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

Health and Wellbeing Board

The meeting will be held at **11am – 1.00pm on Friday 28 June 2019**

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

Membership:

Councillors Susan Little (Chair), Robert Gledhill, James Halden, Luke Spillman and Tony Fish

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

Agenda

Open to Public and Press

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **20 June 2019**

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PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 15 February 2019 1.30-4pm

Present: Councillor Tony Fish

Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group (Thurrock CCG)
Roger Harris, Corporate Director of Adults, Housing and Health
Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Andrew Pike, Managing Director BTUH
Jeanette Hucey, Director of Transformation, Thurrock CCG
Ian Wake, Director of Public Health
Rory Patterson, Corporate Director of Children's Services
Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways
David Archibald, Independent Chair of Local Safeguarding Children's Board
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust

Apologies: Councillors James Halden, Robert Gledhill, Susan Little and Barbara Rice
Dr Anjan Bose, Clinical Representative, Thurrock CCG
James Nicolson, Independent Chair of Thurrock Adults Safeguarding Board
Adrian Marr, NHS England
Kristina Jackson, Chief Executive Thurrock CVS
Tom Abell, Deputy Chief Executive and Chief Transformation Officer Basildon and Thurrock University Hospitals Foundation Trust
Steve Cox, Corporate Director for Place
Kim James, Chief Operating Officer, Healthwatch Thurrock
Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust

Did not attend: Dr Anand Deshpande, Chair of Thurrock CCG

1. Welcome and Introductions

It was noted that Roger Harris was Chair of the meeting in Councillor Halden's absence and apologies were noted.

2. Minutes

The minutes of the Health and Wellbeing Board meeting held on 23 November 2018 were approved as a correct record.

3. Urgent Items

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

4. Declaration of Interests

There were no declarations of interest.

5. Mid & South Essex Sustainability and Transformation Programme (STP) Update

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

- Planning and contracting remained a focus of the STP
- The recruitment process for the Chair and the Executive Lead for the STP had begun and was out for advert at the time of the meeting.

During discussions the following points were made:

- Roger Harris updated members that a decision was taken by the Health Overview and Scrutiny Committee (HOSC) on 10 December 2018 to refer the closure of Orsett Hospital to the Secretary of State. A paper was supplied to this effect and progress had been chased by officers; at the time of the meeting no update had been received.
- It was also acknowledged that Southend had referred the whole STP to the Secretary of State.
- Ian Wake expressed concerns from the recent STP performance meeting that the focus related to centralisation rather than devolving responsibilities. It was described as counter intuitive, required integration and triangulation with both primary and adult social care.
- It was acknowledged that local level leadership was required, which in the instance of Thurrock was provided by the borough's CCG.
- Roger Harris raised concerns about the removal of the local connection and advised that Cllr Halden had written to Dr Watson regarding this matter on a number of occasions.
- Members acknowledged that the confusion surrounding the change in regime meant that it would be difficult to move on, particularly in relation to staffing changes
- It was agreed that Roger Harris would continue to discuss the matter outside of the meeting with the Chair and NHS England, with a longer discussion to be held at the next Health and Wellbeing Board meeting

Action: Roger Harris

RESOLVED: Members noted the update and provided comments.

6. Cancer Waiting Times

This item was presented to members by Andrew Pike, Managing Director BTUH

Key points included:

- Some cancer specialities mean that there were possible increases in waiting times however in general patients understood the fast tracked process
- It was acknowledged that Basildon were the best in the group and ahead of NHS England waiting time figures.
- There had been a slight lag over the Christmas period however Basildon were now on top of this
- Data for the 62 day cancer (urgent GP referral) for Basildon indicated that they were on the trajectory line and were on track, although there were possible delays regarding urology and gynaecology in Southend
- The data suggested a much stronger position for Basildon

During discussions the following points were made:

- Members were reassured by the Basildon data however it would be beneficial to have a Trust position on the matter. It was suggested by Andrew Pike that he would bring the group position back to the Board in two meetings time.
- It was acknowledged that the back log clearance had been necessary to get ahead, with Southend and Mid Essex requiring further work to reduce their back log. Mid Essex had been supported by Basildon and Southend in terms of additional staff to help with cancer tracking and their Patient Tracking List (PTL), including more targeted outsourcing.
- Andrew Pike advised that the Trust as a whole would be in a better position to provide a revised back log trajectory by the end of February.
- Andrew Pike committed to continuing to work with the Thurrock Clinical Commissioning Group (CCG) regarding patient fast track referral and any non-compliance which in turn has an impact on the diagnostic pathway.

RESOLVED: Health and Wellbeing Board members noted the improved Basildon cancer waiting times position, with the overall trend being positive although some further work required for Mid Essex and Southend.

7. Children's Safeguarding Arrangements

This item was presented by Rory Patterson, Corporate Director, Children's Services. Key points included:

- The Children and Social Work Act 2017 and Working Together 2018 dissolved the requirement for Local Safeguarding Children's Boards and required new arrangements to be put into place. The Government had put forward a change in legislation for the country's multi-agency safeguarding arrangements following a review of the performance and effectiveness of Local Safeguarding Children's Board (LSCB). It was found that generally they were not as effective as they could be, however, Thurrock's LSCB was labelled as 'Good' during an inspection in 2016; Thurrock was one of only a small number given this judgement.
- The name changed to Thurrock Local Safeguarding Children Partnership (Thurrock LSCP), all changes to come into effect on 7 May 2019.

- Statutory Partners changed from five to three, removing CAFCASS and Probation as Statutory Partners of the LSCB. They will become two of the "Relevant Agencies" identified to be a part of the new arrangements. Relevant agencies are those agencies the Safeguarding Partners consider are required to be a part of the new arrangements to safeguard and promote the welfare of children.
- Serious Case Reviews changed to become Local or National Practice Reviews. The process for a review changes with new timescales and a slight change to the criteria that determines a review. These will become more proactive and analytical.
- The Child Death Review process was now separate and does not form part of the new arrangements.
- An independent Chair was no longer required, however the safeguarding partners must ensure that independent scrutiny arrangements are in place.
- Thurrock has had a strong partnership over the years although nationally the approach has been inconsistent.
- A multi-functioning independent scrutiny process would be introduced. This would include an Annual Report and also comprise peer reviews, audits and individual scrutineers, including the voice of children, young people, families and communities, to ensure the new arrangements were working effectively.
- Some structure changes to the existing LSCB would take place to meet the new arrangements, this would include changes to the sub-group structure and function.
- The above changes have been submitted to the Department for Education (DfE) for comment, however at the time of the meeting, no comments have been received.

During discussions the following points were made:

- Members commented that the changes were forward thinking and looked at contextual safeguarding approaches, with the three statutory partners undertaking equal responsibility and the value of the CCG, police and council owning the system jointly.
- David Archibald expressed that the changes linked back to the future of the CCG and upwards amalgamation; however there would be a need for local CCG involvement throughout the process
- Jane Forster-Taylor agreed with the above and that a local footprint was needed; although there were local variations. Southend was similar in practice to Thurrock.
- Members commented that there were some boards that had been amalgamated between children and adults including Learning Disabilities and Special Educational Needs which would sit within the Children's Board up to the age of 25. It was also expressed that both children and adult boards required an equal profile and resources.
- It was agreed that local partnerships were working well and that there was a firm commitment to retain local safeguarding arrangements.

RESOLVED: The Health and Wellbeing Board noted the above changes.

8. NHS Long Term Plan

Ian Wake, Director for Public Health, presented this item. Key points included:

- The report set out the direction of travel for the NHS in England over the next 5 years and what this might mean for the borough

- The 5 key themes were:
    1. Finance and Resources
    2. Prevention and Health Inequalities
    3. New models of integrated care
    4. Action to improve care quality and outcomes in different clinical specialities
    5. Workforce

- The most significant aspect of the report was the finance element, the plan set out considerable financial increases to NHS budgets in England of £20.5Bn over the next five years. This extra spending would be required to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities.
- There was also a further move away from individual to system control targets centred on new Integrated Care Systems (ICSs) that will operate at STP level – in Thurrock's case this is Mid and South Essex.
- Public Health funding was not included within the report and adult social care funding dealt within a future further paper and comprehensive spending review.
- The plan committed to a 'more concerted and systematic approach to reducing health inequalities', with a promise that action on inequalities would be central to everything that the NHS does.
- The Plan specifically recognised that there are two major sets of work which need to progress in parallel:
    1. Population Health Management approaches – which required action by everyone, including the NHS
    2. Place Based Approaches – including action on wider determinants such as planning, housing, education and employment outcomes and many other aspects the NHS is not set up to deliver on
- Weight management, diabetes prevention and smoking cessation also included
- The report stated a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be.
- The report discussed new models of care which aligned with what Thurrock were doing locally to have integrated mixed skill workforce teams
- A number of commitments have been given to a group of clinical specialities where outcomes in the UK have sometimes lagged behind other similar western health systems. Priorities include cardio-vascular disease, cancer, mental health, maternity and neonatal health, diabetes and respiratory care.

During discussions the following points were made:

- Members commented that there was the possibility that health visiting and school nursing may end up back again in health, particularly around commissioning. However it was acknowledged this would cause complications regarding existing contracts and budgets; this in turn would have implications for the workforce.

- Ian Wake was concerned with the possible risk of having the footprint moved to an STP level and how that would impact on the ability to align place and care elements – a top down versus bottom up approach.
- Ian Wake also commented that the mental health element was disappointing however transformation plans were more ambitious locally.
- It was acknowledged workforce remained the biggest risk, with little detail provided on how to reduce the vacancy rate.
- Mandy Ansell advised that the CCG needed to make 20% cuts in management allowance in turn putting pressure on delivery.
- Jane Foster-Taylor agreed that workforce remained a concern and commented that definitions of workforce data were not clear as it included voluntary and third sector workers; there was an issue with retaining and recruiting staff.

- Andrew Pike agreed with all the above comments made and stated there was indeed already a strain on resources and that Basildon was in a relatively good place compare to others within the Trust group. Also, joint working was encouraged with the CCG to create an operational plan in order to make further strides in urgent care; demand management was reported as key.
- Roger Harris commented that the wider health and social care demands needed to be considered, the biggest problem in adult social care was reported as domiciliary care. The key issues were late transfers, the instability in the market, and the ability to recruit quality care staff.
- Members commented on the timetable for the planning process, the STP plan was reported to be due in April, however colleagues were awaiting guidance and detail on CCG level plans. A clarity on monies was also required, including what money had been allocated and the visibility of it.
- Roger Harris urged that the STP plan should be signed off by three Health and Wellbeing Boards.

RESOLVED: The Health and Wellbeing Board:

- Noted and commented on the content and recommendations contained within the report.
- Members agreed for the STP plan to be included on the agenda for the next meeting.

9. Proposals to amend Health and Wellbeing Strategy Goal 2 'Healthier Environments'

This item was presented by Julie Rogers, Chair of Thurrock CSP and Director of Environment and Highways. Key points included:

- Proposals for amendments of Goal 2 of the Health and Wellbeing Strategy, Healthier Environments to help ensure that consideration is given to providing healthier and safer environments.
- The statutory duty for working with partners to reduce crime and promote public safety in Thurrock fell to Thurrock Community Safety Partnership (CSP). Thurrock Council is a statutory member of the CSP, as are the Clinical Commissioning Group (CCG) and the Chair of the CSP is a member of the Health and Wellbeing Board.

- The relationship between health and crime is well documented and evidenced. Offenders are more likely to experience multiple inequalities when compared with the general population. The potential to become a victim of crime will affect the public's behaviour and impact on their health and wellbeing and there can be long lasting consequences on a victim's mental and /or physical health. Crime rates and the perception of crime impacts on the public's likelihood of utilising local facilities, in particular, outdoor open spaces.
- The built environment played an important role in crime and disorder. Situational and environmental crime prevention approaches aim to design and manage the built environment to make crime more difficult and less rewarding. It is not only concerned with reducing physical opportunities to commit crime, but also about influencing perceptions about an area and reassuring people that the area is safe.

During discussions the following points were made:

- Julie Rogers advised that more engagement with communities was key and that there was a recent investment in three park engagement officers, with the role focusing on design of parks, getting people active and making use of equipment.
- Jane Foster-Taylor commented, as a partner of the safeguarding board, that safer environments was a recurring theme and therefore welcomed the change in Goal 2.
- Roger Harris stated the importance of working across the health and social care agenda and the community safety agenda.

RESOLVED: The Health and Wellbeing Board approved the proposal to amend the Health and Wellbeing Strategy Goal 2 'Healthier Environments' as above.

10. Ward Profiles

This item was presented by Ian Wake, Director for Public Health. Key points included:

- In representing their constituents and through casework and surgeries, ward councillors should have a good understanding of the needs and concerns of their constituents, and provide a unique source of community intelligence that can be fed into wider policy and strategy work. Similarly, if ward councillors understood the public health issues within their wards, they would be able to assist in communicating positive public health messages to their residents, and sign post residents to existing commissioned services and wider community assets.
- In order to improve members' understanding of the health issues faced by residents, and as a mechanism for engaging councillors in the health and wellbeing agenda, the public health team has developed ward profiles for each of Thurrock's 20 wards.
- The Public Health service were keen that the ward profiles were promoted as widely as possible within individual Board member stakeholder organisation and to the third sector and community.

During discussions the following points were made:

- The data would be refreshed annually.

- Members stated it would be helpful to share more widely with staff such as Local Area Coordinators in order for them to be aware of the issues in each community.
- Tania Sitch advised she would take this information to the Better Care meetings.
- Members commented that the Ward Profiles were not on the council website yet and due to Purdah there may be some issues in publishing crime data during this period.

RESOLVED: The Health and Wellbeing Board agreed to wait until the end of Purdah, a refresh of data would be completed and then the Ward profiles would be published in late May 2019.

11. Mental Health Transformation Paper

This item was presented by Ian Wake, Director for Public Health. Key points included:

- There were many examples of good practice amongst health and care providers, however the current adult mental health treatment system in Thurrock as a whole was not fit for purpose and needed a fundamental system reform. The recent Adult Mental Health Joint Strategic Needs Assessment and Local Government Association Peer Review identified some strong assets within our local system on which to build, including a good service provided by EPUT, Thurrock MIND and Inclusion Thurrock to patients being treated, Local Area Coordination, Public Health Intelligence and Thurrock First. However both also highlighted a number of systemic failures, many of which were also echoed in the Thurrock Healthwatch report – which found that 88% of mental health service users were dissatisfied with the current service offer.
- There were five priority areas for action to improve local mental health services
    1. Address the issue of under-diagnosis of mental health problems
    2. Improve access to timely treatment
    3. Develop a new model for Common Mental Health Disorders
    4. Develop a new Enhanced Treatment Model for people with serious mental ill-health conditions
    5. Integrate commissioning and develop a single common outcomes framework supported with improved commissioning intelligence.

During discussions the following points were made:

- Ian Wake commented that a more holistic and triangulated model was required as well as a new focus on integrated commissioning and outcomes. Historically commissioning had been transactional and process driven, the report highlighted a wish to review Section 75 with Essex Partnership University Trust (EPUT) and the proposal of a new 1 + 4 contract. In additional it was acknowledged there were opportunities for integrated commissioning with the Thurrock CCG.
- A newly appointed Strategic Lead, Maria Payne would be leading on this work. A new Mental Health Transformation Board had been set up, which reported into the Health and Wellbeing Board and 3 further subgroups were also due to be set up

1. Suicide prevention and depression screening
2. New models of care
3. Commissioning & outcomes framework

- Roger Harris advised that the council had a Section 75 Agreement with EPUT which related to the secondment of social care staff to EUPT and the delegation of certain responsibilities under the Care Act. This agreement had been in place for 10 years however it was in need of review; feedback was required in terms of how it is working and scrutinise arrangements. A significant improvement was required and if this does not happen, the council reserved the right to transfer staff back to the Local Authority and end the secondment agreement.
- The report included the suicide prevention work, both within Thurrock and Essex wide.
- The report would go to cabinet in March and had been well received at a previous Health Overview and Scrutiny meeting.

RESOLVED: The Health and Wellbeing Board approved the recommendations of the report.

AOB

- Members agreed that the next meeting on 29 March may need to be deferred until after the local elections in May due Purdah.
- Mandy Ansell raised the lung cancer testing project, whereby Thurrock was identified as the worse place in the country to live in for lung cancer outcomes. Thurrock had therefore been twinned with the Luton CCG as a sample size of 50,000 patients were required; neither CCG had this amount individually. The process would be that individuals in the identified risk group – those over the age of 65 and smokers would be invited for a test (not screening). This scheme had been used in Manchester, Liverpool and it had recently started in Leeds. This testing had demonstrated better outcomes related to early diagnosis of lung cancer. The Macmillan nurse from the Mid Essex CCG would be leading and there would be STP input. Furthermore, there would be a bus located in Thurrock whereby individuals would receive an MRI and smoking cessation intervention. The benefits of this scheme and approach has been well documented.

The meeting finished at 15.05 hours.

CHAIR……..

DATE……

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	ITEM: 5
Health and Wellbeing Board	
Defining the roles, responsibilities and governance of a Thurrock Integrated Care Partnership in the context of the Mid and South Essex Sustainability and Transformation Partnership and local transformation.	
Wards and communities affected: All wards	
Accountable Director: Ian Wake, Director of Public Health Roger Harris, Corporate Director, Adults, Housing and Health Ian Stidson, Director of Commissioning, NHS Thurrock CCG	
Report Author: Ian Wake, Director of Public Health	

1. RECOMMENDATIONS

- That the Health and Wellbeing Board consider and comment on the report and the themes that it addresses, particularly in terms of the proposals set out in section 5 relating to commissioning and delivery functions at Sustainability and Transformation Partnership, Place and Locality level.

- That the Health and Wellbeing Board agree transformation roles and responsibilities at Sustainability and Transformation Partnership, Place and Locality level and that these form the basis of a Memorandum Of Understanding between the Board and Mid and South Essex Sustainability and Transformation Partnership.

- That Health and Wellbeing Board consider and comment on the proposed new governance arrangements at Thurrock and Locality

level and agree a revised structure that is fit for purpose for the stage of our transformation journey.

2. Introduction

2.1. This paper sets out proposed roles, responsibilities and governance arrangements of the Mid and South Essex Sustainability and Transformation Partnership (STP) in the context of local plans on transformation and health and wellbeing already being delivered in Thurrock through the Joint Thurrock Health and Wellbeing Board.

2.2. Thurrock's Joint Health and Wellbeing Board is a formal committee of Thurrock Council, formed following the NHS and Public Health reforms set out in the Health and Social Care Act (2012). Chaired by the Cabinet Portfolio Holder for Education and Health, it brings together Chief Officer/Director/Executive leads from all key stakeholders organisations involved in delivering health and wellbeing including Thurrock Council. NHS Thurrock Clinical Commissioning Group, Basildon and Thurrock University Hospital, North East London NHS Foundation Trust, Essex NHS Partnership Trust, Thurrock Council for Voluntary Services and Thurrock Healthwatch.

2.3. The Thurrock Joint Health and Wellbeing Board is responsible for ensuring delivery of the Thurrock Joint Health and Wellbeing Strategy 2016-2021, with its 20 Objectives centred around five goals: Opportunity for All; Healthier Environments, Better Emotional Health and Wellbeing; Quality Care Centred Around the Person, and; Healthier for Longer. The Board is also ultimately accountable for overseeing a major programme of both transformation and integration of Health and Care services in Thurrock including the *Better Care Together Thurrock*, *Brighter Futures,* Adult and Children's Mental Health transformation and the construction of four Integrated Medical Centres. Thurrock Health and Wellbeing Board has benefited from geographically co-terminous partnership arrangements with a single unitary authority responsible for all local government services, a single Clinical

Commissioning Group responsible for commissioning of most NHS services, a coterminous Healthwatch and Council for Voluntary Services.

2.4. Sustainability and Transformation Partnerships (STPs) were announced in the NHS Planning Guidance published in December 2015. Their aim was to bring NHS organisations and local authorities in different parts of England together to develop plans for the future of health and care services over a centrally defined geographical footprint, usually based on the geographical location of hospitals. 44 geographical areas were defined by NHS England with an average population size of 1.2 million people. Thurrock falls within the geographical footprint covered by the Mid and South Essex Sustainability and Transformation Partnership.

2.5. Partnership arrangements within the Mid and South Essex Sustainability and Transformation Partnership are complex. The geographical footprint encompasses two unitary authorities responsible for all local authority services including public health, adult social care and education (Thurrock and Southend), part of the geography covered by one top tier (Essex County Council) responsible for public health, adult social care and education and seven second tier district and borough councils. It also includes five CCGs, three hospitals, three different Healthwatch organisations, two major NHS community providers, one secondary mental healthcare provider and a number of mental health community providers.

2.6. The NHS Long Term Plan published in January 2019 set out proposals to create “Integrated Care Systems” (ICSs) to become the principal planning mechanism through which NHS commissioners and providers and local authorities will make shared decisions about financial planning and prioritisation. The plan stated that beyond 2019/20 Government will introduce further financial reforms that will support ICSs to deliver integrated care. Through a process of earned financial autonomy NHS England will give local health systems greater control over resources on the

basis of a track record of strong financial and performance delivery, assessed in part through the new Integrated Care Systems accountability and performance framework.

2.7. Whilst the NHS Long Term Plan stopped short of defining the geographical footprint on which Integrated Care Systems will operate, it has been clear that NHS England intends to use Sustainability and Transformation Partnership Footprints to deliver the Integrated Care Systems proposals. The plan requires the NHS to deliver £290 million of savings from commissioning and Clinical Commissioning Group running cost budgets have been reduced by 20%. In Mid and South Essex, NHS England have directed Clinical Commissioning Groups to form a single 'Joint Committee' at Sustainability and Transformation Partnership level to lead hospital and mental health commissioning, and are in the process of appointing a single Accountable Officer to oversee the work of the five existing Clinical Commissioning Groups.

2.8. The NHS Long Term Plan also proposed the creation of Primary and Community Care Networks (PCNs) in recognition of the increasing numbers of the population living with multiple comorbities and the need to integrated Primary Care, Community Healthcare and community mental health provision. The plan proposes that general practices will join together to form primary care networks – groups of neighbouring practices typically covering 30–50,000 people. Practices will enter network contracts, alongside their existing contracts, which will include a single fund through which network resources will flow. Primary care networks will be expected to take a proactive approach to managing population health and from 2020/21, will assess the needs of their local population to identify people who would benefit from targeted, proactive support.

2.9. Alongside primary care networks, the plan commits to developing 'fully integrated community-based health care', ending the current fragmentation of primary and community health care. This will involve developing multidisciplinary teams, including GPs,

pharmacists, district nurses, community psychiatric nurses, reablement teams, community geriatricians, adult social care staff, allied health professionals and staff from the third sector working across primary care and hospital sites

2.10. Whilst there is much to be welcomed in the NHS Long Term Plan in terms of additional resources for the NHS, a focus on prevention and early intervention, and the creation of a more integrated primary care, community and mental health offer at locality level through Primary and Community Care Networks, proposals to move NHS commissioning and system leadership responsibilities from the Thurrock footprint to an Integrated Care Systems that covers Mid and South Essex is potentially problematic, moving decisions about transformation in Thurrock from a local system with a high degree co-terminosity and trust between partners, to a system with highly complex partnership arrangements set over a geographical footprint that makes little sense to our residents. The reduction and centralisation of NHS system leadership capacity over a wider geographical footprint also risks disengagement of key NHS system leaders in local transformation plans. However, this paper also recognised that there are some system-wide activity that it makes sense to undertake once over a wider geographical footprint. As such, there is an urgent need to define and agree across the Sustainability and Transformation Partnership and among all partners what activity, roles and responsibilities sit best at Sustainability and Transformation Partnership versus Health and Wellbeing Board and Primary and Community Care Networks/locality level. As such, it seeks to set out some principles to start a discussion about what best sits where.

3. Background – Thurrock's Transformation Journey to date

3.1. This section provides a brief history of Thurrock's Health and Care Transformation journey to date including all major achievements.

3.2. **Building Positive Futures:** Launched in 2012, Building Positive Futures (BPF) developed its programme of work under three clear building blocks:

- **Stronger Communities** comprising of a range of different initiatives including Asset Based Community Development, Local Area Coordination, Time Banking, Community Hubs, Small Sparks, Micro Enterprises and Shared Lives
- **The Built Environment:** including the establishment of a Housing Planning and Advisory Group as a forum through which Adult Social Care could influence planning decisions to capitalise on opportunities to deliver wellbeing through the built environment, and adoption of Housing Our Aging Population Panel (HAPPI Housing) principles.
- **The Integration of Health and Social Care** including appointment of an Integrated Care Director between the Council and NELFT; creation of a *Thurrock First* – a single point of telephone access and multi-agency team to accept adult social care and mental and community health referrals; creation of a Rapid Response and Assessment (RRAS) team to provide immediate care to residents and support to their carers to prevent avoidable hospital and residential care admissions; and the creation of a Better Care Fund that pooled CCG and Council Budgets around a shared vision for integrated community health and adult social care.

3.3. **Integrated Medical Centres:** In 2015 the Care Quality Commission highlighted a major crisis in Primary Care, rating 80% of our GP surgeries as 'Requiring Improvement' or 'Inadequate'. Thurrock was highlighted as the fourth most under-doctored area in England with ratios of Full Time Equivalent GPs: Patients reaching 1:13,000 in some surgeries. After undertaking locality needs assessments, Public Health recommended the creation of four Integrated Healthy Living Centres (since renamed Integrated Medical Centres) as one solution to both improve primary care capacity and create attractive working environments that would attract new GPs to the Borough. The recommended blue print for

each Integrated Medical Centres encompassed a wide range of health, wellbeing and care services in a single building with integrated teams including a new and expanded Primary Care Offer, diagnostic facilities, secondary care outpatient clinics for the most common specialties, health improvement and lifestyle modification programmes, community and mental health treatment and services that addressed the wider determinants of health including community and voluntary groups, libraries and community hubs, housing advice and Local Area Coordination. Work is currently underway to deliver this programme with the first Integrated Medical Centre in Tilbury due to open in 2022.

3.4. **The Case for Change: A New Model of Integrated Care:** In 2016, Thurrock's Director of Public Health published an Annual Public Health Report that focused on actions to make the adult health and care system sustainable in financial and operational terms. As a result of this report, and in conjunction with Adult Social Care, health and third sector partners, the Director for Public Health developed and published 'The Case for Change: a New Model of Care'. Initially piloted in Tilbury and Chadwell, the New Model of Care has three major work streams addressing Primary Care Capacity and Capability including a new mixed skill clinical workforce, a comprehensive programme of Long Term Condition case finding and improvement in clinical management, and a new model of Integrated Community Health and Domiciliary Care through creation of self-directed 'Wellbeing Teams/Worker'.

3.5. **Better Care Together Thurrock**: **Implementing the New Model of Integrated Care.** Better Care Together Thurrock (BCTT) was formed of senior-level partners from Adult Social Care, the Voluntary and Community Sector, Community Health, Mental Health, the Acute Trust, the CCG, and Primary Care to manage implantation of *The Case for Change*. A key first step was for partners to agree on a vision for the future. The Vision was agreed at a Theory of Change workshop hosted by Thurrock Community and Voluntary Sector and Thurrock Coalition with all key health and local authority stakeholders.

3.6. Better Care Together Thurrock also saw the establishment of a governance structure to manage the implementation of the New Model of Care including a Steering Group and sub groups responsible for delivery of the three work streams. The mixed skill primary care clinical workforce and two wellbeing teams for Tilbury and Chadwell went live in 2019. A Population Health Management Programme consisting of 13 separate programmes relating to primary prevention, long term conditions case finding and improving the management of different long term conditions is also live and early evaluation is already demonstrating a positive impact on demand reduction in secondary care.

3.7. **Community Led Support (CLS):** Community Led Support is a new strengths based model of social work practice embedded into the community. The first team has been based within the Tilbury and Chadwell Community hub and undertake outreach in other community settings. It aims to trust professional staff to work using the same 'strength based' approach used by Local Area Coordinators, starting with 'what's strong?' rather than 'what's wrong?' and moving away from the traditional assessment of needs approach.

3.8. **Thurrock Integrated Care Alliance: integrating commissioning and the move towards a single system wide contract**. The Thurrock Integrated Care Alliance was established in 2018 to provide strategic direction to the local health and care system including the third sector, set shared objectives and outcomes for the system and lead the integration of commissioning. Following discussion at Thurrock Integrated Care Alliance, commissioners have awarded longer term contracts with providers. All stakeholders represented at Thurrock Integrated Care Alliance have developed and signed a Memorandum of Understanding that describes a framework within which partners will work to build a Population Health System which aims to reduce the number of unplanned hospital and residential care admissions; reduce avoidable A&E attendances; reduce the number of delayed

transfers of care; keep people as independent as possible for as long as possible, and; move more services out of hospital and into the community. The next stage of the work programme is to agree a single Integrated Alliance Contract across all providers with high level health outcome priorities and mechanisms for financial risk and reward sharing.

3.9. **Adult Mental Health Service Transformation:** A 2018 JSNA Product on Adult Mental Health Services together with an LGA Peer Review highlighted a series of issues with the way adult mental health services were commissioned and delivered in Thurrock including long waiting times, fragmentation of both commissioning and delivery, and services that had a narrow clinical focus and failed to adequately address wider determinants of health and physical health needs of clients. Further research by Thurrock Healthwatch highlighted significant levels of dissatisfaction amongst service users. To address these concerns a new programme of Mental Health Transformation including proposals to create new models of more holistic and integrated care for Common Mental Health Disorders and Serious Mental Ill Health and a new commissioning outcomes framework. A multi-agency team from EPUT and MIND are currently being trained in the *Open Dialogue* family therapy solutions based approach to managing residents in mental health crisis, and it is envisaged that this will form the basis of a new model of crisis care from 2020/21. A Thurrock Mental Health Transformation Board has been established to manage the programme.

3.10. **The Brighter Futures Programme** integrated services for children and young people (aged 0-19) historically commissioned and delivered separately by the council's Children's Services Directorate, Public Health and Thurrock Clinical Commissioning Group. It comprises of three key work programmes;

- *Children's Centres* that focus on improving outcomes in child development and school readiness, parenting and health and wellbeing;

- *Healthy Families* including the Health Visiting Programme that gives advice and guidance to all new parents, and the School Nursing programme that works to keep children healthy in schools; and
- *The Prevention and Support Service* which provides targeted help to families that have specific needs encompassing issues such as parenting support, domestic abuse, and sexual violence and to Troubled Families with programmes focussing on access to education, worklessness, and parental physical and mental health.

Emerging Learning and Features of 'Vanguard' ICS sites

3.11. The Kings Fund in their report 'A year of integrated care systems' undertook a qualitative evaluation of 'vanguard' Integrated Care Systems sites in England. The purpose of their study was to understand how the early adopter Integrated Care Systems are being developed and identify lessons learned. Eight of the 10 early adopter sites were studied: Bedford, Luton and Milton Keynes; Berkshire West; Buckinghamshire; Dorset; Frimley; Lancashire and South Cumbria; Nottingham and Nottinghamshire and South Yorkshire and Bassetlaw. Two Integrated Care Systems sites (Surrey Heartlands and Greater Manchester) were excluded because of the distinctive characteristics in place in these areas under their devolution deals.

3.12. There is no 'blueprint' for developing an Integrated Care Systems; the changes being proposed by central government create significant latitude for local systems to shape their own understanding of what an Integrated Care Systems could and should look like.

3.13. Across the study, the Kings Fund identified integration activity at three different levels: Neighbourhood, Place and System. There was a broad consensus around the types of activities occurring at each level:

- **Neighbourhoods** tended to cover populations of between 30,000 and 50,000. They were typically based around GP catchment areas, with practices working together in networks or federations. This was usually the level at which multidisciplinary community teams operated, recognising that they need to respond to the characteristics and needs of local populations.

- The **place** level was where most service change and integration was taking place. The 'place' was typically defined by a local authority, clinical commissioning group or acute trust footprint, or

determined by the natural geography of a town. Local authority involvement was often strongest at this level.

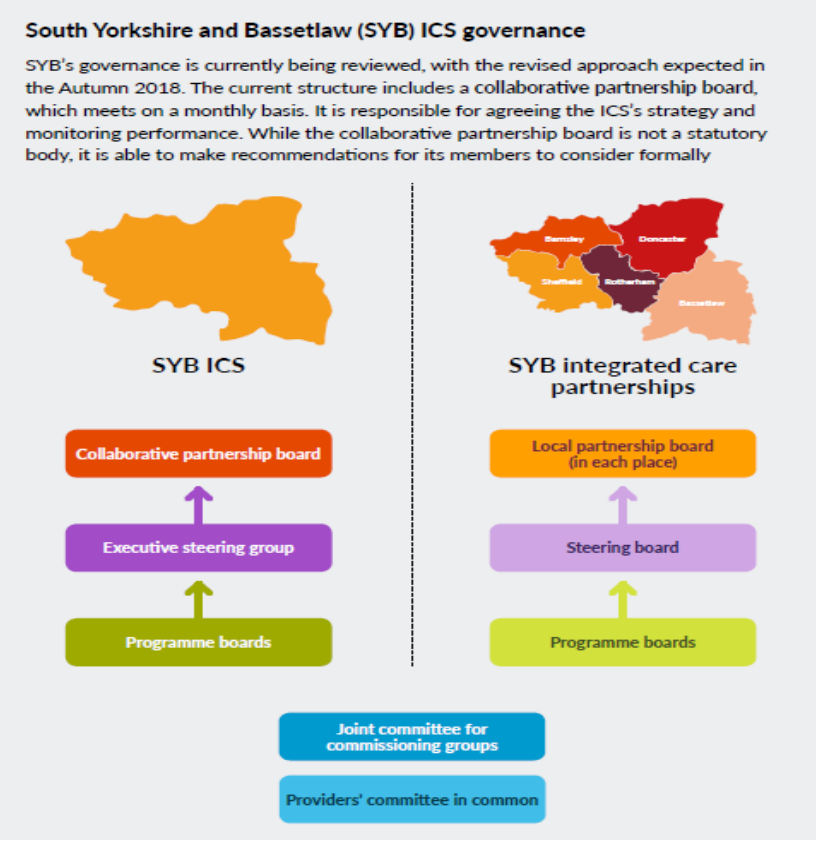
- The **system** level was seen as the basis for activities and functions that need to happen 'at scale'. This included specialised commissioning, acute service reconfigurations, workforce planning, and the development of digital and estates strategies. Its geographical footprint matched that of the entirety of the Integrated Care Systems.

3.14. The Kings Fund Research found broad consensus on the need to cultivate activity at each level to make progress on integration. **They concluded that between 70-90% of the focus of activity/integration should be at the place and neighbourhood levels with the remaining 10-30% occurring at system level.**

"Places within the ICS are more around what people see as 'place'. I think local government boundaries and CCG Boundaries are all part of that, because you can't make it real for clinicians, patients and residents unless you operate at that smaller scale" **Local Authority, Frimley ICS.**

3.15. Governance arrangements within the vanguard Integrated Care Systems sites often reflected the divisions between system, place and neighbourhood. Many ICSs have created an overall Programme Board at system level, and then 'Integrated Care Partnership' boards operating at place level to reflect and manage the majority and variation of integration activity happening at place as opposed to system level. For example, the South Yorkshire and Bassetlaw Integrated Care System has a Collaborative Partnership Board for system level activity, and then five 'Integrated Care Partnerships', each with its own Board and governance structure, covering the four unitary authority areas of Barnsley; Doncaster; Sheffield and; Rotherham, together with the second tier district of Bassetlaw (part of the geography covered by Nottinghamshire County Council).

Figure 1: Governance Arrangements between South Yorkshire and Bassetlaw ICS and its five Local Authority areas.



3.16. The impact of changes to NHS commissioning arrangements were also highlighted in the research. Some Integrated Care Systems had included mergers of constituent Clinical Commissioning Group commissioning functions with shared Accountable Officers, others had left them unchanged. The report highlighted a lack of agreement about the benefits and risks of merging Clinical Commissioning Groups but did highlight resistance in some areas around weakened links with local authorities where coterminous boundaries had previously existed. The research also highlighted the desirability of different commissioning arrangements at different parts of the system, drawing the distinction between 'strategic commissioning' of system wide priorities and 'tactical commissioning' at neighbourhood and place level. The research also concluded that the line between commissioners and providers is becoming blurred as local integrated care partnerships take on

the commissioning functions at place level and the fact that commissioners are increasingly making use of long-term outcomes-based contracts in future rather than the historical 'transactional' commissioning approach used by the NHS.

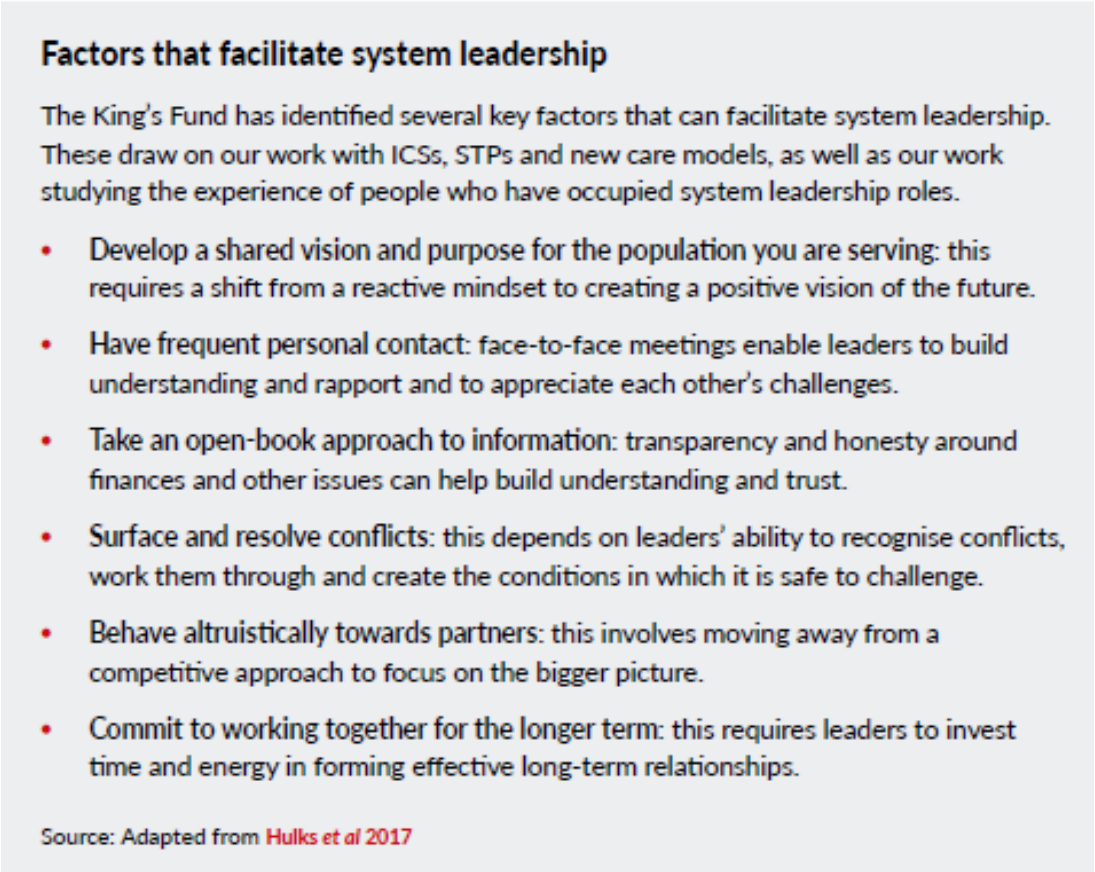
3.17. Many of the 'vanguard' Integrated Care System sites were working to improve information-sharing, particularly in terms of the ability of individual clinicians in different organisations to share information on individual patients for the purpose of improving clinical care, safety and patient experience. Several Integrated Care Systems had developed shared care records at patient level.

3.18. Some Integrated Care Systems had also developed infrastructure for data-analytics for commissioning purposes and to identify needs and determine service priorities, particularly in relation to population health management.

3.19. Prevention and population health were often described as an area where both the place and system levels needed to play a key role. Interviewees emphasised the need to focus not only on healthcare and social care, but also the wider determinants of health such as housing and employment.

3.20. Systems Leadership was identified as one of the critical factors that determined success on integration. Because there is no legislative or statutory framework for Integrated Care Systems, the level of trust and the quality of personal relationships between system leaders from different organisations was critical to the speed at which progress was made. Figure 2 (overleaf) highlights key factors identified by the Kings Fund research that facilitated systems leadership.

Figure 2: Factors that facilitate systems leadership



Factors that facilitate system leadership

The King's Fund has identified several key factors that can facilitate system leadership. These draw on our work with ICSs, STPs and new care models, as well as our work studying the experience of people who have occupied system leadership roles.

- Develop a shared vision and purpose for the population you are serving: this requires a shift from a reactive mindset to creating a positive vision of the future.
- Have frequent personal contact: face-to-face meetings enable leaders to build understanding and rapport and to appreciate each other's challenges.
- Take an open-book approach to information: transparency and honesty around finances and other issues can help build understanding and trust.
- Surface and resolve conflicts: this depends on leaders' ability to recognise conflicts, work them through and create the conditions in which it is safe to challenge.
- Behave altruistically towards partners: this involves moving away from a competitive approach to focus on the bigger picture.
- Commit to working together for the longer term: this requires leaders to invest time and energy in forming effective long-term relationships.

Source: Adapted from Hulks *et al* 2017

4. Discussion: What does this mean for Thurrock and Mid and South Essex Sustainability and Transformation Partnership /Integrated Care Systems?

4.1. The Kings Fund research clearly highlights the variation in form, function and governance arrangements between different Integrated Care Systems vanguards, and the need to develop local arrangements that are meaningful to local partners and transformation activity. There is no 'single blue-print' nor 'one size that fits all' when it comes to the development of Integrated Care Systems. It does however also conclude that most integration activity happens at 'place' and 'neighbourhood' level as opposed to system level.

4.2. As set out in section 3, Thurrock has a strong story to tell at 'place level' in terms of local transformation with a very high degree of trust and strong relationships between stakeholders, a strong

Health and Wellbeing Board integrating wider determinants of health in terms of regeneration, planning, education, employment and housing through our Joint Health and Wellbeing Strategy and associated action planning on the 20 Objectives that sit under it. The Clinical Commissioning Group has also forged a very clear locality focus with General Practice through the establishment of hubs and a stronger working relationship between practices. It is important that any new arrangements with the Sustainability and Transformation Partnership/ Integrated Care Systems preserve and augment these programmes rather than undermine them, whilst also recognising the merit of undertaking some tasks 'system wide' at scale where this makes sense.

4.3. Work on Asset Based Community Development, Better Care Together Thurrock, Primary Care Hubs and four Integrated Medical Centres is increasingly shifting focus to integration at 'neighbourhood/locality' level within the four defined localities of Purfleet and South Ockendon; Grays; Tilbury and Chadwell; and Stanford and Corringham. The mixed skill Primary Care clinical workforce is now live in Tilbury and Chadwell and partly in place in the Grays locality with plans also in place to roll out the programme to all four localities in the next two years. Community Led Solutions Team is live in Tilbury and Chadwell and is already integrating well with other locality council services including the locality housing office and Tilbury Community Hub, and with other third sector assets within the locality. Two Wellbeing Teams is now live in the Tilbury and Chadwell localities and there is an aspiration to create further wellbeing teams in the other three localities.

4.4. The commitments to develop Primary Care Networks at locality level set out in the NHS Long Term Plan create an opportunity to build on this work and develop a comprehensive primary, community and mental health service offer at locality level linked to asset based approaches and third sector capacity, building and further integrating the existing Primary Care Mixed Skill Workforce, Community Hubs, Integrated Medical Centres, Community Led

Solutions and new model of care for Common Mental Health Disorders.

4.5. There are also plans to develop single locality public health contracts encompassing healthy lifestyle services like stop smoking, self-care programmes, NHS Health Checks and weight management, together with Long Term Conditions Case Finding and clinical management improvement including hypertension and Stretched Quality Outcomes Framework. Other NHS and Adult Social Care commissioned enhanced services could in time be added to these to create 'single locality budgets' with the opportunity to devolve part of the Adult Social Care and Clinical Commissioning Group commissioning functions from Thurrock wide to locality level. The Better Care Fund could be revised to act as the financial delivery mechanism to achieve this.

4.6. Thurrock Council and the Better Care Together Thurrock programme also has an aspiration to deliver Community-Led Commissioning/Resource prioritisation. We wish to shift power from organisations to communities, allowing them to drive what is commissioned, what it looks like, and to be part of the decision-making process. This may involve communities actually commissioning directly, being involved in commissioning, or influencing through providing a list of key priorities.

4.7. Thurrock's transformation programme has also been based on the concept of 'distributed leadership' and devolution of decision making down to the front line. Our *Stronger Together* or *Better Care Together Thurrock* programmes have focussed on engaging front line professionals, the third sector and the community in designing and implementing service transformation, basing staff within the community, removing centralised bureaucratic control and empowering them to make decisions. These values are common to many of our programmes including the mixed skill Primary Care clinical workforce, Local Area Coordination, Community Led Solutions and Well-Being Teams. As such, in

deciding where decision making at each level of the system sits, this paper proposes the concept of 'subsidiarity'

4.8. Thurrock Clinical Commissioning Group is seeking to drive forward a programme of primary care transformation that will results in a much wider range of services being delivered from a primary care environment and reducing significantly the number of Thurrock residents needed to attend acute services. Primary care will also evolve within localities to share workload and expertise within each of the four netwoks.

4.9. Given the above, this paper proposes that the principle of '*subsidiarity';* the principle that the starting point for planning, transforming and delivering services should be at as local level as possible, and that any more central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level. The following is therefore proposed as a blue-print for what should be delivered at each level:

4.10. **Locality Level:** Devolution of the maximum number of programmes to create four locality based integrated health, wellbeing and care offers, moving services closer to communities, empowering front line staff to design and deliver a service offer that responds to local need, and engaging communities and the third sector in the wellbeing agenda. New models of integrated locality care would be supported by locality based integrated commissioning arrangements between the Clinical Commissioning Group and local authority with some budgets and integrated through the Better Care Fund to create single locality budgets and commissioning plans.

4.11. Future services that could be delivered at locality level include (but are not necessarily limited to):

- Locality based healthy lifestyle services including self-care/patient education, smoking cessation, sexual health (spoke services), cervical screening, weight management

- Skill Clinical Workforce and integration of community healthcare and Allied Health Professionals
- Wider range of minor operations co-ordinated across GP practices (e.g lumps and bumps, vasectomy services)
- Phlebotomy services
- Long Term Conditions case-finding programmes including hypertension, AF and depression screening.
- Support for Carers
- End of Life care
- Delivery of dental care and improved oral health programmes
- Delivery of MSK services
- Wound Care
- Single, integrated ‘one stop shop’ clinics for the management of diabetes, cardio-vascular disease and respiratory long-term conditions with input from secondary care consultants.
- New model of care for Common Mental Health Disorders and some mental health services for patients with SMI including IAPT, Dementia and Psychiatric Nursing
- Primary community care integration and delivery including development of PCNs, the new Primary Care Mixed Skill Workforce, District Nursing, other Allied Health Professionals and Social Workers as set out in the NHS Long Term Plan.
- Individual IMC clinical models including diagnostics (e.g. 24 hour blood pressure monitoring) and some secondary care outpatient clinic provision
- Consultant led integrated primary/secondary care specialist clinical provision (gerontology, community paediatrics, diabetes, neurology/epilepsy, community cardiology have been suggested by local GPs)
- Proactive clinical outreach to residential care homes
- Community Led Solutions Teams
- Social Prescribing
- Wellbeing Teams (delivery at neighbourhood level)
- Asset Based Community Development approaches (delivery at neighbourhood level) including community assets and community resilience building

- Local Area Coordination
- Locality Housing and employment support
- The Schools Wellbeing Service (defining a school as a community)
- Children's Centres – a wide range of services and support for families with young children.
- The Edge of Care Service (supporting families on the verge of having children taken into care).

Commissioning arrangements at locality level could encompass:

- Locality Based contracts for long term conditions case-finding and clinical management including hypertension case finding depression screening,
- Public Health services currently delivered contracted through individual GP practices healthy lifestyles services including smoking cessation, NHS Healthchecks, sexual health spoke services, cervical screening, weight management
- Current Local Enhanced services with GP surgeries
- Delivery of Local Dental Contracts devolved from NHSE
- Primary and Community Care Networks contracts
- Voluntary Sector contracts were provision is locality focussed
- The provision of some community services delivered through NELFT contract
- The provision of some mental health services delivered through EPUT contract
- The provision of some services delivered by the the hospital that can be delivered in the community through the contract with Basildon hospital
- Some market development for example Micro-enterprises and grass-roots organisations.

4.12. **Place/Alliance (Thurrock Health and Wellbeing Board) level:** Activity that links to key strategic functions of Thurrock Council/Clinical Commissioning Group, where there is a need for borough wide oversight or where there is insufficient universal

demand to plan at locality level. This would include but may not be limited to:

- Strategic management/oversight of:
    - Thurrock Joint Health and Wellbeing Strategy and Outcomes Framework
    - Integrated Medical Centre programme for Thurrock
    - Better Care Together Thurrock
    - Population Health Management Programme
    - Brighter Futures Programme
    - School Based Mental Health Wellbeing Teams Programme
    - Mental Health Transformation Programme
    - Better Care Fund
    - Section 75 Agreement between EPUT and Thurrock Council
    - Community development/empowerment – Stronger Together
    - Market development/delivery

- Thurrock Integrated Care Alliance and shared outcomes focused health and care Alliance Contract
- Thurrock First
- Thurrock Rapid Response and Assessment Service
- Planning and Regeneration Strategic Programmes that impact positively on wellbeing and wider-determinants of health including Older People's Housing Strategy, Housing Planning and Advice Group, Health Impact Assessment
- Commissioning of borough wide specialist Public Health Services including Drug and Alcohol Treatment, Sexual and Reproductive Health (hub), NHS Health Checks, (strategic oversight and social marketing research implementation), Thurrock Healthy Lifestyle Solutions (hub), Brighter Futures Healthy Families (School Nursing and Health Visitors)
- New Model of Care for Serious Mental Ill Health Disorders and proposed new Open Dialogue approach
- Thurrock Joint Strategic Needs Assessment Programme
- Adult Social Care Commissioning where provision is borough wide

- Discharge Planning from secondary to adult social care including Delayed Transfers Of Care
- Whole Systems Obesity Strategic Planning
- Planned care activity Continuing Care
- Minor Injuries
- Primary Care Strategy

4.13. **South West Partnership**

There will also remain a need to commission services across a South West footprint as health commissioners share specific pathways and providers. Examples of existing work are:

- Respiratory pathways (specialist care)
- Diabetes pathways (specialist care)
- Gynaecological, Urology and Neurological care

4.14. **Sustainability and Transformation Partnership (ICS Level):** System level activity that is best done once at scale. The following activities as best delivered at Integrated Care System/ Sustainability and Transformation Partnership level:

- **Planning for the future**: Developing system wide plans for improving health and wellbeing
- **Aligning commissioning**: Rather than taking on all current commissioning functions, the Integrated Care Systems should focus on the 'strategic aspects' where it is sensible to do once at scale, or where the function has already been aligned to the Clinical Commissioning Group Joint Committee: These include:
    - Secondary healthcare where it involves more than one hospital site
    - Specialist NHS commissioning
    - Mental Health secondary care commissioning functions including the new crisis care pathway
    - Specialist Learning Disability and other specialist support
- **Integrating regulation**: Over time, it is expected that some regulatory functions that currently sit within NHS England and NHS

Improvement regional teams will be brought within Integrated Care Systems.

- **Maternity Services**: The local maternity system is a mechanism through which Sustainability and Transformation Partnerships can transform maternity services collaboratively with a focus on delivering high quality, safe and sustainable maternity services with improved outcomes for women and their families. They have been established across England to develop and implement a local vision for transforming maternity services by 2020/21.
- **Performance Management**: Responsibility for overseeing performance across the system including setting local standards and monitoring towards achieving shared goals
- **Owning and resolving system challenges**: Complex system wide pathways, for example the poor local performance on cancer 62 day or A&E waits are best addressed at system level
- **Workforce Health and Planning** including plans to support staff retention, wellbeing, capacity and skills gap mapping and action to address this
- **Data Integration:** Activity to develop a single shared care record between health and care providers is best developed once at system level
- **Health Intelligence:** There is merit in looking to create a single Public Health intelligence function that can analyse system wide data-sets once, develop system wide predictive models, highlight variation in healthcare outcome etc.
- **System Wide Population Health Management and Prevention Activity:** There is merit in undertaking some prevention activity once at system level, particularly where it involves system wide providers e.g. MSB/EPUT. Examples could include embedding prevention activity such as the 'Ottowa' Stop Smoking model within hospitals, Atrial Fibrillation Screening of medical admissions, Hospital Based Alcohol Nurse Liaison Services

  It must be recognised that there will be movement between Localities, Place , South West commissioned services and Sustainability and Transformation Partnership commissioned

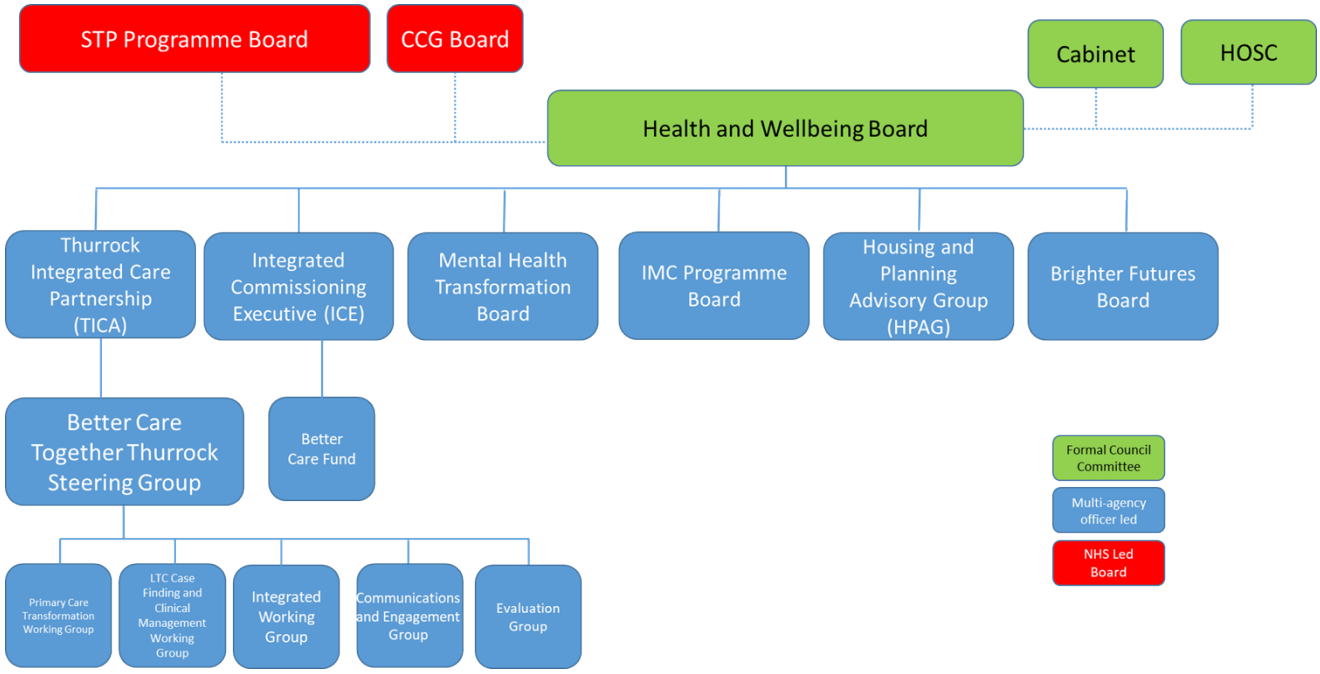
services as our system matures and drives a stronger `place based' service

4.15. Services for Children and Young People (aged 0-19) and their parents described in 3.12 through the Brighter Futures Programme are currently delivered through the Brighter Futures Programme Board. The model also operates partly on a locality level but with three rather than four localities which are not co-terminous with those used for adult health and wellbeing. There may be opportunities over time for integration of these with locality and neighbourhood services described in 5.10, although further discussion with key stakeholders is required.

4.16. Governance arrangements for the health and care transformation programme at Thurrock level have developed over time. There is recognition across all stakeholders that these need review to ensure they remain fit for purpose. This is perhaps particularly important given an increasing focus on integration at locality as well as place level.

4.17. Figure 3 shows at high level, the working groups, programme boards and committees responsible for our health and care transformation programmes.

Figure 3: Current Governance Arrangements – Thurrock Health and Care Transformation



4.18. There are a number of issues with the current arrangements. The Integrated Commissioning Executive and Better Care Fund management sit in parallel silos to the Integrated Commissioning Care Partnership (TICA) and Better Care Together Steering Group. Moving forward, the Better Care Fund needs to act as the strategic financial delivery mechanism for integrated commissioning and locality budgets, and current arrangements do not adequately support this. Integrated Commissioning Executive generally concentrates on the operational management and performance of the Better Care Fund and doesn't adequately link finance to the strategic direction set through (for example any future Alliance Contract).

4.19. Similarly Mental Health Transformation and the IMC Programme, whilst discussed at Thurrock Integrated Care Partnership, also sit in parallel silos despite being key dependencies of successful integrated care.

4.20. There is arguably some duplication between what is discussed at Thurrock Integrated Care Partnership and the Better Care Together Steering Group; both boards receive updates from the three working groups that sit under the Better Care Together Steering Group

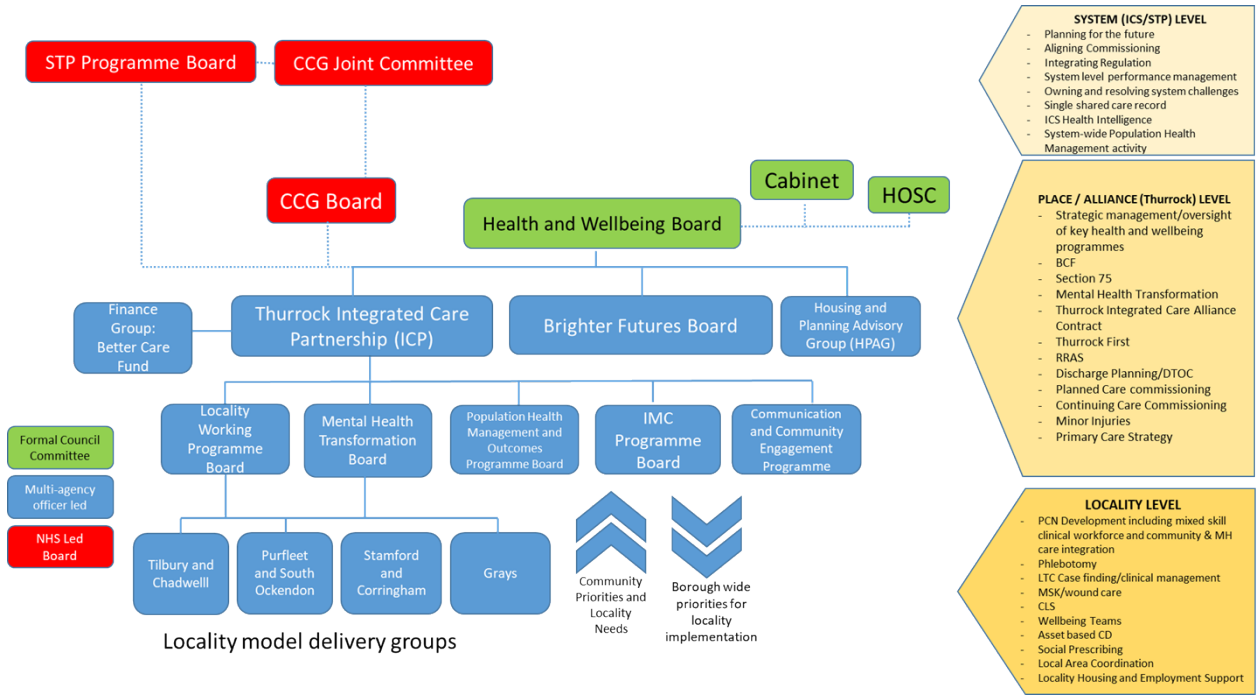
4.21. Multiple strategic groups report into the Health and Wellbeing Board, however the relevant infrequency of the meetings and the fact that as a formal council committee and public meeting limit the scope for open and honest conversations about system transformation issues. The Health and Wellbeing Board also has a much broader agenda encompassing wider determinants of health, children and young people's health and the place based health and wellbeing agenda.

4.22. Evaluation and Communications and Community Engagement sit low down in the structure and are concerned with the narrower focus of Better Care Together as opposed to the wider strategic transformation programme. Neither have met for some time and there is a need to strengthen and integrate their functions such that they are embedded into the entire programme.

4.23. It could also be argued that there is insufficient focus within the governance structure on integration at locality level, and where focus occurs it is split between different working groups. The Primary Care Transformation Working Group has been responsible for overseeing implementation of the Mixed Skill Clinical Workforce at locality level. Conversely the Integrated Care Working group has been responsible for overseeing the implementation of Wellbeing Teams and Community Led Solutions. As such development of a new health and care offer at locality level is split between two groups and we have not potentially maximised opportunities for creating a single integrated offer. There is some evidence of the impact of this, with the new Community Led Solutions Team reporting that they feel strongly integrated with the locality housing office and Tilbury Community hub and third sector assets, but insufficiently linked in the new mixed skill clinical workforce attached to the network of GP surgeries. The Mental Health Transformation Strategy also contains actions to develop an integrated Common Mental Health Disorder offer at locality level, but governance arrangements for this sit in parallel to both Primary Care Transformation and Integrated Working work streams.

4.24. To address the above issues, this paper proposes reforming governance at Thurrock level in line with the structure set on in Figure 4 and invites comment from stakeholders.

Figure 4: Proposed Revised Governance Structure at Thurrock Level



4.25. The strategic commissioning functions of the Integrated Commissioning Executive (ICE), The Better Care Together Thurrock Steering Group and Thurrock Integrated Care Alliance are combined into a single Thurrock Integrated Care Partnership Board (ICP) that would have over-all strategic oversight of the health and care transformation agenda. Whilst the work programme of this board would be considerable, this reform has the advantages of both integrating the Better Care Fund under the strategic commissioning agenda and development of an Alliance Contract, and the Better Care Together Thurrock agenda, allowing it to act more effectively as the financial delivery mechanism for health and care integration. It also removes the duplication of discussion about the Better Care Together Thurrock work streams that currently occurs at both TICA and the Better Care Together Thurrock Board. A finance group would report to the Thurrock Integrated Care Partnership and would

have responsibility for financial monitoring and oversight of the BCF, integration of health and care budgets and for actuarial work in identifying system level savings from integration and more proactive care which could inform issues like 'risk and reward' in an Alliance contract.

4.26. The Integrated Medical Centre Programme Board and Mental Health Transformation Board also report into the new Integrated Partnership Board, meaning a single strategic Board has oversight of all major health and care transformation work relating to adults and older people.

4.27. To support integrated working at locality level, the Primary Care Transformation and Integrated Workforce Groups are combined into a single Locality Working Programme Board to oversee a combined strategic programme of integrated health and care at locality level. This would encompass roll out of the primary care mixed skill workforce in Stanford and Corringham and Purfleet, roll out of Well-being Teams and Community Led Solutions (subject to evaluation) in other localities and the expansion of an integrated locality offer encompassing community NHS staff as set out in the NHS Long Term Plan. This new arrangement removes the separation of oversight of the Primary Care mixed skill workforce and other community initiatives including Community Led Solutions and Wellbeing Teams.

4.28. To enhance capacity at locality level and in anticipation of the further development of Primary Care Networks, four Locality Delivery Groups have been created where clinicians, Adult Social Care professionals and other front line staff can refine individual locality integrated models. Locality groups would have a key function in driving the priorities of the Integrated Care Partnership by identifying and communicating upwards key locality priorities. Comment on the exact function of the locality groups but their remit could also include:

- Co-commissioning of services with the third sector and communities that respond to community needs.

- Integration of health, care and third sector commissioning at locality level including a single locality budget.

- Developing and managing locality based commissioning functions and outcomes based contracts to include the PH LESs, H/T and other case finding, Stretched Quality Outcomes Framework, the Clinical Commissioning Group AQP contracts, Long Term Condition management etc. There is a real opportunity to foster collaboration between networks of practices with a stronger focus on prevention based on single locality contracts.

- Development of the operating models of the Primary and Community Care Networks for example a single triage, sharing of back office functions, developing clinical services that could be delivered once for all practice.

- Development and management of single locality delivery models, joining the dots between the Primary Care mixed skill workforce, secondary care consultants, additional community staff aka proposals in the NHS Long Term Plan, CLS, Wellbeing Teams, wider determinants of health e.g. housing locality offices.

- A forum for further development of the integrated clinical models in each of the four Integrated Medical Centres

4.29. The Long Term Conditions Case Finding and Clinical Management Working Group is rebranded as the 'Population Health Management Programme Board' reflecting its expanding role in also managing primary prevention programmes such as smoking cessation and weight management, and its oversight of data integration through MedeAnalytics and the predictive analysis and risk stratification tools that are being developed. It would also take on new responsibilities for measuring and quantifying population health outcomes and impact of the programme and for programme evaluation, giving a higher profile to these key tasks.

4.30. A new Communication and Community Engagement Programme Board replaces the Communications and engagement group that sat under the Better Care Fund. It would have a broader remit for the entire transformation programme as opposed to simply the Better Care Fund workgroups. It would also give a renewed focus to a stronger programme of community engagement and design of a community co-commissioning function which could be implemented at locality group level.

4.31. The Health and Wellbeing Board, as the highest level strategic board remains responsible for delivery of the Health and Wellbeing Strategy including place and wider determinants of health.

4.32. The Brighter Futures Board remains parallel to the Thurrock Integrated Care Partnership which has a focus limited to Adults and Older People. Stakeholder may wish to consider whether this is ultimately the optimum arrangements. It could be cogently argued that the Brighter Futures Board should also report into the Thurrock Integrated Care Partnership to create a single 'all age' transformation programme. Conversely, given that Brighter Futures works over three non-coterminous localities, and because the new Integrated Care Partnership would already be managing a programme historically covered by three other Boards, the proposed arrangements may be more workable in the shorter term, with the Health and Wellbeing Board retaining overall strategic responsibility for an 'all age' people and place agenda.

6. Conclusions

6.1 The evaluation work from the Kings Fund described in section 4 clearly recognises that most integration happens at place and neighbourhood as opposed to system level. There is a need to reach a formal agreement between Thurrock Health and Wellbeing Board and the Sustainability and Transformation Partnership/any future Mid and South Essex Integrated Care Systems setting out roles and responsibilities set out in 5.11 and 5.12. This could take the form of a Memorandum of

Understanding between the Sustainability and Transformation Partnership and Thurrock Health and Wellbeing Board.

6.2 The model opted by South Yorkshire and Bassetlaw and many other of the Vanguard Integrated Care Systems areas, with an over-arching ICS and then distinct Integrated Care Partnerships (ICPs) at unitary authority would achieve this. The Thurrock Integrated Care Alliance or Thurrock Health and Wellbeing Board could be used as the future Integrated Care Partnership Board. The proposed single population based locality contract to be developed between all key stakeholders as part of the Thurrock Integrated Care Alliance could act has the strategic delivery vehicle.

6.3 There has been an increasing move to devolve focus from borough to locality level in many of our transformation programmes, and the advent of the new Primary Care Networks provides an opportunity to cement and build on this work to create comprehensive and holistic models of integrated service delivery between the NHS, council and third sector.

6.4 There is further opportunity to support locality models of deliver through creation of locality based commissioning contracts with single integrated locality budgets with a potential opportunities for an element of co-commissioning with the community. These could be developed over time by combining existing public health, CCG and Adult Social Care budget lines in a single pot with a single outcome based contract available to practices and other providers dependent on delivery of agreed locality population health outcomes. There are plans to start this process by creating a Public Health contract covering Stretched QOF, hypertension case finding, smoking cessation and NHS Health Checks at locality level in 2020/21. In the medium term, the Better Care Fund is one mechanism through which a broader and more comprehensive locality based contract could be delivered, although further detailed financial analysis and planning.

6.5 There are a number of opportunities within the proposed governance arrangements for greater integration with the children's agenda. It is proposed that a link is developed between the LMS Board and the Health and Wellbeing Board; additionally that the proposed Communications and Engagement Board takes a life-course approach.

6.6 In order to maximise the impact of the Health and Wellbeing board, consideration should be given to having a board of "two halves" defined as follows. A preliminary board discussion referred to as a system leaders meeting, followed by a public meeting. There is also opportunity for board meetings to be themed on either a quarterly or annual basis.

6.7 It is hoped that the proposed changes on governance arrangements at Thurrock Place and locality level provide a useful starting point for further discussion. The proposals seek to integrate the current number of Boards that have developed over time into a more coherent structure under an Integrated Care Partnership, whilst providing further focus on integrated locality models.

7 Implications

7.1 Financial

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

This report discusses possible high level future proposals for further integration of commissioning functions between the council and CCG, and for the devolution of some commissioning responsibilities from Thurrock to locality level to create locality budgets. Further detailed financial planning and agreement between the local authority and CCG will need to take place to make these a reality. Use of the Better Care Fund is one potential financial delivery vehicle.

7.2 **Legal**

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

The report seeks to act as a discussion paper for key stakeholders. There are no immediate legal implementations arising from this report.

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7.3 **Diversity and Equality**

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

The report sets out proposals to further integrate existing clinical, public health, adult social care and third sector services and locality level. Moving services closer to where people live, and by shifting focus their focus to more holistic and preventative models should result in improved access, better care coordination and enhanced opportunities for early intervention and prevention. This will assist key stakeholders to improve the health and wellbeing of our population and reduce health inequalities.

Report Author:

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

Contributions from:

Ceri Armstrong, Adults Health and Housing Directorate Strategy Officer
Ian Stidson, Interim Director of Commissioning, NHS Thurrock CCG

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28 June 2019	ITEM: 6
Health & Wellbeing Board	
Mid & South Essex STP Update	
Wards and communities affected: All	**Key Decision:** For Information
Report of: Jo Cripps, Interim Programme Director, Mid & South Essex STP Mandy Ansell, Accountable Officer, Thurrock CCG Roger Harris, Corporate Director of Adults, Housing and Health, Thurrock Council	
Accountable Head of Service: Not applicable – externally produced report	
Accountable Director: Not applicable – externally produced report	
This report is public	
Date of notice given of exempt or confidential report: N/A	

Executive Summary

This paper provides an update on the Mid and South Essex Sustainability and Transformation Partnership (the Partnership) and is presented for information.

It provides a brief background on the Partnership and its work to date and focuses on the development of a 5-year strategy for the Sustainability and Transformation Partnership, which will build upon the work and priorities of the three Health and Wellbeing Boards.

The paper also describes the recruitment timetable for a new independent chair of the Partnership, as the current chair stands down from this role.

1. Recommendation(s)

1.1 HWB is asked to comment on the current work of the Sustainability and Transformation Partnership and the future relationship with the Thurrock Health and Well-Being Board.

2. Introduction and Background

2.1 The Mid and South Essex Sustainability and Transformation Partnership is a partnership of key organisations and groups within the mid and south Essex footprint:

- Five Clinical Commissioning Groups (Thurrock, Basildon & Brentwood, Mid-Essex, Southend and Castle Point and Rochford)
- Three Local Authorities (Thurrock Council, Southend-on-Sea Borough Council and Essex County Council)
- Three acute hospitals (Basildon & Thurrock, Southend and Broomfield)
- Three community and mental health providers (NELFT, Provide and EPUT)
- Three Healthwatch organisations (Healthwatch Thurrock, Healthwatch Essex and Healthwatch Southend)
- Chairs of the STP Service User Advisory Group and Clinical Cabinet.

There are 42 such partnerships across England.

The Sustainability and Transformation Partnership is not an organisation, it is a collection of partners working together.

2.2 As a partnership, our collective aims are to support the delivery of health and wellbeing priorities to:

- support people to live well and to be independent for as long as possible
- focus on prevention and self-care using an asset-based approach, and ensure people have the right information and tools to support them
- ensure services are in place and available to support people when in need.

2.3 The history of the Sustainability and Transformation Partnership stems from 2015, when mid and south Essex was identified as one of three “Success Regimes”, in recognition of the long-standing challenges faced in relation to service quality and configuration, finance and workforce. Following a diagnostic exercise, the Success Regime focussed in on acute hospital services. This led

to the development of a consolidated clinical strategy across our three acute hospitals, culminating, after a wide-ranging public consultation and clinical assurance processes, in July 2018, with commissioner agreement (via the Clinical Commissioning Group Joint Committee) to a range of service improvements to hospital services.

2.4 Both Thurrock Council and Southend Council referred the decisions of the Clinical Commissioning Group Joint Committee to the Secretary of State of Health and Social Care for independent review. Thurrock Council's concerns related specifically to the closure of Orsett Hospital and the movement of services to planned Integrated Medical Centres. The concerns raised by both Councils have now been referred to the Independent Reconfiguration Panel and we await the outcome of this review.

2.5 This focus on acute care, while much needed, had consumed much attention. The hospitals now have clear plans on moving forward to improve services (subject to the outcome of Secretary of State Referrals).

2.6 The Partnership recognises that it must now focus on broader priorities to support residents, recognising and supporting the work already in train through Health and Wellbeing Boards.

2.7 See Appendix 1 for an overview of the Sustainability and Transformation Partnership Board and its agreed work programmes.

3. Sustainability and Transformation Partnership Strategy Development

3.1 In January 2019, the NHS published a ten year plan (*NHS Long Term Plan*). Through this, the expectation has been set that Sustainability and Transformation Partnerships across the country will develop a 5-year strategy by the autumn.

3.2 While the strategy will need to include information on how the Sustainability and Transformation Partnership will deliver the commitments made in the Long Term Plan (relating to improving quality and outcomes (including cancer, urgent care, referral to treatment, mental health), prevention, digital transformation

(including primary care access, outpatient redesign), new care models (including development of Primary Care Networks, social prescribing), importantly it will also identify how we, as partners, seek to work together to address the broader determinants of health and wellbeing,

3.3 The NHS Long Term Plan has also set the expectation that Sustainability and Transformation Partnerships will move towards becoming Integrated Care Systems by 2021.

3.4 Healthwatch Thurrock have led engagement across the Sustainability and Transformation Partnership on the NHS Long Term Plan on behalf of Healthwatch England, and a report will be available shortly. The engagement sought to identify "what matters" to residents.

3.5 As a partnership, the Sustainability and Transformation Partnership recognises that the vast majority of interactions with residents happen at the local level, and that the work of the Health and Wellbeing Boards are sovereign in this regard.

It would not be appropriate, nor is it the intention, for organisations within the Sustainability and Transformation Partnership to seek to dictate how these local plans should be delivered.

Sustainability and Transformation Partnership partners recognise that Thurrock has well developed place-based plans aimed at supporting residents, which have been endorsed by this Health and Wellbeing Board. This includes the development of localities and primary care networks, and work under the auspices of the *Better Care Together*.

3.6 The development of a 5-year strategy for the Sustainability and Transformation Partnership provides us with an opportunity to focus on these local plans and to identify where, by working at different levels within the system, we can best support delivery of plans through collective action.

3.7 A small "design group" has been established to support development of the Sustainability and Transformation Partnership strategy, which includes input from Roger Harris and Ian Wake. The strategy will:

- Reflect what we have learnt from engagement with residents.
- Recognise that partners within the system operate at different levels – locally at GP practice/Primary Care Network; at "place" level to integrate services; in partnership across areas where relevant (eg. when looking at flows through the three hospitals) and at system/ Sustainability and Transformation Partnership level, where this makes sense.
- Have the principle of subsidiarity at its heart – recognising that local relationships and interactions have the greatest impact on the health and wellbeing of our population and that these relationships and interactions cannot be replicated at a wider system level.
- Recognise that "place based" plans are the building blocks of the strategy.
- Identify an overarching outcomes framework which incorporates key aspects of the three Health and Wellbeing Board strategies and supports their delivery.
- Set the principles of working together at Sustainability and Transformation Partnership level (all organisations together, across the 1.2m population), should only need to occur where:
    - There are "thorny issues" that can only be addressed by partners working together (eg estates, workforce)
    - There are economies of scale in doing things once across the system (eg. digital transformation – the shared care record)
    - There is unwarranted variation in standards of care or inequity in access to services that could be addressed by working together (eg standards across our hospitals)
- Recognise that, increasingly, the Sustainability and Transformation Partnership is used within the NHS as the unit of planning and delivery, and it is through working together on a Sustainability and Transformation Partnership footprint that opportunities for investment can be exploited.

The public health teams across three local authorities are working on a draft Sustainability and Transformation Partnership profile (see attached current draft at Appendix 2) to help to guide the work.

3.6 The draft strategy will be shared with the Health and Wellbeing Board in the coming months.

Changes to Leadership

3.7 The Health and Wellbeing Board is asked to note that Dr Anita Donley OBE, who has been the independent chair of the STP for the past three years, has announced her intention to stand down from this role.

3.8 The Sustainability and Transformation Partnership, through the Chairs' Group, is leading the process of recruiting her successor. Interviews will take place on 22 July.

4. Reasons for Recommendation

4.1 This paper is presented for information.

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

5.1 N/A

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

6.1 N/A

7. Implications

7.1 **Financial**

None.

Implications verified by: Not applicable – external report

7.2 **Legal**

None

Implications verified by: Not applicable – external report

7.3 **Diversity and Equality**

None

Implications verified by: Not applicable – external report

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

N/A

8. Appendices to the report

- Appendix 1 – overview of STP Board and priority work programmes
- Appendix 2 – Draft STP Profile

Author:

Jo Cripps, STP Programme Director (interim)

Roger Harris, Corporate Director, Adults, Housing and Health, Thurrock Council

Mandy Ansell, Accountable Officer, Thurrock CCG

Appendix 1

Overview of STP Board & Work Programmes

The Sustainability and Transformation Partnership Board comprises CEOs and Accountable Officers from all NHS organisations, and lead officers from Local Authorities; also representatives from Healthwatch, and advisory groups as listed above.

Chairs of organisations within the Sustainability and Transformation Partnership, including Health and Wellbeing Board chairs, meet as a Sustainability and Transformation Partnership Chairs' Group to provide strategic oversight to the development of the Sustainability and Transformation Partnership

Partners within the Sustainability and Transformation Partnership have agreed work programmes in the following:

- **Primary Care & Locality Development** – reflecting the work that Clinical Commissioning Groups and Local Authorities are leading to develop place-based plans.
- **Acute Hospitals** – delivering improvements to hospital services,
- **Population Health Management & Prevention** – using data and analytics to understand our populations to predict future needs and to target interventions and support appropriately.
- **Estates** – a system-wide approach to estates and capital planning, involving all partners.
- **Workforce** – a programme to support recruitment and retention across all workforce groups, and develop the health and care workforce including the development of "hybrid roles" to support health and care provision.
- **Digital** – implementation of a Shared Care Record, to support residents and staff to obtain best outcomes from health and care, and a programme of work to oversee digital transformation across the Sustainability and Transformation Partnership, eg with the use of apps, and digital technology to support care.

The Sustainability and Transformation Partnership also has a number of advisory groups supporting its work:

- Service User Advisory Group
- Clinical Cabinet
- Finance Group
- Innovation Advisory Group
- Communications & Engagement Group

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Mid and South Essex STP Profile Pack

Draft v0.3

Essex County Council

Contents

3

Further Information

Forward projections produced for this profile are based solely on population projection estimates (ONS 2016-based).

This does not take into account any other factors that may impact the indicator values.

These projections are marked with a *.

Contact Details

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Summary

Population and Demography

- Population growth since 2011 has been faster in Basildon and Thurrock than across England.
- Thurrock, Basildon and Brentwood are also forecast to show faster population growth than England over the next 5 and 20 years.
- The population is ageing. 1 in 7 people will be aged over 75 years in 2039.

Education Attainment and Skills

- Maldon is the only district with a decreasing skills gap over the last decade.
- The proportion of people with no qualifications has decreased in the last decade faster than England.
- Maldon is the only district which performs better than national comparisons for Reading, Writing & Maths.

Employment and the Workforce

- Job growth across the STP has been the lowest in Castle Point, and is forecast to remain so.
- Employment and productivity is mostly increasing, but the productivity gap is increasing between the STP and national comparators.

Housing and Deprivation

- Thurrock is forecast to exceed Essex and England housing growth, and have largest demand for dwellings growth.
- Homes have become up to 58% less affordable over the last decade.
- Deprivation has increased across the STP, mostly in Chelmsford and Basildon.

Health Behaviours and Outcomes

- Life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females.
- Maldon showed the largest decrease in smoking, and had the lowest proportion of current smokers.
- Basildon will continue to have high and growing alcohol related hospital admissions.
- Southend-on-Sea and Basildon are forecast to continue having the highest and largest increasing proportion of overweight or obese adults.
- Basildon has the lowest proportion of adults physically active and eating healthily, and the largest decrease across the STP since 2015/16.

5 Summary

Health Behaviours and Outcomes

- Maldon and Thurrock were the only districts of the STP with a higher proportion of overweight or obese children than England in Reception and Year 6, respectively.
- NHS Castle Point and Rochford CCG consistently had the highest QOF prevalence of CHD, Hypertension, Stroke, Diabetes and COPD in 2017/18, and the largest prevalence increases since 2009/10.
- Thurrock will continue to have high and growing mortality due to preventable CVD.
- Basildon and Thurrock will continue to have high and growing mortality due to preventable cancer.
- Southend-on-Sea will continue to have high mortality due to preventable liver disease, but will increase most in Thurrock.

Vulnerable Populations

Older People

- Maldon is forecast to consistently have the highest number of old age people per working age person.
- Consistently increasing service demand could be seen due to falls and hip fractures in Braintree and Southend.
- Southend-on-Sea and Rochford had the largest excess winter mortality and dementia diagnosis rate, and respective growths.

Mental Health

- Basildon and Southend-on-Sea have the highest prevalence of mental health conditions among adults and children.
- Basildon has the highest current rate of emergency hospital admissions for self-harm and has increased most, and is forecast to continue to do so.
- Thurrock will continue to have a high and growing suicide rate.

Learning Disability

- Basildon and Thurrock will likely be key areas to target for supporting residents with Learning Disability.

Population and Demography

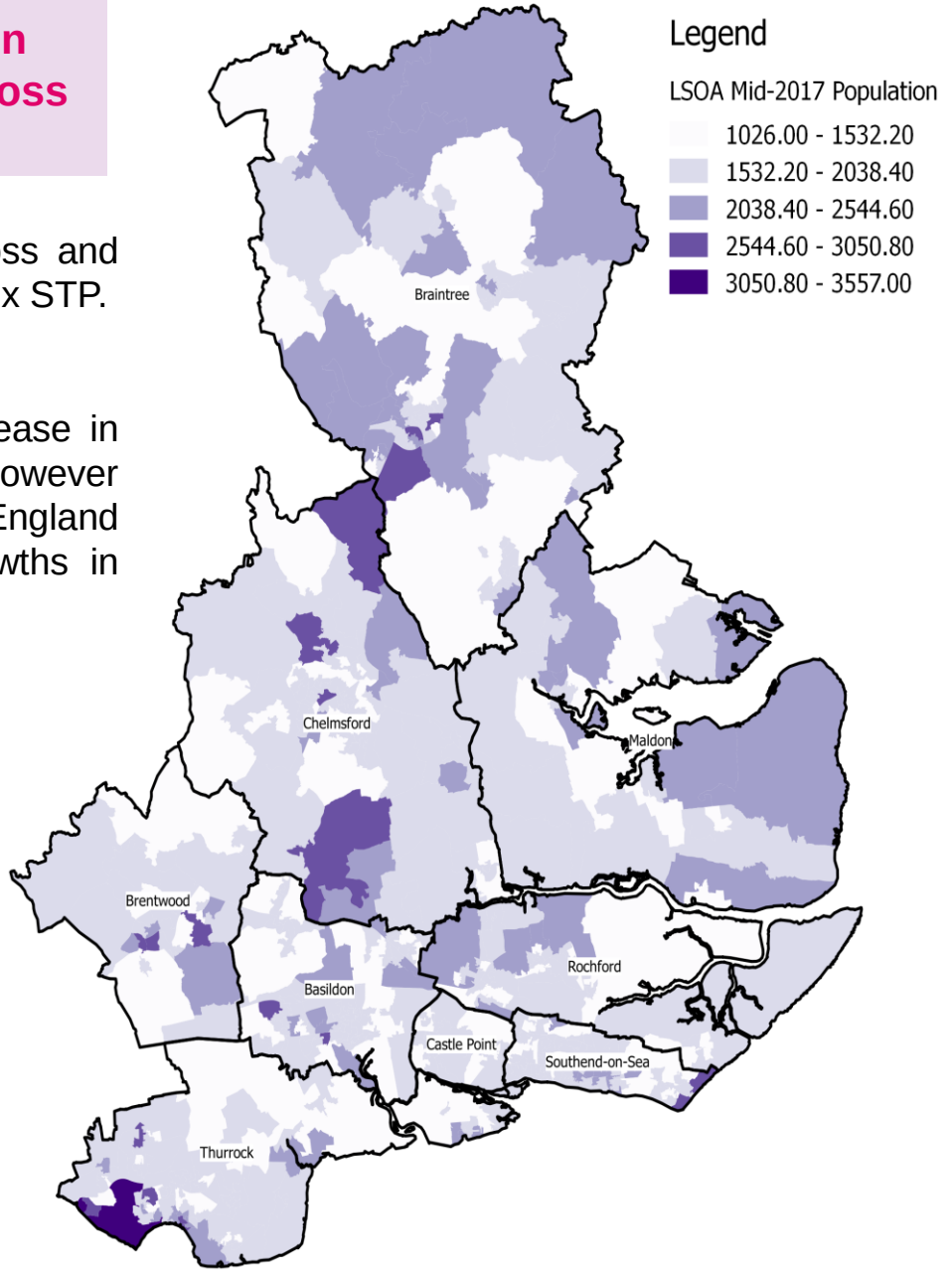
Essex County Council

Population growth since 2011 has been faster in Basildon and Thurrock than across England.

The population size in 2017 varied greatly across and within the Local Authorities of Mid and South Essex STP.

The STP and all localities have shown an increase in population size since the 2011 ONS Census. However this is slightly slower than the growth rate for England (4.92%), with the exception of the largest growths in Basildon and Thurrock.

Area	Total Population (All Ages) 2011 Census	Total Population (All Ages) 2017	# +/- from 2011 Census	% +/- from 2011 Census
Basildon	174,497	184,479	9,982	5.72
Braintree	147,084	151,677	4,593	3.12
Brentwood	73,601	76,575	2,974	4.04
Castle Point	88,011	89,814	1,803	2.05
Chelmsford	168,310	176,194	7,884	4.68
Maldon	61,629	63,975	2,346	3.81
Rochford	83,287	86,209	2,922	3.51
Southend	173,658	181,808	8,150	4.69
Thurrock	157,705	170,394	12,689	8.05
Total STP	1,127,782	1,181,125	53,343	4.73
Essex	1,393,587	1,468,177	74,590	5.35
England	53,012,456	55,619,430	2,606,974	4.92



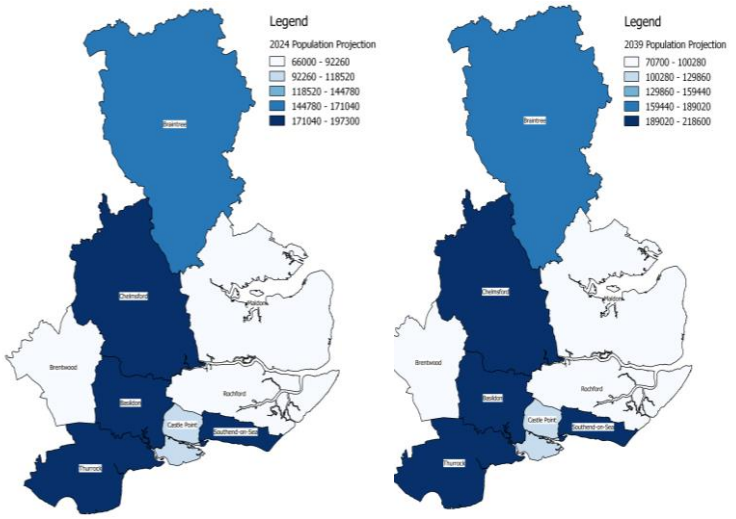
Source: ONS

Some locality's populations are also estimated to grow proportionally more than across Essex and England.

The total population size of Mid and South Essex STP is projected to increase by 5.22% over the next 5 years and 14.70% over the next 20 years.

It is forecasted that Thurrock, Basildon and Brentwood will consistently have the largest population percent growth from 2017 estimates.

These locality's are also estimated to show faster growth than across Essex and England from 2017 to 2024, and to 2039.



Mid and South Essex STP Locality	Population Estimate 2017	2024		2029		2034		2039	
		Population Projection	% +/- from 2017	Population Projection	% +/- from 2017	Population Projection	% +/- from 2017	Population Projection	% +/- from 2017
Southend-on-Sea	181,808	191,100	5.1	197,300	8.5	203,100	11.7	208,700	14.79
Thurrock	170,394	183,800	7.9	192,000	12.7	199,300	17.0	206,400	21.13
Basildon	184,479	197,300	6.9	204,900	11.1	211,800	14.8	218,600	18.50
Braintree	151,677	157,300	3.7	160,600	5.9	163,800	8.0	167,000	10.10
Brentwood	76,575	81,300	6.2	84,300	10.1	87,100	13.7	89,800	17.27
Castle Point	89,814	93,200	3.8	95,600	6.4	98,000	9.1	100,300	11.68
Chelmsford	176,194	183,100	3.9	188,000	6.7	192,400	9.2	196,500	11.52
Maldon	63,975	66,000	3.2	67,700	5.8	69,300	8.3	70,700	10.51
Rochford	86,209	89,700	4.0	92,200	6.9	94,500	9.6	96,800	12.29
Total STP	1,181,125	1242800	5.22	1282600	8.59	1319300	11.69	1354800	14.70
Essex	1,468,177	1549800	5.56	1602800	9.17	1650500	12.42	1695100	15.46
England	55,619,430	57937200	4.17	59300100	6.62	60473800	8.73	61535000	10.64

Source: ONS

The population is ageing. 1 in 7 people will be aged over 75 years in 2039.

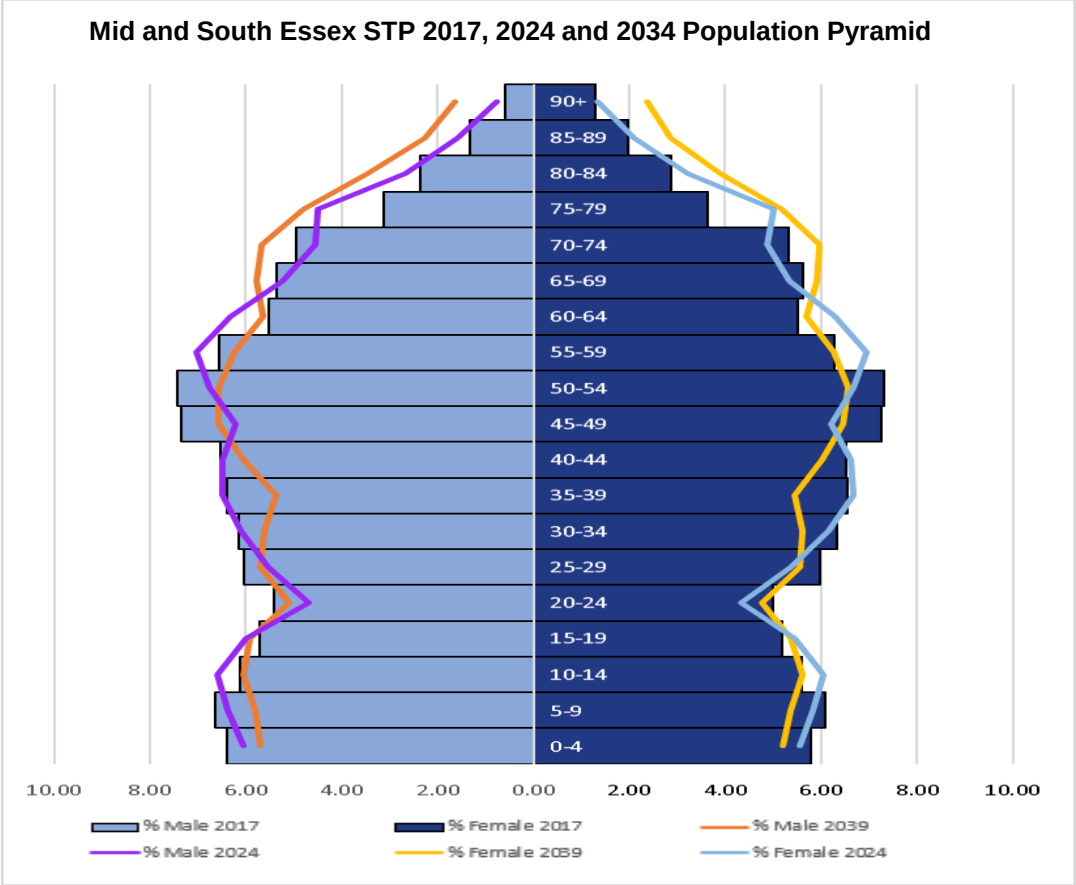
The proportion of the population made up by younger age groups is forecast to decrease, while the proportion of older age groups is forecast to increase in Mid and South Essex STP.

In 2017, 1 in 12 people were aged over 75 in the STP. This is estimated to increase to 1 in 9 by 2024, and 1 in 7 by 2039.

Over the next 5 years the largest increase is forecast among 75 – 79 year olds across all localities, with the largest in Maldon by nearly 60%.

By 2034, the largest increases are forecast for the 90+ years population. This will also be the largest in Maldon, with an increase of 193%.

See Appendix A: 2017, 2024 and 2039 population estimates and % +/- by age group and Local Authority.



Source: ONS

Education Attainment and Skills

Essex County Council

Maldon is the only district with a decreasing skills gap over the last decade.

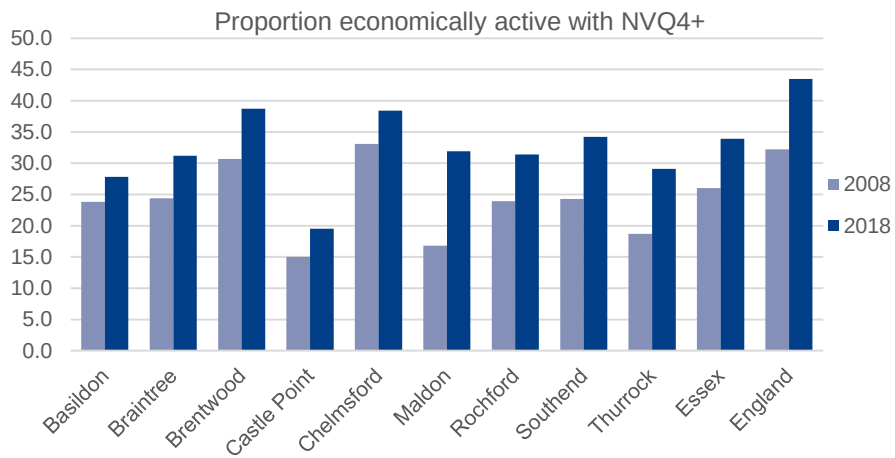
LATEST PICTURE	
ESSEX	England
33.9%	43.5%

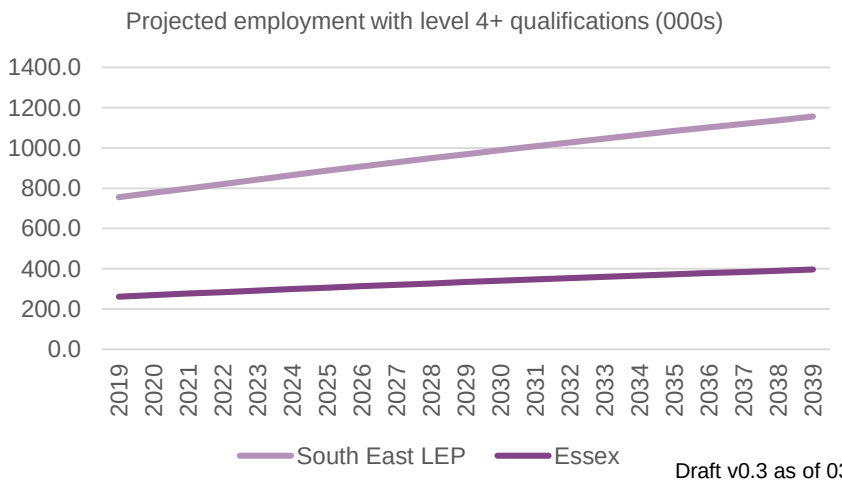
The proportion economically active with NVQ4+ has increased across the STP since 2008, the largest in Maldon (15%) and Thurrock (10%). However, apart from Maldon, the growth has been slower in all local authorities compared to the England average (11%).

There is also an increasing gap between the proportion of people who are qualified at NVQ4+ level across the STP compared to England.

For example, Castle Point had 17% fewer graduates compared to the England average in 2008, but this increased to 24% fewer in 2018. With exception of Maldon, similar patterns are seen in all Local Authorities meaning an increasingly lower level of skills available in Mid and South Essex STP.

In 2018, this skill level made up the highest proportion of those in employment in every local authority except Castle Point (Appendix B). Employment by this skill level is also forecast to increase across Essex and the South East Region. This may therefore discourage businesses with high skilled vacancies to set up in the STP without skills investment.





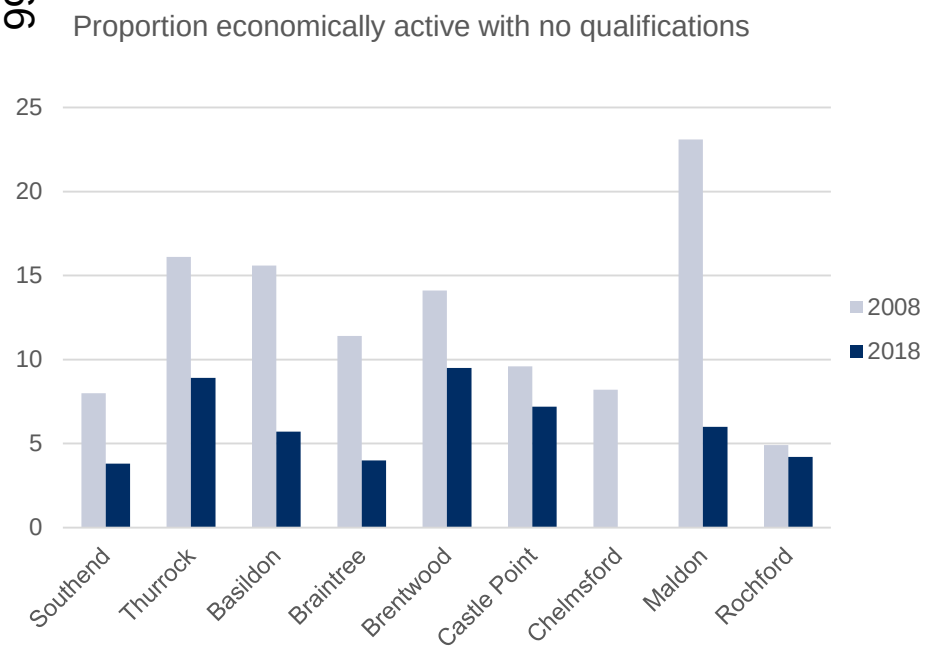
Source: ONS Nomis; EEFM

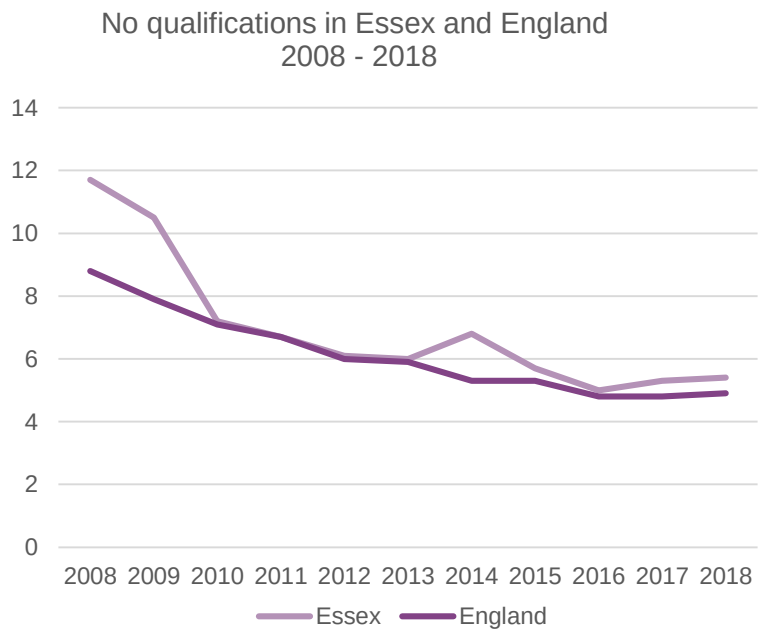
12 The proportion of people with no qualifications has decreased in the last decade faster than England.

LATEST PICTURE	
ESSEX	England
5.4%	4.9%

Individuals with no qualifications are more likely to be in less skilled work with lower productivity levels. The proportion of people economically active with no qualifications has decreased in every locality within Mid and South Essex STP over the last decade and faster than that for England (3.9%), with the largest in Basildon (9.9%) and Maldon (17%).

However, the proportion has not decreased in Southend, Brentwood, Castle Point and Rochford as much as that across Essex as a whole (6.3%). Brentwood had nearly twice as many people with no qualifications compared to the England and Essex average in 2018.





Source: ONS Nomis

Maldon is the only district which performs better than national comparisons for Reading, Writing & Maths.

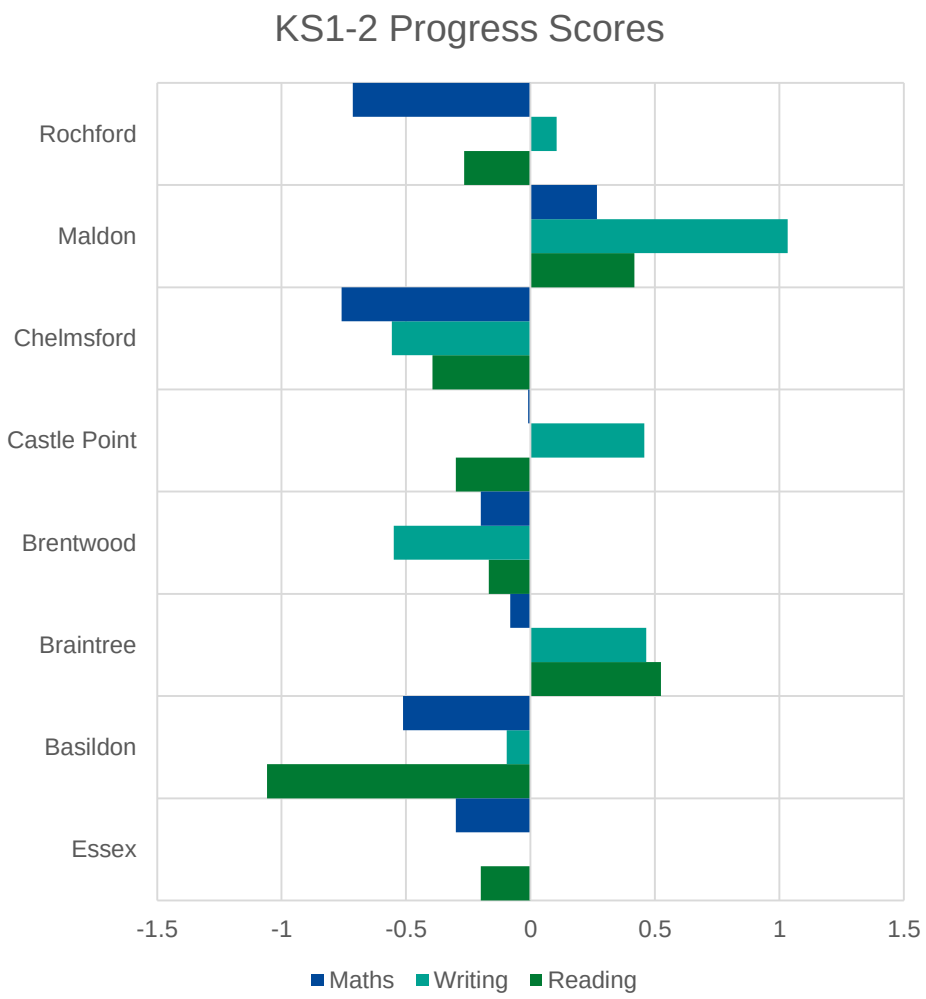
KS1-2 Progress Scores	Essex (in respect to National)
Reading	-0.2
Writing	0.0
Maths	-0.3

Overall Essex is performing worse than national comparisons for reading and maths scores.

Maldon is the only district where students are performing better on all 3 measures and is the only district in the County where Maths performance is above the national average.

There are multiple districts which perform worse on all 3 measures (Chelmsford, Brentwood, Basildon).

The poor relative performance means that Mid and South Essex STP students are not achieving the same level of skills nationally, putting them at a disadvantage for future schooling and ultimately skills for the labour market.



Source: Nexus, DfE

Employment and the Workforce

Essex County Council

Job growth across the STP has been the lowest in Castle Point, and is forecast to remain so.

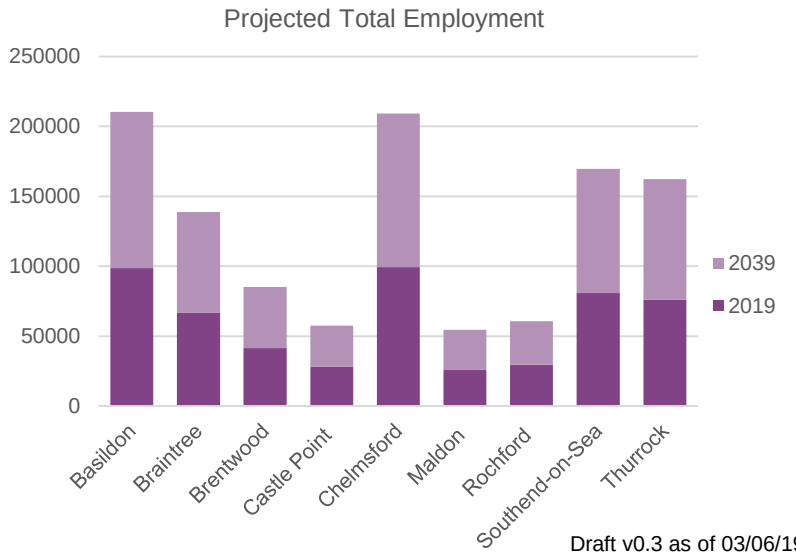
Total employment includes number of employee and self-employed jobs. Job density is the number of jobs in the local authority divided by the 16 – 64 years resident population.

Most local authorities have shown job growth over the last decade. Rochford had one of lowest number of jobs and job density of 2017, but showed the largest percentage growths.

However, total employment in Castle Point decreased by over 7% and job density by nearly 2%. Castle Point also had the lowest TE and JD in 2017 across Mid and South Essex STP.

Total employment is projected to remain relatively stable between 2019 – 24. Between 2019 – 34, this is forecast to increase in all localities. However, this is estimated to be the lowest in Castle Point (4.64%).

Local Authority	Total Employment			Job Density		
	2007	2017	% Change	2007	2017	% Change
Basildon	84,000	96,000	14.29	0.77	0.84	9.09
Braintree	64,000	70,000	9.38	0.69	0.75	8.70
Brentwood	35,000	39,000	11.43	0.79	0.83	5.06
Castle Point	28,000	26,000	-7.14	0.51	0.50	-1.96
Chelmsford	90,000	103,000	14.44	0.83	0.95	14.46
Maldon	23,000	26,000	13.04	0.59	0.70	18.64
Rochford	24,000	31,000	29.17	0.46	0.60	30.43
Southend-on-Sea	77,000	80,000	3.90	0.74	0.72	-2.70
Thurrock	63,000	75,000	19.05	0.63	0.70	11.11
Total STP	488,000	546,000	11.89	**0.69**	**0.75**	8.70



Source: ONS Nomis; EEFM

Employment and productivity is mostly increasing, but the productivity gap between the STP and national comparators is increasing.

LATEST PICTURE		
ESSEX	SELEP	NATIONAL
81.6%	79.9%	78.4%

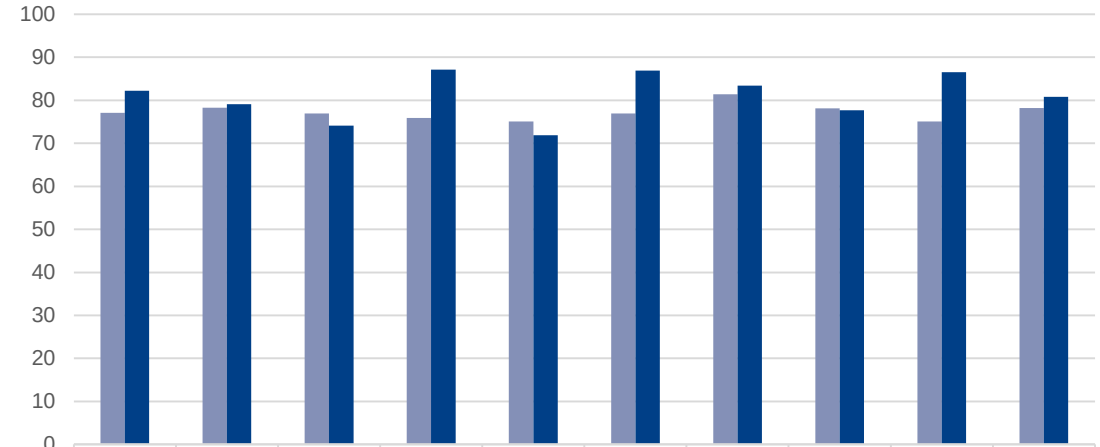
Economic Activity Rate (16-64)

Economic activity includes people in employment or unemployed looking for employment. Higher activity is negatively correlated with productivity.

Across Mid and South Essex STP in 2018, the rate was relatively similar to that across Essex. The highest rate was seen in Rochford, Braintree, and Castle Point.

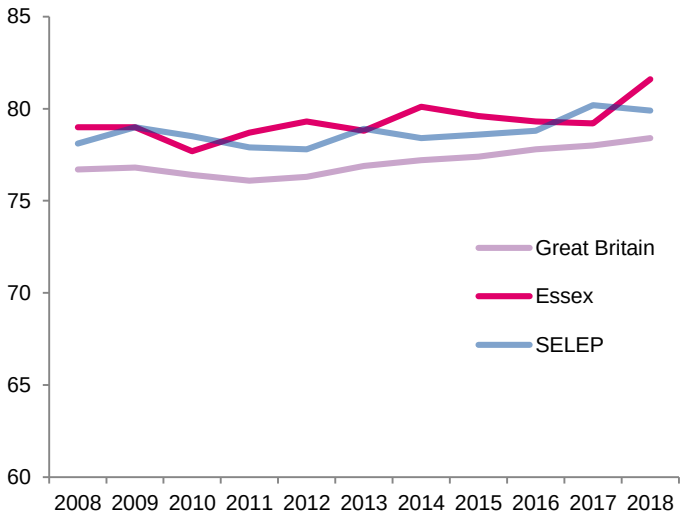
Economic activity has increased across most localities over the last decade and faster than the national average, the largest in Rochford (+11.4) and Braintree (+11.2). However, decreases were seen in Basildon (-2.8) and Brentwood (-3.2), the two localities with the lowest rates of 2018.

Economic Activity Rate 2008 - 2018



	Southend-on-Sea	Thurrock	Basildon	Braintree	Brentwood	Castle Point	Chelmsford	Maldon	Rochford	Essex
2008	77.1	78.3	76.9	75.9	75.1	76.9	81.4	78.1	75.1	78.2
2018	82.2	79.1	74.1	87.1	71.9	86.9	83.4	77.7	86.5	80.8

Economic Activity Rate 2008 - 2018

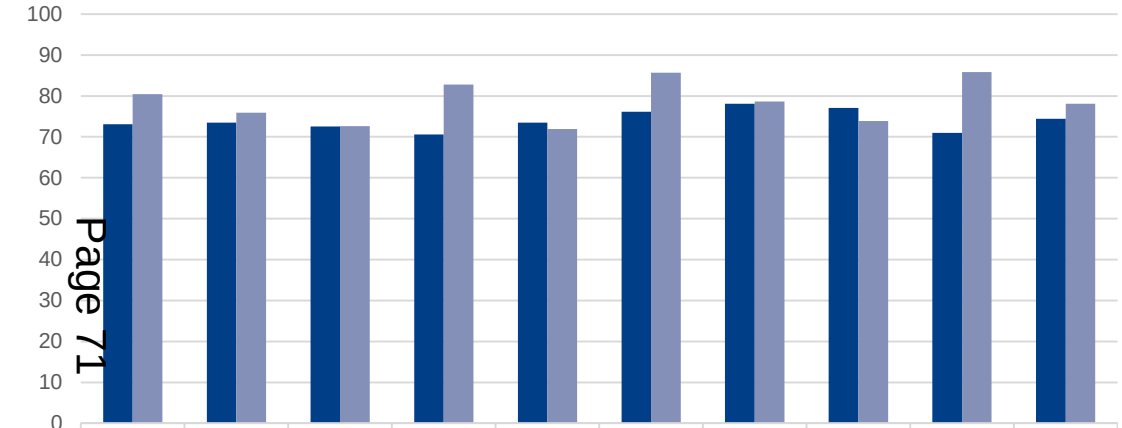


Source: ONS Nomis

Basildon and Brentwood also had the two lowest **employment rates** among 16 – 64 year olds in 2018, and Brentwood was one of only two districts that showed decreased employment since 2008. The rate in other localities were relatively similar to that across Essex.

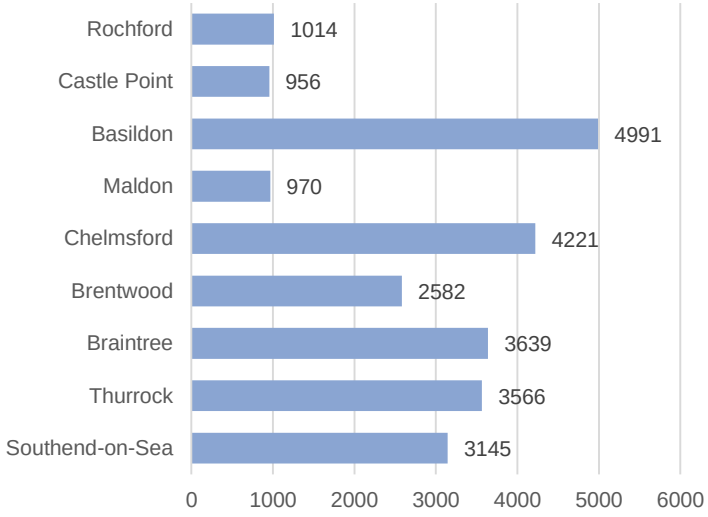
For 2017/18, the highest proportion of workers are in professional occupations, and associate professional and technical occupations in most localities of Mid and South Essex STP.

Employment rate (16-64)



	Southend-on-Sea	Thurrock	Basildon	Braintree	Brentwood	Castle Point	Chelmsford	Maldon	Rochford	Essex
2008	73.1	73.5	72.5	70.6	73.5	76.1	78.1	77.1	71	74.4
2018	80.4	75.9	72.6	82.8	71.9	85.7	78.6	73.9	85.8	78.1

GVA (£ mill) 2017



Gross value added (GVA) is a key measure of productivity. GVA (£ mill) of all industries has also increased between 2007 to 2017, with the largest in Braintree (19%) and Brentwood (23%). However, these were the only two districts where productivity grew faster than the Essex (8.3%), East of England (10.4%) and England average (11.8%). The productivity gap is therefore widening in most local authorities of the STP.

However, a high employment rate is not necessarily good for productivity. Castle Point had one of the highest employment rates but the lowest GVA (£ mill) in 2017.

Source: ONS

Housing and Deprivation

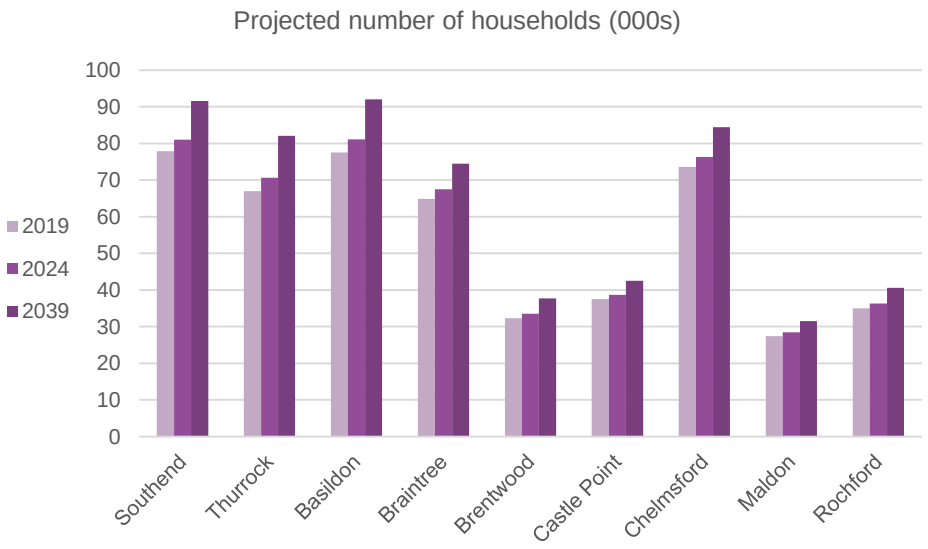
Essex County Council

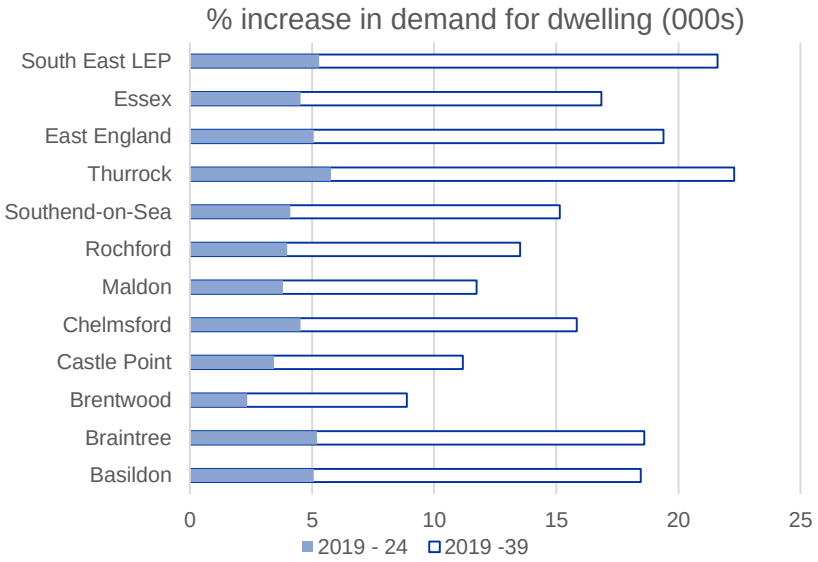
Thurrock is forecast to exceed Essex and England housing growth, and have largest demand for dwellings growth.

The total number of households is projected to increase across Mid and South Essex STP by 4.1% from 2019 to 2024, and 16.96% by 2034. This is higher than the housing growth for England (3.51%, 13.62%), but similar to that across Essex (4.4%, 17.77%).

Thurrock (5.5%, 22.5%) is estimated to have the largest housing growth in the STP, exceeding housing growth across England and Essex over both time periods. However, only Castle Point is forecast to show slower housing growth over 2019 – 39 compared to England.

Demand for dwellings is also projected to increase across the STP. By 2024 and 2039, Basildon and Southend-on-Sea are forecast to have the two highest demand for dwellings (000s). However, the largest percentage growth over the two time periods is forecast in Braintree and Thurrock.





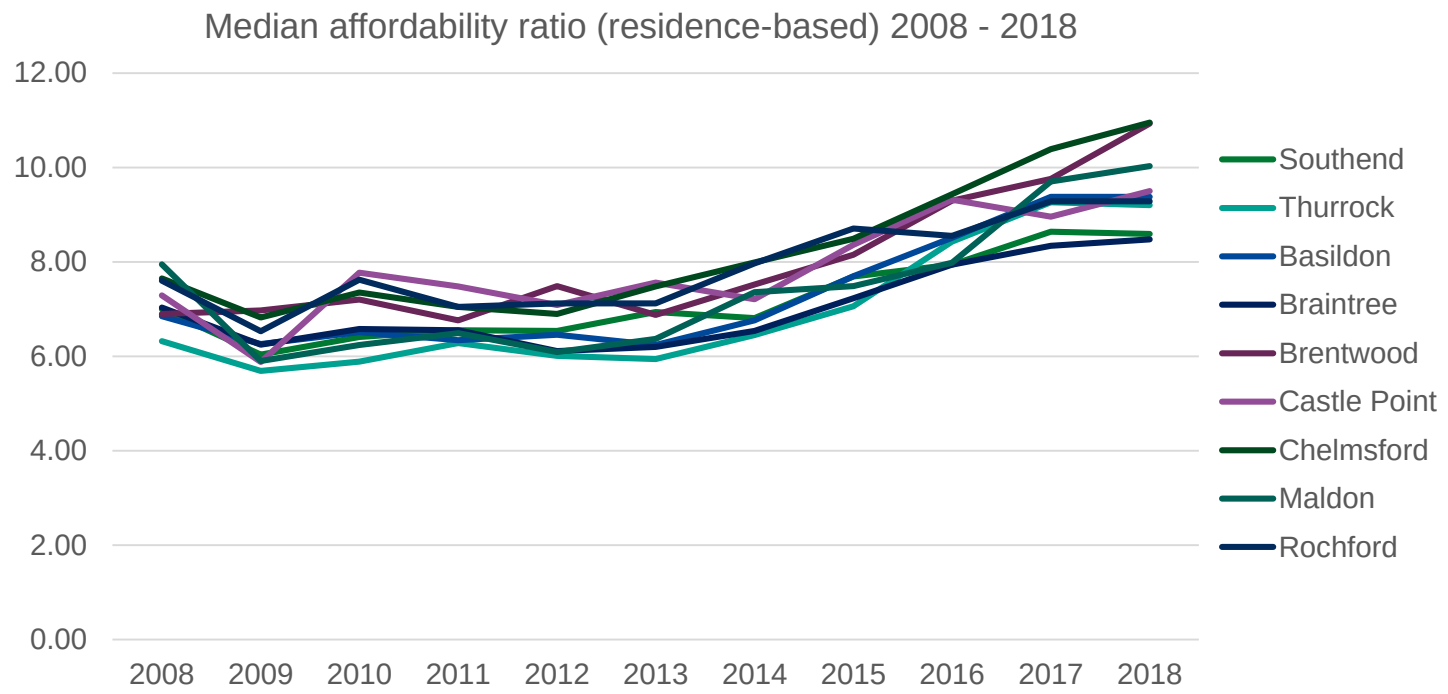
Source: ONS; EEFM

Homes have become up to 58% less affordable over the last decade in the STP.

The median housing affordability ratio is a comparison of the median property price compared to median earnings in the same area. The higher the ratio the less affordable housing in the local area.

Homes in all local authorities of Mid and South Essex STP have become less affordable over the last decade.

Brentwood has one of the least affordable properties in relation to residential earnings in 2018 (10.93 ratio) and has seen the largest reductions across the local authorities, with properties 58% less affordable than in 2008.

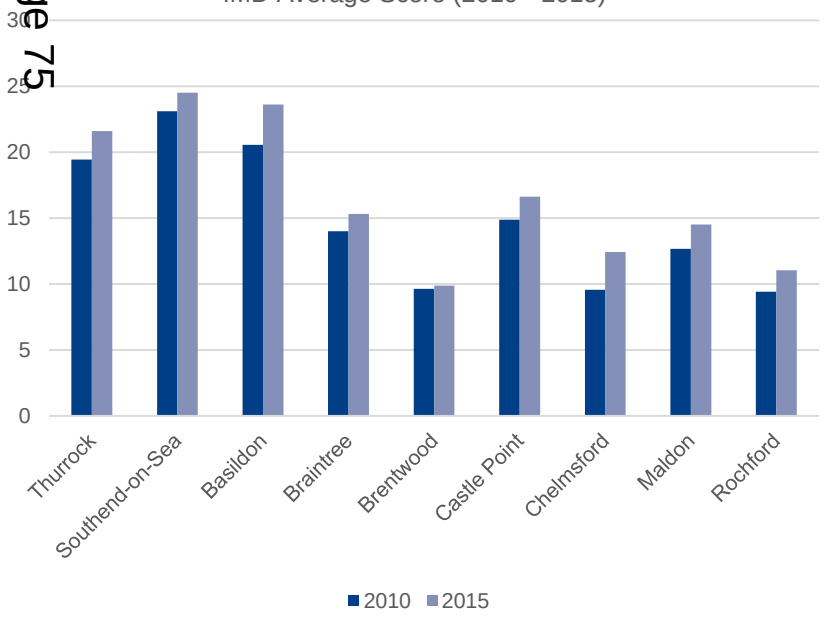


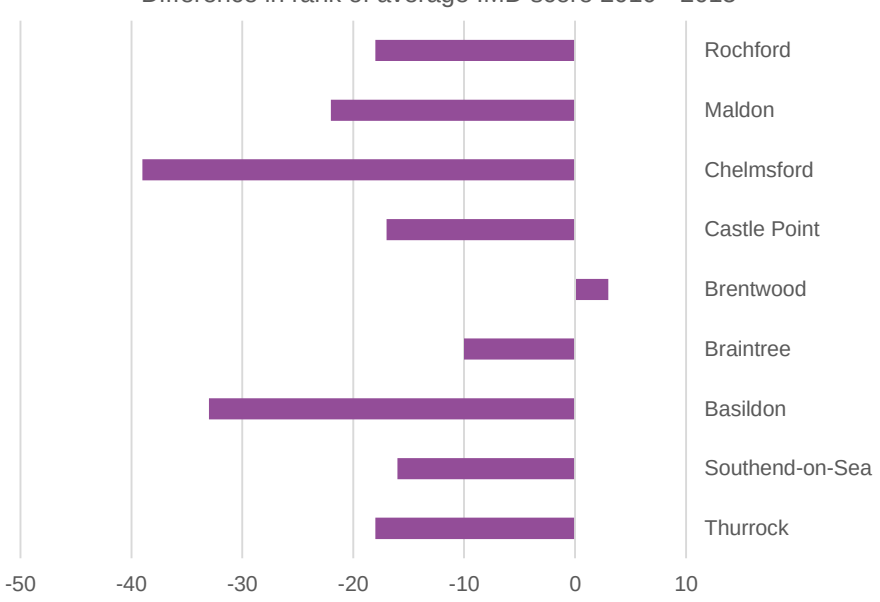
Source: ONS

Deprivation has increased across the STP, mostly in Chelmsford and Basildon.

All Local Authorities of Mid and South Essex STP have seen an increase in average Indices of Multiple Deprivation (IMD) scores, indicating increasing levels of deprivation, from 2010 to 2015. The largest increases in deprivation were seen in Basildon and Chelmsford. Basildon also had the highest average score in 2015.

Similar patterns are seen in the rank of the average IMD score. However, the rank has increased in Brentwood. This suggests that although deprivation may be increasing in Brentwood, this may be lesser relative to that of other local authorities across England.





Source: Ministry of Housing, Communities and Local Government

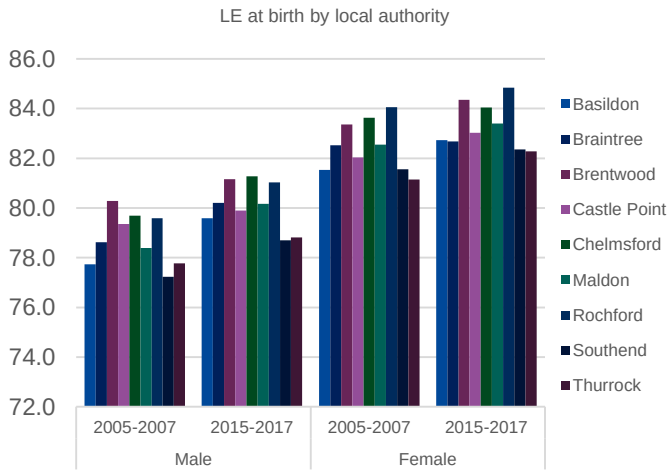
Health Behaviours and Outcomes

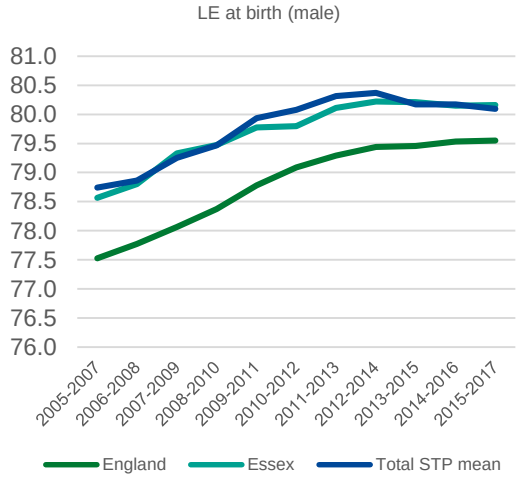
Essex County Council

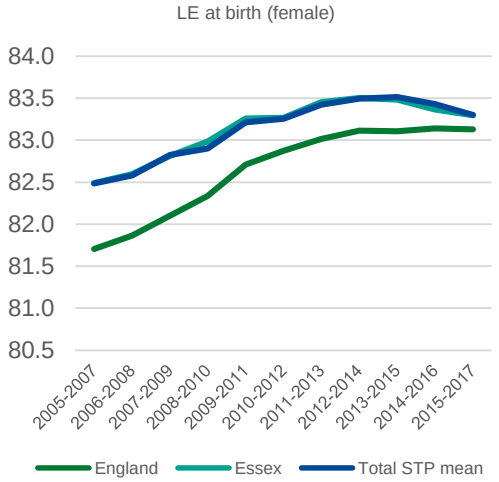
Life expectancy gap between local authorities had decreased by up to 0.59 years among males and 0.35 years among females.

Life expectancy (LE) at birth has increased across the total Mid and South Essex STP since 2005-07 among males and females, and has been consistently slightly higher than the LE across England. Residents are therefore living increasing longer. The largest increase has been seen in Basildon, with males expected to live 1.9 years and females 1.2 years longer compared to 2005-07 estimates.

The LE gap between the local authorities with the highest and lowest values of 2005-07 has also decreased. For example, males of Southend-on-Sea were expected to live 3.05 years fewer than males of Brentwood. By 2015-17, this decreased to 2.46 fewer years. However, the LE gap among females has not decreased as much. Thurrock had a LE of 2.91 years fewer than Rochford in 2005-07, and this decreased to 2.56 years fewer by 2015-07. Overall, there is therefore still wide disparity in LE between the local authorities of Mid and South Essex STP.







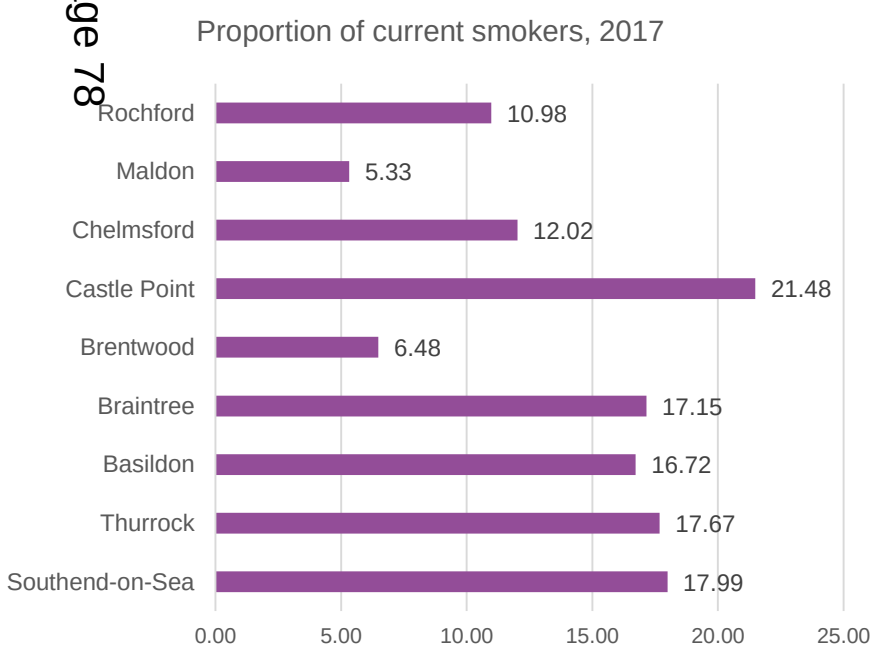
Source: ONS

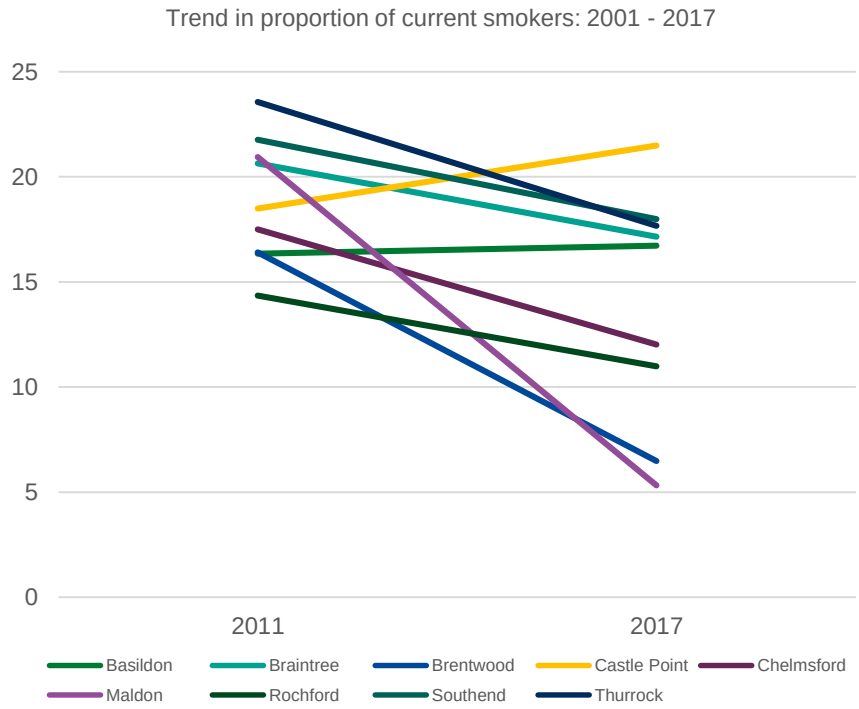
Maldon showed the largest decrease in smoking, and had the lowest proportion of current smokers across the STP.

LATEST PICTURE	
Essex	England
13.8	14.9

Smoking is one of the leading causes of global morbidity and mortality rates. The proportion of current smokers among residents aged over 18 years has mostly decreased since 2011 across the STP.

The largest decrease was Maldon (16.6%) and Brentwood (9.9%), the two local authorities with the lowest proportion of 2017. However, Castle Point had the largest proportion in 2017 and increased by nearly 3% since 2011.





Source: PHE Fingertips; ONS

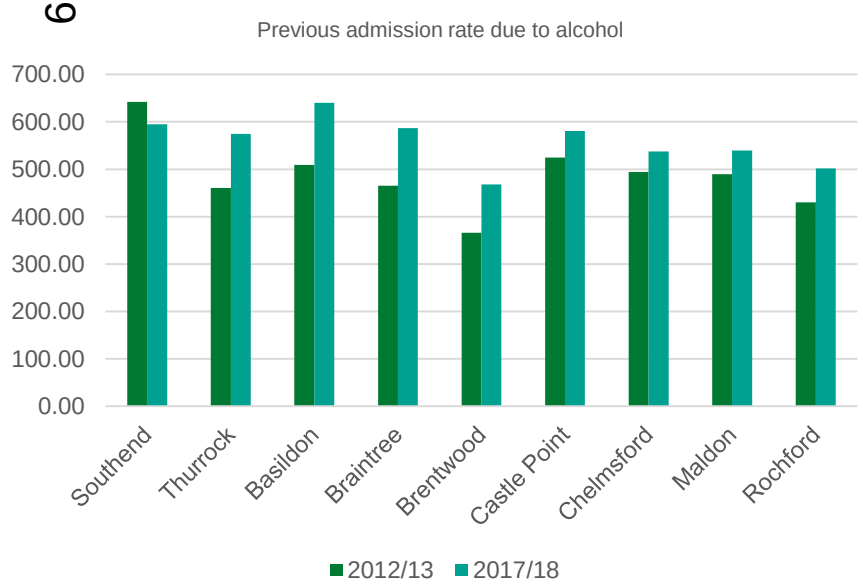
Basildon will continue to have high and growing alcohol related hospital admissions.

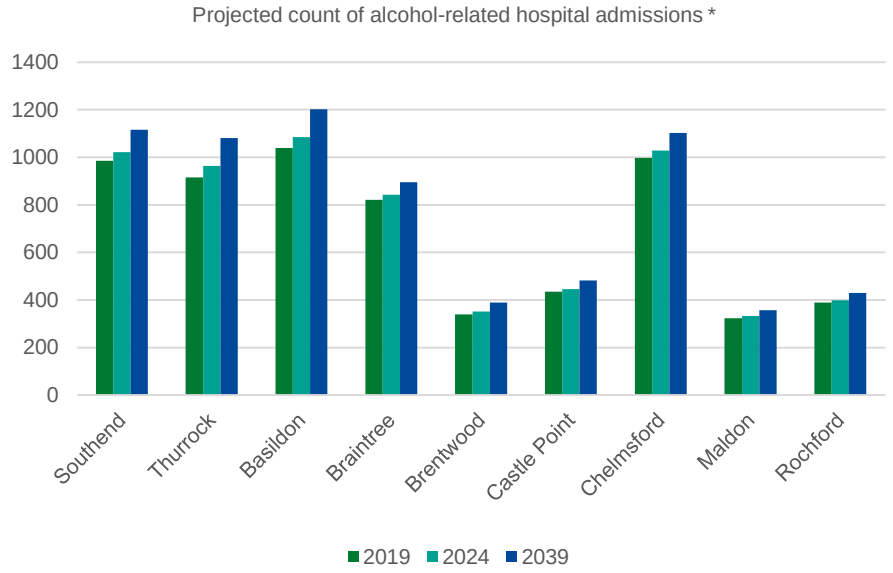
LATEST PICTURE	
Essex	England
589	632

The narrow measure of alcohol related hospital admissions per 100,000 of the population includes only those admissions where alcohol is directly attributable.

In 2017/18, Basildon had the highest rate across the STP local authorities and had the largest rate increase (131) over the previous 5 years. This contrasts Southend-on-Sea which had the second highest rate for 2017 but was the only local authority to show a decline (-47) in admission rates since 2012/13.

Based on population estimates, the number of alcohol-related hospital admissions is likely to increase if the rate remains the same in all local authorities of the STP from 2019. Basildon and Thurrock are forecast to show the largest percentage increase in count over the next 5 and 20 years, and Basildon is also estimated to have the highest number of admissions compared across the local authorities of the STP .





Source: PHE Fingertips; ONS

Maldon and Thurrock were the only districts of the STP with a higher proportion of overweight or obese children than England in Reception and Year 6, respectively.

RECEPTION LATEST PICTURE	
Essex	England
21.1	22.4

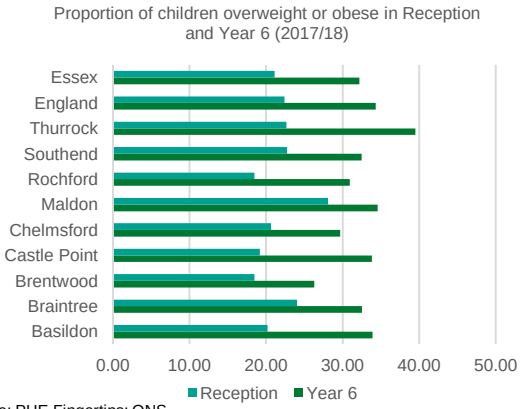
YEAR 6 LATEST PICTURE	
Essex	England
32.2	34.3

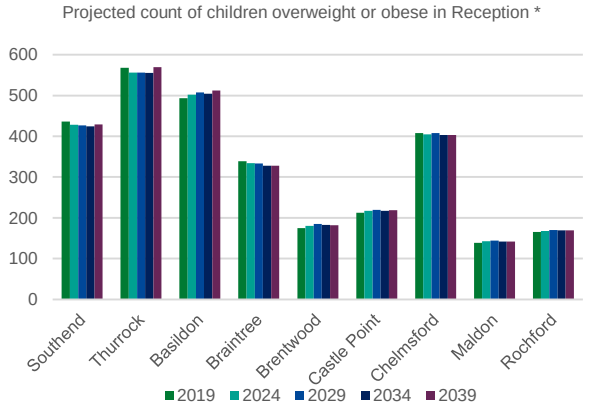
In 2017/18, Maldon and Braintree had the highest proportion of children in Reception overweight or obese. All other local authorities of Mid and South Essex STP had a relatively similar or lower proportion compared to the Essex and England averages. Out of the Districts with 2007/08 data available, these were also the only two to show an increased proportion over the last decade (Maldon +10.39%; Braintree +2.43%).

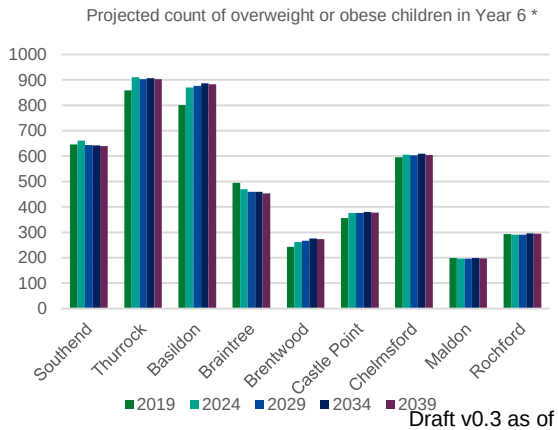
If the proportion of children overweight or obese remain the same, due to projected population increases, the total number is likely to increase across the STP. It is forecast that Southend, Thurrock and Basildon will consistently have the highest count of overweight or obese children in reception. However Maldon is estimated to show the largest percentage increase from 2019 projections in 2024, and Brentwood in 2039.

Maldon and Thurrock had the highest proportion of children in Year 6 overweight or obese, and Thurrock showed the largest percentage increase since 2007/08. However, with the exception of Thurrock, the proportion was also similar to the Essex and England average.

Thurrock, Southend and Basildon are also forecast to have the highest count of overweight or obese children in Year 6. Thurrock and Basildon are also estimated to show some of the largest percentage increased over the time periods.







Source: PHE Fingertips; ONS

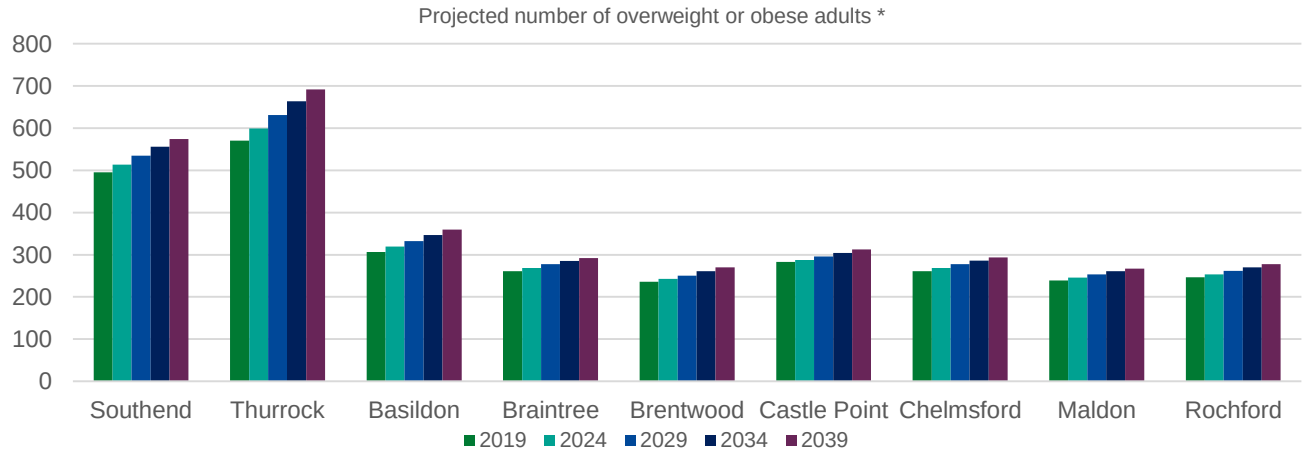
Southend-on-Sea and Basildon are forecast to continue having the highest and largest increasing proportion of overweight or obese adults.

LATEST PICTURE	
Essex	England
62.54	61.98

Obesity is also a major cost pressure for public services. The proportion of adults that are overweight or obese was the highest in the Basildon district of Mid and South Essex STP in 2017/18. However, the proportion in all but 3 local authorities (Rochford, Chelmsford, Brentwood) was higher than across England. Given the contrast to the Reception and Year 6 proportions, this indicates that the problem grows during the school years.

With the exception of Chelmsford (-2.33%), the proportion has increased across the local authorities of the STP since 2015/16 and mostly larger than the increase in the Essex and England averages. The largest increase was seen in Southend-on-Sea.

This is also forecast to increase across the STP from 2019 if the proportion of overweight or obese adults remain the same due to projected population sizes. It is forecasted that Southend-on-Sea, Thurrock and Basildon will consistently have the three highest counts of overweight or obese adults, and the largest percentage increase in count from 2019 to 2024 and 2039.



Source: PHE Fingertips; ONS

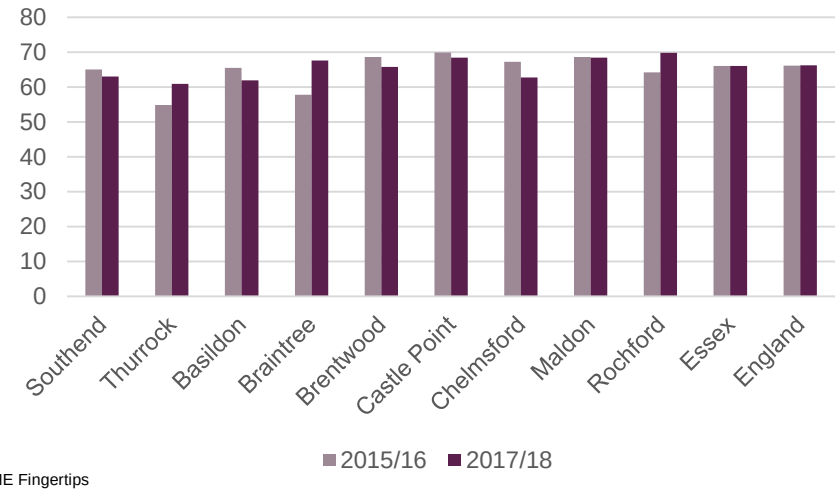
Basildon has the lowest proportion of adults physically active and eating healthily, and this largest decrease across the STP since 2015/16.

ENGLAND LATEST PICTURE		ESSEX LATEST PICTURE	
PA	HE	PA	HE
66.3	54.8	66.1	55.8

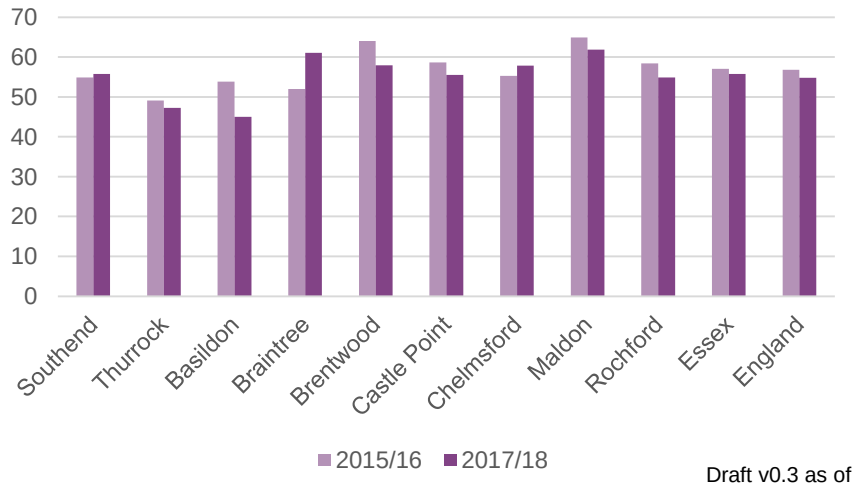
In 2017/18 Basildon and Thurrock also had the lowest proportion of adults that were physically active, and lower than the Essex and England average. While the proportion remained relatively stable across Essex and England since 2015/16, Basildon also showed the second largest percentage decrease. In contrast, Thurrock showed the second highest increase.

Basildon also had the lowest proportion of adults meeting the recommended '5-a-day', and lower than the Essex and England average. Since 2015/16, this proportion also decreased the most in Basildon. However, Thurrock was the only local authority that did not show a proportion decrease as much as that across England. In contrast, Braintree had the second highest proportion of adults eating healthily and the largest increase from 2015/16.

Proportion of physically active adults



Proportion of adults meeting the 5 a day



Source: PHE Fingertips

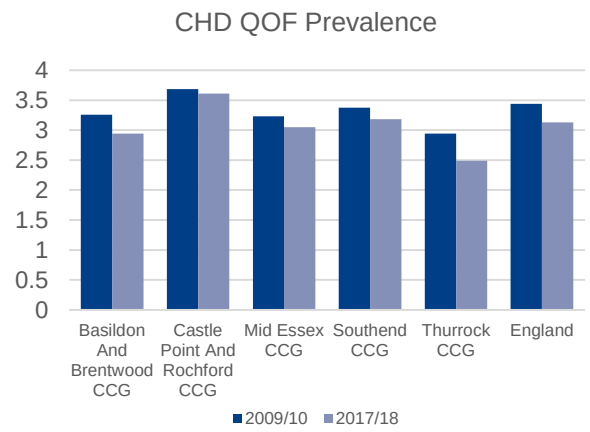
NHS Castle Point and Rochford had the highest CHD, Hypertension and Stroke QOF prevalence in 2017/18, and largest increases since 2009/10.

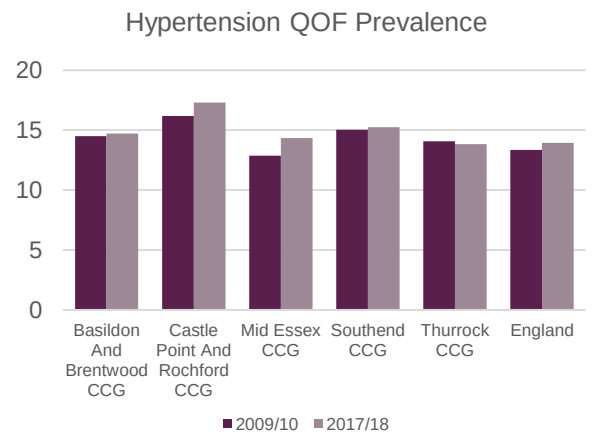
ENGLAND LATEST PICTURE		
CHD	Hypertension	Stroke
3.13	13.96	1.77

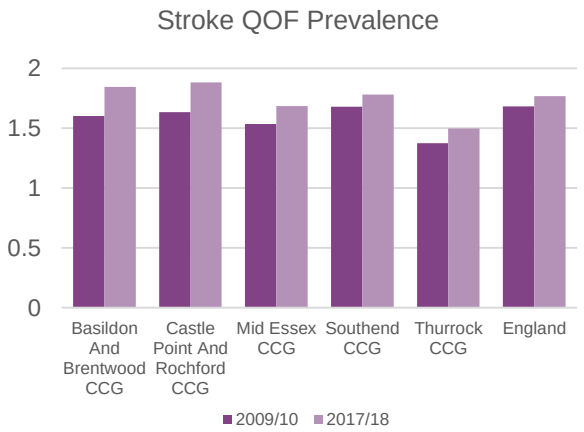
In 2017/18, the QOF prevalence of CHD was the highest in NHS Castle Point and Rochford CCG. This was also significantly higher than the prevalence across England. Since 2009/10, the CHD prevalence has decreased in all CCGs of Mid and South Essex STP. However, this was the smallest in Castle Point and Rochford CCG, and only Thurrock CCG showed a decrease more than that across England.

Hypertension prevalence was also the highest in NHS Castle Point and Rochford CCG in 2017/18. However, the prevalence in all CCGs were similar or higher than that across England. NHS Castle Point and Rochford CCG also showed the second largest increases in prevalence since 2009/10, and this was larger than that across England. In contrast, NHS Thurrock CCG had the lowest prevalence of 2017/18 and was the only CCG to show a prevalence decrease.

NHS Castle Point and Rochford CCG also had the highest Stroke prevalence, higher than that across England. The prevalence has increased in all CCGs of the STP since 2009/10 and more so than the increase across England, but this was the largest in NHS Castle Point and Rochford CCG.







Source: PHE Fingertips

NHS Castle Point and Rochford had the highest Diabetes and COPD QOF prevalence in 2017/18, and largest increases since 2009/10.

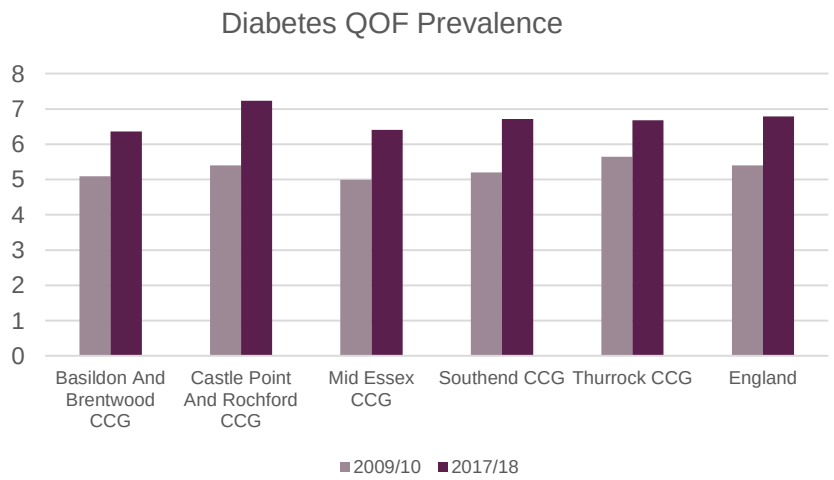
ENGLAND LATEST PICTURE	
Diabetes	COPD
6.79	1.91

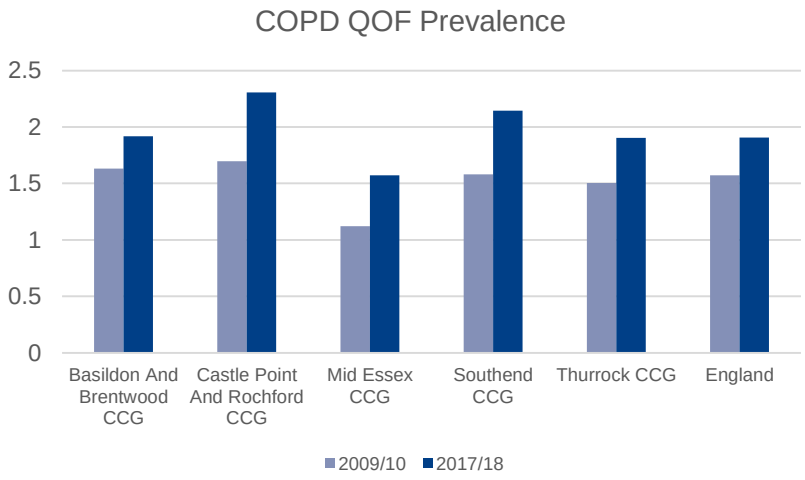
In 2017/18, NHS Castle Point and Rochford CCG had the highest Diabetes QOF prevalence and this was significantly higher than that across England.

The prevalence has increased in all CCGs of Mid and South Essex STP since 2009/10 and most more so than the increase across England (except Thurrock CCG), but this was the largest in NHS Castle Point and Rochford CCG.

The COPD QOF prevalence in 2017/18 was the highest in NHS Castle Point and Rochford CCG and NHS Southend CCG, significantly higher than the England prevalence.

These CCGs also showed the largest COPD prevalence increase since 2009/10, both nearly double that across England.





NHS Castle Point and Rochford CCG is likely a key target area for supporting residents with long-term conditions.

Source: PHE Fingertips

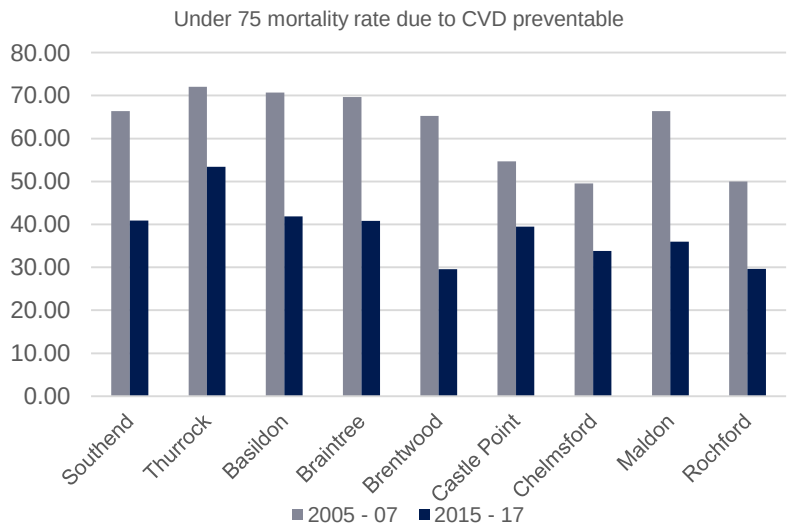
Thurrock will continue to have high and growing mortality due to preventable CVD.

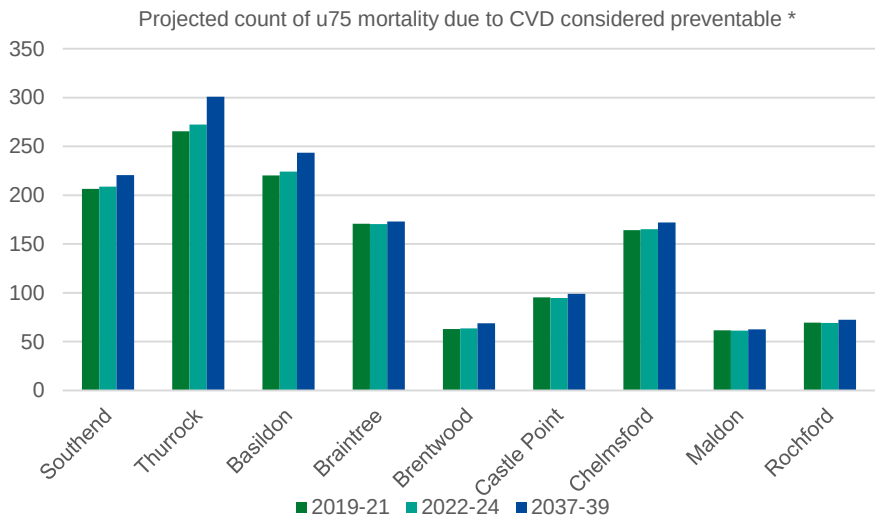
LATEST PICTURE	
Essex	England
38.8	45.9

The under 75 (u75) mortality rate due to cardiovascular disease (CVD) considered preventable has decreased in all local authorities of Mid and South Essex STP.

The largest decrease was seen in Brentwood and Maldon. Brentwood also had the lowest rate of 2015-17. In contrast, Thurrock had the highest rate of 2015-17, and also one of the smallest rate decreases since 2005 - 07.

Based on population projection estimates, the number of u75 mortality due to preventable CVD is likely to increase if the rate remains the same. Basildon and Thurrock are projected to have the highest count of u75 CVD mortality considered preventable from 2019. These local authorities are also estimated to show the largest percentage increase over both time periods.





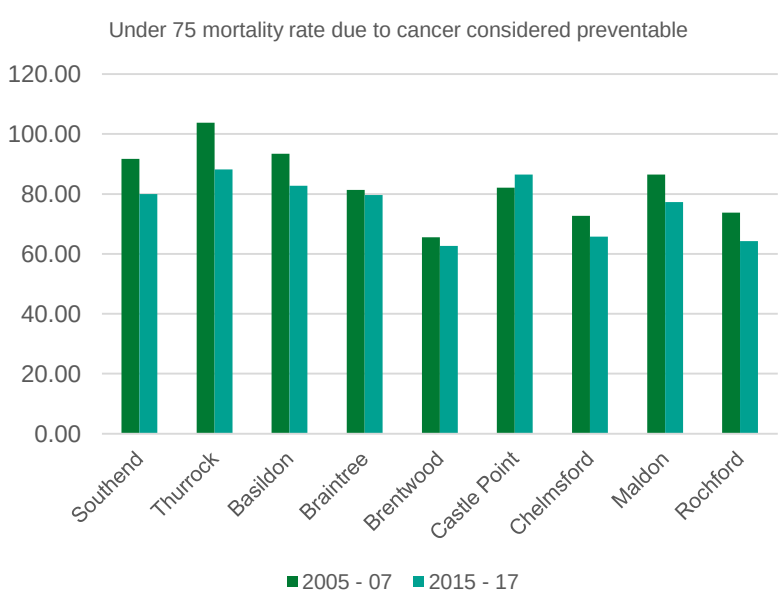
Source: PHE Fingertips; ONS

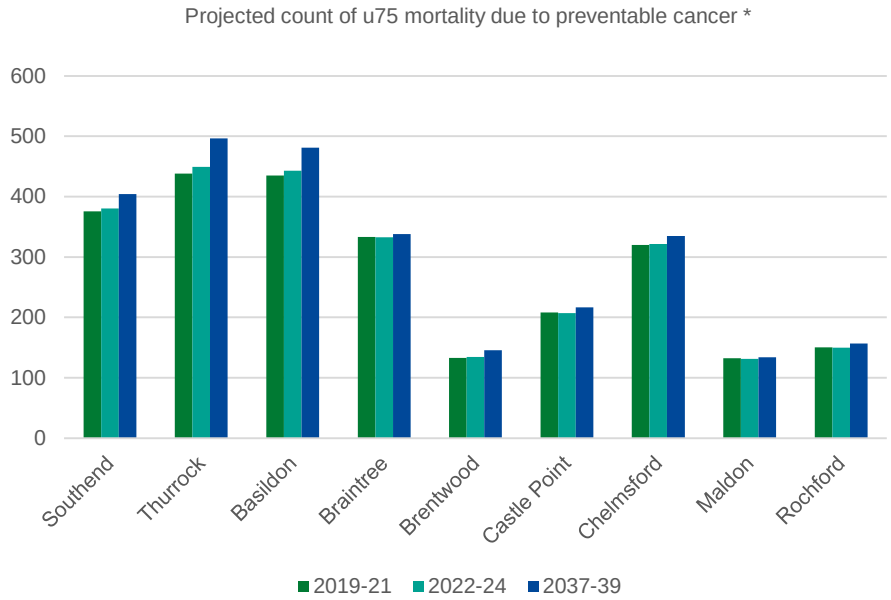
Basildon and Thurrock will continue to have high and growing mortality due to preventable cancer.

LATEST PICTURE	
Essex	England
74.2	78

The u75 mortality rate due to cancer considered preventable has decreased across the STP since 2005-07, except for a rate increase in Castle Point by 4.36. Castle Point also had the second highest rate of 2015 – 17. Thurrock showed the largest rate decrease, but the highest rate in 2015 – 17.

It is likely that the number of u75 mortality due to preventable cancer is likely to increase if rates remain the same, based on projected population estimates. Thurrock and Basildon are estimated to have the highest counts from 2019. These local authorities are also forecast to show the largest percentage increases in count across the time periods.





Source: PHE Fingertips; ONS

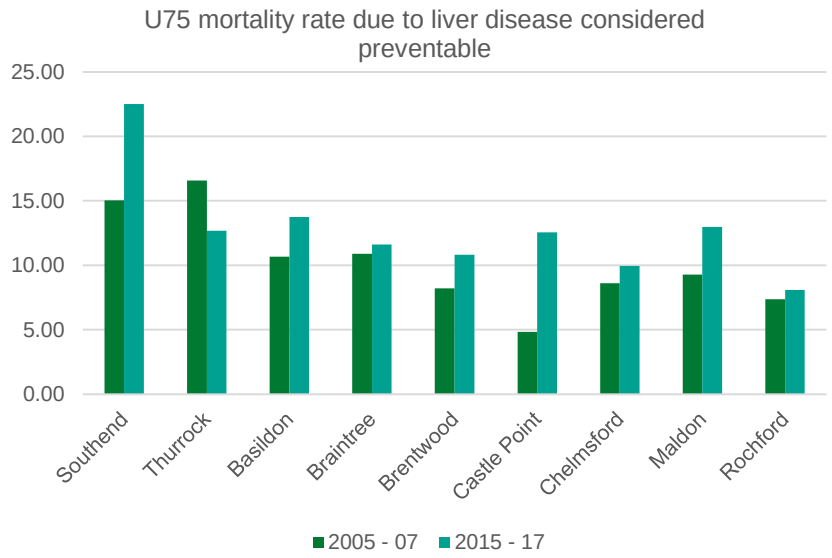
Southend-on-Sea will continue to have high mortality due to preventable liver disease, but will increase most in Thurrock.

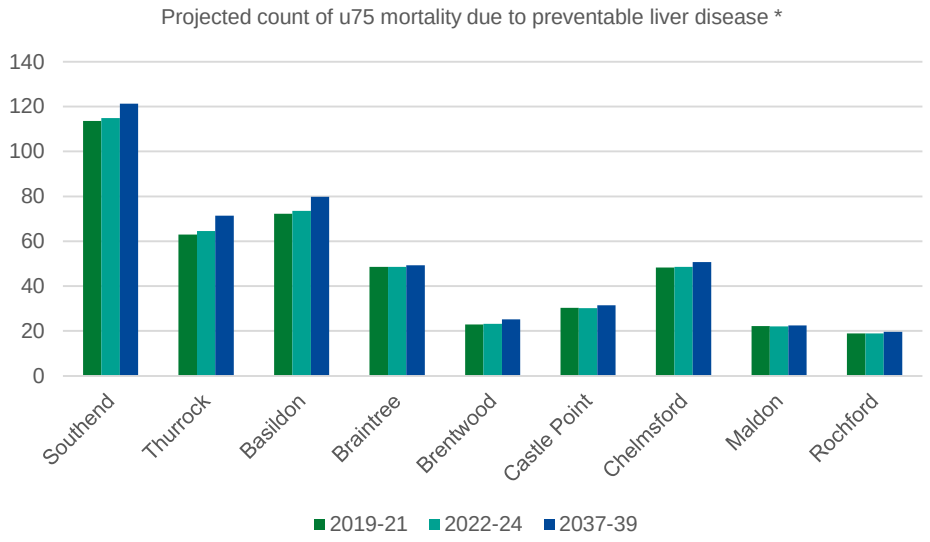
LATEST PICTURE	
Essex	England
12.7	16.3

The u75 mortality rate due to liver disease considered preventable has increased across Mid and South Essex STP since 2005 – 7, with the only decrease in rate seen in Thurrock (-3.91).

The largest rate increase was seen in Southend-on-Sea and Castle Point. Southend-on-Sea also had the highest rate of 2015 – 17 compared across the local authorities of the STP.

If the rate remains the same, due to projected population increases, it is likely to number of mortality due to preventable liver disease will increase. It is estimated that Southend-on-Sea will consistently have the highest count from 2019-21. The largest percentage increase in count is estimated for Thurrock over both time periods.





Source: PHE Fingertips; ONS

Vulnerable Populations

Essex County Council

Older People

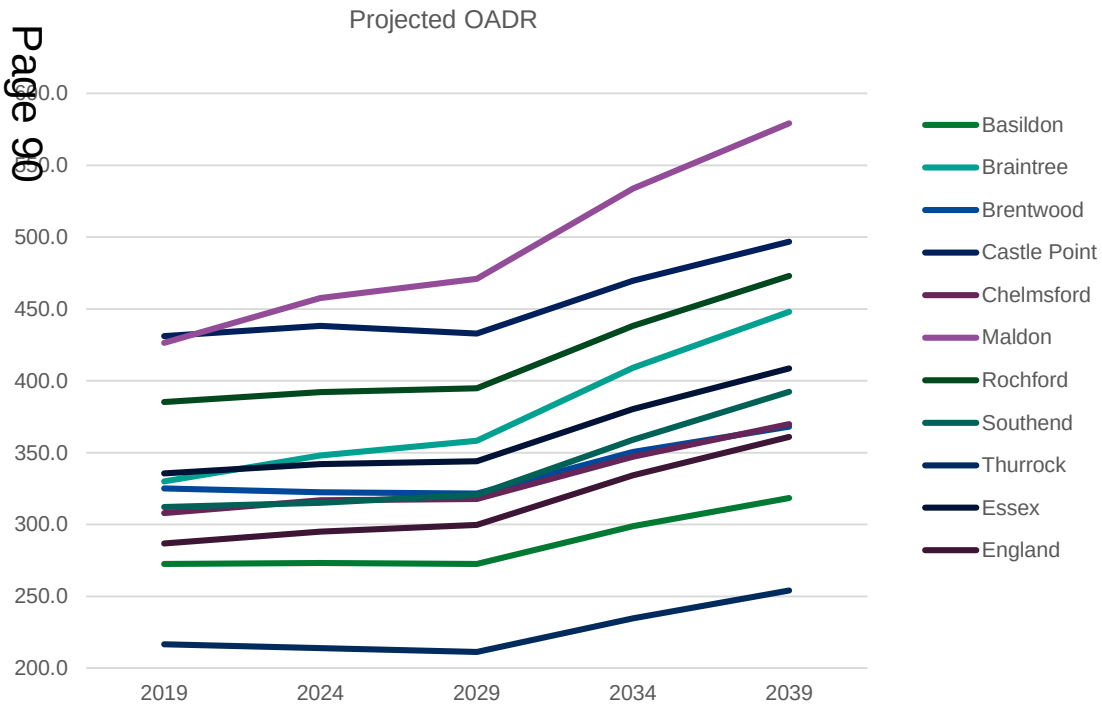
Essex County Council

Maldon is forecast to consistently have the highest number of old age people per working age person.

LATEST PICTURE	
Essex	England
335.5	286.8

The old age dependency ratio (OADR) is the number of people aged over 65 years for every 1,000 people aged between 16 and 64 years. This is forecasted to increase by 21.7% between 2019 and 2039 for Essex which is lower than the national forecasted increase of 25.8%.

There is a wide disparity forecasted within Mid and South Essex STP for 2019 and the next 20 years.



For 2019, Maldon (426) and Castle Point (431) are forecasted to have nearly twice the number of old age dependents than Thurrock (216).

Maldon is also projected to have nearly twice the number of old age dependents than Thurrock (579 vs. 254) by 2039.

It would be expected that Maldon will be the key target area to support older people live independently over the years

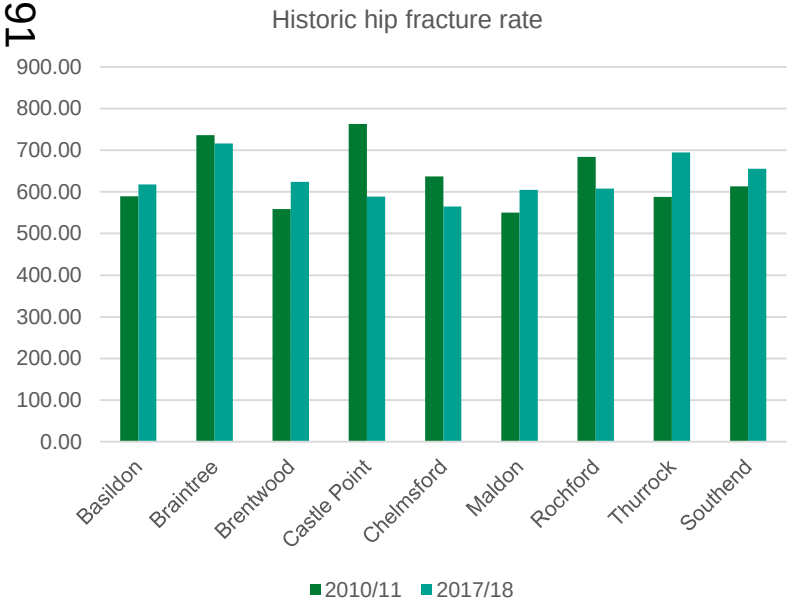
Source: ONS

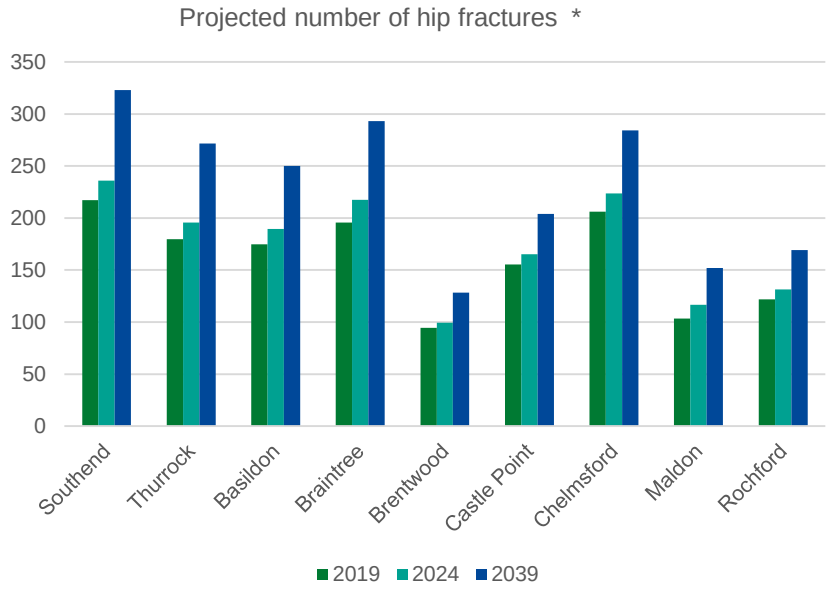
Hip fracture has increased the most in Thurrock, but forecast to increase most in Southend and Braintree.

LATEST PICTURE	
Essex	England
612	578

Braintree and Thurrock had the highest rates of hip fractures among residents aged over 65 years per 100,000 population in 2017/18 across Mid and South Essex STP local authorities. Since 2010/11, the largest increase of this rate was also in Thurrock. Of the 4 localities to show a decrease in rate, this was the smallest in Braintree.

The number of hip fractures is also projected to increase in every local authority of the STP from 2019 to 2024 and 2039 if the rate remains similar due to projected population increases. This is estimated to increase the most in Braintree and Southend-on-Sea consistently.





Source: PHE Fingertips; ONS

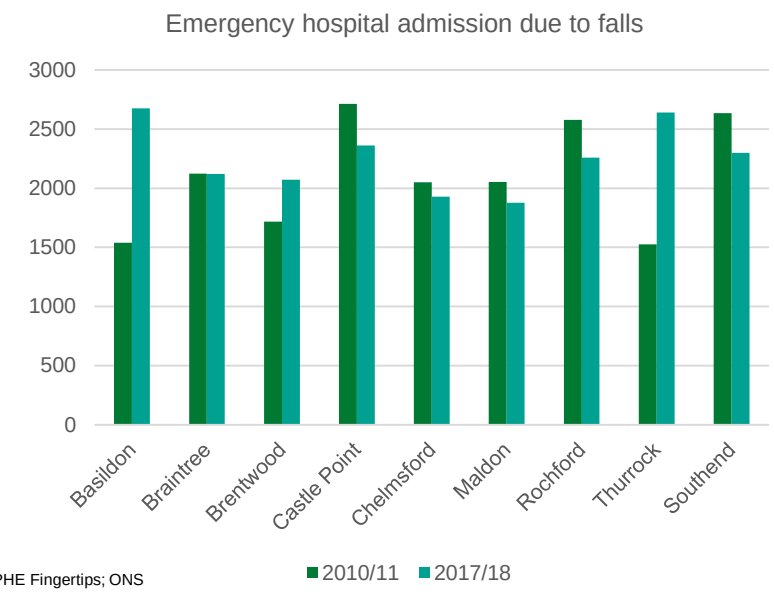
Emergency hospital admissions due to falls is projected to consistently increase in Braintree and Southend.

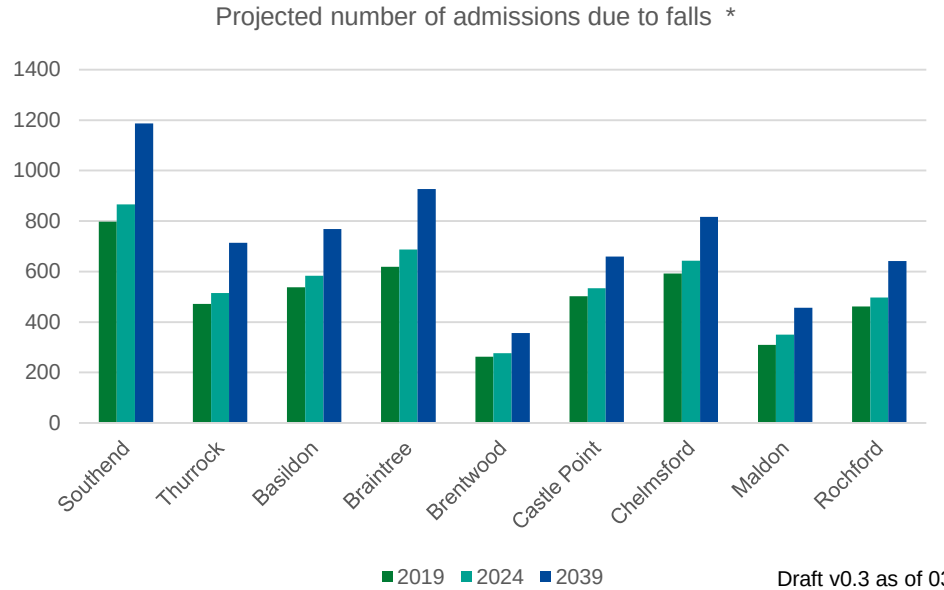
LATEST PICTURE	
Essex	England
2059	2170

The rate of emergency hospital admissions due to falls among residents aged over 65 years was the highest in Basildon and Thurrock. These local authorities also showed the largest rate increase since 2010/11. In contrast, Castle Point had the third highest rate but also the largest decrease over time.

From 2019 to 2024 and 2039, the count is estimated to increase across the STP if the rate remains the same due to projected population sizes. Over the next 5 and 20 years, the largest increase is forecast for Southend and Braintree.

Overall, it would be expected that there would be **consistently increasing service demand** due to falls and hip fractures in **Braintree** and **Southend.**





Source: PHE Fingertips; ONS

Southend-on-Sea and Rochford had the largest EWM and dementia diagnosis rate, and respective growths.

LATEST PICTURE (Dementia)	
Essex	England
61.1	67.5

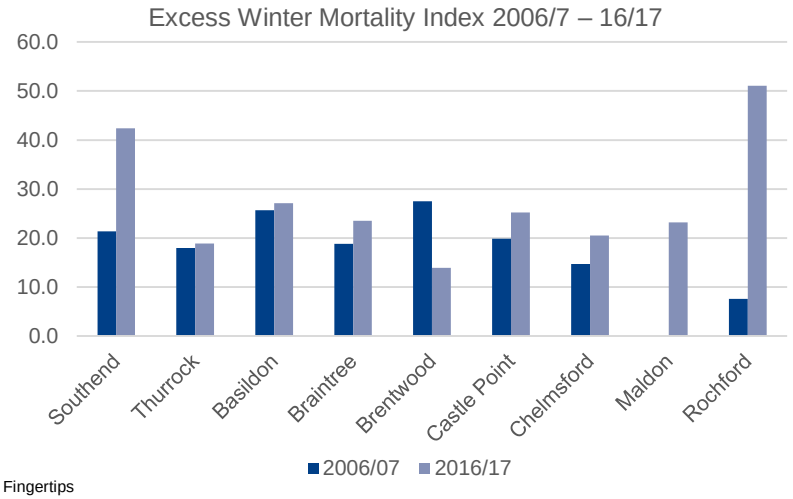
Southend-on-Sea and Rochford had the highest excess winter mortality index (EWM) of 2016/17 across Mid and South Essex STP.

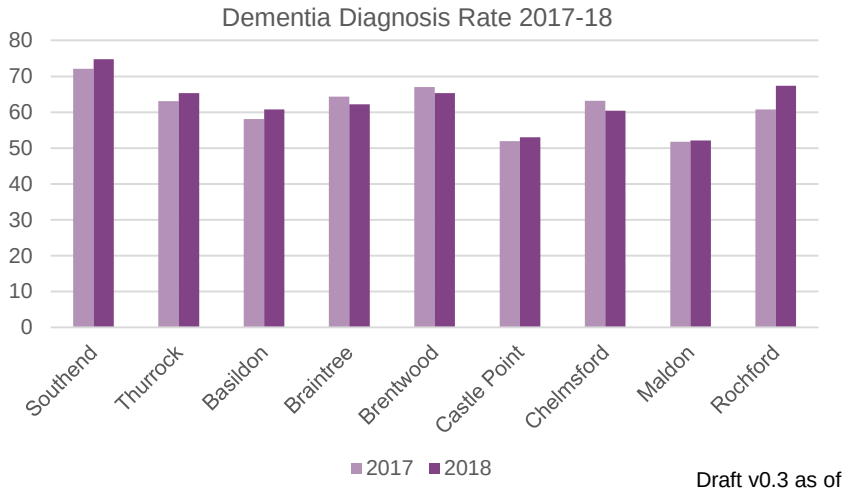
These local authorities also had the largest percentage growth in excess winter mortality since 2006/7, with an increase of 21% in Southend-on-Sea and 44% in Rochford. Brentwood was the only local authority with decreased excess winter mortality.

Among those aged over 65 years, the estimated dementia diagnosis rate in 2018 was also the highest in Southend-on-Sea and Rochford.

The rate has increased since 2017 in most local authorities of the STP, with the largest increase also in Southend-on-Sea (2.7) and Rochford (6.6). Decreases were seen in Braintree, and Chelmsford; the largest was in Chelmsford at -2.8, the locality with the lowest rate of 2018.

In comparison, the rate remained relatively stable across Essex (0.6) and England (-0.4).





Source: PHE Fingertips

Mental Health

Essex County Council

Basildon and Southend-on-Sea have the highest prevalence of mental health conditions among adults and children.

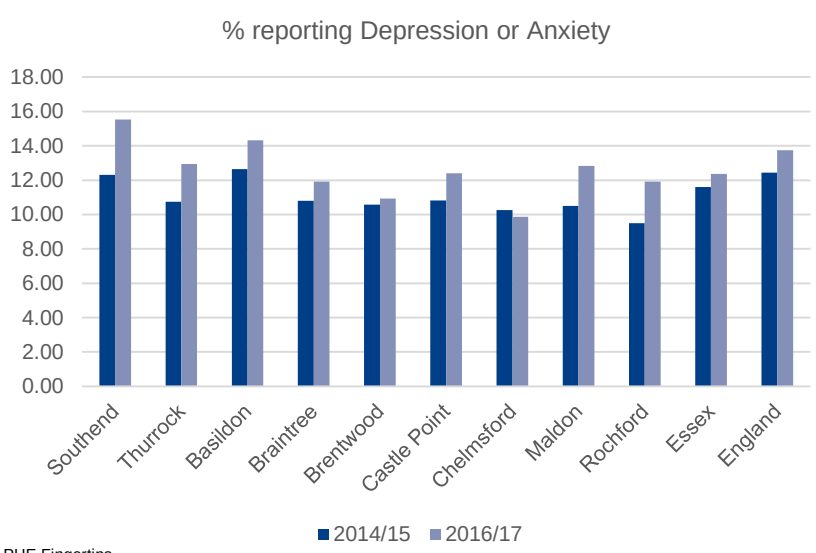
LATEST PICTURE	
Essex	England
12.4	13.7

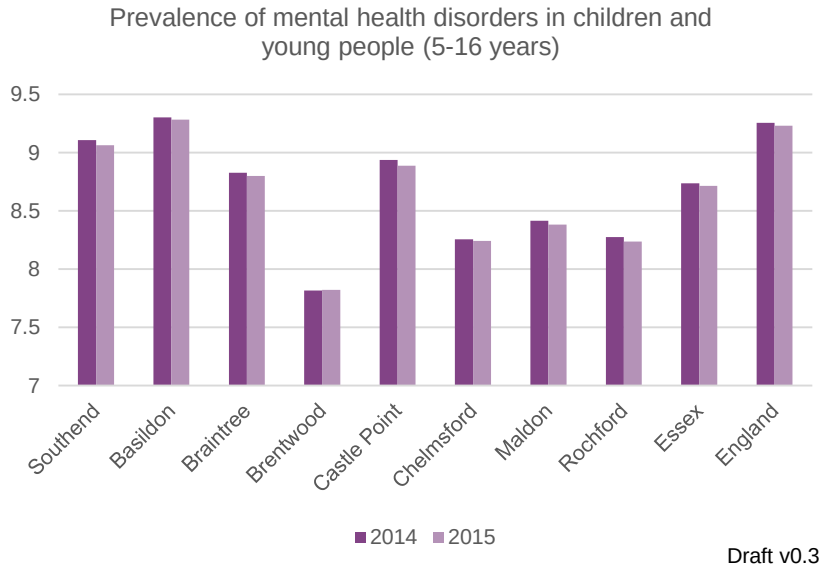
LATEST PICTURE	
Essex	England
8.7	9.2

In 2016/17 Southend-on-Sea and Basildon has the highest levels of Depression or Anxiety across Mid and South Essex STP. Southend-on-Sea also had the largest percentage increase since 2014/15 (+3.24%) In contrast, the Chelmsford District was the only locality to show a decrease in level since 2014/15 and had the lowest levels of Depression and Anxiety of 2016/17.

However, all local authorities increased more than the England and Essex average except for Brentwood.

The estimated prevalence of mental health disorders among children and young people aged between 5 to 16 years has remained relatively stable since 2014 across England, Essex and the Mid and South Essex STP. In 2015, the highest prevalence was in Basildon and Southend-on-Sea but all local authorities prevalence's was similar to that for Essex and England.





Source: PHE Fingertips

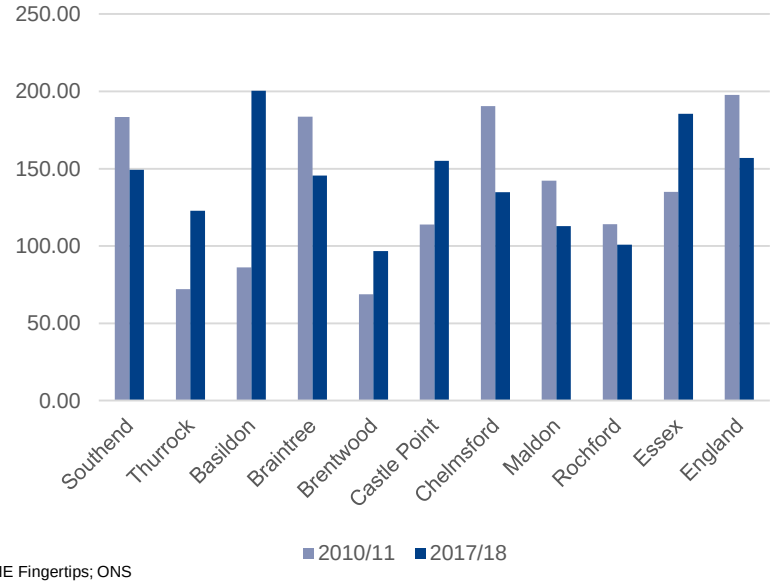
Basildon has the highest current rate of hospital admissions for self-harm and has increased most, and is forecast to continue to do so.

LATEST PICTURE	
Essex	England
157	185.5

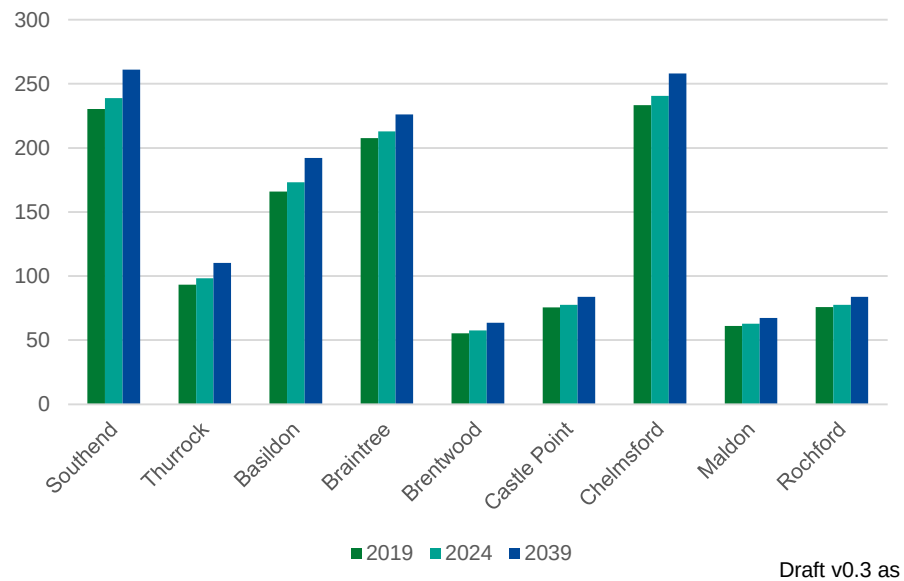
In 2017/18, Basildon, Southend-on-Sea and Castle Point had the three highest rates per 100,000 population of emergency hospital admissions due to intentional self-harm, and the rate in Basildon was higher than that across Essex and England. Basildon also showed the largest rate increase since 2010/11, larger than that across Essex (+50.42) and England (-40).

Based on population estimates, the number of emergency hospital admissions due to self-harm is likely to increase if the rate remains the same. Southend-on-Sea and Chelmsford are forecast to consistently have the highest count of admissions from 2019. However, over the two time periods, it is estimated that Thurrock and Basildon will show the largest percentage growth in count.

Emergency hospital admissions due to intentional self-harm (2010/11 - 2017/18)



Projected count of emergency admissions due to self-harm *



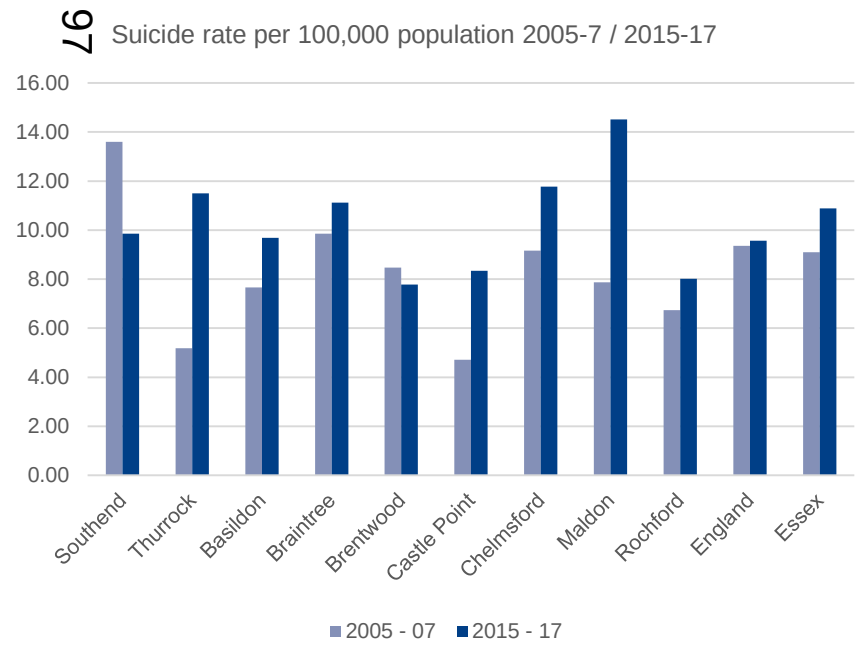
Source: PHE Fingertips; ONS

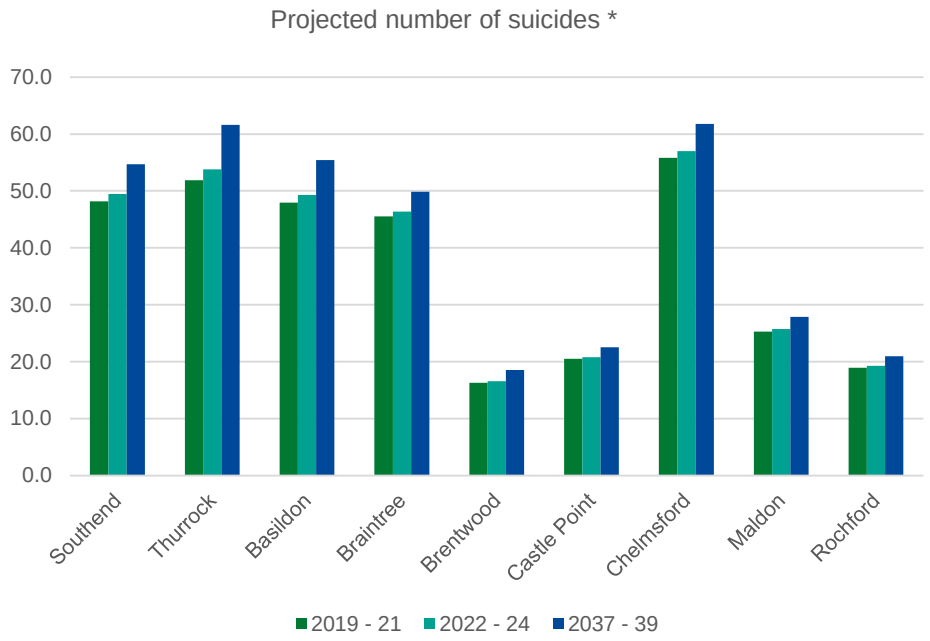
Thurrock will continue to have a high and growing suicide rate.

LATEST PICTURE	
Essex	England
10.88	9.57

The highest suicide rate per 100,000 population was in Maldon, Thurrock and Chelmsford in 2015/17. Maldon and Thurrock also showed the largest rate increase since 2005/7, and increased quicker than that across Essex and England.

Maldon, Thurrock and Chelmsford are also estimated to have highest suicide count across the Mid and South Essex local authorities if the rate of suicide remains similar due to projected population sizes. From 2019-21 estimates, Thurrock is also forecast to consistently show the largest count increases along with Basildon.





Source: PHE Fingertips; ONS

Learning Disability

Essex County Council

Basildon and Thurrock will likely be key areas to target for supporting residents with Learning Disability.

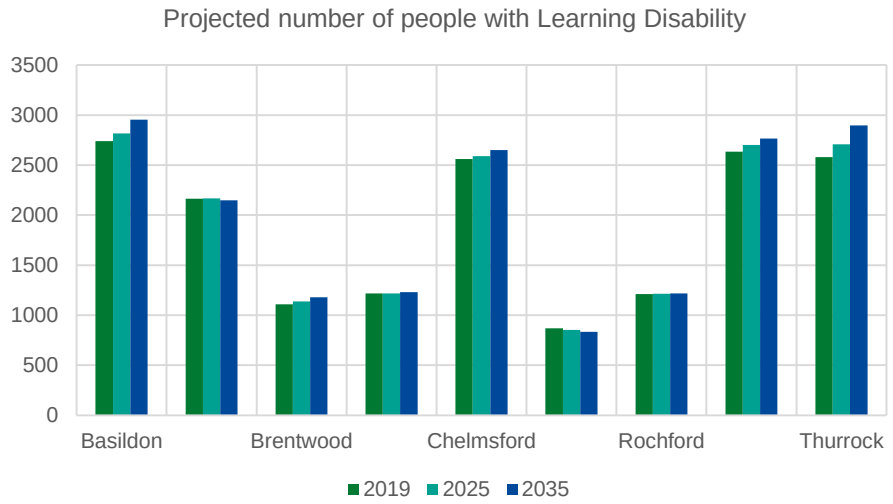
The total number of people aged between 18 and 64 years predicted to have a Learning Disability is forecast to increase across Mid and South Essex STP from 2019, and more so than that across England.

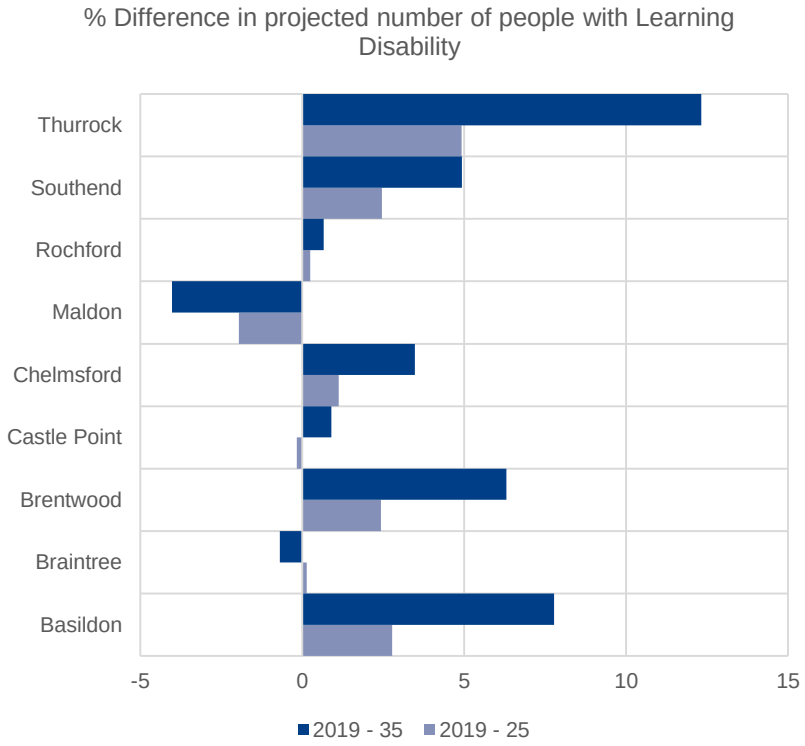
Basildon, Southend and Thurrock are forecast to consistently have the highest number of residents with Learning Disability.

Basildon and Thurrock are also forecast to show the largest percentage increase from 2019 over both time points.

Similar patterns are seen for number of residents with Severe Learning Disability (see Appendix C).

Leaning Disability (18-64)	2019 # Predicted	2025		2035	
		# Predicted	% +/- from 2019	# Predicted	% +/- from 2019
Total STP	17090	17401	1.82	17879	4.62
England	826834	833689	0.83	842807	1.93
Essex	21059	21467	1.94	22030	4.61





Source: PANSI

Appendix A

Population estimates and % changes from 2017 across Mid and South Essex STP by five year age groups.

Essex County Council

Age Group	STP					Basildon				
	2017	2024		2039		2017	2024		2039	
		Estimate	% Change	Estimate	% Change		Estimate	% Change	Estimate	% Change
0-4	71922	71900	-0.03	73800	2.61	12632	12900	2.12	13500	6.87
5-9	75030	75700	0.89	75600	0.76	12346	13300	7.73	13400	8.54
10-14	69195	78400	13.30	78900	14.03	11067	12900	16.56	13500	21.98
15-19	64286	70900	10.29	76400	18.84	10374	11400	9.89	12900	24.35
20-24	61310	55800	-8.99	66800	8.95	9984	9200	-7.85	11500	15.18
25-29	71002	67700	-4.65	76100	7.18	12297	11900	-3.23	13500	9.78
30-34	73828	76200	3.21	76100	3.08	12499	13500	8.01	13600	8.81
35-39	76370	81800	7.11	73300	-4.02	12374	14000	13.14	12700	2.63
40-44	76968	81500	5.89	81800	6.28	11896	13200	10.96	13700	15.16
45-49	86234	77200	-10.48	88100	2.16	13020	12200	-6.30	14400	10.60
50-54	87029	83400	-4.17	89100	2.38	13119	12500	-4.72	14300	9.00
55-59	75818	86800	14.48	84600	11.58	11541	13000	12.64	13200	14.37
60-64	65116	78400	20.40	76900	18.10	9528	11700	22.80	11800	23.85
65-69	64847	65600	1.16	79100	21.98	9123	9700	6.32	11500	26.06
70-74	60753	58700	-3.38	78800	29.71	8338	8100	-2.85	11200	34.32
75-79	39939	59100	47.98	67600	69.26	5623	8000	42.27	9500	68.95
80-84	30892	36600	18.48	50000	61.85	4525	4900	8.29	6900	52.49
85-89	19486	23000	18.03	34700	78.08	2737	3100	13.26	4400	60.76
90+	11100	13100	18.02	27400	146.85	1456	1700	16.76	3300	126.65

Age Group	Braintree					Brentwood				
	2017	2024		2039		2017	2024		2039	
		Estimate	% Change	Estimate	% Change		Estimate	% Change	Estimate	% Change
0-4	8631	8400	-2.68	8300	-3.84	4416	4700	6.43	4800	8.70
5-9	9760	8900	-8.81	8600	-11.89	4411	5000	13.35	5000	13.35
10-14	9005	9700	7.72	9000	-0.06	4443	5000	12.54	5500	23.79
15-19	8203	9000	9.72	8700	6.06	4197	4300	2.45	5100	21.52
20-24	7217	6600	-8.55	7300	1.15	3720	3300	-11.29	3900	4.84
25-29	8643	8000	-7.44	8800	1.82	4437	4400	-0.83	4900	10.43
30-34	9062	9200	1.52	9100	0.42	4465	5000	11.98	4900	9.74
35-39	9303	9800	5.34	8700	-6.48	4848	5500	13.45	5000	3.14
40-44	9645	9800	1.61	9600	-0.47	5000	5500	10.00	5700	14.00
45-49	11451	9400	-17.91	10500	-8.30	5576	5300	-4.95	6300	12.98
50-54	11745	11000	-6.34	10700	-8.90	6044	5500	-9.00	6300	4.24
55-59	9986	11800	18.17	10500	5.15	5244	5700	8.70	5700	8.70
60-64	8986	10700	19.07	9800	9.06	4210	5300	25.89	5000	18.76
65-69	8922	9000	0.87	10800	21.05	4003	4100	2.42	4700	17.41
70-74	8198	8200	0.02	10900	32.96	3942	3500	-11.21	4800	21.77
75-79	5134	8000	55.82	9300	81.15	2656	3700	39.31	4300	61.90
80-84	3759	5000	33.01	7000	86.22	2374	2500	5.31	3300	39.01
85-89	2508	3000	19.62	5100	103.35	1642	1800	9.62	2400	46.16
90+	1519	1800	18.50	4100	169.91	947	1200	26.72	2200	132.31

Age Group	Castle Point					Chelmsford				
	2017	2024		2039		2017	2024		2039	
		Estimate	% Change	Estimate	% Change		Estimate	% Change	Estimate	% Change
0-4	4503	4700	4.37	4700	4.37	10272	10100	-1.67	10200	-0.70
5-9	4845	5100	5.26	5100	5.26	10971	10600	-3.38	10700	-2.47
10-14	4724	5400	14.31	5600	18.54	10348	11500	11.13	11400	10.17
15-19	4885	5000	2.35	5600	14.64	9270	10400	12.19	11100	19.74
20-24	4756	4200	-11.69	4900	3.03	9378	8600	-8.30	10100	7.70
25-29	4881	4600	-5.76	5100	4.49	11071	10300	-6.96	11500	3.87
30-34	4553	4900	7.62	4700	3.23	11555	11600	0.39	11500	-0.48
35-39	4622	5100	10.34	4600	-0.48	11808	12400	5.01	11100	-6.00
40-44	5035	5100	1.29	5400	7.25	11788	12500	6.04	12400	5.19
45-49	6172	5100	-17.37	5900	-4.41	12931	11600	-10.29	13200	2.08
50-54	6613	5900	-10.78	6200	-6.25	12636	12200	-3.45	12900	2.09
55-59	6096	6800	11.55	6100	0.07	11147	12200	9.45	12100	8.55
60-64	5638	6500	15.29	6000	6.42	9621	11100	15.37	10600	10.18
65-69	6259	5900	-5.74	6700	7.05	9386	9400	0.15	10900	16.13
70-74	6329	5700	-9.94	7100	12.18	8931	8400	-5.95	10700	19.81
75-79	4200	6100	45.24	6300	50.00	5788	8800	52.04	9500	64.13
80-84	3093	3800	22.86	4600	48.72	4712	5400	14.60	7500	59.17
85-89	1714	2200	28.35	3200	86.70	2964	3600	21.46	5200	75.44
90+	896	1100	22.77	2400	167.86	1617	2000	23.69	4400	172.11

Age Group	Maldon					Rochford				
	2017	2024		2039		2017	2024		2039	
		Estimate	% Change	Estimate	% Change		Estimate	% Change	Estimate	% Change
0-4	2973	3100	4.27	3100	4.27	4134	4300	4.02	4400	6.43
5-9	3421	3300	-3.54	3300	-3.54	4818	4700	-2.45	4800	-0.37
10-14	3414	3500	2.52	3600	5.45	4860	5200	7.00	5300	9.05
15-19	3446	3300	-4.24	3400	-1.33	4705	5000	6.27	5200	10.52
20-24	2870	2400	-16.38	2700	-5.92	4418	3900	-11.72	4500	1.86
25-29	3105	2900	-6.60	3000	-3.38	4697	4400	-6.32	4800	2.19
30-34	2739	3000	9.53	2900	5.88	4172	4700	12.66	4700	12.66
35-39	3147	3300	4.86	3000	-4.67	4706	5100	8.37	4700	-0.13
40-44	3669	3400	-7.33	3600	-1.88	5354	5300	-1.01	5500	2.73
45-49	4886	3700	-24.27	4200	-14.04	6619	5300	-19.93	6100	-7.84
50-54	5253	4800	-8.62	4500	-14.33	6758	6400	-5.30	6300	-6.78
55-59	4838	5500	13.68	4600	-4.92	5980	6800	13.71	6100	2.01
60-64	4500	5200	15.56	4700	4.44	5249	6300	20.02	5900	12.40
65-69	4709	4800	1.93	5300	12.55	5402	5500	1.81	6600	22.18
70-74	4453	4300	-3.44	5700	28.00	5406	5000	-7.51	6700	23.94
75-79	2754	4400	59.77	4800	74.29	3615	5300	46.61	5900	63.21
80-84	1990	2600	30.65	3700	85.93	2798	3300	17.94	4300	53.68
85-89	1161	1500	29.20	2500	115.33	1655	2000	20.85	3000	81.27
90+	647	700	8.19	1900	193.66	863	1100	27.46	2200	154.92

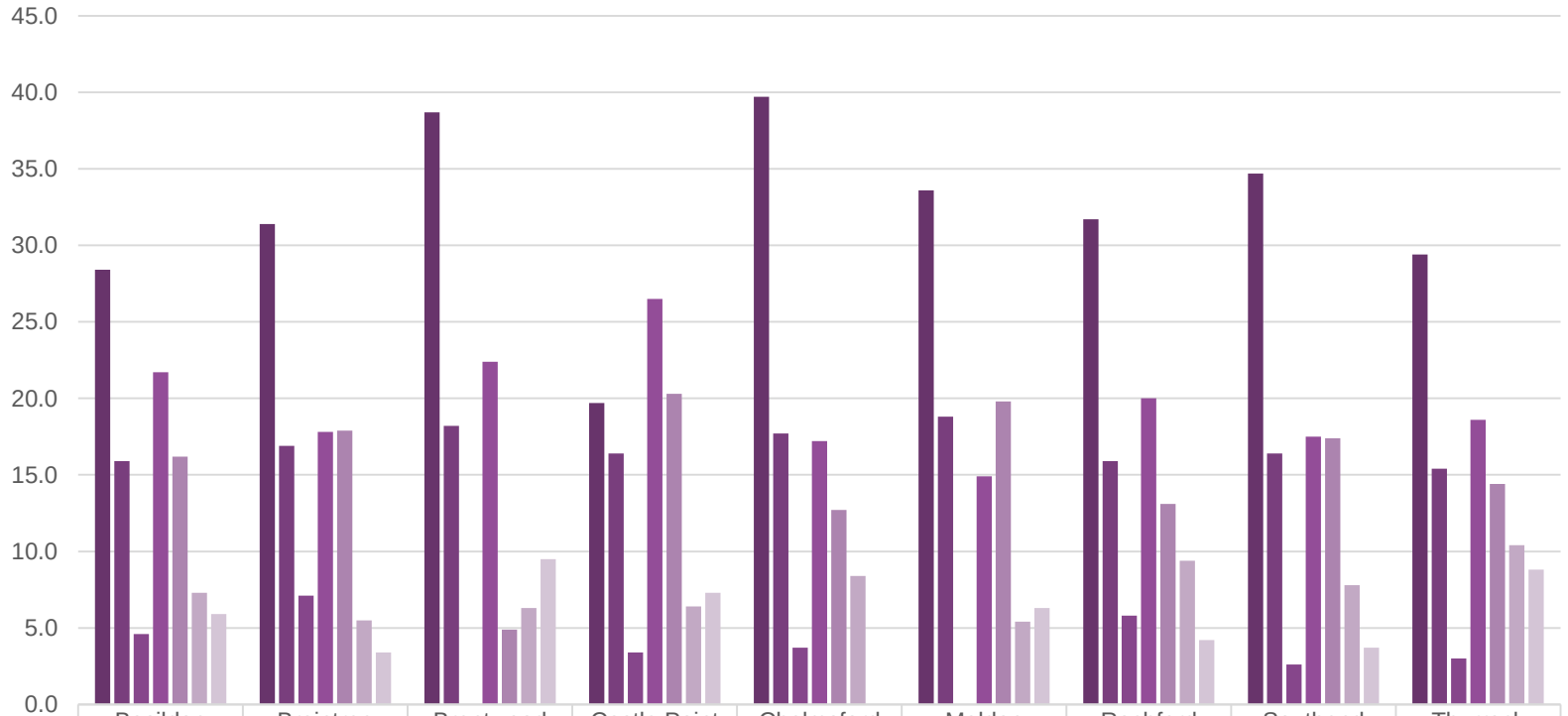
Age Group	Southend-on-Sea					Thurrock				
	2017	2024		2039		2017	2024		2039	
		Estimate	% Change	Estimate	% Change		Estimate	% Change	Estimate	% Change
0-4	11329	11000	-2.90	11400	0.63	13032	12700	-2.55	13400	2.82
5-9	11604	11400	-1.76	11300	-2.62	12854	13400	4.25	13400	4.25
10-14	10267	11800	14.93	11500	12.01	11067	13400	21.08	13500	21.98
15-19	9647	10800	11.95	11300	17.13	9559	11700	22.40	13100	37.04
20-24	9542	8700	-8.82	10300	7.94	9425	8900	-5.57	11600	23.08
25-29	10589	10300	-2.73	11500	8.60	11282	10900	-3.39	13000	15.23
30-34	11764	11600	-1.39	11600	-1.39	13019	12700	-2.45	13100	0.62
35-39	12621	12700	0.63	11200	-11.26	12941	13900	7.41	12300	-4.95
40-44	12387	13100	5.76	12600	1.72	12194	13600	11.53	13300	9.07
45-49	13254	12100	-8.71	13400	1.10	12325	12500	1.42	14100	14.40
50-54	12976	13000	0.18	13700	5.58	11885	12100	1.81	14200	19.48
55-59	11503	13300	15.62	13300	15.62	9483	11700	23.38	13000	37.09
60-64	9527	12000	25.96	12100	27.01	7857	9600	22.18	11000	40.00
65-69	9632	9800	1.74	12600	30.81	7411	7400	-0.15	10000	34.93
70-74	8917	8900	-0.19	12400	39.06	6239	6600	5.79	9300	49.06
75-79	6104	8800	44.17	10700	75.29	4065	6000	47.60	7300	79.58
80-84	4718	5600	18.69	7700	63.20	2923	3500	19.74	5000	71.06
85-89	3254	3700	13.71	5500	69.02	1851	2100	13.45	3400	83.68
90+	2173	2400	10.45	4700	116.29	982	1100	12.02	2200	124.03

Appendix B

Percentage in employment in 2018 by qualification level.

Essex County Council

% in employment by qualification level in 2018 (ONS Nomis, APS)



	Basildon	Braintree	Brentwood	Castle Point	Chelmsford	Maldon	Rochford	Southend	Thurrock
NVQ4	28.4	31.4	38.7	19.7	39.7	33.6	31.7	34.7	29.4
NVQ3	15.9	16.9	18.2	16.4	17.7	18.8	15.9	16.4	15.4
Trade Apprenticeship	4.6	7.1	0	3.4	3.7	0	5.8	2.6	3.0
NVQ2	21.7	17.8	22.4	26.5	17.2	14.9	20.0	17.5	18.6
NVQ1	16.2	17.9	4.9	20.3	12.7	19.8	13.1	17.4	14.4
Other	7.3	5.5	6.3	6.4	8.4	5.4	9.4	7.8	10.4
No Qualification	5.9	3.4	9.5	7.3	0	6.3	4.2	3.7	8.8

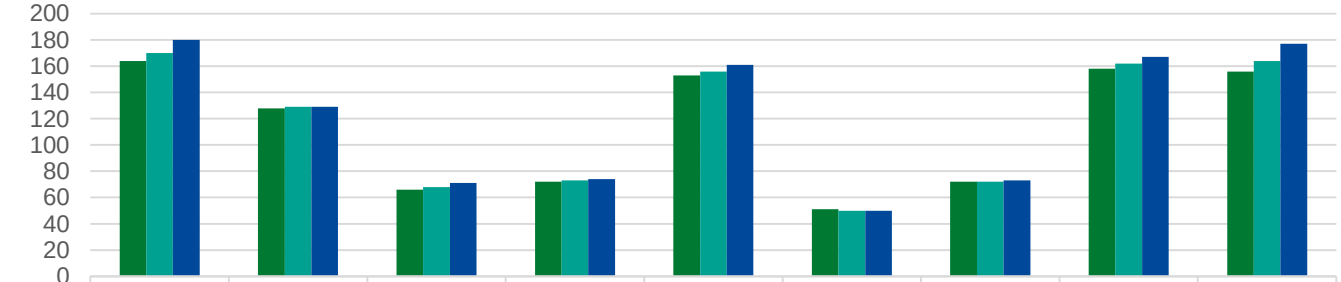
Appendix c

Predicted number of residents with Severe Learning Disability.

Essex County Council

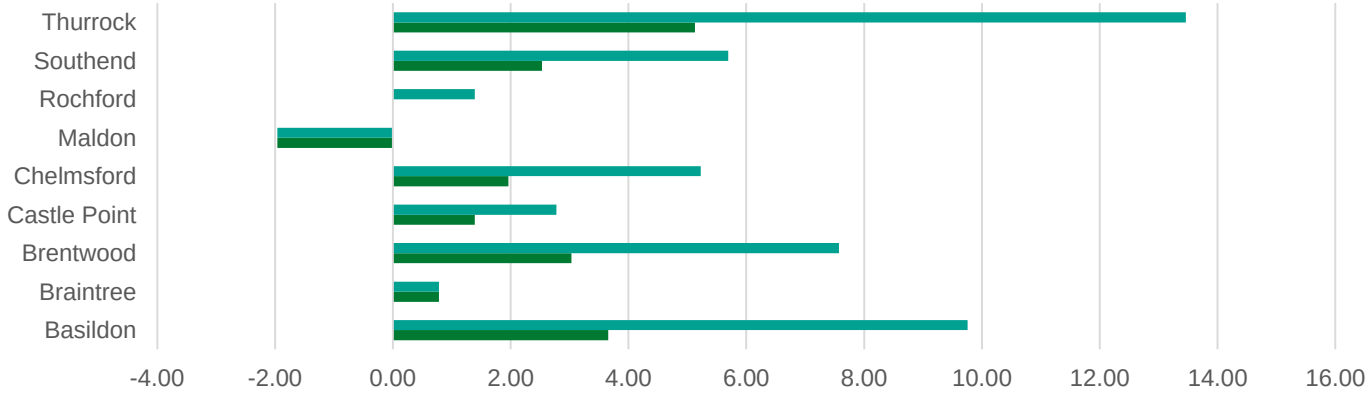
Severe Leaning Disability (18-64)	2019 # Predicted	2025 # Predicted	2025 % +/- from 2019	2035 # Predicted	2035 % +/- from 2019
Total STP	1020	1044	2.35	1082	6.08
England	49878	50500	1.25	51631	3.51
Essex	1257	1287	2.39	1336	6.28

Predicted number with Severe Learning Disability



	Basildon	Braintree	Brentwood	Castle Point	Chelmsford	Maldon	Rochford	Southend	Thurrock
2019	164	128	66	72	153	51	72	158	156
2025	170	129	68	73	156	50	72	162	164
2035	180	129	71	74	161	50	73	167	177

Percentage change from 2019 estimates of Severe Learning Disability



	Basildon	Braintree	Brentwood	Castle Point	Chelmsford	Maldon	Rochford	Southend	Thurrock
2019-35	9.76	0.78	7.58	2.78	5.23	-1.96	1.39	5.70	13.46
2019-25	3.66	0.78	3.03	1.39	1.96	-1.96	0.00	2.53	5.13

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28 June 2019	ITEM: 7
Health and Wellbeing Board	
Integrated Medical Centres – Progress Report	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Cllr Halden, Portfolio Holder Health and Education / Cllr Mark Coxshall, Portfolio Holder Regeneration	
Accountable Head of Service: Roger Harris, Corporate Director of Adults, Housing and Health	
Accountable Director: Detlev Munster, Assistant Director Property, Regeneration and Development	
This report is Public	

Executive Summary

The Council and partners in the health sector have been working together to develop a new model of care. This will provide an integrated health and social care service, delivered from modern, high quality premises and able to attract the best staff.

Four new Integrated Medical Centres are proposed with the intention of locating the new model of care in the heart of the communities that they serve, thereby bringing a greater range of health and care services under one roof so as to improve and simplify care pathways for patients.

Good progress continues to be made with planning, financing and service transformation for all four Integrated Medical Centres, and dedicated programme management is now in place. This report updates the Health and Well-Being Board on progress of the programme, and with each of the centres, and also the work being undertaken which may result in a new integrated health centre in South Ockendon.

1. Recommendation(s)

1.1 The Health and Well-Being Board is asked to consider and note this report.

2. Introduction and Background

2.1 The Health and Well-Being Board will be aware that the quality of health provision in several areas of the Borough falls below the standards that the Council and National Health Service partners would like to see delivered. The Council, with its health partners, have an exciting opportunity to address this and improve the health and well-being of the population of Thurrock by moving from outdated facilities and fragmented services, improving the capacity and capability of primary, community and mental health care, and delivering an integrated health, social care and community/third sector care model with Thurrock's residents at its heart.

2.2 To this end the Council entered into a Memorandum of Understanding (May 2017) with Basildon and Thurrock Hospitals NHS Foundation Trust, Essex Partnership University NHS Foundation Trust, North East London NHS Foundation Trust, and Thurrock Clinical Commissioning Group. This ensured that our strategy locally evolved from the broad concept of Integrated Healthy Living Centres into a firm commitment to deliver four new Integrated Medical Centres in Thurrock. A dedicated programme management resource, reporting to an alliance of the Council and health partners, has recently been commissioned to oversee delivery of the Integrated Medical Centres.

2.3 The Integrated Medical Centres will serve local populations and will be located in:

- Tilbury - to primarily serve Tilbury and Chadwell;
- Corringham – to primarily serve Stanford and Corringham;
- Grays – to primarily serve Grays but also to act as a Central Hub for the whole of Thurrock; and
- Purfleet – to primarily serve Purfleet, Aveley and South Ockendon.

2.4 The Council has been working with the Thurrock Clinical Commissioning Group and health providers to develop the concept of Integrated Medical Centres which will provide an integrated

model of care, in high quality premises located in the communities that they serve. The Integrated Medical Centres, will be crucial to the introduction of the new model of care as presented by the Director of Public Health, including the new Primary Care offer, Well-Being Teams and Technology Enabled Care.

2.5 Discussions have been held with health partners over the future provision of community mental health services with the aim of improving accessibility. The Mental Health Peer Review in 2018 was clear that, where possible, mental health provision should be integrated into the proposed Integrated Medical Centres and officers are now working to see this implemented.

3. Issues, Options and Analysis of Options

The Operating Model for the Integrated Medical Centres Programme

3.1 The new model of service provision which will be delivered from the Integrated Medical Centres is focussed on integration of services across provider boundaries. With the exception of the primary care areas (which have a distinct funding mechanism), providers will not have dedicated rooms that may stand empty outside of set clinic hours, rather rooms will be multifunctional and therefore interchangeable across services. Maximising the use of the space and limiting void time will support the affordability of the Centre for providers and reinforce the integration of services. It will also require a move away from a typical head lease/sub lease arrangement as services taking the sub leases will not have defined square metre areas on which to base sub lease valuations.

3.2 Providers are currently working together to establish a set of finance principles which seek to share the risk and rewards created as a result of actual occupancy levels when the Integrated Medical Centres are operational, and reflecting this principle of shared spaces. The shared approach to risk incentivises all partners to maintain utilisation of the Centres. These broad principles are accepted by all partners in the Thurrock Integrated Care Alliance. Thurrock Integrated Care Alliance is the overall umbrella group established by all National Health Service partners and the Council locally to take forward our integrated health and care agenda. An agreement to define these principles is currently

being drafted and once agreed in final form will be the basis of the financial structure across all four Integrated Medical Centres.

3.3 To ensure this shared approach results in effective, efficient and economic use of space, Public Health are finalising details of all expected health and social care service activity data for the Integrated Medical Centres:

- Service activity across Thurrock will be apportioned to each Integrated Medical Centre;
- Health planners will then be engaged to finalise the design requirements.

3.4 Consideration is being given to services operating at different times to improve space utilisation, along with new ways of working, maximising agile working and the use of Technology Enabled Care including Telecare and Tele-medicine. This work is integral to the development of Integrated Medical Centres. When completed, confirmation of design requirements from all parties can be sought, and funding and other commitments agreed. Thurrock Clinical Commissioning Group has agreed in principle to commit growth monies to support the funding of the Integrated Medical Centres.

3.5 The decision taken by the July 2018 meeting of the Joint Clinical Commissioning Group Committee to close Orsett Hospital and re-locate services into the community potentially further supports the need to develop Integrated Medical Centres in a timely manner. However, this decision has been referred to the Secretary of State and, it is understood, he has referred the matter to Lord Ribeiro for a screening assessment by 19 July 2019. Obviously, the plans for the Integrated Medical Centres cannot be finalised until the matter is determined.

Tilbury and Chadwell Integrated Medical Centre

3.6 The aspiration to deliver four Integrated Medical Centres in 2020/21 remains challenging. However, since the Council took the decision to lead on the delivery of the Tilbury and Chadwell Integrated Medical Centres on the site of the Community Resource Centre in Tilbury work has progressed significantly. The financing of this scheme has been modelled by the Council using prudential borrowing.

3.7 The Council, Thurrock Clinical Commissioning Group and health service providers have worked collaboratively to develop a schedule of accommodation that can be provided at Tilbury and Chadwell Integrated Medical Centre. This accommodation schedule fully subscribes to the integrated vision and includes provision for:

- Multi-functional consultation and examination rooms;
- therapy rooms;
- treatment rooms;
- interview rooms;
- group rooms;
- phlebotomy bay;
- mobile imaging docking bay;
- shared workspace;
- library;
- community hub; and
- public access meeting rooms.

3.8 The suite of flexible clinical rooms enables multiple services to make use of the space meaning patients can access the services they need on a single site. The community elements in the Integrated Medical Centre, including the library and community hub have a key role to play in addressing the wider determinants of health. This is supported by shared workspace which will allow staff from Council departments and other services to be based at the Integrated Medical Centre on a flexible basis, bringing the delivery of public services into the community and creating better opportunities for joined up working across professions and disciplines.

Stanford and Corringham Integrated Medical Centre

3.9 The delivery of the Stanford and Corringham Integrated Medical Centre, on the site of 105 The Sorrells, Stanford Le Hope, is being led and funded by North East London NHS Foundation Trust. Planning consent for this Integrated Medical Centre was secured in 2016 and amended in 2018 to extend the proposed opening hours.

3.10 The building will accommodate the following clinical services:

- General Practitioners (estimated 2,000 patient list size)
- Adult Services - Integrated Community Teams
- Diabetes Services
- Cardiac & Respiratory Services
- Therapy and Rehabilitation (including Hearing Therapy)
- Sexual Health Medicine
- End of Life and Palliative Care
- Children's Services
- Universal Children's Services
- Specialist Children's Services
- Community Children's Nursing Teams
- Therapy and Rehabilitation (including Speech and Language Therapy)
- Emotional Wellbeing Mental Health Service
- Visiting clinicians

3.11 A decision on the Business Case for the development is expected to be taken by the North East London NHS Foundation Trust Board imminently. As this Integrated Medical Centre already has consented development plans, there is a lesser dependency on the outcome of the referral of the decision to close Orsett Hospital. With an estimated build period of 15 months, it is anticipated that this Integrated Medical Centre could be operational from late 2021.

Purfleet Integrated Medical Centre

3.12 The Purfleet Integrated Medical Centre will be delivered as part of the wider Purfleet town centre regeneration scheme. An outline planning application which includes medical facilities was submitted in December 2017 and was approved in March this year. The Purfleet Integrated Medical Centre is part of the wider

Phase 1 development proposal submitted by Purfleet Centre Regeneration Ltd (PCRL), and reflects how key this is to the whole project.

3.13 Purfleet Centre Regeneration Ltd, the appointed developer for the scheme is committed to assisting with the delivery of the Integrated Medical Centre as part of the development. The schedule of accommodation is being finalised with partners and detailed design work will then commence (commissioned by Purfleet Centre Regeneration Ltd). The funding strategy for this Integrated Medical Centre is still to be finalised. Delivery of this Integrated Medical Centre is anticipated to be in 2022.

Grays Integrated Medical Centre

3.14 Thurrock Community Hospital has been designated as the new Integrated Medical Centre for Grays, and is the only Integrated Medical Centre which will be predominantly a refurbishment of an existing healthcare facility rather than an entirely new-build development. The site is owned by Essex Partnership University NHS Foundation Trust which leases part of the site to North East London NHS Foundation Trust, and third sector providers. The site currently has 19 separate buildings, with over half of the buildings vacant or underutilised which means the estate is inefficient in use and offers an opportunity to reconfigure and redesign to improve delivery.

3.15 A master planning exercise for the whole the current site has been undertaken with the support of the Council, and a range of options are under consideration. The layout of the site lends itself to the zoning of two main areas: a "Health Village", incorporating quieter and more long term activities, and a "Day Hub", the space where patients would come for appointments and more short term activities. ARCHUS (consultants) have now been commissioned by Essex Partnership University NHS Foundation Trust to undertake a further detailed costed development plan.

3.16 As the only site already built, Thurrock Community Hospital offers the opportunity to renovate and redesign facilities to accommodate services, with the potential to bring services on line in a shorter time frame.

3.17 Thurrock Clinical Commissioning Group is also in consultation with relevant primary care providers to try and ensure that there is a significant primary care service on site because until recently it was going to be the only Integrated Medical Centre without General Practice services at its core. These discussions are ongoing but health colleagues are confident of a positive outcome.

Integrated Medical Centres (Phase 2)

3.18 The Council is currently procuring the Design Team for a 21st Century Residential Facility on the White Acre/Dilkes Wood site on Daiglen Drive in South Ockendon. This is not an Integrated Medical Centre but may emerge as a related project which will improve health provision in Thurrock.

3.19 The South Ockendon Health Centre on Darenth Lane is adjacent to the White Acre/Dilkes Wood site and is currently occupied by a single handed General Practice, a branch surgery of an Aveley Practice, and a range of other clinical services including Health Visitors and dentists. Health partners have confirmed the building is no longer fit for purpose, and they see potential benefits in redeveloping the site to create a new health centre which could bring together other surgeries from the local area, and to equip it with a fuller range of primary care facilities as well as facilities for the local community. A series of workshops are currently being planned to explore the options.

4. Reasons for Recommendation

4.1 Delivery of the Integrated Medical Centres programme is essential to securing high quality health outcomes for Thurrock residents. The Council has agreed to take the lead on the delivery of the Tilbury and Chadwell Integrated Medical Centre and has already committed funding to the initial design phase. It remains closely involved in the design and delivery of all 4 Integrated Medical Centres, both through the overarching programme board, and its contribution to the development of each individual project.

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

5.1 Reports were presented to Planning, Transport and Regeneration Overview and Scrutiny Committee, and Health and Well-Being Overview and Scrutiny in September 2018. Further consultation on the specifics of each of the Integrated Medical Centres will be undertaken as part of the planning process.

5.2 Health Watch will be organising a People's Panel to gain public input into the development of all four Integrated Medical Centres.

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

6.1 The Integrated Medical Centres programme supports all three subsections of the 'People' element of the Council's corporate vision and priorities.

6.2 The programme also supports the four principles stated in the Thurrock Health and Wellbeing Strategy 2016-2021 and has a specific reference under 'Goal 4 Quality care, centred around the person' of the same strategy.

7. Implications

7.1 Financial

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

7.1.1 This report presents details of the current proposals for the development of 4 Integrated Medical Centres. Any financial implications related to the proposals in this report will be considered at the time decisions related to the proposals are to be taken.

7.2 Legal

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

7.2.1 This report presents details of the current proposals for the development of 4 Integrated Medical Centres. Any legal implications related to the proposals in this report will be considered at the time decisions related to the proposals are to be taken.

7.3 **Diversity and Equality**

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

7.3.1 The Integrated Medical Centres programme is crucial in addressing the health inequalities currently experienced in some areas of the Borough. All buildings developed as part of the programme will need to comply with equalities legislation and pay attention to the particular needs of the visitors to the centre a high proportion of whom are likely to be vulnerable.

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

7.4.1 The development of the Tilbury Integrated Medical Centre will allow staff from several Council departments to work in the community that they serve improving public access to vital services. There is a clear health benefit to pursuing this programme of work.

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):

- None

9. Appendices to the report

- None

Report Author:

Christopher Smith, Programme Manager, Adults, Housing and Health

28th June 2019	**ITEM:8**
Health and Wellbeing Board	
Prevention Concordat for Better Mental Health	
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 Head of Service:	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

This briefing paper gives an overview of the Prevention Concordat for Better Mental Health, including the rationale behind becoming a signatory and the process involved. Attached is the proposed submission which the Thurrock Health and Wellbeing Board would make in its application to become a signatory.

Recommendations

- **That the Health and Wellbeing Board endorse the activity outlined in the Prevention Concordat submission**
- **The Health and Wellbeing Board agree to sign the Prevention Concordat for 2019/20**
- **The Health and Wellbeing Board agree the named lead signatory.**

1 Introduction and Background

1.1 The Prevention Concordat for Better Mental Health was launched in 2018, and is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health

is shown to make a valuable contribution to achieving a fairer and more equitable society.

1.2 The concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities, and encourages actions that impact on the wider determinants of mental health and wellbeing.

1.3 The concordat is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across:

- local authorities
- the NHS
- public, private and third sector organisations
- educational settings
- employers

It represents a public mental health informed approach to prevention, as outlined in the NHS Five Year Forward View, and promotes relevant NICE guidance and existing evidence-based interventions and delivery approaches, such as 'making every contact count'.

1.4 Any partnership, organisation, community or alliance who has a commitment to prevention of mental health problems and promoting good mental health can become a signatory. Current signatory organisations range from Councils (e.g. Hertfordshire, Derby, Leeds etc), to schools (e.g. Shropshire) to Health and Wellbeing Boards (e.g. Doncaster, Warwickshire etc). One area [Oxfordshire] has pledged a number of its organisations at once – its Health and Wellbeing Board, its Clinical Commissioning Group, its district Councils, its hospital trust and its local Healthwatch to name a few.

1.5 The concordat has been endorsed by a number of wider organisations, a few examples include:

- Association of Directors of Public Health UK
- Faculty of Public Health
- Local Government Association
- National Institute for Health and Care Excellence
- NHS England
- Royal College of Psychiatrists

- Citizens Advice
- Homeless Link
- Housing Associations' Charitable Trust
- Mind
- National Suicide Prevention Alliance
- Samaritans
- Young People's Health Partnership

1.6 Organisations that sign the Prevention Concordat agree to the below principles:

1. *To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focussed leadership and action throughout the mental health system; and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.*
2. *There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equality.*
3. *We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.*
4. *We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of limited resources.*
5. *We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, as outlined in the Public Mental Health Leadership and Workforce Development Framework Call to Action[1].*
6. *We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.*
7. *We are committed to supporting local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers and the voluntary and community sector to adopt this Concordat and its approach.*

2 Rationale for Thurrock to sign the Concordat

2.1 Thurrock is already working collaboratively in a manner which the Concordat endorses. Examples of this which are listed in the full pledge submission include:

- *Implementation of a School Wellbeing Service to support whole school approach to mental health and enabling mentally healthy schools environment*
- *Implementation of a programme of service transformation for children and young people through the Open Up Reach Out Strategy 2010 -2020*
- *staff within our organisations are supported to work flexibly where possible, in order to promote a good work-life balance*
- *Thurrock Council has a strong Mental Health Staff Forum and an Anxiety Anonymous group where staff can talk to peers in a safe environment if they should wish to. There is also a high-profile wellbeing offer in place for staff to access.*
- *Mental Health First Aid training is being delivered and accessed by a number of relevant staff across organisations*
- *Thurrock Council have supported the start-up of a number of micro-enterprises, some of which focus on promoting good mental health in the community. One example is Reach Out for Mental Health, which provides a non-clinical out of hours outreach service for those who might feel overwhelmed but not want to access a statutory service.*
- *The existing approach to service delivery in Thurrock which focusses on assets and delivering support closer to home is transforming the way social care is delivered at a locality level, as well as the introduction of a wider range of workforce roles in primary care. During 2019/20, we will be working to embed these principles within mental health care, ensuring better recovery and resilience pathways are in place for those with poorer mental health, and that services & organisations in place to address the wider determinants of health are fully incorporated into this transformative programme of work.*

2.2 The principles in the pledge absolutely align with the approach we have already committed to undertake in both children's and adults mental health. We have got good partnership and collaborative working arrangements in place which recognise the roles we each have, and in particular we are committed to including the expertise

of people with lived experience and the third sector in our service transformation work. We have also got detailed action plans in place outlining how we propose to do this.

2.3 It is an opportunity to 'announce' nationally that our work programme and priorities are dedicated towards addressing the wider determinants of public mental health and supporting people to self-care as well as transforming service provision.

2.4 The process involved is not particularly complex (see section below) and will not require a large amount of ongoing scrutiny. It is not requiring Thurrock partners to do anything additional on top of what we have already agreed to do, as we stipulate the actions we will undertake.

3 Next Steps

3.1 Subject to Board approval, the next steps are:

- Confirm agreement on who the lead signatory should be [Chair of Health and Wellbeing Board, Director of Public Health or joint]
- Approved action plan is then emailed to publicmentalhealth@phe.gov.uk who will then review the plan, and if approved, publish it within the month.
- If approved as a signatory, we would then receive a formal letter and certificate, and our agreement would be announced in national communications led by Public Health England and published on the Prevention Concordat for Better Mental Health web page.

3.2 The next submission deadline is Wave 8 – **Wednesday 17th July 2019.**

3.3 Public Health England would make contact on an annual basis to update on our pledged areas should we wish to continue being listed as a signatory, but the process for this is not very lengthy.

4 Reasons for Recommendation

4.1 Publically declaring our intention for a prevention-focussed approach towards improving the mental health of our population is in alignment with our existing approaches. Signing the Prevention Concordat is an endorsement of this.

5 Consultation (including Overview and Scrutiny, if applicable)

5.1 Support for signing the Concordat was gained from internal Public Health Leadership Team and Adult, Health and Housing Directorate Management Teams. It will be presented to the Children's Directorate Management Team meeting on 19th June.

5.1 The Thurrock Mental Health Transformation Board also voiced initial support for the pledge to be signed.

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

6.1 The principles of the Concordat align with the 'People' priority [*People – a borough where people of all ages are proud to work and play, live and stay*.]

This means:

- high quality, consistent and accessible public services which are right first time
- building 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

6.2 It also aligns with Goal C of the Health and Wellbeing Strategy 2016-2021 [*Better Emotional Health and Wellbeing*].

7 Implications

7.1 Financial

There are no financial implications arising from this report.

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

7.2 Legal

There are no legal implications arising from this report.

Implications verified by: Judith Knight
Deputy Monitoring Officer

7.3 Diversity and Equality

The approach outlined in the pledge statements will address inequalities and seeks to promote a joint approach to preventing mental ill-health.

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

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

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

- A guide to signing the Prevention Concordat, Public Health England

9 Appendices to the report

- Draft Local Commitment Action Plan for Thurrock

Report Author:
Maria Payne
Strategic Lead for Public Mental Health and Adult Mental Health System Transformation
Public Health Team

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Public Health England

Protecting and improving the nation's health

Prevention Concordat for Better Mental Health: information required from signatories to the Consensus Statement

We are delighted that you are interested in becoming a signatory to the Prevention Concordat for Better Mental Health Consensus Statement. You will be joining a number of organisations who have committed to working together to prevent mental health problems and promote good mental health through local and national action.

The Prevention Concordat registration process

Step 1. Complete the local Prevention Concordat action plan template below (Attach any supporting documents that you may want to share**)**

Step 2. Senior leader/CEO of organisation to commit and sign up to approved action plan

Step 3 e-mail your submission to publicmentalhealth@phe.gov.uk

Step 4. Confirmation of receipt

Step 5. A panel will review and approve action plans submitted within one month of submission date;

- wave 8 – Wednesday 17th July 2019

NB: the team are currently reviewing the process for approving action plans and intend to have a digital process set up moving forward. Please see below.

Registration form

Please answer the questions below:

Lead contact name	Maria Payne Elozona Umeh
Lead contact details	Email: mpayne@thurrock.gov.uk / eumeh@thurrock.gov.uk Telephone number: 01375 652626
Job title of lead officer	Strategic Lead – Public Mental Health & Adult Mental Health Service Transformation Senior Public Health Programme Manager - Children
Name of organisation / partnership	Thurrock Health and Wellbeing Board
Who are you representing? *(e.g. Individual*	Multiple organisations – Thurrock Council, Thurrock CCG, Essex Partnership University Foundation Trust, Thurrock Healthwatch, North East London Foundation Trust

organisation, collaboration, partnership, Local Authority, Clinical Commissioning Group, community group and other, please name)	
Please tell us more about your organisation's work (no more than 150 words)	Thurrock's Health and Wellbeing Board is comprised of members and officers from the Council, Thurrock CCG, NHS England, the provider Foundation Trusts, Thurrock Healthwatch and the voluntary sector, The Board was established according to the Health and Care Act 2012 and has a duty to "encourage integrated working" between health and other public services in order to improve wellbeing outcomes for Thurrock. It is responsible for delivery of the Joint Strategic Needs Assessment (JSNA) and Thurrock's Health and Wellbeing Strategy 2016-21. With regard to mental health, Thurrock Health and Wellbeing Board receive reports from and provide a level of oversight to two key Groups that direct and govern mental health priorities locally. One is the Brighter Futures Steering Group, and the other is the Thurrock Mental Health Partnership Board (see further details on each of these in the submission below).
What are you currently doing that promotes better mental health?	Mental Health in both children and adults has been a key transformation priority for the Health and Wellbeing Board. In the last year, reports presented to the Council's Cabinet outlined a number of issues and proposed work programmes relating to mental health transformation, which received a great deal of support from Members. Following on from this, there is a large work programme with regard to mental health transformation underway. Whilst much of this focusses on service development to embed earlier intervention and prevention principles within, there is also work underway to support individuals to self-care, and use an asset-based approach to care where it is required. There is a separate workplan which details the above, but other examples include: - Public Health fund Exercise on Referral, with one specific pathway focussed for those with poor mental health - support to schools in rolling out the Daily Mile as a way of increasing physical activity in schoolchildren - Implementation of a School Wellbeing Service to support whole school approach to mental health and enabling mentally healthy school's environment - Implementation of a programme of service transformation for CYP through the Open Up Reach Out Strategy 2010 - 2020 - staff within our organisations are supported to work flexibly where possible, in order to promote a good work-life balance - Thurrock Council has a strong Mental Health Staff Forum

	and an Anxiety Anonymous group where staff can talk to peers in a safe environment if they should wish to. There is also a high-profile wellbeing offer in place for staff to access. - Mental Health First Aid training is being delivered and accessed by a number of relevant staff across organisations - Thurrock Council have supported the start up of a number of micro-enterprises, some of which focus on promoting good mental health in the community. One example is Reach Out for Mental Health, which provides a non-clinical out of hours outreach service for those who might feel overwhelmed but not want to access a statutory service.
Do you have or are you intending on producing a mental health plan or a mental health needs assessment.	**Yes** ☒ **No** ☐ If yes, please specify: We have produced local authority-led Joint Strategic Needs Assessments covering aspects of both children's and adult's mental health. The Children's Mental Health JSNA was focussed on exploring the protective and risk factors for poor mental health – so had a very strong preventative focus. The Adults Mental Health JSNA was focussed on Common Mental Health Disorders but also incorporated high risk groups. Adult Mental Health has a new Board workplan in place for 2019/20; and the workplan for Children's Mental Health will be developed following recruitment of the new School-based Wellbeing Service lead through the School Wellbeing Emotional Wellbeing Partnership Board.
The Prevention Concordat for better mental health highlights the five domain framework for local action **Please describe what are you planning to commit to in the next 12 months for your area** *(see * page 3 for examples to support completion of this section)*;	
1. Leadership and Direction	- For Adult Mental Health we have established a Thurrock Mental Health Transformation Board which is comprised of senior officers from the Local Authority (Public Health, Adult Social Care, Housing), Mental Health Trusts, third sector organisations and the CCG (Director of Commissioning chairs the Board). This Board will continue to meet bi-monthly throughout 2019/20. - The Board workplan contains a strong focus on developing a more holistic model of treating common mental health conditions in the community, and it is the ambition of the Board to have designed this model in collaboration with partners by the end of the financial year. - There is a Strategic Lead post within the Public Health team who was jointly appointed by Public Health, Adult Social Care and the CCG in order to coordinate mental health transformative work across organisations. - Thurrock CCG also lead the Mental Health agenda across the Mid and South Essex STP; so will be using this opportunity to embed Thurrock priorities into wider pieces of

	work such as the work on a new costed delivery plan setting out key care model, financial, workforce, capacity, digital and estates assumptions - Thurrock representatives work with colleagues across Essex and Southend on aspects of suicide prevention, and a new Board has been set up to provide governance for this. - The Council, CCG and schools and academies are collaboratively funding a Schools-Based Wellbeing Service to actively promote good mental health within schools, following the outcomes of the JSNA. There is a Brighter Futures Partnership Board in place comprising of senior officers from a number of relevant organisations, who will oversee the work of this service, through a sub-group CYP Emotional Wellbeing Partnership Board. The Team Leader for the service has recently been appointed and will be in post in June 2019 The intention is to have a full team establishment in place by September 2019.
2. Understanding local need and assets	- As mentioned above, we have JSNAs produced for both children's and adults mental health, and plans in place to act upon the key findings. During 2019/20, Public Health are also leading on a JSNA product focussing on self-care in adults, which will further support this approach. - Thurrock also participated in an LGA Peer Review in 2018 which gave further insight into priority areas. This has been discussed at a number of relevant Boards, including Health & Wellbeing Board, and was one of the drivers for the development of the transformative work underway around adult mental health. - The Emotional Wellbeing Forum and Healthwatch are represented on the Thurrock Mental Health Transformation Board and are therefore well-placed to support co-production and identification of assets – which is one of our key principles on the workplan for this year. - Thurrock has an existing Stronger Together Partnership approach with the voluntary sector, and this operates on a strong asset-based approach. Members of this are represented across the relevant operational work programmes in place to ensure this approach is replicated going forward. - Partners in Thurrock have invested into a new integrated data solution that links primary care, secondary care, mental health, community healthcare and social care data on NHS number in order to provide a single view of how patients interact with multiple services over time. Data from our IAPT and secondary mental health teams is flowing into this solution, and it is the aim to use this intelligence to better understand the 'trigger points' at which patients are most likely to relapse. - Work on the new care models for both community mental health and serious mental health conditions will incorporate aspects such as Housing, Employment, and physical health screening to incorporate knowledge of high risk groups. - There is work underway in Adult Social Care to better understand employee sickness activity with regard to poor mental health, and to align the current staff wellbeing offer

	with best practice nationally. This will be completed over the coming year. - Thurrock Public Health colleagues will be undertaking a suicide audit in conjunction with Essex and Southend colleagues to inform strategic priorities going forward, which will also align with national strategic priorities around suicide prevention. This will be completed by September 2019. - Much of the local data for Children and Young People comes from the Brighter Futures Survey (BFS). It is a survey focused on pupils in academic Years 5, 8 and 10. The survey provides quantitative data and insight into child and adolescent experiences, attitudes and development including issues related to mental health.
3. Working together	- The comprehensive workplan for Adult Mental Health details the extent to which organisations are working collaboratively. This has been endorsed via the Council mechanisms and the CCG Board, and is in the process of being endorsed by the relevant governance arms of the other partners. - For Children, there is a detailed work programme following the Open up Reach out Strategy which is monitored effectively through a Collaborative forum. The new service for schools is being monitored through the CYP Emotional Wellbeing Board which comprises of a range of senior officers across the CCG, Thurrock Council and schools and academies. - As mentioned above, a number of organisations have invested in embedding Mental Health First Aiders within their workforce. This work will continue for 2019/20.
4. Taking action	- The comprehensive workplan for Adult Mental Health details the actions we have committed to take, with clear quarterly milestones which will be monitored on a day-to-day basis by members of the Mental Health Operational Group, and overseen by the Mental Health Transformation Board. - Thurrock has already adopted an asset-based, community-focused approach to service delivery, which is transforming the way social care is delivered at a locality level, as well as the introduction of a wider range of workforce roles in primary care. During 2019/20, we will be working to embed these principles within mental health care, ensuring better recovery and resilience pathways are in place for those with poorer mental health, and that services & organisations in place to address the wider determinants of health are fully incorporated into this transformative programme of work. - A school wellbeing service delivery model is in place. Work is ongoing on a detailed operational delivery plan for this new service and will be available by September 2019. - There is a detailed implementation plan for the Open Up Reach Out Strategy which is being monitored through a collaborative approach. - The Emotional Wellbeing and Mental Health Service (EWMHS) was launched in November 2015 taking over from the old Child and Adolescent Mental Health Service

	(CAMHS) with the aim of providing a most integrated and accessible service to children and young people with mental ill-health.
5. Defining success	- The comprehensive workplan for Adult Mental Health details the outputs we expect to deliver by the end of 2019/20. - Work is currently underway to define a shared commissioning outcomes framework for mental health across the Council and CCG, which will be centred around holistic person-centred outcomes. This will be completed by the end of 2019/20. - The School Wellbeing Service being new will have a robust independent evaluation of its impact in improving mental health and wellbeing, building resilience and ensuring a mentally healthy school environment for children and young people as well as assessing the wider impact the service has on CYP mental health and wellbeing system, schools and children and young people. This evaluation will be conducted over a 3 year period. - The EWMHS service have a detailed service specification detailing outputs and monitored collaboratively. There also has been a recent independent evaluation of the service with information yet to be received. - The Health and Wellbeing Board will receive regular updates from the Mental Health Transformation Board relating to progress and achievements. In addition, one of the five priority goals for the Health and Wellbeing Strategy 2016-21 is “Better Emotional Health and Wellbeing”. This has four objectives which sit underneath it, each of which is measured by specific performance indicators: • A. Parents will be given the support they need when they need it • B. Children will have good emotional health and wellbeing • C. Fewer people will feel socially isolated or lonely • D. Identification and treatment of mental ill health, particularly those at high risk.
Is your organisation/ partnership happy to provide key impact headlines when contacted related to the commitment specified? Yes ☒ No ☐ *The purpose of this information is to support us to measure progress of the programme and inspire others. Information requests will not occur more than once a year.*	
Upload signature and organisation logo	

In your submission please attach any additional documents that you may want to share to support your commitments e.g. strategies, plans project outlines.

What do we mean by prevention planning?

You may already be doing excellent work in relation to prevention planning that you are eager to share however here are a few examples for you to think about

What does good look like; the framework for effective planning for better mental health in all local areas is evidence based and consists of five steps to delivery:

Steps	Partnerships	Organisations	Communities
Leadership and Direction	Identified lead organisation within the partnership for prevention of mental illness and promotion of good mental health Designated mental health prevention champion at a senior officer level in each organisation Shared vision statement for prevention and promotion that all have signed up to	Designated mental health prevention champion at a senior officer level in each organisation Support and development is given to roles that champion mental health prevention A clear vision for mental health promotion and prevention that fits across the whole organisation , involving all departments and functions and is integrated in all plans and strategies	An identified mental health prevention champion e.g. a local board member or community representative A shared vision and commitment to promote good mental health and prevent mental illness within the community Engagement within local partnerships to advocate for and meet community needs
Understanding local need and assets	Local Authority led Joint Strategic Needs Assessment with a mental health prevention focus Mental Health Equity Audits across the partnership Collaborative analysis of local information and intelligence	Mental health prevention needs assessment of targeted populations e.g. prison population, parents, Black and Minority Ethnic or Black, Asian and Minority Ethnic (BAME) , LGBTQ Engagement with communities to gain insight into their needs and assets	Asking questions of individuals, groups and families within the community about their mental health and wellbeing and what influences it e.g. use of WEMWEBs Engagement events and opportunities that enable citizens to share views and participate in decision making

	sharing Real time surveillance of suicide data Engagement with communities to gain insight into their needs and assets		
Working together	Working together in collaboration across a number of organisations on agreed prevention priorities, shared plans and strategies Involve local communities, including those with lived experience in planning;	Seeking collaboration with other organisations and working collaboratively within the organisation to address issues related to the promotion of mental wellbeing and the prevention of mental ill health e.g. multi agency suicide prevention plan, mental wellbeing plan Working with local communities and involving those with lived experience in planning	Coming together with other community groups and/or working with local partnerships Involving those with lived experience in planning and delivery
Taking action	Delivery of partnership plans and strategies Shared prioritisation and resources Mental Health Impact Assessments to integrate mental health prevention into partnership plans and strategies	Delivery of an organisational plan and/or strategy that has clear identified priorities and resource to support implementation. Prevention activity across the whole of the organisation Developing the workforce's knowledge and skills in promotion and prevention.	Programmes of local activity that promote better mental health. Enable citizens and communities to take action to promote better mental health.

Defining success	Agreed outputs and outcomes across all partners that demonstrate delivery of the plans , level of partnership engagement and the measurement of impact/ improvements in local communities in relation to preventing mental illness and promoting mental health	Agreed outputs and outcomes across the organisation that demonstrate delivery of plans , level of partnership engagement and the measurement of impact/ improvements in local communities in relation to preventing mental illness and promoting mental health	Measuring the impact of activity on people's mental health and wellbeing in local communities

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Meeting Planner

Health and Wellbeing Board

Health and Wellbeing Board Executive Committee

Meeting	Meeting date and time	Agenda Items	Deadlines
HWB	Friday 28 June 11:00pm – 1:00pm (invitations sent) Chair's Briefing Session 10am – 11:00am **Break during meeting for 15 minutes**	1. STP relationships (Ian Wake) 2. STP Operational Plan (Jo Cripps) 3. IMC progress report (Christopher Smith) 4. Prevention Concordat for Mental Health. Maria Payne	Meeting **28 June 19** Publishing Deadline Thurs 20 June Deadline for Imps and Cllr Little Monday 10 June

Meeting	Meeting date and time	Agenda Items	Deadlines
HWB	**20 September** **10:30 – 12:15** Chair's Briefing Session 9:30-10:25 Room to be booked Invitations to be sent to members	1. DAAT Annual Report 2. TOR for HWB 3. Possible item on leisure activity undertaken as discussed with Julie Rogers on 15 Feb (i.e. Park Rangers) 4. HWB Strategy Annual Report 5. HPAG Annual Report 6. **Sexual Violence Joint Strategic Needs Assessment**. This is due at HOSC on 5th September, so I would imagine it going sometime after that date; it will have been through all the relevant governance processes before that. Sareena Gill would be the lead for that item. 7. Homelessness Prevention Strategy Strategic Data Analysis – Ryan Farmer to discuss 8. CSP delivery plan post march, or if later in year the annual O&S report (Michelle Cunningham) 9. Suicide Prevention update. Maria Payne 10. Primary Care Networks (Rahul Chaudari)	Meeting 20 September Publishing Deadline
HWB	6 December 11 – 1pm Chair's Briefing Session 10 – 10:55am		
HWB	March 2020		
HWB	June 2020		
HWB	September 2020		
HWB	December 2020		
HWB	March 2021		