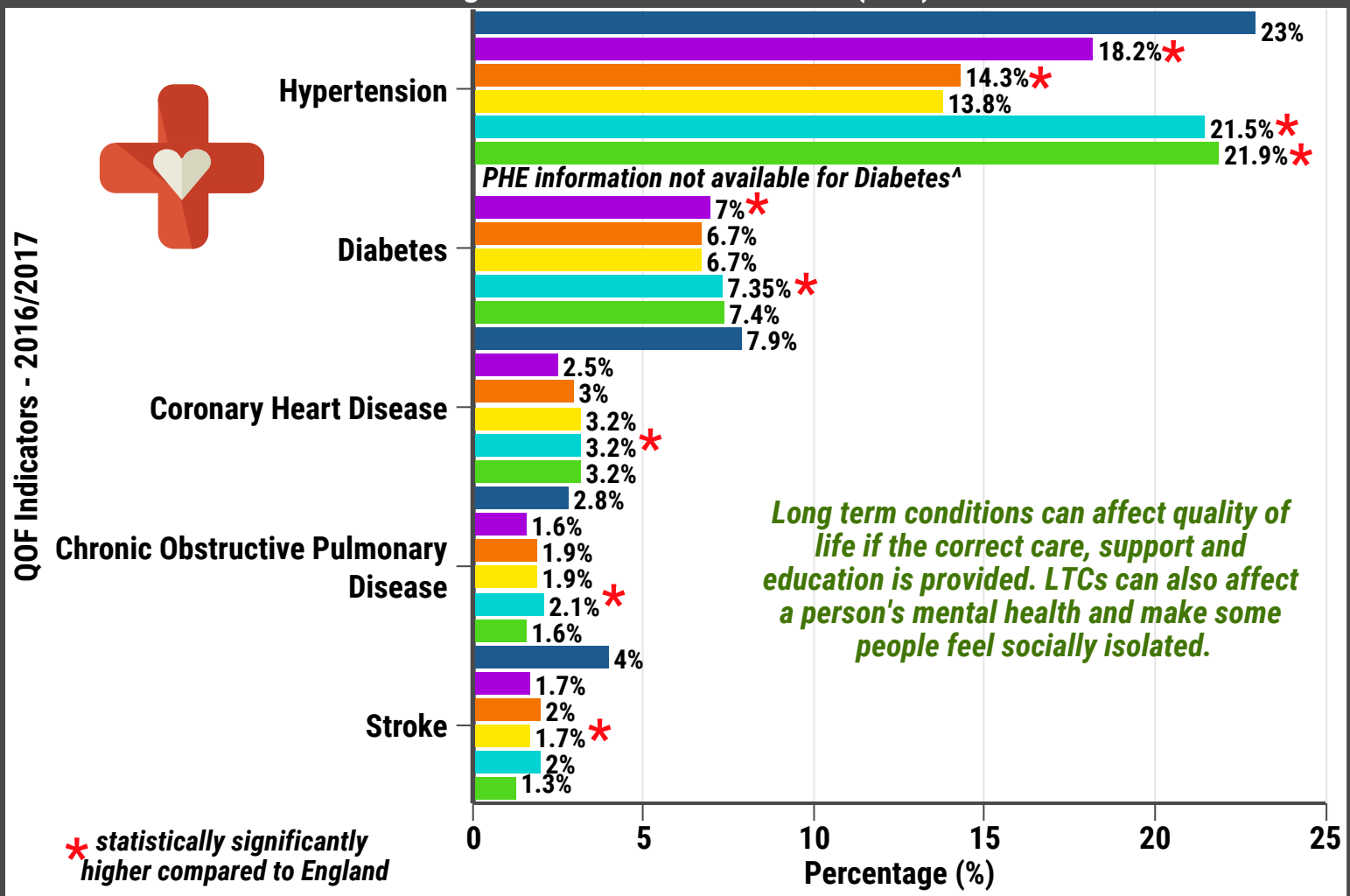


Long Term Conditions 2016/17 (LTC)



- Southend Road Surgery (% of practice adult population diagnosed and receiving treatment)
- The Sorrells Surgery (% of practice adult population diagnosed and receiving treatment)
- England (% of practice adult population diagnosed and receiving treatment)
- Hassengate Medical Centre (% of practice adult population diagnosed and receiving treatment)
- Neera Medical Centre (% of practice adult population diagnosed and receiving treatment)
- PHE Estimates^ for above Practice's (average % of adult population diagnosed and undiagnosed)

PHE Estimate numbers (combined all above GP Practices) of additional undiagnosed patients not receiving treatment^

Diabetes - NA
Hypertension - 1,161
Chronic Obstructive Pulmonary Disease - 156
Coronary Heart Disease - 1,051
Stroke - 455

Source: Thurrock Public Health / PHE Estimated Models^ / QOF 2016-17

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October 2018

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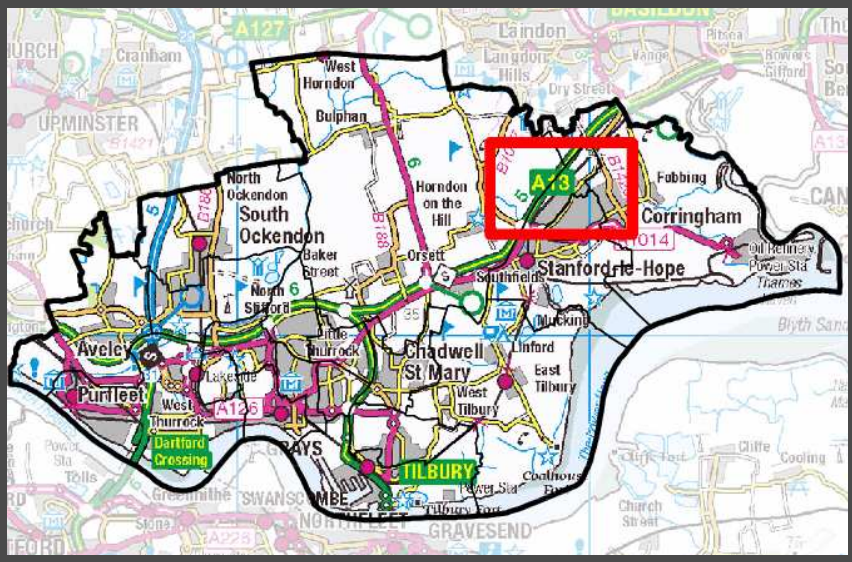

Pharmacies

Hassengate
Southend Road
Stanford-le-Hope
SS17 0PH

Opening Times
Mon-Fri
8-10.30pm

Tues
7.30-10.30pm

Sat / Sun
8-10pm / 9-10pm

Allcures
23 High Street
Stanford Le Hope
SS17 0HD

Opening Times
Mon-Fri
9-5.30pm

Sat / Sun
Closed

Pharmacies near The Homesteads Ward within a two mile radius.

Source: Local Pharmaceutical Committees (LPCs)

Facilities in the community

Community Buildings & spaces

- **Homesteads Hall**

Source: Thurrock CVS - www.strongertogether.org.uk

GP Practices

Southend Road Surgery

List Size - 1,966
CQC - Requires Improvement (Nov 2017)

28% patients had same day appointment (England Average - 38%)

Hassengate Medical Centre

List Size - 12,864
CQC - Good (April 2016)

36% patients had same day appointment (England Average - 38%)

Southend Road Surgery is within Homesteads ward, the other three GP Practices are within a two mile radius.

The Sorrells Surgery

List Size - 3,243
CQC - Good (Mar 2017)

25% patients had same day appointment (England Average - 38%)

Neera Medical Centre

List Size - 3,163
CQC - Good (April 2017)

42% patients had same day appointment (England Average - 38%)

Source: National GP Patient Survey 2017 /NHS Choices

The Homesteads Ward
(E05002245)

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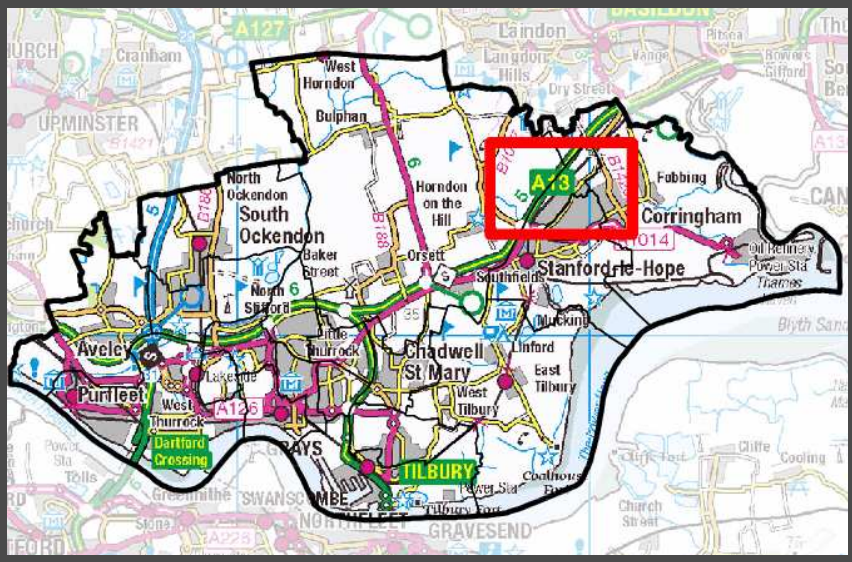
October 2018

thurrock.gov.uk



Your Place Your Voice

For more details on growth within Thurrock please visit - www.thurrock.gov.uk/planning-and-growth

Summary of The Homesteads Ward

Ward population - 8,344
Males - 4,037
Females - 4,307

One GP surgery in ward, three GP's within two miles and two pharmacy's

Smoking prevalence - 19.8% (significantly higher than England - 18%)

Binge drinking prevalence - 17.9% (not statistically different to England - 20.0%)

Obesity (Adults) prevalence - 29.7% (significantly higher than England - 24.1%)

Childhood obesity prevalence - 17.3% (significantly lower than England - 19.3%)

Four primary schools - Abbots Hall, Graham James, Arthur Bugler, St Josephs Catholic

The Homesteads deprivation rank: 18/20

Life expectancy from birth - Male - 82yrs Female - 85yrs

Crime rate per 1,000 persons - 15.2 (lower than the Thurrock crime rate of 47.62)

PHE models of undiagnosed patients - Hypertension - 1,161, Coronary Heart Disease - 1,051, Chronic Obstructive Pulmonary Disease - 156, Stroke - 455

Unemployment is lower, compared to Thurrock

15 February 2018	ITEM: 11
Health and Wellbeing Board	
Adult Mental Health System Transformation	
Wards and communities affected: All	**Key Decision:**
Report of: Ian Wake, Director of Public Health, Mark Tebbs, Director of Commissioning, Thurrock CCG and Catherine Wilson, Lead Commissioner Adult Social Care	
Accountable Head of Service: Mark Tebbs, Director of Commissioning NHS Thurrock Clinical Commissioning Group Catherine Wilson, Strategic Lead Commissioning, Adults Housing and Health	
Accountable Director: Ian Wake, Director of Public Health Roger Harris, Corporate Director, Adults, Housing and Health Mandy Ansell, Accountable Officer, NHS Thurrock Clinical Commissioning Group	
This report is Public	

Executive Summary

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

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

1. Address the issue of under-diagnosis of mental health problems
2. Improve access to timely treatment
3. Develop a new model for Common Mental Health Disorders

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

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

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

Recommendations

- **That Health and Wellbeing Board notes the contents of this report and comments on the direction on travel in terms of adult mental health system transformation**
- **The Health and Wellbeing Board comments on and supports the proposals as set out in section 7.14 to 7.17 of this report to develop a new Section 75 Agreement with EPUT from 1st April 2019 based on a longer term contract, with a revised performance and budget framework**
- **That Health and Wellbeing Board comments on and supports and approves the proposals set out in section 10 of this report in relation to suicide prevention.**

1 Introduction

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

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

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

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

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

2 Background – Current Provider and Commissioning Landscape

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

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

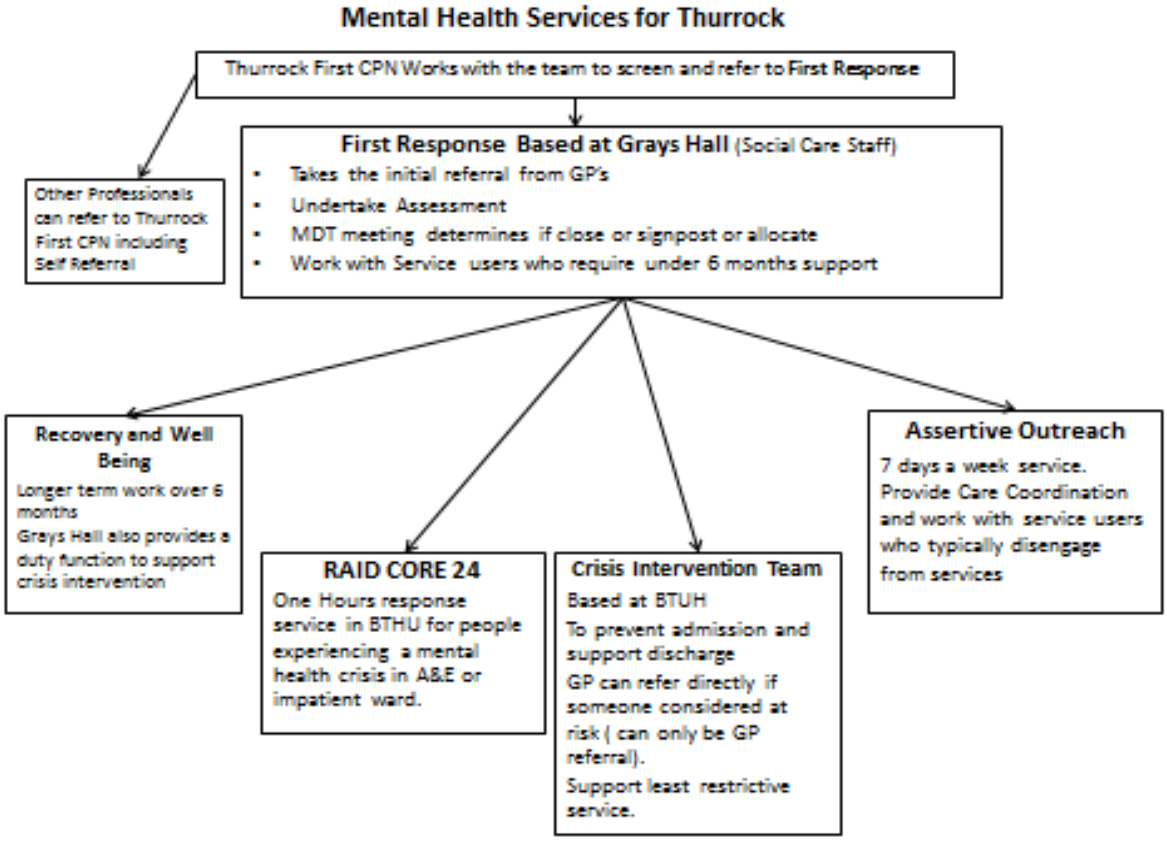
2.3 *Inclusion Thurrock* provide a *Recovery College* consisting of suites of courses which help people recovering from mental health problems self-manage their conditions. This includes programmes on mindfulness, understanding anxiety and food and mood.

2.4 A range of third sector organisations provide support to people with mental ill health. The largest provider of these services is Thurrock MIND, who provide a range of interventions including talking therapies, supported housing, peer mentoring, positive pathways and advocacy. They are also active participants in a 'shared care protocol' which supports clients discharged from EPUT services to stay well and reduce re-admissions to secondary care. The Emotional Well Being Forum supported by Thurrock Coalition and MIND is an opportunity for those with lived experiences of services and

mental health and carers to meet together for support, to gain information and to influence service developments. *The World of Work* provides support and training to enable people to become work ready through CV writing interview practice support with volunteering and support into paid employment.

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

Figure 1



2.6 Thurrock Council delegates to EPUT its statutory duty to provide adult social care assessment and care management services under the Care Act 2014 through a Section 75 Agreement. A Community Psychiatric Nurse (CPN) works within Thurrock First taking initial referrals and supporting the Thurrock First Advisors. The CPN can offer support information and advice and can also refer directly to the First Response Team. The First Response Team works with people who require 6 months of support or less. The Team consists of social workers and community nurses together with psychiatrists and therapists offering a range of supports, including individual therapy, case management, and medication monitoring and risk management. The referral route into the team is via GP's and other professionals, not self-referral.

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

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

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

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

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

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

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

2.14 Commissioning of the current mental health system is also fragmented. NHS Thurrock CCG lead commissioning Inclusion Thurrock to provide IAPT services, the secondary healthcare treatment services provided by EPUT on behalf of the Mid and South Essex CCG Joint Committee and commission some third sector provision. Similarly Thurrock Council Adult Social Care also commission EPUT through the section 75 arrangement for social care staff, and commission a range of third sector and community social care support. The Council's Public Health Team commission drug and alcohol and healthy lifestyles service provision. NHS England commission Primary Care services. Basildon and Brentwood CCG lead commissioning of A&E services on behalf of the Mid and South Essex Joint Committee. NHS England, via specialist commissioning, commission low and medium secure services. West Essex CCG commission children's mental health and emotional wellbeing services.

2.15 Some work has already commenced to integrate commissioned care pathways. This includes improved collaboration between *Inclusion Thurrock* and NELFT; *Inclusion*

Thurrock and EPUT; and within *Inclusion Thurrock* for clients receiving both IAPT services and Drug and Alcohol Treatment (dual diagnosis).

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

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

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

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

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

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

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

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

3.5 A report by the Director of Public Health which aimed to triangulate learning from the JSNA, LGA Peer Review and Healthwatch Research and propose strategic action on transforming the local adult mental health treatment system was agreed at the

September 2018 Thurrock Joint Health and Wellbeing Board. The report set out five priority areas for action to improve local mental health services which are discussed in more detail in sections 5 to 8 and made a series of recommendations. These are included in the action plan in section 10.

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

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

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

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

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

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

depression screening tools into existing E-Consult/Web-GP and NHS Choices software.

5. Improve timely access to treatment

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

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

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

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

5.5 Thurrock CCG is leading the work to develop an open access 24/7 community crisis service in EPUT. The model will enable people to access specialist crisis care via 111. EPUT will provide both the triage and the specialist teams to assess and treatment teams. The ambition is that the funding will be approved to enable the service to begin mobilisation in the new financial year and be operational for the winter 2019.

6. A new treatment model for Common Mental Health Disorders

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

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

6.3 The current treatment offer for CMHDs is too narrow. Currently patients typically are offered anti-depressant medication and/or referral to talking therapies provided by IAPT. However CMHD risk is strongly associated with socio-economic and psycho-social factors. As such, CMHDs are not evenly distributed amongst the population and are dependent at least in part by the environment in which the individual lives. CMHDs are more likely to persist in people in lower socioeconomic groups such as people who are on low incomes, long-term sick or unemployed. The Marmot report*, Fair Society, healthy lives*[1] 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.[2,3] Conversely, there is a wide body of evidence that demonstrates the highly mentally health protective effect of having strong positive social connections and being employed.

6.4 There is a strong and growing evidence base demonstrating exercise to be an effective intervention for treatment of mild to moderate depression a valuable complementary therapy to the traditional treatments for severe depression. Physical activity has been shown to be as effective as anti-depressant medication and psychotherapy in reducing both depression and anxiety with the greatest gain observed in those who already have clinical symptoms. [4] However at present, very few patients with CMHD are referred by GPs into Public Health commissioned physical activity programmes and action needs to occur to ensure exercise on prescription becomes a common treatment offer to local residents who have been diagnosed with depression or anxiety. Further work is required to understand this issue and increase referral rates from GP surgeries into this treatment option.

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

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

6.9 Significant opportunity also exists to design a new model of care for treatment of CMHD that broadens the offer to encompass a 'strengths based' approach to mental health, having a different 'strengths based' conversation with residents suffering from

CMHDs, connecting them with community assets to increase social capital and helping them to address wider determinants of health where appropriate, particularly employment.

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

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

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

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

7.3 Anecdotal evidence on the characteristics of The Missing Middle suggests that they often return to Primary Care, Thurrock Healthwatch and Local Area Coordinators looking to access services from parts of the system that are not best skilled or equipped to provide it. Local GPs and Healthwatch report that many people within the Missing Middle have personality disorders, and often have chaotic lifestyles with multiple issues including housing and drug/alcohol problems. A multi-agency project group has been established to focus on improving outcomes for those with personality disorders. The group is working on:

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

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

mental health crisis before services are available and with insufficient focus on early identification and intervention to prevent patients with SMI entering crisis.

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

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

7.8 Despite these improvements, a radically new model of Enhanced Treatment is required that:

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

7.9 Delivering a new model of care that encompasses the above requires a whole system change across the whole mid and South Essex STP. It is not going to be possible to change one part of the system in isolation. Addressing the 'missing middle' will require a whole system change. It will require co-ordinated changes in prevention, social care, primary care, secondary care and crisis care across the whole STP footprint. To this

end, partners across the STP have embarked upon an exercise to develop a 'costed' strategy. Partners are aiming to work rapidly to articulate a clear case for change, high level care model, workforce plan, estates plan, and digital plan and associated finances. The aim will be to produce a radically different model of care which is deliverable within our current workforce and financial constraints. In effect, the STP plan will 'unpick' the block contract to facilitate, enable and empower our Thurrock locality working.

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

7.11 The *Open Dialogue* approach is humanistic and non-hierarchical. Patients are treated in their own homes (where possible) within 24 hours of reporting mental health crisis and therapy occurs between up to three therapists, the patient with psychosis and their family working together in the same session. The purpose of therapy sessions is to generate dialogue between therapists, patients and their families, and all parties reflect openly about their feelings towards one another and discuss ideas about the situation. The primary purpose of therapy is dialogue and "meaning making" and as a product of this dialogue solutions begin to emerge and relationships begin to be repaired. Medication is kept to an absolute minimum and used for the shortest period of time possible, and only to help patients get over the worst symptoms. Sedatives to help patients sleep are favoured over neuroleptic medication which is seen as preventing "meaning making". Hospitalisation of patients is also avoided in all circumstances possible, with community nurses staying overnight in patients' own homes when they are very seriously unwell. Treatment is continued in terms of 'open dialogue' until medication is ceased.

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

7.13 Following a workshop led by Public Health and NELFT (who are piloting the Open Dialogue Approach in localities outside Thurrock), EPUT, Thurrock Council and NHS Thurrock CCG committed to participation in a national Randomised Control Trial that is

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

7.14 **Section 75 Agreement.** The Section 75 Agreement between Thurrock Council and EPUT allows the Local Authority to delegate its statutory duties under the Care Act 2014 to deliver social work and social care services. The current model is embedded in an existing medical model of GP referral (or referral by other professionals) and the threshold for access to services is very high and not compliant with the Care Act. For a number of years we have tried to address this but with little success. The performance framework within the Section 75 Agreement is not outcome focused and as stated above a considerable amount of joint work between EPUT and the three local authorities is taking place to address this. We are clear that the current Section 75 Agreement is now not fit for purpose however what we have learnt from the development of the Southend, Essex and Thurrock Mental Health Strategy, the outcomes for the Thurrock Health and Well-being Strategy, the recommendations of the Mental Health Joint Strategic Needs Assessment and the Peer Review is that a partnership approach is required to develop a new model for the provision of mental health services.

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

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

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

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

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

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

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

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

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

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

8.7 Future commissioning arrangements need to broaden the current focus and be more holistic and wider than current clinical services, encompassing the key issues of social support, housing and employment highlighted in sections 6.3 to 6.11 and 7.8. A Thurrock Mental Health Partnership Board will be established to drive the local mental health agenda. The Board will bring together CCG, local authority and public health commissioning arrangements. This Board will be the first step towards developing more formal joint commissioning arrangements. The board will provide a specific mental health focus to the work of the *Thurrock Integrated Care Alliance* including a shift from individual contract and provider process/input KPIs to single system wide outcome KPIs with agreed financial risk and reward mechanisms.

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

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

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

9. Joint Work between Mental Health Commissioning and Housing

9.1 The connection between positive mental health outcomes for individuals and settled accommodation is well documented and researched. Shelter's Report – The impact of housing problems on mental health, published in April 2017 highlights that of 3,509 interviewed for the research adults experiencing mental ill health 69% of them said that housing problems such as poor conditions, struggling to pay rent or being threatened with eviction had a negative effect on their mental health (p.11).

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

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

10. Suicide Prevention

10.1 In a recent speech to the Global Ministerial Mental Health Summit on World Mental Health Day, the Prime Minister announced that Thurrock M.P. Jackie Doyle-Price would become the UK's first Minister for Suicide Prevention, with a remit to reduce the current 4,500 people who take their own lives each year in England, and overcome the stigma that prevents people from seeking help. Suicide is the biggest killer of men under the age of 45. She also announced that every local authority area should have a suicide prevention plan in place. In the Autumn Budget, the Chancellor announced an additional investment of £250 million in new mental health crisis services including money for suicide prevention activity, which can be accessed via Sustainability and Transformation Partnerships.

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

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

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

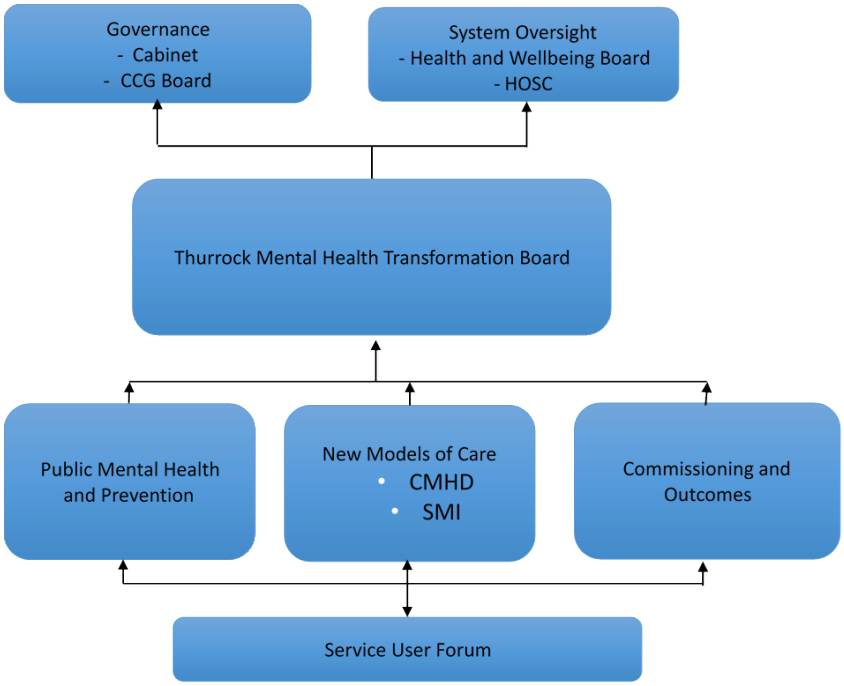
- School Based preventative approaches based on working with young people to identify risk factors for poor mental health and self-harm attempts
- 'Gate keeper' training of relevant health professionals including teachers and the police. There is no evidence that training of GPs specifically has any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

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

- Establishing and participation in multi-agency partnership at Mid and South Essex Level to take action on suicide prevention across all key stakeholders
- Participation in on-going suicide audit work at Essex level to improve understanding and intelligence on suicide. Because of the very small numbers involved, we propose undertaking a suicide audit across Essex based on the last ten years' data
- Development of a new Suicide Prevention Strategy at Essex level, against which new government funding can be accessed based on the findings of the Suicide Audit
- Implementation of the Mental Health Schools Based Wellbeing Service and well-being teams to boost capacity and capability in schools to prevent suicide and identify and intervene early with those young people at risk
- Implementing a training programme of suicide awareness with front line professionals at Essex level in line with the published evidence base
- Develop a local information-sharing system to ensure that information on para-suicides (and other people at very high risk of suicide) is cascaded to relevant agencies.
- Develop protocol for multi-agency action to provide support to prevent further attempts in cases of para-suicide
- Transformation of mental health crisis services as set out in section 7 of this report including improving access to 24/7 crisis care.
- Review of self-harm care pathways and improvement in line with recommendations in the published evidence base.

11. Next Steps and Action Plan

11.1 A new Mental Health System Transformation Board has been formed with senior representation from all commissioning and provider organisations, and met for the first time on 23 January 2019. The Board agreed to form three operational working groups to take forward priorities 1, 2 to 4, and 5 respectively as set out in this paper. It also agreed to form a Service User Forum to ensure that user voice is represented within the process and that new models of care are developed with the principle of 'co-production' at their heart. The governance arrangements of the new Board are set out below.



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

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

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

12. Reasons for Recommendation

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

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

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

13.2 A version of this report was discussed and approved at the January 2019 meeting of the Thurrock Health and Wellbeing Overview and Scrutiny Committee.

14. Implications

14.1 Financial

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

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

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

14.2 Legal

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

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

14.3 Diversity and Equality

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

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

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

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

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APPENDIX A: MENTAL HEALTH TRANSFORMATION ACTION PLAN

Appendix follows.

Recommendation	Key Objective	Lead	Other Key Stakeholders	Timescales
1) Improve the diagnosis of residents with undiagnosed depression and anxiety	a) Expedite roll out of the PHQ2/9 depression screening tool prompt template in SystmOne for patients that are being reviewed for physical Long Term Health Conditions	Healthcare Public Health Team	GPs, Primary Care Development Team	By June 2019
	b) Improve the uptake of NHS Health Checks Programme such that a minimum of 60% of those offered a health check receive one, as a systematic way of screening for depression through implementation of the Health Checks Strategic Plan	Thurrock Healthy Lifestyles Team Manager	GP surgeries, Pharmacies	By March 2019

	c) Embed depression screening into the practice of wider front line professionals including front line house, social care and community workers	Strategic Lead, MH Transformation	Principal Social Worker AD Housing Operations NELFT LTC Management Teams Strategic Lead Community Development	By June 2019
	d) Improve access to depression screening for the general population with the use of online screening tools linked to self-referral mechanisms	Strategic Lead, MH Transformation	Council and CCG Communications Leads	By December 2019
2) Improve Access to timely mental health treatment	a) Undertake capacity modelling to understand and implement actions to reduce IAPT waiting times to the six week minimum	CCG Mental Health Commissioning Lead	Inclusion Thurrock	By March 2019
	b) Develop and commission a new model of 24-7 direct access crisis care	CCG Mental Health Commissioning Lead	EPUT Strategic Lead, MH Transformation	*By Winter 2019

	c) Examine current and agree new system wide thresholds for treatment access for all MH clusters to ensure that *Missing Middle* are able to access timely and appropriate secondary MH services	CCG Mental Health Commissioning Lead Strategic Lead, MH Transformation Strategic Lead – ASC Commissioning	EPUT	By December 2019
3) Develop and commission a New Model of Care for Common Mental Health Disorders	a) Address the variation in referral to IAPT for CMHD amongst GP practices such that a minimum of 25% of patients estimated to have a CMHD receive treatment each year, and that age and sex variation is also reduced	Strategic Lead, MH Transformation Strategic Lead – Healthcare PH	GPs, Inclusion Thurrock	From April 2019 through rolling programme of GP surgery visits

	b) Address variation in clinical management of depression in Primary Care including inclusion of QOF indicators relating to depression review on the GP Practice Profile Card/Practice visits and future Stretched QOF iterations	Strategic Lead MH Transformation Strategic Lead – Healthcare PH	GPs	From April 2019 through rolling programme of GP surgery visits
	c) Expedite integration of IAPT Services with other LTC Physical Health Conditions to create single 'one stop shops' where all LTCs can be dealt with at the same time, as part of *Better Care Together* Transformation Programme building on the new pathway that is now in place between Inclusion Thurrock and NELFT	Strategic Lead – MH Transformation	NELFT LTC services Inclusion Thurrock CCG Mental Health Commissioning Lead	From April 2019

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

	b) Review current referral criteria thresholds across IAPT and secondary care and agree new common standards to ensure service provision for *The Missing Middle*	Strategic Lead – MH Transformation	CCG MH Commissioning Lead Strategic Lead, ASC Commissioning Inclusion Thurrock, EPUT	Initial proposals by September 2019
	c) Reduce current fragmentation in care pathways within EPUT to improve continuity of care	Strategic Lead – MH Transformation CCG MH Commissioning Lead Strategic Lead, ASC Commissioning EPUT Operations Leads		Initial proposals by December 2019
	d) Reduce current fragmentation in care pathways between Primary and Secondary Care including basing Psychiatric Nursing Capacity within Primary Care Mixed Skill Workforce Teams	Strategic Lead – MH Transformation CCG MH Commissioning Lead Director of Primary Care, CCG Director of Transformation CCG		Initial proposals by December 2019

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

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

5) Integrate Mental Health Commissioning across council and CCG	a) Create a single shared commissioning function and strategy between TBC and NHS Thurrock CCG to undertake all commissioning across the current and future provider landscape	Director of Commissioning TCCG Strategic Lead - ASC Commissioning		Initial model by May 2019 further development ongoing through 2019
	b) Develop a single shared commissioning outcomes framework	Director of Commissioning, TCCG Strategic Lead - ASC Commissioning	Strategic Lead – MH Transformation CCG MH Commissioning Lead	Initial framework by May 2019 with ongoing development through 2019

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

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[3] 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

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

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