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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **7 November 2019**

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

Membership:

Councillors Victoria Holloway (Chair), Shane Ralph (Vice-Chair), Tom Kelly, Sara Muldowney, Joycelyn Redsell and Elizabeth Rigby

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

Substitutes:

Councillors John Allen, Alex Anderson, Cathy Kent, Sue Sammons and Sue Shinnick

Agenda

Open to Public and Press

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1. Apologies for Absence

2. Minutes **5 - 20**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 5 September 2019.

3. Urgent Items

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

4. Declarations of Interests

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **30 October 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 Overview and Scrutiny Committee held on 5 September 2019 at 7.00 pm

Present:	Councillors Victoria Holloway (Chair), Shane Ralph (Vice-Chair), Tom Kelly, Sara Muldowney and Elizabeth Rigby *(arrived at 7.13pm)* Ian Evans, Thurrock Coalition Representative Kim James, Healthwatch Thurrock Representative
Apologies:	Councillor Joycelyn Redsell
In attendance:	Councillor James Halden, Portfolio Holder for Health Wayne Bartlett-Syree, Director of Strategic Transformation/Locality Director, NHS England Roger Harris, Corporate Director of Adults, Housing and Health/Interim Director of Children's Services Ian Wake, Director of Public Health Mandy Ansell, Accountable Officer, Clinical Commissioning Group Rahul Chaudhari, Director of Primary Care, Clinical Commissioning Group Helen Forster, Strategic Lead Place, Environment and Community Jane Itangata, Associate Director of Mental Health Commissioning, Mid and South Essex STP (Local Health and Care) Nigel Leonard, Executive Director of Strategy & Transformation, Essex Partnership University NHS Mark Tebbs, Director of Commissioning, NHS Thurrock CCG Jenny Shade, Senior Democratic Services Officer

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

9. Minutes

Councillor Muldowney requested that the comments made on page 11, paragraph 6 of the agenda to be amended to read:

Councillor Muldowney referred back to Dr Google and stated her concerns based on the reading of the subject and Officers saying that there had been varying results from the trials they were doing around digital about how much better some of these APPS are at the moment. Councillor Muldowney stated that personally she thought the one that had been taken on board nationally probably should not had been rolled out yet to live patients and should still be

in beta testing as she did not think it had been properly developed enough. So this was her concern at this level that we are not falsely reassuring people who may have something more serious but would not necessarily get picked up. Councillor Muldowney stated that this was one of the concerns but also the accuracy and the actual fit for purpose of whatever we are using I just want to make sure that it was really robust.

Following this amendment, the Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 13 June 2019 were approved as a correct record.

10. Urgent Items

No urgent items were raised.

11. Declarations of Interests

No interests were declared.

12. Healthwatch

Kim James, Healthwatch, updated Members on a piece of work that would be commencing in October which would focus on dementia care within residential homes, nursing homes and into specialist wards in hospitals and will end with an event in February 2020 for the Dignity in Care Week. Healthwatch would be interested to hear any feedback or views of Members. Mandy Ansell requested that Healthwatch linked in with the Nursing and Quality Teams at the Clinical Care Commissioning and the Chair stated she looked forward to hearing an update at a future committee.

The Chair announced that the order of the agenda would be changed to hear Item 11 first.

13. Reduction of Thurrock Clinical Commissioning Group Budget 2019-20 and wider NHS England proposals to merge five Clinical Commissioning Groups across the Mid and South Essex STP geographical footprint

The Chair welcomed Wayne Bartlett-Syree, Director of Strategic Transformation/Locality Director, NHS England, to the meeting and explained how difficult it had been to get someone from NHS England to attend this evening. The items discussed under this item would be:

- £490K funding taken from Thurrock Clinical Commissioning Group to Cambridgeshire and Peterborough STP
- The proposal for a single Clinical Commissioning Group Accountable Officer
- The merger of the five Clinical Commissioning Groups

Wayne Bartlett-Syree introduced himself and provided Members with an overview of his broad background.

Wayne Bartlett-Syree stated that money was interesting in the NHS and had always been a significant challenge and recognised and had sympathy for local authorities on the challenges that they faced. How monies worked in the NHS was that it would be passed from Government through the Treasury to the Department of Health and Social Care and onto Clinical Commissioning Groups. The majority of that money would go to NHS England who had a strategic responsibility to balance their books which meant that commissioners and providers across the country had to be in a position where the money balanced but the accountability would sit with the Secretary of State and also Simon Stevens now the Joint Chief Executive between NHS and NHSE. There were Trusts and Clinical Commissioning Groups that run surpluses and deficits and what the National Director of Finance would like at the end of the year for deficits and surpluses all to total back to a net zero position but as years had gone by this had become increasingly more challenging where money had been asked from systems or monies been moved from systems to ensure that net zero. For 2019/20, rather than this to take place at national level, regions were asked to balance within NHS England. Currently within the East of England there was a significant gap when coming to the planning element and that gap existed in Cambridgeshire and Peterborough of around £70 million. The approach taken in the East of England was that a contingency reserve could be deployed, this would be a large ask for Cambridgeshire and Peterborough in regard to their savings plan. The said ask for the five STPs with a contribution of £5m each into that deficit in order to balance the books.

Councillor Rigby arrived into the Committee Room at 7.13pm.

Wayne Bartlett-Syree moved onto the mergers of the Clinical Commissioning Group that the long term plan set out the commitment to ICSs over the next four years and the move would mean that each ICS would be covered by one Clinical Commissioning Group. That all regions had written out to their Clinical Commissioning Groups in line with the long term plan. That the first draft is expected by September 2019 asking about each Clinical Commissioning Group were thinking on this and what their expected timelines would be for this merger. Some Clinical Commissioning Groups were further on and looking to merge, some had merged and some were yet to start those conversations. The letter that NHS England sent out was initial to start the process in order to get people’s ideas and understand views on their thinking. If the mergers are going to be made by 2021 there was a lot of engagement and work to be done at both locality and governance. Wayne Bartlett-Syree stated those Clinical Commissioning Groups that had already merged, some over large footprints, the success of those mergers had been down to ensure that Place was well represented. Wayne Bartlett-Syree commented that Thurrock had done well in ensuring that Place had been vital to its success. That going forward to the single merger to create one Clinical Commissioning Group it was vital as part of the merger that Place was well and truly represented and recognised.

The Chair thanked Wayne Bartlett-Syree for attending and noted that he had only been in post for three weeks but questioned whether he was the right person here this evening to answer Thurrock's questions in regard to the depth of the answers that Members were expecting to hear this evening.

Councillor Muldowney questioned how the decision to move funding had been made, who had made it and what process had been followed. Wayne Bartlett-Syree stated that it had been the regional teams and the STP executives who had agreed to move the funding. With concerns raised it had been agreed how the £5m would be distributed and divided at Clinical Commissioning Group level. That NHSE did not have any mandate and it would up to each STP on how the money was divided amongst themselves in that locality.

Councillor Muldowney stated the decision had focused on the attention to Place. Wayne Bartlett-Syree stated that impact was on Place and how the money was divided up in the STP. That a Equality Impact Assessment had been carried out to identify what services would be affected.

Councillor Muldowney asked to see sight of the Equality Impact Assessment. Wayne Bartlett-Syree stated that this document would sit at the STP and ICS level.

Councillor Halden, Portfolio Holder for Health, applauded Wayne Bartlett-Syree for attending this evening as other NHS England colleagues had avoided these questions in the past. Councillor Halden noted Thurrock had moved on at a great pace and one concern would be that with the merger in the attempt to bring other partners along at a fast rate might actually slow Thurrock down. Councillor Halden questioned whether NHS would take a proactive approach on what powers should remain locality rather than system wide. Wayne Bartlett-Syree stated as they moved forward as a system, the system would move to the merger and one factor on the merger would be to look at governance and how decisions are made through one Clinical Commissioning Group, with Place being key to that success. Wayne Bartlett-Syree stated he would be happy to have a separate discussion on the Memorandum of Understanding outside of this committee.

Councillor Halden thanked Wayne Bartlett-Syree for the response and explained that Thurrock had positive experiences and questioned what Place meant and how money would be allocated to projects and what Place would mean going forward.

Wayne Bartlett-Syree stated that following Councillor Halden's conversations with Paul Watson changes had been made in response to the publication of the Long Term Plan and the Implementation Framework. There was now a clear policy which Clinical Commissioning Group should now look to operate on. Wayne Bartlett-Syree concurred that Thurrock would have their voices heard in those conversations as to why it would be important to keep services at Thurrock level.

The Chair asked whether that confirmation would now be put into writing. That not only Members here this evening but Members widely are in agreement and had concerns that the Memorandum of Understanding should now be written and firmed up and asked for NHS England assures this would be undertaken. Wayne Bartlett-Syree questioned who would now put that into writing and based on how NHS England are operating under the model the policy stated that would be an STP and ICS role to come back to NHS England around their plans on the merger and how this would be tackled, with the help of some national guidance around managing mergers, process and governance. Wayne Bartlett-Syree stated NHS England would not be required to write to Thurrock on that subject as the plans would need to be received back from the Clinical Commissioning Group on the merger and look to see what needs to come first, review and address those issues.

The Chair stated that with some uncertainly still on the process did NHS England now understand Thurrock Members concerns and their need to feel confident in this process. Wayne Bartlett-Syree understood the real challenge around local Places having their voices heard in decisions and that to ensure as we go through the process it would be covered off in the establishment of one single Clinical Commissioning Group across Essex.

Ian Wake posed a question on Money and that no assessment on equity had been taken place before the decision to remove the money from Mid and South Essex to Cambridgeshire and asked why. Wayne Bartlett-Syree stated he was not party to the full discussions but the £25m between five Clinical Commissioning Groups it had been the agreement of the STPs to divide by five ways.

Ian Wake stated that people living in the Cambridgeshire and Peterborough area are healthy people and would live six years more than Thurrock residents and questioned why the time was not taken to undertake an impact assessment before the money was taken rather than after the decision had been made and asked where the money went. Wayne Bartlett-Syree stated the money had been divided by the five Clinical Commissioning Groups who all faced challenges and all had chosen to deal with the money in different ways.

The Chair stated that the decision had been forced upon dependent on how the funds were distributed out. That Cambridgeshire and Peterborough had a platinum service and overspent on their budget by millions of pounds. Thurrock had not and had managed to live within their means and balanced the budget. The tricky and difficult thing situation for Thurrock was that the mental health crisis services had to be delayed by months and was now “tricky” for Thurrock residents to access this service.

Kim James, Healthwatch, and Ian Evans, Thurrock Coalition, who represented people independently, repeated what Members had already discussed that it was those much needed services that would now be delayed. People of Thurrock would not know how the impact assessment was undertaken and would look at their local Clinical Commissioning Group. That

the Thurrock Clinical Commissioning Group had no say in the decision, the decision had been forced upon them and for them to now have to make decisions on how they are going to find that money and what services Thurrock will lose for the people of Thurrock was an absolute disgrace.

Councillor Ralph stated that NHS England seem to be passing the buck to the Clinical Commissioning Group and that how NHS England looked at how the money would be divided it appeared that Thurrock had been penalised for being successful and that NHS England would not be accountable for the services that had been reduced as this had been passed down to the next level which had been irresponsible. Wayne Bartlett-Syree stated that it was important that when difficult decisions are being made about local services they are made by the local commissioners and by the local areas. That when difficult decisions are made NHS England had a strategic responsibility to balance the books and NHS England could not get away from that. In terms of how this would then be prioritised on local services NHS England could only defer to Mandy Ansell as it was at the STP level that decisions were made about how that money was to be apportioned. Wayne Bartlett-Syree stated that this was done by NHS England and appreciated that there had been some difficult and complex decisions that had been made which had an impact on local services.

The Chair reiterated that the reason for Thurrock inviting NHS England to the committee and had not accepted the initial decline of the committee's invitation and deferred to Mandy Ansell was because as Members they did not believe that was what had happened and that the responsibility fell to the Clinical Commissioning Groups decision.

The Chair questioned whether the Clinical Commissioning Group could refuse to transfer the money and what would the implications be if it did and would NHS England be taking more monies from Thurrock in the future. Wayne Bartlett-Syree stated that there was no option to refuse to transfer the funding as monies had already been managed and moved at a national level rather than at regional level. Wayne Bartlett-Syree stated that taking extra money in the future the NHS England did not want to be a position to have these difficult and controversial conversations with systems after they had received their money but ultimately this would come down to balancing the books. The long term planning implementation guidance would provide new financial projections that would be coming out for all systems with the NHS expectations being that each systems would live within those financial projectors that had been set for them so should not be looking after the money had come out to move money around the systems. Wayne Bartlett-Syree stated that there would be one caveat as there could be in-year complications or very complex patients that could mean a single system or a single Clinical Commissioning Group having a very large financial hit which could be very difficult to plan in the way that NHS finances work. This would be an example when conversations would be held with systems on how best to help to do that but the plans would be to create a contingency at regional level which would help smooth those situations.

The Chair stated that Thurrock Clinical Commissioning Group were able to manage their budgets within those hurdles and assumed that all Clinical Commissioning Groups are told not to overspend by millions of pounds already and assumed they are not already spending money that they do not have, so which would mean that in the future no further moneys would be taken from Thurrock.

The Chair stated that the money was a loan and questioned how and when this would be repaid. Wayne Bartlett-Syree stated this would be repaid within three years starting from next year.

Roger Harris stated as statutory Corporate Director of Adult Services and statutory Interim Director of Children's Services and with Ian Wake being the statutory Director of Public Health they had been disturbed not to have received one single piece of communication from NHS England who are driving this process and not the STP and questioned why that was. Wayne Bartlett-Syree stated that NHS England expectation was that the local STP and ICS would be having and engaging in those conversations and that NHS England were merely the regional tier for national policy and stated how this was implemented was down to the STP and ICS to be having those conversations. That NHS England had not written to all authorities' chief executives and would not expect NHS England to do so.

Roger Harris stated that he did not accept that answer as a member of the STP Programme Board where a range of issues are discussed, it was clear that all the letters had been sent from the regional office. Roger Harris stated he was deeply concerned that the statutory accountable officer for a number of duties which Thurrock had a statutory duty with the Clinical Commissioning Group not to have had any communication from NHS England was thoroughly deplorable.

The Chair echoed comments made and agreed that Councillors and Cabinet Members had also not received any communication either and had been aware that colleagues in other areas had not received any communications. The Council had relied on the great relationship with their Clinical Commissioning Group to update Officers and Members on what was happening in this process and it was just not acceptable.

Councillor Kelly echoed Members comments and questioned whether extra money had already been spent on setting up projects and implementing ideas that had now been delayed and had this money been picked up in the process. Roger Harris stated that would be a question for Clinical Commissioning Group but Thurrock were trying to manage that process as much as possible but the concern was that it had come after the budgets had been set, it had come after our plans, agreements had already been made on the mental health transformation plan and after the 1 April. Roger Harris stated that although it was deeply regrettable that the money had been taken away following the amount of time spent on the planning, this would not result in any cuts but would cause significant delays and implementation of some services.

Mandy Ansell stated that money had not been lost just services would have to be pushed back and that reflected in the testament partnership around this committee table this evening.

Councillor Muldowney stated there had been no accountability on how the books were balanced and questioned how we had ended up in this situation were money was being clawed back from budgets that had already been agreed from other areas in order to balance the books and questioned what measures are being put in place so this did not happen again. Wayne Bartlett-Syree stated that NHS England would not want to be in a position where half of the budgets had been released and plans had been set to release money rather than in exceptional circumstances so would not expect that to happen. Wayne Bartlett-Syree stated the underlying issues in Cambridgeshire and Peterborough were very long standing and very historic around the finances and had noted the position had got increasingly worse over the most recent years. To ensure that did not happen again and that local systems had an opportunity to scrutinise the works and efforts going into Cambridgeshire and Peterborough in terms of balancing their books and getting back into a financial balance an Oversight Group had been set up which would be formed of different health systems, the five Clinical Commissioning Groups and their constituents who would question the Clinical Commissioning Group and STP Leadership in Cambridgeshire and Peterborough about their in-year budget management and actual finance plans going forward. Therefore Cambridgeshire and Peterborough would be reviewed and scrutinised by NHS England as regulators but also be reviewed and scrutinised by their peers. Wayne Bartlett-Syree stated that Cambridgeshire and Peterborough were working hard and recognised that the proposed review and scrutiny would be challenging.

Councillor Muldowney stated if there had been historic problems why NHS England had not intervened earlier. Wayne Bartlett-Syree stated there had been several interventions in the Cambridgeshire and Peterborough systems around its finances for quite some time but each time had yet to be able to get themselves back into financial balance. Councillor Muldowney questioned whether NHS England accepted any responsibility for this situation which had been going on over time. Wayne Bartlett-Syree stated that taking the fact there was a system with such financial challenge it had been taken very seriously and would be working very hard with that system to get back into financial balance. Councillor Muldowney questioned when the money would be paid back into Thurrock's budget. Wayne Bartlett-Syree could not give details as to how much would be paid back but would be paid from next year over three years.

Councillor Ralph stated that Wayne Bartlett-Syree could say the words "bailing out other authorities" in his response. Wayne Bartlett-Syree stated that Cambridgeshire and Peterborough were facing financial challenges and financial difficulties and hoped this would be the last time that any other organisation in East of England would have to receive funding to help it out of their financial challenges.

Roger Harris made a final statement that Thurrock was very proud of the work that had been done around Place locally in terms of the work, in terms of the transformation, how the better care fund had been used, with some very strong partnership working, working with Healthwatch and the voluntary sector, working with the emerging primary care networks and the involvement in the rolling out of the mental health crisis networks working with Mark Tebbs team working across the STP. Roger Harris stated this concern were how would Thurrock be able to "lock in" that Place based work in a real meaningful way. That work had been undertaken with a lot of areas of the NHS over the last 10-15 years and with moving away in to a much larger configuration it would make Place based working more difficult. That Thurrock did not support the direction of travel but realised that the long term plan had set that direction of travel and the need to ensure that Thurrock had as much as possible locked into those place based arrangements and would work with NHSE on this. Wayne Bartlett-Syree stated that Place was very important and those conversations should be with the STP, with the other Clinical Commissioning Groups around the establishment of a single Clinical Commissioning Group and what that would mean but from a NHS England point of view would be supporting those conversations.

The Chair thanked Wayne Bartlett-Syree again for his time this evening and hoped that the tough questions asked this evening demonstrated how passionate Thurrock felt about the plans and how strong Members felt about the successes in Thurrock and how these should be continued. The Chair stated that Thurrock should be involved to all discussions that were taking place particularly those that would have such fundamental changes to Thurrock's areas and would not expect to have to fight with NHS England as a partner. Thurrock was aware that we all formed part of a system and NHS England was also a partner in that system and would expect all parts of that system to come and speak with Thurrock Members as requested and hoped in the future would not have to fight to get someone from NHS England here to speak.

Councillor Halden and Wayne Bartlett-Syree left the Committee Room at 8.00pm.

14. 2018/19 Annual Complaints and Representations Report - Adult Social Care

Roger Harris, Corporate Director of Adults, Housing and Health, presented the report on the operation of the Adult Social Care Complaints Procedure covering the period 1 April 2018 to the 31 March 2019 and updated Members on the representations included in this statutory annual report. Roger Harris referred Members to the Appendix which summarised the representations received for this period.

The Chair noted the consistency of representations when compared to those from 2017/18.

Ian Evans, Thurrock Coalition, questioned how learning and outcomes were cascaded and embedded. Roger Harris stated it depended on the nature of the complaint and that the appropriate action would be taken with complaints being taken very seriously.

Councillor Muldowney congratulated Officers on the larger number of compliments compared to the number of complaints. Roger Harris welcomed the compliments but stated he had concerns that residents still felt that services would be taken away if they made complaints. That residents should be encouraged to put their concerns forward even if these were anonymous or through a third-party.

Kim James stated that Healthwatch receive calls about services but those residents are reluctant to make an official complaint as they were afraid they would lose their services. That Healthwatch did monitor and look for any trends in services and support those in need of help and that regularly meetings are held with Roger Harris.

The Chair stated that it was sad to hear that residents were too nervous to share their concerns and questioned whether concerns received could be unofficially tracked and could monitor those pre-complaints and provide a more realistic figure. Roger Harris stated that concerns raised are registered but not as a formal complaints process.

RESOLVED:

That the Health and Wellbeing Overview and Scrutiny Committee considered and noted the report.

15. Whole Systems Obesity Strategy Delivery and Outcomes Framework

Helen Forster, Strategic Lead Place Environment and Community, presented the report to Members and explained that the Whole Obesity Strategy had been developed as the driver for preventing and reducing obesity in Thurrock. The Delivery Framework which accompanied the strategy would continue to be developed as a result of a number of engagement activities and in collaboration with a range of key stakeholders and detailed the specific actions that set out how the strategy could be achieved. Helen Forster stated that a lot of work was already going on and this was an exciting time to embrace the further recommendations with Members being reminded that the Delivery Framework was a dynamic document and would evolve. She welcomed comments and questions.

The Chair thanked Public Health for another excellent report.

Councillor Ralph asked who the community champions were. Helen Forster stated there were a number of people who attended and were invited to the 'Citizens Panel' which included Kristina Jackson from Thurrock CVS, Residents and Sericc to name a few. Helen was happy to discuss the 'Citizens Panel' membership outside of the meeting.

Councillor Ralph stated the report detailed lots of activities but did not focus on what was already there in the borough and what green spaces were already being used. Helen Forster thanked Councillor Ralph for his comment and agreed that a lot of work had been undertaken and the work would continue to grow. She emphasised again the delivery framework was a working document and welcomed further input from members going forward.

Councillor Muldowney questioned the two figures for overweight and obese adults in paragraph 2.3 of the report compared to the figure shown in Figure 1 of 4.1. Helen Forster stated they were both correct as there had been a change in the way the data was recorded.

The Chair questioned whether it was the level of BMI that identified obesity. Ian Wake, Director of Public Health, stated it was the measure in identifying people who are overweight and obese.

Councillor Ralph stated had consideration had taken place to reduce the number of take away shops in the borough. Helen Forster stated that the Public Health team were working with Planning and Regeneration about how to tackle this issue and further consideration on this would be featured throughout the delivery framework.

Kim James, Healthwatch, stated that the exercise referral programme for those residents with mental health concerns or a long term condition required a form to be signed by their general practitioner before they were allowed to use a gym. Unfortunately some general practitioners were charging for this letter, some up to £80, and questioned was it not for general practitioners to support their patients and not to make money.

The Chair questioned what could be done about this. Rahul Chaudhari, Director of Primary Care, stated that general practitioners need to take responsibility for their patients otherwise those patients would be returning back to their general practitioner with health issues. Contact would be made with the general practitioners to see whether the charges could be waivered or supplemented or for general practitioners to be more consistent in their charges. The Chair thanked for the update and stated this was a very important issue. Mandy Ansell, Accountable Officer, Clinical Commissioning Group, asked for any specific details to be forwarded to the team.

Councillor Muldowney questioned the target setting and the potential of looking at a more stretched target and could pushing for a more aspirational target be more advantageous. Ian Wake stated the target of 0.5% was realistic with obesity being one of the most complex public health issues.

The Chair stated that it was wrong how obesity was categorised around weight rather than how healthy a person was. That a larger person may be considered overweight but might be healthy. That it was important to talk about health, healthy living and not just about people losing weight. That bullying on body shaming or body image at schools needed to be managed

around obesity with people being encouraged to take up an activity rather than just attending weight management sessions.

Councillor Ralph questioned whether schools recognised that bullying on body shaming and body image was taking place and how were they addressing this. Ian Wake stated that a lot of the schools in the borough were now academies and this would need to be addressed by head teachers. Ian Wake stated that we cannot underestimate that child obesity is an issue in Thurrock and is rated worse than the national average.

The Chair stated that involvement in the Local Plan was vital to address how residents can get access to open and green spaces. Helen Forster stated that pre-planning applications and applications are also sent to the Public Health team and are screened with regards to recommendations on a Health Impact Assessments being carried out. Public Health are also around the table with the Housing Planning and Advisory Group (HPAG).

Councillor Kelly stated that if Members were to see Thurrock on Google Earth it would be evident that overtime some misjudgement on approving planning applications had taken place as there was little or no green areas in the borough. It was now vital that these concerns were fed into the Local Plan.

Councillor Kelly stated that the option of closing take away shops could result in empty shops in the borough and as a Council this would need to be looked into and monitored going forward.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee provided member input and commented on the Whole Systems Obesity Delivery Framework recognising that obesity was everyone's business.

Helen Forster left the Committee Room at 8.30pm.

16. 24-7 Mental Health Emergency Response and Crisis Care Service

Mark Tebbs, Director Mental Health Commissioning, Mid and South Essex Sustainability and Transformation Plan provided Members with a progress update on the third phase of the Mid and South Essex Sustainability and Transformation Plan Urgent and Emergency Care Mental Health programme. Members were referred to Appendix 1, the 24/7 Mental Health Emergency Response and Crisis Care where Mark Tebbs took Members through the response pathway, the project implementation structure and the key milestone with the go live date of the service being 1 April 2020.

Nigel Leonard, Executive Director of Strategy & Transformation, Essex Partnership University NHS, stated that this was an exciting project working with the Clinical Commissioning Group with the models being driven by clinicians, primary care and the trust. Members were reassured that job vacancies were being advertised imminently and any financial risk cost by

staffing starting early would be met. Recruitment remained a challenge with a strategy in place which would entail working alongside universities.

Councillor Ralph commended Officers on the report and stated that the street triage was brilliant but questioned whether the service was available to different age ranges. Mark Tebbs clarified there is separate work being undertaken to develop a 24/7 crisis offer for Children and Young People. Jane Itangata, Associate Director Mental Health Commissioning, stated that work had been undertaken with Children Services to ensure the interface worked.

Councillor Ralph questioned whether the street triage was easily accessible to the Police. Mark Tebbs asked for details of the issues raised by Councillor Ralph. Mark Tebbs stated that he shared the same aspirations that crisis care needs to be easily available to take pressure off the accident and emergency assessment service. He confirmed that the crisis café will also provide a service for high intensity users so that they can be supported in a pro-active way and would provide follow ups.

Councillor Muldowney thanked Officers for the report and the fantastic service and although the service had been delayed due to funding reduction it was great that it was now going ahead. Councillor Muldowney questioned whether there had been any aspirations to increase the hours over time. Jane Itangata stated that the home treatment service will change from 8.00am to 8.00pm to a 24/7 response service.

The Chair echoed Members comments with the service being needed for some time and work towards this has been undergoing for some time. The Chair spoke highly of the positives of this report and thanked all those that had been involved.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted the progress made in the development of a responsive 24-7 Mental Health Emergency Response and Crisis Care service that will be available via 111 to anyone in a mental health crisis.

17. Primary Care Networks

Rahul Chaudhari, Director of Primary Care, Clinical Commissioning Group, provided Members with an update on the Primary Care Networks and how these were impacting on Thurrock. That the report was a good initiative with the change being welcomed amongst general practices. The update included how the networks would help address workforce shortages in general practices and focus on improving primary and community services to get residents healthy and to look at the proposals on the range of clinical priorities. Rahul Chaudhari updated Members on the additional roles under the Primary Care Networks and the financial entitlements and how funding would be allocated to support the employment of additional staff. The Thurrock Primary Care Network profile was explained against the

requirements for the Stanford Le Hope and Corringham, Tilbury and Chadwell, Grays and Aveley, South Ockendon and Purfleet Primary Care Networks.

The Chair thanked Rahul Chaudhari for the report and how important it was that the report was brought back to committee with the focus on Thurrock. The Chair requested that an update report be brought back to committee in March 2020 which would allow time for this transformative service to have ran.

Councillor Muldowney thanked Rahul Chaudhari for the report, for his enthusiasm and that the local detail helped.

Councillor Muldowney had concerns on artificial intelligence and requested more detail. Rahul Chaudhari stated that e-consult shared the same concerns and that IT should be used to better effect. With every Clinical Commissioning Group using e-consult triage service to enter details to navigate to the right person or outside practices. That one single product should be available for all Clinical Commissioning Groups to use and for development to find what this produce should look like and then carry out impact assessments.

Councillor Muldowney requested some information on how the Primary Care Network in Chadwell and Tilbury had been performing. Rahul Chaudhari stated that the centre had only been seeing patients on a daily basis for the last three to four months and requested more time to evaluate the effectiveness and would provide further information following that evaluation.

Councillor Ralph asked if two health centres in Tilbury and Chadwell would both be expected to open 24/7. Rahul Chaudhari stated that not both would need to be open 24/7 as long patients had access. With patients being able to access any Primary Care Network but funding would follow with that patient.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted the update.

18. Mid & South Essex Health & Care Partnership Update

Roger Harris, Corporate Director of Adults, Housing and Health, provided Members with an update on the work of the Mid and South Essex Sustainability and Transformation Plan. That following the decision of the referral to the Secretary of State of Health and Social Care the concerns relating to the proposal to close Orsett Hospital and the movement of services to the planned Integrated Medical Centres. Following the advice from the Independent Reconfiguration Panel to the Secretary of State it had now been concluded that in relation to services at Orsett Hospital until new services are in place, the proposals should proceed.

Mandy Ansell, Accountable Officer, Clinical Commissioning Group, stated that the Peoples Panel was still on going and that a meeting had been arranged for next week to meet with the new independent chair of the Mid and South Essex Sustainability and Transformation Partnership, Michael Thorn..

Kim James, Healthwatch, stated the Peoples Panel had now reconvened with Tom Abell the Deputy Chief Executive and Chief Transformation Officer, Basildon & Thurrock Hospital Trust attending their meeting. That the Peoples Panel had requested a list of all services in Orsett Hospital and who provided those services. That “champions” were being sought in those areas so they could provide a patient experience/blog to residents. That Ian Wake, Director of Public Health, would be invited to the Peoples Panel to talk about the future plans of the Integrated Medical Centres.

The Chair stated it was still important to scrutinise the decisions being made for Orsett Hospital and the Orsett Hospital Task and Finish Group would going forward ensure services are managed better. The Chair agreed that the understandings from the feedback provided from the Peoples Panel was important and requested that the item be monitored and progress on the Integrated Medical Centres be brought back.

RESOLVED

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

19. Work Programme

Members agreed to add the following items onto the work programme for 2019/20 municipal year.

- Update on the Library Peer Review be added to the 7 November 2019 committee.
- Whole Obesity Strategy be brought back to the 5 March 2020 committee.
- Primary Care Networks be brought back to the 5 March 2020 committee.

The meeting finished at 9.15 pm

Approved as a true and correct record

CHAIR

DATE

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

7 November 2019	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
Flash Glucose Monitoring Report	
Wards and communities affected: Defined Type 1 and Type 2 Diabetic patients	**Key Decision:** Not applicable
Report of: Mandy Ansell, Accountable Officer, Thurrock Clinical Commissioning Group	
Accountable Assistant Director: N/A	
Accountable Director: N/A	
This report is public	

Executive Summary

The NHS Long Term Plan announced that 'the NHS will ensure that, in line with clinical guidelines, patients with type 1 diabetes benefit from life changing flash glucose monitors from April 2019,ending the variation patients in some parts of the country are facing'.

A Flash Glucose Scanning Commissioning Policy (for a single product FreeStyle Libre® (FSL)) was developed to facilitate the use of Flash Glucose Monitoring (FGM) in Mid and South Essex Sustainability and Transformation Partnerships (STP). This paper provides details of:

1. Current commissioning arrangements
2. The additional patient cohorts in which FSL is commissioned
3. The current financial expenditure

1. Recommendation(s)

1.1 The Health and Wellbeing Overview and Scrutiny Committee are invited to note the update.

2. Introduction and Background

2.1 FreeStyle Libre® is a type of 'flash glucose monitoring system' that measures glucose levels in people with diabetes using a sensor applied to the skin. Flash Glucose Scanning systems monitor blood glucose levels using interstitial fluid levels rather than capillary blood glucose from finger prick testing. It consists of a handheld reader and a sensor, which is sited on the

arm. When the reader unit is passed over the sensor, the reader shows a reading based on interstitial fluid glucose levels. The sensor lasts for up to 14 days and then needs to be replaced.

FreeStyle Libre® is an alternative to finger-prick blood glucose testing, and can produce a near-continuous record of measurements which can be accessed on demand. Readings are taken by scanning the sensor with a FreeStyle Libre® reader or some mobile phones. Diabetics using FreeStyle Libre® will still need to use some finger-prick blood glucose testing in certain circumstances, for example:

- when they feel unwell; for example when they have the flu, diarrhoea or are vomiting
- when the FreeStyle Libre® reader shows low glucose readings (hypoglycaemia) or warns that hypoglycaemia is likely
- when symptoms do not match meter readings
- before they drive and during driving (to meet DVLA requirements).

2.2 In March 2019:

- NHSE published a guidance document that set out the criteria for flash glucose monitoring (for a single product FreeStyle Libre® (FSL)) and the maximum amounts CCGs will be reimbursed for the ongoing costs of flash glucose sensors. The re-imbursement figure has assumed that there will be a reduction in overall blood glucose testing strips and lancet spend.

- Agreement and support from diabetes specialists across Mid and South Essex STP led to the development and publication of a Mid and South Essex wide Flash Glucose Scanning Commissioning Policy. The patient criteria are in line with NHSE guidance, with an extension of two patient cohorts:

1. Pregnant woman with type 2 diabetes requiring insulin; and
2. Insulin-treated type 2 diabetes unable to routinely self-monitor blood glucose at home due to severe mental or physical disability.

2.3 At present there is only one product where prescribing on the NHS is supported- FreeStyle Libre®.

2.4 Flash Glucose Scanning is not the same as continuous glucose monitoring.

3. Issues, Options and Analysis of Options

3.1 This is a monitoring report for noting, therefore there is no options analysis.

3.2 Summary of Funding mechanism

From 1 April 2019, for patients who satisfy NHS England criteria, CCGs are being reimbursed for the ongoing costs of flash glucose sensors for 2 years for only for up to 20% of their type 1 diabetes population

Organisation	No. of patients with Type 1 Diabetes	20% of T1 patients	Funding (£) by NHSE- A	Total annual cost of FreeStyle Libre® (in primary care)- B	19/20 CCG Deficit (B-A)	Minimum anticipated cost savings (£) BGTS + Lancets- 50%
THURROCK CCG	620	124	83,921	103,168	19,247	59,706

Table 1: Maximum anticipated reimbursement and savings levels 2019/20

3.3 **Summary of Financial Spend**

Organisation	Period	Total number of prescriptions	Spend
THURROCK CCG	April to July 2019	160	£9,010

Table 2: Freestyle Libre® Primary Care Prescribing Data April to July 2019

Current primary care prescribing FSL expenditure is below the anticipated NHSE trajectory for the first four months of 2019 financial year.

Organisation	Type of Product	Time period	Average Growth vs same period last year/%	Increase in cost/£
THURROCK CCG	Lancets	Dec 2018 to March 2019	10.20%	1,204
		Apr 2019 to Jul 2019	4%	433
	Blood Glucose Testing Strips (BGTS)	Dec 2018 to March 2019	1.20%	218
		Apr 2019 to Jul 2019	-2%	-3700

Table 3: Lancet and BGTS growth summary

Lancet usage costs for the last two quarter time periods show an increase in spend while BGTS data shows a small reduction in the most recent quarter.

At this point in time the correlation between an increase in FSL and an overall reduction in use of lancets and BGTS is uncertain. When August to November 2019 data is reviewed alongside other explanatory causes commissioners may be in a better position to have a better understanding of the correlation.

4. Reasons for Recommendation

4.1 It is good practice to produce a monitoring report to review overall usage. This report is for monitoring and noting.

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

5.1 This report has been agreed with Denise Rabbette, Head of Medicines Management, Thurrock CCG.

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

6.1 Reporting ensures that data is scrutinised alongside the Flash Glucose Scanning Commissioning Policy to provide feedback to service providers to support the goal of managing long term conditions which is part of the Health and Wellbeing Strategy.

7. Implications

7.1 Financial

Primary care expenditure for FSL is below the NHSE trajectory at this point in time. If usage exceeded the NHSE funding allocation a review of the commissioning arrangements for FSL is compulsory.

Implications verified by: **Thurrock CCG**

There are no specific financial implications arising from the report at this point in time

7.2 Legal

N/A

7.3 Diversity and Equality

To meet the monitoring requirements of the diabetic population who are less able to use recognised monitoring methods as outlined in appendix 1, high quality FSL is accessible.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

None

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

- Health and Wellbeing Strategy. Available from:

https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy
- Flash Glucose Monitoring: National arrangements for funding of relevant diabetes patients. Available from: https://www.england.nhs.uk/publication/flash-glucose-monitoring-national-arrangements-for-funding-of-relevant-diabetes-patients/
- The NHS Long Term Plan. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
- Commissioning arrangements for Freestyle Libre. Available from: https://www.thurrockccg.nhs.uk/about-us/document-library/policies-and-procedures-1/service-restriction-policy/freestyle-libre/

9. Appendices to the report

- Appendix 1: Flash Glucose Scanning, Policy Statement, Mid and South Essex Sustainability and Transformation Partnerships

Report Author:

Sanjeev Sharma

Pharmacy Lead Commissioner Acute

Mid and South Essex CCGs Acute Commissioning Team on behalf of NHS Thurrock Clinical Commissioning Group

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Policy statement:	**Flash Glucose Scanning**
Status:	**Group (Notification) / Individual Prior Approval**

Flash Glucose Scanning systems monitor blood glucose levels using interstitial fluid levels rather than capillary blood glucose from finger prick testing. It consists of a handheld reader and a sensor, which is sited on the arm. When the reader unit is passed over the sensor, the reader shows a reading based on interstitial fluid glucose levels. The sensor lasts for up to 14 days and then needs to be replaced. The reader can show a trace for the last 8 hours and displays an arrow showing the direction the glucose reading is heading.

Flash Glucose Scanning is not the same as continuous glucose monitoring (CGM).

At present there is only one product where prescribing on the NHS is supported- FreeStyle Libre®. The following policy therefore applies only to this product and funding for any other flash glucose scanning products is not currently available.

Group Prior Approval

M&SECCGs commission use of FreeStyle Libre® on a restricted basis, and only for people with diabetes on insulin, aged 4 and above, attending specialist care using multiple daily injections or insulin pump therapy, who have been assessed by the specialist diabetes clinician and deemed to meet one or more of the following criteria:

- Patients with Type 1 diabetes with poorly controlled Hba1c (>8.5% or >69 mmol/mol) requiring self-monitoring blood glucose testing nine times or more daily to achieve safe control as demonstrated on a meter download/review over the past 3 months and determined by those with clinical responsibility for their diabetes care and where they are satisfied that the patient's clinical history support this (supported by NICE TA151, NG17 & NG18)

- Patients with Type 1 diabetes with multiple episodes of diabetic ketoacidosis (DKA) and/ or severe hypoglycaemic episodes (i.e. needing external support) and/ or multiple admissions due to poor glycaemic control, requiring self-monitoring blood glucose testing nine times or more daily (supported by NICE TA151, NG17 & NG18)

- Patients with Type 1 or Type 2 diabetes on haemodialysis **and** on insulin with poorly controlled Hba1c (>8.5% or >69 mmol/mol) requiring self-monitoring blood glucose testing nine times or more daily as demonstrated on a meter download/review over the past 3 months

- Diabetes associated with cystic fibrosis on insulin treatment

- Pregnant women with Type 1 or Type 2 diabetes requiring insulin – this will only be funded for 12 months in total inclusive of post-delivery period

- Patients with Type 1 diabetes who the specialist diabetes multi-disciplinary team

determines have occupational (e.g. working in insufficiently hygienic conditions to safely facilitate finger-prick testing) or psychosocial circumstances that warrant a 6 month trial of FreeStyle Libre® with appropriate adjunct support.

- Patients with Type 1 unable to routinely self-monitor blood glucose at home due to severe mental or physical disability. Evidence must be provided that they require carers to directly support glucose monitoring and insulin management, and that these carers struggle to manage simple blood glucose monitoring.

- Patients with Type 1 diabetes previously self-funding Flash Glucose Scanning where those with clinical responsibility for their diabetes care are satisfied that their clinical history suggests that they

    - would have satisfied one or more of the above criteria prior to them commencing use of Flash Glucose Scanning had these criteria been in place prior to April 2019

AND

    - has shown improvement in HbA1c over a period of 6 months since using the self-funded sensors.

Additional Requirements

In addition all patients (or carers) must be willing to:

- undertake training in the use of FreeStyle Libre®
- agree to scan glucose levels no less than 8 times a day and use the sensor for more than 70% time
- agree to regular reviews with the local specialist clinical team
- complete a Type 1 diabetes structured education programme (DAFNE, BERTIE or equivalent). Previously completed approved courses will be recognised.

The decision to start FreeStyle Libre® will only be made by the diabetes specialist team and will initially be for a 6 month trial period.

Use will only be continued at the discretion of the diabetes specialist if there is sustained benefit in patient outcomes whilst they are using the device as demonstrated by one or more of the following:

- Reduction in severe / non-severe hypoglycaemia episodes
- Reduction in HbA1c of 0.5%/5mmol/mol or more within 6 months
- Agreed reduction in use of self-monitoring blood glucose test strips
- Reduction in episodes of DKA
- Reductions in admission to hospital
- In severe disability to ensure clear benefit to the carer support for the patient

If there has not been sufficient improvement in one or more of the above areas over a 6 month period then the use of FreeStyle Libre® under NHS prescription will be discontinued and an alternative method of monitoring should be used.

Individual Prior Approval

Patients with Type 1 Diabetes with recurrent severe loss of hypoglycaemia awareness or impaired awareness of hypoglycemia may be considered for Flash Glucose Scanning on a case by case basis. These patients ideally do not need FreeStyle Libre® but will need a different Continuous Glucose Monitoring system with an alarm component - requested on a named patient basis- see VBCP- **Continuous Glucose Monitoring**

NICE suggests that Continuous Glucose Monitoring with an alarm is the standard. Other evidence-based alternatives with NICE guidance or NICE TA support are pump therapy, psychological support, structured education, islet transplantation and whole pancreas transplantation. (supported by NICE TA151, NG17 & NG18)
Any patient individually approved for FreeStyle Libre® must also meet the **additional requirements** listed in section above.

Patients not meeting the above criteria will only be funded where there are exceptional clinical circumstances.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

Additional Information

Under national criteria and this policy the following groups do not currently meet the criteria for NHS funding:

- Any Type 2 diabetes patient unless **on insulin and** pregnant **or** on haemodialysis requiring more than 8 tests daily, **or** fulfils the severe disability criteria
- Otherwise well Type 1 diabetes patients with no major disabling symptoms, recurrent hospital admissions, psychosocial issues, severe disabilities, poor Hba1c or any other of the criteria stated above
- Poor engagement or compliance with glucose testing- no evidence use of FreeStyle Libre® solves this

Patients who by choice self-fund FreeStyle Libre® will continue to be supported (and data viewed) in routine NHS clinics.

References

Flash Glucose Monitoring: National Arrangements for Funding of Relevant Diabetes Patients
Issued by NHS England March 2019
https://www.england.nhs.uk/publication/flash-glucose-monitoring-national-arrangements-for-funding-of-relevant-diabetes-patients/

Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus July 2008
https://www.nice.org.uk/guidance/ta151

Type 1 diabetes in adults: diagnosis and management July 2016
https://www.nice.org.uk/guidance/ng17

Diabetes (type 1 and type 2) in children and young people: diagnosis and management November 2016
https://www.nice.org.uk/guidance/ng18

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7 November 2019	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Targeted Lung Health Checks Report	
Wards and communities affected: All	**Key Decision:** For information
Report of: Sam Brown, Programme Director, Thurrock and Luton CCGs	
Accountable Assistant Director: N/A	
Accountable Director: Mandy Ansell, AO, Thurrock CCG	
This report is public	

Executive Summary

This paper provides the detail on the Targeted Lung Health Checks Programme of Thurrock CCG and is presented for information. The paper provides an update on:

- The background to the programme;
- The governance arrangements;
- Key programme roles;
- Funding arrangements;
- The co –designed service model aligned to the National Standard Operating Protocol - Publications Gateway Reference 08586 January 2019;
- Procurement arrangements;
- Communications and engagement;
- Risks and Issues.

Members are asked to note: Luton CCG information has been included to represent the joint programme delivery.

1. Recommendation(s)

1.1 The paper is provided for information and the Health and Wellbeing Overview and Scrutiny Committee is asked to note the report and to champion the rationale for the criteria population to participate in lung health checks.

2. Introduction and Background

2.1 The aim of the Targeted Lung Health Checks (TLHC) Programme is to identify those at risk of developing lung cancer and increase the number of lung

cancers diagnosed at an early stage by providing targeted low dose CT scans in a targeted population.

2.2 In February 2019 the East of England Cancer Alliance was awarded Cancer Transformation Funding by NHS England (NHSE) to implement Targeted Lung Health Checks in two nationally identified CCGs, Thurrock and Luton. There are fourteen sites in ten Cancer Alliances across England. Luton and Thurrock CCGS were identified for targeted funding due to high smoking prevalence, high lung cancer incidence, late stage lung cancer diagnosis and high morbidity rate.

	Luton CCG	Thurrock CCG
Total population size	223,000	179,000
Smoking prevalence	10% of population	9.8% of population
Successful quitters (Apr – Sept 2017)	863	427
Lung cancer incidence per year	Approx. 110 new cases	Approx. 100 new cases
Emergency presentations for (all cancers)	23%	20%
Early stage diagnosis (All cancers)	50%	52%
Stage 4 diagnosis for lung cancer	48%	56%
Lung cancer one year survival	39%	38%
Lung cancer under 75 mortality	41%	43%
Lung cancer most common cause of death	6th	4th

Source: CADEAS

2.3 Governance
A TLHC Joint Oversight Delivery Group was established in May 2019 and meets fortnightly and the CCG TLHC Project Teams meet monthly. A detailed delivery plan has been established in line with requirements from the National Cancer Programme Team.

2.4 Programme Roles	Names
Accountable CCG AO	Mandy Ansell Accountable Officer, Thurrock CCG
TLHC SRO	Dr Rory Harvey East of England Cancer

	Alliance
TLHC Oversight Delivery Group Joint Clinical Director / Chair	Dr James Ramsay, BLMK Clinical Lead, L&D Medical Director
TLHC Oversight Delivery Group Joint Clinical Director/ Deputy Chair	Dr Donald McGeachy, MSE STP Clinical Lead
Programme Director	Sam Brown
Programme Manager	Carol Ord
Communications Lead	Louise Banks, Head of Communication, Thurrock CCG

2.5. Funding

NHSE wrote to the East of England Cancer Alliance and Thurrock and Luton CCG Accountable Officers in January 2019 outlining the four-year funding profile for the TLHC Programme and confirmed in the Cancer Alliance 2019/20 Funding Agreement. Reference table below for original funding allocation:

CCG / £'000	2019/20	2020/21	2021/22	2022/23	Total
NHS Thurrock CCG	1,003	1,095	917	826	**3,840**
NHS Luton CCG	1,063	1,162	972	873	**4,069**

A National Cancer Programme Team finance paper dated 8th July 2019 outlined the financial arrangements and profile as a combination of two amounts: a fixed amount to cover the underlying infrastructure and a variable amount to cover the cost of the lung health checks and low dose CT scans.

The TLHC Programme is working towards delivering lung health checks from January 2020 and complete initial checks and scans by March 2021; the funding arrangement outlined is based on four principles defined by the National Cancer Programme Team that:

- Funding is not an artificial barrier to implementation;
- Projects have agreed delivery and financial plans in place;
- Projects submit timely and accurate monthly management information against plan; and
- Underspends are redeployed by the National Cancer Programme Team as early as possible each financial year.

The National Cancer Programme Team confirmed the same level of fixed funding each year of the programme, distributed at the end of Q1.
£655k was transferred as the fixed funding allocation to the East of England Cancer Alliance in June 2019 for 2019/20 for the TLHC Programme and variable funding of £264 per low dose CT scan was confirmed.

Thurrock and Luton CCG Finance and Performance Committees have received and agreed a paper outlining the TLHC funding arrangements.

2.6 Finance Update

Following the confirmation of the fixed and variable finance model the TLHC Joint Oversight Delivery Group identified a potential shortfall from the original

four-year funding allocation of £1.52m. This was based upon the trajectory over the delivery period. Concern was raised that a variable rate has the potential to be high risk to organisations procuring equipment or services. This was escalated to the National Cancer Programme Team and assurance has been given that funding will not be an issue. A Memorandum of Understanding is awaited from the National Team.

2.7. Communications and Engagement

Led by the Communications Lead, a Joint Communication and Engagement Task Group meets monthly and a Joint Communications and Engagement Plan has been developed.

1. Thurrock and Luton Oversight and Scrutiny Committees have received papers and presentations.
2. Multiple local press releases have been issued and the TLHC website is live. http://www.lutonandthurrocklunghealthcheck.nhs.uk.
3. Promotional materials in readiness for the launch have been approved.
4. Healthwatch Thurrock and Healthwatch Luton are active members of the Communication and Engagement Task Group and presented at the second National TLHC Collaboration Event and NHS Expo 2019 and are featured in the National TLHC promotional video.
5. A partnership with Roy Castle Foundation with Mega Lungs organised for Lakeside Thurrock and Asda Tilbury in early October.
6. Programme Team visit to Manchester and Leeds pilot sites.
7. Twelve Team members completed the ACT Academy Transformational Change through System Leadership course.

2.8. Risks & Issues

A risk register and issues log is held by the TLHC Joint Oversight Delivery Group – Appendix 1.

The top six risks to the programme are:

1. Fixed and variable strategic funding model – associated potential funding shortfall and associated risk to procuring organisations.
2. Possible length of the procurement process impacting on start date.
3. Availability of mobile scanning unit from providers impacting on start date.
4. Timely mobilisation of two clinical teams for Thurrock and Luton localities impacting on start date.
5. Recruiting the right level of skills and experience for operational management.
6. Participant take up impacting on the number of LHCs and scans performed impacting on variable rate funding allowance.

3. Issues, Options and Analysis of Options

3.1 Service Model

The design principle, defined in the National TLHC Protocol is for people in the selected areas who are aged 55 to 74 with a smoking history (current smoker or ex-smoker) will be invited to attend a lung health check. The lung health check will be conducted by a lung specialist nurse and will involve discussion around lung cancer symptoms, a breathing test (spirometry) and smoking cessation advice (as appropriate). The results of this will then be used to calculate a person's individual lung cancer risk.

- Anyone at high risk of lung cancer will be invited to have a low-dose CT scan. The Thurrock and Luton TLHC service model will also deliver smoking cessation advice.
- The TLHC Programme Team has co-designed a service delivery model with participation from their wider local stakeholders based on predicted demand and capacity.

Thurrock CCG

Stage	No.	%	Comment
Total eligible population	30,359	100.0%	Aged 55-74/364
Ever smoked	15,483	51.0%	Of Total eligible population
Appointments booked	7,742	50.0%	Of Ever Smoked
LHC's performed	7,122	92.0%	Of Appointments Booked
Positive LHC's	3,988	56.0%	Of LHC's analysed
Initial CT scans performed	3,869	97.0%	Of Positive LHC's
Negative CT Scan - 24 months follow-up	3,196	82.6%	Of Initial CT Scans performed

Luton CCG

Stage	No.	%	Comment
Total eligible population	33,019	100.0%	Aged 55-74/364
Ever smoked	13,967	42.3%	Of Total eligible population
Appointments booked	6,984	50.0%	Of Ever Smoked
LHC's performed	6,425	92.0%	Of Appointments Booked
Positive LHC's	3,598	56.0%	Of LHC's analysed
Initial CT scans performed	3,490	97.0%	Of Positive LHC's
Negative CT Scan - 24 months follow-up	2,883	82.6%	Of Initial CT Scans performed

Activity Impact of Cancers Identified

Findings	No.	%	Comment
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	228	5.9%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Cancers found	116	50.8%	Of Needing clinic investigation
24 months follow-up	3,196	82.6%	Of Initial CT Scans performed
Patient needing clinical investigation following 24 month scan	77	2.4%	Of 24 month scans
Cancers found at 24 months follow-up	50	65.5%	Of Needing clinic investigation
Total cancers found	166	N/A	Including those found at initial, 3, 12 and 24 months scans
Surgery	85	51.0%	Of Cancers found

Activity Impact of Cancers Identified

Findings	No.	%	Comment
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	206	5.9%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Cancers found	105	50.8%	Of Needing clinic investigation
24 months follow-up	2,883	82.6%	Of Initial CT Scans performed
Patient needing clinical investigation following 24 month scan	69	2.4%	Of 24 month scans
Cancers found at 24 months follow-up	45	65.5%	Of Needing clinic investigation
Total cancers found	150	N/A	Including those found at initial, 3, 12 and 24 months scans
Surgery	76	51.0%	Of Cancers found

Source: National TLHC Trajectory Profile

3.2 Nine contributing factors informed the service model design:

1. The service model must align to the National Targeted Lung Health Check Standard Operating Protocol.
2. A joint CCG model to support economies of scale.
3. The geographic distance between Thurrock and Luton is approximately 65 miles.
4. Limited CT scanning slots availability at both Basildon and Thurrock University Hospital (BTUH) and Luton & Dunstable Hospital (L&D).
5. No capacity with current radiology reporting arrangements.
6. Limited responses to a call for expressions of interest to other NHS organisations.
7. No spare capacity within BTUH or L&D lung clinical teams to currently perform lung health checks.
8. BTUH and L&D currently outsource radiology reporting to the same company (Everlite).
9. The NHSE funding allocated does not allow for the cost of two mobile units.

3.3 Co-designed service model solution:

1. One shared mobile unit with low dose CT scan and technical clinical support – two weeks in Thurrock locality and then two weeks in Luton locality. Open six days per week 8:00 – 6.00pm.
2. Two clinical teams – one in Thurrock locality and one in Luton locality (as one team across both localities was deemed not practical due to the geographic distance).
3. Outsource of radiology reporting.
4. A joint clinical model of incidental findings developed.

3.4 A soft launch of circa 200 patients will take place with two GP practices in Thurrock and Luton in late November / early December 2019 to test the process before a full launch with the procured mobile unit and clinical teams in January 2020. Both the clinical teams in BTUH and L&D have supported this testing.

3.5 Procurement

Working with Thurrock and Luton CCGs, with support from their respective CSUs and NHS Supply Chain the TLHC Oversight Delivery Group has initiated the procurement process. Indicative costs have been defined.

1. A preferred provider has been identified to supply the mobile unit (Colbalt Health and Siemens Healthineers - https://www.cobalthealth.co.uk/cobalt-and-siemens-healthineers-are-working-to-develop-mobile-lung-cancer-screening). The L&D have agreed to be the procuring organisation.
2. The clinical teams will be sourced from existing community / acute providers as CCG contract extensions.
3. Radiology reporting will be sourced from existing arrangements with provider Everlite.

4. Reasons for Recommendation

4.1 To ensure Members have an understanding of the Targeted Lung Health Check Programme in Thurrock and Members are able to champion the rationale for the criteria population to participate in lung health checks.

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

- N/A

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

- N/A

7. Implications

7.1 Financial

- N/A

7.2 Legal

- N/A

7.3 Diversity and Equality

- The programme will target the group of patients that have historically had the poorest health outcomes with lung cancer and in doing so, based on research, these outcomes will be improved.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

- N/A

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

- N/A

9. Appendices to the report

- Appendix 1 - Risk Register and Issues Log

Report Author:

Sam Brown

Targeted Lung Health Check Programme Director

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Risk Register: Targeted Lung Health Check Programme - 25th September 2019										APPENDIX 1
ID	**Date Raised**	**Risk Description**	**Likelihood**	**Impact**	**Severity**	**Owner**	**Mitigating Action**	**Contingent Action**	**Progression actions**	**Status**
1	23/4/19	Access to primary care data impacting on numbers of participants				CO/CCGs	Work with CCG Boards and team	TBC	Communications to patients to register smoking status with GP	Open
2	23/4/19	Quality of primary care data to establish cohorts impacting on numbers/ inappropriate participation				CO/ CCGs	CCG audit and quality review under taken prior to invite extract	TBC	Initial searches undertaken and aligned to modeling. Named participant lists to be validated prior to invite	Open
3	23/4/19	Alignment to existing/planned smoking cessation programmes impacting on service capacity				CO/ CCGs	Work with CCG/PHE in design and delivery	TBC	Meetings planned to review capaicty	Open
4	23/4/19	Difference in approach between CCGs impacting on purchasing/ leasing arrangements				SB	Work collaboratively with CCGs in co-design and procurement	TBC		Closed
5	23/4/19	Procurement process may cause delay to planned go live date (October)				SB	Design specification, test the market early	TBC	This is further delayed due to financial uncertainty	Open
6	23/4/19	National availability of mobile scanners and/ or reporting capacity may impact on planned go live date				SB/CO	Test the market early, work with National Team on availability	TBC	NHS Supply Chain discussion undertaken. OBS developed. Preferred provider route and extension to existing contracts for radiology reporting	Open
7	23/4/19	Delay in the recruitment to clinical team may impact on planned go live				SB	Identify key clinical leaders and team early	TBC	Extension to community/acute contracts approach. Meetings undertaken in Sept	Open
8	23/4/19	Lack of participant take up will impact				CCGs	Develop robust	TBC	To be raised at inaugural	Closed

		on trajectory					comms plan and recruitment process		Joint Programme Delivery Group	ref 10
9	23/4/19	Delay in information governance arrangements will impact on service delivery				CO/ CCGs	Work with IG Leads early in process to define requirements and sign off		DPIAs completed and signed off by IG Lead	Closed
10	12/8/19	Lack of communication and engagement will impact on the number of lung health checks participants.				LB/AM CCGs	Proactive planned comms including Healthwatch at both CCGs	TBC	Thurrock Comms underway Slight delay in Luton comms. Comms Lead now appointed	Open
11	12/8/19	Revised go live of early January risk with poor uptake with bad weather				SB	Slower planned start. Communication to patients			Open
12	12/8/19	Procurement expertise available to support robust service specification development and due diligence				SB/CO	Contact NHS Supply Chain early. Contact CCG Attain support early		Advice sought	Closed
13	12/8/19	Impact on programme delivery with Programme Manager on contractor basis				SB	Fixed term NHS contract		2 year fixed term contract arranged	Closed
14	12/8/19	Consultant tax and pension concerns impacting on hours available for the programme				SB/JR/ DM	Raise with National Team		Escalated	Open
15	12/8/19	Capacity of radiology reporting provider to deliver additional reports used by both Trusts with existing backlog				NB/EC	Ensure early conversation with provider – investigate alternate providers			Open
16	12/8/19	National financial payment modeling based on fixed and variable funding				SB	Raise with National Team		Escalated to National Team. MoU from National	Open

		may not cover planned activity and may put procuring organisations at risk							Team	

Initial Issues Log: Targeted Lung Health Check Programme

ID	Date Raised	Issue Description	Status	Priority	Owner	Reported by	Escalation Date	Impact	Actions	Resolved by & date
1	23/4/19	Clinical and management concern on impact to current lung pathway diagnostics and treatment capacity	Open	High	SB/JR	SB/CO	May Meeting	**High**	Engaged with key clinicians and operational managers. Clinical meeting to discuss and plan for incidental findings w/c 30/9	**30/9/19**
2	23/4/19	Potential overlap with current respiratory monitoring in primary care	Open	High	SB	CO/CCGs	May Meeting	**High**	PCNs and practices kept informed of the programme	**01/01/20**

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7 November 2019	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
Charging Review Adult Social Care Services 2020/21	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Catherine Wilson Strategic Lead Commissioning and Procurement	
Accountable Director: Les Billingham Interim Director Adult Social Care	
Accountable Director: Roger Harris, Corporate Director Adults, Housing and Health and Interim Director Children's Services Children's Services	
This report is Public	

Executive Summary

Adult Social Care has decided to review possible options to increase discretionary charges for services. After careful review of all the charges within adult social care and noting the charges that are set nationally, the services that are free of charge and those charges which are discretionary and set by adult social care, we are considering four areas:

- Domiciliary Care
- Day care for older age adults
- Support services in extra care housing
- Carer's services

We will consult with people who receive services and the wider community asking their views on our proposed options.

1. Recommendation(s)

1.1 That Health and Wellbeing Overview and Scrutiny Committee note that the consultation is taking place.

1.2 That Health and Wellbeing Overview and Scrutiny Committee comment on the consultation proposals

1.3 That the results of the consultation and any recommendations are presented to Health and Wellbeing Overview and Scrutiny Committee in January 2020

2. Introduction and Background

2.1 Adult Social Care is part of the wider Fees and Charges work to annually review all charges across the Council. We want to undertake a specifically focused consultation as part of our response to growing needs within the community. We want to ensure that services offer value for money and part of that approach is to review our charges.

2.2 It is important to give consideration to the fragility of the market and the risks associated with proposals to consider increasing charges for services. It is key that people who need services are not discouraged form requesting support because they may have to pay an increased charge.

2.3 We are legally required to ensure that a financial assessment is undertaken for those receiving chargeable services, to ascertain what they can afford to pay, people will only pay what they can afford.

2.4 The situation in Thurrock regarding adult social care has reflected national challenges regarding the fragility of the market. An example of this is our experience of market failure on a significant scale. Within the last 3 years 3 domiciliary care providers have handed back contracts to the council for reasons of financial instability and poor quality care. The market was stabilised through an increase in the hourly rate from £13 to £16.25 an hour. The creation of our own in house domiciliary care provider Thurrock Care at Home. The procurement of the external domiciliary care contracts at the higher rate with a locality community focus which also contributed to the reduction of additional expenditure such as travelling across the borough. Although we have significantly increased the hourly rate we did not increase the maximum charge to service users it remained at the £13 an hour level.

2.5 The 4 areas that are being considered are discretionary regarding charging. They are:

Domiciliary Care services
The Council commissions and provides domiciliary care services for people in their own home supporting them with personal care and helping them to remain as independent as possible. Currently as noted above the maximum charge is £13 an hour.

Day care services for older age adults
The council provides day care to older age adults, providing one day sessions, which includes food and drinks, at a cost of £65.40 a day, we charge £10 a day.

Support services in extra care housing
The council provides funding for support services within extra care housing. Currently the residents are charged £40 a week and the Council wants to review this and consider the option of increasing this to £50 a week.
The Council already subsides the housing support by 50%

For some residents the option to increase would be covered through housing benefit but for some it would be full cost. The core services ensure that there is a staff presence in the building, support with housing concerns and response to emergency situations**.**

Carer's services
This is direct support for the carer, examples of which are to attend a social group, undertake a hobby or go to the gym. This does not include services that benefit the cared for person e.g. day care. Currently services directly for the carer are provided free of charge. The Care Act 2014 gives council's the discretion to charge for any carers services they provide

2.6 We have developed a questionnaire detailing the proposed options to ask the views of people who receive the above services and the wider community. (Appendix 1)

2.7 The options are for each of the above services to remain at the current level of charging, noting that carer's services are currently provided free of charge or for an increase to be applied. The options are as follows:

Domiciliary Care:

- **The maximum charge remains at £13 an hour**
- **The charge should increase to £14.25 an hour**
- **The charge should increase to £15.25 an hour**
- **The charge should increase to £16.25 an hour**

Day care services for older age adults:

- **The charge remains the same at £10 a session**
- **The charge increases to £12 a session**
- **The charge increases to £15 a session**
- **The charge increase to £20 a session**

Support services in extra care housing:

- **The charge remains at £40 a week**
- **The charge increases to £50 a week**

Carer's services:

- **Charge for some types of services to cares e.g. breaks away for carers, training**
- **Charge carers a lesser contribution than the actual cost of the service**
- **Financially assess cares to work out their contribution to the charge**
- **Do not charge for any carers services.**

3. Issues, Options and Analysis of Options

3.1 All charges within adult social care have been reviewed and the focus is on the 4 services outlined with the report for which the charge is at the discretion of the Local Authority.

4. Reasons for Recommendation

4.1 To ensure that Health Overview and Scrutiny Committee are aware of the consultation and are able to contribute to the consultation regarding charges for adult social care services.

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

5.1 The consultation started in October 2019. The questionnaire has been sent to all service users who access the services outlined within the report, the consultation has been posted on the consultation portal and consultation events are being held around the borough throughout November 2019.

5.2 The results of the consultation and the recommendations for any proposed charges will be presented to Health Overview and Scrutiny Committee in January 2020.

5.3 The proposals and recommendations will then be presented to Cabinet as part of the wider Council's Fees and Charges work for 2020/21

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

6.1 The delivery of the services outlined in this report, domiciliary care, day care for older age adults, support services in extra care housing and carer's services impact on the following Council Priority: *People – a borough where people of all ages are proud to work and play, live and stay*

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead Corporate Finance

As part of the 2020/21 budget setting process, the Council is required to review all of its fees and charges. The charges pertaining to Adult Social Care are included within the body of the report, and are subject to the consultation. The charges are set, where possible, to ensure that the cost of providing the service is recovered. It is important to ensure that the services delivered are value for money and also that risks are mitigated for vulnerable people. Revenue that is raised from the charging of service form part of the

Adult Social care budget, and the results of the consultation and subsequent recommendations inform the budget setting process.

7.2 **Legal**

Implications verified by: **Courage Emovon**

Strategic Lead/Deputy Head of Legal Services

Clause 93 of the Local Government Act 2003 enables the Council to charge for a service if it is authorised but not required by enactment to provide the service and provided the service user has agreed to its provision.

Clause 14 of the Care Act 2014 also provides a legal framework for charging for care and support and due consideration has been given within this consultation to the legal duties of the Local Authority under the Care Act 2014. This ensures it is clear that individuals in receipt of services are financially assessed, with their agreement, and therefore pay what they can afford. The consultation states the discretionary nature of these charges under the Care Act 2014.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The services outlined within this report provide support to some of the most vulnerable residents living in Thurrock. The consultation is reviewing options for charging for these services and must be mindful of the risks of vulnerable people disengaging from or not accessing services because they may be worried about being charged. An Equality Impact Assessment will be required for any recommendations that are made to increase charges.

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

N/A

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

- N/A

9. Appendices to the report

- Appendix 1 - Charging Review for Adult Social Care Services Consultation document

Report Author:

Catherine Wilson
Strategic Lead Commissioning and Procurement
Adults Housing and Health
Commercial Services and Commissioning

Appendix 1

Charging Review for Adult Social Care Services

What is this Consultation about?

We are currently reviewing our charges for adult social care services and are seeking people's views on this.

Why is the Council doing this?

The needs of people in the community are growing and we are always looking at ways of delivering more effective value for money services. Part of this approach is to review our charges.

We work out how much people can pay towards their care and services and we do this by undertaking a financial assessment, people will only pay what they can afford.

We also want to make sure that nobody is put off coming to us for help because they might be asked to pay more towards their care.

Some charges are set nationally for services. Some services are free of charge. Some charges are made at the discretion of the Local Authority, these are the charges we are reviewing.

We are reviewing our current charges for:

Domiciliary Care

Day Care for older age adults

Support services in extra care housing

Carer's services

Your thoughts on reviewing charging for adult social care

Please tell us if you, or the person on whose behalf you are completing this survey receives any of the following services from the council (please select as many as apply)

Domiciliary Care

Day Care for older age adults

Support services in extra care housing

Carer's services e.g. direct support for the carer

To what extent do you agree the council could review its current charges and ask people that can afford it, to contribute more to the cost of their care services costs?

- Strongly disagree
- Disagree
- Unsure/no view
- Agree
- Strongly agree

Please tell us why you agree or disagree:

Do you think this review and any possible introduction of an increased charge will stop people asking the council for support?

- Yes
- No

If yes what could the council do to help people feel less worried about asking for support?

Domiciliary Care services

The Council commissions and provides domiciliary care services for people in their own home supporting them with personal care and helping them to remain as independent as possible.

The current maximum charge for this service is £13 an hour.

The actual cost of the service is £16.25 an hour. The Council wants to consider a range of options for reviewing the charge for domiciliary care. Please tick the option you agree with:

- **The maximum charge remains at £13 an hour**
- **The charge should increase to £14.25 an hour**
- **The charge should increase to £15.25 an hour**
- **The charge should increase to £16.25 an hour**

Please tell us why you have ticked the option you have

Day care services for older age adults

The council provides day care to older age adults, providing one day sessions, which includes food and drinks, at a cost of £65.40 a day, we charge £10 a day.

The Council is reviewing this charge.

Please tick the option you agree with:

- **The charge remains the same at £10 a session**
- **The charge increases to £12 a session**
- **The charge increases to £15 a session**
- **The charge increase to £20 a session**

Please tell us why you ticked the option you have

Support services in extra care housing

The council provides funding for support services within extra care housing. Currently the residents are charged £40 a week and the Council wants to review this and consider the option of increasing this to £50 a week.

The Council already subsides the housing support by 50%

For some residents the option to increase would be covered through housing benefit but for some it would be full cost. The core services ensure that there is a staff presence in the building, support with housing concerns and response to emergency situations**.** Please tick the option you agree with:

- **The charge remains at £40 a week**
- **The charge increases to £50 a week**

Please tell us why you have ticked the option you have

Carer's services

This is direct support for the carer, examples of which are to attend a social group, undertake a hobby or go to the gym. This does not include services that benefit the cared for person e.g. day care. Currently services directly for the carer are provided free of charge. The Care Act 2014 gives council's the discretion to charge for any carers services they provide. The council has a number of options, please tick the option you most agree with:

- **Charge for some types of services to cares e.g. breaks away for carers, training**
- **Charge carers a lesser contribution than the actual cost of the service**
- **Financially assess cares to work out their contribution to the charge**
- **Do not charge for any carers services.**

Please tell us why you have ticked the option you have

7 November 2019	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
Sexual Violence and Abuse Joint Strategic Needs Assessment	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Maria Payne, Strategic Lead for Public Mental Health and Adult Mental Health System Transformation	
Accountable Assistant Director: n/a	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

Every Health and Wellbeing Board has the responsibility to produce a Joint Strategic Needs Assessment (JSNA) for their area, which should give a comprehensive overview of the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services. In Thurrock, the Public Health team produce JSNA documents themed around particular topics, and the most recent of these covers the needs of survivors of sexual violence and abuse.

The report sought to further our understanding of the nature and prevalence and types of sexual violence and abuse occurring locally. Findings from this needs assessment were developed from the analysis of literature, data from specialist and non-specialist sexual violence and abuse services and referral data and engagement with local professional and victims/survivors.

1. Recommendation(s)

1.1 That the Health and Wellbeing Overview and Scrutiny Committee note and comment on the content and recommendations contained within the report.

1.2 That the Health and Wellbeing Overview and Scrutiny Committee endorse the recommendations contained within the document.

2. Introduction and Background

2.1 Tragically, sexual violence and abuse is a widespread problem that is still very much prevalent in our society. These crimes are serious and can have devastating and long-lasting effects on victims/survivors including a range of physical, emotional and psychological impacts. The experience of sexual violence and abuse at any age can have significant effects on every aspect of a person's being and life; on their mind, body, behaviour, thoughts and feelings. Sexual violence and abuse affects not just the victim/survivor, but the offender and the families and communities around both of them.

2.2 We estimate that there are 12,101 Thurrock residents who have experienced sexual assault since the age of 16, and 2,718 residents of all ages who experienced some form of sexual violence or abuse in the last 12 months.

2.3 However, a large number of these may be unknown to existing support services. The report details a number of issues including inconsistent data recording practices, perceived barriers to disclosure, barriers to accessing support and fragmentation between services where survivors are known to more than one provider.

2.4 The JSNA report outlines recommendations to address each of these issues; the most fundamental of which proposes a new pathway of support to be established. It is suggested that a new sexual violence and abuse stakeholder partnership is set up in order to take forward the recommendations from this JSNA and ensure an ongoing and consistent focus on sexual violence and abuse locally. The proposed recommendations will not be successful unless sexual violence and abuse is viewed as everybody's responsibility and key stakeholders work in partnership.

2.5 There has been a lot of national interest recently with regard to improving support to sexual violence and abuse survivors, and this piece of work has the opportunity to influence change beyond the Thurrock borders. There are few existing examples of JSNA reports on this topic, and none that explore the topic to this extent.

3. Issues, Options and Analysis of Options

3.1 These are set out in detail in the report itself.

4. Reasons for Recommendation

4.1 This report has been produced based on extensive stakeholder and survivor inputs, evidence review and wide-ranging data analyses in order to provide the most comprehensive assessment of sexual violence and abuse possible. The recommendations within should provide a starting point for further work to be done to improve the experiences of survivors and provide a level of consistency

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

5.1 A wide range of stakeholders were consulted and contributed to this report. These are set out in the acknowledgements section of the report. Additionally, this needs assessment features information collected from a large number of local victims/survivors (83 responses to the survey and 6 victims/survivors who were interviewed and videoed, and 10 young people who planned and delivered the South Essex Rape and Incest Crisis Centre (SERICC) REAL Conference in April 2019).

5.2 The report was presented and discussed at internal Public Health Leadership Team and Directors Board meetings, and relevant amendments have been made following these discussions. The report is due to be presented and approved at Health and Wellbeing Board on 6th December.

5.3 Following this, it is intended to launch this report to a wider audience at a summit in early 2020, and invite further discussion on the report findings.

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

6.1 The report contributes towards the 'People' priority – *a borough where people of all ages are proud to work and play, live and stay*, as it builds on our partnerships with statutory, community and voluntary groups to work together to improve health and wellbeing.

6.2 The recommendations also contribute towards the Thurrock Health and Wellbeing Strategy 2016-21 Objective D2. *When services are required, they are organised around the individual.*

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead, Corporate Finance

The report looks at potential unmet needs of survivors of sexual violence and abuse. Whilst exact costs have not been calculated, the report indicates that there may be future increases in demand for specialist services; but it also includes a number of potential areas for future financial savings if the impacts of sexual violence and abuse were mitigated.

Any specific investment decisions arising from the recommendations in this report would be subject to the approval of detailed business cases for individual services and these would be approved through the normal governance processes.

7.2 Legal

Implications verified by: **Lindsey Marks**

Deputy Head of Legal Social Care and Education.

The provision of support for sexual violence survivors is governed by a number of key strategies and policies, such as the National Statement of Expectations regarding Violence Against Women and Girls (2016, updated 2019), the Victims Strategy (2018) and the NHS Strategic Direction for Sexual Assault and Abuse Services. All of these detail commitments towards improving access to specialist support, reducing fragmentation in pathways and placing the survivor's needs at the heart of the support provided. The recommendations within this JSNA report align with all these principles.

7.3 **Diversity and Equality**

Implications verified by: **Becky Price**

Team Manager - Community Development and Equalities

The JSNA report states that whilst sexual violence and abuse can happen to anyone anywhere, sexual violence and abuse crimes tend to disproportionately affect the most vulnerable in society / those likely to experience health inequalities more widely. In addition, the report demonstrates variation in those 'known' to the Police or other services when compared to those estimated to have experienced sexual violence and abuse. The recommendations made in this report should reduce barriers to accessing support and the current fragmentation seen between some services. This JSNA report will be subject to a full Community Equality Impact Assessment.

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

Recommendations contained within the report should also contribute towards improved reporting of sexual violence and abuse crimes.

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):

- Detailed references are given in the main report.

9. Appendices to the report

- Appendix 1 - Sexual Violence Joint Strategic Needs Assessment
- Appendix 2 - Sexual Violence Joint Strategic Needs Assessment Appendices

Report Author:

Maria Payne

Strategic Lead for Public Mental Health & Adult Mental Health System Transformation

Public Health

Sareena Gill

Public Health Programme Manager

Public Health

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Sexual Violence and Abuse: A Thurrock Joint Strategic Needs Assessment

October 2019

Authors:

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Maria Payne, Strategic Lead – Public Mental Health

Katie Powers, Public Health Graduate Trainee

Contents

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Editor:

Ian Wake, Director of Public Health

This needs assessment features information collected from a large number of local victims/survivors (83 responses to the survey and 6 victims/survivors who were interviewed and videoed, and 10 young people who planned and delivered the South Essex Rape and Incest Crisis Centre (SERICC) REAL Conference in April 2019). Our thanks go to you, to SERICC, Healthwatch and Quest Music Services for helping us to truly tell your stories and use it to influence our findings.

Our thanks also go the 128 professionals who completed the survey and those who supplied commentaries and data in order to inform our understanding of sexual violence and abuse in Thurrock.

Notes to the reader

In this document, sexual assault, sexual violence, sexual offence and sexual abuse are used interchangeably and are not necessarily in their technical or legal definitions. The term victim/survivor is used to refer to those subjected to sexual violence and/or abuse and encompasses ‘victim’, ‘patient’, ‘complainant’, ‘client’ and ‘survivor’. Where reference is made to a time since a victim/survivors incident of sexual violence or abuse, the terms ‘recent’ and ‘non-recent’ are used interchangeably with ‘historic’ and ‘non-historic’.

Within this document, reference is also made to the names of specific organisations who provide a range of specialist and non-specialist sexual violence and abuse services in Thurrock. It is to be noted that although these were correct at the time of publication, they are subject to change based on commissioning outcomes.

Where videos have been embedded, please right click on the film icon and select ‘*open hyperlink’*. You will be directed to a YouTube page and will need to press play.

Executive Summary

Tragically, sexual violence and abuse (SVA) is a widespread problem that is still very much prevalent in our society. These crimes are serious and can have devastating and long-lasting effects on victims/survivors including a range of physical, emotional and psychological impacts. The experience of sexual violence and abuse at any age and whether male or female can have significant effects on every aspect of a person's being and life; on their mind, body, behaviour, thoughts and feelings. It is also recognised that sexual violence and abuse affects not just the victim/survivor, but the offender and the families and communities around both of them.

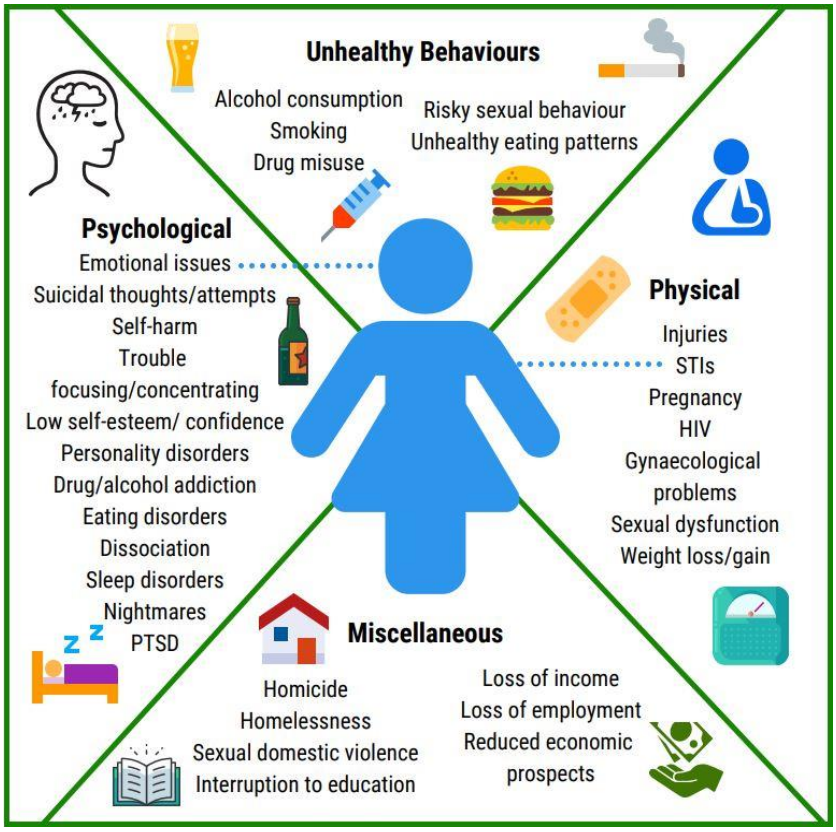
This needs assessment sought to further our understanding of the nature, prevalence and types of sexual violence and abuse occurring locally. This understanding will enable us to ensure that efforts are made to prevent these horrific crimes happening in the first place and ensure survivors are appropriately supported to cope and recover from the aftermath of their experience through the provision of suitable and high quality support when they need it. A number of key stakeholders were involved in the development of this needs assessment including professionals from a range of organisations including health, social care, criminal justice, specialist sexual violence and abuse services and most importantly, local victims/survivors. Findings from this needs assessment involved the analysis of literature, data from the Police and Social Care, specialist and non-specialist sexual violence and abuse services, referral data and engagement with local professional and victims/survivors.

It is widely accepted that there are difficulties establishing the true prevalence of sexual violence and abuse, predominately due to survivors not wishing to report or disclose their experience to formal sources. **Only 17% of victims/survivors of sexual violence and abuse report their experience to the Police.** Whilst some victims/survivors chose to disclose their experience to a friend, relative, colleague or professional, **it is estimated that 31% of victims/survivors do not tell anybody**. This is particularly evident in cases of child sexual abuse, with the **average time taken to disclose suggested to be 26 years**. National estimates from the Crime Survey for England and Wales suggest that 20% of females and 4% of males aged 16-59 have experienced sexual assault since the age of 16. Locally this is equivalent to 10,116 females and 1,985 males**. It has been estimated that locally approximately 2,718 Thurrock residents of all ages, experienced some form of sexual violence or abuse in the last 12 months.**

Respect for the preferences of survivors should be the golden thread that runs through any local provision of support for victims/survivors of sexual violence and abuse. For this reason, extensive engagement work was conducted via surveys and in-depth interviews with local victims/survivors and has formed a fundamental part of our understanding of survivor's experiences. Local survivors spoke bravely of the multitude of impacts that have resulted as a consequence of their assault or abuse, as well as their expectations and experiences of disclosure and accessing local services.

In order for victims/survivors to cope and recover from the experience of sexual violence and abuse, it is imperative that they have timely access to effective services that support them in a manner that is suitable to their needs and preferences. Due to

the wide-ranging impacts that SVA may have on victim's/survivors, it is recognised that survivors may require a number of services, often from a range of providers, examples of which may include counselling, advocacy, drug and alcohol, sexual health and support with housing, financial and criminal justice needs. Some of the impacts are summarised below:



The effects of sexual violence and abuse also incur vast socioeconomic costs which manifest as both tangible and intangible costs as well as direct and indirect costs. The tangible costs of SVA are taken to include direct costs such as; medical, physical and mental health costs as well those related to housing, police investigations and criminal prosecutions. Indirect costs may also occur through employee's loss of productivity and income and personal financial losses due to injury or inability to work. Intangible costs are taken to include the psychological pain and suffering of victims/survivors, and a generalised, heightened fear of victimisation which may impact on ability to function normally and achieve aspirations. It is important to recognise that these costs can stretch on for years and decades following an incident of SVA. Providing survivors with prompt access to services that support them to recover in the immediate aftermath and beyond is not only ethical but also likely to be highly cost effective.

Through the provision of appropriate and early intervention it is likely that we are able to prevent, if not mitigate, some of the complex, long-term health and mental health problems amongst victims/survivors, in turn reducing the long-term costs and consequences for victims/survivors and their communities.

Locally a number of services are in place to support victims/survivors, with the offer including both specialist and non-specialist sexual violence and abuse services. Whilst some services are specifically commissioned to work with victims/survivors, with specialist provision including the Sexual Assault Referral Centre (SARC) at Brentwood Hospital and specialist sexual violence and abuse counselling services including counselling, advocacy and Independent Sexual Violence Advisor (ISVA) service delivered by SERICC, others provide a more generic offer e.g. sexual health, drug and alcohol and mental health services. The responsibilities for commissioning these services sit with a number of organisations from a range of sectors. The above presents a number of difficulties in the local provider landscape and requires a number of organisations and commissioners to work together in order to ensure effective approaches are in place to support victims/survivors of SVA.

We know that not all survivors are known to local services.

In 2018, **316 victims of reported sexual offences were recorded in Thurrock**. This has increased from the previous year at a faster rate than the corresponding population growth. The majority of these victims:

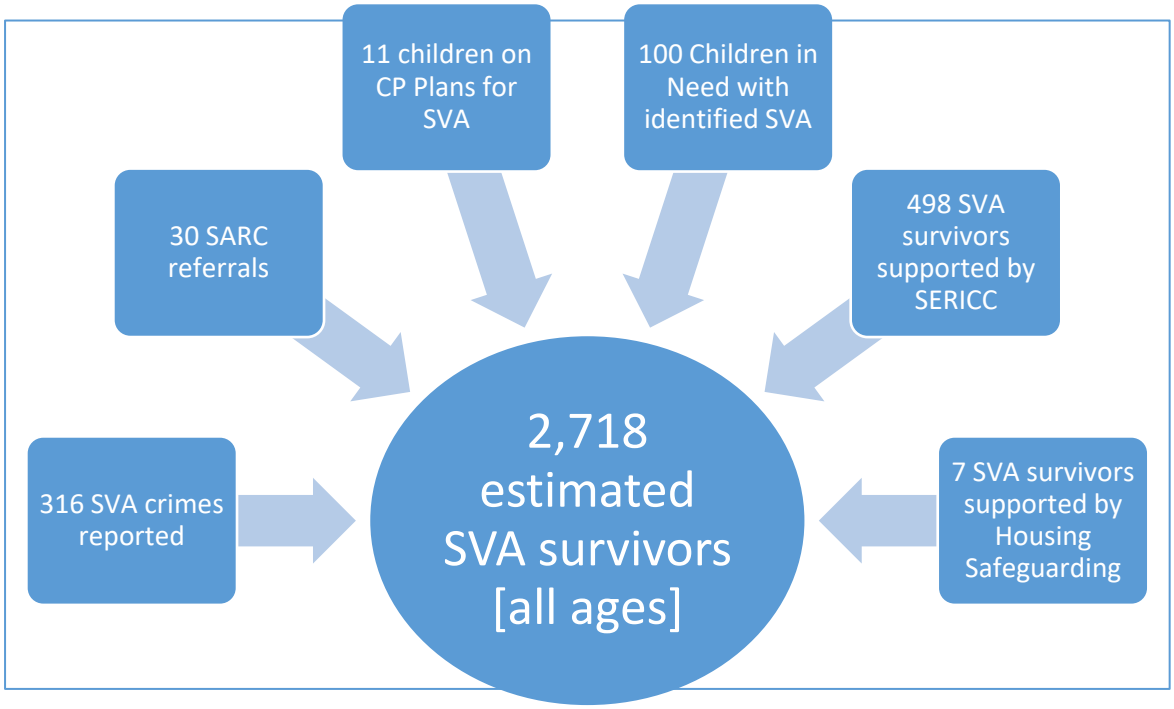
- **Young (over half were aged < 17 years)**
- **Female (over three quarters were female)**

The vast majority (91%) of suspected perpetrators were male, a higher proportion than seen in national data from the Crime Survey for England and Wales which shows a male perpetration proportion of 74-79% for sexual offences. Locally, suspected perpetrators tended to be younger men, with peaks occurring in the 18-34 age range (42%). However a quarter of suspected perpetrators were aged < 17 years, potentially signalling some 'peer on peer' activity; although given their age, they may be subject to increased safeguarding measures and therefore more likely to disclose or seek help following experience(s) of SVA.

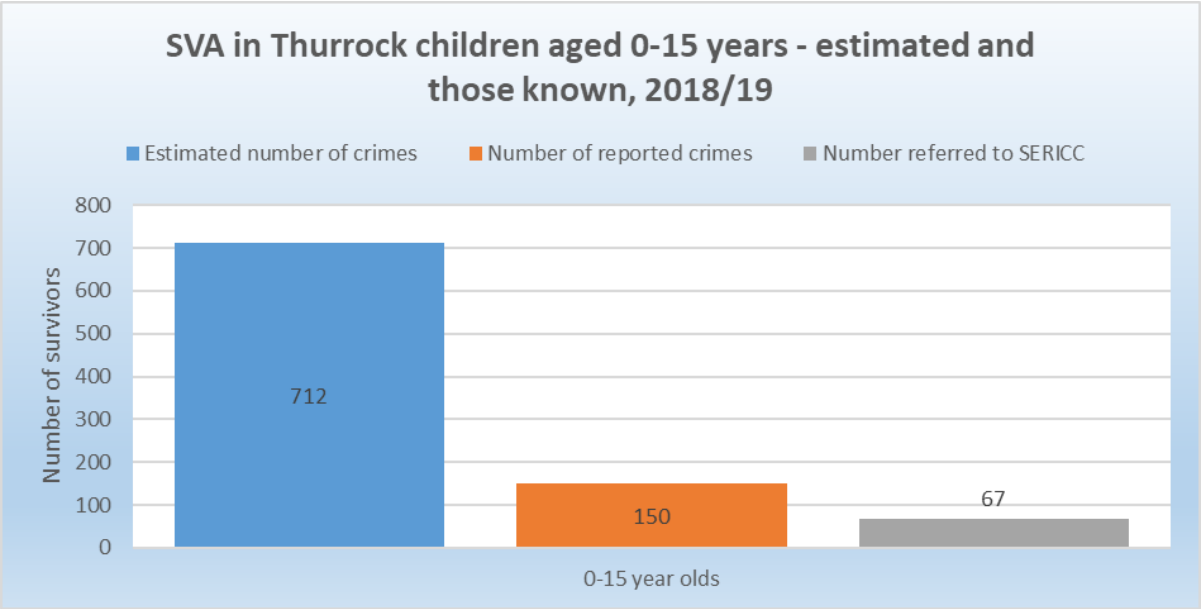
Sexual violence and abuse can occur in a number of different contexts. Crimes related to SVA often represent an exertion of power from the perpetrator over the survivor and may be used as forms as a form punishment, blackmail and to instil fear within a victim. Victims may also by sexually abused or exploited through forms of criminal activity including human trafficking, modern day slavery, forced work within brothels and grooming, often for the financial gain of somebody other than the victim. Anecdotal intelligence from local stakeholders suggests that Thurrock may have specific issues and crimes occurring that relate to SVA however at present we do not have robust evidence to enable us to understand the full extent of any overlaps that may occur. Due to an absence of crime related data, the only link we are able to establish is that of Domestic Violence (DV) and SVA, with 18% of the Thurrock sexual offences reported to Essex Police in 2018 specifically linked to DV. The presence of gangs and organised criminals targeting and exploiting of people cannot be underestimated and is currently one of Essex Police's biggest challenges.

The number of Thurrock residents accessing the local Rape Crisis Centre provided by the South Essex Rape and Incest Crisis Centre (SERICC) for a range of services related specialist sexual violence and abuse counselling and advocacy services has **increased** by 20% between 2015/16 and 2018/19, with **498 residents accessing in 2018/19**. This is still much lower than the 2,718 victims/survivors who are estimated

to have experienced SVA in the last 12 months. The below summarises the known presentations of SVA survivors.



Whilst under-reporting and subsequent service presentation is present across all age groups, children and young people reporting SVA may still not be receiving specialist support, even amid the tighter safeguarding protocols in place around them. The chart below shows that of the 712 children likely to have experienced SVA, approximately 21% of them were reported to Essex Police and SERICC received referrals for only **9.5%** of these estimated victims/survivors.



User Voice

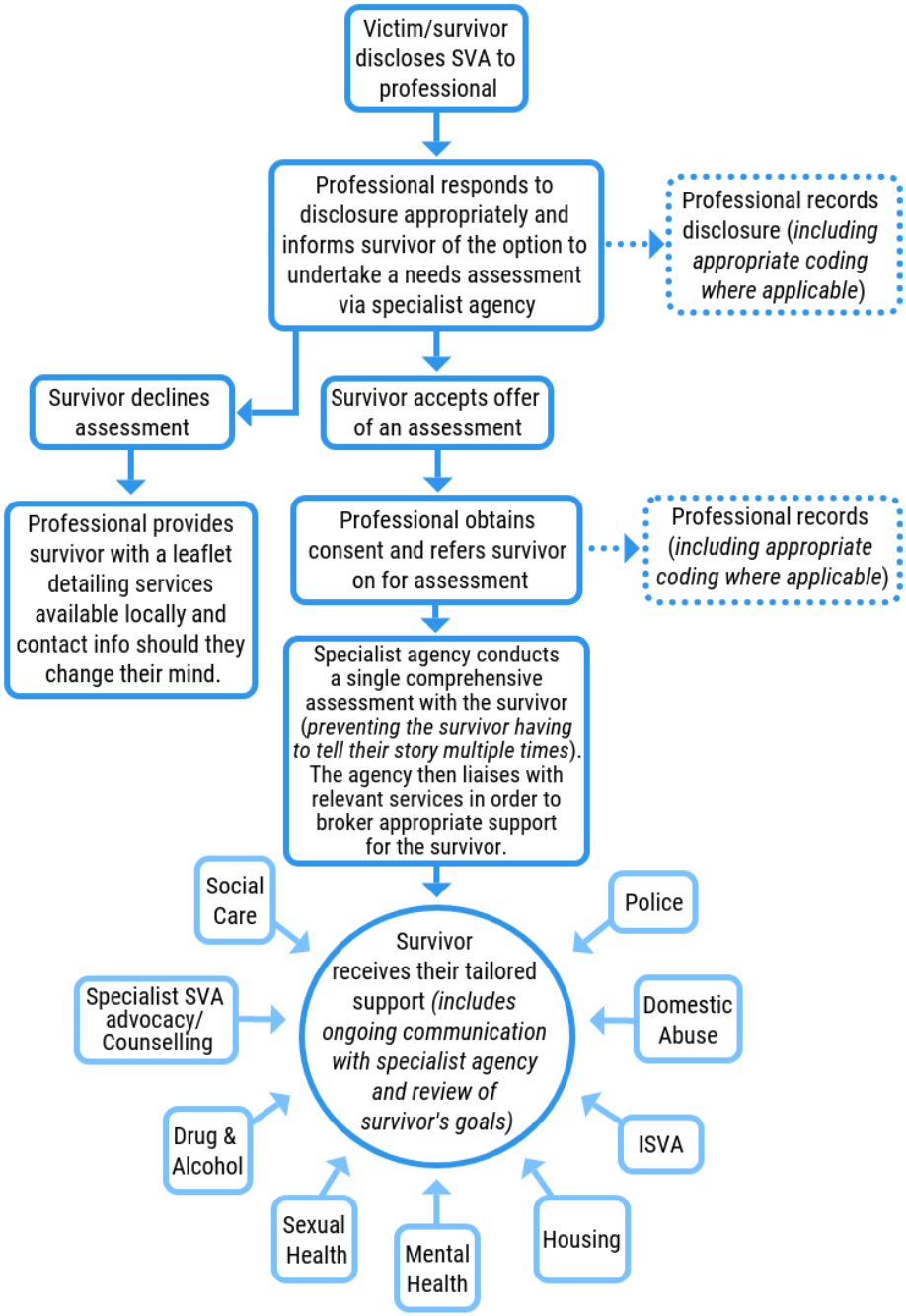
Local victims/survivors spoke of the experiences of fragmented pathways, poorly handled disclosures, difficulties navigating the landscape of numerous providers and to their frustration, often having to repeat their traumatic experiences to multiple members of staff across various services. victims/survivors frequently mentioned the poor responses they were often met with following disclosure or attempts to seek help or support. This left victims/survivors feeling a range of emotions including shame, guilt and embarrassment, commonly reported as being just as traumatic as the abuse itself. It is important to recognise that the majority of victims/survivor who participated in the engagement had accessed specialist sexual violence and abuse support from SERICC, and therefore this needs assessment lacks an understanding of the thoughts and experiences of local victims/survivors who may not have not accessed services, whether specialist or non-specialist. Although local professionals generally had a good level of understanding of local services available to support victims/survivors, they had varying views regarding how well services worked together to support victims/survivors and many professionals requested further training to help them handle disclosures appropriately. This must be addressed within future work.

Whilst this needs assessment considers the current population in Thurrock, it is imperative that future work considers the projected population increase of 20.04% by the year 2041 and changes in migration patterns. Thurrock has a number of assets in place that will help drive forward the approach to sexual violence and abuse. As a unitary authority, Thurrock benefits from one single Clinical Commissioning Group, one Health and Wellbeing Board and one Healthwatch, providing a geographical foot print for planning, delivery and integration of healthcare, social care, public health and other local authority services. The Essex Sexual Abuse Strategic Partnership in collaboration with key partners is also pioneering innovative ways of working including the development of **Project Goldcrest.** This project allows victims of sexual violence who do not currently wish to participate in the prosecution of their perpetrator to anonymously store forensic evidence at the Essex SARC should they wish to proceed with a criminal justice process at a later date. In the meantime Essex Police are able use this evidence anonymously to disrupt and prosecute perpetrators.

A new integrated model of care for victims/survivors.

The most significant recommendation of this needs assessment is the proposal to develop a **new pathway of support** (see Chapter 11) for local victims/survivors of sexual violence and abuse. The implementation of this pathway will ensure a radical transformation in the way survivors are offered support to help them cope and recover from their experience. Too often, we heard examples of agencies involved in SVA not working effectively together, of survivors having to tell their story multiple times, and of having to access a myriad of different agencies to obtain the support they required. This pathway recognises that SVA may have a number of wide ranging impacts on a survivor and therefore a number of organisations may be involved in providing support to survivors, regardless of whether they are a specialist sexual violence and abuse service or not. Examples of services to be included within the pathway include; specialist sexual violence and abuse advocacy and counselling services, Independent Sexual Violence Advisors, community mental health services, drug and alcohol services, sexual health services and housing.

Our ambition is for every survivor who makes a disclosure of sexual violence and abuse to be offered a comprehensive assessment to identify any appropriate support to help address their needs. Should the survivor agree and provide consent, the professional they disclose to will refer them to a specialist agency in order to undertake an assessment once which will assess which service(s) are appropriate. Following this assessment, the specialist agency will liaise with the appropriate support services in order to provide the survivor with a tailored package of support. The survivor will then be able to access their support. This coordinated offer of support will drive collaboration between all relevant agencies and in turn, facilitate better access in to services for survivors whilst reducing the number of times they are required to tell their story to professionals. This pathway is demonstrated below and explained in detail in Chapter 11.



Key issues and recommendations.

The key issues and recommendations are set out in the table overleaf.

We recommend that locally a Sexual Violence and Abuse Stakeholder Partnership is established in order to take forward the recommendations from this needs assessment and ensure an ongoing and consistent focus on SVA is present in Thurrock. These recommendations will only be successful if sexual violence and abuse is viewed as everybody's responsibility and key stakeholders work in partnership.

Issue Identified	Recommendation to address this	Responsibility
Recommendations around improving data		
Locally there are low levels of reporting of SVA crimes to the Police. Although this is observed nationally, the Thurrock rates are lower than comparable authorities (see chapter 7 for further information)	The Essex Sexual Abuse Strategic Partnership should commission dedicated SVA campaign work s in order to increase public confidence in reporting crimes, which in turn should reinforce positive outcome messaging.	Essex Sexual Abuse Strategic Partnership (working with Essex Police and Crown Prosecution Service)
Data collection mechanisms are not currently set up to enable identification of the number of survivors accessing all agencies in Thurrock	Non-specialist SVA organisations (e.g. sexual health, mental health, drug and alcohol services) should embed questions related to SVA in to their relevant templates/assessments in order to improve identification of SVA survivors.	All relevant non-specialist SVA organisations, to be determined and overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership
The systems/ databases/ datasets used by some organisations locally are not appropriately set up to record SVA related information.	Relevant agencies including General Practice, hospitals, sexual health, mental health provider NHS trusts, drug and alcohol treatment services, domestic abuse services should develop a single, consistent recording protocol in order to facilitate disclosures and identify SVA survivors. This protocol should include: - the use of mandatory questions - appropriate datasets - appropriate coding/categories - minimising opportunities for SVA to be lost within free text sections of case notes. For health settings, this may be most effective at a Mid & South Essex STP (Sustainability and Transformation Partnership) approach considering the shared resources i.e. hospitals, Police force, Single Point of Access for Rape Crisis Centres).	To be overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership with support from relevant organisations
Due to inconsistent data capturing across organisations, it is difficult to identify victims/survivors use of services and their pathways between services (e.g. at what point they access support, type and frequency of support received, the duration support was received for)	Thurrock SVA Stakeholder Partnership should undertake baseline mapping activity to identify current data recording practices within each agency around service usage in order to make adaptations to reporting requirements and data collection.	Thurrock Sexual Violence & Abuse Stakeholder Partnership

Issue Identified	Recommendation to address this	Responsibility
Recommendations around the prevention of SVA		
Local approaches to prevention of SVA are predominately school-based	Thurrock SVA Stakeholder Partnership should identify other options and channels to communicate prevention messages regarding so that a population based approach can be achieved. Messages should also be adapted to particular population groups where appropriate (e.g. those at high risk of SVA).	Thurrock Sexual Violence & Abuse Stakeholder Partnership
Existing school based prevention activity is inconsistent and often focuses only on particular year groups. There are opportunities to strengthen school-based approaches to prevention activities.	Schools, Academies and Thurrock Council's Education and Skills Department should capitalise on the opportunities presented by the Department of Education's mandatory requirement for the delivery of Relationships Education in Primary Schools and Relationships and Sex Education in Secondary Schools from September 2020 to ensure that knowledge of SVA and services available to support survivors is embedded and consistently covered within the curriculum.	Thurrock Council's Education Department, Head teachers, PSHE Leads, Safeguarding Leads etc.
	Proactive messaging on SVA and key topics such as consent, grooming and CSE should be consistently delivered to all age groups and embedded into each school's wider pastoral offer.	Thurrock Council's Education and Skills Department, Head teachers, PSHE Leads, Safeguarding Leads etc.
Recommendations on addressing harmful behaviour of perpetrators		
Local Police data tells us that the majority of SVA crime victims and suspected perpetrators are young (25% aged 0-17 and 42% aged 18-34). However, locally there is an absence of programmes targeted specifically towards those in this age group who are displaying harmful sexual behaviours	*See recommendations above regarding approaches to the prevention of SVA (5.4)*	
	Thurrock's LSCP should develop a training proposal to ensure the wider children and young person's workforce (e.g. social workers, teachers, youth workers, School Wellbeing Service) are trained and appropriately supported to identify and screen for concerns linked to harmful sexual behaviours and/or sexual violence and abuse.	Thurrock Local Safeguarding Children Partnership (LSCP)
	Thurrock's LSCP should specifically include actions to address the issue of young suspected perpetrators within their relevant policies and action plans.	Thurrock Local Safeguarding Children Partnership (LSCP)
	Thurrock Sexual SVA Stakeholder Partnership should review and assess the appropriateness of existing provision designed for young people who are displaying harmful sexual behaviours to ensure an effective offer is in place locally.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
	Thurrock's LSCP and NHS Thurrock Clinical Commissioning Group should ensure the Guidance from the National Institute for Health and Care Excellence (NICE) regarding harmful sexual behaviour among children and young people (NG55) is adopted and successfully implemented locally.	Thurrock Local Safeguarding Children Partnership (LSCP)
	Thurrock SVA Stakeholder Partnership should review the findings of the Learning and Development Group of Southend's Safeguarding Children's Board who have recently reviewed Harmful Sexual Behaviours in order to knowledge and best practice county- wide and implement changes locally where appropriate.	Thurrock Sexual Violence & Abuse Stakeholder Partnership

Issue Identified	Recommendation to address this	Responsibility
Locally, there is an absence of programmes targeted specifically to those displaying harmful sexual behaviours for those who are outside the age remits mentioned above	Thurrock SVA Stakeholder Partnership should conduct a review of the evidence base of relevant programmes and potential demand locally in order to identify a suitable programme. Funding is to be secured if applicable.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
Local Police data shows that 11% of suspected perpetrators (of SVA offences reported by Thurrock residents) were reported for committing more than one offence. We are currently unaware of how this compares to other areas/nationally	The Essex Sexual Abuse Strategic Partnership should conduct a review of the offer of programmes to those who have been convicted of sexual violence and abuse crimes and create a sustainable behaviour change programme for perpetrators of SVA (to be informed by the Essex Sexual Abuse Strategic Partnership's Sexual Violence Strategy, due to be published late 2019).	Essex Sexual Abuse Strategic Partnership
Local and national data and engagement with survivors shows that both children and adults experienced SVA in a domestic setting or had a close relationship to the perpetrator (e.g. partner, ex-partner family member)	Embed knowledge related to recognising SVA in domestic settings amongst front line professionals to increase confidence in recognising and reporting incidences of SVA.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
Recommendations for improving responses to disclosure		
Locally, survivors report a lack willingness to disclose their experience of SVA to anybody (including formal and informal sources). A number of factors are known to deter disclosures and willingness to seek support. Local engagement tells us that these factors include lack of confidence to access services, fear of not being believed and a low perpetrator conviction rate	The Thurrock SVA Stakeholder Partnership should implement a coordinated programme of communications activities to be delivered to the public, to include; reducing the stigma of SVA, tackling social myths and stereotypes in order to increase public confidence in reporting crimes and seeking appropriate support	Thurrock Sexual Violence and Abuse Stakeholder Partnership

Issue Identified	Recommendation to address this	Responsibility
Locally, disclosures are more commonly being made to informal sources (i.e. family and friends) rather than to professionals. This may result in disclosures not being handled appropriately and/or survivors not being aware of the relevant services and support available	Thurrock SVA Stakeholder Partnership should review suitable training programmes (whether existing or bespoke) that can be delivered in order to support informal sources respond appropriately to disclosures. Examples may include the Thurrock Community Safety Partnership's (CSP) Challenging Myths Changing Attitudes training, or a variant of the J9 Domestic Abuse Awareness training tailored towards SVA. These should be delivered consistently across Thurrock, including to families/friends where requested.	Thurrock Sexual Violence and Abuse Stakeholder Partnership
Locally, not all responses to disclosure, whether to formal or informal sources, have been handled appropriately and sensitively, which can be extremely traumatic to the survivor. Survivors often reported that professionals in a rush to follow organisational protocol and 'cover their own back' disclosed information to multiple additional professionals leaving the survivor feeling that 'they had lost control of the process'	Thurrock Council's Education and Skills Department in partnership with local schools and Academies should audit all school policies on SVA disclosure to ensure a consistent approach based on best practice that keeps the needs of the survivor at the centre of the process	Thurrock Council Education and Skills Department Head Teachers and Academy Chief Executives
	Thurrock SVA Stakeholder Partnership should commission a coordinated programme of training/communications activities to be delivered to professionals and informal sources, to include; reducing the stigma of SVA, tackling social myths and stereotypes, in order to improve responses to disclosure.	Thurrock Sexual Violence and Abuse Stakeholder Partnership
	Thurrock SVA Stakeholder Partnership should develop a bespoke toolkit for professional use in order to facilitate appropriate responses to disclosure. This toolkit should be issued to all appropriate frontline professionals in Thurrock. The toolkit should be used to supplement training and provide information including safeguarding requirements, appropriate language, local service provision and referral pathways.	Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services
Some professionals surveyed said that they did not feel confident dealing with disclosures, with many professionals requesting further training in this area	Thurrock SVA Stakeholder Partnership should conduct a full evaluation of training possibilities, seeking input from staff/management within key organisations, in order to determine which are most effective in increasing professionals' confidence responding to disclosures. This training should be then made available to professionals in order to ensure they are appropriately informed, skilled and confident in handling disclosures.	Thurrock Sexual Violence and Abuse Stakeholder Partnership

Issue Identified	Recommendation to address this	Responsibility
	A toolkit to be developed and issued to all frontline professionals in Thurrock in order to improve ongoing confidence during and following disclosure and ensure survivors are informed of options for support. This toolkit should: - Include information regarding conducting risk/needs assessments for survivors, as per relevant safeguarding processes - Contain information including operational protocols, safeguarding policies, practical skills and information regarding service provision and referral pathways - Provide professionals with a clear understanding of how to respond appropriately to disclosures, including the actions that should follow - Incorporate the findings of this needs assessment and the Thurrock REAL. Conference - Seek input from specialist SVA services - Be coordinated by the new Thurrock SVA Stakeholder Partnership to oversee the development and support implementation (see recommendation in chapter 11).	Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services
Some survivors reported that their disclosures/information related to their SVA was shared with more people than they felt was necessary	The toolkit and training as mentioned above should address this issue through providing professionals with a clear understanding of the processes following disclosure including what information should be shared and with who.	Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services
Following disclosure, 68% of local survivors relied on professionals giving them further information/ signposting towards seeking specialist help themselves rather than a referral being made on their behalf. Whilst SERICC appear to be well-known in the borough, the process would be smoother and may result in better outcomes if survivors were referred directly using appropriate mechanisms	Referral pathways and processes into specialist SVA services must be developed, agreed with key stakeholders and used by all referring organisations.	Thurrock Sexual Violence and Abuse Stakeholder Partnership
	Organisations to network more effectively so that they better understand each others' service offer for survivors, and to be directed to make referrals in to specialist support services as opposed to signposting. Thurrock Public Health Service to organise a conference for all local stakeholders to launch this Joint Strategic Needs Assessment product and commence discussion between stakeholders.	All providers of services that may support SVA survivors, to be identified and facilitated by the Thurrock Sexual Violence and Abuse Stakeholder Partnership Thurrock Council Public Health Service
	Where practicable, referral forms to SVA support services should be automated or embedded into organisational information systems (e.g. the Systm One or EMIS systems in General Practice and hospital systems)	Thurrock Sexual Violence and Abuse Stakeholder Partnership

Issue Identified	Recommendation to address this	Responsibility
Recommendations for those in the reporting of crimes to the Police		
Thurrock has lower levels of reporting SVA offences to the Police than other similar areas, and of those that are reported, there is a very low proportion that lead to the suspect being charged. There is variation by age group in terms of the proportion of women estimated to have experienced SVA who have reported it to the Police, particularly seen in women aged 25-44 years (the rate is between 6-8%)	The Essex Sexual Abuse Strategic Partnership should ensure that Project Goldcrest is evaluated in order to determine whether it is effective in encouraging survivors to participate in forensic evidence gathering and supporting the Police with prosecuting perpetrators.	Essex Sexual Abuse Strategic Partnership
	Communications activity as previously recommended should seek to target women in this age group to increase confidence in reporting.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
Recommendations for improving access to services		
Survivors reported difficulties accessing the right service(s) at the right time. The extent to which barriers to accessing support occur locally remain largely unknown. Within our engagement work with survivors who had accessed services barriers to support were seldom mentioned, however the Needs Assessment lacked input from local survivors who were not known to have accessed support.	As part of the implementation of the new pathway of support (see chapter 11) a full communication programme to be effectively implemented to all relevant front line services. This will ensure survivors are able to access the right services at the right time.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
	A communications plan to inform the public of the new pathway should be developed. The plan should be informed by survivor's preferences for receiving information in order to increase knowledge and confidence in accessing services.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
	Engagement work should be conducted with local survivors who have not accessed support in order to better understand local barriers.	Providers and Commissioners of specialist SVA services
Recommendations for improvements to existing service provision		
Engagement with survivors recognises that they value a holistic offer of support and there is also a strong body of evidence in favour of this. However, local engagement with professionals and survivors identified that services do not always work together and where partnership working does occur, there is often fragmentation of pathways indicating more work is	Providers and commissioners of specialist SVA services should agree a new integrated model and care pathway of support and then jointly commission/deliver it. The new pathway of support (as proposed in chapter 11) is to be further developed in consultation with survivors and all relevant services. The new pathway should be tested by local professionals in order to ensure it works effectively and expose any flaws or issues (e.g. through a dedicated training workshop).	Providers and Commissioners of specialist SVA services including Adult and Children's Social Care Commissioners, Mental Health Commissioners at NHS Thurrock Clinical Commissioning Group

Issue Identified	Recommendation to address this	Responsibility
perhaps needed to reduce these inconsistencies		
Local survivors told of how their experiences of service provision has not always met their needs or expectations e.g. due to fragmentation of pathways, waiting times, quality.	Local survivors should be invited to co-produce the new pathway of support and their views are used to develop services and form part of quality assurance of commissioned services.	Providers and Commissioners of specialist SVA services
Locally, multiple services are commissioned to support survivors however they are mostly working to different outcomes. It is recognised that certain contracts related to SVA are commissioned at a county-wide level, considering the close proximity of all three local authorities in Essex (as well as sharing the same Police force, hospitals , SARC and single point of access for Rape Crisis Centres), there may be benefit in commissioning more SVA services at a county-wide level. However, it is to be noted that this needs assessment was solely focussed on Thurrock and therefore further work is required in order to ensure an appropriate offer is provided across Essex.	Adult and Children's Services Commissioners in Thurrock Council and NHS Thurrock CCG should review existing mechanisms for recording performance outcomes within specialist SVA services with the ambition to agree a consistent approach to monitor SVA outcomes within local contracts.	NHS, Council and Criminal Justice commissioners of specialist SVA services
	Council and NHS commissioners should integrate commissioning of SVA services and seek to develop a single contract, shared budget, single outcomes framework and collaboratively commission specialist SVA services across Essex.	NHS and Council Commissioners of specialist SVA services
	Specialist SVA services should be commissioned based on the evidence base presented within this Needs Assessment and accounting for data which will be collected through the proposed recommendations.	NHS, Council and criminal justice commissioners of specialist SVA services
Local engagement with survivors identified that over 50% said they waited for less than one month before receiving support, however, some survivors reported finding it hard to be on a waiting list once they made the decision to access support	An offer of emotional and practical support must be made available to all survivors on the waiting list for specialist SVA services. This could be informed by the evaluation of the locally delivered Synergy Essex '*First Responder Project'.*	NHS, Council and Criminal Justice commissioners of specialist SVA services

Issue Identified	Recommendation to address this	Responsibility
Recommendations around improving strategic oversight for SVA		
There are already a large number of existing strategic groups, networks and leadership opportunities to champion this agenda, however it is not quite clear where the lead responsibility sits locally	Form a dedicated Thurrock Sexual Violence and Abuse group reporting in to the Thurrock Violence Against Women & Girls Strategy Group (it is to be noted that despite the name, this group also address men and boys). This group will provide a focal point for SVA and drive the majority of recommendations from this needs assessment.	Thurrock Community Safety Partnership
	Advocate for provision of SVA to be included in the refresh of the Health and Wellbeing Strategy for Thurrock in 2020 so that there is a continued strategic focus on this agenda.	Thurrock Council Public Health Service
Locally, there are a number of existing policies, in place, particularly those related to safeguarding, where there is scope to strengthen the presence of SVA to ensure a partnership approach to supporting victims/survivors of SVA working towards prevention and reduction	Thurrock's Adult and Children's Safeguarding Boards should take a proactive approach to addressing SVA, including: -Policies are reviewed and detail clear responses to SVA -Ensuring professional adherence to policies and guidelines -Supporting professionals to feel confident in understanding and addressing SVA.	Thurrock's Adult and Children's Safeguarding Boards
	Thurrock's Adult and Children's Safeguarding Boards should support partner organisations to produce policies that address SVA, whether this is included within a generic safeguarding policy or as a standalone policy. This should include: - Training requirements - Information gathering/collection - Information sharing - Safeguarding protocol/standards - Safeguarding supervisions (where appropriate).	Thurrock's Adult and Children's Safeguarding Boards

Chapter 1: Introduction

1.1 What is sexual violence and abuse?

The World Health Organisation (2010) defines sexual violence and abuse (SVA) as 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home or work'[1]. This definition includes rape. As per the Sexual Offences Act 2003 (SOA 2003), rape has legally been defined in the UK as the penetration with a penis of the vagina, anus or mouth of another person without their consent. Rape is defined as 'physically forced or otherwise coerced penetration, even if slight, of the vulva or anus using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape.

The SOA describes penetration of a person's vagina, mouth or anus with any part of the body other than the penis or with an object without their consent as "assault by penetration". Sexual violence can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus. Any sexual activity with or without consent of a child under the age of 16 is an offence, including non-contact activities or encouraging children to behave in sexually inappropriate ways.

It is important to recognise that sexual violence and abuse can happen to anybody, of any age, regardless of gender, sexuality, religion, cultural, social or ethnic background. It should also be understood as a cause and consequence of gender inequality, and as a result, impacts disproportionately on women and girls. SVA may be a one-off event or happen repeatedly over any period of time. In some cases it can involve the use of technology such as phones, internet or social media. SVA can occur anywhere including in public, within the home or workplace and within organisations and institutions such as schools, religious settings and sports clubs. It may also occur when the person is unable to give consent while drunk, drugged, asleep or mentally incapable of understanding the situation.

Child Sexual Abuse (CSA) involves forcing or enticing a child or young person aged under 18 to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Both CSA and Child Sexual Exploitation (CSE) can involve the presence of some form of exchange, i.e. the child receives 'something' e.g. gifts, drugs, alcohol, accommodation or food in return for the sexual activity.[2] In all cases, those exploiting

the child/young person have power over them whether it is by virtue of age, gender, intellect, physical strength and/or economic or other resources. It is important to remember that the victim may have been sexually exploited even if the sexual activity appears consensual.

Over the recent years, the profile of sexual offences has risen significantly due to high profile inquiries such as the Inquiry into Child Sexual Exploitation in the family environment, the Independent Inquiry into Child Sexual Abuse (IICSA) and the Independent Inquiry into Child Sexual Exploitation in Rotherham. Campaigns such as the #METOO movement and high profile media coverage cases involving well known individuals such as Jimmy Savile and Michael Jackson have also contributed to raising the profile of sexually motivated crime. Recently, there has been a significant increase in the number of victim/survivors accessing specialist sexual violence and abuse services. The year ending 2017-18 saw over 6,300 children and adults, predominately women and girls on the waiting lists of Rape Crisis Centres nationally, with the network seeing a 17% increase in survivors accessing support compared to the previous year.[3] It is thought this increase may be attributable to increased willingness to disclose and report and greater awareness of services and support available to cope and recover.

1.2 Why is it an important issue?

Being a victim of any kind of crime can be frightening and upsetting however sexual violence and abuse crimes are particularly distressing and devastating crimes for the victim/survivor. The impact of any sexual assault or abuse is largely hidden and often not fully understood, with no identified effects that are unique to these crimes. However, it is well known that the damage and devastation caused is enormous, extremely varied and often lifelong. SVA may have a range of resulting impacts on victims/survivors, as discussed in section 4.3. These impacts may present in different ways for different individuals, with the commonality being serious trauma, which is often compound and complex. The effects of SVA can also incur significant costs to society as demonstrated in sections 4.5 and 4.6. Recently there has also been a significant increase (17%) in the number of survivors accessing specialist support from Rape Crisis Centres.

The demographics of the population and geographical location of Thurrock may be an important factor in the current and future of prevalence sexual violence and abuse. It is to be noted that Thurrock's population is mostly young, with 33% of the population aged under 25 years of age[4] and an average age of 37 years old.[5] The population is set to increase by 20.04% between 2019 and 2041,[6] with a large proportion attributable to migration from London' boroughs and due to Thurrock currently experiencing a large amount of investment and regeneration taking place. Also, whilst we have more children and young people recorded with trafficking as a risk factor compared to other areas (see section 8.3.6), we are unable to conclude for sure whether the geographical location of Thurrock, along the River with ports that can be used as entry and exit points, makes Thurrock a place at greater risk of risk of trafficking compared to other areas. Further information regarding Thurrock as a place can be found in Appendix 1 and a breakdown of its population can be found in Appendix 2.

The video below provides an introduction to the experiences of the survivors interviewed as part of this needs assessment. Their journeys, thoughts and feelings are explored further in the videos that follow throughout this document.

1.3 How this needs assessment was conducted

In order to conduct this needs assessment the following processes were undertaken as described below.

Establishment of a Task and finish group	This group was comprised of key stakeholders including specialist sexual violence and abuse service providers and commissioners, Thurrock Clinical Commissioning Group, safeguarding professionals, Social Care, Community Safety, Essex Police and Public Health staff. The group met regularly and all contributed to the development of this needs assessment.
Reviews of Literature and Research	Extensive research was conducted in order to gain an understanding of sexual violence and abuse, including the national prevalence, risk factors, impacts of SVA on a victim/survivor and those around them, best practice for supporting victims/survivors of SVA, the legislative framework and commissioning responsibilities and preventative measures.
Information and data requests to local service providers	Information regarding local service provision and service level data was obtained from specialist sexual violence and abuse services and where possible from non-specialist services. Data and information was also collected from safeguarding services and prevention and perpetrator programmes.
Data analysis	Data analysis was conducted in order to determine the prevalence of SVA locally and to understand the usage of specialist and non-specialist SVA by local victims/survivors. This also enabled the socio-economic impact of SVA locally to be estimated.
Engagement with local victims/survivors and professionals	This needs assessment sought to capture the learning from service users and operational and strategic staff in order to further understanding of local experiences of disclosure and service provision. Between 3rd April and 8th May 2019 Healthwatch Thurrock conducted two surveys to seek feedback from victims/survivors in Thurrock and also the professionals across the wider Thurrock workforce. Surveys were available both online and in paper format. A total of 211 responses were received (83 from victims/survivors and 128 from

	professionals). Where appropriate, these insights are included within the needs assessment.
Interviews with victims/survivors of SVA	In order to obtain deeper insights regarding victims/survivors experiences of SVA, a series of six interviews were conducted. The victims/survivors were asked questions regarding the impacts the SVA had on them and their friends and family, experiences of disclosure, thoughts on the support and services they received and their recommendations and suggestions for future provision. A series of six videos containing interview footage is included within this needs assessment. It is to be noted that all six victims/survivors had accessed specialist SVA services from SERICC. Unfortunately, attempts to recruit victims/survivors who had not accessed support from SERICC services were unsuccessful and therefore this needs assessment is lacking in-depth insights from local victims/survivors who have not accessed specialist support. This requires further exploration in the future.

The findings and understanding gained from the above has enabled a series of recommendations to be formed which are included throughout the needs assessment. Further to this, the findings have identified the requirement to develop a new vision for future service provision of sexual violence and abuse of which centres around the implementation of a new comprehensive, integrated approach to SVA in Thurrock.

Chapter 2: National Context and Legislative Framework

2.1 Legislative framework

There are two critical pieces of legislation governing the sex offence laws in the UK; the Sexual Offences Act 1956 and the Sexual Offences Act 2003 (England and Wales). The 2003 Act came into force on 1st May 2004 and applies to all offences committed on or after that date. The 1956 Act relates to cases where the offence took place before 1st May 2004 and remains relevant for some non-recent sexual violence and abuse cases. Key offences covered within the Acts include the following where the victim does not consent to the act and where the defendant "does not reasonably believe" that the victim has consented; rape, assault by penetration, sexual assault, causing sexual activity without consent. The age of consent in the UK is 16 and a child under the age of 13 cannot legally consent to any sexual activity and this is therefore classified as statutory rape.

2.2 National strategies and guidance

The Istanbul Convention is a comprehensive legal framework that sets out the minimum standards for countries to adhere to in combatting Violence Against Women and Girls (VAWG). It is described as the "gold standard" of legislation on gender-based violence and addresses sexual abuse as well as domestic violence, child marriage and Female Genital Mutilation. Countries that incorporate the treaty commit to ensuring survivors of these crimes can have access to specialist support services and refuges, monitoring data about gender-based violence and having age-appropriate education at schools. The UK signed the convention in 2012 however are yet to ratify it. A 2014 Home Office report stated the UK "will only take steps towards ratification when we are absolutely satisfied that the UK complies with all articles of the Convention".[7]

In 2016 the Home Office issued a National Statement of Expectations regarding Violence Against Women & Girls, which was updated in 2019. The statement sets out what local areas need to put in place in order to ensure their response to sexual violence and abuse (as well as other gender-based violence issues) is as collaborative, robust and effective as it can be so that all victims and survivors can get the help they need (Home Office, 2016). Within this, there are 5 key expectations in regards to local strategies and services:

1. Put the victim at the centre of the strategy
2. Have a clear focus on perpetrators in order to keep victims safe
3. Take a strategic, system-wide approach to commissioning acknowledging the gendered nature of VAWG
4. Are locally-led and safeguard individuals at every point
5. Increase local knowledge of the issues and involve, engage and empower communities to seek, design and deliver solutions to prevent VAWG.

The Ministry of Justice's (MOJ) Victims Strategy (2018) details commitments to support survivors of all crimes including those of a sexual nature. The strategy describes a commitment to increase the availability of services through more joined up and sustainable funding by; working across Government to better align funding for services that support victims/survivors, reviewing effectiveness and increasing and

improving the support for victims/survivors. Plans to achieve this include improving the services and pathways for victims and survivors who seek support from Sexual Assault Referral Centres (SARCs), ensuring better integration between statutory and third sector services in order to provide joined-up and life-long care and support, funding rape services for a minimum of two years and exploring further local commissioning of services to Police and Fire Crime Commissioner (PFCC) to improve support at a local level. The MOJ will also develop commissioning guidance and work with the Association of Police and Crime Commissioners to improve best practice sharing in order to ensure commissioned services meet the specialist needs of sexual violence and exploitation victims.

The NHS (National Health Service) Long Term Plan supports the justice system to provide healthcare support to victims and survivors of sexual assault through the 47 statutory Sexual Assault Referral Centres (SARCs) across England and various other NHS services. The Plan also indicates intentions to expand provision to ensure survivors of sexual assault are offered integrated therapeutic mental health support, both immediately after an incident and to provide continuity of care where needed. New services will be developed for children who have complex needs that are not currently being met; including a number of children who have been subject to sexual assault but who are not reaching the attention of SARCs.

The NHS Strategic Direction for Sexual Assault and Abuse Services outlines how services for victims and survivors of sexual assault and abuse in all settings of the health and care system must evolve between now and 2023. If successfully delivered, it is believed that there will be better health outcomes for victims and survivors, greater value for money and a reduction in: emergency department attendances, GP visits and recidivism of survivors as offenders (both non-sexual and sexual offending). This strategy has been backed by investment from the NHS of £4million per year until 2020/21. The 5 year strategy sets out six core priorities that NHS England will focus on to reduce inequalities experienced, as demonstrated in Figure 1 below.

Figure 1: Six core principles of the NHS Strategic Direction for Sexual Assault and Abuse Services

2.3 Safeguarding responsibilities

Safeguarding is a term used to denote measures to protect the health, wellbeing and human rights of individuals, which allow people, especially children, young people and vulnerable adults, to live free from abuse, harm and neglect. Safeguarding is recognised as the most effective way to protect children, young people and vulnerable adults against any form of abuse and neglect, including sexual violence and abuse.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect, and outlines local authorities' safeguarding duties. They have the opportunity to intervene early and direct the victim/survivor to the most appropriate statutory and non-statutory services.

The Children's Act 2004 places a statutory duty on all agencies to ensure they have processes in place to safeguard and promote the welfare of children and young people. Health and Social Care professionals have a responsibility to safeguard those known to be vulnerable and those who are placed in the care of others. Measures should be in place to safeguard those who require it and ensure suspicions of SVA are investigated and acted upon where appropriate. If such measures are not in place or acted upon, the risks of SVA become higher. In particular, the risks of re-victimisation and re-traumatisation becomes greater, to the detriment of victim/survivors health and wellbeing.

2.4 Commissioning responsibilities

A range of statutory bodies have responsibility for commissioning local and national services to support victims and survivors of sexual violence and abuse (as detailed below).[8] At the national level, these include the Ministry of Justice, Home Office, the Department of Health and Social Care, and NHS England. Locally, Clinical Commissioning Groups (CCGs), Police and Crime Commissioners (PCCs) and Local Authorities all have a responsibility to ensure access to services.

Figure 2: Commissioning Responsibilities

NHS England

- Sexual Assault Referral Centres (SARCs) – responsible for forensic medical examinations, medical care/support and follow up services in SARCs with Police and Crime Commissioners/Police
- Child and Adolescent Mental Health Services Tier 4 (CAMHS Tier 4)
- Contraception provided as an additional service under the GP contract
- HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE)
- Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and patient-requested testing by GPs
- Sexual health elements of prison and Immigration Removal Centre health services
- Cervical screening
- Specialist foetal medicine services

Clinical Commissioning Group (CCG)

- Mental Health and Improving Access to Psychological Therapies (IAPT); services for depression and Post-Traumatic Stress Disorder (PTSD) that understand the specific needs of the victims and survivors of sexual assault and abuse, including the third sector
- Most abortion services
- Sterilisation
- Vasectomy
- Non-sexual health elements of psychosexual health services
- Gynaecology, including any use of contraception for non-contraceptive purposes
- Secondary care services, including A&E
- NHS 111
- Sexual health services for children and young people including paediatric care/ support
- Specialist voluntary sector services (in some areas)
- Ambulance/blue light services

Police and Fire Crime Commission (PFCC)

- Specific commissioning responsibilities for victims, including victims of sexual assault and abuse
- Specialist voluntary sector services
- (In some forces, the PFCC lead on the procurement of SARC services)

Local Authority

- Comprehensive sexual health services, including most contraceptive services and all prescribing costs (excludes additional services commissioned from primary care)
- STI testing and treatment, chlamydia screening and HIV testing
- Specialist sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention sexual health promotion and services in schools, colleges and pharmacies
- Specialist voluntary sector services

Ministry of Justice

- National Male Survivor Helpline
- Rape support services with dedicated emotional and practical support services for victims of rape and other forms of sexual abuse aged 13 or over

Home Office

- National Services for victims of child sexual abuse

Chapter 3: Incidence and prevalence of Sexual Violence and Abuse

3.1 National prevalence

Figures for the true prevalence of SVA crimes are difficult to establish, particularly those relating to children and young people. The Crime Survey for England and Wales (CSEW) has been used to provide a robust estimate* of the prevalence of crime since 1981. The survey asks people aged 16-59 living in households in England and Wales about their experiences of crime in the last 12 months. It is to be noted that sexual assaults of those under 16 are not captured within the CSEW. This survey is the preferred measure of trends in the prevalence of sexual assault since this is unaffected by changes in police activity, recording practices and propensity of victims to report such crimes. Sexual assaults measured by the CSEW cover rape or assault by penetration (including attempts), and indecent exposure or unwanted touching and are measured as part of the self-completion module on domestic abuse, sexual assault and stalking.

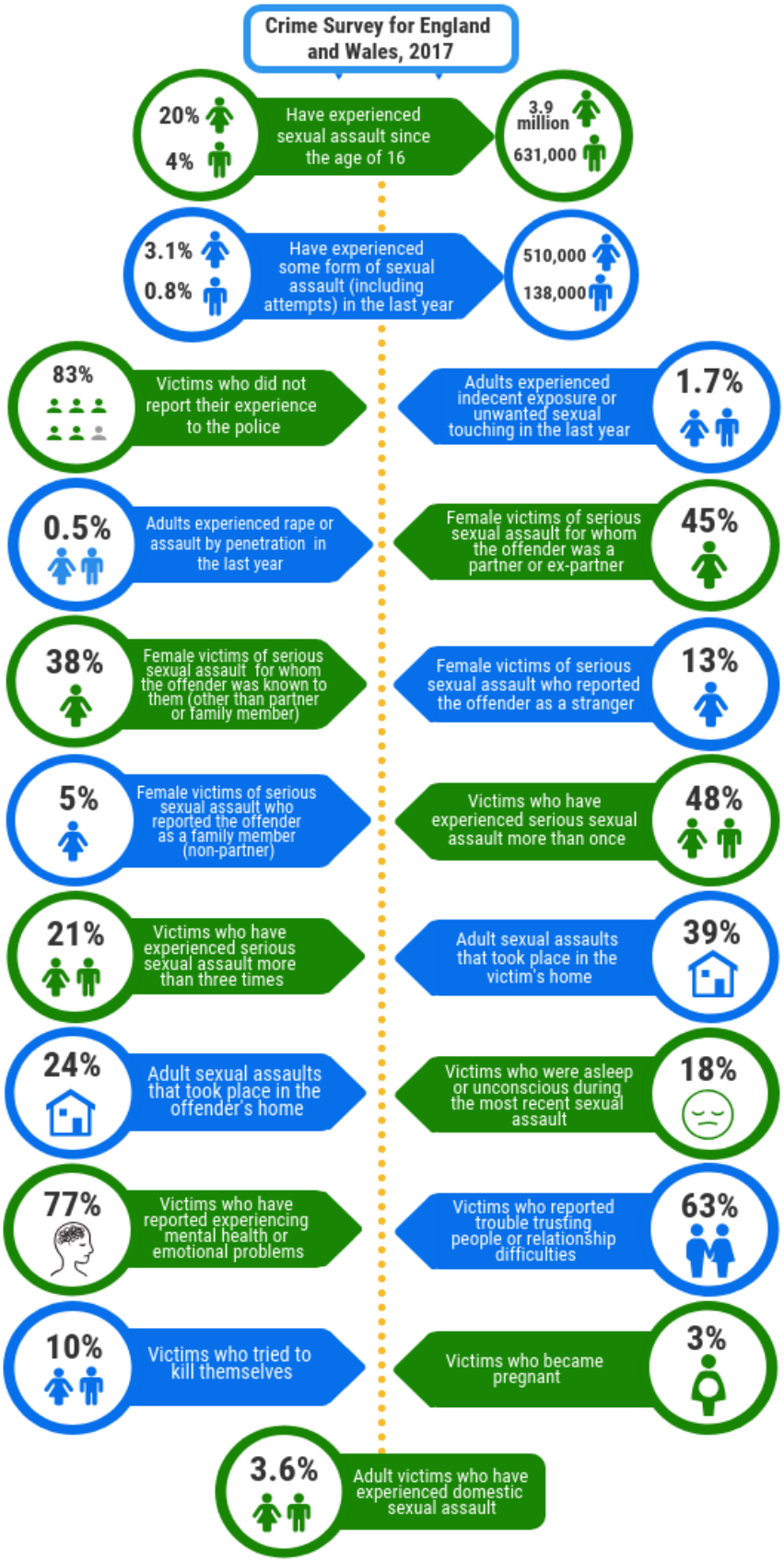
The CSEW estimates that 3.1% of women (510,000) and 0.8% of men (138,000) aged 16 to 59 experienced sexual assault in the last year, and 20% of women and 4% of men have experienced some type of sexual assault since the age of 16, equivalent to an estimated 3.4 million female victims and 631,000 male victims.

It is important to note that the term “sexual assault” in police recorded crime refers to one type of sexual offence, that is, the sexual touching of a person without their consent. This definition differs from the CSEW term of “sexual assault” which is used to describe all types of sexual offences measured by the survey. For this reason, police recorded crime figures are not directly comparable to the CSEW given the broader range of sexual offences covered within police recorded crime (e.g. child sexual exploitation and grooming).

Key findings from the most recent, year ending 2017 CSEW, are summarised in Figure 3 below and have been modelled to the Thurrock population in Figure 7.

* All changes reported, based on the CSEW, are statistically significant at the 5% level unless stated otherwise

Figure 3: Key findings from the CSEW (2017)

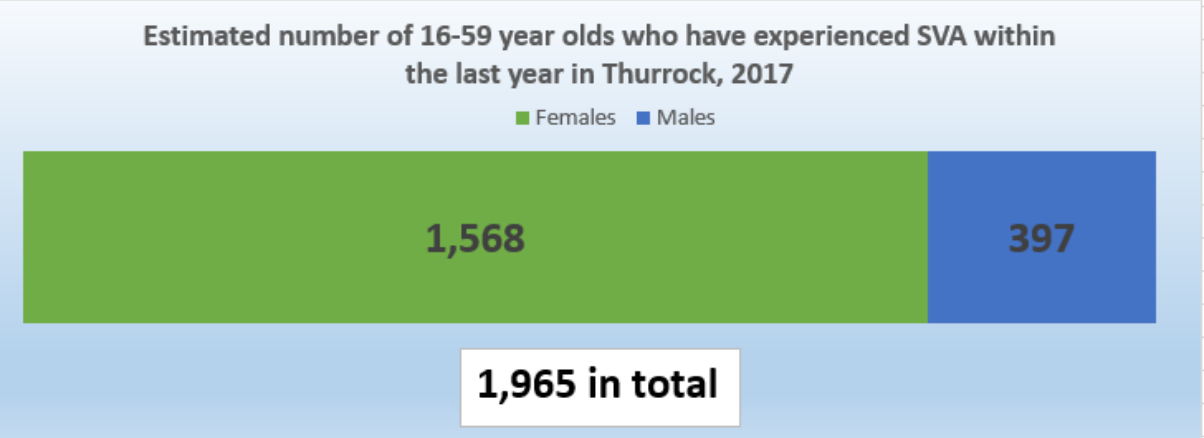


3.2 Estimated local incidence and prevalence

Applying the CSEW prevalence estimates (Figure 3) to the local population of Thurrock shows we are likely to have approximately **12,101** people aged 16-59 who have experienced sexual assault since the age of 16 and **1,965** people who have experienced sexual assault in the last year. We can break these down by gender as below:

Figure 4: Estimated number of Thurrock survivors who experienced SVA since the age of 16

Figure 5: Estimated number of Thurrock survivors who experienced SVA in the last year

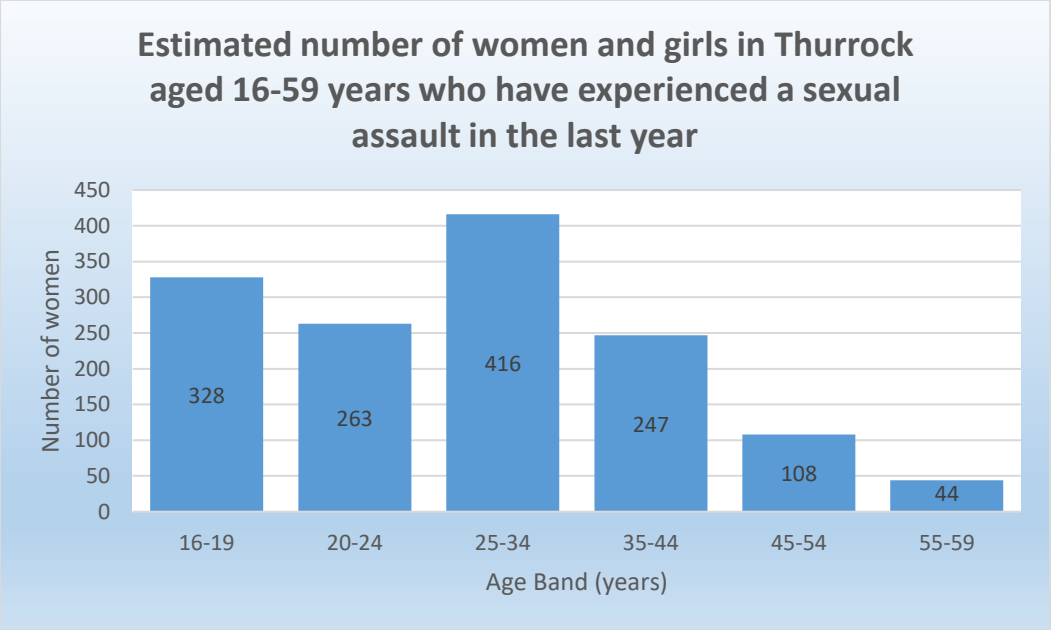


The above estimates are to be used with caution as they only include individuals aged 16-59 years old; however the number of victims/survivors in the 0-15 and 60 and over categories can be estimated using the crime data reported to Essex Police. Police data from 2018 shows that there were a total of 128 reports to the police amongst those aged 0-15 and 60+.[∇] Assuming that this number accounts for 17% of the actual SVA crimes it can be estimated that the actual number of victims/survivors in these age groups is likely to be around 753 and i**t is therefore estimated that the number of Thurrock residents who experienced sexual violence and abuse within the last year is approximately 2,718.**

[∇] In 2018 a total of 128 sexual offences were reported to the Police; 121 were aged 15 and under (F:99 and M:22) and 6 were aged 60 and over, all female.

The *Violence Against Women and Girls Ready Reckoner* tool allows us to apply age-specific prevalence estimates to our local population of females. Figure 6 below depicts the estimated number of women and girls in Thurrock likely to have experienced a sexual assault in the last year by age group. It can be seen that 591 of the victims were aged 16-24 years, equating to roughly 42% of the total estimated number of victims in Thurrock, or a prevalence rate of around 7.2% in that age group. Information about age-specific presence of SVA known to Thurrock professionals is shown in section 7.2.

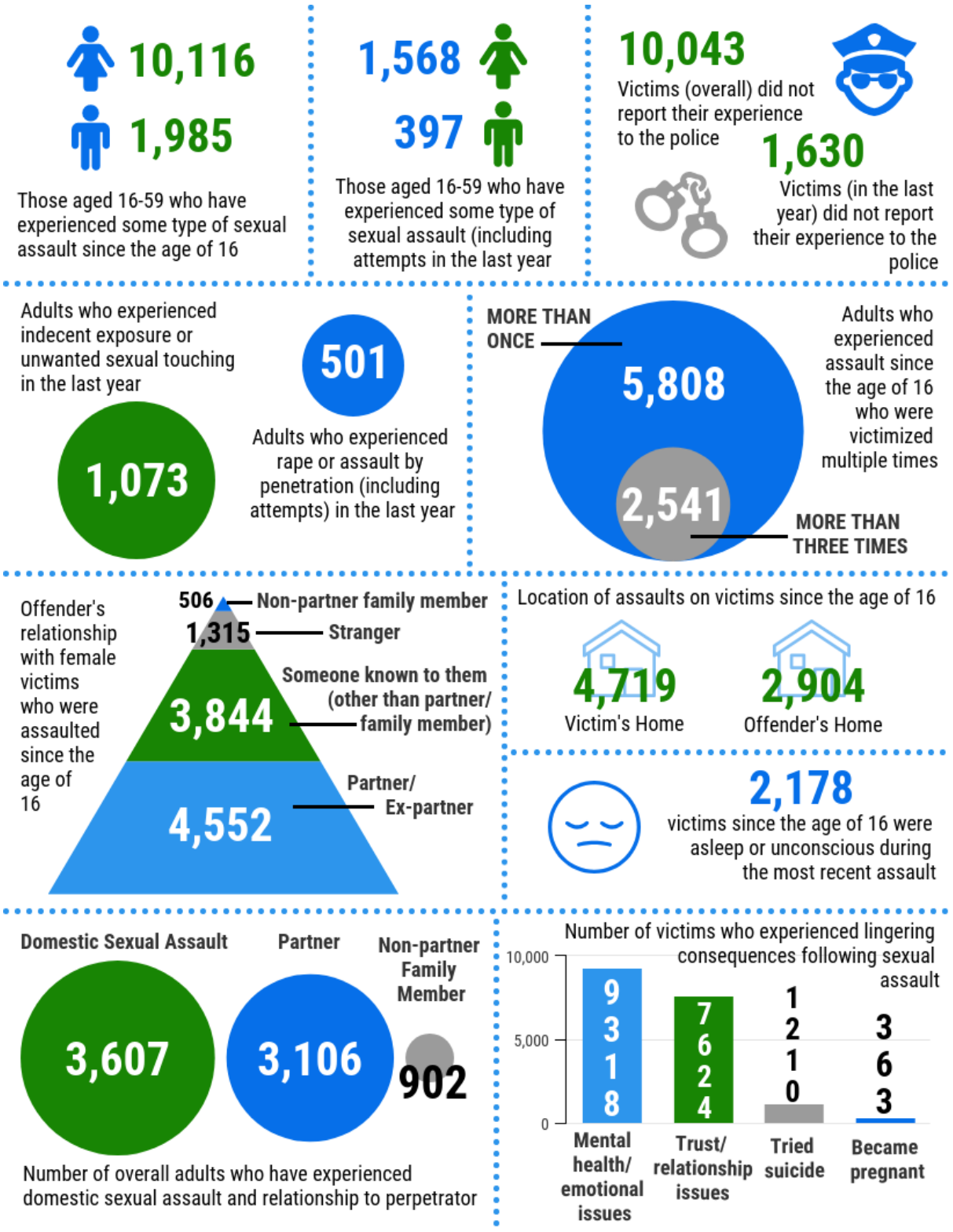
Figure 6: Number of Thurrock women and girls who experienced sexual assault in the last year



Source: VAWG Ready Reckoner and ONS Mid-Year Population Estimates

The CSEW findings have been modelled to the Thurrock population in Figure 7 below.

Figure 7: Crime survey for England and Wales findings modelled to the Thurrock population


10,116
1,985
Those aged 16-59 who have experienced some type of sexual assault since the age of 16
1,568
397
Those aged 16-59 who have experienced some type of sexual assault (including attempts in the last year
10,043
Victims (overall) did not report their experience to the police
1,630
Victims (in the last year) did not report their experience to the police
Adults who experienced indecent exposure or unwanted sexual touching in the last year
1,073
501
Adults who experienced rape or assault by penetration (including attempts) in the last year
MORE THAN ONCE
5,808
2,541
MORE THAN THREE TIMES
Adults who experienced assault since the age of 16 who were victimized multiple times
Offender's relationship with female victims who were assaulted since the age of 16
506 Non-partner family member
1,315 Stranger
3,844 Someone known to them (other than partner/ family member)
4,552 Partner/ Ex-partner
Location of assaults on victims since the age of 16
4,719
Victim's Home
2,904
Offender's Home
2,178
victims since the age of 16 were asleep or unconscious during the most recent assault
Domestic Sexual Assault
Partner
Non-partner Family Member
3,607
3,106
902
Number of overall adults who have experienced domestic sexual assault and relationship to perpetrator
Number of victims who experienced lingering consequences following sexual assault
10,000
5,000
0
9318
7624
1210
363
Mental health/ emotional issues
Trust/ relationship issues
Tried suicide
Became pregnant

3.3 Implications of local data

These local figures modelled from the CSEW provide a bit more insight into the experiences our survivors might have had. Some of the key inferences for us locally are listed below:

- In excess of 10,000 victims/survivors who have experienced SVA in their adult life have not reported it to the Police. Whilst it is not possible to say for certain that these survivors would not have access to support to help them cope and recover from the effects of SVA, these may have been missed opportunities to offer appropriate support services at the earliest opportunity.

- 4,719 of victims/survivors who were assaulted since the age of 16 were assaulted in their own home. This is of importance as it highlights that the majority of perpetrators of SVA are known to the victim/survivor, contrary to the 'stranger danger' myth that is often associated with sexual assault. This may also be linked to a higher incidence of repeated assaults or abuse as the victim/survivor and perpetrator are likely to have repeated contact.

- Over 9,300 victims/survivors have experienced mental health/emotional issues following their sexual assault which may have significant impacts on their personal lives and also pressure on the health sector, as described in sections 4.5 and 4.6.

- Of the adults who experienced sexual assault since the age of 16; over 5,800 were assaulted more than once, and of which over 2,500 were assaulted more than three times. This may indicate missed opportunities for disclosure, help seeking and prevention of further assault or abuse.

Although the CSEW modelling to the Thurrock population provided in Figure 7 provides some estimations as to the number of Thurrock victims/survivors who may experience negative impacts following their experience of SVA, the local data available did not allow us to fully understand the impacts and lingering consequences for victims/survivors and also local services, including but not exclusive to; mental health provision, sexual and reproductive health, termination of pregnancy, education, Social Care, benefits and housing support.

3.4 Barriers to determining accurate local data

3.4.1 Data recording

During the development of this needs assessment, inconsistencies were noted in the recording of data related to sexual violence and abuse across a number of organisations in Thurrock. It was only the Police and specialist sexual violence and abuse services that were able to provide robust data that contributed to our understanding of known sexual violence and abuse locally.
The following matters in particular were identified:

- Information is often lost within a patient/service user's case notes, particularly within free text boxes (this was particularly apparent within Social Care notes)

- Certain databases/systems (particularly within General Practice and hospital settings) are only able to record one primary need at a time and often this is recorded as the presenting symptom and not the cause (e.g. bruises and not sexual assault)

- Staff are not aware of the codes that can be used to record SVA and therefore these are not being utilised, particularly in health settings

- Organisations are only able to record information that the patient/service user discloses or is willing to share.

- Some organisations also mentioned specific concerns regarding their patients/ service users not reporting their experience of SVA or not recognising that they had been a victim of SVA and therefore this is left unreported.

3.4.2 Data sharing

It was also identified that data related to sexual violence and abuse is seldom shared locally. Data sharing arrangements, whether formal or informal, are not consistent amongst organisations in Thurrock. However, a particular example of good practice identified locally is the Memorandum of Understanding (MoU) that has been developed at a county-wide level in order to set out the joint co-operation between residential and foster care providers and police, as supported by the Southend, Essex and Thurrock (SET) Local Authorities. The MoU seeks to improve the quality and timeliness of information sharing between carers and providers with Essex Police relating to children at risk of going missing from care, being trafficked, who are gang associated and at risk, or who have been and / or are victims of CSE. The expected outcome is that with prior shared key child-level information, the location and safeguarding of missing children will be expedited. Compliance with the MoU is due to be reflected in the revised SET Child Protection Procedures and Providers will be subjected to checks to ensure that requirements contained in the MoU are complied with.

3.4.3 Recommendations to address known issues with data collection

It is imperative that we improve local data collection in order to further our understanding of SVA locally. For this to be possible, the following recommendations are suggested:

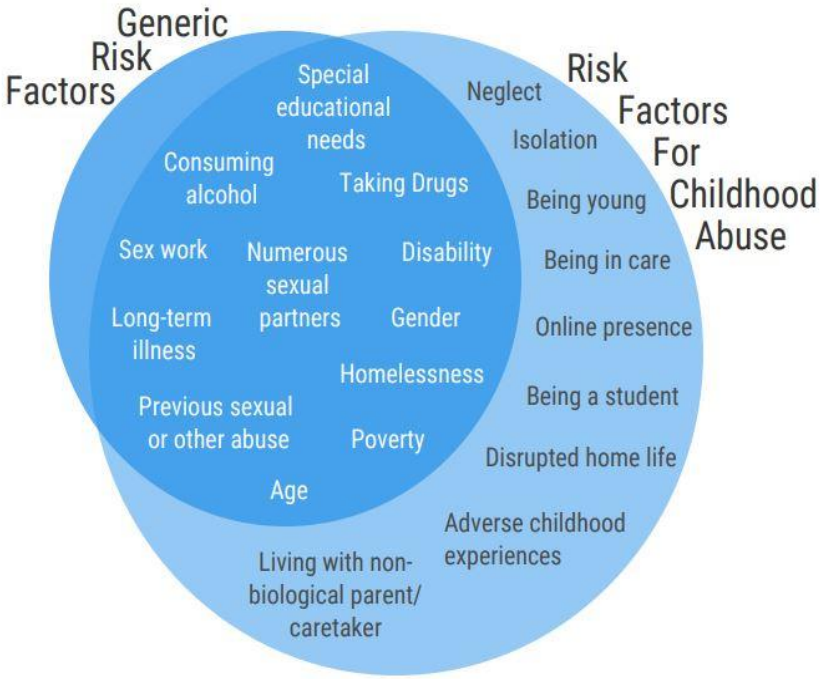
Issue Identified	Recommendation to address this	Responsibility
Recommendations around improving data		
Locally there are low levels of reporting of SVA crimes to the Police. Although this is observed nationally, the Thurrock rates are lower than comparable authorities (see chapter 7 for further information)	The Essex Sexual Abuse Strategic Partnership should commission dedicated SVA campaign work s in order to increase public confidence in reporting crimes, which in turn should reinforce positive outcome messaging.	Essex Sexual Abuse Strategic Partnership (working with Essex Police and Crown Prosecution Service)
Data collection mechanisms are not currently set up to enable identification of the number of survivors accessing all agencies in Thurrock	Non-specialist SVA organisations (e.g. sexual health, mental health, drug and alcohol services) should embed questions related to SVA in to their relevant templates/assessments in order to improve identification of SVA survivors.	All relevant non-specialist SVA organisations, to be determined and overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership
The systems/ databases/ datasets used by some organisations locally are not appropriately set up to record SVA related information.	Relevant agencies including General Practice, hospitals, sexual health, mental health provider NHS trusts, drug and alcohol treatment services, and domestic abuse services should develop a single, consistent recording protocol in order to facilitate disclosures and identify SVA survivors. This protocol should include: - the use of mandatory questions - appropriate datasets - appropriate coding/categories - minimising opportunities for SVA to be lost within free text sections of case notes. For health settings, this may be most effective at a Mid & South Essex STP (Sustainability and Transformation Partnership) approach considering the shared resources i.e. hospitals, Police force, Single Point of Access for Rape Crisis Centres).	To be overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership with support from relevant organisations
Due to inconsistent data capturing across organisations, it is difficult to identify victims/survivors use of services and their pathways between services (e.g. at what point they access support, type and frequency of support received, the duration support was received for)	The Thurrock SVA Stakeholder Partnership should undertake baseline mapping activity to identify current data recording practices within each agency around service usage in order to make adaptations to reporting requirements and data collection.	Thurrock Sexual Violence & Abuse Stakeholder Partnership

Chapter 4: Risk factors for, and impact of SV and abuse

4.1 Risk factors

Any child or adult can be a victim of sexual violence or abuse; however it is recognised that sexual violence and abuse crimes tend to disproportionately affect the most vulnerable in society. There are a range of personal and environmental factors that make certain individuals more susceptible to SVA. The vast majority of risk factors are relevant to both children and adults however some may be more applicable to certain age groups, as demonstrated in Figure 8 below.

Figure 8: Risk factors for SVA[9]



Perpetrators of sexual violence and abuse offences may target children who don't have many friends or lack attentive parents as this can facilitate access and manipulation, however, those who are not vulnerable and have attentive parents can also become victims. It is well recognised that the internet and social media are places where children can be met, sexually groomed and persuaded to provide sexual imagery.[10]

Gender

Risk factors vary depending on gender.[11] Girls are at greater risk of being sexually abused by a family member and women are at greater risk if they have low educational attainment or were exposed to their mother being abused by a partner.[12] Young boys are at greater risk of sexual abuse from strangers, institutional and clergy abuse as children, and prison-based sexual violence as adults.[13] The World Health Organisation (WHO) recognise being married or co-habiting as a risk factor, however the Office of National Statistics (ONS) cite being single a risk factor, indicating further insight is required to understand the nature of relationship in sexual assault.

Age

Age is also an important factor, with girls aged between 15 and 17 years reporting the highest rates of sexual abuse in the UK.[14] Children aged 12-15 are most at risk of child sexual exploitation although victims as young as 8 have been identified, particularly in relation to online concerns.[15] While some victims/survivors who were sexually groomed as children continue to be sexually abused as adults, others who are vulnerable can also be open to exploitation and sexual abuse starting in adulthood, particularly as young adults. This is often as a result of heightened vulnerability, although not always.

Vulnerabilities

A review on the prevalence and risk of violence against children with disabilities, published in July 2012, found that overall children with disabilities are 2.9 times more likely to be victims of sexual violence than non-disabled children. Children with mental or intellectual impairments appear to be among the most vulnerable, with 4.6 times the risk of sexual violence compared to their non-disabled peers.[16]

Adults with disabilities are at a higher risk of all types of violence than are non-disabled adults, and those with mental illnesses could be particularly vulnerable. This finding is generally applied to sexual violence, however, there is a lack of robust evidence about specific types of violence. A review and meta-analysis found the risk of violence in disabled adults was 1.5 times higher than non-disabled individuals, 1.31 times higher for people with non-specific impairments, 1.6 times higher for people with intellectual impairments, and 3.86 times higher for those with mental illnesses.[17]

Factors which place people with disabilities at higher risk of violence include stigma, discrimination, and ignorance about disability, as well as a lack of social support for those who care for them. Placement of people with disabilities in institutions also increases their vulnerability to violence. In these settings and elsewhere, people with communication impairments are hampered in their ability to disclose abusive experiences.[18]

In addition to this, young or disabled children and adults may find it harder to protect themselves, to tell somebody what's happening or seek help, or to even recognise they are being sexually abused. They may also have fewer, if any, opportunities to disclose, particularly if they are socially isolated or have none or limited opportunities to see health or social care professionals without the abuser present. It is to be recognised that a range of other vulnerabilities also exist, e.g. working in the sex industry, mental health and self-harm and this is not an exhaustive list.

4.2 Associated links with SVA

There are links between SVA and other forms of abuse and criminal activity, including but not limited to those described below:

Domestic Violence

There is evidence suggesting the presence of physical abuse increases the likelihood of sexual violence and general domestic violence (all violence within the family setting) increases the likelihood of child sexual abuse in the home.[19] In the year ending March 2018, the Crime Survey for England and Wales (CSEW) estimated that 2 million adults aged 16-59 experienced domestic abuse, equating to a prevalence rate of

approximately 6 in 100 adults. Women were around twice as likely as men to have experienced domestic violence (7.9% compared with 4.2%) equivalent to 1.3 million female victims and 695,000 males. This measure of domestic abuse combines partner abuse (non-sexual), family abuse (non-sexual) and sexual assault or stalking carried out by a current or former partner or other family member and do not take into account the context and impact of the abusive behaviours experienced. Domestic sexual assault was experienced by 0.3% of adults aged 15-69 in the last year; 0.2% of adults had experienced sexual assault by a partner and 0.1% had experienced sexual assault by a family member. Evidence suggests that different types of violence may occur simultaneously in the same family, and that the presence of one form of violence may be a strong predictor of the other.[20]

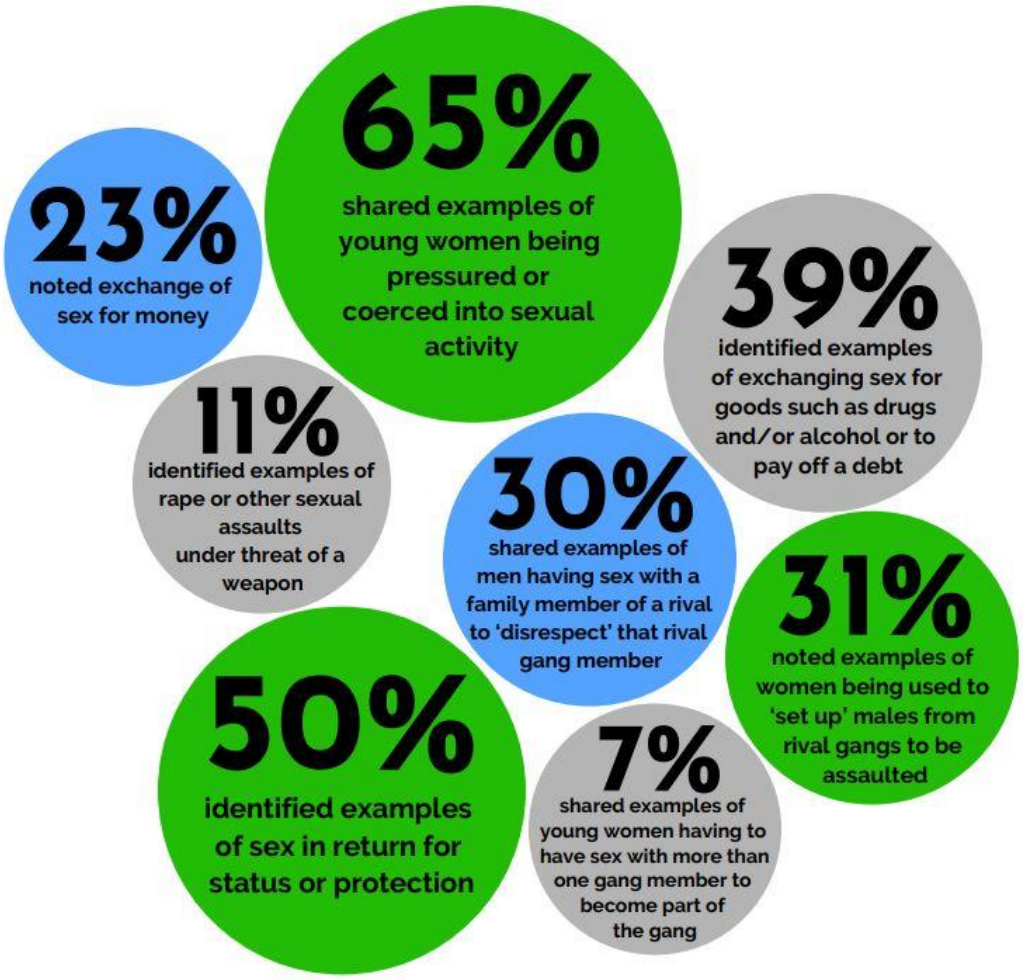
Substance Misuse

There is a strong link with drug and/or alcohol consumption and SVA crimes as they can be used to facilitate or make an individual more vulnerable to sexual assault/violence/abuse. Alcohol is the most common substance used to facilitate sexual assault with approximately half of all reported sexual assaults involving alcohol consumption by the perpetrator, the victim/survivor or both.[21] Drugs (including 'date-rape' drugs) may be used surreptitiously by perpetrators to facilitate sexual assaults but more frequently a victim's own willing substance use is exploited. In both situations, the role of drugs/alcohol is to increase a victim's vulnerability to sexual assault by impairing their ability to consent. The stress and trauma of sexual violence or abuse can lead victim/survivors to self-medicate with drugs and/or alcohol leading to addiction or dependence. Unfortunately, this particular coping mechanism puts victim/survivors at higher risk of re-victimisation and disadvantages them further within society with the double stigmas of sexual victimisation and substance user.[22]

Gangs

The significant problem of sexual violence within organised gangs is both part of the power structure within gang culture as well as a reflection of sexual violence that occurs in wider society but is further amplified by the hyper-masculine gang environment. Young women are particularly vulnerable to gang-associated sexual violence and exploitation. A 2013 research study by the University of Bedfordshire [23] explored the links between sexual violence and abuse and gang activity amongst 188 young people. Key findings are presented in Figure 9 below.

Figure 9: Key findings from research regarding Gangs and SVA



It is to be noted that wording used within this infographic is that used by the researchers and respondents within the study. In the majority of these cases, the law may define these incidents as rape or sexual assault as consent was not freely given.

There is likely sexual violence used against both males and females in gangs, however there is a lack of evidence to support this due to associated stigma and lack of reporting. While the sexual violence within gang settings is horrific, incidents are often not reported and they are somewhat normalised amongst those who live day-to-day with gangs. There is also a high level of fear of retribution for reporting an incident and an overall lack of confidence that services can/will do anything to help or protect victims.

Trafficking/Sex Trafficking

In the UK, human trafficking falls under the term Modern Slavery and is defined within the Modern Slavery Act 2015. These crimes include holding a person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after. Human trafficking is often thought of as an international crime, but it is also possible to be trafficked within a country, the UK included. Trafficking is normally more prevalent among the most vulnerable or within minority or socially excluded groups. Poverty, limited opportunities at home, lack of education, unstable social and political conditions, economic imbalances and war are

some of the key drivers that contribute to someone's vulnerability in becoming a victim of trafficking.[24] Trafficking for the purpose of sexual exploitation and child sexual exploitation has seen 4.8 million people worldwide forced into sex work with 99% of these being women and girls, though men and boys can also be victims.[25] Sexual exploitation involves any non-consensual or abusive sexual acts performed without a victim's permission; this includes prostitution, escort work and pornography. Many victims are deceived with promises of a better life and then controlled through violence and abuse. Sexual abuse can be used by traffickers as a way of grooming and entrapping both adults and children into trafficking by convincing them they are in a genuine loving relationship or else it can be used as a way to subdue and control victims.[26]

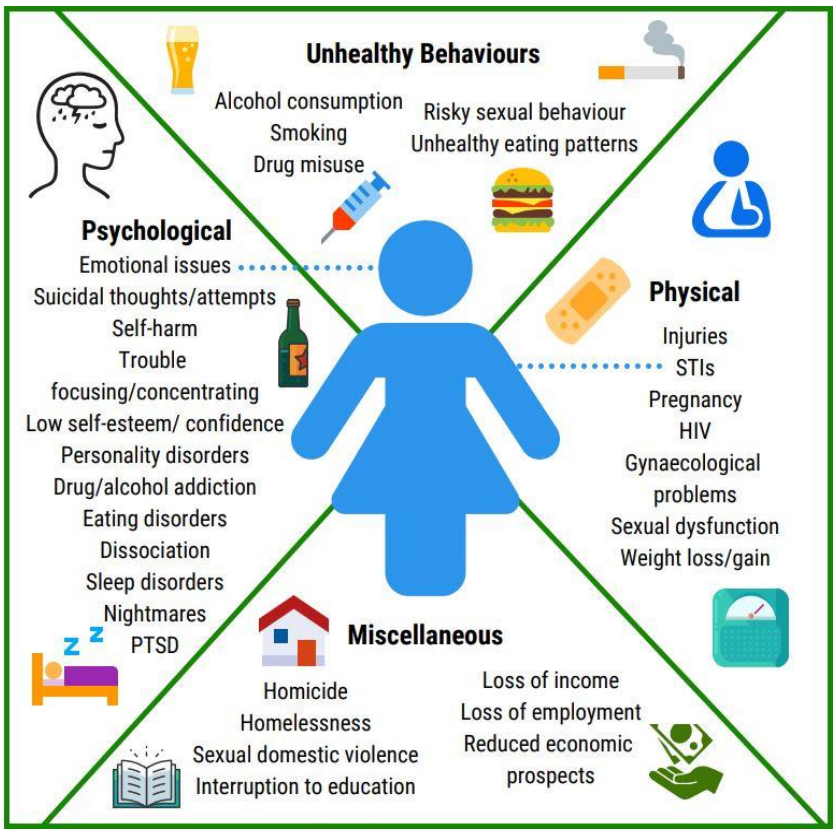
4.3 Impacts of sexual violence and abuse

For victims/survivors, these crimes represent a violation and can have significant and ongoing consequences for health and wellbeing. As a direct result of the trauma, survivors of sexual violence and abuse may suffer from a variety of physical, mental, behavioural and relationship impacts (see Figure 10 for examples) in the short, medium and long term, even over a lifetime.[27] Many victims/survivors of sexual violence or abuse cope with this trauma by using drugs, drinking alcohol, smoking, or overeating. Research shows that about 90% of women with substance use problems had experienced physical or sexual violence.[28]

Adults with a history of CSA are more likely than the general population to experience physical health problems including diabetes, gastrointestinal problems, arthritis, headaches, gynaecological problems, stroke, hepatitis and heart disease.[29] It has been suggested that these poorer outcomes are due to the impact that early life stress has on the immune system or to the greater propensity for adult CSA victims/survivors to engage in high-risk behaviours e.g. smoking, alcohol abuse and risky sexual behaviours.[30]

Impacts vary from person to person and present in different ways for different individuals. Both men and women suffer from the common adverse effects and there is no difference in the severity of effects. However, male victims of sexual violence and abuse can be more confused about their sexual orientation following sexual abuse because their perpetrators are predominantly men. Women and girls experience a general 'fear' of men, which also has an impact on their intimate relationships. For women and girls who are subject to inequalities of race, class, poverty and/or are part of a particular monitoring group (e.g. traveller or migrant communities) these issues can be compounded by multiple, intersecting inequalities.[31]

Figure 10: Impacts of SVA on victims/survivors32



4.3.1 Impacts on adults who were sexually abused as children (Adult survivors)

The effects of Child Sexual Abuse (CSA) are not always obvious during either childhood or in adulthood. The Independent Inquiry into Child Sexual Abuse (IICSA) runs the Truth Project. Research from the Truth Project revealed that victims of CSA carry their experiences in to adulthood, though there is variation between individuals both in terms of when problems emerge as well as what those difficulties are.[33] Not all survivors of sexual abuse show poor outcomes as adults; however it is associated with increased risk of anxiety disorders, depression, eating disorders, Post-Traumatic Stress Disorder (PTSD), sleep disorders and suicide attempts (see further information in section 4.3.2).

CSA can also lead some victims/survivors to be particularly protective of their loved ones, particularly children and grandchildren.[34] Many factors can influence whether a victim/survivor will show problems in later life and include; the age of the victim at the time, the type, frequency and duration of the abuse and the relationship with the perpetrator.[35]

4.3.2 Impacts on mental health

Experiences of sexual violence and/or abuse can be deeply traumatic and victims/ survivors are at greater risk of a variety of short and long term mental health issues. The information in

Table 1 below, taken from the 2016 'Hidden Hurt' Report[36] unless otherwise stated, shows how much greater the likelihood of certain common mental health conditions are if someone has experienced sexual violence/abuse.

Table 1: Common mental health conditions in victims/survivors of SVA

Vulnerability	Prevalence (%) within SVA survivors
Common mental disorder (including depression and anxiety)	32%
Multiple (3+) mental disorders	10%
Post-traumatic stress disorder (PTSD)	16%
Borderline Personality Disorder	15.6% (mid-point of range)*
Self-harm (at least one attempt ever)	56%
Suicide attempts	10%
Substance misuse problems	38%
Eating disorders	3%
Financial crisis	12%
Homelessness (ever experienced)	6%

*Referenced in section below

Borderline Personality Disorder (BPD) and SVA

There is a lot of published research that indicates SVA is frequently present in patients with BPD. BPD is a mental disorder which seems to result from an interaction between biological and psychosocial factors, and is characterised by instability with emotional regulation, relationships with others, self-image and impulse control.[37] A review by de Aquino Ferreira et al. [38] found that the prevalence of CSA within BPD patients ranged from 16.1-85.7%, and that between 1.8-29.3% of CSA victims/survivors have BPD. Narrowing down the extent of the overlap is further complicated by the fact that **symptoms of BPD overlap with complex PTSD, which as above is also associated with SVA.** This study also found that the presence of SVA in a BPD patient was a predictor for increased severity of clinical presentation and poorer prognosis. In addition, the authors found that a BPD patient with a history of CSA was 10 times more likely to attempt suicide than a non-CSA BPD patient.

Inpatient admissions and SVA

A 2014 review by Quadrio[39] looked at a number of studies of those admitted to mental health inpatient units, and identified that a high proportion of them had experienced sexual abuse within their childhood. On average, half (50%) of female inpatients had experienced CSA and over a quarter (28%) of male inpatients had experienced CSA.

4.3.3 Impacts of SVA on relationships with family/friends

Research has found that positive social responses to disclosure of sexual violence and abuse are associated with better individual coping for victim/survivors while negative responses can cause “secondary trauma” and lead to more severe poor outcomes.[40] Anger, disbelief, victim blaming and even disownment can be reactions of family members, often when the abuse/assault was perpetrated by a relative or when the relatives knew the sexual abuse was taking place but failed to intervene. Victims/survivors may even be pressured to lie about the incidence of sexual abuse to protect the perpetrator. Negative responses to disclosure can have ripple effects for victims/survivors’ capacity for trust or self-worth in the future which can put them at risk for further sexual violence/abuse. CSA victims/survivors may also feel responsible for possible changes to family dynamics and the wellbeing of family members.

Disclosures may also disrupt friendship groups and cause difficult relationships with friends and peers that may result in bullying, isolation and loneliness.[41] Those with closer relationships to the victim/survivor (i.e. partners, family and close friends) are known to experience guilt and secondary trauma themselves, and in some cases and may not respond appropriately to a disclosure and may also require support themselves to cope with the knowledge of the SVA.[42] The mental health of parents/ carers can also be affected if they felt responsible for having been powerless and unable to protect their child.[43] Locally, survivors spoke of how their experiences of SVA impacted those around them with common responses including difficulties maintaining relationships with families, friends and partners and in some cases loss of relationships and difficulties parenting. Quotes are included below:

4.4 User voice on impact

Locally, victims/survivors spoke of how sexual violence and abuse impacted their lives. Most survivors reported multiple impacts which ranged amongst survivors, including impacts on their relationships (particularly the ability to form or maintain healthy relationships), various mental health issues, the ability to parent, ability to work, lack of ability to trust others and lack of sleep. Examples of the impacts experienced by local survivors are included below:

The video below provides accounts of the impacts of sexual violence and abuse on local victims/survivors.

4.5 Socioeconomic costs

The socioeconomic costs of sexual violence and abuse manifest as both tangible and intangible costs as well as direct and indirect costs. Tangible costs of SVA are taken to include direct costs such as:

- Medical care
- Physical health
- Sexual health
- Pregnancy
- Mental health services
- Housing/Refuge
- Administration costs
- Police investigations
- Criminal prosecutions
- Costs associated with the correctional system

Indirect costs may also occur through employee's loss of productivity and income and personal financial losses due to injury or inability to work.

Intangible costs are taken to include the psychological pain and suffering of victims/survivors, and a generalised, heightened fear of victimisation which may impact on ability to function normally and achieve aspirations. Many costs can stretch on for years following an incident. Adults with a history of abuse as a child, especially sexual abuse, are more likely than people with no history of abuse to become frequent users of GP, emergency and medical care services.[44]

Many of these costs were not available specifically for SVA survivors. However the table below looks to break down as many elements of the mental health service costs as possible and are shown as an annual estimated cost per person. The majority of these costs were taken from the Saied-Tessier (2014)[45] report unless otherwise stated.

Table 2: Yearly costs associated with CSA

Co-morbidity	Estimated annual service cost per survivor
Common mental disorder (including depression and anxiety)	£332
Multiple (3+) mental disorders	*Unable to quantify*
Post-traumatic stress disorder (PTSD)	£1,040
Borderline Personality Disorder	£14,909[46]
Self-harm attempts	£2,094
Suicide attempts	£2,094
Substance misuse problems	£454 (drug) - £920 (alcohol)
Eating disorders	£8,900 (inpatient admission)[47]

Given that these calculations are missing out large areas where direct and indirect costs may occur, we must assume these as extremely conservative estimates for potential economic impacts.

When considering potential costs to be avoided through better prevention of SVA or management of survivor needs, the other substantial 'cost' is the cost to one's emotional wellbeing following SVA. Human Impact, both emotional and physical, is the estimated equivalent price someone would pay to avoid the suffering caused by an incident of sexual violence, and therefore does not necessarily represent actual money paid. Research by Oliver et al. (2019)[48] estimates this figure to be **£62,180** per rape and **£10,561** per other type of assault.

4.6 Estimated socioeconomic cost of SVA in Thurrock

The tables below aim to apply both the estimated incidences of these other co-morbidities/vulnerabilities quantified above, and their approximate costs to the total number of SVA survivors in Thurrock, in order to begin to quantify the likely local impacts to wider services. It should be noted that these are conservative estimates, as survivors may not necessarily disclose associated conditions, and they may not be accessing treatment (or they may access privately-funded treatment). The first table applies the prevalence and cost estimates to the number of survivors estimated to have experienced SVA within the last year aged 16-59 years (1,965 people); and the

second table applies these to the total number of survivors who have ever experienced SVA aged 16-59 years (12,101 people).

Table 3: Estimated number of SVA survivors in Thurrock with specific vulnerabilities and annual cost of treating these (abused within the last year)

Symptom/mental health issue	Prevalence (%) within SVA survivors	Estimated number of survivors with this co-morbidity	Estimated annual treatment cost (assuming they all access NHS treatment)
Common mental disorder (including depression and anxiety)	32%	629	£208,828
Multiple (3+) mental disorders	10%	197	*Unable to quantify*
Post-traumatic stress disorder (PTSD)	16%	314	£326,560
Borderline Personality Disorder	15.6% (mid-point of range)	307	£4,577,063
Self-harm (at least one attempt ever)	56%	1,100	£2,303,400
Suicide attempts	10%	197	£412,518
Substance misuse problems	38%	747	£513,189
Eating disorders	3%	59	£524,655
Financial crisis	12%	236	-
Homelessness (ever experienced)	6%	118	-

Table 4: Estimated number of SVA survivors in Thurrock with specific vulnerabilities and annual cost of treating these (abused since the age of 16)

Symptom/mental health issue	Prevalence (%) within SVA survivors	Estimated number of survivors with this co-morbidity	Estimated annual treatment cost (assuming they all access NHS treatment)
Common mental disorder (including depression and anxiety)	32%	3,872	£1,285,504
Multiple (3+) mental disorders	10%	1,210	*Unable to quantify*
Post-traumatic stress disorder (PTSD)	16%	1,936	£2,013,440
Borderline Personality Disorder	15.6% (mid-point of range)	1,888	£28,148,192
Self-harm (at least one attempt ever)	56%	6,777	£14,191,038
Suicide attempts	10%	1,210	£2,533,740
Substance misuse problems	38%	4,598	£3,158,826
Eating disorders	3%	363	£3,230,967
Financial crisis	12%	1,452	-
Homelessness (ever experienced)	6%	726	-

The Thurrock data modelled from the CSEW in Figure 6 showed that over 9,300 victims/survivors have experienced mental health/emotional issues since their SVA incident/incidents. This indicates there are likely to be several thousand survivors who are experiencing mental ill-health but not at a diagnosable threshold to be counted in the figures above.

Chapter 5: Preventing Sexual Violence and Abuse

It is of paramount importance that we prevent sexual violence and abuse from happening at all. For victims and survivors of previous incidents we must also reduce the risk of future re-victimisation is central to their recovery, healing, ability to rebuild their lives and ongoing safety.

Although it is likely that prevention programmes will not eradicate sexual violence entirely, it may contribute to a reduction in sexual offences. In order to do so, we must challenge social norms, attitudes and behaviours and reduce the stigma that surrounds talking about sexual violence and abuse. This requires changing individual behaviours on a scale that produces a culture shift; to this end, there is evidence (laid out below) of effective interventions at different levels (universal prevention, targeted prevention for individual groups at risk, and interventions aimed at perpetrators). A multi-layer approach will ensure the broadest coverage for prevention and re-offending efforts.

Research in to the management of sex offenders in the UK has suggested that sexual offending should be reframed in a public health context around education as well as outreach and support for potential perpetrators, supporting current interventions and treatment programmes. [49] Such an approach should entail a coordinated range of multi-faceted interventions, especially given the estimated costs of sexual offences as detailed in sections 4.5 and 4.6. Three levels of a Public Health approach have been identified and are described below:[50]

- Primary prevention around education to recognise the signs of sexual abuse
- A secondary level of targeted prevention around help and education for individuals who could (potentially) commit a sexual offence with aim to prevent them from committing an offence in the future
- A tertiary level about the wider integration for offenders convicted of a sexual offence, which protects the public and reduces re-offending.

5.1 Evidence base

5.1.1 School-based Programmes

Interventions focused on relationships involve helping people understand the nature of healthy relationships and how they might ensure that themselves and others have safe and respectful interactions. They also empower people to look out for those around them. Healthy Relationships Programmes aim to educate, inform and challenge young people about healthy relationships, including abuse, consent and relationship abuse. Programmes also aim to build young people's awareness of known issues such as pornography, consent, sexual violence and abuse, harmful sexual behaviours and relationship abuse. Provision often varies between schools however this will be supported by the implementation of mandatory Relationships Education programmes in primary schools and Relationships and Sex Education programmes in secondary schools from September 2020.

5.1.2 Targeted prevention

It is important that prevention activities are also targeted at those who are displaying signs of unhealthy relationships and harmful sexual behaviours in order to deter them from going on to commit sexual offences. Such programmes aim to ensure these problems don't escalate and possibly lead to them being charged with a sexual offence

and aim to ensure no-one is unnecessarily referred to specialist services. Approaches used may include the use of CBT and multi-systematic therapy for problematic sexual behaviour. Recognised treatment resources or guided interventions include the AIM and AIM2 programmes, which provide a framework for information gathering along with a toolkit of interventions. Guidance from the National Institute for Health and Care Excellence (NICE) was published in 2016 regarding harmful sexual behaviour among children and young people.

5.1.3 Prevention aimed at perpetrators/offenders

Individuals convicted of a sexual offence and given a custodial sentence undertake a risk assessment process in order to determine their eligibility for any prison programme to be completed as part of their sentence. Programmes known as Sex Offender Group work Programmes may also be undertaken through probation and may form part of a community sentence or as a condition of a prison license. A number of offender treatment programmes were available for those convicted of sexual offences, including; the Core Sex Offender Treatment Programme (Core SOTP), and the Healthy Sex Programme. Studies have explored the effectiveness of sex offender programmes, with some evidence suggesting that individuals who received treatment having lower reconviction rates than those who do not.[51] Research also indicates that CBT is the most effective method of treatment compared to counselling or non-behavioural treatment[52].

5.2 Local provision

Relationships and Sex Education

Thurrock Council's Public Health Department commission Brook to support schools deliver the Relationships and Sex Education curriculum. This offer includes the delivery of classroom based targeted education sessions, drops in and teacher training delivered in secondary schools. Topics relevant to the sexual violence and abuse agenda include; healthy relationships, self-esteem, sexuality and porn pressure and consent. In the 2018/19 academic year, these sessions were delivered to approximately 575 students.

The Good Man

The Good Man Project is a male-mentoring programme (The Good Man Project) delivered by the Essex County Council Youth Services. This is a 5-week programme that can be delivered in a group or one-to-one, for young men aged 13-18 who are at risk of entering into abusive relationships. The programme aims to educate participants to show respect in relationships, and what differentiates a healthy relationship from an unhealthy one. Since 1st April 2019, 14 referrals for one-to-one support have been received from Thurrock agencies, with 5 of those currently still waiting for support. Group work is underway in four of our secondary schools over the course of this academic year, and schools have been incredibly supportive with this.

Thurrock Youth Offending Team

The Thurrock Youth Offending Service (YOT) will assess all offenders convicted of a sexual offences using the AIM 2 specialist assessment, as described above as best practice. A tailored intervention using the AIM2 project (Assessment, Intervention, Moving On) is then delivered. The project is designed to reduce the risk of further harmful sexual behaviours occurring or offences being committed. The project is delivered to young people and their families, where there are concerns about

problematic or harmful sexual behaviours, through the provision of advice, information, training and the development of practice frameworks and guidance. The AIM2 project assessments and related interventions can also be provided to young people who have not been sentenced in a court but only with an agreement between Social Care and the YOT. Over the last 2 financial years the YOT have supported 4 Thurrock young people who have committed sexual offences.

Prison-based support

It is likely that the majority of Thurrock's male prisoners would go to Chelmsford Prison, whilst an absence of a female prison locally means the female prisoners are most likely to go to Peterborough Prison. The support available to those who are convicted and imprisoned for committing sexual offences currently remains unknown.

Police community-based support

Essex Police currently deliver interventions in the community for offenders who have committed sexual offences. These are accredited programmes; Horizon and iHorizon. iHorizon is only available to those who have committed 'internet only' offences, currently or in the past. These programmes aim to help individuals manage unhelpful feelings and unhelpful sexual thoughts and behaviours, strengthen 'New Me' healthy thoughts and behaviours relating to sex and to develop a positive self-identity with the hope of reducing the likelihood of reoffending. The programmes are designed using the Bio-Psycho-Social Model of Change and Desistance Theory. We are currently unable to ascertain how many Thurrock residents have accessed these programmes.

5.3 Identification of gaps

The above has allowed the following gaps to be identified:

- Local Police data tells us that the majority of SVA crime victims and suspected perpetrators are young (25% aged 0-17 and 42% aged 18-34) however locally there is an absence of programmes targeted specifically towards those in this age group who are displaying harmful sexual behaviours

- Locally, there is an absence of programmes targeted specifically to those displaying harmful sexual behaviours for those who are outside the age remit of that mentioned above

- The majority of prevention programmes (e.g. the Good Man) are tailored towards and delivered to males. Whilst the Police data tells us that males make up 91% of known suspects of sexual offences locally, it is recognised that prevention programmes should also be delivered to females who are displaying harmful sexual behaviours.

5.4 Recommendations

Recommendations to address the local approach to prevention of sexual violence and abuse and those aimed at targeting perpetrators are included below:

Issue Identified	Recommendation to address this	Responsibility
Recommendations around the prevention of SVA		
Local approaches to prevention of SVA are predominately school-based	The Thurrock Sexual Violence & Abuse Stakeholder Partnership should identify other options and channels to communicate prevention messages regarding so that a population based approach can be achieved. Messages should also be adapted to particular population groups where appropriate (e.g. those at high risk of SVA).	Thurrock Sexual Violence & Abuse Stakeholder Partnership
Existing school based prevention activity is inconsistent and often focuses only on particular year groups. There are opportunities to strengthen school-based approaches to prevention activities.	Schools, Academies and Thurrock Council's Education and Skills Department should capitalise on the opportunities presented by the Department of Education's mandatory requirement for the delivery of Relationships Education in Primary Schools and Relationships and Sex Education in Secondary Schools from September 2020 to ensure that knowledge of SVA and services available to support survivors is embedded and consistently covered within the curriculum.	Thurrock Council's Education Department, Head teachers, PSHE Leads, Safeguarding Leads etc.
	Proactive messaging on SVA and key topics such as consent, grooming and CSE should be consistently delivered to all age groups and embedded into each school's wider pastoral offer.	Thurrock Council's Education and Skills Department, Head teachers, PSHE Leads, Safeguarding Leads etc.
Recommendations around targeting suspected perpetrators		
Local Police data tells us that the majority of SVA crime victims and suspected perpetrators are young (25% aged 0-17 and 42% aged 18-34). However, locally there is	*See recommendations above regarding approaches to the prevention of SVA (5.4)*	
	Thurrock's LSCP should develop a training proposal to ensure the wider children and young person's workforce (e.g. social workers, teachers, youth workers, School Wellbeing Service) are trained and appropriately supported to identify and screen for concerns linked to harmful sexual behaviours and/or sexual violence and abuse.	Thurrock Local Safeguarding Children Partnership (LSCP)

Issue Identified	Recommendation to address this	Responsibility
an absence of programmes targeted specifically towards those in this age group who are displaying harmful sexual behaviours	Thurrock's LSCP should specifically include actions to address the issue of young suspected perpetrators within their relevant policies and action plans.	Thurrock Local Safeguarding Children Partnership (LSCP)
	Thurrock SVA Stakeholder Partnership should review and assess the appropriateness of existing provision designed for young people who are displaying harmful sexual behaviours to ensure an effective offer is in place locally.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
	Thurrock's LSCP and NHS Thurrock Clinical Commissioning Group should ensure the Guidance from the National Institute for Health and Care Excellence (NICE) regarding harmful sexual behaviour among children and young people (NG55) is adopted and successfully implemented locally.	Thurrock Local Safeguarding Children Partnership (LSCP)
	Thurrock SVA Stakeholder Partnership should review the findings of the Learning and Development Group of Southend's Safeguarding Children's Board who have recently reviewed Harmful Sexual Behaviours in order to knowledge and best practice county- wide and implement changes locally where appropriate.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
Locally, there is an absence of programmes targeted specifically to those displaying harmful sexual behaviours for those who are outside the age remits mentioned above	Thurrock SVA Stakeholder Partnership should conduct a review of the evidence base of relevant programmes and potential demand locally in order to identify a suitable programme. Funding is to be secured if applicable.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
Local Police data shows that 11% of suspected perpetrators	Essex Sexual Abuse Strategic Partnership should conduct a review of the offer of programmes to those who have been convicted of	Essex Sexual Abuse Strategic Partnership

Issue Identified	Recommendation to address this	Responsibility
(of SVA offences reported by Thurrock residents) were reported for committing more than one offence. We are currently unaware of how this compares to other areas/nationally	sexual violence and abuse crimes and create a sustainable behaviour change programme for perpetrators of SVA (to be informed by the Essex Sexual Abuse Strategic Partnership's Sexual Violence Strategy, due to be published late 2019).	
Local and national data and engagement with survivors shows that both children and adults experienced SVA in a domestic setting or had a close relationship to the perpetrator (e.g. partner, ex-partner family member)	Embed knowledge related to recognising SVA in domestic settings amongst front line professionals to increase confidence in recognising and reporting incidences of SVA.	Thurrock Sexual Violence & Abuse Stakeholder Partnership

Chapter 6: Disclosure

6.1 National evidence around disclosure

Where a 'disclosure' of sexual violence of abuse is discussed, this should be taken to mean a victim/survivor telling any other person about their experience of sexual violence/abuse for the very first time, whether formally or informally. Disclosure is often the first step to recovery and/or justice for many victims/survivors. Most victims/survivors who chose to disclose do so in an attempt to gain support, assistance and/or justice. There is a decision-making process that precedes disclosure.[53] Firstly, victims/survivors evaluate the nature of the incident/abuse to determine whether they have been victimised. Secondly, they weigh the pros, cons and anticipated reactions of disclosure and if the perceived benefits outweigh the costs, disclosure is more likely. Survivors are more likely to disclose if they feel it would be personally beneficial e.g. to help them feel better, provide them with access to support or if it would deter future crimes. Victims/survivors are less likely to disclose if they feel it would result in negative consequences such as not being believed, blame, shame and inappropriate responses from those who they have disclosed to.

Non-disclosure or delayed disclosure can prolong or even exacerbate the impacts of sexual victimisation. Despite this, 83% of victims do not report their experiences to the police.[54] For those who choose to disclose, whether it be planned or unplanned, it can take many years, particularly those who have been sexually assaulted or abused as a child or have a disability, with research showing the average time taken for victims/survivors to disclose childhood sexual abuse is 26 years.[55]

Findings from the 2017 Crime Survey for England and Wales (CSEW) regarding disclosure are demonstrated in Figure 11 below.

Figure 11: Crime Survey for England and Wales findings[56]

6.2 Barriers to disclosure

There are a number of internal barriers to disclosing sexual violence and abuse, with the most commonly reported summarised in Figure 12 below. Beyond an inability to label an experience, a lack of knowledge limits understanding of the nature of the consequences of an assault or abuse and so harmful feelings of guilt, shame and loss of control can fester.

A key barrier is lack of knowledge regarding sexual violence and abuse itself. It is to be noted that there is generally a lack of awareness regarding what causes and constitutes sexual violence and abuse, common impacts of victimisation, and coping skills and available resources. The ability to recognise an experience of SVA is essential to seeking help. Without knowing how an experience of violence might affect them, some victims/survivors may not feel that they need to seek help if they were not physically harmed.[57]

Figure 12: Barriers to disclosure[58, 59]

6.3 Professional responsibilities following disclosure

Where there has been a disclosure, report or concern of sexual violence, the professional should make an immediate risk and needs assessment which should be considered on a case-by-case basis. The risk and needs assessment should consider the victim/survivor (their capacity to consent, their immediate and future protection and support), the alleged perpetrator and any other individuals who may be at risk of sexual violence/abuse. Where a child has been harmed, is at risk of harm, or is in immediate danger a safeguarding referral should be made to local Children's Social Care. A referral to Social Care may not require in instances where the harm is in the past and is no longer present.

No child under the age of 13 can ever consent to any sexual activity and therefore under-13s are given additional protections in law due to their age and vulnerability.[60] Circumstances concerning suspected or reported sexual violence/abuse involving a child or young person under the age of 13 should result in an automatic referral to the Police and Children's Social Care. Generally, parents or carers will be informed for children under the age of 16 (the legal age for consent) unless there are compelling reasons not to, for example, informing the parent/carer is going to put the child/young person at additional risk. Local engagement with professionals and findings from the

REAL. conference identified varying levels of knowledge regarding the safeguarding processes required post-disclosure (see section 6.7.3 for further information).

6.4 Importance of a positive reaction

It is imperative that all disclosures are met with the sensitivity and support required. Supportive responses can reaffirm self-worth and improve psychological and physical wellbeing.[61] Unfortunately disclosures do not always produce supportive responses or the response desired by the victim/survivor. Poor reactions include those that are judgmental, blame and shame the victim/survivor and/or provide incorrect and poor information based on myths of sexual violence and abuse. Such responses can have a detrimental impact on recovery and may result in negative outcomes such as feelings of shame and isolation, an increased likelihood of the victim/survivor experiencing additional psychological trauma, not accessing appropriate support and becoming withdrawn or isolated.[62]

6.5 Thurrock data on disclosure

Modelling the disclosure information from the Crime Survey for England and Wales to our estimated numbers of SVA survivors in Thurrock would give the following (*note that victims may have told more than one person so could be counted in more than one of the latter categories*):

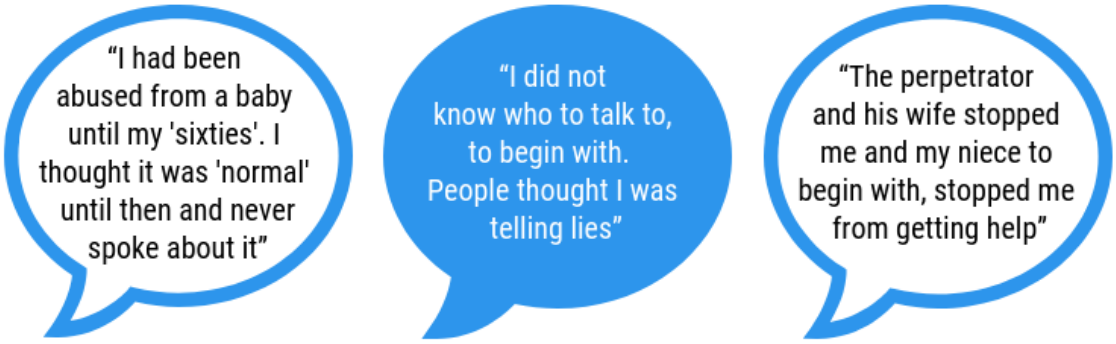
CSEW finding	Estimated number of Thurrock victims (within the last year aged 16-59)	Estimated number of Thurrock victims (ever experienced abuse aged 16-59)
31% victims told no one of their most recent experience	609	3,751
58% victims told someone close to them	1,140	7,019
30% victims told a professional	590	3,630
17% victims told the police	335	2,057

Local engagement with survivors identified the following key points regarding survivors' experiences of disclosure:

- Survivors reported that disclosures had most commonly been made to their family and friends
- Whilst many survivors disclosed within 3 months of the abuse having occurred, one third of respondents said they disclosed over 2 years later.
- The most common responses to disclosures centred around onward referrals, provision of direct support (if the disclosure was to an agency), listening, or following specific processes.

6.6 Local engagement with survivors regarding barriers

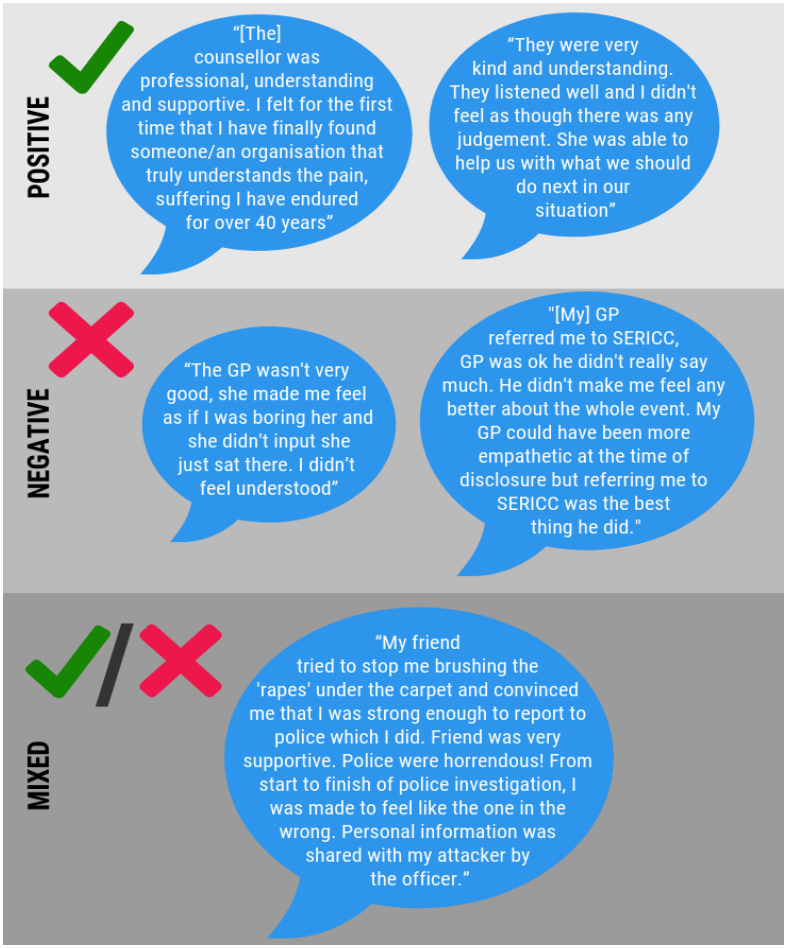
Local survivor's thoughts and experiences related to barriers to disclosure were predominately discussed during the interviews. Key barriers mentioned included; embarrassment, guilt, feeling ashamed, not wanting to be judged by others, a low conviction rate of perpetrators and a lack of confidence in future action. Examples are included below:



6.7 Experience of reaction to disclosure

6.7.1 Engagement with survivors

Local engagement with survivors has identified that victims/survivors want to be asked what their preferred options were and they want to be informed of the processes that must or could happen post-disclosure. Survivors spoke of how their disclosures were responded to in varied ways, which also varied dependent on who they initially disclosed to. Positive experiences of disclosure included those which made the survivor feel listened, supported and resulted in positive outcomes such as onward referral to support services. Negative experiences of disclosure included those which were judgemental and lacked consideration for the feelings of the survivor, e.g. sharing information with people where not necessary. Quotes from local survivors are included below:



The video below provides accounts of the experiences of local survivor's experiences of disclosure.

6.7.2 Engagement with professionals

Professionals' awareness of services

Engagement with local professionals identified that generally there is a good level of awareness of the services available in Thurrock to support victims/survivors. Respondents were asked to name support services that they were aware of (more than one could be listed). Specialist support was reasonably well known by respondents. Non-specialist sexual violence and abuse services that may also provide services to survivors (e.g. Mental Health GP, A&E and Social Care) were only mentioned by a small number of individuals.

Professionals' responses of actions following a disclosure

When asked about actions that were taken following a disclosure of sexual violence and abuse, common responses included; referral to SERICC/specialist sexual violence service, to follow safeguarding processes and to inform of support services available. It is to be noted that asking the victim/survivor what they wanted was only the tenth most common response given. Respondents were then asked exactly where they would signpost survivors towards if they were unable to support them further. SERICC was the most commonly response, provided by 56.3% of respondents. The police and GP/nurse were the next most common. It is unclear if those reporting 'counselling/talking therapies' meant specialist counselling or generic counselling.

6.7.3 The REAL. Conference

Respect. Empathy. Awareness. Listen. A full stop to represent ending the silence.

On 2nd April 2019 a group of ten young victims/survivors who have accessed sexual violence and support from SERICC delivered a powerful conferenced aimed at raising awareness of sexual violence amongst professionals. Key focuses of the conference were how disclosures should be handled and the information sharing processes that follow. Throughout the day a series of four group sessions were delivered, each focussing on the importance of the four key requirements for disclosure, as identified in the title; Respect, Empathy, Awareness and Listening. The young people clearly and innovatively demonstrated how a poorly handled disclosure translates into a loss of control of the situation and can be just as traumatic as the incident(s) of sexual violence and abuse that victims/survivors have experienced.

Through the group sessions, the young people clearly demonstrated how a disclosure to one person could quickly result in up to 15 different professionals/ friends/ family knowing about the incident(s). This is often a professionals desire to safeguard young people and an assumption that the more people that know, the better than young person can be safeguarded and cared for. This often left young people with no control over their situation and a sense of feeling powerless, adding to the feeling of not having control that will have formed a part of their rape/assault/abuse. Instead, young people expressed the need for the process to be slowed down, with professionals taking the

time to think about who actually does need to be informed within the laws that surround child protection as opposed to the default mode of informing everyone connected to that young person.

The conference also highlighted that amongst the professionals in attendance there was a misconception that every case had to be reported to the Police, however in fact this is not true for young people aged over 13 years old and are Fraser/ Gillick competent to make that decision. That choice should therefore lie with the young person and should only be breached should that young person be in immediate danger of further threat or harm. Another key theme was that young people wanted to be consulted where this happened to give them back control.

Following on from the conference the Local Authorities Children's Commissioner has compiled a 'step by step' guide detailing how professionals should respond appropriately to disclosures of SVA by children and young people.

6.7.4 Challenging Myths, Changing Attitudes Training

Locally, efforts have already been started to improve professional's understanding of SVA and appropriate actions following disclosure. In 2018 SERICC delivered a bespoke training course to over 200 professionals from a range of organisations in Thurrock. This course requested and commissioned by Thurrock Community Safety Partnership in order to enable professionals to understand sexual violence and abuse and the potential impacts of SVA on the victim/survivor and their friends/family/partner. The training also sought to help professionals feel confident to challenge commonly held myths around SVA, to build their skills and confidence in order to enable them to provide effective responses to disclosure. The training was also an opportunity to raise awareness of the relevant services available locally.

6.8 Recommendations to address barriers and poor response to disclosure

It is recognised that locally, we must improve our responses to disclosure in order to ensure that victims/survivors are treated respectfully and with dignity and are provided with correct information and prompt access to appropriate services when they require them.

The following recommendations are suggested in order to improve responses to disclosure locally:

Issue Identified	Recommendation to address this	Responsibility
Recommendations for improving responses to disclosure		
Locally, survivors report a lack willingness to disclose their experience of SVA to anybody (including formal and informal sources). A number of factors are known to deter disclosures and willingness to seek support. Local engagement tells us that these factors include lack of confidence to access services, fear of not being believed and a low perpetrator conviction rate	Thurrock SVA Stakeholder Partnership should implement a coordinated programme of communications activities to be delivered to the public, to include; reducing the stigma of SVA, tackling social myths and stereotypes in order to increase public confidence in reporting crimes and seeking appropriate support	Thurrock Sexual Violence and Abuse Stakeholder Partnership
Locally, disclosures are more commonly being made to informal sources (i.e. family and friends) rather than to professionals. This may result in disclosures not being handled appropriately and/or survivors not being aware of the relevant services and support available	Thurrock SVA Stakeholder Partnership should review suitable training programmes (whether existing or bespoke) that can be delivered in order to support informal sources respond appropriately to disclosures. Examples may include the Thurrock Community Safety Partnership's (CSP) Challenging Myths Changing Attitudes training, or a variant of the J9 Domestic Abuse Awareness training tailored towards SVA. These should be delivered consistently across Thurrock, including to families/friends where requested.	Thurrock Sexual Violence and Abuse Stakeholder Partnership

Issue Identified	Recommendation to address this	Responsibility
Locally, not all responses to disclosure, whether to formal or informal sources, have been handled appropriately and sensitively, which can be extremely traumatic to the survivor. Survivors often reported that professionals in a rush to follow organisational protocol and 'cover their own back' disclosed information to multiple additional professionals leaving the survivor feeling that 'they had lost control of the process'	Thurrock Council Education and Skills Department in partnership with local schools and Academies should audit all school policies on SVA disclosure to ensure a consistent approach based on best practice that keeps the needs of the survivor at the centre of the process	Thurrock Council Education and Skills Department Head Teachers and Academy Chief Executives
	Thurrock SVA Stakeholder Partnership should commission a coordinated programme of training/communications activities to be delivered to professionals and informal sources, to include; reducing the stigma of SVA, tackling social myths and stereotypes, in order to improve responses to disclosure.	Thurrock Sexual Violence and Abuse Stakeholder Partnership
Some professionals surveyed said that they did not feel confident dealing with disclosures, with many professionals requesting further training in this area	Thurrock SVA Stakeholder Partnership should develop a bespoke toolkit for professional use in order to facilitate appropriate responses to disclosure. This toolkit should be issued to all appropriate frontline professionals in Thurrock. The toolkit should be used to supplement training and provide information including safeguarding requirements, appropriate language, local service provision and referral pathways.	Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services
	Thurrock SVA Stakeholder Partnership should conduct a full evaluation of training possibilities, seeking input from staff/management within key organisations, in order to determine which are most effective in increasing professionals' confidence responding to disclosures. This training should be then made available to professionals in order to ensure they are appropriately informed, skilled and confident in handling disclosures.	Thurrock Sexual Violence and Abuse Stakeholder Partnership

Issue Identified	Recommendation to address this	Responsibility
	A toolkit to be developed and issued to all frontline professionals in Thurrock in order to improve ongoing confidence during and following disclosure and ensure survivors are informed of options for support. This toolkit should: - Include information regarding conducting risk/needs assessments for survivors, as per relevant safeguarding processes - Contain information including operational protocols, safeguarding policies, practical skills and information regarding service provision and referral pathways - Provide professionals with a clear understanding of how to respond appropriately to disclosures, including the actions that should follow - Incorporate the findings of this needs assessment and the Thurrock REAL. Conference - Seek input from specialist SVA services - Be coordinated by the new Thurrock Sexual Violence and Abuse Stakeholder Partnership to oversee the development and support implementation (see recommendation in chapter 11)	Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services
Some survivors reported that their disclosures/information related to their SVA was shared with more people than they felt was necessary. Following disclosure, 68% of local survivors relied on professionals giving them further information/ signposting towards seeking specialist help themselves rather than a referral being made on their behalf. Whilst SERICC appear to be well-known in the borough, the process would be smoother and may result in better outcomes if survivors were referred directly using appropriate mechanisms	The toolkit and training as mentioned above should address this issue through providing professionals with a clear understanding of the processes following disclosure including what information should be shared and with who	Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services
	Referral pathways and processes into specialist SVA services must be developed, agreed with key stakeholders and used by all referring organisations	Thurrock Sexual Violence and Abuse Stakeholder Partnership
	Organisations to network more effectively so that they better understand each other's service offer for survivors, and to be directed to make referrals in to specialist support services as opposed to signposting. Thurrock Public Health Service to organise a conference for all local stakeholders to launch this Joint Strategic Needs Assessment product and commence discussion between stakeholders	All providers of services that may support SVA survivors, to be identified and facilitated by the Thurrock Sexual Violence and Abuse Stakeholder Partnership Thurrock Council Public Health Service

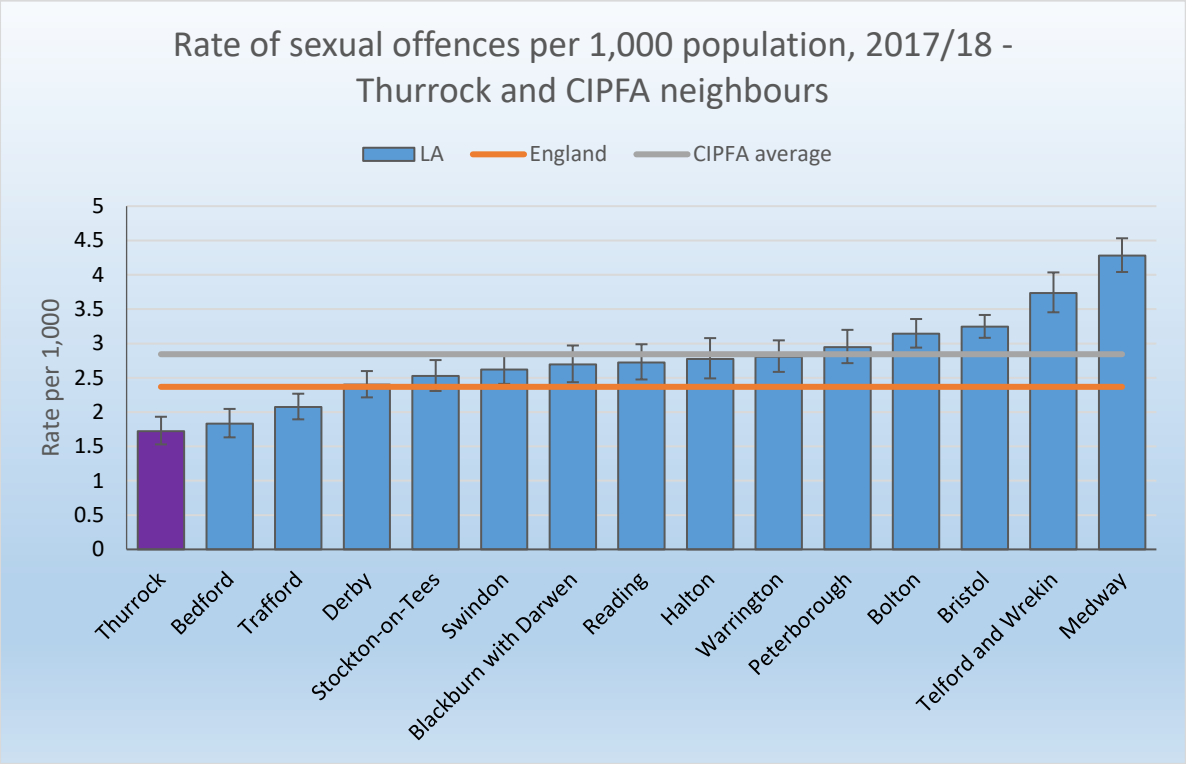
Issue Identified	Recommendation to address this	Responsibility
	Where practicable, referral forms to SVA support services should be automated or embedded into organisational information systems (e.g. the Systm One or EMIS systems in General Practice and hospital systems)	Thurrock Sexual Violence and Abuse Stakeholder Partnership

Chapter 7: Criminal Justice for victims/survivors

7.1 Comparison of SVA crime with other areas

Thurrock has a reported sexual offence rate of 1.7 per 1,000 population. This is a crude rate per 1,000 population including crimes of all ages and sexes that have been reported to the Police. The Thurrock rate is significantly lower than the England average of 2.4 per 1,000. When compared to our most similar local authority areas as defined by CIPFA (Chartered Institute of Public Finance and Accountancy), Thurrock ranks the lowest, whereas Medway has the highest rate of 2.8 per 1,000. It is to be noted that this only includes incidents reported to the Police. Incidents that were not reported to the police and incidents that the Police decided not to record are not included.

Figure 13: Rate of sexual offences- Thurrock compared to CIPFA comparators



Source: Home Office and Public Health England

The above chart tells us that Thurrock has a lower rate of reported sexual offences per population head when compared to other areas. But it doesn't tell us how this relates to the likely expected prevalence, or expected number of offences that actually took place. These are modelled in section 7.4 below.

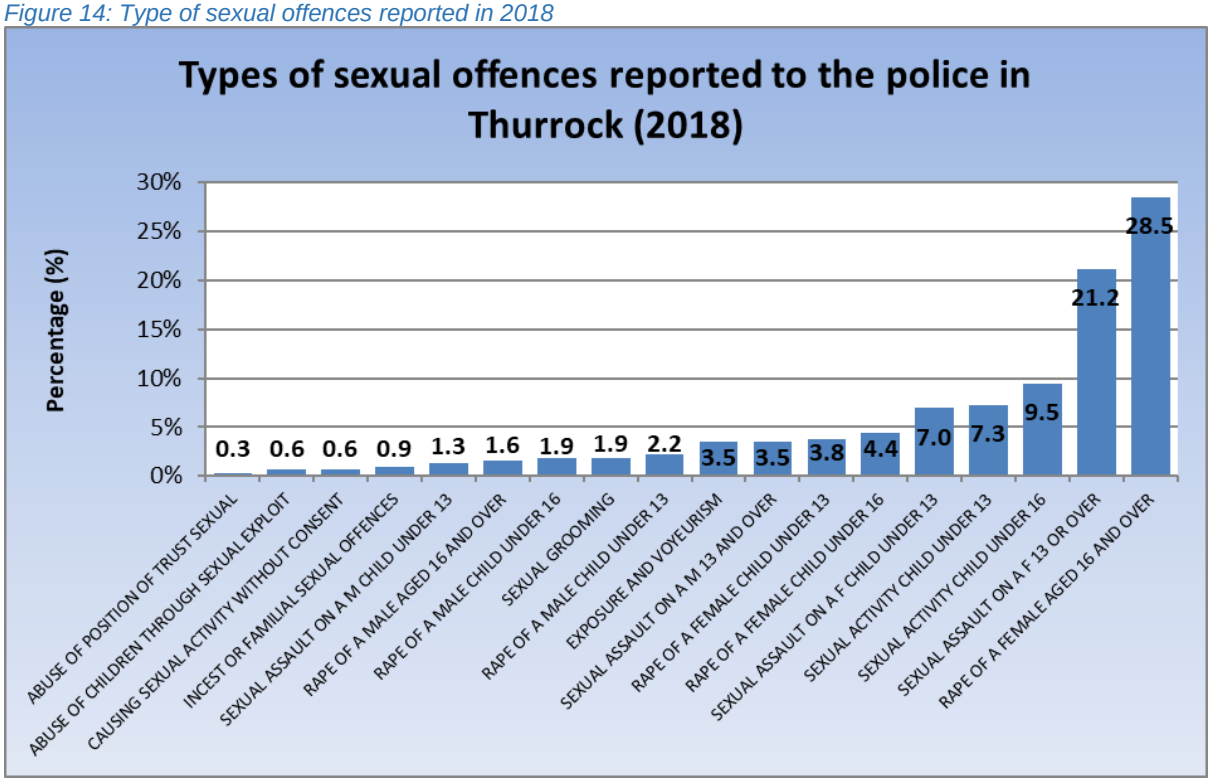
7.2 Sexual Violence & Abuse in Thurrock reported to Essex Police

The following includes information related to the sexual offences reported and is therefore only likely to be a small proportion of all sexual offences actually committed. In 2018, **316** victims of reported sexual offences were recorded in Thurrock. This compares with 297 in 2017, an increase of 6.4% in one year; this increase is larger than expected considering a population increase in that same time of 1.2%.

7.2.1 Type of crime

Victims of reported rape or attempted rape accounted for 42% of total victims of sexual offences in Thurrock, compared with 35.8% of total offences nationally. Of the 316 recorded sexual offences in Thurrock in 2018, the most commonly reported (90) was 'rape of a female aged 16 and over'.

Figure 14: Type of sexual offences reported in 2018



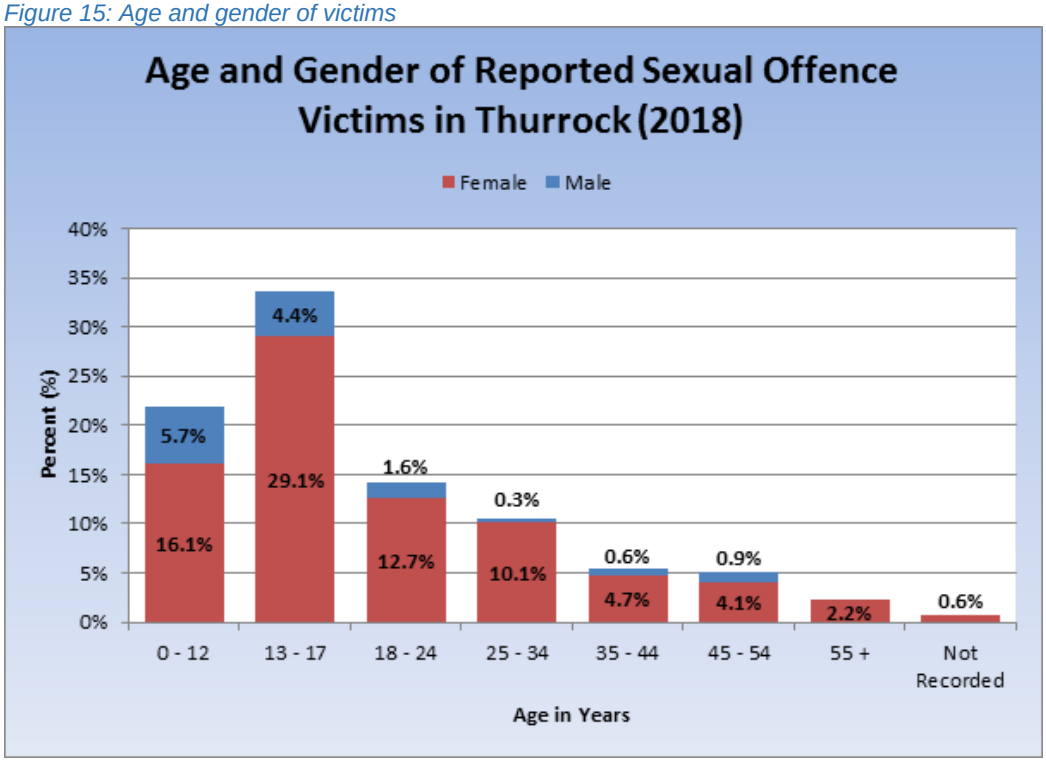
7.2.2 Sexual offences linked to Domestic Violence

Domestic violence (DV) related offences account for 57 (18%) of these offences, of which 19 were of high risk and 19 medium. Where a DV marker was 'Not Recorded', this indicates that **there was no domestic abuse reported, or that** the risk level was not entered into the box where it would be expected. It is noted that DV markers were included for approximately 50% of incidents within the 25-34, 35-44 and 55-64 age groups. DV markers were also noted in 10% of the sexual offences in the 13-17 year age group. Given the strong links explained in chapter 4 regarding domestic violence and sexual violence and abuse, it is expected that this is an under representation of the true extent.

7.2.3 Victims' Demographics

The majority of victims of reported sexual offences in 2018, where gender is recorded, were women (79.7%), and for men 13.6%; for rape offences the percentage of female victims rises to 87%. The highest proportion of victims are in the 13-17 age range, followed by 0-12 years; From 17 years old, reported sexual offences tail off as age increases.

Figure 15: Age and gender of victims



The largest proportion of victims described themselves as 'White' 54%, with 7% from Black, Asian and Mixed self-defined headings. Self-defined ethnicity was not recorded or not stated for 39% of victims; this makes comparison to the wider Thurrock population not possible.

7.2.4 Location

Whilst this data reflects crimes committed within the Thurrock area, 9% of victims lived elsewhere in Essex (not Thurrock) and the largest proportion, 23.7%, didn't live in Essex at all. While we cannot establish all the reasons a non-Thurrock resident was victimised within Thurrock, some common reasons include:

a) The victim is reporting an historic offence that occurred in Thurrock, the precise address of the victim at the time of the offence could not be established at the time of the recording so their current address at time of reporting has been recorded.

b) The victim was visiting the offender in Thurrock – a friend, partner, date, relative or other associate.

c) The offence occurred online (social media or other platforms) with the identified suspect in Thurrock and the victim living elsewhere.

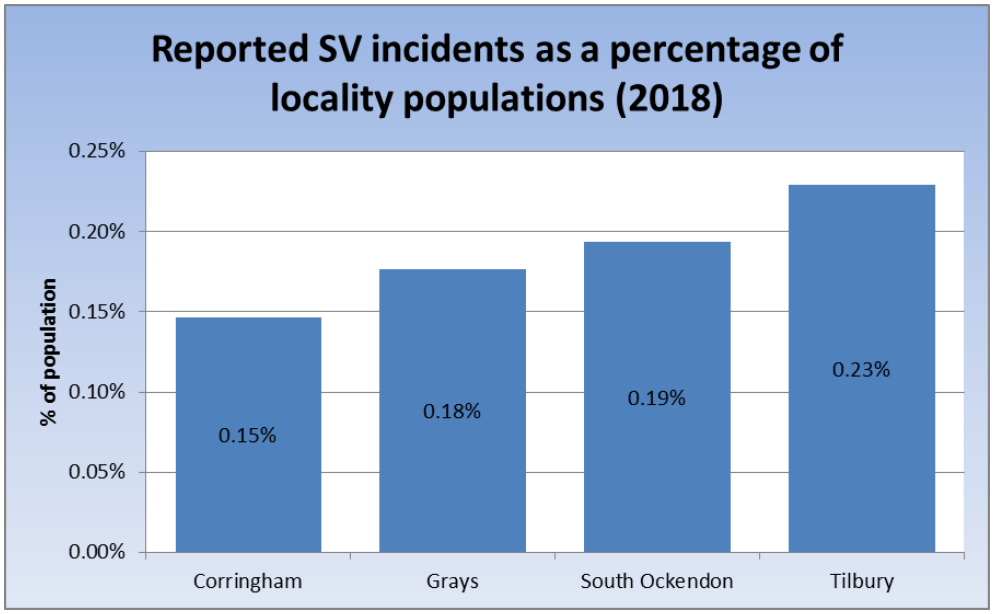
d) The victim and offender met elsewhere and the suspect has then taken them into Thurrock on the day of the offence. This may be to a dwelling, hotel or business premises.

e) The victim was attending a party, shopping centre or visiting friends (not including the suspect).

f) The victim was attending an educational establishment or business.

For the 67.3% of victims that lived in Thurrock, the chart below shows the location of reported SV incidents as a percentage of locality populations. The range of proportions (0.15%-0.23%) is not wide despite the considerable difference in population size between the localities. This indicates that there are slightly more reported incidents per head in Tilbury and fewer reported per head of population in Corringham.

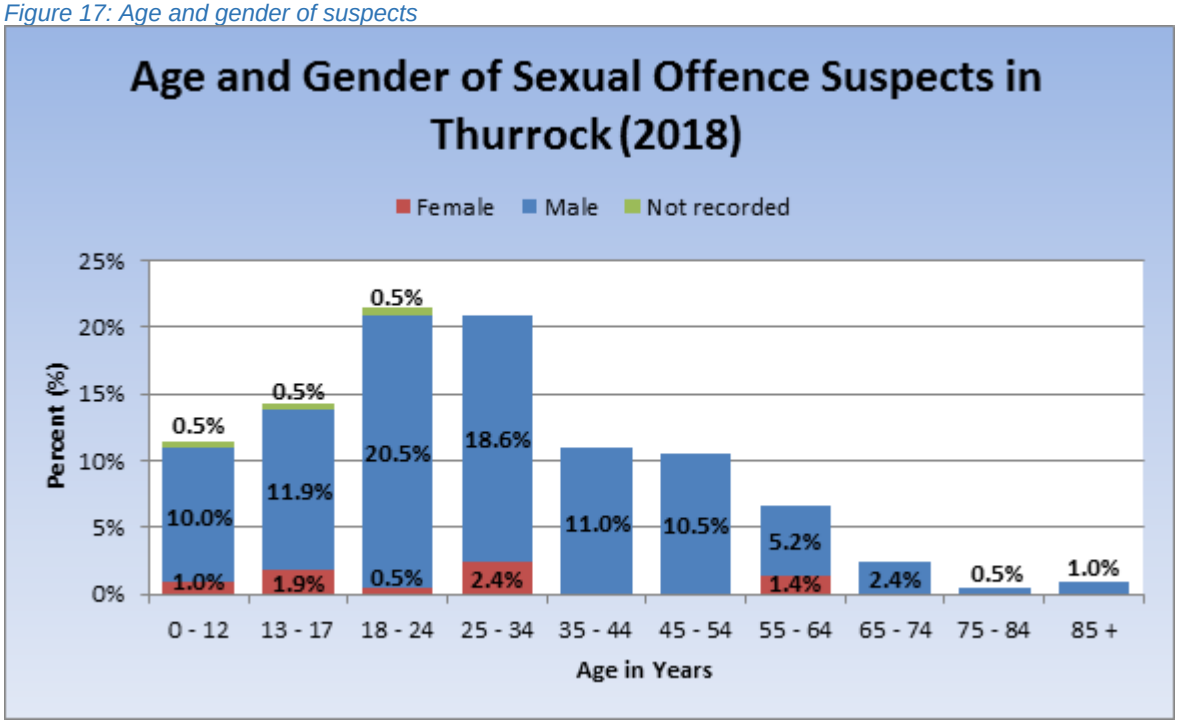
Figure 16: Locality of crimes



7.2.5 Suspects' Demographics

The chart below displays the demographics of suspected perpetrators of sexual offences in Thurrock in cases where a suspect is known to the police. The vast majority (91%) of suspected perpetrators are male, which is a higher proportion than seen in national data from the Crime Survey for England and Wales which shows a male perpetration proportion of 74-79% for sexual offences. Suspected perpetrators tend to be younger men with peaks occurring in the 18-34 age range (42%). The next largest group of suspects is 13-17 years (14%) followed by 0-12 years (11%); 5.7% were under the age of criminal responsibility (10yrs). Suspects tail off as age increases with very few being aged over 65years. The data collected on suspects' ethnicity was not of sufficient quality for conclusions to be drawn; 33% of suspects had their ethnicity listed as '*Not stated'*, *'Not recorded'* or *'Other'*.

Figure 17: Age and gender of suspects



7.2.6 Repeat offences

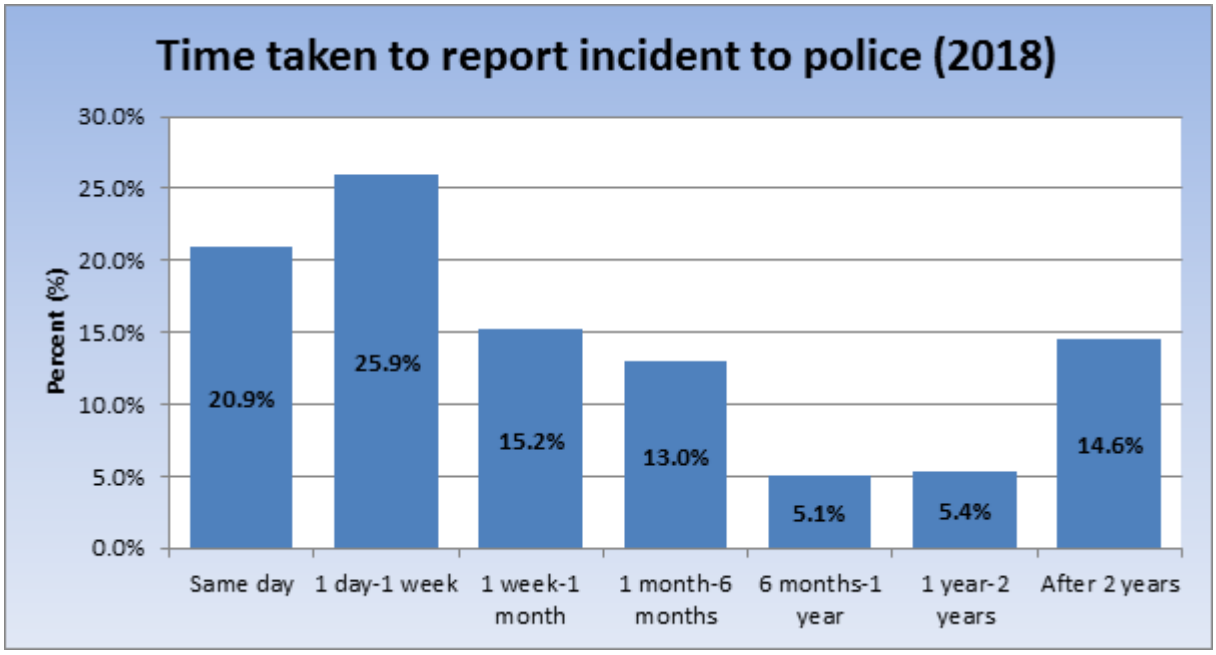
The majority (92%) of victims have reported a single incident whilst the remaining 8% have reported multiple incidents. Multiple offences may have been committed by the same or multiple different perpetrators.

The majority (89%) of suspected perpetrators have been reported for a single sexual offence while only 2% are suspected serial offenders (3 or more offences). Multiple offences may have been against the same or multiple different victims however it is not possible to determine the extent to which this occurs.

7.2.7 Time taken to report/record

The following diagram shows how long after the incident the crime is reported for those victims of sexual offences in Thurrock during 2018. 47% reported within a week and 21% the same day, 15% reported two or more years after the offence. It is to be noted that the *'two or more years' category will include victims who have disclosed ten, twenty plus years after the offence took place.*

Figure 18: Time taken to report to the Police



7.2.8 Outcomes of police reported crime

The largest proportion of outcomes in 2018 was 'Not Recorded (not yet finalised)' at 28%; 24% did not support action and 13.6% are recorded as '*Named Suspect Identified: Victim Supports Police Action But Evidential Difficulties Prevent Further Action*'. All of the top three recorded outcomes involve '*evidential difficulties*'. Type 20 outcomes (Further action to be taken by another body) are overwhelmingly made up of crimes in which the victim is aged 0-17 years. The proportional relationship between type of crime and type of outcome is very similar to the proportion of overall outcomes displayed in the table below.

Sexual crimes from 2017 have fewer outcomes recorded as '*Not yet finalised*' (as this refers to crimes still subject to ongoing investigations) than those in 2018; however, 'Type 15: *Named Suspect Identified: Victim Supports Police Action But Evidential Difficulties Prevent Further Action'* was significantly higher in 2017 than 2018. The data available does not give insight into prosecutions, *Type 1: Charged/Summonsed/Postal Requisition* is the furthest stage available; 5.1% of incidents reached this point in 2017 and 4.4% reached it in 2018.

Figure 19: Incident outcomes of SVA reported crimes

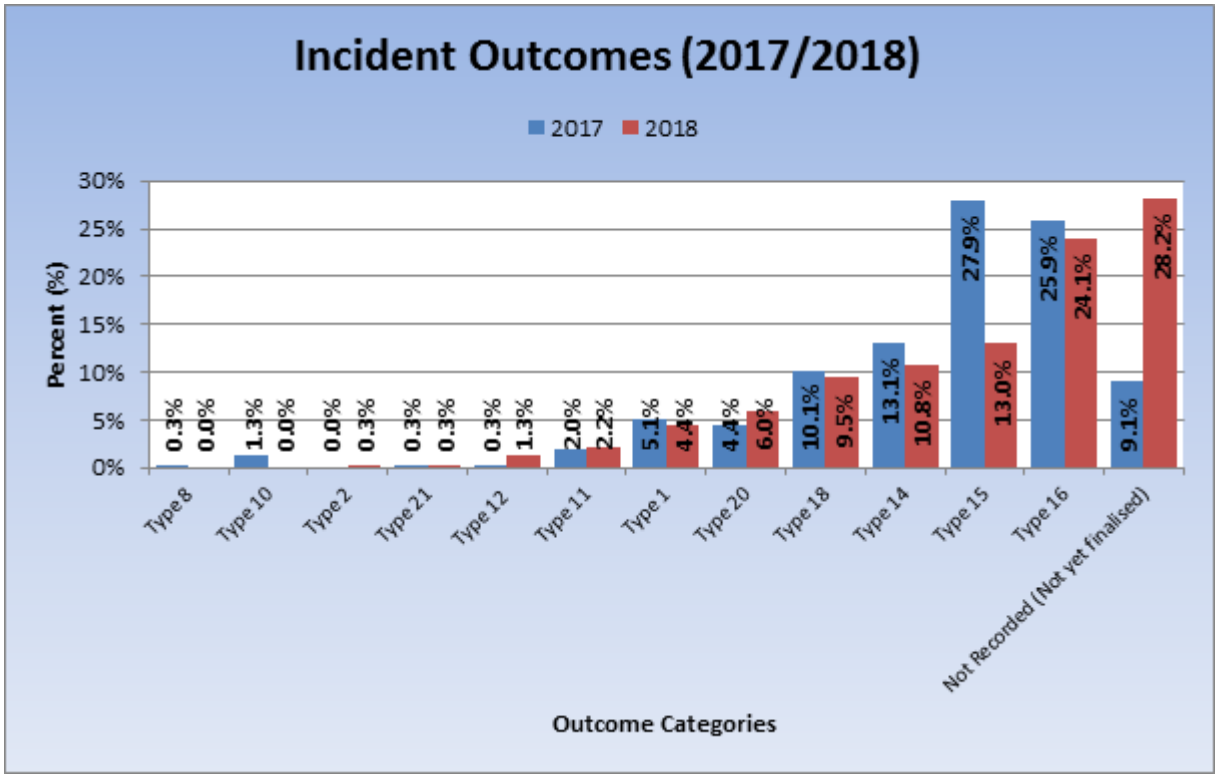


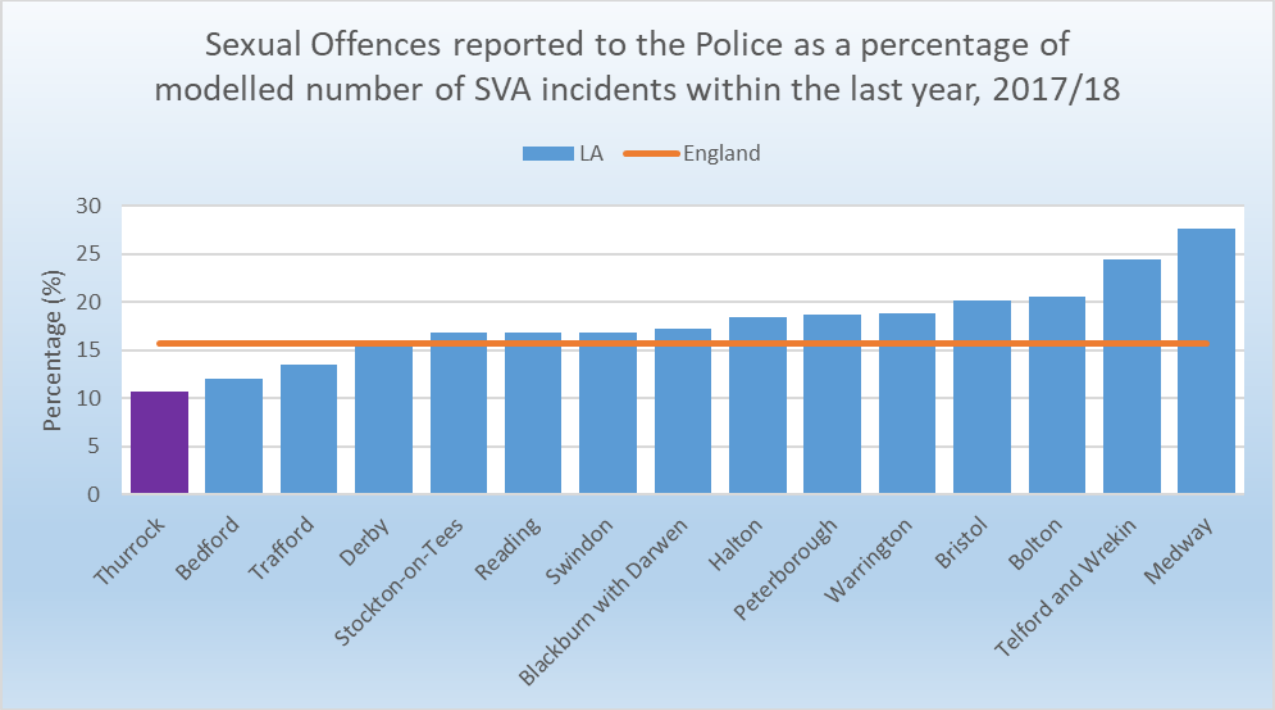
Figure 20: Definitions of outcome categories

- Type 8: *Community resolution (Crime)* *restorative justice
- Type 10: *Formal Action against Offender is not in the Public Interest (Police)*
- Type 2: *Caution Youth*
- Type 21: *Further investigation resulting from crime report which could provide evidence sufficient to support formal action against the suspect is not in the public interest - police decision.*
- Type 12: *Prosecution Prevented-Named Suspect Identified But Is Too Ill (Physical Or Mental Health) To Prosecute*
- Type 11: *Prosecution Prevented-Named Suspect Identified But Is Below The Age Of Criminal Responsibility*
- Type 1: *Charged/Summonsed/Postal Requisition*
- Type 20: *Further action resulting from the crime report will be undertaken by another body or agency subject to the victim (or person acting on their behalf) being made aware of the act to be taken*
- Type 18: *Investigation Complete; No Suspect Identified. Crime Investigated As Far As Reasonably Possible-Case Closed Pending Further Investigative Opportunities Becoming Available*
- Type 14: *Evidential Difficulties Victim Based- Suspect Not Identified: Crime Confirmed But The Victim Either Declines Or Unable To Support Further Police Investigation To Identify The Offender*
- Type 15: *Named Suspect Identified: Victim Supports Police Action But Evidential Difficulties Prevent Further Action*
- Type 16: *Named Suspect Identified: Evidential Difficulties Prevent Further Action: Victim Does Not Support (Or Has Withdrawn Support From) Police Action*

7.3 Comparison to estimated number of survivors

Applying the same methodology as described in section 7.1 to the other comparator areas, enables us to see that Thurrock is reporting the lowest proportion of its estimated number of offences (11%) compared to the national average (16%) and other comparable areas – Medway for example appears to be reporting 28% of SVA offences to the Police.

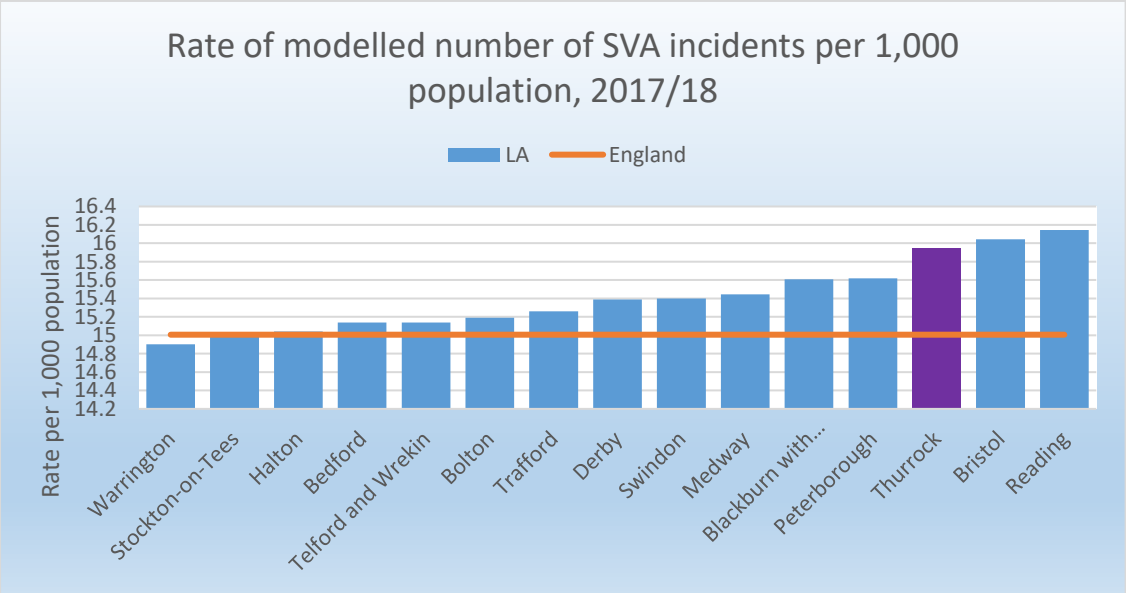
Figure 21: Sexual offences reported to the Police as a percentage of the modelled number of SVA incidents within the last year



Source: Home Office, Office for National Statistics and CSEW

We can use the modelled estimated number of SVA incidents for each area to ascertain whether the actual level of need (reported or unreported) is different in Thurrock compared to other similar areas. The chart below shows the estimated number of incidents as a rate against the populations of each area, and it can be seen that Thurrock is likely to have a higher rate of SVA need per population head than other similar areas.

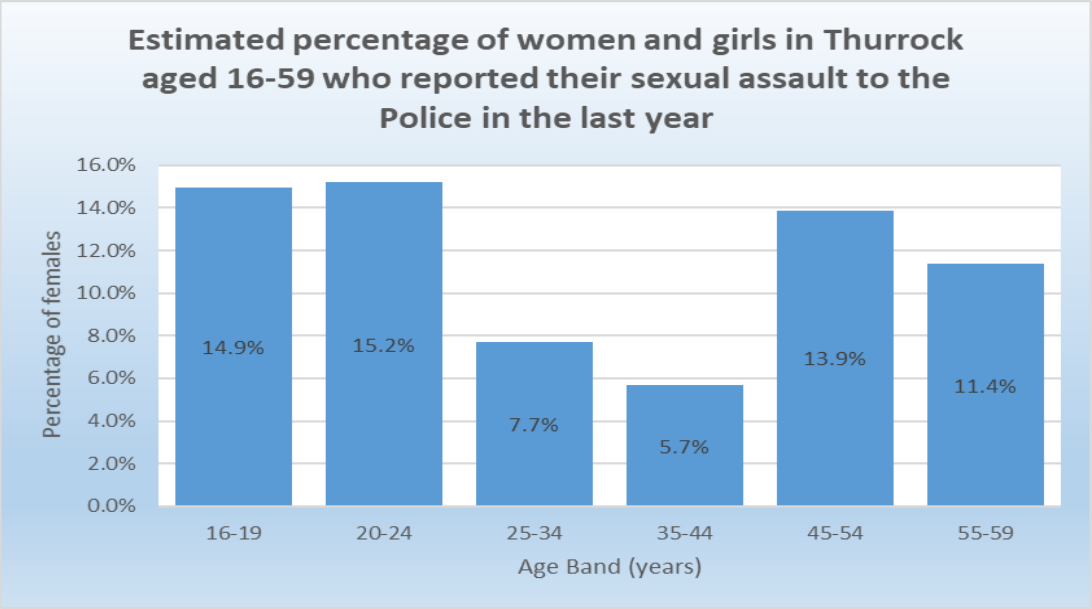
Figure 22: Rate of modelled number of SVA incidents



Source: Home Office, Office for National Statistics and CSEW

Taking the modelled prevalence estimates per age group (see section 3.2) and the number of reported crimes per age group (see section 0) for women and girls, it can be seen that this issue of under-reporting is even more prevalent in women aged 25-44 years, with the number of crimes reported by those aged 35-44 years equating to fewer than 6% of those estimated to have occurred. (This looked at comparing crimes by the age of the survivor when it was committed, against the modelled estimates of incidents for that age group). As shown in Figure 21, Thurrock's reporting rate across all ages and genders is around 11% of expected crimes, so although the below chart is just for females, it is expected to also be an issue for males.

Figure 23: Estimated percentage of women and girls in Thurrock aged 16-59 who reported sexual assault to the police in the last year



Source: VAWG Ready Reckoner and Essex Police data

7.3.1 Suspect Demographics

Of the suspects that are reported to the Police, Thurrock has a higher proportion of males suspected of SVA offences compared to nationally (91% vs 74-79%). The reason for this currently remains unknown however, may be attributable to a local underreporting of SVA crimes committed by females.

The data regarding suspect's demographics indicates that the majority tend to be younger men with peaks occurring in the 18-34 age range (42%). The next largest group of suspects is 13-17 years (14%) followed by 0-12 years (11%); 5.7% were under the age of criminal responsibility (10yrs). This highlights that there are young people in Thurrock displaying harmful sexual behaviours. When compared with the age of victims/survivors in Figure 15, this would suggest the likelihood of sexual offences being peer-on-peer.

7.3.2 Time taken to report to the Police

As demonstrated in section 7.2.7 Time taken to report/record locally the time taken report offences to the Police varied greatly. It is to be noted that whilst the Police data currently only reports offences in the category of 2+ years after the incident, these statistics vary greatly from national estimations which suggest that the time taken to disclose is 26 years[63].

7.3.3 Outcomes as a proportion of all estimated offences

The Police data shows that a very small proportion of reported sexual offences result in the suspect being charged, for example; 15 out of 297 offences in 2017 were charged at this point, a rate of **5%.** Looking at this against the number of offences estimated to have actually occurred within that year (2,718), this means that approximately **0.55%** of SVA offences in Thurrock in 2017 led to the suspect being charged; and this does not guarantee a conviction. Actions underway currently to address this can be seen in section 7.6 below.

7.4 User voice

Whilst this needs assessment did not specifically seek to obtain survivors thoughts and experiences of the Criminal Justice System, it is recognised that some of the negative consequences associated with reporting to the Police (e.g. fear of not being believed, fear of being questioned or examined and a local perpetrator conviction rate) may act as a deterrent. This was specifically mentioned by one of the survivors interviewed:

"I just thought it wouldn't be in my best interest to report it because I didn't feel anything would happen… and I think possibly has well to do with the conviction rate of rapists and abusers…its low so then it automatically goes to…'well that person possibly wasn't found guilty, so, maybe she did choose to, have sex with that person… I didn't want to be judged by other people because, what I said before, the first question people ask is "was the person drinking, what was the person wearing, where were they, what time were they out" and I think that's the main reason that I didn't want to have to deal with those things as well."

7.5 Measures taken locally to improve the criminal justice process for victims/survivors

As crime increases, Essex Police have seen the proportion solved fall. This is not specific to Essex and is seen across the country. A different way of thinking is required to reverse this trend. It is their priority that more offenders are brought to justice thus reducing the risk to further victims being harmed. In order to do this Essex Police are working with partners to improve the response to Victims of sexual offences monitored through their rape improvement plan. The Plan is a review of the Police's processes and procedures and the work to date has included introducing a dedicated team for historic child sexual abuse, work with victim support services to have better pathways to support and introduction of rape scrutiny panels. The Plan also focuses on bringing more offenders/perpetrators to justice. In order to do this Essex Police are working closely with the Crown Prosecution Service (CPS) to improve criminal justice outcomes for victims.

Project Goldcrest is an example of innovative practice that aims to address the issues of time taken to disclose and incident outcomes identified above. Project Goldcrest is a project led by Essex Police and developed with Thurrock Council and SARC to look at alternative ways to engage high risk young people who typically may not disclose or engage with services. This project is due to launch in the Autumn of 2019. Current procedure requires the young person to disclose the assault, provide police with an evidential account and for forensic evidence to be obtained for any action to be taken. Understandably, many young people will, for the reasons explained above, be reluctant to engage with statutory services. This results in the police being unable to

bring any perpetrators to justice and remove the risk to the child and others. For this small but high-risk cohort of children, we are proposing to remove the emphasis of providing an evidential account and allowing them a choice about how forensic evidence is obtained which can be stored securely and anonymously until a point in the future where they feel able to disclose. Using this anonymous intelligence, Police can begin to proactively disrupt perpetrators without the need for the young person to be identified, putting themselves at further risk from the perpetrator.

7.6 Recommendations to address

The following recommendations are made in order to improve the reporting of offences locally:

Issue Identified	Recommendation to address this	Responsibility
Recommendations for those in the reporting of crimes to the Police		
Thurrock has lower levels of reporting SVA offences to the Police than other similar areas, and of those that are reported, there is a very low proportion that lead to the suspect being charged. There is variation by age group in terms of the proportion of women estimated to have experienced SVA who have reported it to the Police, particularly seen in women aged 25-44 years (the rate is between 6-8%)	Ensure Project Goldcrest is evaluated in order to determine whether it is effective in encouraging survivors to participate in forensic evidence gathering and supporting the Police with prosecuting perpetrators.	Essex Sexual Abuse Strategic Partnership
	Communications activity as previously recommended should seek to target women in this age group to increase confidence in reporting.	Thurrock Sexual Violence & Abuse Stakeholder Partnership

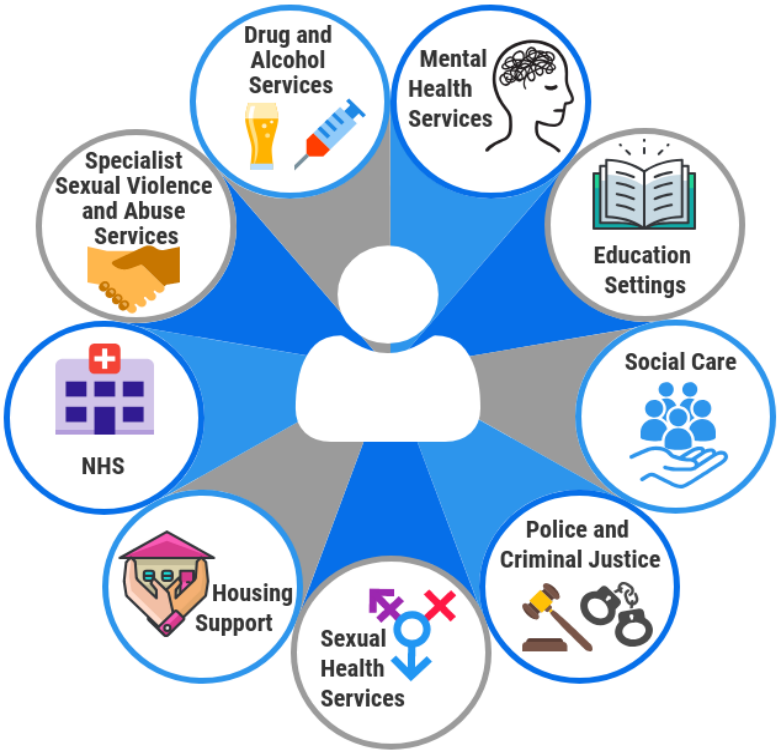
Chapter 8: Accessing Support

8.1 National evidence base

Sexual violence and abuse can have severe psychological, emotional consequences as well as physical impacts. However, when victims/survivors receive the support they need, when they need it, they are more likely to take positive steps to recovery. Being able to access the right support at a time which is right for a victim can be important to help them cope with their experience. There is no generic approach to providing services to victims/survivors of sexual violence and abuse as their needs may be complex and range from individual to individual. For this reason it is imperative that provision should meet the complex needs for victims/survivors.

Due to the wide range of needs that a victim/survivor might have, they may well be receiving support from a range of agencies to help them cope and recover, as demonstrated in Figure 24 below:

Figure 24: Services that may support a victim/survivor of SVA



8.1.1 SARC Provision

A Sexual Assault Referral Centre (SARC) is a one-stop location where male and female victims/survivors of recent rape and serious sexual assault can have a forensic examination, receive medical care and have the opportunity to assist the police investigation, should they wish.[64]

SARC services should provide equitable access to an individually tailored care package based on comprehensive need assessments, with a choice of action at every stage of care, clinical and non-clinical care and support, forensic examination and referral to appropriate services. The model of service of a SARC may vary according to the demographics and level of sexual violence in an area, and the resources

available within the partner agencies, however, all SARC services are expected to provide the following key elements within their service model to ensure consistency of provision for service users nationally.[65]

The SARC staff are well placed to raise awareness of services available to help victim/survivors cope and recover such as ISVA and counselling. The staff are also able to provide onward referrals to a range of health, social, specialist counselling and mental health organisations according to the preferences and need of the victim/survivor. Victim/survivors who attended the SARC (and consent to follow up contact) are followed up via telephone call at either three or six weeks post-attendance in order ensure aftercare and referrals to additional support services are progressing.

8.1.2 Counselling and Advocacy services

A range of counselling services may be beneficial to victims/survivors, some of which are specific to sexual; violence and abuse whilst others may be more generic. Counselling may also be provided by a range of services including clinical services such as Improving Access to Psychological Therapies (IAPT), Child and Adolescent Mental Health Services (CAMHS), private counselling and specialist sexual violence and abuse services. Generic therapy for sexual violence and abuse victim/survivors can include one-on-one therapy, group therapy and, in some cases, medication used alongside other therapies. The type of therapy used depends a lot on the individual and their circumstance but common therapies include:

- Cognitive Behavioural Therapy** (CBT)
- Eye Movement Desensitisation Reprocessing*** (EMDR)
- Supportive counselling.

8.1.3 Specialist SVA Counselling

Rape Crisis England and Wales define specialist sexual violence and abuse as ‘holistic, victim-centred, and needs-led, and delivered by the third sector (voluntary sector) organisations whose *primary purpose* is the provision of such specialist services.[66]

Specialist sexual violence and abuse services are predominately centred around therapeutic responses, often through the provision of medium to long term counselling. Such services work with victims/survivors who have experienced sexual violence or abuse at any point in their lives. Specialist counselling is generally based around empowerment, resilience building and the ability to cope and recover. Counselling provides a space and opportunity for survivors to explore and work through their experiences of sexual violence and abuse. Specialist sexual violence and abuse counsellors have a profound understanding of the nature of the psychological effects that occur as a result of sexual violence and abuse. Counselling provides the victim/survivor with the appropriate skills and techniques required to enable them to manage such effects that can carry over into post-trauma life. Counselling can also be provided to parents, carers, partners, family and friends of victims/survivors. During

** Cognitive behavioral therapy focuses on the relationship among thoughts, feelings, and behaviors; targets current problems and symptoms; and focuses on changing patterns of behaviors, thoughts, and feelings that lead to difficulties in functioning.
*** A structured therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories. EMDR therapy differs from other trauma-focused treatments in that it does not include extended exposure to the distressing memory, detailed descriptions of the trauma, challenging of dysfunctional beliefs or homework assignments.

their counselling process, most victims/survivors will go through three stages in recovering from the trauma of sexual violence and abuse:

- Stabilisation and safety building: Overcoming dysregulation
- Managing/coming to terms with traumatic memories
- Integration and moving on. [67]

8.1.4 Specialist Advocacy

The consequences of sexual violence and abuse on the lives of victims/survivors are far reaching and advocacy support may be required to support the individual's wider needs. Advocacy is defined as "*taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice*".[68] The primary aim of advocacy is to enable vulnerable individuals to maintain their independence and accommodation within the community in the aftermath of sexual violence and abuse and to put in place safeguards and support to prevent escalation to adult safeguarding.

8.1.5 Independent Sexual Violence Adviser (ISVA)

ISVAs play an important role in providing specialist criminal justice system tailored support to victims and survivors of SVA, irrespective of whether they have reported to the Police. ISVAs provide impartial information to victims/survivors about all of their options such as reporting to the Police, accessing the Sexual Assault Referral Centre (SARC) services and specialist support such as pre-trial therapy and sexual violence counselling. The nature of the support that an ISVA provides varies from case to case and depends on the needs of the victim/survivor and their particular circumstances.

8.1.6 Pre-Trial Therapy Guidance

The Ministry of Justice's Code of Practice for victims of crime stipulates that victims of crime should be informed that pre-trial therapy is available if needed, and, if requested will be facilitated.[69] Whilst Victims are entitled to pre-trial therapy, guidance from the Crown Prosecution Service (CPS) regarding Pre-Trial Therapy advises that certain clinical therapies such as EMDR and Reprocessing Therapy are not appropriate for victims/survivors who have open police cases. Generally, group therapy sessions should also not be provided, due to the risk of the individual taking on the experiences of others within the group. [70]

Victims and Survivors will need different levels of care and different types of support at different times in their lives and this will be dependent on their circumstances, the pace of their recovery and the level of expertise and support received at the point of disclosure.[71] In order to address and support these needs a holistic and trauma informed approach is most effective. A trauma informed approach is described as below: [72]

> *'One that realises the widespread impact of (psychological) trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatisation'*

Commissioning arrangements of support services is most effective when looking at the holistic approach and recognising the strength of specialist sexual violence and abuse support services within the voluntary sector.

8.2 Description of local provider landscape

In Thurrock there are number of services that are able to support victims/survivors of SVA. This includes both specialist and non-specialist sexual violence and abuse services. Specialist SVA services may include SARC provision and specialist SVA ISVA, counselling and advocacy services and non-specialist provision may include support from mental health services, sexual health services, drug and alcohol services, housing support etc.

8.2.1 The Sexual Assault Referral Centre

The Essex SARC is delivered by Mountain Healthcare Limited and is commissioned jointly between Essex Police and Fire Crime Commissioner and NHS England. The SARC provides services to any child, young person or adult who have experienced recent or non-recent rape or sexual assault in the geographical area of Essex. The SARC operates from a dedicated facility at Oakwood Place at Brentwood Community Hospital. There are three main referral routes for a client to access the SARC; police, self, or referral by another agency (with consent of the victim/survivor). The SARC is not a drop-in centre as bookings for examination are required prior to attendance. All requests for examination should be made via the Mountain Healthcare call centre who operate 24/7 telephone line. For self-referrals, appointments are made with the client and are available from 8am-8pm, 7 days per week. For young people under the age of 13 years, there is a 7 day a week service and examinations are carried out during 9-5pm during the week and 10-2pm on weekends and Bank Holidays.

The Sexual Offence Examiner (SOE) is responsible for the health and welfare of the victim/survivor attending the SARC. As well as conducting a forensic medical examination, there is a requirement to assess the physical and mental health needs of the client, as well as considering their emotional wellbeing, safeguarding and other vulnerabilities. It is the duty of all staff working directly with the client to consider the client's safety when leaving. A joint risk assessment will be undertaken by the SOE, the police (if present) and the SARC's crisis worker prior to the client leaving.

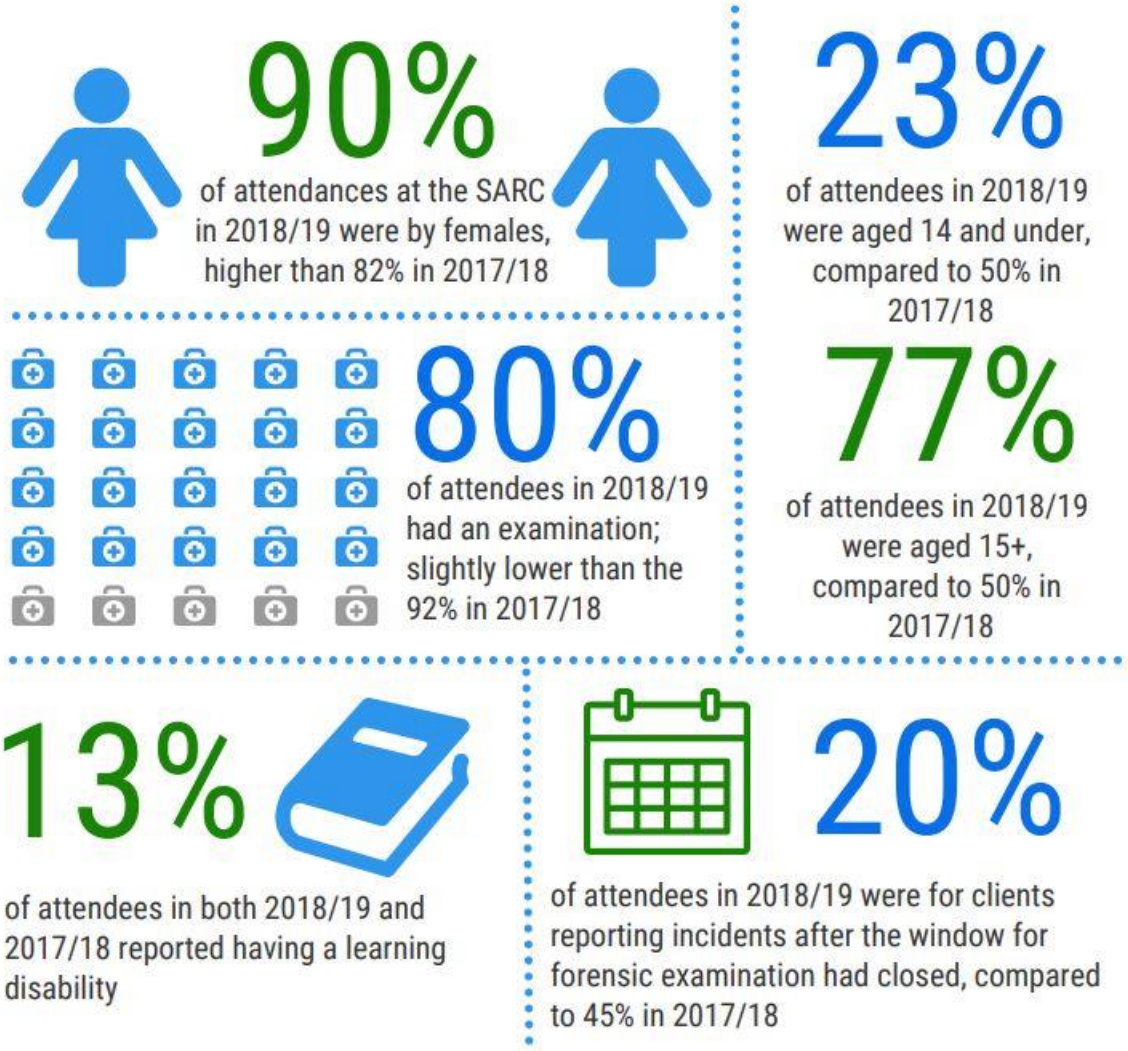
8.2.2 Attendances at the SARC by Thurrock Residents

In 2017/18, 38 Thurrock victim/survivors attended the Essex SARC, of whom 45% were referred by the police, 26% by Social Care, 16% by GP/Agency and the remaining 8% were self-referrals.

The number of victim/survivors attending the SARC in 2018/19 was similar, with 30 attendances (of whom 53% were referred by the Police, 20% by Social Care and 22 % were self-referrals, the remaining 5% from A&E/GP's).

The number of self-referrals to the SARC tripled between 2017/18 and 2018/19. Due to the low numbers of Thurrock victims/survivors accessing the SARC, in-depth analysis cannot be published however key findings are included in Figure 25 below.

Figure 25: A summary of SARC attendances for 2017/18 and 2018/19



The statistic that 20% of SARC attendees were attending 'late' i.e. reporting incidents after the window for forensic window had closed disguises the variation between paediatric and adult SARC service provision. Data from the SARC shows that approximately two thirds of children seen at SARC were for non-recent incidents of SVA while less that 5-10 % of adults were for non-recent incidents. Due to an absence of data from other areas, it was not possible to compare the SARC attendances made by Thurrock residents with attendances from similar areas.

Of the victims/survivors attending the SARC in 2018/19, 53% had one or more vulnerability factors. This was higher than the 24% in 2017/18. The vulnerability factors are broken down below:

Figure 26: Vulnerability factors of the SARC attendees

	2017/18	2018/19
Mental Health	18%	45%
Learning Disabilities	8%	7.5%
Domestic Violence	5%	17%
Self-harm concerns	11%	7.5%

It is to be noted that 45% of victims/survivors attending the SARC in 2018/19 reported having a mental health condition, significantly higher than 18% reported in 2017/18. The SARC have reported that this is attributable to improved data recording amongst their staff. A summary of the onward referrals made from the SARC attendees are included in tables 6-9 below.

Table 5: Summary of onward referrals (all age groups – whether examined or not examined)

Agency	Number of survivors referred	% of all total survivors referred
Sexual Health	18	58% (of those 13+)
Safeguarding	8	34% (of adults)
Mental Health	4	13% (of those 13+)
Social Care	10	71% (of those aged <17)
Children's ISVA	6	100% (of those aged <13)
ISVA	17	73% (of adults)

It is noted that the onward referrals as described above do not match the vulnerabilities identified by the victim's/survivors upon assessment at the SARC. Whilst it was not possible to ascertain whether the survivors who were not referred for onward support were already known to services or had already had a referral made/self-referred, this is particularly relevant for mental health services and sexual health services. Some survivors may have also been allocated an ISVA prior to attending the SARC.

If a Thurrock resident did access another SARC outside of Essex they should be accepted, however there have been incidents where this has not happened. Information gathered by Essex Police indicates that there were no Thurrock residents who accessed another SARC within the East of England region.

8.2.2 Specialist sexual violence and abuse counselling

South Essex Rape and Incest Crisis Centre (SERICC) are currently the only sexual violence and abuse counselling, advocacy and support service in Thurrock. The Essex Rape and Sexual Abuse Partnership known as 'Synergy Essex' was formed in 2015 and is comprised of three providers:

- SERICC (South Essex Rape and Incest Crisis Centre) covering South Essex (Thurrock, Basildon, Brentwood, Harlow and Epping)
- CARA (Centre for Action on Rape and Abuse) covering mid and north Essex (Chelmsford, Colchester, Braintree, Uttlesford, Tendering and Maldon).
- SOS (Southend–on–Sea Rape Crisis) covering Southend, Castle Point and Rochford.

SERICC is the lead partner in this arrangement. SERICC receives some dedicated funding specifically for Thurrock and also allocates a proportion of Essex-wide grants, contracts and donations towards Thurrock residents.
Synergy Essex provides a single point of access to specialist sexual violence and abuse services across Essex. Following a referral in to Synergy Essex, a referral is received by the Synergy Essex Triage Team and contact made with the victim/survivor within 48 hours. A risk and needs assessment is conducted and a referral made in to the relevant service as required.

SERICC provides psychological therapy services; offering assessment, signposting and specialist sexual violence and abuse counselling provision to adults, young

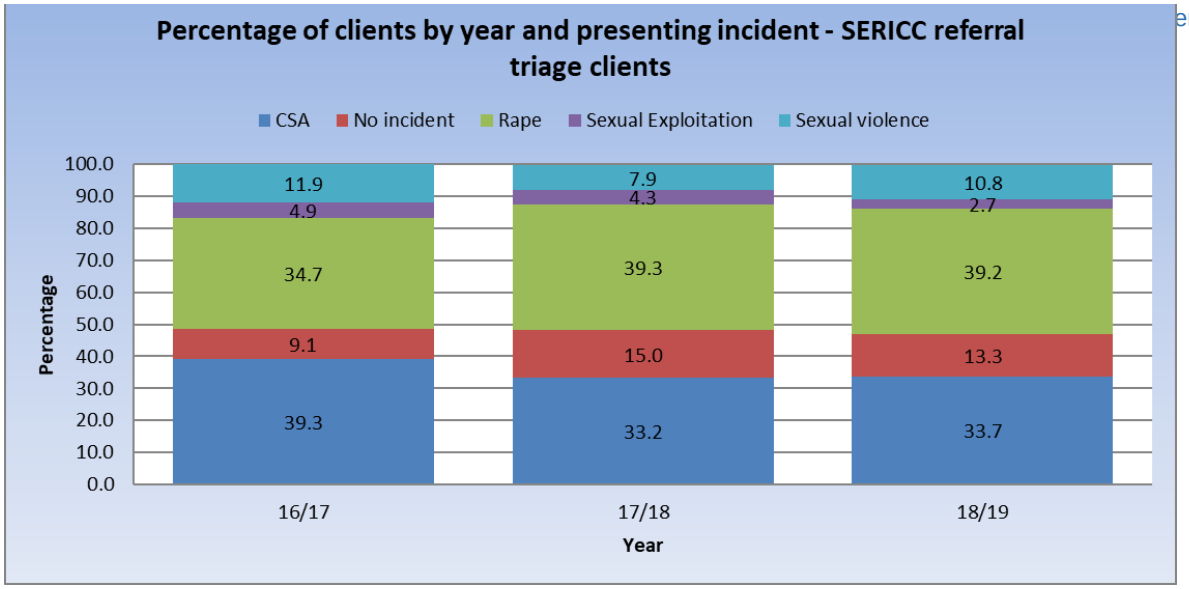
people, children, families and carers who are referred to the service. SERICC's specialist Sexual Violence Counsellors use a wide range of therapeutic approaches including; sensorimotor psychotherapy, resilience and empowerment models, mindfulness, person centred counselling, solution focussed, play therapy, family therapy, couples therapy and art therapy. For those of SERICC's service users who have open police cases, SERICC follows the Crown Prosecution Service (CPS) Pre-Trial Therapy guidance, which along with national research, advises that certain clinical therapies (including EMDR and Reprocessing Therapy) may not be appropriate in pre-trial cases.

SERICC are partly funded by Thurrock Council Local Authority, Thurrock Clinical Commissioning Group (CCG) and the Essex Police, Fire and Crime Commission (PFCC) to deliver a range of services to victims/survivors in Thurrock, as demonstrated below. A summary of each contract and its activity is detailed in Appendix 6.

	Local Authority (Adults)	Local Authority (Children's)	PFCC	CCG
ISVA: Adults			X	
ISVA: Children's			X	
Advocacy & Floating Support	Age 16+		X	
Family Support		X		
Counselling: Adults			X	Age 18+
Counselling: Children & Young People (age <25)		X	X	Age 18+

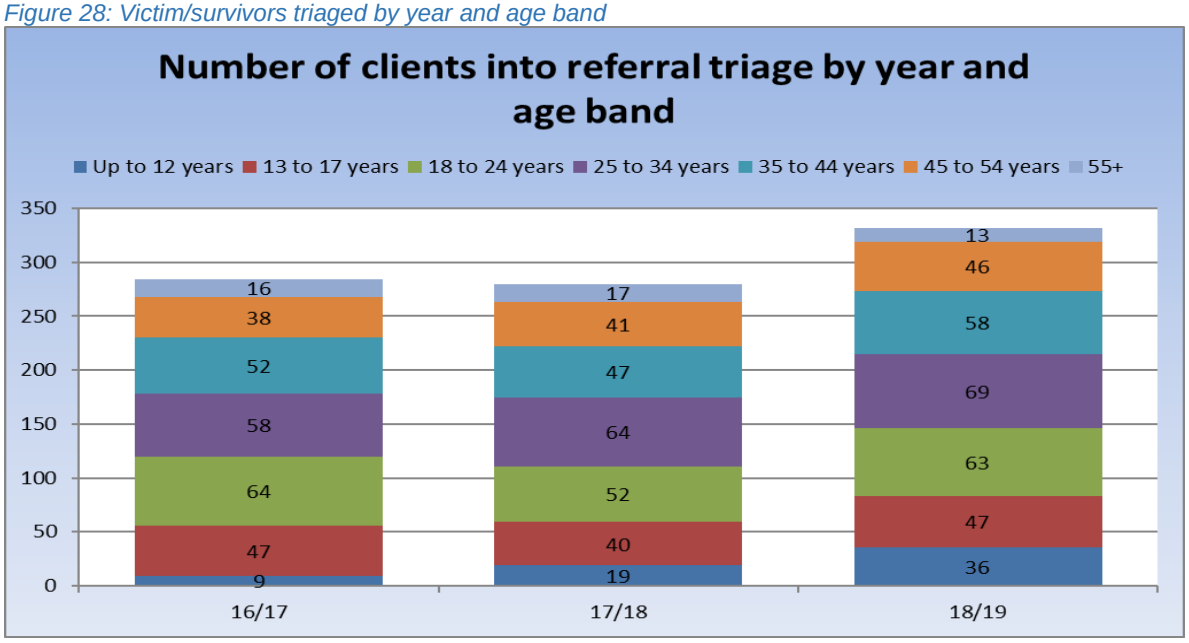
8.2.2.1 Referral Triage Activity

In 2018/19 332 victims/survivors were triaged for specialist sexual violence services via SERICC's single point of access. This has increased from 280 in 2017/18 and 284 in 2016/17. Of those triaged, approximately a third each year presented with CSA, and almost 40% reported a rape. It is to be noted that 'no incident' refers to those who have not experienced sexual violence or abuse themselves however have been affected e.g. partners, parents and siblings.



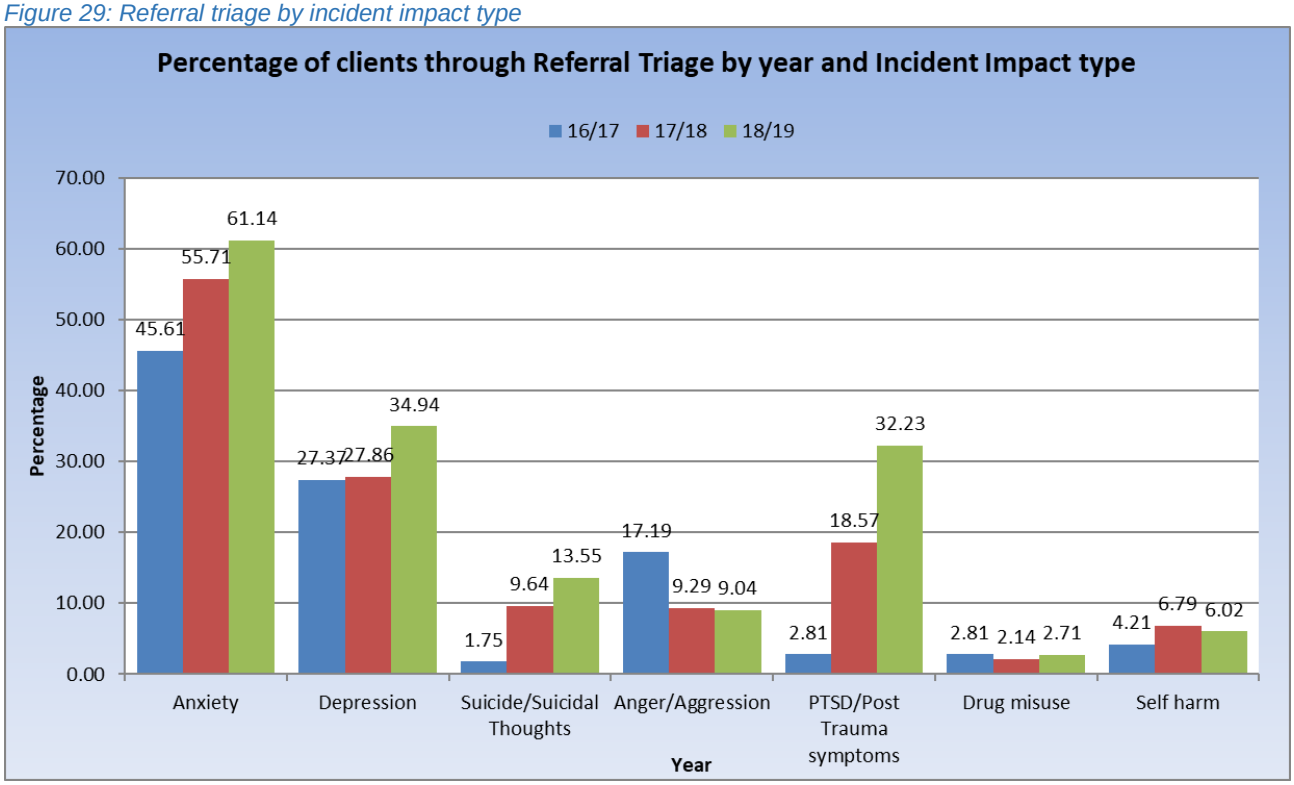
Of these victims/survivors, many were young, with 83 out of the 332 service users in 2018/19 under the age of 18 years. The number of under 12 year olds has increased year on year since 2016/17, as has the number of 45-54 year olds.

Figure 28: Victim/survivors triaged by year and age band



Data collected by SERICC also records the presence of other co-existing issues upon entering referral triage. It can be seen from the figure below that over 60% of service users in 2018/19 had anxiety, and around one third had depression. Both of these proportions have increased each year. In addition, **the proportion presenting with PTSD or trauma symptoms has also increased, from 2.8% in 2016/17 to 32.2% in 2018/19.**

Figure 29: Referral triage by incident impact type



One other co-existing issue that is not shown in the chart above is the proportion of referrals where domestic violence had either been experienced in the past or was still ongoing at the time of abuse. Domestic violence was recorded on 49 out of the 332 referrals in 2018/19 – equating to 14.8% of cases.

8.2.2.2 Usage of SERICC services

In 2018/19 a total of 498 victims/survivors accessed support from SERICC. A breakdown of this usage by service can be found in Appendix 7.

Figure 30 below shows the overall use of SERICC services over the last four financial years. It is to be noted that these totals includes victims/survivors who are accessing more than one service e.g. accessing counselling in conjunction with advocacy services. In 2018/19, 77% of attendees were new and 23% were existing service users.

Figure 30: The number of SERICC services accessed by Thurrock victims/survivors

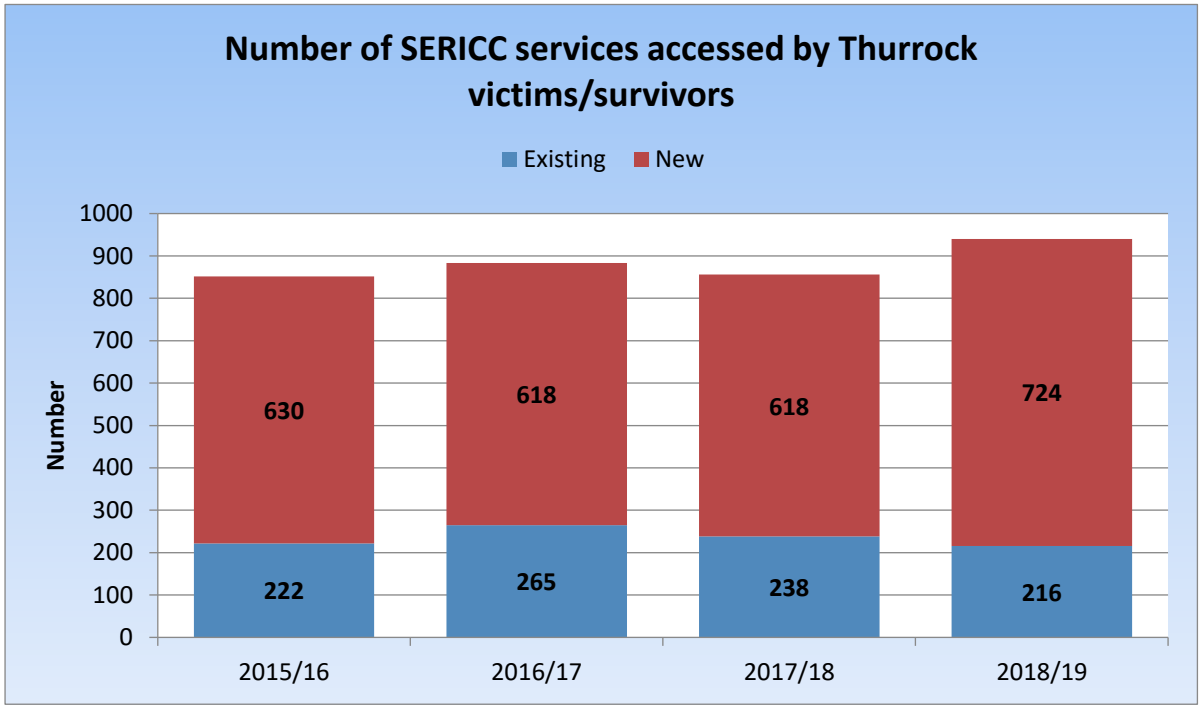


Figure 31 below shows the number of victims/survivors SERICC have supported over the last four financial years. It is to be noted that there has been a year on year increase in the number of victims/survivors accessing SERICC services, equivalent to a 20% increase over the last 4 years.

Figure 31: Total number of survivors accessing support from SERICC

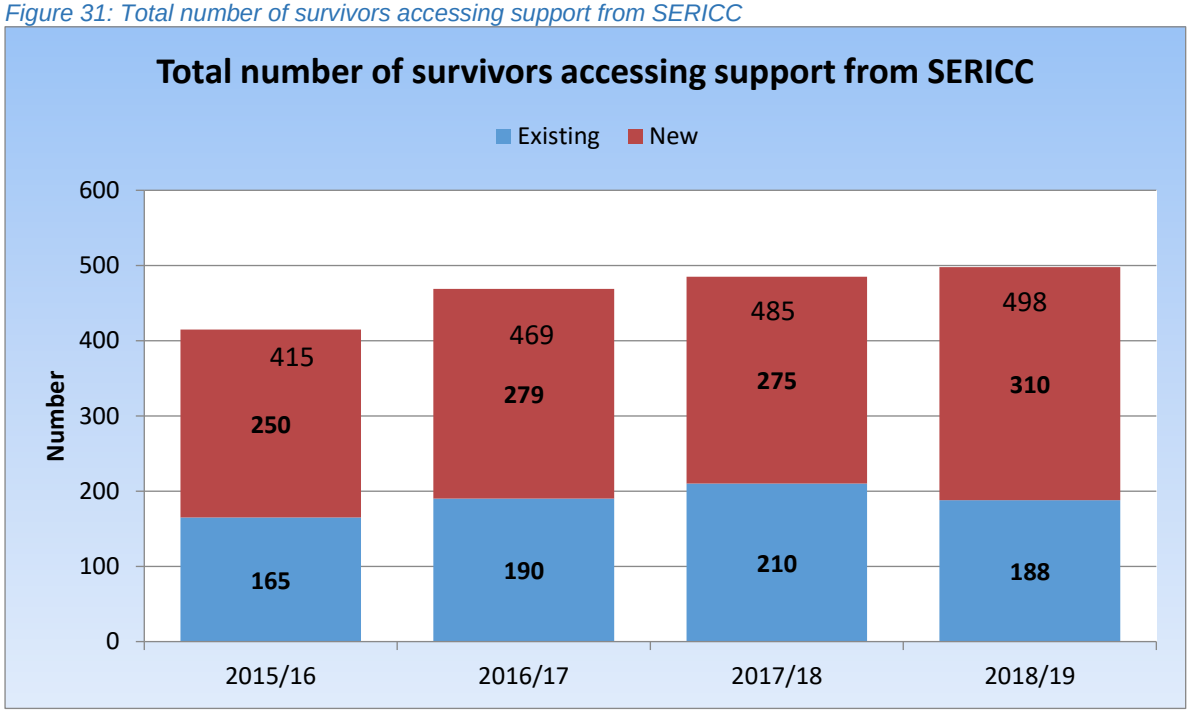


Figure 30 and Figure 31 show that the average service use per victim/survivor is different for new and existing victims/survivors for 2018/19. In 2018/19 there were 310 new survivors who accessed 724 services provided by SERICC, equating to an average of 2.33 services used per person. This was greater than the usage by existing survivors (216 survivors using 188 services, equating to an average of 1.15 services used per person). The way in which specialist SVA services are commissioned locally makes it difficult for the service provider to support survivors holistically as each commissioned service requires separate reporting outcomes.

Further to this, current reporting mechanisms do not take in to account the duration that victims/survivors receive support for, nor does it take in to account that some victims/survivors may require more support than others. This needs assessment therefore lacks understanding of the frequency and duration that local survivor's access specialist SVA counselling and advocacy for.

8.2.2.3 Waiting times for SERICC services

Due to set requirements through commissioning arrangements, SERICC do not have waiting lists for any victim/survivor who lives in Thurrock and is under the age of 25. For victims/survivors aged 25 and over, the average wait time experienced in the year 2018/19 was 49 calendar days for specialist sexual violence counselling. At the point of initial assessment, each victim/survivor is allocated a First Contact Navigator (FCN) who holds their case whilst on the waiting list. During this period, all victims/survivors have access to emotional and practical support via the Synergy Essex information and support line, as well as through their FCN. We were unable to ascertain waiting times regarding specific services within the SERICC contracts.

It is also to be noted that not all victims/survivors want to receive support straight away, particularly counselling. This was evidenced in the local engagement with victim/survivors and the evaluation of the Talking Therapies service.

8.3 Non-specialist SVA specific services

It is recognised that victims/survivors of sexual violence and abuse may present at a number of services including those identified in Figure 24. Below are examples of services locally where victims/survivors may attend. Victims/survivors may or may not chose to disclose their experiences whilst accessing these services, however the below seeks to describe what happens when a victim/survivor attends each service.

8.3.1 General Practice

GPs and nurses are able to sign post or refer victims/survivors to a range of appropriate support services including but not limited to; SERICC, Mental Health Services, substance misuse services and sexual health services. They also have a statutory responsibility to refer to Children's Social Care should they have concerns that a child/young person is at risk of harm. Initial investigations have found that there are specific read codes on Systm One (the clinical system used by most GP practices locally) which denote sexual abuse, but the usage of these codes appears to be varied. Local conversations are underway with General Practice in Thurrock to explore the current process and the extent to which they interface with sexual violence and abuse in more detail. Locally, engagement showed that local professionals viewed GPs as a point of referral when receiving disclosures therefore it is imperative that current practices are understood and improved upon if necessary.

8.3.2 Hospital

The main acute hospital that is likely to be accessed by Thurrock SVA survivors is Basildon and Thurrock University Hospital. If it is clear from the initial presentation at A&E that it is related to sexual violence, it should be coded as such. However, it is known that there have been inconsistencies with coding practices both at Basildon Hospital and nationally. This is also the case for the coding of emergency admissions data – running a report on the most relevant national ICD10 code – T742 (sexual abuse) yielded only 65 admissions in 2018/19 across the country with T742 recorded as the primary diagnosis. It could be that other codes are used or that T742 is perhaps coded as a lower diagnosis category than primary – which is likely to be the case if a patient presents with a differing more visible symptom (e.g. there has also been drug use or injuries following domestic violence also). Further work should be undertaken locally to explore this further – including to ascertain how onward support for SVA is offered within both A&E and ward settings.

8.3.3 Sexual Health Services

The Thurrock Sexual Health Service is run by Provide Community Interest Company and provides a range of sexual health and contraception services including HIV and STI testing and emergency contraception. The Service has safeguarding policies in place for children and young people and adults. As part of consultations with service users of all ages, a series of safeguarding questions are asked that may identify previous or current sexual abuse as well as risk factors for vulnerability and exploitation. The assessment process includes a range of questions linked to sexual behaviour with a focus on risks including transactional arrangements as part of sexual activity, thoughts and feelings about sex and partners, as well as details about their sexual partner. The assessment process includes all elements of the 'Spotting the Signs' framework developed by Brook.

For children and young people, all service users under the age of 16 must have a face to face consultation in order to assess Fraser and Gillick competency. All suspected cases of CSE must be referred to the Local Authority, following the Local Authority's threshold, by using the appropriate referral form. This referral is made regardless of any other immediate actions that have been taken to reduce harm to a child or a young person. A CSE Risk and Vulnerabilities Assessment is also completed. An assessment of 'actual' and potential' harm is categorised into Standard Risk, Medium Risk, High risk and Actual indicator of CSE. Any threshold for high level risk and above must be referred to the local authority and concerns should be shared with Essex Police's Operations Centre Triage Team. If a disclosure of rape or sexual assault is made an immediate risk assessment is conducted and dependent on any immediate risk, options are presented or immediate referral is made.

The Thurrock Sexual health Service has very close links with the Essex SARC and robust pathways are in place to support a rapid referral to the Essex SARC for both recent and non-recent disclosure. This referral process ensures that victims/survivors of sexual assault and rape are offered both support and choice with the welfare of the victim/survivor being at the centre of the process.

8.3.4 Domestic Violence and Abuse Services

Changing Pathways are the provider of Domestic Violence and Abuse support services in Thurrock which includes refuge, advocacy and therapy/counselling.

Through the Brighter Futures service, Changing Pathways are also commissioned to provide an eight week therapeutic one-to-one programme for adults with children. Topics included within this programme include understanding abusive behaviours, power and behaviours, strengthening positive relationships, building resilience and self-esteem, speaking to children about abuse and keeping safe (safety and support planning). During the programme, women are empowered to address the issues affecting them and their children. As well as exploring the emotional impact of abuse on them and their children, the programme also provides an opportunity to develop/build on positive parenting, building resilience and emotional well-being after domestic abuse. The staff within the service ask their service users questions related to sexual violence and abuse as part of the Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment. It is has been noted that amongst service users disclosures of sexual violence and abuse are not forthcoming, often attributable to victims/survivors not being aware of what constitutes as sexual violence and abuse. This is particularly the case for those in relationships and requires further awareness.

8.3.5 Substance misuse services

Inclusion Visions is the adult drug and alcohol treatment service in Thurrock. The service offers a free and confidential service to residents of Thurrock aged 18 and over affected by drug or alcohol use. They support people to facilitate change in their lives through motivation and providing evidence-based interventions. Support may include; one-to-one and/or group work psychological support, substitute prescribing, community or residential detoxification and/or rehabilitation, needle exchange services and health and lifestyle support.

The Wize-Up young person's substance misuse service offers specialist support to children and young people in Thurrock under the age of 18 and their families. The service offers free and confidential advice, information and support to help young people cut down or stop using alcohol or drugs, including new psychoactive substances. The offer includes; specialist one-to-one sessions, support for young people affected by the hidden harm of parental substance misuses, access to counselling, advice and information for parents and carers and support to access other health and lifestyle support.

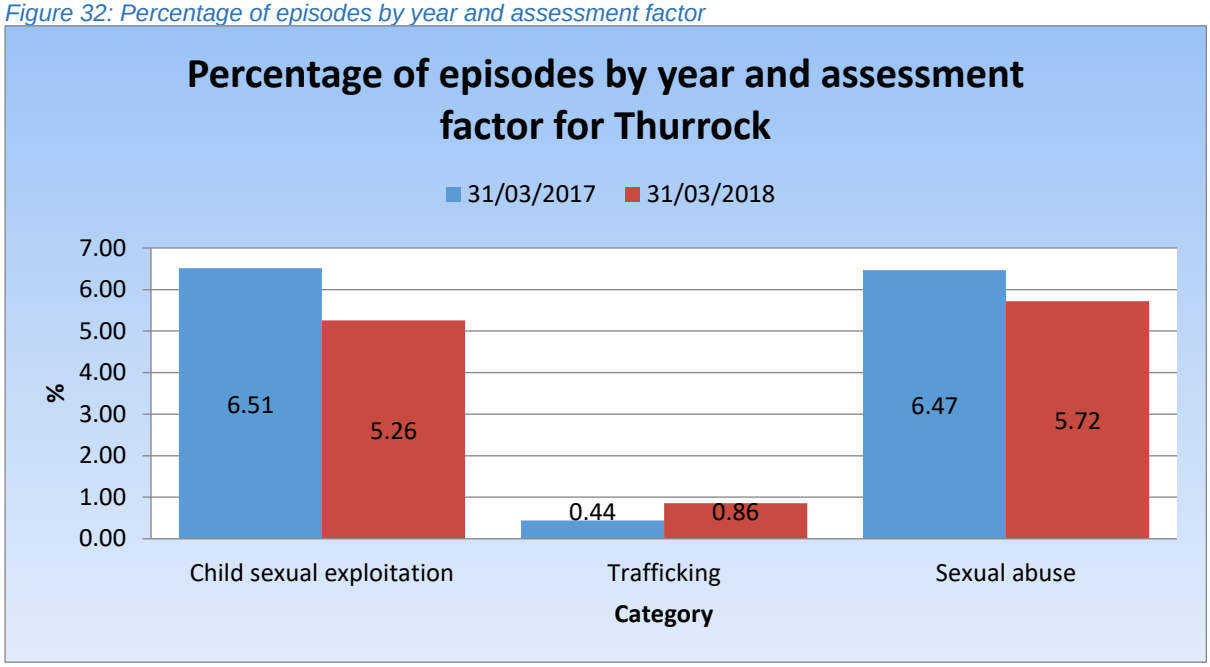
8.3.6 Children's Social Care Provision

Children and young people who are victims/survivors of sexual violence and abuse may be known to Children's Social Care. Thurrock Council have a Multi-Agency Safeguarding Hub (MASH) in place to handle safeguarding referrals address safeguarding needs appropriately. The purpose of the MASH is to enhance information sharing across all organisations involved in safeguarding the welfare of children in Thurrock - encompassing statutory, non-statutory and third sector sources. Core agencies (including Social Care, health agencies, police, probation, housing, mental health services, sexual violence services, domestic violence services) will ensure that their representatives either sit in the MASH office on specific days or have 'virtual' contact. All partners will work together to provide the highest level of knowledge and analysis to make sure that all safeguarding activity and intervention is timely, proportionate and necessary. Upon receipt of a referral, the MASH 'Hub' will analyse information that is already known within separate organisations in a coherent format to inform decisions. Referrals are then RAG rated and acted on accordingly. Decisions may include referrals in to Children's Social Care services such as the

Prevention and Support Service (PASS) or to specialist sexual violence and abuse services.

As of 31st March 2018, there were 226 children who were subject of a Child Protection Plan in Thurrock. 11 of these had their latest category listed as sexual abuse, which equates to 4.87%. This is slightly higher than the proportion from the previous year, which showed that 4.28% had a latest category of sexual abuse. *It should be noted that the true number of children on Child Protection Plans who have experienced sexual abuse is likely to be higher, due to the fact that the recording process only allows one category of abuse/neglect to be selected; meaning that if sexual abuse was not selected as the highest identifying category, it will not show in the reported figures.* When looking at children classified as Children In Need, as of 31st March 2018 there were 1,749 assessment episodes in Thurrock which supplied information on key risk factors. Of these, sexual abuse was recorded in 100 episodes, 92 recorded child sexual exploitation and 15 recorded trafficking. Comparing this to the previous year, the proportion of episodes highlighting child sexual exploitation reduced (5.26% compared to 6.51% in 2017), and there were no significant changes to proportions identifying sexual abuse or trafficking. It should be noted that each episode can record multiple risk factors on it.

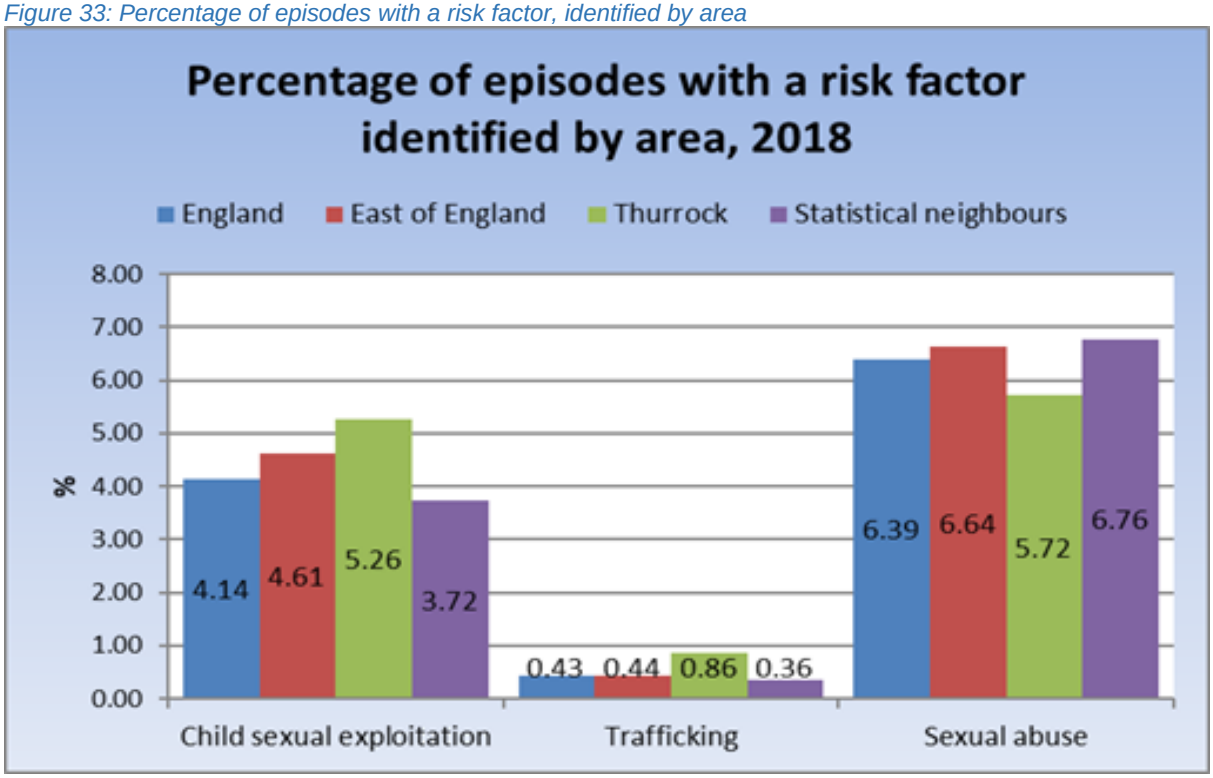
Figure 32: Percentage of episodes by year and assessment factor



Source: Children in Need and Child Protection Statistics, 2019

When comparing Thurrock to other areas, Thurrock has a higher proportion of episodes with child sexual exploitation and trafficking recorded, and a lower proportion of episodes with sexual abuse recorded.

Figure 33: Percentage of episodes with a risk factor, identified by area



Source: Children in Need and Child Protection Statistics, 2019

8.4 Primary and Secondary Care Mental Health Services

A number of mental health services are provided in Thurrock, as summarised in Figure 34 and Figure 35. Further information can be found Appendix 5. It is to be noted that there are some elements of specialist mental health treatment that are provided to SVA survivors presenting with trauma symptoms.

Figure 34: Mental Health Provision for Adults

IAPT	• Improving Access to Psychological Therapies •Delivered by Inclusion Thurrock •Talking therapies for those with common mental health problems
Recovery College	• Delivered as partnership between Inclusion Thurrock and Thurrock MIND • Peer support pivotal component • Open access but specifically for those with a health need
Third sector provision	• The biggest provider is Thurrock MIND, who deliver a range of opportunities towards both those with mental health needs and to improve general wellbeing • Support includes counselling, peer support, advocacy and carers provision
Secondary Mental Health Care	•Essex Partnership University Foundation Trust provide a range of specialist mental health services •One particularly accessed by SVA survivors is the Personality Disorder Service. Work is underway to transform this pathway

Improving Access to Psychological Therapies (IAPT)

Inclusion Thurrock is the provider of IAPT support to patients aged 18+ registered at a Thurrock GP practice with a common mental health problem such as anxiety or depression. Within the IAPT offer, there are a number of specific services available:

- **Core IAPT** – this is the provision of IAPT therapies to patients with a common mental health problem. This is mandated by NHS England and has a number of monitoring targets to it around waiting times, access and recovery rates.

- **IAPT for those with long term conditions** – this is a newer service which aims to provide IAPT therapy to those where their physical long term condition is a contributor towards their mental ill-health, or their mental health negatively impacts the management of their long-term health condition. Inclusion Thurrock begun trialling this for patients with Diabetes, by developing new referral pathways within pilot GP practices and with long term condition management services provided by North East London Foundation Trust (NELFT). This new pathway will soon be expanded to include a focus on patients with Chronic Obstructive Pulmonary Disease.

- **IAPT Analgesic Pilot** – this is an innovative pilot aiming to provide specialist IAPT treatment to those addicted to legal opioid medications such as morphine products. A pharmacist has been recruited to specifically review and treat patients referred through the pathway, and IAPT therapists are providing psychological support where needed.

As well as the services listed above, Inclusion has been commissioned by Thurrock CCG to provide trauma-focussed treatment to Thurrock victims/survivors aged over 18 years of age, who have experienced sexual violence and sexual abuse at any time in their lives.

Thurrock IAPT have estimated that one third of their patients have experience of sexual assault or sexual abuse in their past. In order to meet this demand the service has continued to invest in ongoing training and development of staff to provide effective, evidence-based treatment for trauma, for example, in February 2017 the service invited a trauma specialist working for the Traumatic Stress Service to deliver a one-day training course on enhanced CBT treatment for trauma. In April 2017, the service began investing in EMDR training for its therapists, and currently have 9 qualified EMDR therapists in post. In December 2019, a further 9 therapists will be undertaking accredited training in EMDR, ensuring that the majority of CBT therapists in the IAPT service can also deliver EMDR. Thurrock CCG recently made a commitment to invest in 2 full time additional trauma CBT therapists to provide continuity of care and named link workers with SERICC to enable the delivery of integrated care models.

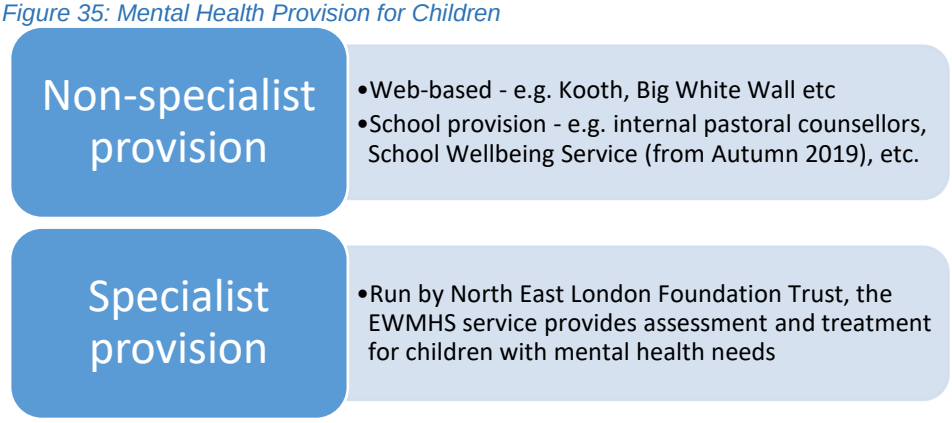
Inclusion Thurrock referred 19 patients to SERICC in 2017/18, all of whom required specialist support for issues relating to their sexual assault, but have not received any referrals directly from SERICC – although survivors might self-refer to Inclusion as that route is also available to them. Work has begun to improve the referral process and improve the joint working for patients known to both agencies.

Personality Disorder Service

The current specialist service for those with Personality Disorders is run by Essex Partnership University Foundation Trust (EPUT) and operates across the whole of the county. The service estimates that 70% of the patients on their current PD caseload (circa. 600) have a history of sexual assault and abuse.

There is a transformation programme dedicated to reforming the Personality Disorders service and further developing it within primary care. This should improve the level of joint working between Inclusion Thurrock, EPUT's Psychology team and Thurrock MIND, and should result in improvements to service delivery for patients with personality disorder (and in all likelihood sexual abuse histories). Part of this work also involves rolling out specific personality disorder training to primary care staff to further aid therapists in treating patients with co-morbid personality disorder and sexual abuse trauma. A pilot programme adopting these principles is being scoped currently and if successful will be rolled out across Thurrock.

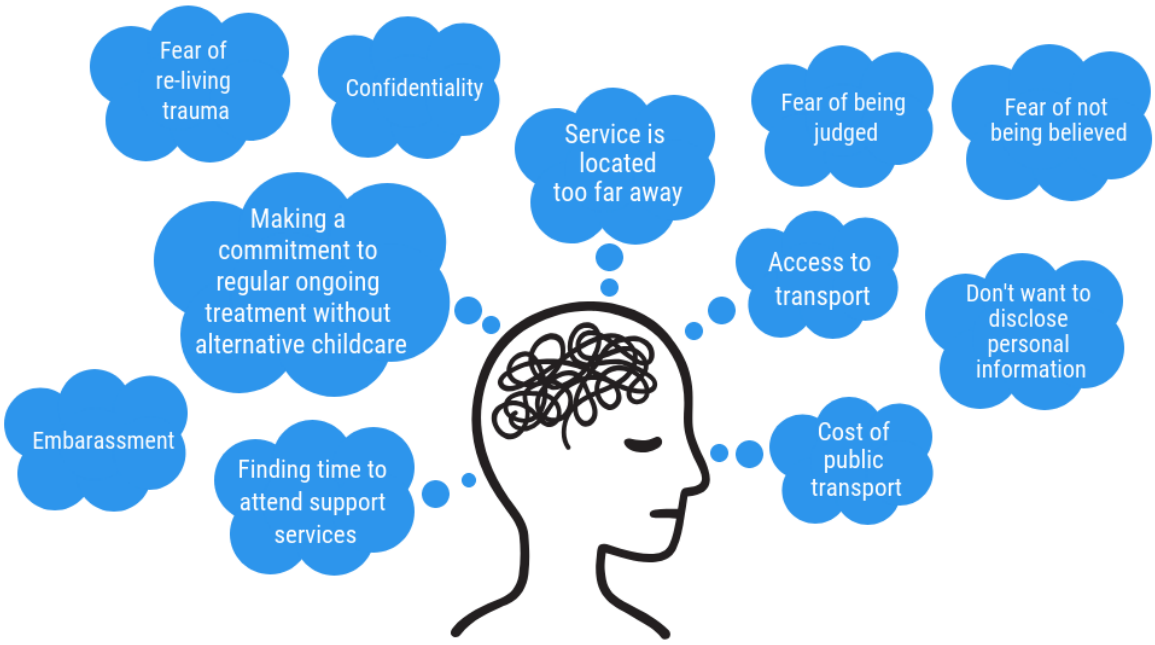
Figure 35: Mental Health Provision for Children



8.5 Barriers to accessing support

It is recognised that there are a range of barriers to seeking help and support. While these issues tend to affect those from more deprived groups,[73] they are not exclusively barriers of deprivation, with some examples of barriers demonstrated in Figure 36 below.

Figure 36: Why victims/survivors may not access support



Some barriers may be particularly pertinent within particular population groups. The 9 protected characteristics within the Equality Act 2010 should be considered; age, disability, gender, marriage and civil partnership, race, religion or belief, sex and sexual orientation.

Social stigma and perception of sexual and gender minority individuals in particular reduce service access and often render service responses inappropriate. This may exacerbate existing distrust of authorities and services among some members of these communities.[74] The lack of services specifically tailored for these populations is also a significant barrier. In a survey of 684 intimate partner violence and sexual violence agencies, 94% of responders said that they did not provide services tailored to sexual and gender minority communities.[75]

Though many barriers are shared across all gender and sexual identities, it is important to understand the cumulative effects of multiple barriers. Beyond gender and sexual identity, victims may also face barriers pertaining to their race, religion, age, language, disability or socioeconomic status. Sex work and drug use can further complicate relationships with formal support services and decisions to disclose sexual violence and abuse.

8.6 Recommendations to address problems of access

The following recommendations are made to address problems of access in to local service provision.

Issue Identified	Recommendation to address this	Responsibility
Recommendations for improving access to services		
Survivors reported difficulties accessing the right service(s) at the right time. The extent to which barriers to accessing support occur locally remain largely unknown. Within our engagement work with survivors who had accessed services barriers to support were seldom mentioned, however the needs assessment lacked input from local survivors who were not known to have accessed support.	As part of the implementation of the new pathway of support (see chapter 11) a full communication programme to be effectively implemented to all relevant front line services. This will ensure survivors are able to access the right services at the right time.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
	A communications plan to inform the public of the new pathway should be developed. The plan should be informed by survivor's preferences for receiving information in order to increase knowledge and confidence in accessing services.	Thurrock Sexual Violence & Abuse Stakeholder Partnership
	Engagement work should be conducted with local survivors who have not accessed support in order to better understand local barriers.	Providers and Commissioners of specialist SVA services

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8.7 Issues on local provision

Locally, it is recognised that a number of organisations are involved in the commissioning and provision of sexual violence and abuse services, as identified in section 2.4. The fact that multiple commissioning organisations are commissioning local services recognises the value of specialist support services, however, these services continue to be commissioned in silos by a range of organisations. It is suggested that collaborative commissioning should be explored in order to consider whether the following are advantageous to the commissioners and victims/survivors accessing services:

- Commissioning services at a county-level in order to yield the benefits of economies of scale
- A reduction but ideally avoidance of duplication (e.g. tendering, performance and contract monitoring)
- Streamlined commissioning outcomes.

8.8 Victim/survivor voice on experience

The vast majority of feedback from victim/survivors regarding service provision was positive. It is apparent that the majority of survivors had accessed specialist SVA support from SERICC. Survivors frequently spoke highly of the staff within the service received with key themes including; being listened to, believed, respected and supported.

"SERICC were understanding from the start. They didn't push me or pressurise me. There was no pressure to report to the police or tell anyone else what happened. They just wanted to support me. [The staff member] that I saw was so knowledgeable and not only empowered me but helped me understand why I actually felt the way I did. The building was women only on the days that I went which was something I hadn't thought about before I went but actually meant a lot to me in my sessions."

Survivors also mentioned positive factors such as the flexibility of appointments, the benefits of group work, being able to meet with others who shared the same experiences, the location and the flexibility of appointments and staff.

Where negative feedback was provided, these included instances of waiting times, not being believed by staff, finding mutually convenient appointment times, barriers related to transport, difficulties accessing specialist SVA counselling and mental health services in conjunction with each other. It is to be noted that the organisations referred to above were not always mentioned.

The video below shows survivors the responses of local survivors when asked what support they hoped for and what support they received.

8.9 Recommendations to address issues with existing overall service provision

The following recommendations are made to address issues with service provision.

Issue Identified	Recommendation to address this	Responsibility
Recommendations for improvements to existing service provision		
Engagement with survivors recognises that they value a holistic offer of support and there is also a strong body of evidence in favour of this. However, local engagement with professionals and survivors identified that services do not always work together and where partnership working does occur, there is often fragmentation of pathways indicating more work is perhaps needed to reduce these inconsistencies	Providers and commissioners of specialist SVA services should agree a new integrated model and care pathway of support and then jointly commission/deliver it. The new pathway of support (as proposed in chapter 11) is to be further developed in consultation with survivors and all relevant services. The new pathway should be tested by local professionals in order to ensure it works effectively and expose any flaws or issues (e.g. through a dedicated training workshop).	Providers and Commissioners of specialist SVA services including Adult and Children's Social Care Commissioners, Mental Health Commissioners at NHS Thurrock Clinical Commissioning Group
Local survivors told of how their experiences of service provision has not always met their needs or expectations e.g. due to fragmentation of pathways, waiting times, quality. Locally, multiple services are commissioned to support survivors however they are mostly working to different outcomes. It is recognised that certain contracts related to SVA are commissioned at a county-wide level, considering the close proximity of all three local authorities in Essex (as well as sharing the same Police force, hospitals , SARC and single point of access for Rape Crisis Centres), there may be benefit in commissioning more SVA services at a county-wide level. However, it is to be noted that this needs assessment was solely focussed on Thurrock and therefore further work is required in order to ensure an appropriate offer is provided across Essex.	Local survivors should be invited to co-produce the new pathway of support and their views are used to develop services and form part of quality assurance of commissioned services.	Providers and Commissioners of specialist SVA services
	Adult and Children's Services Commissioners in Thurrock Council and NHS Thurrock CCG should review existing mechanisms for recording performance outcomes within specialist SVA services with the ambition to agree a consistent approach to monitor SVA outcomes within local contracts.	NHS, Council and Criminal Justice commissioners of specialist SVA services
	Council and NHS commissioners should integrate commissioning of SVA services and seek to develop a single contract, shared budget, single outcomes framework and collaboratively commission specialist SVA services across Essex.	NHS and Council Commissioners of specialist SVA services

Issue Identified	Recommendation to address this	Responsibility
	Specialist SVA services should be commissioned based on the evidence base presented within this needs assessment and accounting for data which will be collected through the proposed recommendations.	NHS, Council and criminal justice commissioners of specialist SVA services
Local engagement with survivors identified that over 50% said they waited for less than one month before receiving support, however, some survivors reported finding it hard to be on a waiting list once they made the decision to access support	An offer of emotional and practical support must be made available to all survivors on the waiting list for specialist SVA services. This could be informed by the evaluation of the locally delivered Synergy Essex '*First Responder Project'.*	NHS, Council and Criminal Justice commissioners of specialist SVA services

Chapter 9: Ascertaining the suitability of current support services to meet needs of all SVA survivors

9.1 Issues with current provider landscape

This needs assessment has identified a number of issues with the current provider landscape, as described below:

- Locally, multiple services are commissioned to support survivors however they are mostly working to different outcomes.

- It is recognised that certain contracts related to SVA are commissioned at a county-wide level, considering the close proximity of all three local authorities in Essex (as well as sharing the same Police force, hospitals , SARC and single point of access for Rape Crisis Centres)

- Local survivors told of how their experiences of service provision has not always met their needs or expectations e.g. due to fragmentation of pathways.

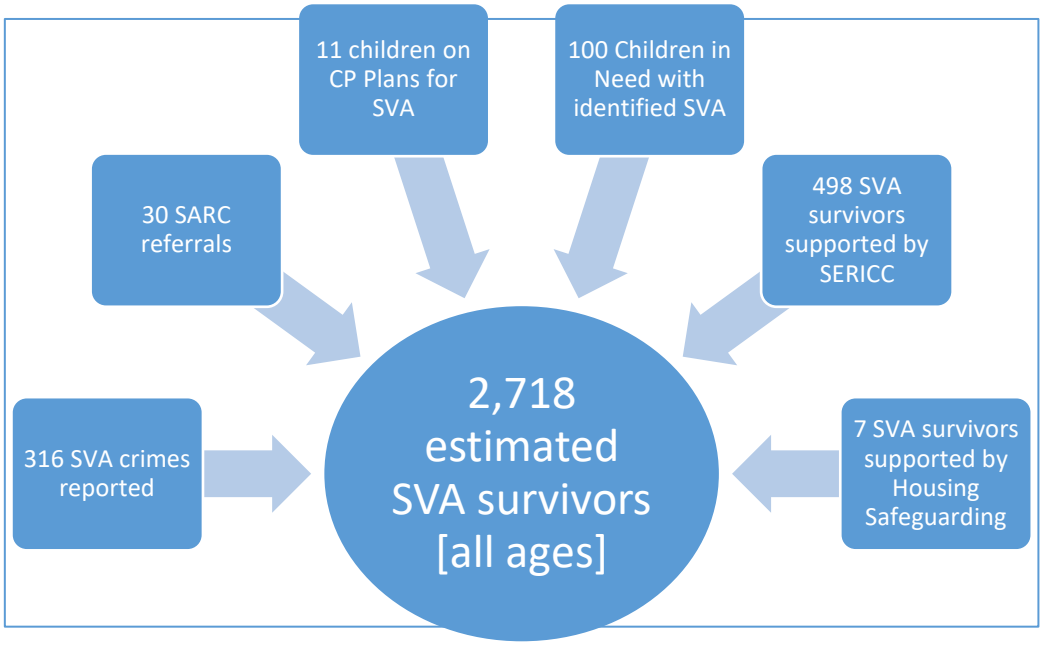
9.2 Quantifying the gap locally

It is difficult to establish an accurate level of need for sexual violence and abuse services in the Thurrock population. This is attributable to a number of factors, including:

- underreporting of sexual violence and abuse offences to the Police
- the length of time between the incident(s) and reporting to the police
- the length of time between the incident(s) and accessing support
- a lack of information sharing between agencies supporting survivors
- agencies not collecting information regarding whether or not the victim/survivor has reported to the Police
- victims/survivors may be accessing multiple services within the same organisation and therefore posing a risk of 'double-counting'
- victims/survivors may be accessing support for recent and non-recent sexual violence and abuse

As mentioned in section 3.2, it is estimated that the number of Thurrock residents who experienced sexual violence and abuse within the last year is approximately 2,718. As outlined in the various sections above, SVA victims/survivors are seen by a range of services and organisations. What we were able to establish is summarised in the diagram below:

Figure 37: SVA survivors being supported in Thurrock - 2018/19



As mentioned in sections 3.3 and 8.3 it not been possible to define the level of SVA presenting in GP and hospital settings. In addition, *it is not possible to deduce overlaps between those accessing services.*

Age is captured in differing age bands per service, but our data indicates that a large number of our known victims/survivors are young:

- The 100 children who are CIN and 11 who are subject of a CP Plan due to SVA are all aged 0-17 years – although as above, there may be other children with SVA known to Social Care who do not have SVA as their primary vulnerability factor

- 7 of the 30 SARC attendees were aged under 14 years

- 187 of the 316 reported crimes were aged 0-17 years when the incident occurred [59.2% of all reported SVA crimes]; although there were only 151 crimes reported by 0-17 year olds, indicating that some of these young people waited for a while before disclosing to the Police

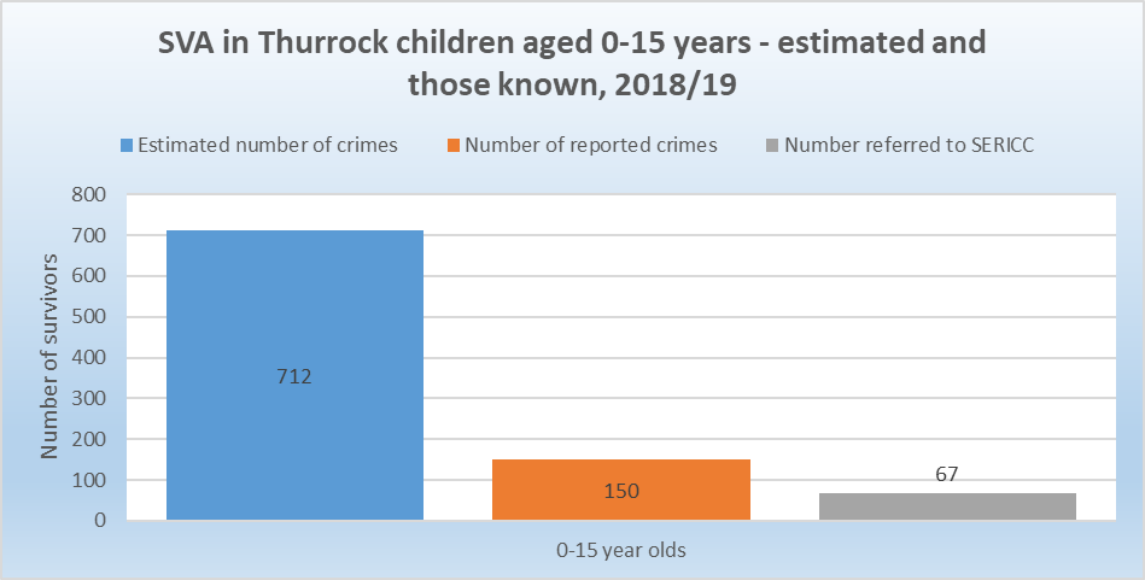
- 25% of the referrals triaged by SERICC in 2018/19 were for those aged 0-17 years – equating to 83 individuals.

- As mentioned in sections 8.3.1 and 8.3.2, it has not been possible to define the age profile of SVA in GP and hospital settings

The chart below looks to show the likely need for children aged 0-15 years in context with the numbers we know of in terms of recorded crimes and those known to SERICC.

It was not possible to directly compare the other data mentioned above relating to young people because of the differing age groups; however it can be seen that there is a large amount of unmet need in children also – despite large proportions of those known to services being younger. Approximately 21% of the expected number of crimes to 0-15 year olds were reported to Essex Police last year, and SERICC received referrals for only 9.5% of the estimated activity for that age group.

Figure 38: SVA in Thurrock children aged 0-15 years



Source: CSEW, Essex Police and SERICC data

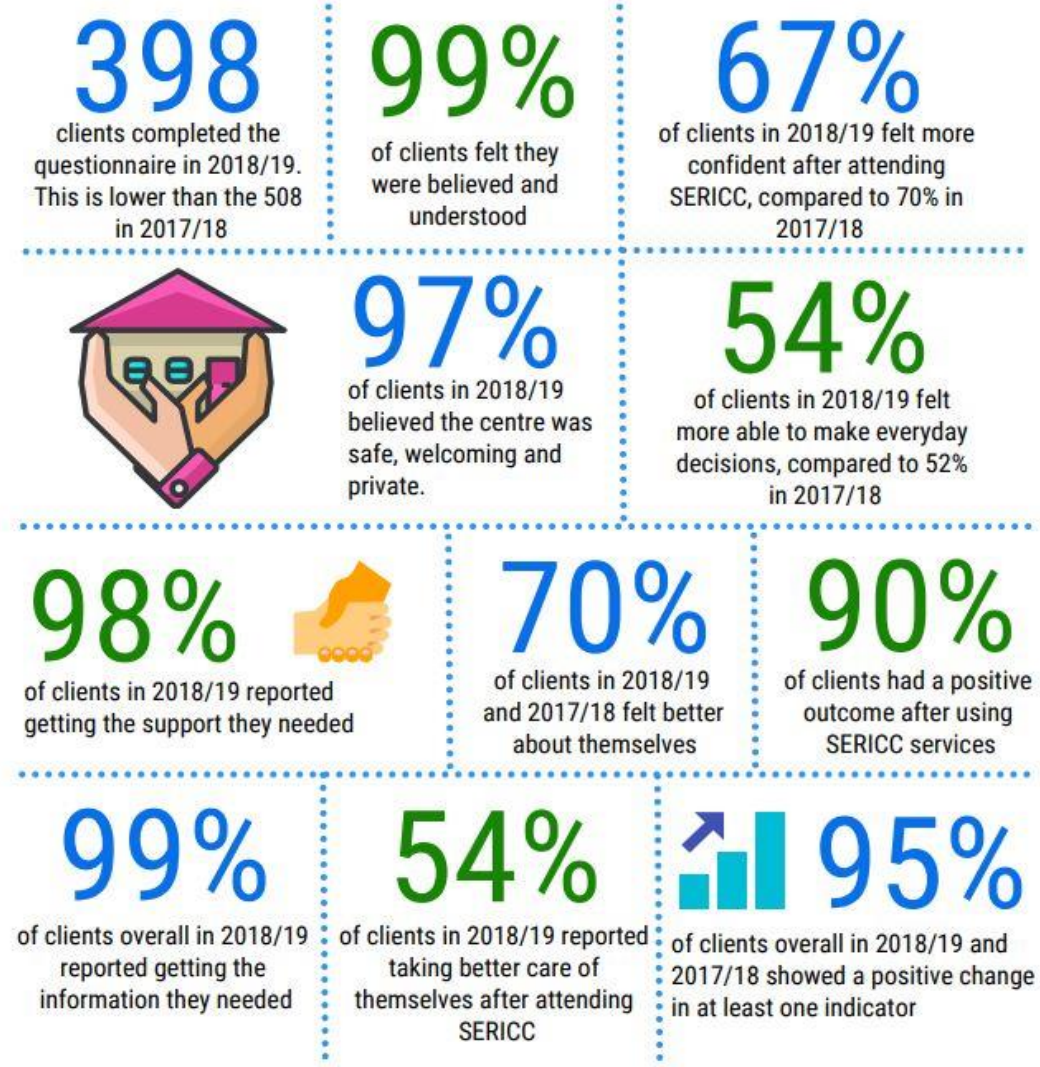
It is also to be noted, due to the low reporting rate of SVA offences to the Police, this data is not entirely representative of the type of sexual violence and abuse occurring in Thurrock. Considering the age groups of these young people, they *may* be more likely to be able to disclose and report their experiences due to increased opportunities for safeguarding etc., however the extent to which this impacts disclosure is unknown. The number of young people displaying harmful sexual behaviours is of concern and further exploration is required in order to understand this further. It is thought that lack of concern regarding consent, changing attitudes towards relationships and sex amongst young people and access to pornography may be contributing factors.

9.3 User voice

9.3.1 SERICC pre and post questionnaires

As part of their contract monitoring and evaluation of service provision and service user satisfaction, SERICC ask victims/survivors questions upon commencing the service and the same questions during their last session. A summary of the findings from 2017/18 and 2018/19 are included in Figure 39 below.

Figure 39: Findings from the SERICC before and after questionnaires



9.3.2 Findings from the engagement

Findings from the engagement regarding service provision were generally very good, however it must be noted that the majority of survivors who responded appeared to have accessed specialist service provision from SERICC and are likely to be those who have contributed to the views above in Figure 39. It is to be noted that some survivors mentioned waiting times to access services however did not specify which service(s) this was in reference to.

Survivor's perceptions of how services worked together were varied. Of the 44 survivors who responded to this question; 64% felt services worked together very well, 7% well, 7% were neutral and 23% felt services worked together poorly. A range of services were mentioned however it was noted that a number of survivors mentioned SERICC supporting them with Social Care. Some survivors also mentioned that they wished to receive mental health support as well as specialist sexual violence support however were informed that they were unable to receive mental health whilst accessing specialist support. Examples of local survivor's views are included below:

"When my SERICC worker contacted mental health as I was struggling the mental health team said I couldn't see them if I was having counselling at SERICC."

"SERICC worked really well with the drug and alcohol support services, social services, police, sexual health etc... SERICC have always provided a support worker I knew to take me to appointments and support me to have a voice at meetings etc...These other services have worked together with SERICC to ensure I had the best support."

"Mental health group in Grays not allowed to see me until SERICC has stopped seeing me as the woman from the group said you can't have two support at once."

"Extremely well giving me the support and guidance I need. SERICC and Changing Pathways have been brilliant."

The video below includes local survivor's accounts of the support they received.

9.4 Professionals views

Of the 128 professionals who provided their thoughts regarding whether services worked well together to provide support to survivors; 43% felt yes, 22% felt variably, 21% didn't know and 14% felt no. When asked how this could be improved the most common responses were to increase collaboration, communication between services and to provide continuous awareness of the services available to support survivors. Examples are included below:

"We all work very separate and perhaps having opportunity to meet these other services ourselves would help with better working practices"

"I believe services do their best, however I feel as though services need to communicate better and take a holistic approach so that the service user has an easier journey. I feel as though not enough information is shared amongst services and sometimes staff members can take a long time to reply to emails"

9.5 Recommendations

Collaborative working is required between services that support survivors in order to support survivors holistically and break down working in silos. The following recommendations are suggested in order to improve collaborative working:

Issue Identified	Recommendation to address this	Responsibility
Engagement with survivors recognises that survivors value a holistic offer of support, there is also a strong body of evidence in favour of this. However, local engagement with professionals and survivors identified that services do not always work together and where partnership working does occur, there is often fragmentation of pathways indicating more work is perhaps needed to reduce these inconsistencies	The new pathway of support (as proposed in chapter 11) is to be further developed in consultation with survivors and all relevant services. The new pathway should be tested by local professionals in order to ensure it works effectively and expose any flaws or issues (e.g. through a dedicated training workshop).	Providers and Commissioners of specialist SVA services

Chapter 10: Local safeguarding and strategic focus

10.1 Local Safeguarding arrangements in Thurrock

The Care Act of 2004 requires every local authority to establish a Safeguarding Children's Board (LSCB) and the Care Act of 2014 requires every Local Authority to establish a Safeguarding Adults Board. The safeguarding arrangements in place in Thurrock are either determined at a local level or county wide, otherwise known as SET (Southend, Essex and Thurrock). These are listed below and further information can be found in Appendix 8.

- Local Safeguarding Children Partnership (LSCP)
- Local Safeguarding Adults Partnership
- SET Child Protection Procedures
- SET Vulnerable Adults Policy/Guidelines.

10.2 Existing Networks and Strategic Groups

A number of networks and strategic groups are in place at a local and county level. These are listed below and summarised in Appendix 9. Local groups include:

- Thurrock Community Partnership (CSP)
- Thurrock Violence against Women and Girls (VAWG) Strategic Group
- Missing children: Risk Management Meeting
- Multi Agency Child Exploitation Group (MACE)
- Addressing Gang Related Violence Meetings
- Multi-Agency Risk Assessment Conference (MARAC).

Regional groups include:

- Southend, Essex and Thurrock (SET) Strategic CSE Board
- Essex Sexual Abuse Strategic Partnership (SASP).

The Essex SASP is a multi-agency partnership which includes a range of providers and commissioners from the health sector, criminal justice agencies and local authority. The partnership is chaired by Essex Police which meets quarterly. The objectives of the partnership are to:

- Provide strategic leadership to address sexual violence and abuse in Southend, Essex and Thurrock
- Develop a partnership sexual violence and abuse strategy, which sets out and monitors the key shared outcomes partners are seeking to achieve through collaborative work around sexual violence and abuse. The strategy is currently being developed and is due to be published towards the end of 2019.

- Understand and review the performance of local sexual violence and abuse support services and their impact

- Seek new ways of working together and promote best practice

- Hold each other to account for complying with appropriate legislation and statutory responsibilities in addition to monitoring the effective delivery of the partnership Sexual Violence and Abuse Strategy

It is anticipated that the Essex SASP will play a key role in supporting the implementation of the majority of the recommendations proposed as part of this needs assessment, particularly those at a county-wide level. This will ensure the benefits of having shared county-wide resources including a shared SARC, hospitals, Police Force and single point of access for Rape Crisis Centres within Essex are fully utilised. It is to be noted that whilst there are a number of existing networks and groups in Thurrock that reference SVA, however none of which explicitly focus on SVA and therefore locally SVA is often neglected of the dedicated attention required.

10.3 Recommendations

The following recommendations are suggested in order to improve the local strategic approach to sexual violence and abuse.

Issue Identified	Recommendation to address this	Responsibility
Recommendations around improving strategic oversight for SVA		
There are already a large number of existing strategic groups, networks and leadership opportunities to champion this agenda, however it is not quite clear where the lead responsibility sits locally	Form a dedicated Thurrock Sexual Violence and Abuse group reporting in to the Thurrock Violence Against Women & Girls Strategy Group (it is to be noted that despite the name, this group also address men and boys). This group will provide a focal point for SVA and drive the majority of recommendations from this Joint Strategic Needs Assessment.	Thurrock Community Safety Partnership
	Advocate for provision of SVA to be included in the refresh of the Health and Wellbeing Strategy for Thurrock in 2020 so that there is a continued strategic focus on this agenda.	Thurrock Council Public Health Service
Locally, there are a number of existing policies, in place, particularly those related to safeguarding, where there is scope to strengthen the presence of SVA to ensure a partnership approach to supporting victims/survivors of SVA working towards prevention and reduction	Thurrock's Adult and Children's Safeguarding Boards should take a proactive approach to addressing SVA, including: -Policies are reviewed and detail clear responses to SVA -Ensuring professional adherence to policies and guidelines -Supporting professionals to feel confident in understanding and addressing SVA.	Thurrock's Adult and Children's Safeguarding Boards
	Thurrock's Adult and Children's Safeguarding Boards should support partner organisations to produce policies that address SVA, whether this is included within a generic safeguarding policy or as a standalone policy. This should include: - Training requirements - Information gathering/collection - Information sharing - Safeguarding protocol/standards - Safeguarding supervisions (where appropriate).	Thurrock's Adult and Children's Safeguarding Boards

Chapter 11: A vision for future service provision

11.1 High level vision and principles

Locally, our vision is to improve the response to disclosures of sexual violence and abuse and facilitate access to services that support victims/survivors to cope and recover from the impacts of their experience and rebuild their lives, whilst also seeking to prevent these crimes occurring in the first instance.

This will only be achieved through the following:

- Ensuring a dedicated local approach to tackling sexual violence and abuse
- Ensuring victims/survivors are provided with appropriate high quality services that support them to cope and recover
- Driving collaboration amongst all relevant organisations and partners and developing a workforce that views SVA as everybody's responsibility and a shared priority
- Reducing fragmentation in service provision within the local provider landscape
- The provision of holistic support to victims/survivors, ensuring survivors receive prompt access to the support they require from the services they require
- Ensuring the commissioning of services that are based on outcomes, rather than focussed on activity
- Improving operational aspects within the local provider landscape and workforce i.e. working towards a system where SVA is reported and recorded properly and a workforce who handle disclosures sensitively and appropriately and make onward actions as appropriate
- Respecting the needs and preferences of local survivors as identified through this needs assessment, e.g. survivors are not required to unnecessarily repeat their story more than required and chase referrals in to services

A new pathway of support should be developed and introduced. This pathway will ensure that all victims/survivors who make a disclosure of sexual violence and abuse to a professional within the Thurrock workforce are informed of and offered referrals into the services available. Further information regarding this pathway is detailed below.

11.2 Proposal of a new pathway of support

This needs assessment identified a number of issues with the current provision of support services for survivors of SVA. Engagement with local professionals and survivors identified that:

- Survivors reported difficulties understanding and navigating the complex landscape of support services
- It is frustrating and traumatic for survivors to 'repeat their story' multiple times to a number of different professionals
- There is a lack of collaborative working amongst professionals to ensure the needs of survivors are appropriately met.

The ambition of the new pathway of support is to ensure all survivors who make a disclosure of sexual violence and abuse are provided with access to a full range of services to help them cope and recover from their experience. The most appropriate way to achieve this is for survivors to undertake a single, comprehensive and holistic assessment which seeks to identify any needs or requirements for support that they may have. This assessment should be conducted by a specialist sexual violence and abuse agency wherein the staff have the appropriate knowledge and skills to support victims/survivors.

Following the assessment the specialist SVA agency will be responsible for liaising with the relevant support services and broker a tailored support offer which is personalised specifically for the survivor. Through these discussions, the specialist SVA agency will be able to provide the support services with an overview of the survivor's information and their identified requirements, therefore reducing the number of times survivors are required to repeat their story.

The specialist agency will maintain regular contact with the survivor whilst the survivor is accessing support from the other support services. This will enable the specialist agency to check the status of the referrals, monitor the survivor's compliance with accessing support and review the survivor's progress against their goals.

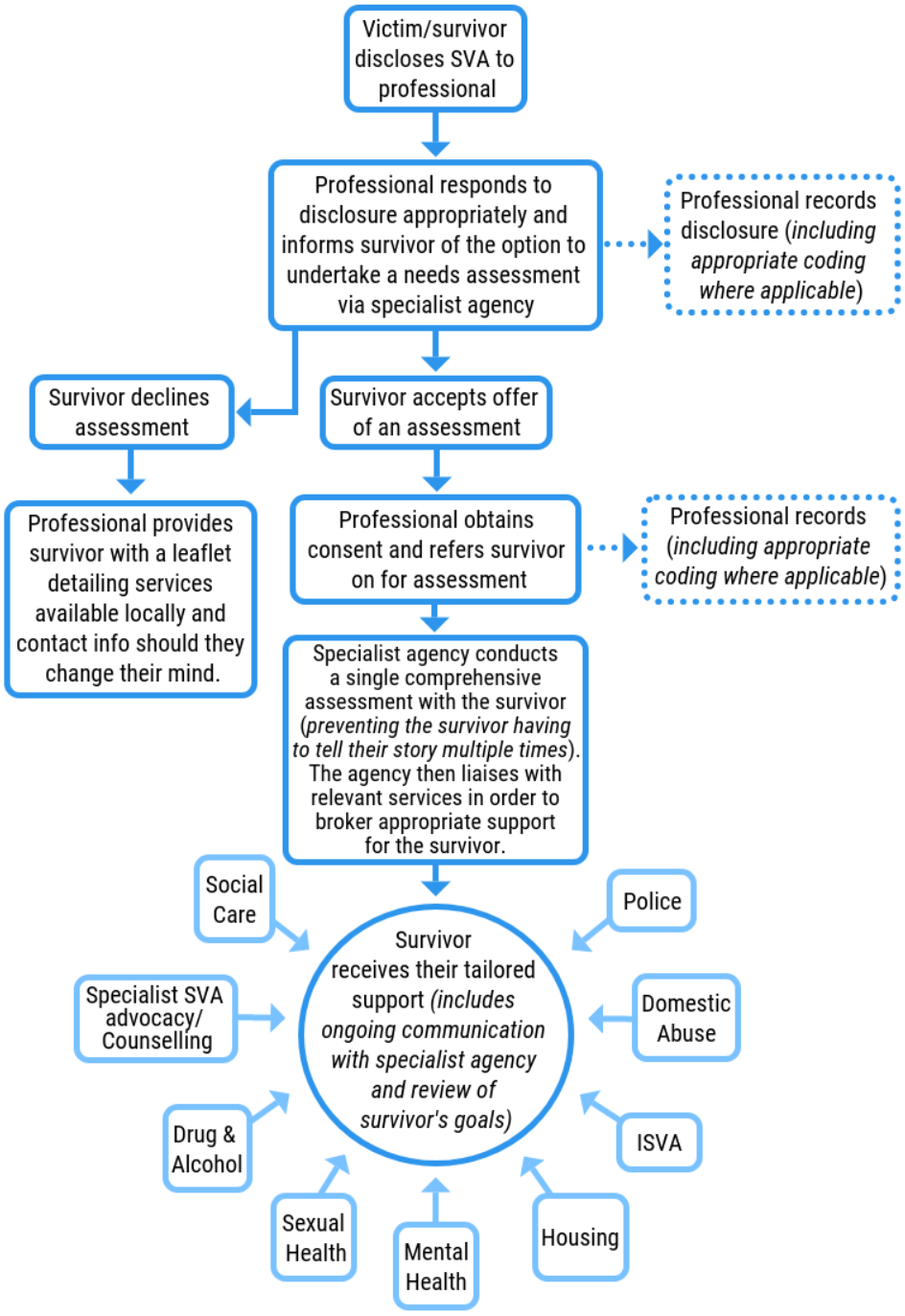
This pathway will address the majority of issues identified within this needs assessment through ensuring:

- The providers who may be required to support survivors of sexual violence and abuse, regardless of which sector they work in, work in partnership to provide a holistic offer of support to survivors
- Every survivor who discloses to a professional in Thurrock is offered the option to be referred to a specialist agency in order to undertake a full and holistic needs assessment in order to identify any services they may benefit from in order to help them cope and recover
- Referral processes are significantly improved, yielding the following benefits:
    - Less confusion for professionals and survivors
    - Referrals are made in a timely manner
    - Minimising the number of times they are required to 'tell their story'

In theory, the assessment that a survivor undertakes should act as a survivor's '*passport*' in to services. An illustration of how this proposed pathway may look is included in below/

Figure 40 below/

Figure 40: The proposed pathway of support



Whilst an overview of the proposed model of support has been provided, a number of factors must be considered in greater detail by all parties involved (i.e. commissioners, service providers and local victims/survivors). Some initial considerations are summarised below:

Expertise	It is suggested that the agency conducting the assessment is one which has specialist expertise in supporting victims/survivors of sexual violence and abuse. The frequency at which the assessments are reviewed should also be considered.
Finances	It is recognised that such a model would be an addition to already existing delivery and consideration should be given to how and by whom this can be funded. There is also the potential that if awareness of available support options increases and the access mechanisms are streamlined, it could increase demand on wider services, thereby increasing financial pressures across a range of organisations.
Outcomes for survivors	It is imperative that this pathway is effective in meeting the preferences and requirements of victims/survivors. In order to seek that this pathway is monitored on outcomes rather than being solely focussed on activity. It is suggested that upon initial assessment, or soon after, survivors are asked to set goals based on what they would like to achieve through the support they receive from the service(s) they wish to access. The progress of these goals may be used as a tool to monitor the effectiveness of the new pathway.
Communication between organisations	In order for a collaborative approach to be successful, effective communication is required between all organisations involved in the pathway. The following basic principles must apply: - Providers must acknowledge receipt of referrals - Providers should provide the specialist agency with relevant updates regarding the status of referral and whether the victim/survivor attended the service or not - Providers should inform the assessor of any updates relevant to the pathway or service e.g. changes to services offered, eligibility criteria or contact information.
Reporting	It is proposed that a new pathway should include robust reporting outcomes and quality indicators in order to monitor its effectiveness. A high level reporting template must be developed to include key reporting requirements such as; the demographics of victims/survivors, goals set and progress against these goals, the number and outcomes of referrals to services and adherence to assessments. Reporting requirements should be agreed with all relevant stakeholders.
Co-production	This model of support should be developed in collaboration by all key agencies/ organisations who may support victims/survivors of SVA. These assessments should also be discussed or trialled with local victims/survivors in order to ensure they are effective and appropriate. Information sharing agreements and mechanisms may also require development.
Governance and Oversight	The oversight arrangements around this model would need to be agreed between all agencies; whether this becomes a function of the new Thurrock SVA group or an agreement underneath an existing commissioning forum. If this is adopted

	as a SET wide approach there is the possibility of the Essex SASP supporting with this function.

11.3 How the new model addresses issues identified

The new model/offer of support as described above would address some of the key issues identified throughout this needs assessment, namely:

Issue	Way in which the model will address this
Current data systems are not set up to support accurate identification or follow up support offered to SVA survivors disclosing to wider agencies.	Coding practices proposed at both disclosure point and onward referral point.
Some survivors may be facing barriers to disclosure.	Communication around the way the disclosure will be handled and the new assessment process.
Survivors and professionals have both reported mixed experiences of disclosure.	As well as the training recommendations listed elsewhere, this will enable a consistent onward approach following the point of disclosure.
These needs assessment analyses show there to be a gap between those estimated to have experienced SVA and those known to services.	As above, better recording processes may improve the quality of the existing datasets, but also aim to improve access into onward specialist services if the process/pathway is made clearer.
Commissioning of existing provision is fragmented and confusing.	By implementing one consistent pathway, with agreed outcome measures.
Professional agencies are not always working as well together as they could around the needs of the survivor.	Completing one assessment should reduce the number of times a survivor has to 'tell their story' and the ongoing coordination role of the specialist agency would improve joint working across partners.

The video below provides a summary of the recommendations that local survivors have proposed based on what they believe needs to happen moving forwards.

Appendices

See separate document.

SVA JSNA appendices.docx

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APPENDIX 2

Thurrock Sexual Violence and Abuse Joint Strategic Needs Assessment Appendices

Contents

Appendix 1: Thurrock as a place

Thurrock is situated north of the River Thames, twenty miles east of central London in south Essex. The borough has a diverse range of land uses within its 165sq km coverage including 18 miles of riverfront which is mostly urbanised with a mixture of industrial and residential development at the western and eastern ends and green belt land forming 70% of the borough. The main settlements in the area are Grays, Stanford-le-Hope, Corringham, South Ockendon and Tilbury, with smaller villages throughout the green belt. West of Grays is the relatively newer Chafford Hundred community and Lakeside Regional Shopping Centre while in the east at Coryton, Thames Enterprise Park is situated as the UKs largest logistics operation.

In terms of health geographies, Thurrock local authority and NHS Thurrock CCG share their boundaries, and they often work at sub-borough level within four locality areas in line with the GP practices and the future Primary Care Networks (Corringham and Stanford, Purfleet and South Ockendon, Tilbury and Chadwell, and Grays). Thurrock has a Minor Injuries Unit at Orsett but does not have an A&E in the borough – the majority of Thurrock patients attend Basildon and Thurrock University Hospital in Basildon.

Thurrock is well served by transport networks from London, north Essex and Kent with the A13 and the M25 running through the borough as strategic crossroads of national importance, and the C2C trainline operating frequent services between Shoeburyness and Fenchurch Street, London. Thurrock also hosts three international ports including London Gateway and the Port of Tilbury and is positioned relatively near to the six airports of London including Southend.

Thurrock has a diverse and thriving economy with employment predominantly found in retail, public services, manufacturing, ports and logistics. While there are high levels of employment in Thurrock, the economic output per head of the population is however low. Thurrock also attracts a proportion of residents who commute out to London.
Significant investment into the area is driving up the creation of new jobs and homes which is likely to attract more people to the area. The likely impact to Thurrock's population figures which can be seen in Appendix 2: Overview of the Thurrock population below.

Appendix 2: Overview of the Thurrock population

2.1. Age

Mid-year estimates from June 2017 show Thurrock to have a population of 170,394. The population pyramid shows that Thurrock has a higher percentage of young people (those aged 0-14) than England. It also has a slightly higher population percentage of middle-aged people (those aged 30-49). However in the older population the percentage is lower than England.

Figure 1: Population Pyramid 2017

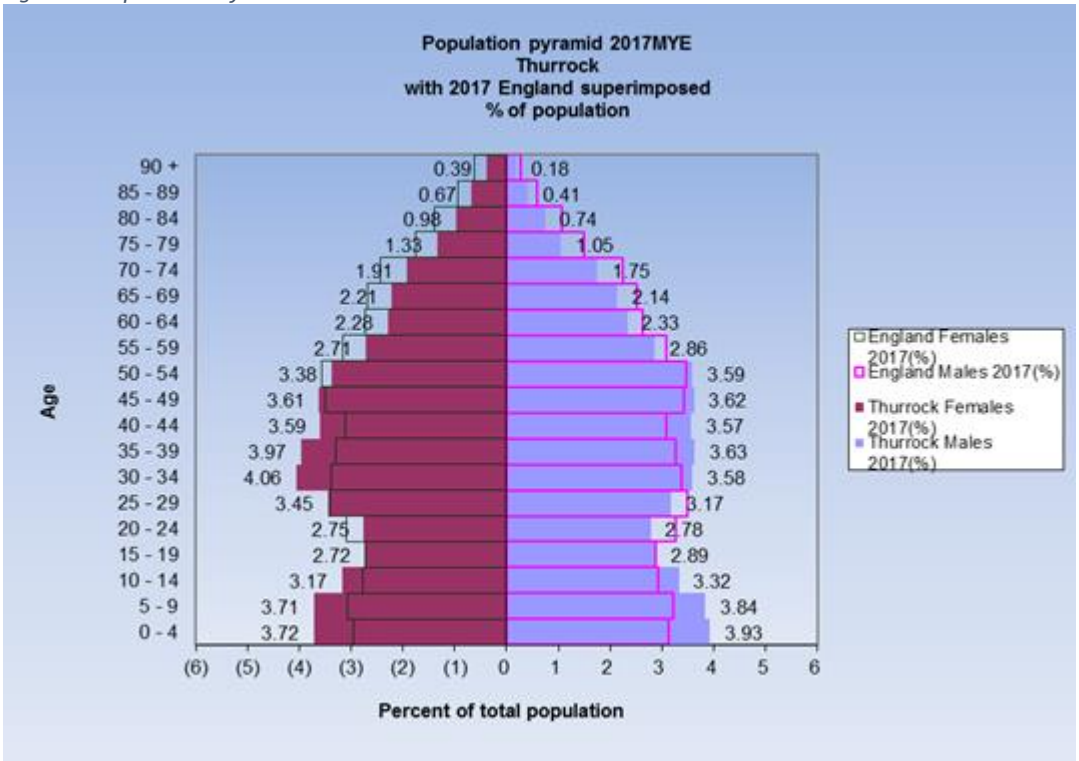
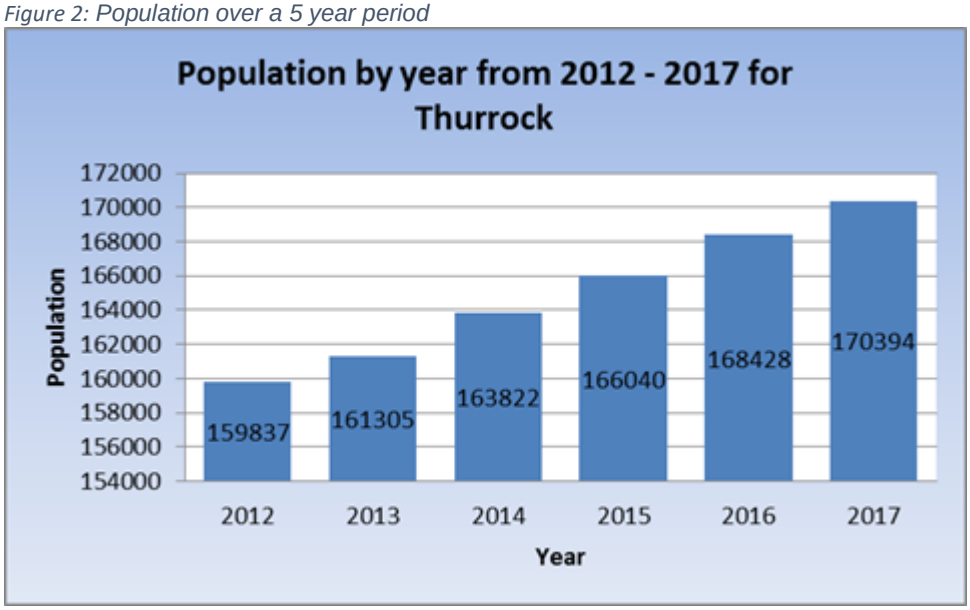
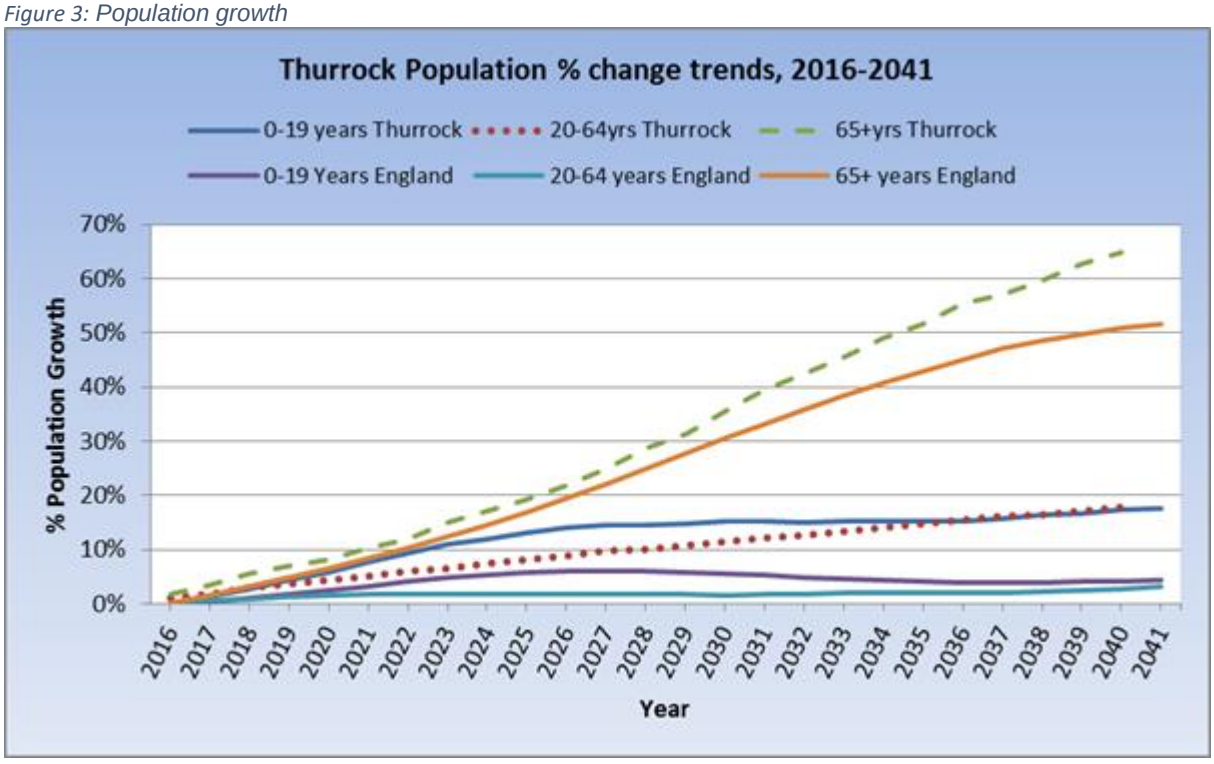


Figure 2: Population over a 5 year period



The population in Thurrock has increased by 7% in a 5 year period to 2017, this equates to an increase of over 10,000 people.

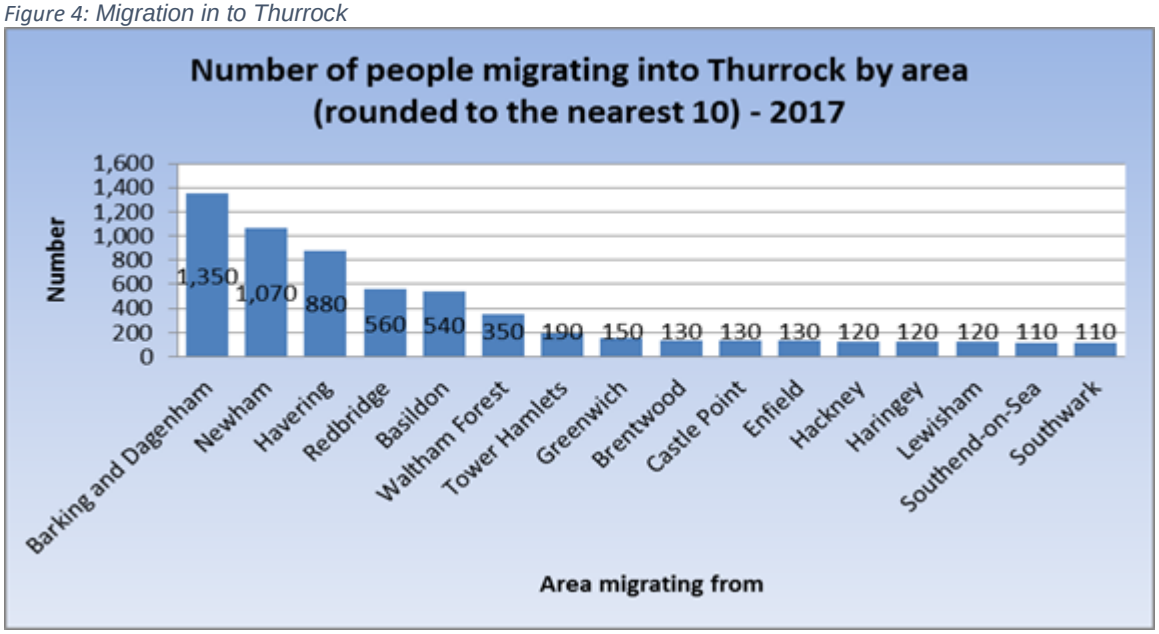
Figure 3: Population growth



Looking at the predicted population growth in Thurrock by age groups, it can be seen that the largest population growth percentage up to 2041 is for those aged 65+ with over a 60% rise. For those aged 0-19 and 20-64 there is predicted to be a rise of just under 20%. These population increases are significantly higher than for England, for those aged 0-19 and 20-64 the increase is only around 5% and for those aged 65+ just over 50%. It is to be noted that this population increase is likely to result in increased numbers of victims/survivors within Thurrock, therefore increasing the demand for services that support victims/survivors of sexual violence and abuse.

When considering the likely drivers for this population increase, it is expected that natural change (difference between births and deaths) accounts for approximately 1,100 extra residents per year, a figure which remains relatively constant into future years. The net international migration appears also to remain constant, accounting for around 400 residents each year. Internal migration appears to decline after around 2027. The impact of external influences such as European Union exit may affect this at a national level.

Figure 4: Migration in to Thurrock

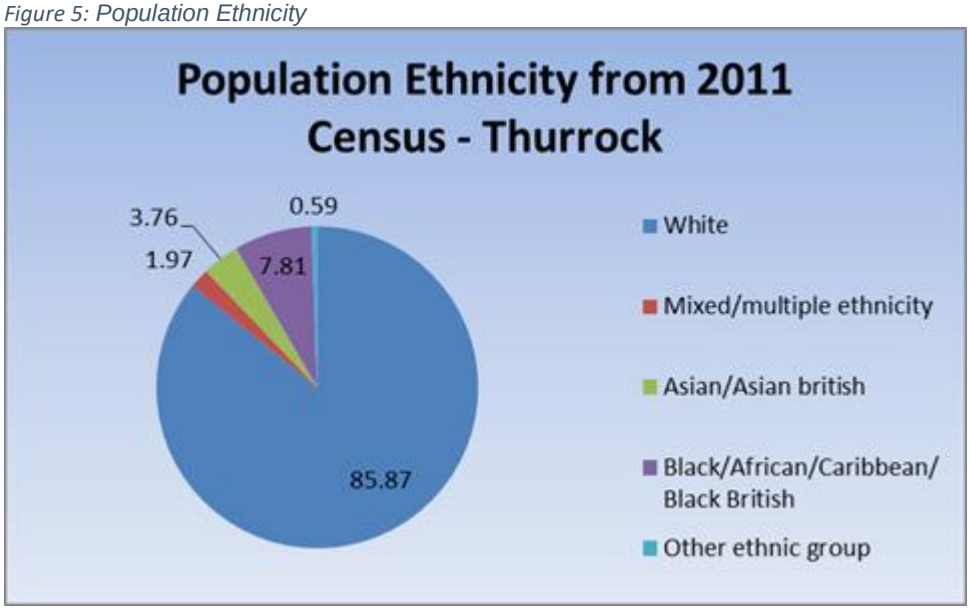


Source: ONS

Looking more in-depth at those migrating in to Thurrock the chart above shows where these people migrated from in 2017. 1350 migrated in from Barking and Dagenham and 1070 from Newham. So we can assume that a vast majority of those migrating in are coming from London.

2.2 Ethnicity

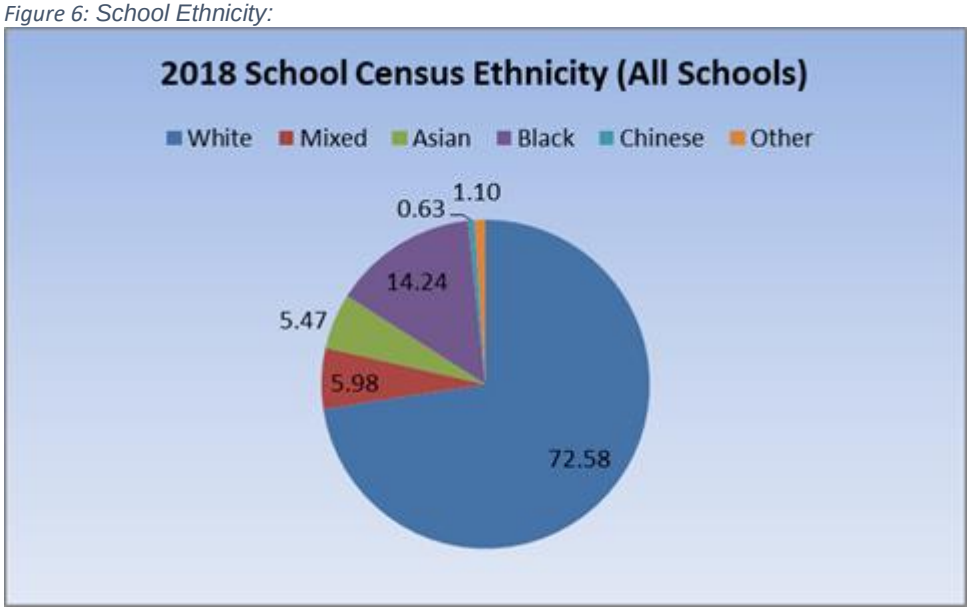
Figure 5: Population Ethnicity



Source: 2011 Census

Over 85% of the Thurrock population is White, with the next largest ethnic group being Black/African/Caribbean/Black British at almost 8%.

Figure 6: School Ethnicity:



The percentage of those from the minority ethnic categories is slightly bigger in the 2018 schools census. The 2011 whole population census showed over 85% of the population being white where the 2018 schools census shows less than 73%.

Appendix 3: Summary report – Professionals Engagement

These findings are based on 128 respondents (it should be noted that not all respondents answered all questions).

Profile of Respondents

The 128 respondents came from a variety of agencies, including Thurrock Council, Police, provider organisations, third sector organisations and schools. The range of job titles given made it difficult to standardise across organisations, but there were a number of counselling staff, police officers, care workers and other front line roles completing the survey.

Awareness

Respondents were asked to name support services that they were aware of (more than one could be listed). The top 10 services named are listed below. Specialist support was reasonably well known by respondents. General support such as GP, A&E and Social Care were only mentioned by a handful of individuals.

2. What sexual violence support services for Thurrock residents are you aware of in both the statutory and voluntary sector?	Total
SERICC	99
SARC	19
Changing Pathways	17
Synergy	16
ISVA	12
Rape Crisis	10
Thurrock Sexual Health Service	8
Police	8
Victim Support Service	8
CARA (another Essex Rape Crisis Centre)	6

Actions

Respondents were asked two questions about what they would do if someone disclosed sexual violence or abuse to them. The top ten responses are listed below (respondents could list more than one action). It should be noted that these were grouped from free text responses. So ‘referral to SERICC/specialist sexual violence service’ was the most common agency identified, but it could have been that respondents incorporated a referral to SERICC within ‘referral: appropriate services’ etc.

Something else notable about the below was that ‘ask the victim/survivor what they want’ was only the tenth most common response given.

3. When someone discloses sexual violence and/or abuse to you what action do you take?	Total Responses
Referral: SERICC/specialist sexual violence service	23
Follow safeguarding procedures	21
Inform of support services available	21
Follow Police Processes	18
Seek guidance/supervision from manager/safeguarding officer	18
Referral: Appropriate services	16
Referral: Safeguarding/MASH	13
Risk assess	13
Sign post to appropriate services	13
Ask the victim/survivor what they want	12

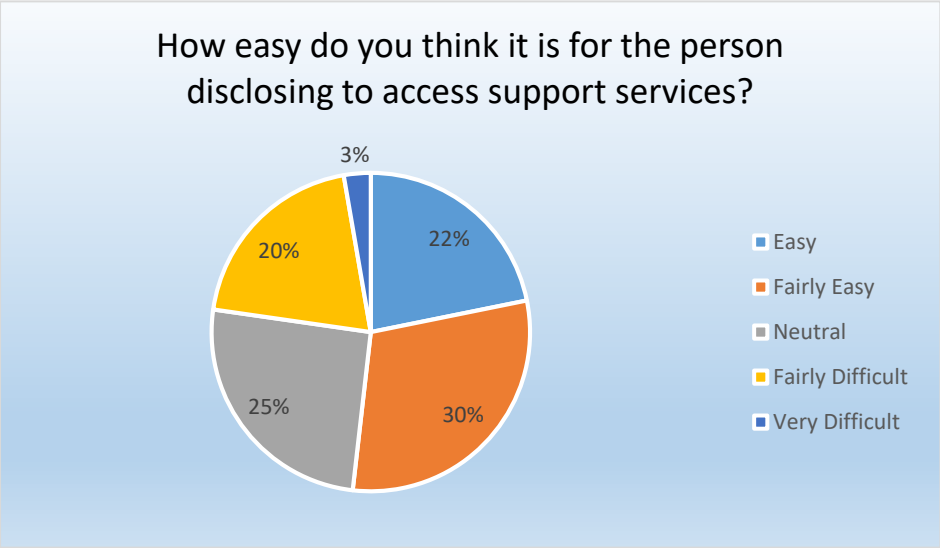
Respondents were then asked exactly where they would signpost survivors towards if they were unable to support them further. SERICC was the most commonly given answer, given by 56.3% of respondents. The police and GP/nurse were the next most common. It is unclear if those reporting 'counselling/talking therapies' meant specialist counselling or generic counselling.

4. Where would you suggest they seek support if they wish to do so?	Total
SERICC	72
Police	26
GP/Nurse	23
Changing Pathways	16
SARC	16
Counselling/Talking Therapies	9
Social Care/ Social Worker	9
ISVA	7
Synergy Essex	7
Family	6

Views

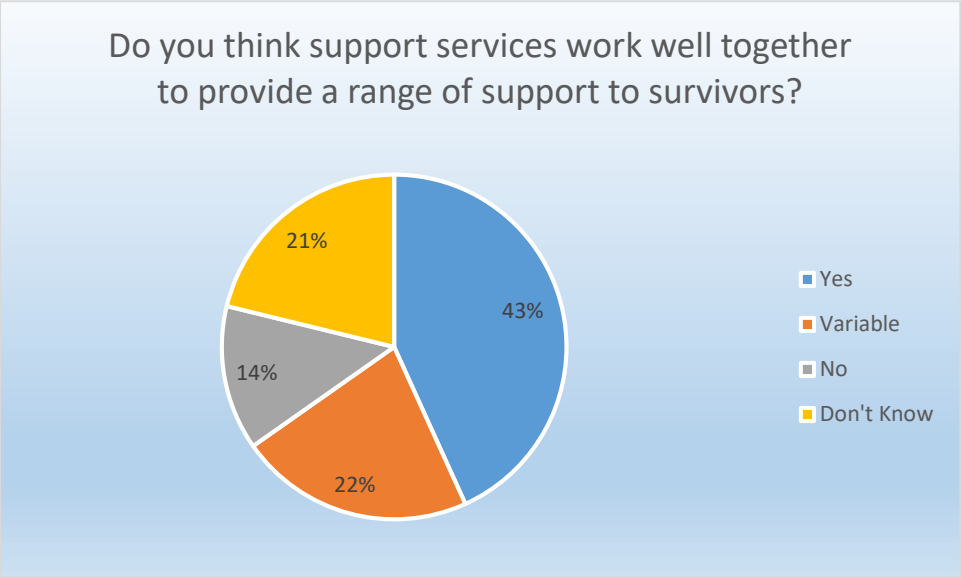
When asked their opinion on how easy it currently is for a survivor to access support services, over half of those giving an answer felt it was easy (22%) or fairly easy (30%). 20% felt it was fairly difficult and 3% felt it was very difficult. 18 out of 128 respondents did not answer this question.

Figure 7: Professionals perception of survivors ease of accessing support services:



Professionals were then asked their view on whether support services worked well together to support a survivor, or if not, how they could improve. 51 out of the 118 respondents to the question felt they did work well together (43%). However 21% said they did not know and 22% said it was variable, indicating more work is perhaps needed to improve awareness of how other services work and to reduce the perceived inconsistencies between agencies.

Figure 8: Professionals perception of how services work together



Where people offered suggestions for improvement, these often centred around improved collaborative working or better information sharing.

Training

96 out of 117 respondents to this question said that they had attended training enabling them to respond to disclosures of sexual violence and abuse, and 94% of those who had, said they felt the training did equip them to do so. Specific types of training that were mentioned included Safeguarding training, training delivered by SERICC, training delivered by the Police and Child Protection training.

Even though training received was largely seen to be positive, there were some comments made asking for more to be made available – some citing refresher training (the question did not stipulate the currency of the training attended) as being useful.

Key Findings from Professionals Survey

- The professionals surveyed showed good awareness of specialist sexual violence service provision in Thurrock
- Many respondents stated that, upon receiving a disclosure of sexual violence or abuse, they would either refer to a specialist service, or follow specific processes. However notably, relatively few said they would ask the survivor for their wishes first.
- The most commonly reported agencies to signpost to for further support were SERICC, the Police or GP/nurse
- Over half of respondents felt it was easy or fairly easy for a survivor to access support services, and 43% felt support services worked well together.
- However 22% felt the way services worked together was varied, indicating more work is perhaps needed to reduce these inconsistencies.
- Most staff said they had attended relevant training and found it beneficial; however there were some calls for further training to be provided.

Appendix 4: Summary Report – Survivors Engagement

These findings are based on 83 respondents (it should be noted that not all respondents answered all questions). A number of organisations supported survivors to complete this, including SERICC, Thurrock MIND, EPUT and the Police.

Profile of Respondents

From demographic information provided, the majority of respondents were female (90.3%) and of White ethnic origin (80.8%). Over two thirds of those giving their age said that they were between 26-55 years, and 21.1% were under 25 years. 31 out of the 83 respondents reported that they had a disability.

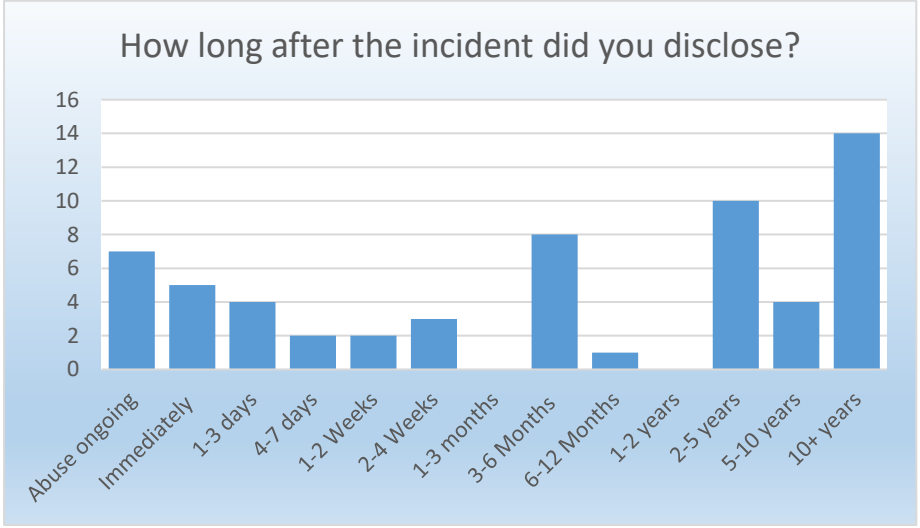
Disclosure Circumstances

Survivors were asked about who they first disclosed their SVA to and what sort of time it took to receive some support after this happened. The top five recipients are shown below – it can be seen that disclosures were most commonly made to family or friends; however GPs, Social care and Mental Health agencies also received initial disclosures. (Note that this is just the record of the initial disclosure – survivors may have then gone onto to tell more agencies after this).

1a) Who did you first disclose to?	**Total**
Family Member	20
Friend	14
GP	8
Social Care	7
Mental Health Agency	6

The time period between abuse and disclosure varied – for some survivors they disclosed relatively quickly, or whilst abuse was still ongoing, and others waited a number of years – 28 respondents disclosed more than 2 years later (the time period was not known for 23 respondents).

Figure 9: Time taken to disclose:



Action taken following disclosure

Survivors were also asked about the response to their disclosure and the actions taken. Not all respondents answered this and a variety of answers were given. Common themes that emerged included:

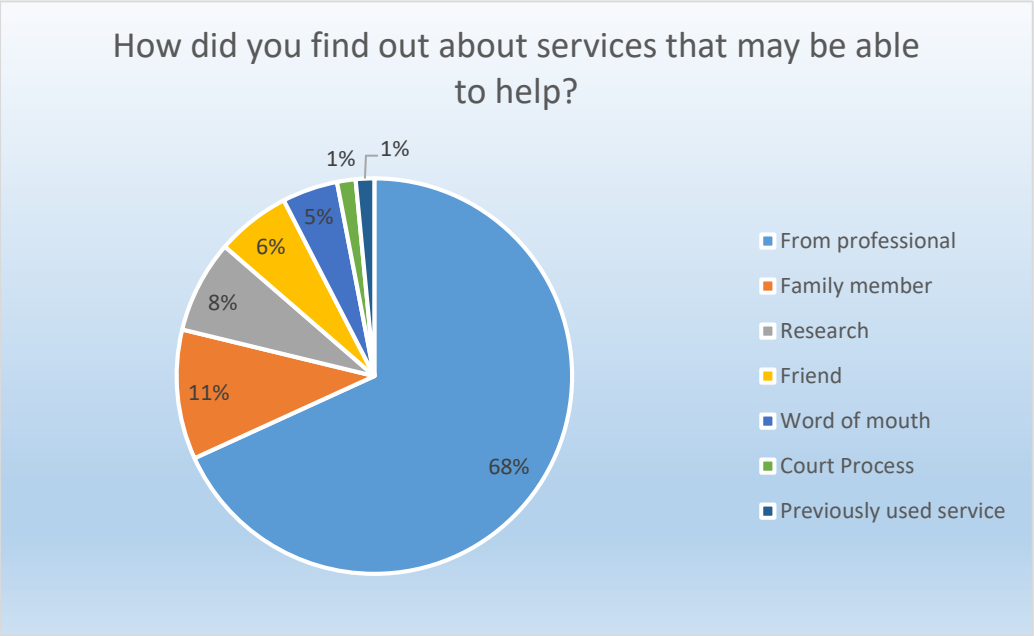
1) Making an onward referral to another agency
    - “She respond[ed] very well and she asked me if i would like to have counselling. She found SERICC and referred me”
    - “The EWMHS told me I was too complex to stay with them and referred me on.”
2) The agency receiving the disclosure providing direct support
    - “They were really supportive and sent officers to see me the same day who took me to have forensics taken. Th[e]y also took my video statement the same day.”
    - “The person who answered turned out to be a SERICC counsellor. She has counselled me since then. I am sure that she saved my life as I was often 'suicidal'.”
3) Listening and understanding
    - “My Doctor was sympathetic and understanding of the situation and gave me the contact details for SERICC.”
    - “The officer was and is excellent. She was empathic and understanding and made me feel at ease.”
4) Following processes
    - “She told me she had to speak to her manager then they both told me they had to report it.”
    - “Business-like”

When asked a bit more specifically about things that went well and not so well at the time of disclosure, many responses were service-specific. There were a number of responses citing SERICC, the Police and the GP, which are to be expected considering these are the main agencies that the professionals that were surveyed would consider referring to.

Accessing Support

Survivors were asked how they found out about available support services. The majority of those who gave a response (45 out of 66 respondents – 68%) said they had found about further support available from a professional, with the next most common group being family members.

Figure 10: Awareness of services



In addition, 19 of 58 respondents to the question around the driver towards accessing support said that they had been referred by a professional. These two responses are verifying that SVA survivors are reliant on professionals feeling confident with supporting them to access further support.

Specific barriers were only identified in a relatively small number of cases, and they most commonly centred around:

1) Waiting List
    - "Initial waiting list was difficult to deal with as I contacted for help when I was ready so was hard to wait."
2) Location
    - "I do not drive, so I have to take two buses to get to my appointment. As someone who struggles to leave the house on my bad days, it has been challenging to get myself to go. However, both Inclusion and SERICC have been very supportive and understanding."
3) Appointment Times
    - "I had difficulty finding childcare for my young daughter whilst [I] went for counselling"

With respect to waiting times, respondents were asked how long they had to wait for support. Over 50% said that they waited for less than one month before receiving support. Only a handful of respondents waited more than 3 months for support. 38 out of 43 respondents said they felt the waiting time was reasonable.

Figure 11: Time taken to receive support

Perceptions of support received

Survivors were asked their view as to whether partnership working was effective. The majority of those who responded did say services had worked well together to support them:

- "They have worked very well at insuring I get all the correct help."
- "My counsellor and advocate have supported me with other services and professionals. SERICC have sorted out my de[b]t, bus pass, social services meetings, legal meetings and housing. i would not have been able to attend a lot of these without that support from SERICC"

Where respondents said it was not working so well, one theme that did occur several times related to mental health service and SERICC service interaction:

- *"I only see my psychiatrist every few months, Mental health group in Grays not allowed to see me until SERICC has stopped seeing me as the woman from the group said you can't have two support at once."*
- *"Unfortunately I do not believe it is possible to use both Inclusion and SERICC at the same time. At least, this option was not provided to me. However, when moving to SERICC I was informed I was welcome back to Inclusion at any time."*
- *"When my SERICC worker contacted mental health as I was struggling the mental health team said I couldn't see them if I was having counselling at SERICC."*

This indicates a need to ensure the joint working between these two services is improved, and also perhaps an element around the messages that are given to survivors about dual use of services to ensure they are given the correct information.

Overall perceptions of support

Participants were given the opportunity to make free-text comments about what they felt was positive and negative about the overall support they received. The word-clouds below show the positive comments most commonly left. Support from SERICC

was mentioned many times in the positive comments, and it can be seen that themes around understanding, helping and counselling were also positively reviewed.

Figure 12: Positive feedback from the survivor engagement

There were fewer negative comments left – where they were, lack of funding was mentioned the most times, with training, Social Care and a perceived lack of empathy from professionals coming up as well.

Key Findings from Survivors Survey

- 83 survivors of SVA completed the survey – the majority were female and of white ethnic origin
- Survivors reported that disclosures had most commonly been made to their family and friends
- Whilst many survivors disclosed within 3 months of the abuse having occurred, one third of respondents said they disclosed over 2 years later
- The most common responses to disclosures centred around onward referrals, provision of direct support (if the disclosure was to an agency), listening, or following specific processes.
- 68% of respondents found out about support available from a professional, indicating that SVA survivors are reliant on professionals feeling confident with supporting them to access further support.
- Where barriers were identified, these generally related to waiting list, location of services or appointment times.
- The majority of respondents felt their time to access services was reasonable – and over 50% waited less than a month for support

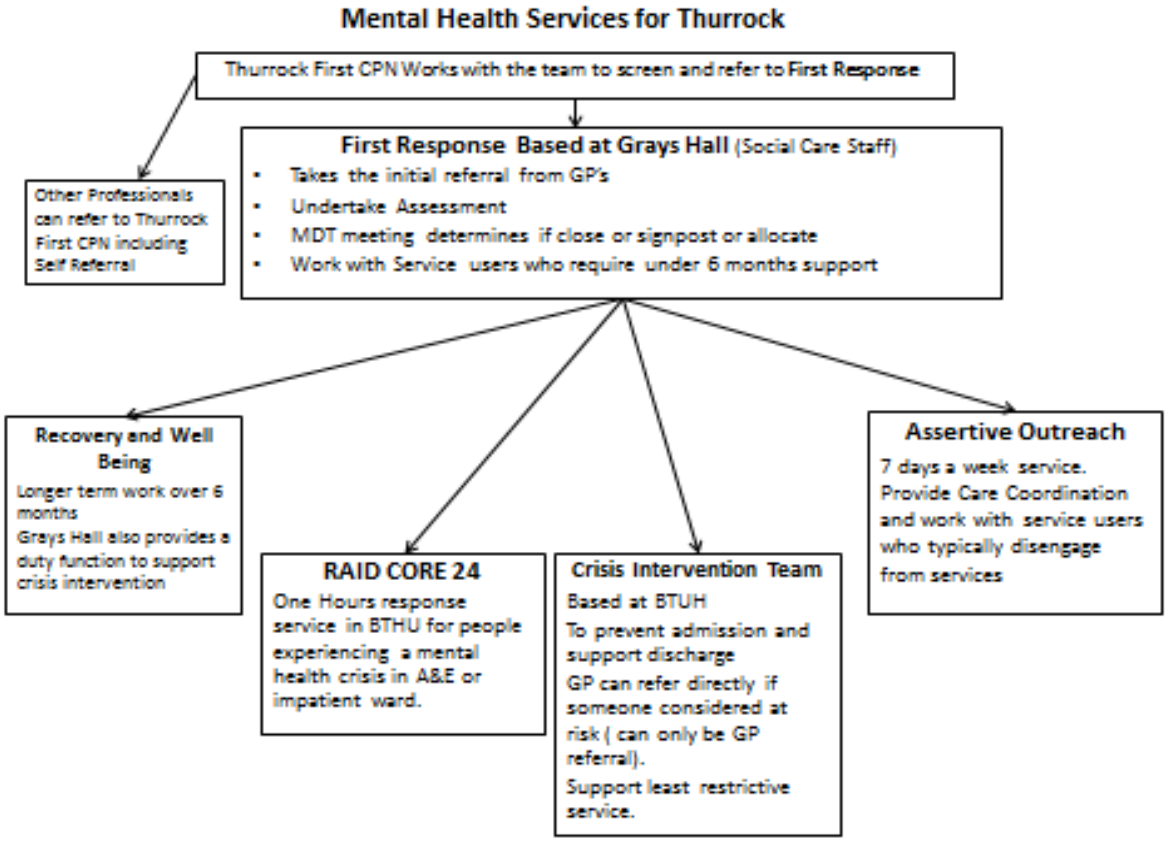
- The majority of respondents felt that partnership working was good – although the interaction between mental health services and SERICC was mentioned in particular a number of times. This indicates a need to ensure the joint working between these two services is improved, and also perhaps an element around the messages that are given to survivors about dual use of services to ensure they are given the correct information.
- Overall, survivors had a number of positive comments relating to SERICC and themes around understanding, helping and counselling were also positively reviewed.
- Negative comments, where given, – other than the comments relating to barriers listed above, related to a perceived lack of funding for specialist provision, training, Social Care and a perceived lack of empathy from professionals.

Appendix 5: Other Mental Health services in Thurrock

5.1 Secondary Care Mental Health Services

EPUT also deliver a number of other services to those with serious mental illness, as demonstrated in the pathway demonstrated in Figure 13 below.

Figure 13: Mental Health Services in Thurrock



Thurrock First is a single point of access for a range of social care, physical and mental health services. EPUT have a Community Psychiatric Nurse (CPN) working within the service, 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 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. Within Grays Hall, the Recovery and Well Being Team and the Assertive Outreach Team provide longer term support from both health and social care practitioners.

The Crisis Intervention Team is based at BTUH and works with individuals to prevent admission and facilitate discharge. The Mental Health Liaison Team (formerly known as RAID Core 24) offers a one hour response to patients presenting with mental health challenges at BTUH accessing A&E or for inpatients. 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.

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

5.2 Children and Young People's Mental Health Provision

North East London Foundation Trust (NELFT) are commissioned to provide mental health services for children aged 0-18 years in Thurrock (or up to the age of 25 years with special educational needs). The service is known as the Emotional Wellbeing and Mental Health Service (EWMHS), and they will work with children and young people who exhibit the following:

- Mood and anxiety disorders
- Behavioural and conduct disorders
- Emerging personality and attachment disorders
- Eating disorders
- Psychotic disorders
- Deliberate self-harm and suicidal thoughts
- Substance misuse
- Autistic spectrum disorder (ASD) (only) with comorbid mental health difficulties.
- Attention-deficit hyperactivity disorder (ADHD) (only) with comorbid mental health difficulties.
- Neurodevelopmental disorders (only) with comorbid mental health difficulties.
- Prolonged bereavement problems

Referrals can be via phone or email, and can be self-referrals or professional. The support offer can range from face to face, to online resources such as Big White Wall. Whilst EWMHS does not offer a service specifically for survivors of child sexual abuse, many of the children they work with have experienced trauma, and staff within the service have undertaken Basic CBT training for trauma, EMDR and DBT so can offer these as clinical treatments. Members of the service are also participating in the DECRYPT ('Delivery of Cognitive Therapy for Young People after Trauma') trial, which is aimed at supporting children and young people aged 8-17 years who have developed post-traumatic stress disorder (PTSD) as a result of exposure to multiple traumas. The service cannot quantify the numbers of sexual abuse survivors known to them, and direct disclosures of SVA are relatively rare. In cases where these do occur, they are most common when the child has built up a trusted relationship with the therapist, rather than dependent on particular skills or experience of the staff member. After a disclosure, the team will take the child's wishes into account and support them with a referral to SERICC if they would like one. This can be instead of or alongside support offered by EWMHS. The service have also received referrals from young people experiencing sexually violent behaviour; although in those cases a referral to a more specialist agency such as Tavistock and Portman or NSPCC would be recommended.

Within this we also include the work NELFT does within the contract to engage with service users outside of formal treatment pathways, work with local partners, and build capability across the system (such as training in schools).

Kooth

Is a SET wide programme, jointly commissioned by the Children's Education Forum primarily aimed at promoting positive mental health however is also used as a general mental wellbeing tool. Also provides an outlet for young people to talk about their thoughts and feelings.

5.3 Recovery College and third sector mental health & wellbeing services

Thurrock Recovery College is a partnership between Inclusion Thurrock and Thurrock MIND, which offers learning opportunities to those aged 16 years and above to support them to live more fulfilling lives. The services are particularly aimed towards supporting:

- experiencing common mental health problems,
- with long term conditions (LTCs)
- attending surgeries with Medically Unexplained Symptoms (MUS)
- with substance misuse problems
- attending secondary care services
- stepping down from secondary care services
- caring for those with MH problems and LTCs (carers)
- with a diagnosis of dementia and their carers
- experiencing mental health problems attending colleges (including A level)
- experiencing first episode psychosis and their families

Their provision of peer recovery and self-management support is not specifically aimed towards victims/survivors of sexual violence/abuse however they may still choose to access the support.

5.4 Thurrock MIND

Thurrock MIND offer a number of support services which are not specific to sexual violence survivors, but can enhance their recovery and wellbeing. There are numerous entry routes to these – some are via professional referral, but others can be self-referred into. These services are summarised in Figure 14 below.

Figure 14: Summary of services provided by Thurrock MIND

Name of service	Brief description
World of Work (18+ for those with mental health issues, autistic spectrum disorders or learning difficulties) (The mental health component ends on 30/09/19 as CCG will then be funding IPS – Individual Placement and Support)	• One to One CV writing, Job search, Applications forum Workshops to prepare for work: • Confidence building • Interview preparation • Workplace expectations • Overcoming barriers
Positive Pathways (18+ for EPUT / 14+ for EIP/ 16-18 for NELFT (EWMHS)	• A Recovery Transfer Facilitator (for adults) or Youth Transition Worker (for young people) works closely with primary and secondary care colleagues to ensure there is suitable support in place once patients have been transferred from secondary mental health care support back to the care of their GP. • Requires secondary care referral at point of transition to primary care
Volunteering (16+)	A range of volunteering opportunities are available through all of our projects, including administration and retail.
IAPT and Recovery College (in partnership with Inclusion), and IPS from 1st October 2019	See above
Advocacy	Care act advocacy for people who have a Learning Difficulty, Mental Health, Sensory Impairments, Acquired Brain Injury, substantial difficulty, Dementia, Drug & Alcohol and Carers of the above client groups. • Support people to advocate for themselves • Advocate for an individual/group • Attend appointment / voice individuals opinions Additional Support- Form filling service Independent Mental Health Advocate (IMHA) for people detained under eligible sections of the Mental Health Act both in hospital and the community
Thurrock Carers Service	Providing information, advice and support • Peer support groups • Training • Volunteering • Employment • 1-1 • Carers assessment
Housing	Thurrock Mind has a small number of accommodation units which can be accessed by those with a number of needs. However this does not come with an on-site support package. • Short term tenancy (6month – 2 years) • To support independent living
Stepping Stones Garden Project (18+)	• Allotments • Garden Nursery\Group
Peer Mentoring and Peer Support	• 1-1 mentoring from trained mentor with lived experience • Group support based on shared experience, diagnosis or interest
Day Opportunities	Thurrock Mind offer a range of wellbeing activities to also promote social inclusion.
Counselling & Group work Services	- 1-1 Counselling - Bereavement counselling - Multi-ethnic counselling services - Group work courses
Private Services Therapies: Training:	- 1-1 Counselling - Couple Counselling - Hypnotherapy Training to professionals, such as; - Mental Health First Aid (MHFA) (adults and youth) - Mental Health Awareness in schools - Mental Health Awareness for Sports & Physical Activity (MHASPA)

Appendix 6: Services provided by the South Essex Rape and Incest Crisis Centre (SERICC)

First Contact Navigator Services: Referral Triage & Crisis Intervention

Funded by: National Lottery Community Fund
End date: 30th June 2019. SERICC are currently funding this service whilst another alternative is sought.

The First Contact Navigator Service provides an Essex-wide single point of access and triage service (including Thurrock) for all victims and survivors of sexual violence and abuse, regardless of referral source. Victim/survivors are allocated a key worker who will support them from an individualised assessment and triage process through the network of provision necessary to in order to address their identified support needs. This includes a range of emotional and practical support as well as specialist sexual violence therapeutic interventions. Upon assessment and triage, SERICC are able to identify additional needs or preferences victims/survivors may have. This includes the provision of interpreters and translators and either male or female counsellors. There may be occasions where victims/survivors residing in Thurrock may wish to access specialist rape crisis support outside of Thurrock's boundaries for example in order to maintain anonymity or access a service close to their workplace. Generally, this does not happen across the country due to funding arrangements, however Thurrock residents are able to access the other two services available within Essex (CARA and SOS).

This service involves the use of 3 full-time members of staff and IT infrastructure to ensure victims/survivors are triaged appropriately. To date, this model has been found to be highly effective as it frees up the time of all client facing staff, enabling increased capacity for client-facing hours, opposed to arranging appointments and conducting risk assessments. London Metropolitan University is currently evaluating this service, with the final report expected Summer 2019.

Synergy Essex First Responder Service

Funded by: The Essex Police, Fire, and Crime Commissioner
End date: 31st March 2020

The Synergy First Responder scheme is a pilot project was set up in order to ensure victims/survivors who report their experience to the Police are aware of support specialist available and allow them to access support promptly, without the need for referral. The scheme provides victims/survivors access to support, using the First Contact Navigator Service model, within one working day of reporting the offence. This includes the provision of emotional support, detailed information about the criminal justice process, and providing access to local specialist rape and sexual abuse counselling and advocacy services. This scheme is the result of partnership work between Essex Police and the Essex rape and sexual abuse partnership known as Synergy Essex. It is thought to be the first of its kind in the country. The service launched on 21st January 2019.

Commissioned Services

A summary of the services SERICC are contracted to deliver are detailed below:

Independent Sexual Violence Advisor Service (ISVA) and Specialist Sexual Violence and Abuse Counselling

Commissioned by: The Essex Police, Fire and Crime Commissioner (PFCC)
End date: 31st March 2020

SERICC are commissioned to provide services to victim/survivors to cope and recover from the impact of the crime following their experience of sexual violence and abuse. These services are provided to all victims/survivors; regardless of age, gender, when the offence happened, and whether the victim has reported to the Police. There are 2 elements to this contract; the Specialist Independent Sexual Violence Advisor Service (ISVA) element and a community-based service providing wrap around counselling and advocacy, typically long-term specialist support.

The ISVA service provides information and support to those who are going through the criminal justice process as well as those who have not reported to the police, but are considering doing so, thereby allowing victims and survivors to make an informed choice. Victims/survivors who choose to report to the Police and proceed through the criminal justice process are provided with support from 'report to court and post court'.

The counselling and advocacy element provides individuals with a range of specialist sexual violence and abuse services, including talking therapies, advocacy services (for housing, financial, life skills, health and employment needs) specialist counselling (including for those with learning difficulties and family counselling) and group work sessions.

The main outcome of the services within this contract is to support victims of rape, sexual violence and child sexual abuse to '*cope with the immediate impacts of the crime and recover from the harm they have experienced'* (in line with the Victims Code of Practice 2015).

Floating Support Advocacy Service

Commissioned by: Thurrock Council Adult Social Care
End date: 31st March 2022

SERICC are commissioned to deliver floating support and advocacy for Thurrock residents aged 16+ who have experienced sexual violence or abuse. This service is provided through the SERICC Floating Support Scheme. The scheme's primary client group are vulnerable adults and those with disabilities, particularly those who have a learning difficulty. The scheme offers offer advocacy and support tailored to the needs of the victim/survivor and may include legal, educational, employment, financial, health, housing and support for those with no recourse to public funds. The primary aim of the scheme is to enable vulnerable adults to maintain their independence and accommodation within the community in the aftermath of sexual violence and abuse and to put in place safeguards and support to prevent escalation to adult safeguarding. This contract is to support up to 10 clients per year.

Specialist Young Persons Sexual Violence Counselling Service
Commissioned by: Thurrock Council Children's Service
End date: 30th September 2020

SERICC are commissioned to deliver a counselling support and advocacy service for Thurrock residents between the ages of 13 to 25 who have experienced any form of sexual violence or abuse. This contract provides specialist counselling, support and advocacy to victims/survivors of all genders. The offer also includes specialist support work with siblings of victims who have been impacted by sexual violence/abuse within the family. SERICC are contracted to accept a minimum of 60 young people referrals per annum for the counselling element of the service. The contract also includes specialist preventative professional support for children under the age of 13 who have or have not experienced an incident of sexual violence/abuse however are considered to be at risk or have been affected by sexual violence or abuse in another way, e.g. sexual violence or abuse within their family. SERICC are contracted to accept 15 referrals annually for children aged 13 and under. This service is available by referral from Thurrock Children's Service only.

Sexual Violence and Abuse Support Services: Brighter Futures Contract
Commissioned by: Thurrock Council Children's Services
End date: 31st December 2020 (option to extend to 2022)

This contract is to provide support to families in Thurrock referred by Social Services and are subject to a Children in Need Plan, Child Protection and other issues relating to sexual violence and abuse. SERICC are commissioned to provide a minimum of 900 client-facing hours per annum to a minimum of 19 service users per annum on a rolling programme with no defined timescales in order to ensure that support is at a pace to suit the victim/survivor's needs.

The programme delivered to two groups:

Group 1 is for adult victims/survivors. The service works one-to-one with female and male adult victims of sexual violence and abuse. The service will include direct work with any children that have been impacted in the family in addition to the parents, wider family members and foster carers. The service will include work with partners of the main attendee (adult victim) of the programme, providing they are not the perpetrator.

Group 2 is for child/young person victims/survivors. The service works one-to-one with parents (both genders with the exception of the perpetrator where relevant) where their child has been the victim of sexual violence and abuse. This will include direct work with the child and their siblings, where they have been impacted, in addition to the parents.

Strategic and Operational Support
Commissioned by: Thurrock Council Children's Services
End date: 30th September 2020

SERICC are commissioned to assist with supporting the Council to develop and maintain its strategic and operational response (for children, young people and adults of any gender) to all forms of sexual violence and abuse (including rape, child sexual

abuse, child sexual exploitation, sexual assault, stalking and female genital mutilation). This offer includes awareness raising and delivery of accredited and non-accredited training to the public, schools/colleges and the wider workforce as well as attendance at relevant safeguarding and strategic meetings. The funding also contributes to the delivery of facilitated and non-facilitated group work including the Health & Wellbeing Focus Groups and Survivor Consultation Groups, the aims of which are to increase the self-esteem of victims/survivors.

Examples of services delivered as part of this contract include:

- Delivering training (e.g. CSE training to Foster Carers and social care staff, Disclosure Awareness training to the Police and Crown Prosecution Service and the 16 days of activism training to over 200 professionals)
- Delivering awareness and prevention work in schools (e.g. Youth at Risk)
- Attendance at stakeholder and strategic meetings (e.g. Project Goldcrest, Sexual Exploitation and Transition Task & Finish Group)
- Attendance at safeguarding meetings (e.g. Child Protection Meetings and the Multi-Agency Risk Assessment Group)
- Additional specialist consultation with social care staff
- Hosting open days at SERICC
- Supporting open days at the Essex SARC and Grays Police Station
- Attendance at training courses and workshops

Adult counselling service

This grant is by Thurrock Clinical Commissioning Group (CCG) to provide specialist counselling for Thurrock residents aged 18+ who have experienced sexual violence or abuse at any point in their life regardless of when it occurred. SERICC have been commissioned to provide this service until the end of September 2019 however plans beyond this are currently unknown.

The Mental Health treatment services in Thurrock are listed in section 8.4.

Appendix 7: Breakdown of SERICC usage by service

The tables below show a breakdown of the total number of victims/survivors accessing each service provided by SERICC.

Table 1: Activity for the Adult ISVA Service

	Adult ISVA Service				
	Existing service users	**New Females**	**New Males**	**Other**	**Total Service Users**
2017/18	26	42	4	0	**72**
2018/19	24	39	6	1	**70**

Table 2: Activity for the Children's ISVA Service

	Children's ISVA Service (age <18)				
	Existing service users	**New Females**	**New Males**	**Other**	**Total Service Users**
2017/18	9	15	3	0	**27**
2018/19	7	18	4	0	**29**

Table 3: Activity for the Adult Counselling Service

	Adult Counselling Service (age 25+)				
	Existing service users	**New Females**	**New Males**	**Other**	**Total Service Users**
2017/18	73	119	5	2	**199**
2018/19	77	124	11	0	**212**

Table 4: Activity for the Young Person's Counselling Service

	Young Persons Counselling Service (age 13 -25) NB. Under 13s included in the Children & Family section				
	Existing service users	**New Females**	**New Males**	**Other**	**Total Service Users**
2017/18	36	48	9	1	**94**
2018/19	21	64	9	2	**96**

Table 5: Activity for the Advocacy Service

	Advocacy Services				
	Existing service users	**New Females**	**New Males**	**Other**	**Total Service Users**
2017/18	43	47	0	0	**90**
2018/19	32	67	3	0	**102**

Table 6: Activity for the Child and Family Services

	Child & Family Services				
	Existing service users	**New Females**	**New Males**	**Other**	**Total Service Users**
2017/18	28	31	15	1	**75**
2018/19	32	14	18	0	**64**

Appendix 8: Local safeguarding arrangements

8.1 Local Safeguarding Children Partnership (LSCP)

Under statutory guidance,[1] all children who are victims of sexual abuse should be assessed and safeguarded. The Thurrock LSCP has a unique statutory role and a clear responsibility to undertake a scrutiny, quality assurance and challenge role in respect of how agencies individually and collectively promote the welfare and safety of children living in Thurrock.

The Safeguarding Partners are accountable and responsible for ensuring the new Thurrock LSCP safeguarding arrangements are effective. There will be an Annual Plan and Report published by the LSCP that will be informed by the strategic objectives of those agencies involved in safeguarding children and young people in Thurrock. The Partnership will take into account national and locally agreed safeguarding children priorities and safeguarding practice as set out in the statutory guidance Working Together 2018.

The LSCP will be reviewing this JSNA and using its findings and recommendations to inform future plans and provision in Thurrock. It has already been agreed that a section on working with children displaying harmful sexual behaviours will be included within the LSCP Delivery Plan for 2019/20.

8.2 Local Safeguarding Adults Partnership

Thurrock Safeguarding Adults Board (TSAB) is a statutory, multi-agency partnership, which was set up to seek assurance that:

- Local safeguarding processes are in place, in accordance with the Care Act and Care and Support statutory guidance,
- Practice is person centred and outcome focused,
- Relevant agencies work well together to prevent abuse and neglect of adults with care and support needs,
- Agencies respond swiftly and proportionately when abuse and neglect occurs, and,
- Measures are taken to ensure that safeguarding arrangements improve in line with best practice

TSAB has three core responsibilities; to publish a strategic plan, to publish an annual report and to commission Safeguarding Adult Reviews as and when the criteria is met.

The TSAB is established in line with the Care Act 2014 and Care and Support Statutory Guidance. Adult safeguarding is driven by Making Safeguarding Personal; the adult's views and wishes are paramount, even in situations where it appears that the adult is making unwise decisions, or increasing the risk to their wellbeing. The main difference between adult and children safeguarding is mental capacity and consent. The TSAB works closely with the Essex and Southend SABs to develop policies and guidelines to ensure a consistent approach is taken across the county of Essex.

[1] Department for Education. *Statutory Guidance: Working together to safeguard children*. 21st February 2019.

8.3 SET Child Protection Procedures

The Southend, Essex and Thurrock Child Protection Procedures are underpinned by Working Together to Safeguard Children (2018) which sets out what should happen in any local area when a child or young person is believed to be in need of support. The SET procedures ensure that professionals in all agencies, whatever the nature of the agency (whether public service or commissioned providers services) who come into contact with children, who work with adult parents/carers or who gain knowledge about children through working with adults should:

- Be alert to potential indicators of abuse or neglect
- Be alert to the risk which individual abuses or potential abusers may pose to children
- Be alert to the impact on the child of any concerns of abuse or maltreatment
- Be able to gather and analyse information as part of an assessment of the child's needs

Each agency should have single/internal agency child protection procedures, which are compliant with SET child protection procedures. The LSCB will hold agencies to account. Each agency or organisation must provide instruction to professionals in:

- Identifying potential or actual harm to children, and referral process to Children's Social Care
- Discussing and recording concerns with a first line manager/in supervision
- Analysing concerns by completing an assessment
- Discussion concerns with the agency designated safeguarding professional lead.

Whenever a child reports they are suffering or have suffered significant harm through abuse or neglect, or have caused or are causing physical or sexual harm to others, the initial response from all professionals should be limited to listening carefully to what the child says to:

- Clarify the concerns
- Offer re-assurance about how the child will be kept safe
- Explain what action will be taken and within what timeframe

The child must not be pressed for information, led or cross examined or given false assurances of absolute confidentiality, as this could prejudice police investigations especially in cases of sexual abuse. If the child can understand the significance and consequences of making a referral to local authority children's social care they should be asked their view. However it should be explained to the child that whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure the child's safety and the safety of other children

8.4 SET Vulnerable Adults Policy/Guidelines

Southend, Essex and Thurrock (SET) Safeguarding Adult Boards have worked together to develop the SET SA Guidelines. This is an interactive document that is aimed at all professionals who come into contact with adults with care and support needs. The Guidelines intends to set out the responsibility of the professional, and the four stage adult safeguarding process, from raising a concern to concluding a section 42 safeguarding enquiry. Some professionals' role in the safeguarding process will stop at stage one, therefore the guidelines is merely about process. Professionals who will be expected to be involved further in the safeguarding are expected to have some

working knowledge of abuse types and should be supported via the supervision process and the adult safeguarding team where further knowledge is required.

The Care Act specifies 10 types of abuse (page 48 in the Guidelines) of which Sexual Abuse is one however, the Guidelines does not set out to explain abuse types, or signs and symptoms, which is why there isn't a specific section on this and many of the other abuse types.

Appendix 9: Existing Networks and Strategic Groups

A number of networks and strategic groups are in place at a local and regional level. These are summarised below:

9.1 Missing children: The Risk Management Meeting

The Risk Management Meeting is a sub-group of the Local Safeguarding Children Partnership, and operational arm of the Strategic Multi Agency Child Exploitation (MACE), chaired by the Strategic Contextual Safeguarding Lead. It meets weekly and is attended by a range of statutory and voluntary partners. All of the children (Thurrock residents/those who are Looked After and placed out of borough) who have been reported and accepted as missing to the Police, are discussed at the Risk Management Meeting, regardless of length of time missing, or apparent circumstance. There is no minimum time for a child to be missing before they are reported to the Police. Therefore, the times children have been reported as missing before they are found, can range from minutes upwards. The Risk Management Meeting facilitates challenge, oversight and development of plans to reduce the vulnerability of children, and equally, identifies opportunities to target/investigate possible perpetrators.

9.2 Multi Agency Child Exploitation Group (MACE)

With strategic responsibility for developments in Thurrock around Child Exploitation and Missing Children and overseeing the Risk Management Meeting, the LSCP's MACE Group, is attended by a range of statutory, criminal justice and voluntary agencies. The role of the MACE is to ensure that cases of suspected or actual child exploitation are well-managed and coordinated and all possible action has been taken to protect the victims. The MACE will provide a detailed overview of the profile of Child Exploitation within Thurrock and determine the multi-agency response. It will develop and deliver The Thurrock Exploitation Strategy and Action Plan. It aims to reduce incidents of exploitation through the delivery of an integrated strategy, sharing information and intelligence and producing data on current trends and threats. It is working towards an integrated strategy to identify, address and reduce incidents of all child exploitation supporting the work being undertaken across SET.

9.3 Essex Sexual Abuse Strategic Partnership (SASP)

The SASP is a multi-agency partnership which includes health, criminal justice agencies and local authority, chaired by Essex Police which meets quarterly. The objectives of the partnership are to:

- Provide strategic leadership to address sexual violence and abuse in Southend, Essex and Thurrock
- Develop a partnership sexual violence and abuse strategy, which sets out and monitors the key shared outcomes partners are seeking to achieve through collaborative work around sexual violence and abuse. The strategy is currently being developed and is due to be published in the Autumn of 2019.
- Understand and review the performance of local sexual violence and abuse support services and their impact
- Seek new ways of working together and promote best practice
- Hold each other to account for complying with appropriate legislation and statutory responsibilities in addition to monitoring the effective delivery of the partnership Sexual Violence and Abuse Strategy

9.4 Thurrock Community Partnership

Thurrock Community Safety Partnership (CSP) helps agencies to work together to improve the safety of residents in Thurrock.
Our priorities for 2019/20 are:

1. Tackling Offending
2. Violence and Vulnerability
3. Local Community and Visibility
4. Counter Extremism and Terrorism

These priorities are aligned with those of the Police Fire and Crime Commissioner for Essex. In delivering the 4 identified priorities the Community Safety Partnership will ensure that there is a victim-centred approach. The priorities were informed by our strategic assessment, which identifies the scale and scope of crime, disorder and community safety issues within Thurrock.

Priority 2 includes the Thurrock response to the national work regarding Violence Against Women and Girls (VAWG). The United Nations defines violence against women as: 'violence that is directed at a woman disproportionately' this includes a wide range of abusive behaviours including physical, sexual, financial, emotional and psychological abuse. The priority sub heading include:

- Support all victims of domestic abuse, sexual offences including rape, child exploitation and abuse, stalking and honour based abuse i.e. forced marriage and Female Genital Mutilation and target the perpetrators of those offence
- Tackle Violence Against Women and Girls in line with current strategy 2017/20.

9.5 Thurrock Violence against Women and Girls Strategic Group

Thurrock are unique in Essex to have a standalone VAWG strategy to tackle these crimes and activities. The overarching aim of the current Thurrock VAWG strategy is for 'Everyone in Thurrock to live a life free from domestic and sexual violence and abuse and harmful practices, defined as "Violence Against Women and Girls" (VAWG). This will be delivered by:

- Putting the victim at the centre of service delivery
- Having a clear focus on perpetrators in order to keep victims safe
- Safeguarding individuals at every point
- Raising local awareness of the issues and involve, engage and empower communities to seek, design and deliver solutions to prevent VAWG.

The strategy and action plan are monitored by a VAWG Strategic Governance Group, which is accountable to the Thurrock Community Safety Partnership (CSP). Thurrock Council have recently recruited a coordinator to develop the local response which has improved governance and partnership working. The CSP have continued to host J9 domestic abuse awareness training and have developed an awareness raising programme for Sexual Abuse "Challenging Myths Changing Attitudes". The CSP also continue to promote events during the international '16 days of action'. The current strategy is coming to an end and therefore the CSP we will work closely with their partners to develop the refreshed strategy and ensure that our actions are fit for purpose and making a difference to the lives of Thurrock residents. The Thurrock Community Safety Partnership is committed to meeting the needs of both women and men by tackling all forms of exploitation and abuse across Thurrock by delivering preventative measures, protection, and legal redress for all.

9.6 SET Strategic CSE Board

The Southend, Essex and Thurrock (SET) Child Sexual Exploitation (CSE) Board sits quarterly and brings together key partners from across the county to consider the strategic challenges and response to CSE and Child Criminal Exploitation. The group focuses on a number of key strategic issues including missing children, looked after children and specific issues arising from complex and organised child abuse cases. At the board there are senior representatives from Essex Police and Children's Social Care from Southend, Essex and Thurrock.

9.7 Gang Related Violence Meetings

Thurrock Council have a Gang Related Violence Strategy in place which is based on the intelligence and feedback from professionals at the workshop held in 2016 and the throughput and performance data of the Thurrock Gang Related Violence Operation Group and its Partners. Locally there are two gang related violence meetings; strategic and operational.

This strategic meeting is owned by the multi-agency gang related violence strategy group which is made up of partners from the Local Authority, police, National Probation Service, Community Rehabilitation Company and Youth Offending Service. The Strategy group coordinates the partnership approach to gang related violence and associated gangs in Thurrock, has direct governance of the operation group and is responsible for the strategic management and deliverables within this strategy and subsequent delivery plan.

The purpose of the operational meeting is to share information and put together multi-agency action plans for the prevention, reduction, and detection of crime and reduce the risk of children being criminally exploited. The group is multi agency and works on a 'prevent, disrupt and enforce' model. This information will contribute to the Prevention & Detection of Crime; Apprehension & Prosecution of offenders; and Prevention of harm to individuals. The group has identified key performance indicators and is a forum for gathering local intelligence and data that drives the gang related violence strategic group, the Thurrock gang related strategy and subsequent action plan.

9.8 Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is a regular multi-agency meeting to discuss how to help victims at high risk of murder or serious harm. MARAC considers cases identified as 'high risk' by use of the Domestic Abuse, Stalking and Harassment and 'Honour'-based violence (DASH) risk model and develops a coordinated safety plan to protect each victim. Attendees typically include an Independent Domestic Violent Advisor (IDVA) and representatives from the Police, Children's Social Care, health and other relevant agencies. The group share relevant information about the victim, the family and perpetrator in order to develop an action plan to reduce risk for each victim. Everyone present commits to taking forward the agreed actions. The IDVA advocates for the survivor, and ensures that afterwards they understand what is being agreed.

Appendix 10: Glossary

A&E	Accident & Emergency
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CIPFA	Chartered Institute of Public Finance and Accountancy
CP	Child Protection
CPS	Criminal Prosecution Service
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
CSEW	Crime Survey for England and Wales
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Honour
DV	Domestic Violence
EMDR	Eye Movement Desensitisation and Reprocessing
EPUT	Essex Partnership University Trust
EWMHS	Emotional Wellbeing and Mental Health Service
IAPT	Improving Access to Psychological Therapies
ISVA	Independent Sexual Violence Advisor
JSNA	Joint Strategic Needs Assessment
LSAB	Local Safeguarding Adults Board
LSCP	Local Safeguarding Children's Partnership
MACE	Multi Agency Child Exploitation Group
MASH	Multi-Agency Safeguarding Hub
MoU	Memorandum of Understanding
NCA	National Crime Agency
NELFT	North East London Foundation Trust
ONS	Office for National Statistics
PD	Personality Disorder
PTSD	Post-Traumatic Stress Disorder
REAL.	Respect Empathy Awareness Listen. End the silence
RSE	Relationships and Sex Education
SARC	Sexual Assault Referral Centre
SASP	Sexual Abuse Strategic Partnership
SERICC	South Essex Rape and Incest Crisis Centre
SET	Southend, Essex and Thurrock
SOE	Sexual Offence Examiner
SV	Sexual Violence
SVA	Sexual Violence and Abuse
TSAB	Thurrock Safeguarding Adults Board
VAWG	Violence Against Women and Girls

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7 November 2019	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Library Peer Challenge Report	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Rosalyn Jones Library Services Manager	
Accountable Assistant Director: Les Billingham, Assistant Director – Adult Social Care and Community Development	
Accountable Director: Roger Harris – Corporate Director, Adults, Housing & Health	
This report is Public	

Executive Summary

Thurrock Library Service successfully applied to participate in a Peer Challenge organised by the LGA and Arts Council. A small team spent two days reviewing a number of core documents and meeting key stakeholders 8th and 9th July 2019. We have received the final report from the Peer Challenge team. Health and Well Being Overview and Scrutiny is invited to comment and support next steps.

The report is very complementary about the service. Currently Thurrock Libraries are seen to be at a cross roads with a great deal of opportunity to grow and thrive, linking more with cross cutting council agendas and building on the community relationships in place through the hubs programme.

The report commends the strategy agreed by Cabinet in December 2018. It does however suggest further consideration to the capacity and revenue budget necessary to deliver on this aspiration.

A delivery plan is already in place to support the alignment of the library service and community hubs. This will be updated to include recommendations from the Peer Challenge report.

This report highlights progress to date and seeks comments from the committee to support the promotion and development of Thurrock Library Service.

1. Recommendation(s)

1.1 That Health and Wellbeing Overview and Scrutiny Committee consider the recommendations in the Peer Challenge report and comment on the proposed actions

2. Introduction and Background

2.1 Thurrock is growing with an increasingly diverse population. It is important that hubs and libraries can continue to develop to remain 'anchors' within their community.

2.2 We welcome the recommendations made by the Peer Challenge and work has started to incorporate these into a delivery plan to implement the Communities First strategy agreed by Cabinet in December 2018 – this seeks to align Thurrock Libraries with the Community Hub Programme.

2.3 Thurrock's Library Service is highly valued by its residents. Footfall and the number of members are high compared with other similarly sized services. Libraries engage with around 1,500 residents each day.

2.4 The public consultation in summer 2018 confirmed that access to books and computers remained very important for the majority of residents.

2.5 The development of Community Hubs closely aligned with the library service was recognised as a positive way forward, providing additional support, an increased range of activities, community engagement around local priorities and valuable volunteering opportunities.

2.6 The Community Hubs in South Ockendon, Chadwell and Tilbury are well established with community led steering groups identifying local priorities and developing programmes in partnership with libraries. In each venue the hub volunteers and library staff are managed by one Supervisor enabling a close working partnership. (At South Ockendon in addition to the supervisor, a centre manager is employed through CVS to provide additional support at a venue open 6 days a week often including evenings with a variety of community led activities) With the re-opening of East Tilbury in 2019 after the fire and the new Community Hub and Library in Aveley due to open January 2020, this will bring the number of hubs within libraries to 5.

2.7 Although 5 hubs are co-located in libraries, the programme remains a true partnership across Thurrock Council, Thurrock CVS including ngage, and local communities through steering groups that involve key stakeholders. Each partner brings distinctive skills and resources to the programme which, through discussion and agreement, help to find the best solution to local issues. At Purfleet, it is the Hub that hosts a self-serve library, and CVS employ a community builder to support development in this area.

2.8 Staff and volunteers have embraced the opportunities the hub programme has afforded. The Peer Review team commented that the staff and volunteers

were knowledgeable, passionate and committed to provide the best service/offer to residents that they could.

2.9 A learning programme has recently been refreshed to support volunteers active at hubs. The programme, coordinated by ngage, includes four core training sessions. Volunteers from across hubs are encouraged to attend with volunteers from other hubs to support networking and the sharing of best practice. This has recently been refreshed following feedback from volunteers to included community engagement techniques, first aid and bespoke training as a need is identified. This was launched at a successful volunteer celebration day hosted by Thurrock Adult Community College September 2019.

2.10 A training plan is currently under development to ensure staff continue to have the skills required to meet changing needs. This will include First Aid, a refresh of customer care plus mandatory Health and Safety and specialist library training around Reader Development and stock management.

3. Issues, Options and Analysis of Options

3.1 A summary of the actions being taken to embed the recommendations in the Peer Challenge report into the Library and Hub Delivery plan are summarised below:

Recommendation 1 - Develop a clear plan to roll out the new library strategy

3.1.1 The 5 year 'Communities First' strategy for libraries and hubs approved by Cabinet in December 2018 agreed that all libraries would remain open and develop into hubs looking to improve sustainability through co-location and increased income generation.

3.1.2 Capital investment has been identified for technology and investment in libraries' infrastructure. East Tilbury has reopened following the fire in 2017 and the new Aveley hub and library is due to open January 2020

3.1.3 A feasibility study has been completed to consider a refurbishment of Chadwell to maximize use of the building, expand community space and create meetings rooms for hire and community use.

3.1.4 There is a need to Increase revenue investment in the book and resources fund, currently one of the lowest in the country. This will improve residents' access to current information and educational and leisure reading especially for children and families in poverty

3.1.5 Additional meetings rooms for hire have been and will be incorporated into redesigned/relocated buildings. Hire charges for meetings rooms and buildings out of hours have been reviewed for April 2020. These simplify the

range of charges and strike a balance between income generation and the need to provide accessible space for priority groups supporting local priorities.

3.1.6 Though capital funding, improved technology within libraries is being rolled out. By January 2020 all libraries and hubs will have:

- New PCs with Windows 10 for both public and staff
- Self-service kiosks to allow residents to issue, return items, book computers and pay for printing
- Multi-Functional Devices will enable residents not only to photocopy but also scan documents directly to council departments and pay and print from their own devices via WIFI
- Council staff will be able to print, supporting the roll out of agile working

3.1.7 This improved offer will improve the ability of the service to explore income generation opportunities. We are committed to developing business plans for individual hubs in partnership with local steering groups, as well as a service wide approach to sustainability alongside council investment. As part of the strategy development, funding for developing business plans was assigned to the service. Our planned restructure will enable new business ideas to be explored and supported by staff as we develop new ways of working.

3.2 Recommendation 2 - Consider appropriate timing for staff restructure

3.2.1 A restructure of the library service is currently being considered. Our restructure will:

- Increase management capacity to drive and embed change, support staff as the alignment of hubs and libraries gathers pace and identify income generation opportunities/develop business plans for longer term sustainability and expansion of the programme.
- Recognise and value the increased responsibilities staff have taken on with the introduction of hubs and changes in library priorities, including support for residents to ensure digital inclusion.
- Ensure capacity for staff to network, develop on-going partnerships and collaborate more closely with the community.

3.3 Recommendation 3 - Increase the profile of Thurrock and its libraries locally, regionally and nationally

3.3.1 We aim to increase the library profile, locally, regionally and nationally and seek the opportunity to share the programme more fully with Councillors and the wider community. This will be achieved through a local campaign to raise the profile of libraries and the range of support on offer as well as through promoting case studies and applying for awards that recognise the innovation and achievements made by libraries.

3.3.2 We recognise that much has been achieved to position Thurrock's libraries as the Face to Face image of the council e.g. residents encouraged to visit

the libraries and hubs to apply for parking permits, blue badges, bus passes but more can be done. Adult Social Care Community Led Support Teams and Local Area Coordinators currently work from hubs and libraries and phones have been installed in all venues for vulnerable residents to contact the council directly.

3.3.3 A performance framework is in place to improve the collection of statistical data and combine data from libraries and hubs. Training and a methodology to collect qualitative impact stories is currently in development and this will feed into a marketing strategy.

3.3.4 We intend to review the current KPIs and comments are welcome to shape our approach in the future.

3.4 Recommendation 4 - Continue to develop and network

3.4.1 The 2018 public consultation was invaluable to identifying views of the wider community. Now we need to develop an on-going methodology to ensure a continuing dialogue with residents. This will build on the existing relationships with hub steering groups and community forums and make use of the new council consultation portal.

3.4.2 We will consider developing a Friends network ensuring this is complementary to existing networks.

3.4.3 Comments are welcome to shape this approach.

3.5 Recommendation 5 – Develop one brand with shared understanding

3.5.1 Libraries and hubs have shared one management structure for a comparatively short period and much has been achieved with all hubs reporting a positive team spirit. Work remains to be done not least the decision how buildings should be named to reflect their changing role while not losing the established and trusted branding that the term ‘library’ affords to residents.

3.5.2 We recognise that residents are not always aware of all the services libraries and hubs provide. We do not always celebrate achievements in the wider world and promote Thurrock libraries as a progressive library service. For example, new initiatives this year have included the establishment of English Speakers of Other Languages (ESOL) sessions in partnership with the Thurrock Adult Community College and a new job club at South Ockendon to support economic prosperity.

3.5.3 Revenue support is required to develop a marketing strategy and branding to promote the library and hub offer ensuring the community led approach is paramount.

3.6 Recommendation 6 – Recognise the contribution that libraries can make to literacy, digital literacy and educational attainment

3.6.1 The Peer Challenge team commented that the contribution that libraries can make to literacy, digital literacy and educational attainment is not always recognised. Additional training and development is planned to ensure staff and volunteers are confident in their understanding and able to communicate effectively the benefits of the library programme to residents and partners and demonstrate how they contribute to wider council agendas.

3.6.2 Three staff training days have been arranged for 2020

3.6.3 We recognise libraries can contribute more to support business development

- Staff and volunteers support residents using computers to complete job applications
- Libraries contribute to the work of the Economic Development and Skills Partnership delivery group
- A job club has started at South Ockendon with plans for a second one at Chadwell
- Two Apple MACS will be installed in libraries as part of the new technology roll out to support emerging businesses.

3.6.4 Comments are welcome to contribute to this development.

4. Reasons for Recommendation

4.1 To introduce the Peer Challenge report, reflect upon its recommendations and request support to proceed

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

5.1 N/A

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

6.1 The Peer Challenge process seeks to complement and support a council's own performance and improvement focus. The recommendations reflect the agreed position of Thurrock's library service and the 'Communities First' strategy which is to continue to meet community and corporate priorities in accordance with policy and process and provide a progressive, inclusive and collaborative library service and hub offer to residents.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Finance Manager

Funding through the capital programme has been allocated to support the acquisition of digital technology and improvements to infrastructure at Aveley. Options regarding proposed changes to the staffing establishment and book fund will need to be presented in future detailed business cases to determine the potential ongoing budgetary impact and funding options. There is no ongoing new funding identified within the MTFS. A review of all fees and charges and income generation opportunities will be carried out as part of the 2020-21 budget setting process.

7.2 **Legal**

Implications verified by: **Tim Hallam**

Acting Head of Law, Assistant Director of Law and Governance and Monitoring Officer

There are no direct legal implications. Any legal implications arising from the proposed library staff restructure would be advised upon as necessary at the relevant time.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

Team Manager, Community Development and Equalities

The peer review acknowledged the diversity of the combined library and hubs offer that is available to all local residents regardless of their protected characteristic/s and in line with duties set out in the Equality Act 2010. A range of inclusive provisions and services are currently in place across the libraries and hubs network and accessible to residents - these are not limited to a balanced range of stock, applying for parking permits, blue badges and bus passes as well as accessing Adult Social Care's Community Led Support Teams and Local Area Coordinators. The Communities First Libraries and Hubs strategy prioritises the importance of maintaining and expanding the service commitment to community engagement with a range of mechanisms now in place to support the evolution of libraries and hubs working with local residents and the wider voluntary and community sector to realise locally determined priorities.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

None

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

9. Appendices to the report

Appendix 1 – Library Peer Challenge Report August 2019

Report Author:

Rosalyn Jones
Library Services Manager
Community Development, Adults Housing and Health

Local Government Association

Thurrock Council

Library Peer Challenge

Report of the Peer Challenge Team

Date 8 - 9 July 2019

1. Executive Summary

Thurrock Council Library Service (TL) was awarded a peer challenge through the Arts Council England (ACE) and Local Government Association (LGA) partnership. Nine library peer reviews were funded by the Arts Council this year for the first time in addition to three culture peer challenges. The scope and focus for this library challenge is set out in section three of this report.

On 12 December 2018 Thurrock Council's Cabinet agreed a "Communities First Strategy for Thurrock Libraries and Community Hubs." This is the first ever plan for Thurrock Libraries. It sets out the ambition for service development within the context of the agreed council vision for Thurrock, the place. TL are considering how to make the strategy a reality and are working up delivery plans, whilst continuing with an ongoing programme of refurbishment and renewal of the library buildings. The accompanying report states that additional funding will be required to secure the service at current levels. One off funds will be allocated to support the development of individual business plans and financial implications will be considered at that stage. A key aim of this will be to develop an investment plan for the long term future, by considering all development opportunities to enhance future provision.

The strategy was produced following public consultation that took place in June 2018. This guarantees that all nine of Thurrock's libraries and the self-serve community hub will remain open, and seeks to enhance and improve the offer to residents by continuing to develop community hubs within library buildings. The intention is to develop libraries and hubs as an "anchor" in which to extend support to residents.

The strategy also looks to extend the services on offer in libraries and build on the excellent work already being done. As well as providing books, libraries will:

- offer support to those looking to learn and enhance their skills
- support health and well-being
- provide a range of cultural experiences and arts events
- provide excellent digital resources, including access to PCs and Wi-Fi
- give children and adults the skills they need to become skilled digital operators ready to take advantage of the latest technological advances.

There is a strong cross party political commitment to the library service. The council has stated that it will not close any libraries. They will remain in their current locations, although some of the library buildings may change this will be to enhance services.

The peer team met with a very welcoming, passionate and committed group of staff, volunteers and Portfolio Holder. TL managers recognise that some staff feel undervalued, and this impression is compounded by the need to restructure the service, to align with the desired outcomes of the new strategy.

The service is self-aware and describes itself as “being at the crossroads” and recognises that it is time to realise the full potential of the service. TL is not alone in holding aspirations for the library service, with support evident at the most senior levels of the council. The peer team recommend that you use the peer challenge process to support your forward planning. The team offered both individual and organisational support to assist TL on its journey. There are other library authorities that are further down the line of library/community hub development that will be able to share their experience with Thurrock.

Most commentators’ feel that TL have found a suitable home in the Adults, Housing and Health Directorate of the council. The peer team was told that “Being in the adult services directorate is the best fit we have experienced.” This organisational arrangement has helped stabalise the service and provides comfort to staff and users that the council is serious about its library service provision. Prior to this libraries had been located in range of different directorates and this had proved unsettling.

During the visit the peer team visited the South Ockendon library/hub. We learned that in 2012 three groups using separate buildings merged into one community hub. This included the library, the housing office and South Ockendon Community Forum shop front. The model appears to be a good prototype for other similar developments. TL are currently building a replacement for a branch library in Aveley, refurbishing East Tilbury and working up proposals for an integrated health, hub and library in Tilbury. Other buildings are in phase 2 of a development programme and early thoughts are being given as to what a virtual library/hub could be. It appears that the library service provides the anchor around which other services/community led support can be provided to suit local need as defined in community profiles and by the refinement of further detailed consultation with the local community.

Thurrock is an exciting place to be with great potential. TL need to find a way to engage in the wider place agenda.

2. Key recommendations

The peer team recommendations are grouped under the three priorities set out in the council’s vision, agreed in January 2018. These are People, Place and Prosperity.

1. Develop a clear plan to roll out the new library strategy (People)

The recently agreed library/hub strategy “Communities First” sets out a five year plan to improve the service and place it at the centre of the communities that live in Thurrock. The council is aware that it needs to decide how it is going to deliver these aspirations and work is well underway on investing in infrastructure improvements.

2. Consider appropriate timing for staff restructure (People)

Time now needs to be spent on bringing staff and volunteers fully into delivering the aims of the strategy. This will require consideration of the timing of the staff restructure to ensure alignment with the skills required to deliver the strategy. The current structure and job specifications, role descriptions are out of date and will be reviewed as a necessary consequence of implementing the strategy. Once a delivery plan is agreed, it should be shared with staff, properly resourced, timetabled and implemented at pace. Some staff are feeling “unloved” and would like to welcome a greater recognition by senior council officers and councillors.

3. Increase the profile of Thurrock and its libraries locally, regionally and nationally (People)

TL has a lot to be proud of and now is the time to consider how to better promote TL as a progressive library service. In particular the success of the South Ockendon community hub, with its core library offer combined with the delivery of other offers seems an appropriate model for wider recognition. As Thurrock continues to develop the model it would be useful to commission an independent evaluation. This will provide a useful basis from which to roll out the infrastructure improvements set out in the TL strategy. The South Ockendon success story would be suitable for a case study. Both the LGA and ACE will help Thurrock promote this story. It would be good to see Thurrock appear in a future edition of Arts Council’s Libraries as Community Hubs: Case Studies and Learning[1] and as a case study in the LGA/ACE online culture hub

It would be useful to collect and use impact stories, and build this into the new performance management framework, perhaps by making this a performance indicator. The new libraries campaign can use these stories to raise the profile of libraries. Consideration should be given as to whether the current KPIs are the correct ones to inform on the value of Thurrock Libraries. Consideration should also be given to improving data collection to support TL’s work and profile.

4. Continue to develop and network (People)

TL has some valuable alliances locally, resulting in good collaboration within the library/hubs. These can be further developed and matured for the benefit of the Thurrock communities. Much effort has been expended in consultation and it would be useful to consider how to maintain this relationship. One idea would be to consider developing a Friends network, building on responses to recent consultation and providing a platform for continuing dialogue with the public.

5. Develop one brand with shared understanding (Place)

[1] https://www.artscouncil.org.uk/sites/default/files/download-file/Libraries-CommunityHubs-Renaisi.pdf

The presentation of the library/hub service is confusing and much effort is being expended to try and describe what goes on within the library/hub buildings. This requires a discussion and agreement about developing the one brand for TL.

6. Recognise the contribution that libraries can make to literacy, digital literacy and educational attainment (Prosperity)

As the strategy develops it will be important to explore the libraries contribution to increase prosperity in Thurrock e.g. supporting business development. This area appears to be underdeveloped and may be a consequence of no libraries voice being heard at the “top table."

3. Summary of the Peer Challenge approach

The peer team

Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at Thurrock were:

- Carol Stump – Chief Librarian, Kirklees Council
- Helen Parrott – Senior Manager Strategic Partnerships, Arts Council England
- Mark Harrison – LGA Peer Challenge Manager

Scope and focus

The peer team considered the following areas three core questions:

- is the council getting best value from its library assets?
- how effective is the library service’s contribution to cross cutting agendas of other services?
- what is the role of the library service and council in the local community?

In addition, Thurrock asked the peer team to consider the following questions:

- what are the relationships and role that the service has within the wider council?
- what opportunities are there for income generation, what can TL learn from other councils?
- is Thurrock getting the balance right between its community and its traditional roles?

The peer challenge process

It is important to stress that this was not an inspection. Peer challenges are improvement-focussed and tailored to meet individual councils’ needs. They are designed to complement and add value to a council’s own performance and improvement focus. The peer team used their experience and knowledge of local government to reflect on the information presented

to them by people they met, things they saw and material that they read.

The peer team prepared for the peer challenge by reviewing a range of documents and information in order to ensure they were familiar with the council and the challenges it is facing. The team then spent two days onsite at Thurrock, during which they:

- spoke to more than 34 people including a range of council staff together with councillors and external partners and stakeholders
- gathered information and views from more than 13 meetings, visits to key sites in the area and additional research and reading
- collectively spent more than 80 hours to determine their findings – the equivalent of one person spending more than two weeks in Thurrock.

This report provides a summary of the peer team's findings. It builds on the feedback presentation provided by the peer team at the end of their on-site visit (8 - 9 July 2019). In presenting feedback to you, they have done so as fellow local government officers and members, not professional consultants or inspectors. By its nature, the peer challenge is a snapshot in time. We appreciate that some of the feedback may be about things you are already addressing and progressing.

4. Feedback

Is the council getting best value from its library assets?

TL staff are working hard to get better value from the library assets. There is more work to be done as some of the building stock is not fit for purpose and opening hours have been reduced as a consequence of budget reductions. The council is addressing this through a planned programme of infrastructure investments and is considering how to realign opening hours to better suit public requirements.

Despite this TL are bucking the national trend on visitor numbers, with a high number of active borrowers and physical visits (CIPFA stats comparative profile February 2019). TL has high levels of computer use and high take up on the Summer Reading Challenge strongly supported by young volunteers.

There is an emerging recognition that libraries are so much more than buildings and the recently adopted strategy sets out for the first time a forward plan for library improvements. This is ambitious and although the proposals for building improvements is clearly stated there needs to be further consideration given to the capacity and revenue budget necessary to deliver on the aspiration.

The council is investing capital, as it rolls out a programme of library/hub renewal. More work is

required to explore opportunities for existing branches that are not currently within scope for redevelopment. We were pleased to learn that communities will be actively involved in this process. There is also work required to assess the impact of the major developments within Thurrock, including 30,000 new homes.

There is a clear recognition the TL contributes to social cohesion and community wellbeing. However the value of this work is not recorded or measured, therefore it is difficult to assess if the council is getting best value from its library service in this area. So the question that arises is TL measuring the right things?

We were told that spaces/rooms could be better used and this would increase engagement by the wider community. Staff feel disempowered and would welcome the opportunity to take risks, within boundaries and without the fear of sanction. It may be time to think of a different approach to room hire within the library buildings. It may be that the income targets are preventing the best use of the assets by the community. A shift toward offering the use of the space to community groups and partners in pursuit of delivering library strategy outcomes is worth considering.

Many people commented about inadequate corporate support e.g. I.T and assets. This seems to be a long term issue and is using up much time, goodwill and capacity that would be better directed to the front line and library/hub development activity.

During our focus group sessions a number of improvement ideas were identified by staff and volunteers, and these require consideration and resolution. They are:

- staff feel undervalued by the rest of the council and some are circumspect as previous reviews and reports have not led to any improvement
- action is required to improve opening hours, especially on Saturday afternoons
- investment is required in digital infrastructure and related training/skills development
- opportunities to improve skills and capability to better respond to user requirements
- focus required to improve marketing, image and profile of the library service/hub
- clarification about the role of volunteers
- unified management approach across the network i.e. one manager for library/hub
- better promotion of library activities and events, including inter-generational activity
- refocus on literacy and educational attainment
- realism about the budget
- progress on restructuring and recognition of the contribution that staff make, maybe a celebration of success
- improvement to stock and its presentation
- better access, both physical and reading materials.

We were pleased to meet a passionate and knowledgeable group of library staff. Despite budget constraints they are fully committed to doing the best they can for their communities.

How effective is the library service's contribution to cross cutting agendas of other services.

There is lots of potential in this Directorate and beyond for TL to demonstrate its contribution to the wider agenda of the council and partners. Some excellent work is in place, but it remains under celebrated and the opportunity exists to ensure that the outcomes that will be described in the library/hub delivery plans can be developed in a way that better reflects TL's contribution to Place, People and Prosperity aims.

Libraries could underpin so much more of the Council's work, and the strategy sets out a number of offers that reflect this, as follows:

- reading
- learning
- wellbeing and community
- cultural and arts
- digital.

It appears that libraries have not featured when new developments are being shaped. This opportunity should not be missed in future, the potential of libraries/hubs should be a part of the prospectus for future housing growth and other suitable regeneration initiatives. The inclusion of a library/hub space in a new leisure centre or school can be a low cost/high impact solution.

The ambition expressed in "Communities First" is not matched by the current resources. Consideration is required to stabilise the library revenue budget and to provide additional capacity and capability to work out how best to deliver the strategy.

TL need to develop and share a compelling narrative. Much of this is set out in "Communities First" and we understand that there will be a media campaign to raise awareness of the library/hub offer under the championship of the Portfolio Holder for Communities.
Staff are very excited about the future and it is important both to recognise this and to find a way to better equip staff to contribute ideas. They should be involved in the continuing infrastructure improvements and helped to acquire the skills necessary to deliver on the strategy.

We recognise that the Book Start scheme is well understood in Children's Centres. This initiative makes a significant contribution to children's development and literacy.

What is the role of the library service and council in the local community?

The role of libraries in Thurrock is a provider of books and reading opportunities, and also learning, literacy and information. Above all libraries are about communities and people and responding to their needs. Libraries can help people to live independent, happy and fulfilled lives in line with the emerging ambition expressed in "Communities First".

TL is very much part of the council vision this means that libraries/hubs should aim to provide

(People)
- high quality, consistent and accessible public services which are right first time
- the opportunity to build on partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
- the library/hub model that helps empower communities to make choices and be safer and stronger together

(Place)
- accessible public spaces that connect people and places
- fewer public buildings with better services

(Prosperity)
- 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.

Libraries are a safe and neutral space in which the above can be provided. The contribution to the people and place elements of the council vision are evident, and could be better documented to demonstrate the connections. The prosperity element is less evident and therefore requires further consideration and promotion to ensure that TL clearly understands its potential contribution to the prosperity of Thurrock.

The success of the library/hub model demonstrates the appetite to make co-location and co-production work. Despite some teething problems this model is maturing and the benefits of working in a new way focused on the local community is proving to be beneficial for residents.

The national Universal library offers support the “Communities First” strategy. Some work needs to be done to ensure that staff understand the connection between TL and the wider council and national agendas.

Thurrock understands that its libraries offer an inclusive environment and a safe space in which bespoke activities can be developed to respond to local needs. There is a common understanding that Thurrock consists of a number of “urban villages” each having its own unique characteristics. This profile needs taking into consideration as each new community/hub reflects the specific requirements of its own local community.

What are the relationships and role that the library service has with the wider council?

TL is moving in the right direction and is well positioned within the Adults, Housing and Health directorate. This has helped the council, at a corporate level, to develop an understanding of the

potential of libraries.

TL has been undervalued as a resource corporately and is playing catch up. Much valuable work has been carried out in the last 18 months to improve the service and to roll out the continuing infrastructure improvements. The scene is now set for the next five years and will be mapped out in business plans that deliver on the “Communities First” strategy. More work is required to make the strategy a reality and TL staff are key to its successful implementation.

It would be useful for TL to develop a narrative to assist in the marketing and promotion of the library offer. Part of the development of the narrative will describe clearly TL’s contribution to the wider council agenda.

Now is the time to recognise and share strengths, to be aspirational and to communicate and celebrate success.

As TL raises its profile in the council, staff would value more contact with senior management and councillors.

What opportunities are there for income generation, what can Thurrock learn from other councils?

We are aware of the existing proposal to recruit to a business development post for TL. This is a specialist area and one where libraries have not been particularly successful. We think that a One Council approach is necessary. That is a review of the income generation potential of library/hubs in the context of the Thurrock estate and a recognition of the value of the other TL assets (people, stock, acquisitions, and services) as social capital.

TL has realised the clear potential in new developments of raising capital from S.106, public health and the council’s community hub capital funds. It would be useful to explore other funds and this requires time and resource to do so effectively e.g. Corporate Social Responsibility/sponsorship, ACE and other grants, working with the economic development team.

Funding partners will be looking to develop sustainable relationships, with pay back more likely in the medium to long term. It is not envisaged that any new income generation would cover the current revenue gap. To fully realise the ambition set out in the new strategy, the council needs to fund the service properly and consolidate the current operation.

The untapped potential of volunteers represents a significant potential resource for TL. Currently volunteers are active in home delivery, summer reading schemes and library assistant roles. However, the role of the volunteer varies across the service and staff have a range of views about the benefits of volunteers. Now is the time to reconsider the relationship with volunteers. For example advantages of volunteering include:

- work experience and expanding your CV
- helping your local community and giving back to society
- meeting new people and making friends
- staying active and feeling appreciated
- improving your wellbeing and discovering new purpose.

All of the above are opportunities that are provided within “modern” library services. Now is the time to work together to provide an expanded role for volunteers within TL in partnership with volunteers and their representative organisations, such as Thurrock CVS. One important point is to consider how to better match the skills of the volunteer cohort with the aspirational outcomes of Thurrock’s new library strategy. An exemplar is Norfolk library service that has progressed the opportunities available for volunteers by developing nearly 40 role descriptions. Thereby clarifying and expanding the volunteer role and creating a better alignment with the work and desired outcomes of the Norfolk library and Information service.

Is Thurrock getting the balance right between its community and its traditional role?

The peer team’s view is – is this the right question to ask given the ambitions of the council and its partners? The development of the community hub model with the library anchor reflects a good combination of a new integrated service. A key role of community hubs is to galvanise communities around the issues they feel passionate about; supporting opportunities to improve local conditions including health and wellbeing, community safety and helping people into work. As the library service and hubs programme align, the council aims to build on this opportunity for residents to influence local decisions and shape the future of their borough through hubs.

The library/hub will help support the delivery of Your Place Your Voice engagement activities and support residents with a passion for active citizenship to develop the skills and confidence to take an active role in their neighbourhood.

There is an awareness amongst library staff and senior management that work remains to be done to ensure that the library service is better positioned to contribute fully to the achievement of the Thurrock ambition. In particular the following require attention:

- develop and document a shared understanding of the contribution libraries can make to Thurrock outcomes
- frame the library service in the context of the library universal offers
- engage and inspire colleagues through leadership, direction and vision.

As well as the national agencies, Thurrock should work with various local and regional partners to achieve the ambitions of “Communities First”. The strategy conforms to good practice, as it includes a clear vision for the future outlining what the service should achieve and deliver. We note that DCMS approve the approach taken in Thurrock in developing the library/hub model.

Networking opportunities are not being maximised and learning is not being migrated to help with the TL response to the Thurrock vision. Currently there is an opportunity to take a pause, reflect on work to date and identify the capacity and capability to fully engage with the national, regional and local agendas. The following may be of assistance as you move towards a new plan for TL to become fit for the future.

Library Taskforce publications/Blog. The Taskforce was set up to enable libraries in England to exploit their potential and be recognised as a vital resource for all. On this **blog**, members of the Taskforce talk about their work. https://librariestaskforce.blog.gov.uk/

Arts Council is the development agency for libraries in England. The focus is on public libraries, which operate within a wider framework of library provision and local and national government services. They have taken on the work of the Libraries Task force until 2020.
https://www.artscouncil.org.uk/supporting-libraries

ACE/LGA online culture hub:
https://www.local.gov.uk/topics/culture-tourism-leisure-and-sport/good-practice-culture

Two case studies from Peterborough Libraries currently on the culture hub, both for their content on the use of technology and as examples of published case studies.
https://www.local.gov.uk/new-delivery-model-peterborough-city-councils-library-service

https://www.local.gov.uk/peterboroughs-open

Libraries Connected. The Society of Chief Librarians (SCL) has become Libraries Connected as part of its new role as a Sector Support Organisation with Arts Council England (ACE) funding. The new role will see Libraries Connected support and advocate for public libraries, building on successes such as the Universal Offers. The name change is part of a broad rebranding that has seen SCL adopt charity status, as part of the ACE funding deal worth £500,000 a year.
https://www.cilip.org.uk/page/LibrariesConnected1

The Reading Agency is a charity that works throughout the United Kingdom to harness the proven power of reading to tackle life's big challenges like literacy, health and wellbeing and isolation and loneliness. Its vision is for a world where everyone is reading their way to a better life. It works closely with partners including public libraries, colleges and prisons to promote the benefits of reading among children and adults. https://readingagency.org.uk/

CIPFA Nearest Neighbours. Allows councils to download reports comparing each English library authority that returned data (134 of the 150 councils in England have been published: reports updated March 2017) with their family group, as defined by the CIPFA Nearest Neighbours Mode. Thurrock has a near neighbour comparator in Peterborough, and this may be worth progressing a conversation between the two library authorities. The peer team can facilitate this

introduction.

JISC champions the use of digital technologies in UK education and research. It provides a range of online services and training to education, learning and research communities in the UK. Providing shared services, infrastructure and advice to help you manage your library resources, research publication lifecycle and research outputs. https://www.jisc.ac.uk/

LGA is a founder member of the Libraries Taskforce and has oversight of cultural activities through its Culture, Tourism and Sport Board. It provides guidance and case study material as well as blogs, leadership conferences and peer challenges. https://www.local.gov.uk/sites/default/files/documents/12.6_LGA%20Cllr%20handbook_Delivering%20local%20solutions%20for%20public%20library%20services.pdf

CILIP is the Chartered Institute of Library and Information Professionals. It is a professional body for librarians, information specialists and knowledge managers in the United Kingdom. https://www.google.com/search?q=CILIP&oq=CILIP&aqs=chrome..69i57j35i39j0l4.2367j0j8&sourceid=chrome&ie=UTF-8

LOCALITY (funding and income) is the national network supporting community organisations to be strong and successful. https://locality.org.uk/

Both peers on this team offered the ongoing support as individuals and on behalf of their respective organisations, Libraries Connected, Kirklees Council and Arts Council England. Kirklees Chief Librarian will share information and support around volunteer recruitment and roles, the Libraries of Sanctuary awards and national opportunities for recognition.

Finally the peer team evidenced much good practice internally, it is important to find a better way of sharing this across the service and council. The Library Services Manager produced an excellent narrative and supporting documents for the peer team. It would be useful to share these as appendices to this report when it is reviewed by the council's overview and scrutiny committee.

5. Next Steps

Immediate next steps

We appreciate the senior managerial and political leadership will want to reflect on these findings and suggestions in order to determine how the organisation wishes to take things forward.

The LGA is well placed to provide additional support, advice and guidance on a number of the areas for development and improvement and we would be happy to discuss this. Gary Hughes, Principal Adviser is the main contact between your authority and the Local Government

Association (LGA). His contact details are: gary.hughes@local.gov.uk

In the meantime we are keen to continue the relationship we have formed with the council throughout the peer challenge. We will endeavour to provide signposting to examples of practice and further information and guidance about the issues we have raised in this report to help inform ongoing consideration.

For more information please contact

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Health Overview & Scrutiny Committee
Work Programme
2019/2020

Dates of Meetings: 13 June 2019, 5 September 2019, 7 November 2019, 16 January 2020, 5 March 2020

Topic	Lead Officer	Requested by Officer/Member
13 June 2019		
HealthWatch	Kim James	Officers
Mid & South Essex Sustainability and Transformation Partnership (STP)	Roger Harris / Mandy Ansell	Officers
Targeted Lung Health Checks Programme	Mandy Ansell / Sam Brown	Officers
Primary Care Networks – Presentation Only	Mandy Ansell / Rahul Chaudhari	Officers
5 September 2019		
HealthWatch	Kim James	Officers
24-7 Mental Health Emergency Response and Crisis Care Service	Mark Tebbs	Members
Mid & South Essex Health & Care Partnership Update	Mandy Ansell / Roger Harris	Officers
Whole Systems Obesity Strategy Delivery and Outcomes Framework	Faith Stow	Officers
Reduction of Thurrock Clinical Commissioning Group 2019-20	Roger Harris / Ian Wake	Officers
Primary Care Networks	Mandy Ansell / Rahul Chaudhari	Members
2018/19 Annual Complaints and Representations Report – Adult Social Care	Lee Henley	Officers
7 November 2019		

HealthWatch	Kim James	Officers
Flash Glucose Monitoring Report	Mandy Ansell	Members
Sexual Violence and Abuse Joint Strategic Needs Assessment	Ian Wake / Maria Payne / Sareena Gill	Members
Targeted Lung Health Checks Programme	Mandy Ansell / Sam Brown	Officers
Charging Review Adult Social Care Services 2020/21	Roger Harris / Catherine Wilson	Officers
Library Peer Challenge Report	Natalie Warren	Officers
Verbal Update on CCG Merger and Accountable Officer	Roger Harris / Mandy Ansell	Officers
16 January 2020		
HealthWatch	Kim James	Officers
Developments on Primary Care	Ian Wake	Members
Budgets	Roger Harris / Sean Clark	Members
Services for People with a Personality Disorder/ Complex Needs	Roger Harris	Officers
Update on CCG Merger and Accountable Officer	Roger Harris / Mandy Ansell	Officers
5 March 2020		
HealthWatch	Kim James	Officers
Primary Care Networks	Mandy Ansell / Rahul Chaudhari	Members
Update on the Whole Systems Obesity Strategy Delivery and Outcomes Framework	Faith Stow / Helen Forster	Members
Update on CCG Merger and Accountable Officer	Roger Harris / Mandy Ansell	Officers

Further reports (date to be agreed):

- Integrated Medical Centres

Reports for 2020/21:

- Update on Cancer Waiting Times
- Case for Change 2

Clerk: Jenny Shade
Last Updated: October 2019

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