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

Health and Wellbeing Board

The meeting will be held at **10.30 am** on **31 January 2020**

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

Membership:

Councillors Susan Little, Tony Fish and Robert Gledhill

Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock NHS Clinical Commissioning Group
Dr Anand Deshpande, Chair Thurrock NHS Clinical Commissioning Group
Jane Foster-Taylor, Executive Nurse Thurrock NHS Clinical Commissioning Group
Roger Harris, Corporate Director of Adults, Housing and Health / Interim Director for Children's Services
Trevor Hitchcock, Lay Member Patient Participation - Thurrock NHS Clinical Commissioning Group
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Nigel Leonard, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Nicola Martin, HM Prison and Probation Service
Andrew Millard, Interim Director of Place
Andrew Pike, Executive Member Basildon and Thurrock Hospitals University Foundation Trust
Ann Radmore, Director Level Executive NHS England Midlands and East of England Region
Julie Rogers, Chair Thurrock Community Safety Partnership Board / Director of Environment and Highways
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust (NELFT)
Preeti Sud, Executive Member Basildon and Thurrock Hospitals University Foundation Trust
Ian Wake, Director of Public Health
Chair of the Adult Safeguarding Partnership or Senior Representative, Chair of the Adult Safeguarding Partnership or Senior Representative

Agenda

Open to Public and Press

		Page
1	**Welcome and Apologies for Absence**	
2	**Minutes**	**5 - 14**
	To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 20 September 2019	
3	**Urgent Items**	
	To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.	
4	**Declaration of Interests**	
5	**Mid & South Essex Health & Care Partnership 5-Year Strategy & Delivery Plan**	**15 - 138**
	Jo Cripps, Programme Director (interim), Mid & South Essex Health & Care Partnership	
6	**Sexual Violence and Abuse Joint Strategic Needs Assessment**	**139 - 264**
	Maria Payne, Strategic Lead for Public Mental Health and Adult Mental Health System Transformation Sareena Gill-Dosanjh, Public Health Programme Manager	
7	**Ofsted Inspection of Local Authority Children's Services (ILACS)**	**265 - 280**
	Sheila Murphy Assistant Director, Children's Social Care & Early Help	
8	**Costed Mental Health Delivery Plan**	**281 - 312**
	Mark Tebbs, MSE STP Director of Adult Mental Health Commissioning Nigel Leonard, EPUT Executive Director of Strategy and Transformation McKinsey Consultancy	

9	**An integrated approach to Children's Partnership Working and Governance across Thurrock** Teresa Salami-Oru, Assistant Director and Consultant in Public Health	**313 - 322**
10	**ICE Minutes as part of oversight of Better Care Fund**	**323 - 326**

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - Adults Housing and Health Directorate by sending an email to DKristiansen@thurrock.gov.uk

Agenda published on: **23 January 2020**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 20 September 2019 10.30am-12.15pm

Present:	Councillor Susan Little (Chair) Councillor Tony Fish Roger Harris, Corporate Director of Adults, Housing and Health and Interim Director of Children's Services Kim James, Chief Operating Officer, Healthwatch Thurrock Trevor Hitchcock, Patient and Public Lay Member, Thurrock CCG Maria Payne, Strategic Lead – Public Mental Health & Adult Mental Health Systems Transformation, Thurrock Council Ryan Farmer, Housing Strategy and Quality Manager, Thurrock Council Ceri Armstrong, Senior Health and Social Care Development Manager, Thurrock Council Jo Cripps, Programme Director (Interim), Mid & South Essex Sustainability and Transformation Partnership Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways Tania Sitch, Director of Operations, Essex and Kent (North East London Foundation Trust). Kristina Jackson, Chief Executive Thurrock CVS Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Apologies:	Councillors James Halden, Robert Gledhill and Luke Spillman Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust Andrew Pike, Managing Director BTUH Ian Wake, Director of Public Health Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group (Thurrock CCG)
Did not attend:	Dr Anand Deshpande, Chair of Thurrock CCG Dr Anjan Bose, Clinical Representative, Thurrock CCG Tom Abell, Deputy Chief Executive and Chief Transformation Officer Basildon and Thurrock University Hospitals Foundation Trust James Nicolson, Independent Chair of Thurrock Adults Safeguarding Board Nigel Leonard, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust Alan Cotgove, Independent Chair of Local Safeguarding Children's Partnership Andy Millard, Corporate Director for Place, Thurrock Council Adrian Marr, NHS England – Essex and east Anglia Region
Representation:	Ian Wake was represented by Teresa Salami-Oru (Assistant Director of Public Health, Thurrock Council)

1. Welcome and Introductions

Apologies were noted.

2. Minutes

The minutes of the Health and Wellbeing Board meeting held on 28 June 2019 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. Sustainability and Transformation Partnership 5 Year Strategy Development Update

This item was presented by Jo Cripps, Programme Director (Interim), Mid & South Essex Sustainability and Transformation Partnership. Key points included:

- The Sustainability and Transformation Partnership footprint covers a population of 1.2 million, encompassing 17 organisations working together to develop one strategy that recognises the local aspects of its population.
- The Sustainability and Transformation Partnership supports the delivery of the NHS Long Term Plan which Identifies priorities for:
    - Prevention
    - Reducing health inequalities
    - Integration of health and care to Services at populations of 30-50k
    - Enhancing and supporting the workforce
    - Investing in innovation and technology
    - Tackling waste and inefficiency and
    - Improving service sustainability
- Through various consultation and engagement activities across the Sustainability and Transformation Partnership, residents have identified they want access and control over their treatment and to stay living independently for as long as possible. Those with long-term conditions highlight the importance of post-diagnosis support and knowledge about local support available to them.
- Evidence shows that across the Sustainability and Transformation Partnership footprint there is an ageing population; an increase in obesity and there continue to be low rates of uptake of screening for breast and cervical cancer. The STP are committed to addressing these challenges and ensuring that action is taken against the wider determinants of health to improve health and wellbeing outcomes for the people of Thurrock.
- The Sustainability and Transformation Partnership will become an Integrated Care System by April 2021, which will work with Integrated Care Partnerships of South East Essex, Thurrock, Basildon and Brentwood and Mid Essex, with a focal point of prevention, self-care support and primary care networks in alignment with the NHS Long-Term Plan.

- A draft of the developing strategy is due to be submitted by the end of September, finalised by 15 November and published shortly afterwards. During this time there will be further engagement and consultation activities.

During discussions the following points were made:

- Members remain concerned about the impact of creating a single CCG across the STP footprint by merging the five existing CCG and agreed that the current local arrangements of a single CCG which is conterminous with a single Unitary Local Authority area provides the optimum structure for Health and Care integration and transformation.
- Members noted that the interviews for the Accountable Officer would be held late 2019, with a single executive team expected to be in place by 31 March 2020.
- Members were advised that Chief Officers within the council are currently working with the STP to develop an MOU defining what we believe is best delivered at System, Place and Locality level.
- Members discussed the merit of a children's mental health model feeding into the strategy, for example Thurrock's School Wellbeing Service.

RESOLVED: The Health and Wellbeing Board noted, considered and commented on the current work of the Sustainability and Transformation Partnership.

6. Review of the Terms of Reference for the Health and Wellbeing Board

This item was presented by Roger Harris, Corporate Director of Adults, Housing and Health and Interim Director of Children's Services. Key points included:

- The Health and Wellbeing Board is a committee of the Council whereby its Terms of Reference are agreed by Council and are contained within the Council's Constitution.
- The Monitoring Officer has the authority to make consequential amendments to the Constitution including the current clarifications to the Board's Terms of Reference.
- Key changes proposed are:
    - Minor amendments have been made to the Board's membership to ensure the Terms of Reference continues to reflect the current membership.
    - The meeting frequency will be amended from bi-monthly to quarterly. The length of meetings will be shorted from 2 and a half hours to 2 hours, with the introduction of a 15 min refreshment break taking place during the meeting.
    - Some decision making powers, such as the approval of some documents, will be delegated to the Health and Wellbeing Board Executive Committee.

- During discussions some members questioned how the Board will be made aware of decisions taken by the Executive Committee on its behalf. It was agreed that any decisions taken by the Executive Committee would be reported to the Board at its' next meeting. This will provide members with an opportunity to scrutinise decisions taken if member's wish.

RESOLVED: Health and Wellbeing Board members agreed to:

- The changes to the Terms of Reference as outlined in the report.
- Delegate some decision making powers to the Health and Wellbeing Board Executive Committee on the basis that Board members will be updated on any decisions that have been taken.
- Proposals to amend the frequency and length of meetings.

7. Better Care Fund Plan 2019-20

This item was presented by Ceri Armstrong, Senior Health and Social Care Development Manager. Key points included:

- The Better Card Fund provides the mechanism for joining up health and social care planning and commissioning, bringing together budgets from the Clinical Commissioning Group funding allocations, the Disabled Facilities Grant, Winter Planning monies and funding paid directly to the local government for adult social service – the Improved Better Care Fund. The Clinical Commissioning group has contributed £16 million and the council £28 million, which is significantly more than the minimum contribution.
- NHS England require all Better Care Fund Plans to be approved by local Health and Wellbeing Boards.
- All local areas are required to have Better Care Fund plans in place. The BCF Plan is subject to a regional assurance process, with final sign off expected in the week commencing 18 November 2019. This will follow a submission deadline of 27 September.
- Traditionally the focus of the Better Can Fund Plan was the over 65 cohort as it was agreed that this group would benefit the most. However, as the fund has expanded there is now more of a whole population focus with financial support also being provided to preventative type services.
- The previous 2017-19 Plan contained 4 key themes:
    1. Prevention and early intervention,
    2. Out of hospital community Integration.
    3. Immediate Care
    4. Disabled Facilities Grant
- From the later part of 2019, governance arrangements relating to the Better Care Fund Plan 2019-20 will be via the Thurrock Integrated Care Partnership which was discussed at the previous Health and Wellbeing Board in June. Current responsibilities overseen by the Integrated Commissioning Executive will be subsumed within the Terms of Reference for the Thurrock Integrated Care Partnership.

During discussions the following points were made:

- Members noted that some of the targets for the year are not locally determined such as delayed transfers of care, which is calculated using a national formula.
- Members were presented with anecdotal evidence that Thurrock residents are receiving comprehensive support which addresses delayed transfers of care challenges.
- Members welcomed a further update on the Better Care Fund Plan is to be included at the next Health and Wellbeing Board meeting in December 2019 after the final sign off in November.

RESOLVED: The Health and Wellbeing Board:

- Agreed Thurrock's Better Care Fund Plan for 2019-20
- Agreed to delegate the approval of any minor changes made to the Plan after 20 September Board meeting to the Board Chair, Corporate Director for Adults, Housing and Health and Interim Director for Children's Services and Thurrock Clinical Commissioning Group's Accountable Officer.

A refreshment break was held from 11.15am-11.30am

8. Suicide Prevention in Thurrock – update report

Maria Payne, Strategic Lead – Public Mental Health & Adult Mental Health Systems Transformation presented this item. Key points included:

- Prevention needs to start at the earliest opportunity via a partnership approach with the involvement of different agencies such as schools, colleges, the prison service, NHS England and Mental Health Trusts etc.
- Within Thurrock there were 10 suicides in 2018 and 8 in 2017. The low number of incidents makes it difficult to identify particular characteristics/patterns amongst suicides which would facilitate preventative actions.
- Known suicide risk factors including relationship issues, social isolation, financial issues, legal issues, unemployment and ill health were noted in the cases reviewed. A suicide prevention approach will therefore need to address these issues.
- The Health and Wellbeing Board were asked to note the Maughan decision by the Court of Appeal in April 2019 which now changes the understanding of the required standard of proof required to return a conclusion of 'suicide' in an inquest from the criminal court standard 'beyond reasonable doubt' to the lower civil court standard 'on the balance of probabilities'. This may result in more deaths being recorded as suicide and could therefore create what could be perceived as an increase in suicide rates amongst Thurrock residents.
- A Suicide Prevention Steering Board has been established by Southend, Essex and Thurrock Councils to provide system-wide leadership and expertise across the Local Authority and the Sustainability and Transformation Partnership footprint on suicide prevention.

During discussions the following points were made:

- It was acknowledged that ascertaining suicide figures for children is difficult although there is a need to consider the risk factors of suicide in children. A suicide prevention toolkit has been supplied to schools via the Children's Commissioning Forum.
- Members agreed that loneliness and isolation should be considered as a potential driver for mental ill health, particularly within the 16-25 age group.
- Members recognised the mental health of Looked After Children needed to be considered at an earlier age and that support should be provided to individuals as soon as possible.
- Following the Chair advising members about testing the council system it was agreed that training should be made available for council staff who may take telephone calls from people who feel

suicidal (such as call centre staff) and to support individuals and families who have been affected by suicide through signposting them to appropriate services.
- Members welcomed guidance that Thurrock First staff had been trained to handle suicide related calls.
- It was agreed that the report would be presented at a Community Safety Partnership meeting as an opportunity for wider discussion and input.
- Members advised that there was a need to consider failed suicide attempts as these were not captured within the report; A&E recording may be a useful tool to achieve this. Members acknowledged the challenges with securing data on suicide attempts.

RESOLVED: The Health and Wellbeing Board noted the contents of the report and agreed the following:

- The draft Southend, Essex and Thurrock Prevention Steering Board Terms of Reference and authorise that the Steering Board has decision-making responsibility on behalf of the Health and Wellbeing Board as appropriate. Amendments to the membership would be made as per discussions.
- To support the next steps as proposed within the report.

9. Homelessness Prevention and Rough Sleeping Strategy Report

This item was presented by Ryan Farmer, Housing Strategy and Quality Manager. Key points included:

- The current homelessness strategy was adopted in Thurrock in 2015 and a new Homelessness Prevention and Rough Sleeping Strategy is now being developed which takes into account current homelessness in the borough, the introduction of the Homelessness Reduction Act 2017, the impact of recent welfare reforms and new opportunities for preventing homelessness.
- The enactment of the Homelessness Reduction Act 2017 was widely welcomed by homelessness charities and support organisations. This now includes a greater level of support via an extension of the period of time whereby people are considered to be 'threatened with homelessness' by local authorities and the creation of personalised housing plans
- Since the introduction of the Homelessness Reduction Act in April 2018, the council has experienced an increase in the number of households which are homeless or at risk of homelessness that have approached the Housing department for assistance.
- Members of staff will continue to require regular training to ensure that their expertise and knowledge enables them to provide homeless individuals and those at risk of homelessness with the necessary support.

During discussions the following points were made:

- The local plan envisions 30,000 homes to be built over the next 20 years, the majority of these will be within the private sector
- Members learned that there is an agreed target of 1000 new homes via Thurrock Regeneration Limited and 500 homes through the Housing Revenue Account over the next 5 years. Rents have been

frozen for the last 4 years which has reduced the council's ability to build homes during this time.

- . Members recognised that some rough sleepers do not take up the offer of support as maintaining a tenancy can be challenging, however the number of rough sleepers in Thurrock is very low.

RESOLVED: The Health and Wellbeing Board noted the contents of the report and commented on the themes identified to develop a new homelessness prevention and rough sleeping strategy.

10. Thurrock Community Safety Partnership update

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

- Crime statistics for Thurrock are continuing to rise, a trend reflected across Essex and nationally.
- There care clear links between crime, fear of crime and health and wellbeing. This is demonstrated in the Health and Wellbeing Strategy whereby Goal 2 was amended from 'healthier environments' to 'healthier and safer environments'.
- The priorities for 2019/20 include:
    - Tackling Offending – preventing youth offending, targeting repeat and prolific offenders and reducing victims of burglary
    - Violence and Vulnerability – tackling gang related activity and offensive weapons, ensure a coordinated approach to safeguarding against gangs and child criminal exploitation and supporting all victims of domestic abuse, sexual offences and child exploitation
    - Local Community and Visibility – identifying patterns, trends and hot spots for anti-social behaviour through increased visibility and enforcement, safeguard victims from hate crime and community engagement
    - Counter Extremism and Terrorism – preventing violent extremism locally
- The Community Safety Partnership is developing a protocol with schools to safeguard children against knife crime and gangs; the offer of support to schools has only been taken up by 21 schools in the last year. A meeting will be arranged with head teachers to encourage schools to take up this offer as there is a need to raise awareness and use proactive measures. Home Office funding of an additional £93,000 has been pledged to address violence and vulnerability in schools and links with Thurrock's preventative agenda.
- As part of creating safe and accessible spaces, park engagement officers have been employed to liaise with the public in terms of park designs, encouraging pride of these open spaces and the reporting of anti-social behaviour.
- Town centre policing teams have been introduced which cover Grays, Ockendon and Stanford-Le-Hope.
- The Community Safety Partnership are continuing to engage with planning colleagues and developers to design crime out of new housing estates by thinking of lighting and areas of possible concealment.
- To address violence against women and girls, a coordinator has been recruited to develop Thurrock's response to the National strategy.

Members learned that this approach has improved governance and partnership working.

- Thurrock have provided additional funding to Operation Raptor , enabling them to conduct 14 proactive patrols and enforcement of C17 injunctions, 1 undercover operation with 10 officers and a joint operation with the fraud team which resulted in 30 arrests and breaches.

During discussions the following points were made:

- Members noted that the violence against women and girls strategy is across all genders and not only women and girls.
- Members were advised that gang awareness was delivered to 6 schools within the borough, however it was recognised that more schools need to be involved with this preventative work. Members were reassured that the Community Safety Partnership now have a representative for schools who is proactively encouraging schools to participate. The Community Safety Partnership will attend the head teachers briefing in September along with Essex Police and representatives of the youth offending team to discuss gangs and gang related violence.
- The focus of rural areas was discussed, it was recognised that a communications campaign across Southend, Essex and Thurrock had been aimed at middle class individuals who use recreational drugs. Members acknowledged evidence that suggests that these type of 'social' drug users often do not consider the consequences of their drug use and feed into the chain of events such as young drug runners and gangs.
- Members discussed the merit in taking photographs of graffiti tags as this can help to identify possible gang links, these are then sent to the police. Members welcomed new approaches to joint working, particularly with private landlords, the police and the council's Environmental Enforcement Officers.
- It was noted that a member of the Community Safety Partnership liaises closely with colleagues in the Planning Department providing feedback on how to design crime out of new housing estates. Environmental leads were encourage to review planning and design briefs, including attending the Planning Committee meetings.

RESOLVED: The Health and Wellbeing Board:

- Noted the performance of the Thurrock Community Safety Partnership for the year 2018/19
- Supported the 4 priorities of the Community Safety Partnership for the year 2019/20
- Recognised the links that have been made to Thurrock's Health and Wellbeing Strategy
- Are required to work collaboratively across Essex in the Police and Fire Crime Commissioners Violence and Vulnerability framework.

11. Work Programme

- Members discussed the work programme for the next meeting in December - additional items suggested included the 10 year Plan for NHS and Healthwatch, and an update on Primary Care Networks and Place.

- Members noted the possibility of another meeting before March 2020, potentially 31 January 2020.

The meeting finished at 12.30pm hours.

CHAIR……..

DATE……

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31 January 2020	ITEM: 5
Health & Wellbeing Board	
Mid & South Essex Health & Care Partnership 5-Year Strategy & Delivery Plan	
Wards and communities affected: All	**Key Decision:** For noting and approval
Report of: Jo Cripps, Interim Programme Director, Mid & South Essex Health & Care Partnership Mandy Ansell, Accountable Officer, Thurrock CCG Roger Harris, Corporate Director of Adults, Housing and Health, Thurrock Council	
Accountable Head of Service: Not applicable external report	
Accountable Director: Not applicable external report	
This report is Public	
Date of notice given of exempt or confidential report: Not applicable	

Executive Summary

This paper presents the final draft 5-Year Strategy and Delivery Plan for the Mid and South Essex Health and Care Partnership (the Partnership), for noting and approval (see Appendix 1). The draft summary plan is also attached at Appendix 2.

The paper provides an overview of the strategy content and an update on Partnership activities.

Health & Wellbeing Board members are asked to note that Ian Wake, Director of Public Health for Thurrock Council, is now a member of the Partnership Board.

1. Recommendation(s)

1.1 The Health & Wellbeing Board is asked to note and approve the draft 5-year Strategy and Delivery Plan, recognising that the draft has been approved by the Partnership Board and is in line with national NHSE/I expectations on finance and key metrics for delivery.

1.2 The Health & Wellbeing Board is invited to note and offer comment on the current work of the Partnership and the future relationship with the Thurrock Health and Well-Being Board.

2. Introduction and Background

2.1 The Mid and South Essex Health and Care Partnership (the Partnership) is a collection of organisations working to support our 1.2m residents, comprising three local authorities, three main community and mental health service providers, five clinical commissioning groups, three acute hospitals, nine community and voluntary sector organisations and three Healthwatch organisations. Across the footprint we have over 150 GP practices, which have now formed into 28 primary care networks (PCNs) serving populations of 30-50,000 people. We also have four defined "places" across mid and south Essex, where local partners will work together to design and delivery services to support local populations, of which Thurrock is one.

2.2 The Partnership is now called the *Mid and South Essex Health and Care Partnership* (rather than STP), reflecting the desire to become a fully integrated care system by April 2021 as described in the NHS Long Term Plan. This will bring significant benefits to the local area through more funding and joined up planning to avoid wasteful duplication. The Partnership is not an organisation, it is a collection of partners working together.

3. 5-Year Strategy & Delivery Plan

3.1 Over recent months, colleagues from across the system have worked to develop our 5-year strategy and delivery plan. We were keen to ensure that this strategy was fully owned by partners and reflective of the work being done at a local level to support our population. The previous update to the Thurrock Health & Wellbeing Board provided information on how the strategy was being developed in partnership, including engagement with local residents led by Thurrock Healthwatch.

The strategy has now been approved by our Partnership Board, which comprises senior officers from health and local authority organisations as well as other key partners. We will be publishing the full strategy and delivery plan shortly, in line with national timescales. The document will be available on our new website www.msehealthandcarepartnership.co.uk

The final draft of the strategy is presented here for noting and approval.

3.2 Our strategy was formed around some key concepts:

- The principle of subsidiarity was central to our strategy - the vast majority of interactions with residents take place locally – and this is where we can have most impact on supporting health and wellbeing. The focus of the strategy is therefore on those local plans that are owned by residents and local partnerships, aligned to the relevant Health and Wellbeing Board. The concept of subsidiarity (to deal with issues at the closest level) is key.

- The recognition that an individual's ability to live a happy and healthy life is heavily impacted by wide-ranging factors such as housing, education and

employment, not just the availability of health and care services. Our strategy recognises that it is only by partners working together with communities on the wider determinants of health, that we can hope to positively impact people's lives and reduce demand for services.

The figure below illustrates the relative impact on an individual's wellbeing of the various factors.

- The experiences of our residents and patients, which we have collected through the engagement activities of individual organisations, and through the wide-scale public consultation held on acute reconfiguration plans, and the work that Thurrock Healthwatch led on engagement on the NHS Long Term Plan, have helped to shape our strategy and delivery plan. We are keen to ensure that people's voices continue to be heard as we move into implementation and we are currently mapping these opportunities to develop an engagement framework across the Partnership.

- We also took account of the vast amount of data collected on our populations – working with our three Public Health teams to develop a profile pack for the mid and south Essex footprint, as well as information on outcomes for common health conditions. These data helped to shape our priorities for action.

3.3 Our Vision

The Partnership has agreed the following vision:

"A health and care partnership working for a better quality of life in a thriving Mid and South Essex, with every resident making informed choices in a strengthened health and care system"

We are committed to supporting:

Healthy Start – helping every child to have the best start in life
- supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.
- supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide

Healthy Places – creating environments that support healthy lives.
- creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – spring from participation
- making sure everyone can participate in community life, empowering people to improve their own and their communities' health and wellbeing, and to tackle loneliness and social isolation

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives
- helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home
- from advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

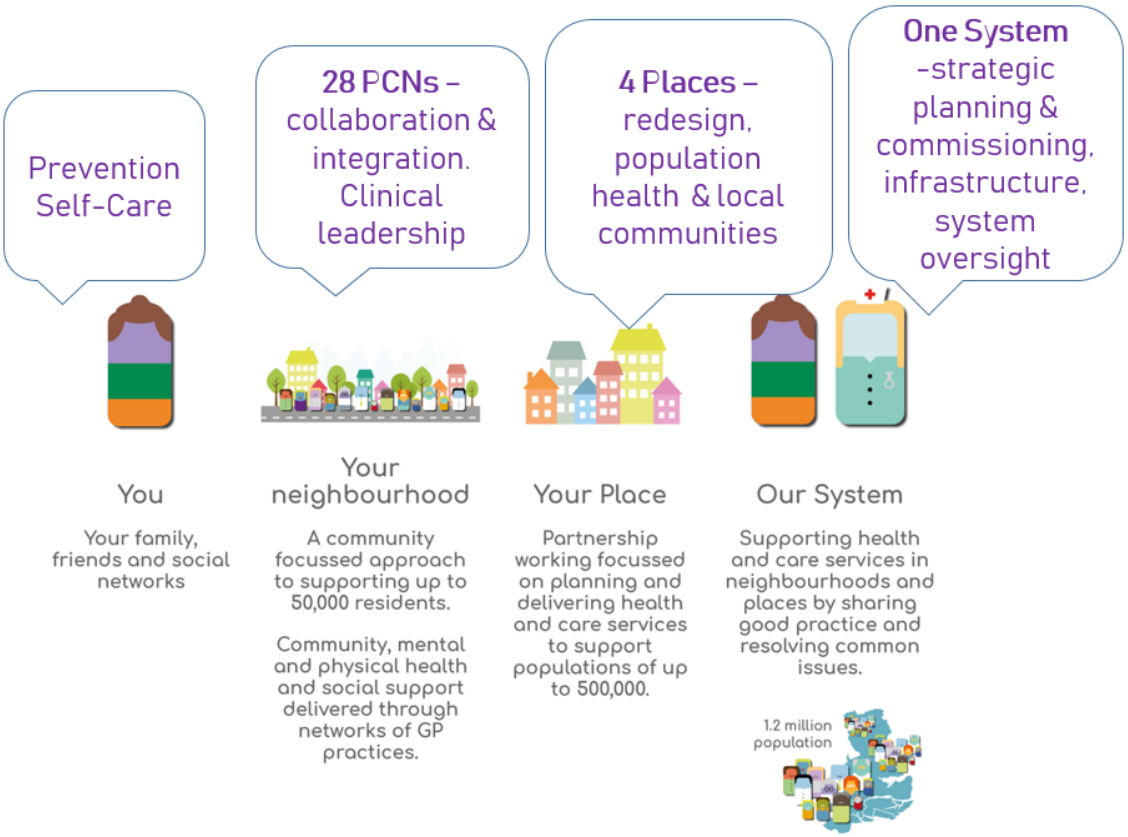
3.4 **Our Ambitions**

As a Partnership, our overarching ambition is to **reduce inequalities**. We will do this by:

We are currently working to develop an outcome framework that will enable us to track our progress against these ambitions, recognising that some will take several years to show progress. This work is being led by Ian Wake.

3.5 **Our Operating Model**

Our strategy is built around the concept of interconnected layers – starting with the individual, their family and social networks, working through neighbourhoods, places and the wider system:



3.6 **Our Places**

Our four Places will be the lynchpin of delivering the strategy – they are partnerships of primary care networks, commissioners, providers, local authority and community and voluntary sector partners. The strategy describes the emerging plans of the four Places in mid and south Essex which, over time, will become integrated care partnerships (ICPs):

- Thurrock
- Basildon and Brentwood
- Mid-Essex
- South East Essex

As Board members will be aware, the Thurrock model is well developed and already delivering on improvements for local residents.

4. **Implementation**

We have a number of developments happening during 2020/21 that will support implementation of the strategy:

In April 2020, our three acute hospitals, which have been working closely together for some time, will formally merge. We will also see the continued implementation of the changes to hospital services as agreed by the five CCGs. These changes will help us to deliver improvements to our hospital services.

At the same time, our local health and care model will continue to develop – our primary care networks will start to work collaboratively with partners across health and social care to deliver for patients and the wider community. We will see, through our four places, a real focus on using population health data to design and deliver support for specific community needs.

Early in 2020, a Joint Accountable Officer (to cover the 5 CCGs) and Executive Lead for the Partnership will be appointed. The Joint AO/Executive Lead will work with the CCG chairs to develop an application for the CCGs to merge (subject to stakeholder support and NHS England approval) and will work closely with the Independent Chair of the Partnership, Professor Michael Thorne, to achieve Integrated Care System status by April 2021.

3.8 As we work towards Integrated Care System status, we have commenced a number of work programmes:

A task and finish group has been established to look at: governance at the system level; arrangements between the system and the four places; and arrangements at place level. This work aims to be person-centric and not focussed on organisations, and to be as “light touch” as possible, recognising that the Partnership is not an organisation and that individual organisations must maintain their statutory obligations. The principle that decisions should be taken as close to the resident as possible (subsidiarity) will be an overriding concept. The MoU drafted by Thurrock Council to support defining arrangements between the system and the four places has been instrumental in this work, which we hope will conclude in the spring.

We have established a finance leaders group, comprising local authority and NHS finance leaders to support work on developing a financial framework for the system and an integrated approach to risk, investment, etc, where this is permissible by individual organisations. This work will report in the spring.

Our Population Health strategy was approved by the Partnership Board in December 2019, and over the coming months we will develop our approach, with work being led by Ian Wake, Director of Public Health for Thurrock Council, on behalf of the system. We have secured resources to support this work.

During 2020 we will also start to implement our integrated shared care record to support health and care professionals to work more effectively for people.

Work is underway to develop a joint (health and care) workforce strategy, and there has been good engagement from health and local authority partners to deliver this.

Similarly, our approach to estates utilisation has been well supported by partners and we will be taking forward some innovative approaches to making best use of our estates for our population.

We continue to work with residents and patient groups to ensure they have a strong voice in our plans. During 2020, we will launch *Virtual Views*, a demographically representative panel of c1500 residents from across mid and south Essex with whom we can obtain views, test ideas and obtain feedback. This is in addition to the various routes for feedback and engagement that already exist across the system.

Our innovation programme continues to go from strength to strength, we have launched a Quality Improvement Leadership programme across the footprint and have just appointed our second intake of innovation fellows who will receive expert advice and support on bringing new innovations to fruition for the benefit of our residents.

All of this is alongside the work that partners are already engaged in to improve the services and support offered to our local residents.

3.9 As a partnership, we have selected two specific areas of focus – **cancer,** because our outcomes are not where we would want them to be; and the **support for older people**. We will be holding dedicated summit sessions in the spring to identify how we can take these areas of work forward in partnership.

4. Reasons for Recommendation

4.1 The Health & Wellbeing Board is asked to note and approve the draft 5-year strategy and delivery plan – recognising that the strategy has been co-developed with partners across the system, has been approved by the Partnership Board and is in line with national NHSE/I expectations.

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**

Implications verified by: **NA External report**

7.2 **Legal**

Implications verified by: **NA External report**

7.3 **Diversity and Equality**

Implications verified by: **NA External report**

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

NA

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

9. Appendices to the report

- Appendix 1: Draft 5-Year Strategy & Delivery Plan of the Mid and South Essex Health & Care Partnership
- Appendix 2: Draft Summary of the 5 Year Strategy

Report Author:

Jo Cripps, Programme Director (interim), Mid & South Essex Health & Care Partnership

Mid and South Essex
Health and Care
Partnership

Our 5 Year Strategy & Delivery Plan

Working together for better lives

Contents

Welcome from the Independent Chair of the Mid & South Essex Health & Care Partnership

As the newly appointed Independent Chair of the Mid & South Essex Health & Care Partnership, I am delighted to present this strategy to you. Over the past three years, the Partnership has had many successes. I hope you will see from our strategy that we plan for our Partnership to go from strength to strength.

We recognise that an individual's ability to live a happy and healthy life is heavily impacted by factors such as housing, education and employment. We want our communities to thrive, for our residents to manage their own lives and to help each other. That's why we are changing the way we work to address these wider determinants and to support people to live well.

Of course, we still must make sure that our health and care services are there for people when needed and offer a high quality, easily accessible route to getting help.

We have already started to reform and improve our acute hospital services. We have bold plans for redesigning the rest of the health and care system through our four places, with primary care networks as the bedrock of person-centred care and support.

An important part of our development will be to achieve Integrated Care System status – and we are working to achieve this by April 2021.

I commend this strategy to you and I look forward to working with our partner organisations to deliver our ambitious programme of improvement.

Professor Michael Thorne
Independent Chair
Mid & South Essex Health & Care Partnership

About this Document

This document is in two parts;

Part 1 describes our vision and objectives for the further development of our Health and Care Partnership; it sets out how, by working together, we expect to improve the health and wellbeing of our 1.2m residents.

It also provides detail on our operating model, and the role of our four places and primary care networks.

Part 2 provides a more detailed delivery plan, outlining how the Partnership will work to deliver the commitments in the NHS Long Term Plan. It also describes the work we will undertake to achieve Integrated Care System designation, in order to bring further benefits for our residents and staff.

Mid & South Essex Health & Care Partnership – who we are

The Mid and South Essex Health and Care Partnership serves a population of 1.2 million people, living across Braintree, Maldon, Chelmsford, Castle Point, Rochford, Southend, Thurrock, Basildon and Brentwood.

Our Partnership comprises the following partners:

Mid Essex
390k population

9 Primary Care Networks:

3 - Chelmsford

2 - Braintree

2 - Maldon/ Chelmsford

1 - Maldon/Braintree

1 - Braintree/Chelmsford

One hospital group with main sites in Southend, Basildon and Chelmsford

Over **150** GP practices, operating from over **200** sites, forming **28** Primary Care Networks.

Three main community and mental health service providers

Five clinical commissioning groups

3 top tier local authorities and **7** district and borough councils

Basildon & Brentwood
276k Population

6 Primary Care Networks:

5 - Basildon

1 - Brentwood

3 Healthwatch organisations

One ambulance trust

Thurrock
176k Population

4 Primary Care Networks:

Tilbury & Chadwell

Grays

Purfleet

Corringham

South East Essex
370k Population

9 Primary Care Networks:

2 - Castle Point

2 - Rochford

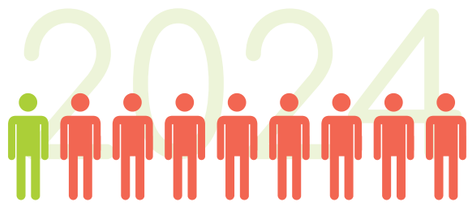
5 - Southend

Nine voluntary and community sector associations

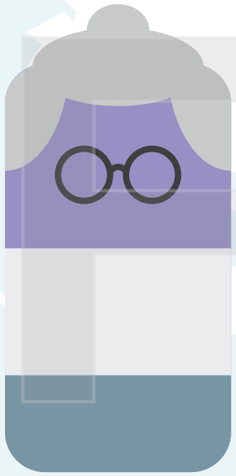
Our Population

Our public health teams have created a Mid & South Essex Population Profile (see appendix 1) to describe our population in detail. The following headlines provide an overview for our area - but mask sometimes significant differences across the areas. The details contained within the profile pack, along with the Joint Strategic Needs Assessments and strategies of our three top tier Health & Wellbeing Boards, has helped to define our priorities.

// In 2017 1 in 12 people were aged over 75; this is estimated to increase to 1 in 9 by 2024 and to 1 in 7 by 2039.



Demography



// Over the next 5 years the largest increase is forecast among 75 – 79 year olds. By 2034 the largest increases are forecast for the 90+ years population.

90+

5.22%

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

14.70%

// The life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females, but there is still variation even within boroughs/districts.

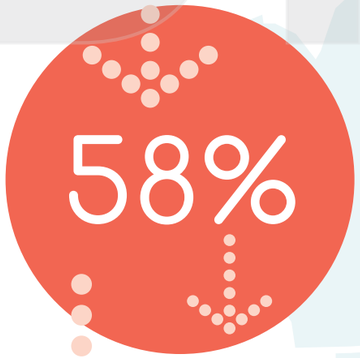
Education, Employment & Prosperity

// Deprivation has increased across the 1.2m population

// Overall Essex is performing worse than national comparisons for reading and maths scores creating a disadvantage for future schooling and ultimately skills for work

// The productivity gap is increasing between mid and south Essex and national comparators.

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



Health Behaviours & Outcomes

// There are high and increasing proportions of overweight or obese adults.

// There are increasing numbers of overweight or obese children in early years schooling

// Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease

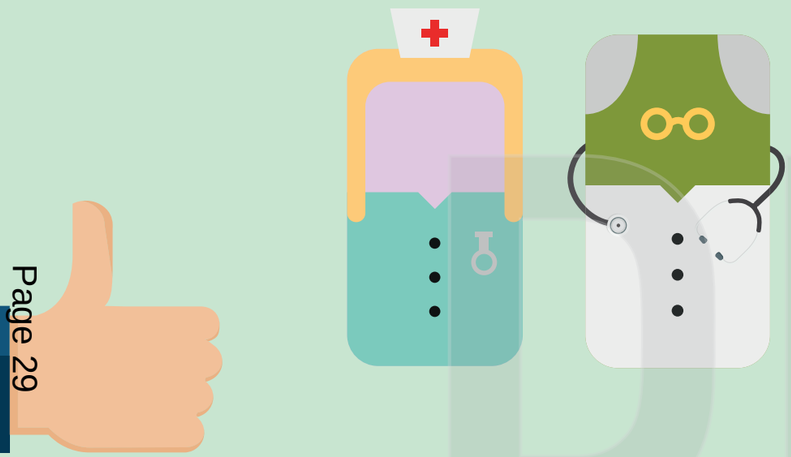
// More people in this area die from cancer, heart disease and liver disease than expected

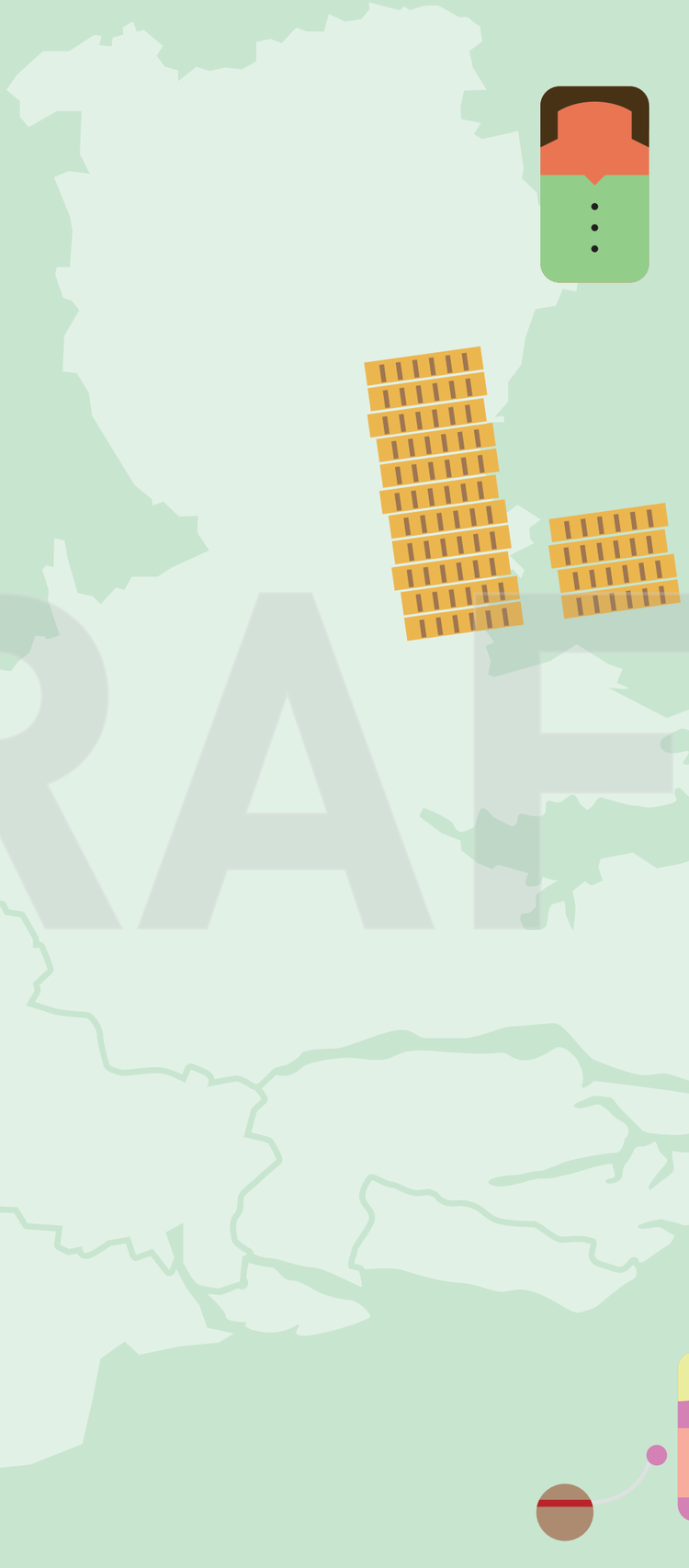
// More people are being diagnosed with dementia

// Mental health conditions are increasing in adults and children and in some areas suicide rates are increasing

Health and Wellbeing Board Strategies

Our Health and Wellbeing Boards are important partners and their agreed priorities are aligned with this strategy.





Essex HWBB Priorities

// Improving mental health and wellbeing

// Addressing obesity, improving diet and increasing physical activity

// Influencing conditions and behaviours linked to health inequalities

// Enabling and supporting people with long term conditions and learning disabilities

Thurrock HWBB Priorities

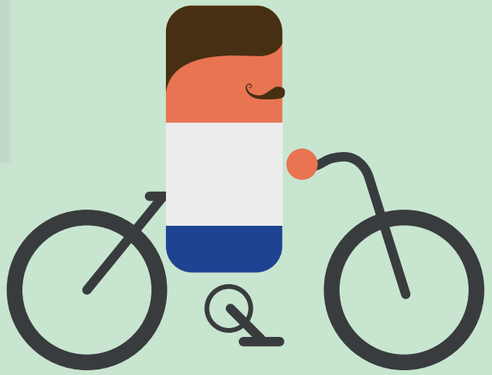
// Opportunity for all

// Healthier environment

// Better emotional health and wellbeing

// Quality care, around the person

// Healthier for longer



Southend HWBB Priorities

// Increasing physical activity

// Increasing aspiration and opportunity

// Increasing personal responsibility and participation

Our Vision

A health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident making informed choices in a strengthened health and care system

This means:

Healthy Start – helping every child to have the best start in life

// supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.

// supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide

Healthy Places – creating environments that support healthy lives.

// creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – which spring from participation

// making sure everyone can participate in community life, empowering people to improve their own and their communities' health and wellbeing, and to tackle loneliness and social isolation

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives

// helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home

// from advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

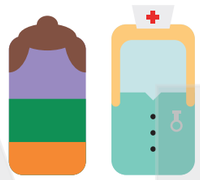
Delivering Our Vision

The health and wellbeing of people in some of our areas is much poorer and on average people die younger there than in other areas. As a Partnership our overriding aim is to change this.

We have set four ambitions to help us achieve this aim:

1. Creating Opportunities

For our communities to thrive we need good education, opportunities for employment, decent housing and a vibrant local economy. Our Partnership represents some of the largest employers and purchasers of goods and services locally, so we have an important role to play. By working together, we can harness these opportunities for the benefit of local residents.

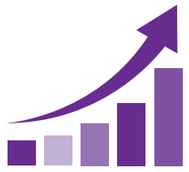


2. Supporting Health and Wellbeing

By working in different ways and in closer partnership with our communities we can do more to prevent the things that cause poor health and mental illness. Up to 40 per cent of ill heath can be avoided so by getting a grip on issues sooner we can stop them becoming bigger problems in the future.

3. Bringing Care Closer to Home

Joining up our different health, care and voluntary sector services means we can bring services closer people's homes – whether that is through support on-line, or by bringing health and care services into the community, such as some hospital outpatient appointments, tests like x-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.



4. Improving and Transforming Our Services

We want to make sure our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can. Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical advances and new ways of working to treat people at an earlier stage and avoid more serious illness.

Executive Summary

The way we live and the lifestyles we lead have changed a great deal over the years.

Our population is growing, new technology is being developed and research into the things that can affect our wellbeing is providing new answers.

We are living longer, but not all of those extra years are spent in good health and some of our communities experience significantly poorer health than others. Our health and care staff are also under a great deal of pressure, coping with increased demand for our services.

All of this means the support and help we sometimes need to lead a happy and healthy life must change and adapt too.

We want our residents to have a good quality of life, from education and employment opportunities, to making better choices about being active and what they eat.

We are changing the way we work together as organisations to harness the power our communities and residents have to take more control of their lives and wellbeing.

Part 1 of our five year plan sets out our goals, priorities and the actions we want to take to play our part in improving the health and wellbeing of people living in our cities, towns and villages right across mid and south Essex.

Starting with you, your family and social networks, the first section of our plan describes how we will make it easier to find out about ways to prevent you from becoming unwell and where you can get support to make the changes you need to improve your health

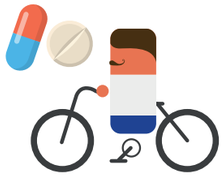
If you have a long term condition such as diabetes or breathing problems, you will be able to work together with range of health and care professionals to explore the support you need to manage your health and prevent more serious illness developing.

To do this we are setting-up teams comprising different health and care professionals to provide joined up care. These teams will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists and colleagues from the voluntary sector, working together in Primary Care Networks.

Supporting Primary Care Networks will be four "Place", partnerships covering South East Essex, Thurrock, Basildon and Brentwood and Mid Essex. These will bring together groups of Primary Care Networks, with local council teams, community and mental health service providers, the hospital teams serving that location and voluntary sector partners to ensure the health and care needs of their local population are met.

In Part 2, we explain how we will deliver the commitments set out in the national NHS Long Term Plan (LTP) for improving care for major health conditions (www.longtermplan.nhs.uk)

We set out the actions we're taking to improve care for conditions such as cancer, mental health conditions, cardio vascular disease, diabetes and for people at key points in their lives, for example having a baby or at the end of life. These include:



Prevention – see section 9

// our work on prevention for major health conditions including cancer, diabetes, and cardiovascular disease

// work on reducing childhood obesity through the adoption of the Daily Mile across our schools

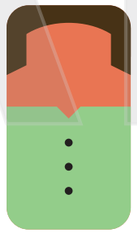
// increasing physical activity in adults, linking with Sport England and Active Essex

Cancer - see section 14

// introducing a new test to help detect and diagnose bowel cancer earlier, so we can treat people quicker and improve their health outcomes

// setting up a Rapid Diagnostic Centre for patients with non-specific symptoms which could indicate cancer

// becoming a pilot area for the National Targeted Lung Health Check to support earlier diagnosis of lung cancer



Mental Health – see section 15

// creating safe places for people to walk-in such as community cafés, where they can find emotional support when they feel their anxieties or other mental health problems are escalating

// setting-up mental health support teams in schools to provide therapy and support to children and younger people

// improving how we support people with a personality disorder at an early stage, so that they can manage their condition and are less likely to need to go to hospital

Cardiovascular disease – see section 19

// focusing on atrial fibrillation (irregular and often abnormally fast heart beat) to improve earlier detection and treatment to prevent stroke

// reviewing existing patients to ensure their medication is appropriate

// improving access to specialist care at the Essex wide Cardiothoracic Centre, with more patients requiring an angiography being seen within 72 hours.

Diabetes – see section 22

// rolling-out the NHS Diabetes Prevention Programme to provide personalised support to people to reduce their risk of developing diabetes

// reducing the impact of diabetes among harder to reach/less engaged groups

// piloting the MyDiabetes app with 500 newly diagnosed Type 2 diabetics to support them to understand and better manage their condition and reduce the risk of more serious complications developing

Maternity – see section 25

// launching the Maternity Direct App to allow mums-to-be to speak online with an NHS midwife about non-urgent concerns at anytime

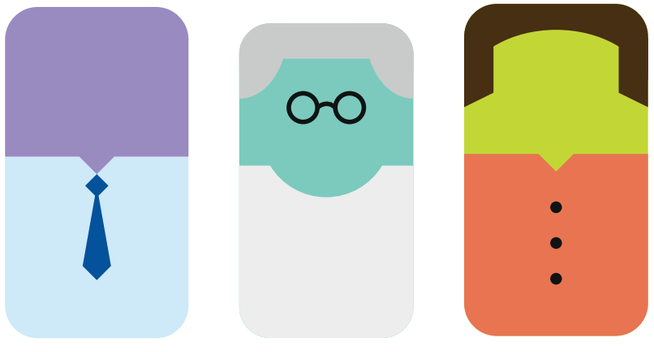
// creating personalised care plans to support women to have choice and opinions about the care they receive

// reviewing our current perinatal mental health services to make it easier for those in need to access support and care.

We have also set out our ambition to become a fully Integrated Care System for our 1.2 million residents, by 2021 as set out in the NHS Long Term Plan. This will bring significant benefits to our area through more funding and joined up planning to avoid wasteful duplication.

Overall though, our plan isn't just about the NHS because we need to think wider than that. By linking up with our local councils, social care teams and voluntary sector organisations, we can look at the impact housing, our environment and air quality have as well as how we can prevent ill heath in the first place by identifying earlier those people at risk, and also provide support for those who have a long-term illness.

We all have a role to play – as public services, as individuals, families and communities - all taking responsibility to think differently about our health and wellbeing and working together for better lives in mid and south Essex.



Part 1: Our Strategy

1. Foreword and Introduction

The Mid and South Essex Health and Care Partnership (the Partnership) comprises the key NHS and Local Authority organisations covering the mid and south Essex area. Our ultimate aim is to reduce the inequalities that our residents face.

Through working in partnership over recent years, we have made good progress – for example:

In primary care:

// We are investing in primary care to address the significant challenges faced relating to demand for services, the availability of professionals to support patients and updating our buildings and infrastructure. Additional monies will be invested in primary care over five years to enhance the primary care workforce with new roles and enable patients to access a wider range of services locally. Patients will have full digital access to primary care through on-line consultations, appointment booking and prescription ordering.

// We have established 28 Primary Care Networks (PCNs), which are groups of general practices working together across populations of 30-50,000 patients. These networks form the basis for local collaboration and integration of services. Clinical Directors for each network have been appointed.

In our community & mental health services

// We have a pan-Essex Mental Health and Wellbeing Strategy, which puts mental health at the heart of all policy and services in Greater Essex, outlining work with our communities to build resilience and emotional well-being, and ensuring that anyone with a mental health need can access the right service at the right time. We have strong plans in place to improve urgent and crisis mental health services.

// Our emotional health and wellbeing service for children and young people is well established and using innovative ways of delivering services, including mental health teams working across schools.

// Our community physical and mental health teams are working closely with primary care and voluntary sector organisations to collaborate and join services around the needs of the local population.

// Our community teams are working in an integrated way to support keeping people at home, and ensuring timely, safe discharge from hospital.

// There is already significant integration between health and social care services at place level and we will develop this further over time.

In our hospitals:

// Our consolidated clinical strategy across the three acute hospitals is reducing unwarranted variation in access and service quality, improving our specialist services and addressing significant workforce challenges.

// Our plans for improving services have been approved by the Secretary of State for Health and Social Care and we have commenced a programme of service redesign to improve services for our patients.

// We secured £118m capital funding to support improvements to our estates and infrastructure across the hospitals to enable these changes to take place.

// Work with our Cancer Alliance has seen significant investment in transforming our cancer services and supporting early detection – with a pilot Lung Health Check programme in Thurrock.

// We have also been selected as a Rapid Diagnostic Centre pilot, bringing faster diagnosis and treatment of cancers for our residents.

In clinical & professional leadership

// We have strong clinical engagement and leadership in developing our plans and ensuring the quality and safety of services.

// Clinical leaders have been identified for all of our transformation programmes.

// Our clinical leaders have opportunities for development through quality improvement and leadership fellowships.

// Our Primary Care Network Clinical Directors are benefitting from specific development targeted to their new roles as system leaders.

In engagement with our residents:

// We have strong engagement with our communities through all of our organisations and ensure that insight gathered through engagement is used to full effect

// We work closely with our Healthwatch organisations.

// We link closely with community groups and voluntary sector organisations at local level. Our CCGs have strong patient participation forums to bring the local voice to primary care development.

In supporting our workforce:

// We have built strong foundations for ensuring effective recruitment and retention across our health and care services, including the development of new roles, a preceptorship programme for newly qualified nurses, and opportunities for staff development.

// Our local medical school at Anglia Ruskin University will support our ambitions to grow a local medical workforce.

// We have implemented a range of innovative solutions to meet our workforce challenges – this includes the introduction of trainee nurse associates, physician assistants, and apprentices.

In using our estate effectively

// We have developed a system-wide estates strategy that ensures we are working together to make best use of our buildings and infrastructure, and ensures that we are planning for housing growth in a strategic way and utilising available development funding to support our communities.

In digital transformation

// Our digital plans include the development of an Integrated Shared Care Record, so that all health and care professionals working with residents will be able to see their records. This will support more coordinated care and enable our health and care professionals to do their jobs better.

In research & Innovation:

// Our strong work on innovation has enabled us to develop and support our staff to introduce new techniques, products and services that benefit our residents.

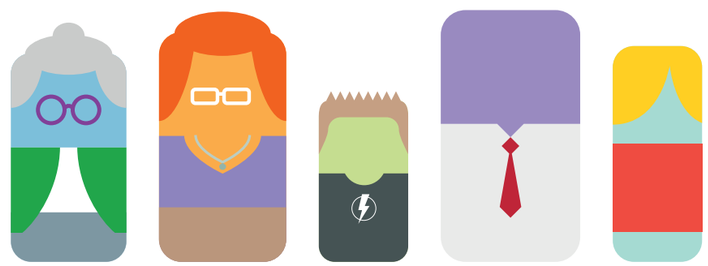
// We have agreed a way of working with industry partners to ensure our residents can benefit from cutting edge technologies and innovations.

// We have excellent links with our academic partners, including UCL Partners and the Eastern Academic Health Science Network, bringing new ideas and innovations to improve services for our residents.

While we have had many successes, we know that there is much more to do. Traditionally, we have provided services in relative isolation, focussed on specific organisations and resulting in fragmentation and a variable experience for our population. We have also not always fully considered the impact of the wider determinants of health (such as housing, education, employment), and how, by working together, we can impact on these issues in a positive way.

The challenge, and therefore the opportunity, is to support individuals and communities to proactively use their strengths and assets. By working together, we can plan for our workforce, enhance our digital capabilities and take advantage of opportunities for research and innovation, using the wealth of data we collect to maximum effect, and ensure that we are making best use of our resources, delivering efficient and effective services.

We believe that coming together as an integrated care system will enable us to deliver for our residents.



2. What have our communities told us?

There are 17 organisations in our Partnership, which together link with and represent a vast range of organisations and networks.

Each of those organisations engage regularly with local residents or citizens, including those who use local health and care services in a variety of different ways and we are committed to ensuring those voices are reflected in the programmes of work we undertake together.

Since the start of our Partnership, we have undertaken a wide ranging programme of engagement as well as a recent full-scale public consultation. As a collective, we engage regularly with thousands of people across the local area, so it is important to note we are not starting our engagement with residents from scratch and we have a wealth of expertise via local place engagement networks, patient reference groups, and community forums which has helped us to maximise our existing engagement mechanisms without duplication of effort and cost.

The bespoke engagement around the NHS Long Term Plan, provided for us through our local Healthwatch organisations, gave the opportunity to continue conversations on the future of health and care in our area and is to be welcomed alongside the willingness of the community to seek greater understanding and become more informed. The report from this engagement is provided at Appendix 2.

What we have heard

We've heard from and spoken to lots of local people, organisations and health and care professionals to help develop our plan over a number of months. Here is a summary of what we have heard and how we are responding.

We should do more to support people to stay healthy and well, and prevent people from getting ill.

Our approach to prevention will have a focus on children and young people, together with support for parents and carers, and on building active and involved communities.

We have committed to addressing the wider determinants of health, such as housing, education and income through our Partnership, recognising it takes everyone to join forces and tackle inequalities if we are going to make a real difference.

People don't want to have to repeatedly tell their story to different health and care professionals.

Our plan describes how we will better coordinate the different professionals and services supporting individuals, working with them to shape their care, in locally-based teams to deliver personalised care. We are also developing a shared care record which will enable all professionals to access to vital information when they need it, to improve how we join up the care we provide.

We aren't making the most of the opportunities that new technology offers to improve people's care.

From the success we have already seen in projects across mid and south Essex we know that investing in technology will help to put people in control of their health and care, while also providing the opportunity to reduce the pressure on our services. We are committed to focusing on digital transformation across health and social care to benefit both our residents and staff.

Recruiting more people to work in health and care, and supporting our workforce must be a priority.

Our plans mean nothing if we do not have a highly skilled workforce, working in dedicated teams to deliver high quality, person-centred care. Our plans set out how we will recruit new people to work in the health and care sector, as well as do much more to retain and develop our existing NHS and social care workforce through the development of new roles and career development.

People have difficulty in being able to get an appointment at their GP surgery.

We have and are continuing to invest in primary and community care so that different health and care professionals work together in teams based around groups of GP practices. This will make gaining access to care and support easier for our residents and presents a real opportunity to make sure our residents get the care they need, delivered by the most appropriate professional; at the time they need it.

Improving mental health care needs to be a priority area.

We want people of all ages to be able to get the help and support they need quickly and easily, so that mental health needs are identified and treated early. We are increasing our focus on prevention and wellbeing, as well as providing enhanced support for people in crisis and providing effective inpatient care.

We should work more closely with local community groups and voluntary organisations.

Our plan is centred on linking everybody in our communities together to help keep people healthy, well and active, to support people when they are ill and care for people when they need help.

It's important we consider travel and transport to and from health services and activities which keep people healthy and well.

We recognise transport can be a barrier to people accessing the care they may need. Our plan aims to ensure our services join-up in the very heart of our communities, to make more support available closer to where people live. And if they need to travel for very specialist care, support is in place for those who need it.

Next steps

The Partnership is committed to do all it can to make sure people's voices remain at the heart of our development and we will continue to build on the excellent work Healthwatch partners and engagement colleagues have done to date.

We are developing at citizens' panel – called Virtual Views, to support us to research and understand the views of a demographically representative sample of our population.

We will also continue to draw on insight, both quantitative and qualitative, gathered within our Partnership member organisations.

Given their multi-agency membership, the Health and Wellbeing Boards across Essex, Southend and Thurrock, both upper tier, and at district level, continue to provide an effective public forum for discussions on local plans and wider challenges.

We have already begun a series of conversations with our community, voluntary sector and service user groups with the aim of co-producing a refreshed engagement framework. This will be an important foundation to deliver the ambition outlined in this strategy to become a fully integrated care system by April 2021.

3. Delivering Our Vision – Our Ambitions

3.1 Ensuring Equality: Addressing Inequality & Reducing Unwarranted Variation

Reducing inequalities is a complex challenge and we are committed to working with our partners to address this. We aim to do this by:

3.2 Creating Opportunities: Education, Employment, Housing & Growth

Tackling wider determinates ~ a system of anchors

As key employers and commissioners of services, partnership organisations are well placed to impact on local economic opportunities and to focus on addressing inequalities. Major areas of opportunity include employment and recruitment practice, local procurement targeted at small and medium sized business, and work with schools and other education providers to encourage educational attainment and aspiration.

Employment and Recruitment.

Basildon Hospital is leading work in this area and is seen as a national lead with a focus on understanding the local job market. The hospital is also working with Essex County Council to support people with learning difficulties to enter the workplace.

Thurrock Council have worked with NELFT to develop a new shared vision of an integrated front line health and care worker, with a defined career pathway. These posts are being recruited to and have proved very popular in offering a new career choice where carer jobs were seen as unpopular. Essex County Council is starting work on how to explicitly recruit from more deprived areas, recognising that there are barriers to accessing work that will need to be addressed.

Working with schools

As large employing organisations with significant workforce challenges, partners are recognising the importance of working with our schools to address aspiration and employment issues, particularly in more deprived areas. The Essex Children's Partnership Board, including head teachers, has endorsed this approach. With support from a public health grant, Basildon Hospital is embarking on an outreach programme to local schools to help improve interest and recruitment to NHS roles.

Case Study:

Enabling Carers to Care – Essex County Council

Under the Care Act, local authorities have a statutory duty to offer carers assessments and to provide appropriate information, advice and guidance on other forms of support available to promote wellbeing.

Care givers contribute to enabling and empowering their loved ones to stay healthy and live meaningful lives. In Essex, it is estimated over 145,000 people provide care to their loved ones at an estimated value of £822,300,544 per annum.

The commissioning approach for care givers is fragmented across the system. Our research and engagement has identified areas for improvement where we can make a genuine impact on carers' lives and the lives of those they care for. To support this, we designed a strategic framework to underpin how, as organisations and systems, we can support and improve the lives of all care givers, structured around the five A's:

// Becoming a care giver – 'adopting' the role of a care giver
// Identifying as a care giver – 'accepting' life as a care giver
// Living well – 'adapting' to life as a care giver
// Responding to change - remaining 'alert' to the changing demands of being a care giver
// Life after caring – 'adjusting' to life after being a care giver

Our plan for the coming months we will see us work with partners to design and implement a Care Giver's Charter to establish commitment across communities to better support people in a care-giving role and implement a cultural change programme to support individual resilience.

We will work with newly formed Primary Care Networks to re-design the community offer for care givers and help develop networks of support around them, including supporting the increased take up of care technology, and developing a digital tool to support carer networks.

Procurement

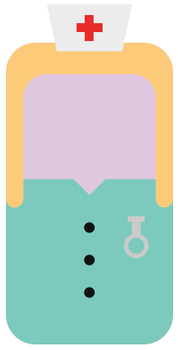
Partners are committed to supporting the local economy and commissioning services locally where possible. Essex County Council perform well compared to other counties with over two thirds of commissioned spend occurring within Essex, and one third with small and medium sized enterprises. As a system we will consider how best we can work within existing procurement regulations to support the local economy and will also consider how to ensure local social value is in contracts, including, for example, the number care leavers or people with physical and learning difficulties employed.

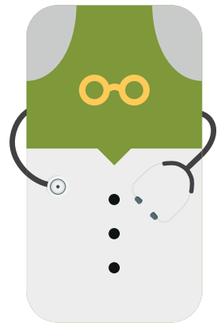
South Essex 2050

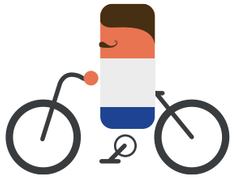
The councils of Basildon, Brentwood, Castle Point, Rochford, Southend-on-Sea, Thurrock and Essex County are working together to develop a long-term growth ambition to underpin strategic priorities across the region. The 'South Essex 2050 Ambition' aims to ensure that the local authorities retain control of South Essex as a place, putting them in a strong position to shape and influence wider plans and strategies from government and other investment priorities.

In January 2018 the local authorities formed the Association of South Essex Local Authorities (ASELA) to ensure implementation of the ambition. The association will focus on the strategic opportunities for the south Essex economic corridor to influence and secure the strategic infrastructure that will help our communities to flourish and realise their full economic and social potential. The aims of the association are to:

// Develop a strategy to open up spaces for housing, business and leisure development;
// Transform transport connectivity;
// Support industrial opportunity;
// Shape local labour and skill markets;
// Create fully digitally-enabled places;
// Secure a sustainable energy supply;
// Influence and secure funding for necessary strategic infrastructure; and
// Enhance health and social care through co-ordinated planning.







3.3 Health & Wellbeing: Healthy Lives & Healthy Behaviours

Through partners working together, we aim to support individuals to live healthy lives through:

// Providing information and support for people to self-care including through on-line and digital options.

// Focusing on prevention of ill-health by:

- // Providing good housing through the Local Plan of each local authority, with a particular focus on the quality of housing
- // Improving diet and increasing physical activity by building on the "Livewell" and "Active Essex" initiatives, and targeted investment from Sport England.
- // Weight management services supported by a range of community-led delivery partners.
- // Ensuring good air quality
- // Offering smoking cessation services and smoke free environments
- // Working to improve alcohol treatment services across our three hospitals, ensuring links to wider mental health and community drug and alcohol support services.
- // Identifying and supporting individuals at risk of developing ill health, for example through the National Diabetes Prevention Programme.
- // Providing people with long-term conditions access to talking therapies to prevent the onset of anxiety and depression as a result of their condition,
- // Using social prescribing to provide help to people who have "social" needs, for example, through provision of information and guidance on housing or welfare issues.
- // Signposting people to local support mechanisms in their communities that help to address issues of social isolation and loneliness.

3.4 Moving more care closer to home

We are committed to bringing as many services as possible closer to people's homes – whether that is through digital channels, where residents can access support on-line or through designated apps, or by bringing a range of physical, mental health and social care services into the community.

It is our intention that the vast majority of services will be delivered locally – including lifestyle support services, outpatient appointments, some diagnostic tests and long-term condition support. We will also ensure swift and safe return to home for our residents after a period of hospitalisation.

Part two of this document describes, for some major health conditions, how we will be bringing care closer to home, through our primary care networks and places.

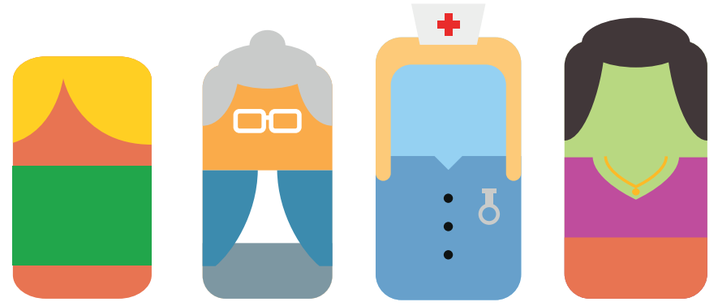
3.5 Transform & Improve Health and Care Services

While the standard of care offered through our health and care services is generally good, we know that we need to make improvements. We have established programmes to improve and transform:

// Primary and community care
// Cancer services
// Mental health services
// Cardiovascular disease
// Elective care
// Care for older people
// Respiratory services
// Maternity services
// Care for people with learning disability and autism

Part two of this document provides further detail on each of these areas.

4. How will we know if we've made a difference?



4.1 Our Outcomes Framework

Our Directors of Public Health have developed a Partnership-wide outcomes framework (see Appendix 3) to help us to track our progress in the key areas where we believe, by working together in partnership, we can make a difference.

Linked to our five ambitions described above, table 1 illustrates a selection of indicators that we will use to monitor our progress. Over the coming months, we will work to develop stretching ambitions over the 5 year period of this strategy for each of the indicators given below.

Table 1: Outcomes framework

	How will we know we've made a difference?	What metrics will we use to track progress?
Reducing Inequalities	Inequality will reduce and our residents will enjoy longer, healthier lives.	// Slope Index of Inequality // Healthy Life Expectancy measures

Creating Opportunity	Our children achieve good development and educational attainment.
	
	Employment will rise.
	
	Homelessness will reduce and we will have good housing stock.
		// School Readiness
		// Percentage of people in employment
		// Educational attainment
		// Statutory homelessness
		// Number of non-decent dwellings
		// Air quality

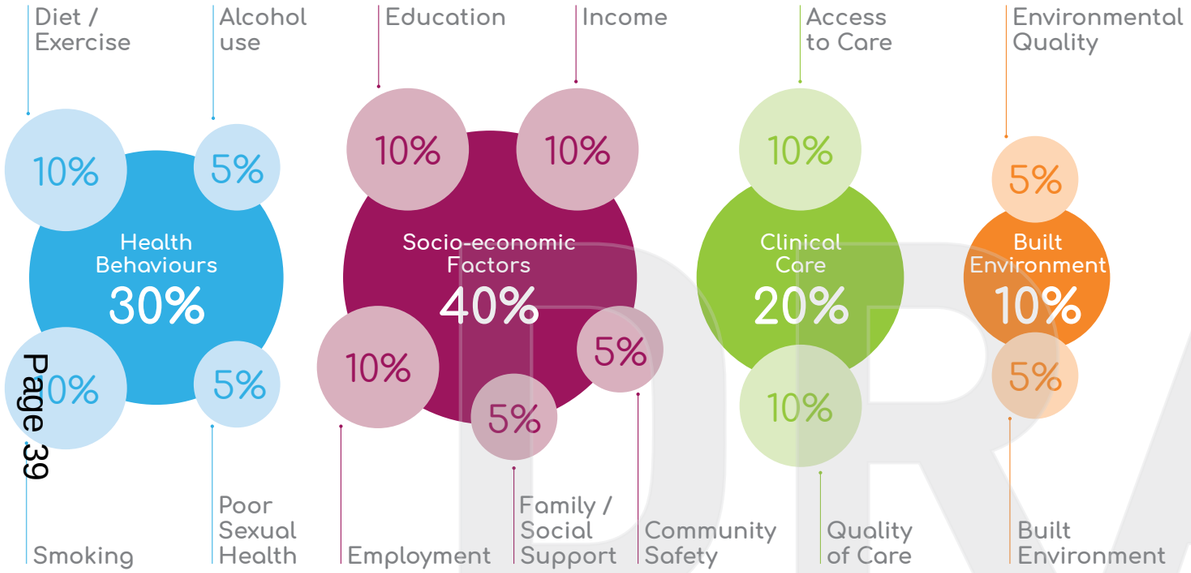
Health & Wellbeing	Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.	// % of adults classified as overweight or obese.
		// Reception and year 6 prevalence of overweight children
		// % of adults physically active
		// Smoking prevalence
		// Admissions for alcohol related conditions
		// QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol.
		// % of people self-caring after reablement
		// Patient Activation Measures

Moving care closer to home	Our residents report good access to and experience of primary and community services.	// Patients reporting good overall experience with practice appointment times and good experience of making an appointment.
		// Patients reporting a positive experience of their GP practice.
		// Delayed transfer of care
		// A&E attendances conveyed by ambulance

Transforming our services	Our residents have consistent, timely access to safe, high quality health and care services.
	
	The outcomes from our services are improved.
		// Breast and bowel screening uptake
		// Cancer waiting times
		// Elective waiting times
		// % of residents with high self-reported happiness
		// Reduction in depression cases
		// Reduction in self-harm
		// Reduction in suicide
		// Treatment and recovery rates for IAPT services
		// Physical health checks for patients with serious mental illness
		// Mental health admissions to hospital

5. Addressing the Wider Determinants of Health

It is well known that socio-economic factors and behavioural aspects have a significant impact on individual health and well-being; the provision of clinical care provides a relatively small impact as illustrated below.



SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

To ensure sustainability of our health and care system in the future, far more emphasis must be placed on the wider determinants of health.

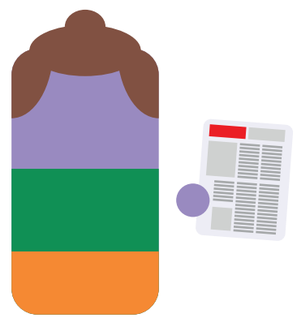
The vast majority of interactions with residents take place locally – and this is where we can have most impact on supporting health and wellbeing. The focus of this strategy is on those local plans that are owned by local people and local partnerships, aligned to the relevant Health and Wellbeing Board. The concept of subsidiarity (to deal with issues at the closest level) is key to the success of this strategy.

While partners operate at a number of different levels, we have sought to ensure that there is no hierarchy attached to these levels.

5.1 What will be different?

We are changing the model of care in mid and south Essex, from one which is reactive and heavily reliant on acute hospital services, to one which is focused on empowering people to stay well and look after themselves, ensuring local access to care and support when required.

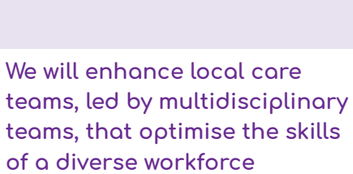
Current System	New System
Reactive care, focused on treating illness and an over-reliance on hospital services	Personalised and anticipatory care, with a focus on preventing ill health and supporting wellbeing
Emphasis on organisations and professionals	Emphasis on empowering people to look after themselves and offering seamless health and care services when required
Services are fragmented – mental and physical health are seen as separate	Integrated care means that holistic needs are supported
Variable quality of services	Remove unwarranted variation and improve standards
Variable access to services	People can access advice and support quickly and as close to home as possible

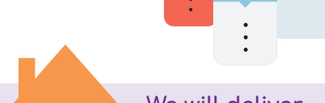


5.2 Our design principles

In line with this shift in care model, we have started to develop a new collaborative operating model to describe our approach. The design principles of this operating model can be summarised as:

Design Principle	Description

We will co-design with insights and intelligence, putting residents at the centre 	// We will work with our residents and staff to shape services that are focussed on better outcomes, long-term sustainability and continuous improvement, driven by a feedback culture.
	// We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity.
	// We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.

We will connect people together, delivering integrated care in the community 	// Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions. // We will ensure different organisations work together, meaning people get the right care more quickly and easily.
We will support people to stay well through prevention, self-care and independence thus building resilient communities	// We will shift from the reactive transactional model currently in place, to a responsive, proactive and sustainable system that focuses on keeping residents well and supports them through all stages of their life. // We will reduce inequalities by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention.

We will adopt digital and technology by default	// Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions.
	// Other channels will remain available but used only when most appropriate.
	// Staff and residents are supported to adapt to new ways of working and champion innovation.

We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce	// Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset.
	// Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services.
	// We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.

We will deliver services as close to home as possible	// Community based provision of services is the default position, unless necessitated by clinical need. This ensures residents are able to access health, care and wellbeing services in the most appropriate setting for their needs, including online.

5.3 Defining our Future Operating Model

Our operating model is based around the following anchor points:

You

Your family, friends and social networks

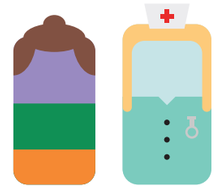
Your neighbourhood

A community focussed approach to supporting up to 50,000 residents.

Community, mental and physical health and social support delivered through PCNs.

Your Place

Partnership working focussed on planning and delivering health and care services to support populations of up to 400,000 through 4 places: Thurrock, Basildon & Brentwood, Mid Essex, and South East Essex.



Our System

Supporting health and care services in neighbourhoods and places by sharing good practice and resolving common issues across 1.2m population

5.3.1 You

Our model of delivery starts with the individual, their family, friends and social networks. We want to support people to live healthy lives, to make good decisions and to look after themselves.

We will ensure that as individuals and communities people have the right information and support to stay as well as possible for as long as possible. This information and support will be developed in partnership with individuals and communities so that it meets their needs, and it will take advantage of the growing number of channels available to people to consume information in a format and at a time that suits them. We acknowledge that a "one size fits all" approach to care and support will not work across 1.2m people.

When individuals are unwell, or are living with a long-term condition, we are committed to adopting the key principles of the personalisation agenda to support them to be part of their care planning, and where appropriate to tailor the support that they receive to meet their individual needs.

5.3.2 Your Neighbourhood

People are embedded in their local community and this is where good support for health and care is most impactful. Evidence suggests that "natural communities" comprise around 30-50,000 residents and, across mid and south Essex, we are using this footprint as a means of ensuring that social care, welfare, advice, physical and mental health services collaborate to provide seamless care and support to residents. To support this approach, 28 Primary Care Networks (PCN) have been formed; these are groups of practices collaborating around populations of 30-50,000 residents to provide better access and more streamlined services. Practices will work together to deliver some specialist services closer to home, and also provide services such as home visiting, extended hours access, and same-day appointments. With a focus on prevention and personal empowerment, PCNs will over time become the key operational delivery units for local and national transformation programmes, for example health screening and vaccinations, personalisation and ensuring people age well. PCNs are newly established and these deliverables will emerge over time.

Through PCNs we will deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care, consistent with what doctors report is needed. We will move to a GP-led system of care that focuses on improving population health and wellbeing, and supporting the sustainability of primary care and supporting services. The PCNs are developing their plans to open up new methods of accessing care and support, and expanding the workforce to incorporate new roles that will support people in different ways. These new roles in primary care include social prescribers, who can signpost individuals to different means of advice and support, and pharmacists working alongside GPs to manage medicines reviews and provide advice to patients.

5.3.3 Your Place

For mid and South Essex, "place based" systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

In mid and south Essex we have defined four Places:

// Thurrock

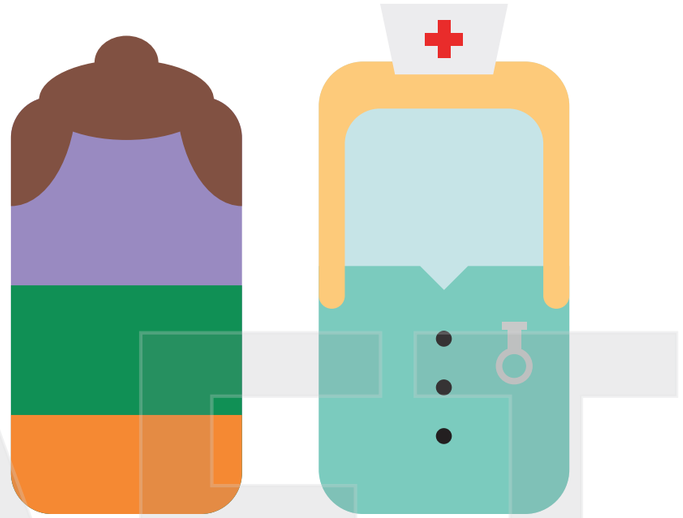
// Basildon & Brentwood

// Mid-Essex (comprising three district council areas – Maldon, Braintree and Chelmsford)

// South East Essex (comprising Southend, Castle Point, and Rochford).

Over time we expect that the four places become **Integrated Care Partnerships** – an alliance of local authority, NHS, community and voluntary sector organisations coming together to build and support resilient communities.

Each of our Places have defined local plans for and with local communities – these plans are described later in this strategy.



5.3.4 Our System

Some services and activities are best undertaken at system level (across the 1.2m population of mid and south Essex). We are working together on plans focusing on:

// The provision of acute hospital and acute mental health services

// Planning and development for our workforce

// System-wide estates and capital planning

// System-wide digital transformation

// Data and analytics to support population health

// Clinical leadership

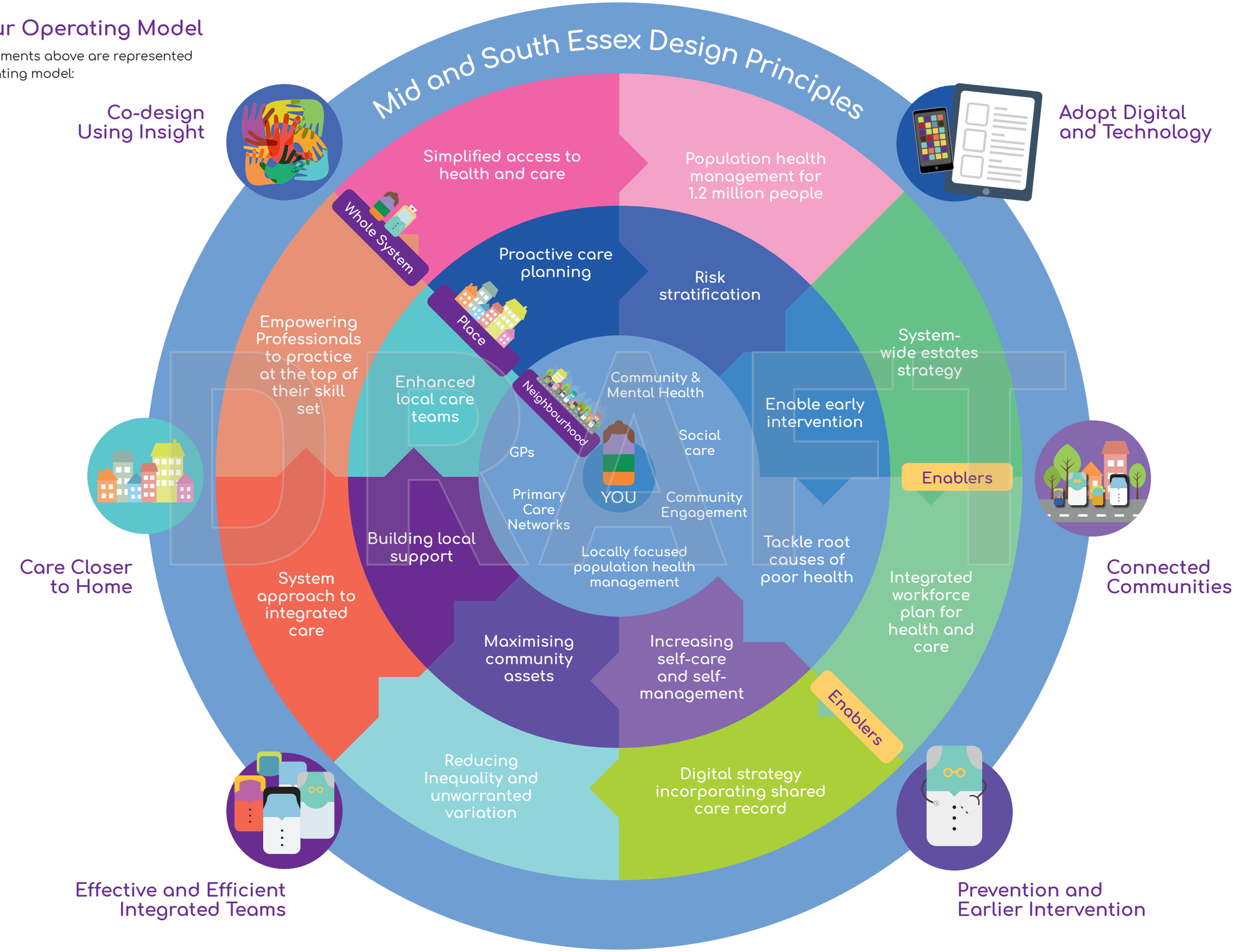
// Opportunities for research and innovation

We are committed as a partnership to meet the ambition set out in the NHS Long-Term Plan to become an integrated care system by 2021. This means that we will put our partnership working on a more formal footing, enabling better collaboration to help us to support the health and wellbeing of our population.

Part two of this document describes the work we will undertake to achieve this designation.

5.3.5 Our Operating Model

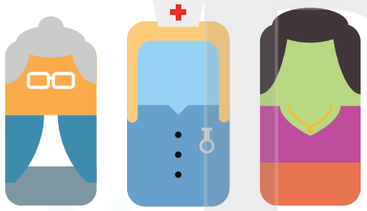
All of the elements above are represented in our operating model:



6. Place – Based Plans

Our "place based" systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

The following sections provide detailed information on our four places.



PRIORITIES:

1. Implementation of the aligned team model
2. Support patients and carers to better manage their own health and wellbeing
3. Support residents to access alternative services

PRIORITIES:

1. Transform community and primary care services
2. Develop strong and resilient communities
3. Transform how residents with long-term conditions are managed in the community
4. Reconfigure the out of hospital estate

PARTNERSHIP:

Basildon & Thurrock University Hospitals NHSFT

North East London NHSFT

Thurrock CCG

Essex Partnership University NHSFT

Thurrock Council

Community Voluntary Sector

Primary Care Networks – 4

Basildon & Brentwood

Predicted population growth

Age Band	2020	2041
0-14	19.23%	20.82%
15-24	16.48%	19.30%
30-64	46.03%	49.81%
65-89	17.30%	23.83%
90+	0.97%	2.12%
Total	269.4	312.2

PARTNERSHIP:

Basildon & Thurrock University Hospitals NHSFT

North East London NHSFT

Basildon & Brentwood CCG

Essex Partnership University NHSFT

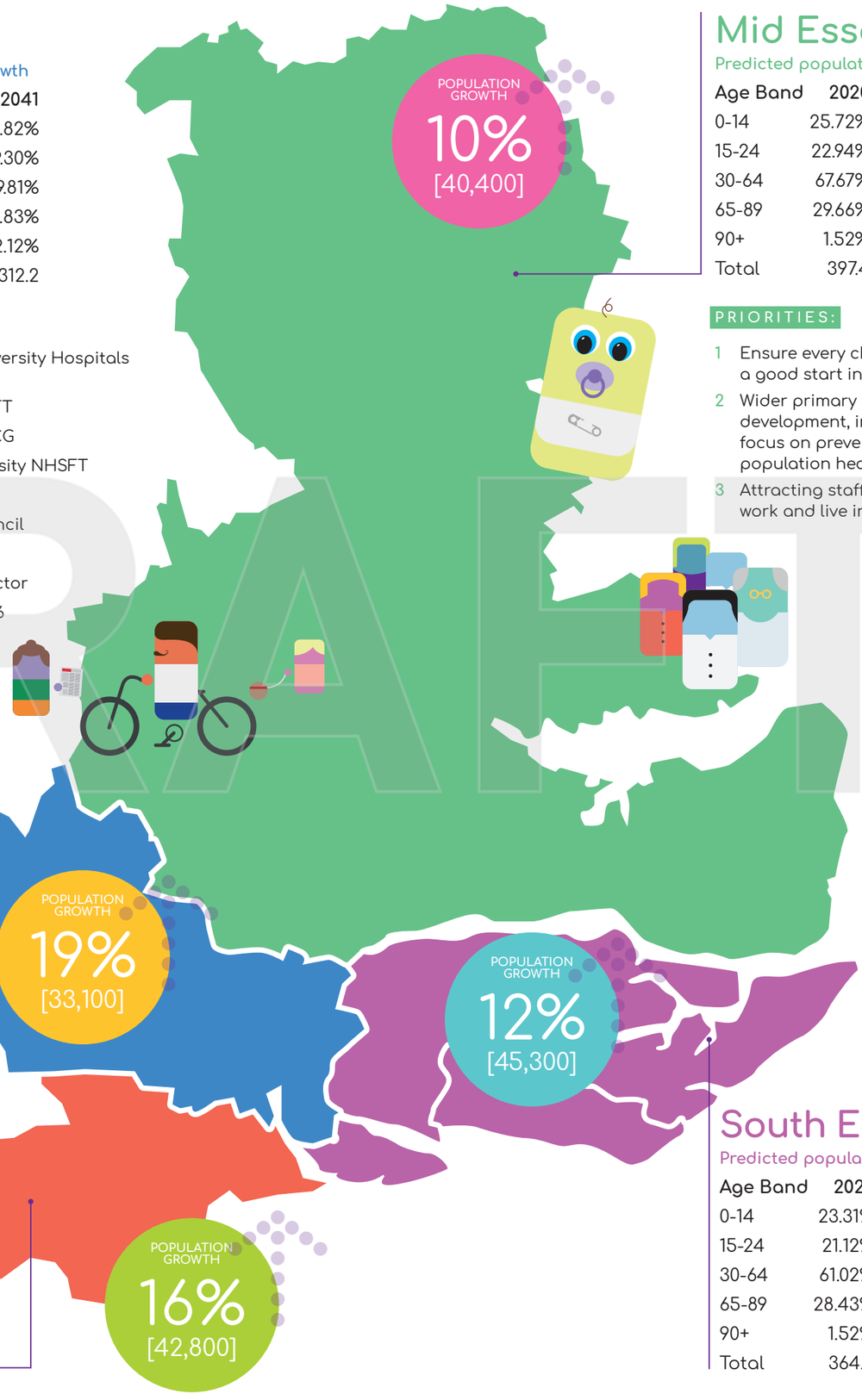
Essex County Council

Brentwood Borough Council

Basildon Council

Community Voluntary Sector

Primary Care Networks – 6



Thurrock

Predicted population growth

Age Band	2020	2041
0-14	14.29%	15.14%
15-24	11.28%	14.03%
30-64	30.59%	34.26%
65-89	8.87%	13.40%
90+	0.37%	0.85%
Total	176.2	209.3

Mid Essex

Predicted population growth

Age Band	2020	2041
0-14	25.72%	25.45%
15-24	22.94%	24.72%
30-64	67.67%	67.41%
65-89	29.66%	40.91%
90+	1.52%	4.01%
Total	397.4	437.8

PRIORITIES:

1. Ensure every child can have a good start in life
2. Wider primary care network development, including a focus on prevention and population health
3. Attracting staff to want to work and live in mid Essex

PARTNERSHIP:

Mid Essex CCG

Essex County Council

Chelmsford City Council

Braintree & Witham District Councils

Maldon District Council

Provide CIC

Mid Essex Hospital

Farleigh Hospice

Community Voluntary Sector

Anglia Ruskin University

Essex Partnerships University NHSFT

Primary Care Networks - 9

South East Essex

Predicted population growth

Age Band	2020	2041
0-14	23.31%	23.90%
15-24	21.12%	23.42%
30-64	61.02%	62.40%
65-89	28.43%	38.90%
90+	1.52%	3.60%
Total	364.8	410.1

PRIORITIES:

1. Strengthened GP services
2. Appropriate access to secondary care
3. Improve outcomes for all-age mental health
4. Support self-care and prevention for all

PARTNERSHIP:

Southend CCG

Castle Point & Rochford CCG

Southend Borough Council

Essex County Council

Castle Point Borough Council

Rochford District Council

Essex Partnerships University NHSFT

Southend University Hospital NHSFT

Community Voluntary Sector

North East London NHSFT

Primary Care Networks - 9

6.1 Thurrock

Better Care Together Thurrock sets out our plans for delivering a fundamental change in how health and care services are delivered in Thurrock, recognising the importance of addressing the wider determinants of health and wellbeing. Our statutory Health and Wellbeing Strategy, overseen by Thurrock Health and Wellbeing Board, considers and stimulates action on those wider determinants.

Our vision

The Health and Wellbeing Board's vision is to 'add years to life and add life to years'. The Thurrock Health & Wellbeing Board strategy focuses on five key goals, each with a number of aligned objectives.

1. Creating opportunity for all, including objectives on educational progress. employment and training and prosperity
2. A healthier, safer and accessible environment, including objectives on outdoor spaces, good homes, air quality and connected communities
3. Better emotional health and wellbeing including objectives on supporting parents , reducing social isolation and supporting children and young people's mental health
4. Quality care, centred around the person, including objectives on the creation of four integrated medical centres (IMCs) in communities across Thurrock, improving GP services and supporting people to take control of their own healthcare
4. Healthier for longer including objectives on reducing obesity, increasing early identification of long term conditions, supporting smoking cessation and improving prevention and treatment for cancer

Our Population:

As of 2019, the Borough of Thurrock is home to an estimated 172,500 people. By 2041 this population is projected to grow to over 209,000 residents, an increase of approximately 21%.

Thurrock is a culturally and linguistically diverse borough. An estimated 25% of the population are 'non-white British', with this figure rising to around 30% amongst school-aged children. The population speaks over 70 distinct languages.

Thurrock has a relatively young population, with an average age of 36.9 years (lower than both the East of England average (41.6 years) and the England figure (39.9 years). This is directly comparable to the age profile seen in most London boroughs. The average age in Thurrock has been increasing over recent years however and this trend is expected to continue over the next 20 years, leading in time to a fundamentally different population structure - by 2041 Thurrock is projected to see a more evenly distributed age profile, with an increased proportion of residents in the 65+ and 90+ age groups in particular. This will mean an additional 14,000 residents aged 65+ years and 1,300 aged 90+ years respectively.

Thurrock's overall level of deprivation is lower than the national average, however some Thurrock neighbourhoods (predominantly in the southern and western parts of the borough) are within the most deprived 20% nationally. These areas also experience the highest levels of worklessness and benefit claimant rates.

Health outcomes within Thurrock vary by geography with a life expectancy gap between the best and worst performing wards of 9.7 years for males and 10.2 years for females.

In recent years healthy life expectancy has fallen from 65.7 years (males) and 64.5 years (females), to 62.6 years and 61 years respectively. This suggests that whilst individuals in Thurrock are living longer, they are doing so whilst experiencing more chronic, long term conditions, such as cancer, cardiovascular disease (CVD), diabetes and respiratory disorders.

Our Challenges

Thurrock experiences a number of challenges , these include:

// Staff recruitment and retention, particularly when competing with inner London allowances.

// Travel and access to services – the area comprises urban, rural and industrial areas

// Regeneration – costs are consistent with London boroughs but land values are lower than in neighbouring authorities.

Our Partnership

The Thurrock Integrated Care Alliance, jointly chaired by Mandy Ansell, Accountable Officer for Thurrock CCG and Roger Harris, Director of Adults, Housing and Health for Thurrock Council, oversees the local plan for health and care.

The Alliance is the result of strong historical collaboration between organisations. The Alliance comprises the following partners:

// Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)

// North East London NHS Foundation Trust (NELFT)

// Thurrock CCG

// Essex Partnership University NHS Foundation Trust (EPUT)

// Thurrock Council

// Community & Voluntary Sector partners

// Primary Care Network Leads

"The local authority recognises it is essential to work with the NHS to deliver services that are more joined up, more community based and reflect local community needs and aspirations. Place is important because all the evidence suggests that transformational change and genuine community engagement happens at a local level. That is why we are passionate about supporting our local agenda without forcing people into a 'one size fits all' arrangement, across unrecognisable bureaucratic boundaries"

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

The Thurrock Health and Wellbeing Board oversees the programme and is closely aligned with its delivery.

Thurrock has four primary care networks:

// Tilbury & Chadwell
// Corringham
// Grays
// Purfleet

Partnership working in Thurrock has been driven by a comprehensive Case for Change, which proposed using one locality (Tilbury & Chadwell) as an innovation site This is acting as the `route map', setting the direction of travel for the locality and enabling the alliance to test and learn how best to enable residents to stay well and independent. Shifting the system towards early intervention and prevention was a significant part of the work.

Our Priorities – Better Care Together Thurrock

Our Vision

To provide better outcomes for individuals that are closer to home, holistic and that create efficiencies (by shifting resources to deliver a better impact) within the health and care system

Our Aims

The alliance has five key aims:

1. Reduce the number of unplanned hospital and residential admissions
2. Reduce the number of A&E attendances for conditions that could have been treated elsewhere within the community
3. Reduce the number of delayed transfers of care
4. Keep people as independent as possible for as long as possible, and reduce/ prevent/delay entry into care and support services
5. Move more services out of hospital/acute care into the community

To deliver this a programme of transformation has been taking place across Thurrock that radically changes how services are accessed and delivered for residents. This programme has five main priorities:

Priority 1: To transform community and primary care services; this includes:

1. Improved access to primary care and an enhanced range of services available
2. Streamlining how primary care and community services work together in local teams
3. Greater emphasis on prevention and early treatment and support

Case Study:

Extended Primary Care Teams

In Tilbury and Grays the following professionals are working as an extended primary care team across all practices in the primary care network; paramedic, practice based pharmacist, physician associate, physiotherapists, advanced nurse practitioners and social prescribers. A process is underway to recruit mental health practitioners to join this enhanced team.

In addition existing health and social care services, community and voluntary services and assets, also work together to build a seamless service for residents.

Priority 2: To develop strong and resilient communities, this includes:

// Improved access to health and care solutions within the community, with a focus on prevention and early intervention
// Personalised care that focuses on 'what's strong' rather than 'what's wrong'
// Care solutions that incorporate a greater use of technology and of community assets

The approach looks at what is available within the community, how technology can help, and what friends and family can do before looking at a service option. A number of initiatives have been introduced to test and develop the approach, including:

Community-Led Support – One team has been introduced in Tilbury and Chadwell to give local people immediate access to social work and enable social workers to support and advise people at the earliest opportunity. The team has focused on reducing bureaucracy so that it can spend a greater amount of time face-to-face, and uses a strength-based assessment approach.

Wellbeing Teams – two Wellbeing Teams have been introduced in Tilbury and Chadwell. The teams focus on helping people to achieve what matters to them. The Wellbeing Teams will be working alongside enhanced primary care teams and will play a proactive role in helping others in the community to remain independent.

Local Area Coordinators (LACs) – Running successfully since 2013, there are 14 LACs in place to support people who are on the cusp of a crisis and work alongside them to enable them to articulate and achieve what a good life looks like to them. The approach increases individual resilience and reduces the need for formal service solutions.

Priority 3: To transform how residents with Long Term Conditions are managed in the community, this includes:

// Earlier identification of long term conditions (LTC)
// Emphasis on self-care and assistive technology
// Redesign of pathways of care to support people with LTCs

To support this priority we have implemented thirteen long term condition projects to improve outcomes, including:

// Increasing the uptake of NHS Health Checks, targeting high risk cardio-vascular disease patients
// Increasing detection, diagnosis and treatment of hypertension and atrial fibrillation to prevent emergency admissions and strokes
// Improving diabetes and pre-diabetes detection
// Increasing depression and anxiety screening and treatment for patients with LTCs
// Improving smoking cessation services
// Improving uptake of flu vaccinations amongst high risk patient groups
// Improved support for patients with respiritary conditions

Priority 4: To reconfigure the out of hospital estate

Over the coming three years, we will open an integrated medical centre (IMC) in each of our four localities. In addition to improving the provision of primary care services, following public consultation in 2018, the outpatient and diagnostic services currently delivered from Orsett Hospital will be redistributed to these local centres, enabling Orsett Hospital to close.

The IMCs will provide a range of services traditionally delivered from a hospital setting, including cardiology, haematology, and dermatology, ear, nose and throat, pain management, respiratory services and rheumatology. Thurrock has established a Peoples' Panel to support the transformation work required to re-provide services currently delivered in Orsett Hospital to the four new IMCs.

"Thurrock has always seen the value of working in partnership to develop solutions that meet the needs of our community. We are very lucky to be co-terminus with our Council and we work closely across many streams of work, sharing information and developing our system for the benefits of Thurrock residents."

Mandy Ansell, Accountable Officer, Thurrock CCG Officer

Engaging with our Community

Thurrock has a strong history of engaging with its community. The CCG has engaged on the changes to health and care in Thurrock through consultation, local engagement and through working closely with our Healthwatch. The initial conversations around doing things differently were taken out to the public in April – September 2016 through For Thurrock in Thurrock, the council further consulted in the summer 2017 with the 21st Century Health and Care consultation. The CCG has a number of avenues to gain information. This includes our patient group, the Commissioning Reference Group and through visiting local community hubs and support groups including the Thurrock Over Fifties Forum, stroke group and diabetes groups.

Thurrock Council also encourages feedback in its Your Place Your Voice community engagement work, where residents are asked about their priorities for health and care.

As our alliance develops further, there will be further opportunities for our residents to engage with our plans.

6.2 Mid-Essex

Our Population:

With a population of circa 392k, Mid Essex is the largest place in the mid and south Essex system. Estimated population increases to 2039 suggest there will be a 10.8% increase; in line with England averages.

Within mid Essex there are three district authority areas: Braintree, Chelmsford and Maldon, which have distinct population profiles. The Maldon population profile is significantly different to the other districts especially in the 20-40 year age categories.

The future increases in the 75-year plus categories across all districts is significant, while the population for under 75s on the whole reduces. This is likely to have a significant impact on our ability to support the more elderly population.

All local authorities in mid and south Essex have seen an increase in average Indices of Multiple Deprivation (IMD) scores, indicating increasing levels of deprivation between 2010 to 2015. The largest increases in deprivation were seen in Basildon and Chelmsford, although on the whole, the deprivation across mid Essex is lower than most other areas in Mid and South Essex.

Our key health challenges in mid-Essex relate to poor management of diabetes, a growing level of poor mental health, particularly for young men, and a growing homelessness problem.

Our Partnership

The Mid-Essex Live Well Partnership brings together partners enabling them to work together to understand the local social determinants of health and working with our wider population to implement changes. The Partnership is chaired by the CCG Director of Clinical Transformation, and is a collaboration between organisations working to support the population in mid-Essex. The Partnership comprises the following:

// Mid Essex CCG
// Essex County Council (Adult social care, Education, Children)
// Chelmsford City Council
// Braintree & Witham District Council
// Maldon District Council
// Provide CIC
// Mid Essex Hospitals
// Farleigh Hospice
// Chelmsford CVS
// Maldon CVS
// Community 360 (Braintree CVS area)
// Anglia Ruskin University
// Essex Partnership University NHS Foundation Trust (EPUT)
// Clinical Directors for each of the Primary Care Networks

Over time it is possible that further links will be made with statutory authorities and other key providers.

At partnership level, we interact with Broomfield Hospital, our community and mental health service providers primary care, and our local hospice to oversee integration and ensure consistent pathways of care. We can look at pooling or sourcing funding and joining up resources to support local service sustainability. The partnership links closely with the Essex County Council Health and Wellbeing Board.

We recognise, however, that for many areas of concern we can have most impact by working at the local level. To this end, we also work closely with our district authority partners on issues such as housing and leisure, as well as with voluntary sector partners to deliver support at the local level.

Across Mid Essex there are nine primary care networks. These are very much at an early stage of development. We have clear plans in place to support their development. Over time, the CCG expects to align staff with partners at district authority and primary care network level to maximise the benefits that local partnership working can bring. District Health and Wellbeing Groups will oversee the implementation of the local Live Well agenda. At this very local level, we also work to engage with our communities.

> "Our place based plans in Mid Essex will provide us with the opportunity to work with our local stakeholders around our common goal of ensuring that everyone in Mid Essex can livewell. The real excitement is that our plans will be built around our local population and maximise the use of our local community assets alongside our health and care services"
>
> **Caroline Rassell**, Accountable Officer, Mid Essex CCG

Our Priorities

The vision for the Mid Essex Live Well Partnership is "Creating Opportunities to Live Well".

By working together, we will jointly own issues and seek to act in a proactive way to support our residents. The Partnership has decided that its initial priorities will be focused in three areas:

Start Well

// Working together to ensure every child can have a good start in life and the education to ensure they can live well.

Wider Primary Care Network Development

// Development of the PCNs with support from system partners to align services so that there is greater sustainability across both health and care services. This will also focus on the preventative and population health agenda to mitigate demand on public services.

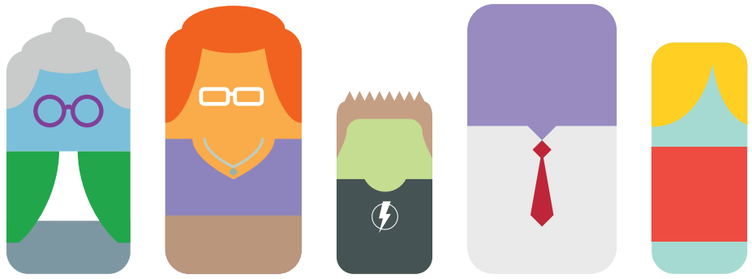
Workforce/Education

// Doing more to attract staff to want to work and live in Mid Essex. This will include being more proactive with schools to highlight the career opportunities within the public sector.

These priorities reflect the findings of the Joint Strategic Needs Assessment and align with the Joint Essex Health & Wellbeing Strategy. Over the coming months the Partnership will agree some outcome measures to track the success of these priority programmes.

Engaging with our Community

There is strong community engagement through individual organisations within the Partnership. Over the coming months, the Partnership will develop its plans on continuing community engagement.



6.3 Basildon & Brentwood

Our Population:

Basildon and Brentwood is coterminous with the boroughs of Basildon (population 185,000) and Brentwood (population 78,000) and has a GP-registered population of 279,000. There are 35 GP practices working across six primary care networks. The area has a mixed demography with some very affluent wards, and some of the more deprived wards in the country, pockets of high density housing to low density rural communities.

Pitsea and Laindon are more deprived areas with a significant regeneration planned which can support health and care integration. It is anticipated that by 2037, the overall population will have grown by 18%, with those aged over 65 years growing by 61%. The working age population (<45 years), will shrink whilst there will be a sizeable increase in the younger age group (0-14 years). The birth rate has remained fairly constant in recent years, although risk in maternal health must be addressed to reduce perinatal mortality and teenage pregnancies.

Brentwood is relatively more affluent whilst Basildon has very large disadvantaged communities. There is at least a seven year difference in life expectancy across the boroughs. There is a pronounced level of premature mortality, with cancer (134 per 100,000) and circulatory diseases (60 per 100,000) being the greatest burden. The inequality in health is highlighted by the difference in mortality rate in cancer between Pitsea North West in Basildon (140 per 100,000) and Tipp Cross in Brentwood (64 per 100,000).

While there has been progress in some quality measures, compared to the CCG's peer group (ONS Cluster of similar CCGs), the performance against metrics such as potential years of life lost from causes amenable to healthcare, health-related quality of life for people with long term conditions and those with long term mental health conditions are amongst the lowest recorded. Basildon has a significant proportion of excess deaths in winter especially in the older age group. The CCG has the highest proportion of people living with a common mental health condition compared to its peers.

It is estimated that 10% of local residents are acting as unpaid carers and many will experience changing health and housing needs. Around 6% of older people live alone in Essex and it is now estimated that 60% of them could develop dementia and therefore be more likely to enter residential/nursing care.

Our Partnership

Partners working across local health and care come together in the Basildon and Brentwood Alliance Forum. The Alliance Forum is chaired by Dr Boye Tayo, chair of Basildon & Brentwood CCG, and oversees planning and delivery of local health and care transformation. The Alliance is a collaboration between organisations working to support the population in Basildon & Brentwood and comprising the following partners:

// Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)
// North East London NHS Foundation Trust (NELFT)
// Essex Partnership University NHS Foundation Trust (EPUT)
// Primary Care Networks Clinical Directors (x6)
// Essex County Council
// Brentwood Borough Council
// Basildon Borough Council
// Basildon and Brentwood CCG
// Voluntary Sector organisations (via the CVS)

Basildon and Brentwood has six Primary Care Networks (PCNs) around the neighbourhoods of Billericay, Brentwood, Central Basildon, East Basildon, West Basildon and Wickford. The PCNs were formed this year to bring together general practices to form a strong foundation for the local integration of community based teams with primary care.

Basildon and Brentwood CCG is an active participant in three Health and Wellbeing Boards – Essex County Council, Basildon and Brentwood. The work of the Alliance aligns closely with the priorities of these three Health and Wellbeing Boards.

Our Priorities

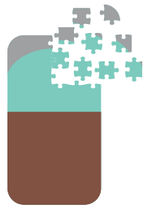
The Basildon and Brentwood Alliance have agreed the following priorities:

// Support local people to improve their health and wellbeing and stay independent for longer
// Reduce health and wellbeing inequalities for people of all ages
// Integrate health and care services
// Deliver safe and sustainable services
// Progress towards becoming an Integrated Care Partnership.

By working together around four initial priority areas we will strengthen our local partnerships and build a culture of integrated working that delivers improved outcomes of our population.

Aligned Teams

Improve integration of health and social care services around PCN footprints.

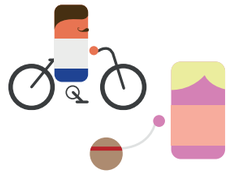


Dementia

Improve diagnosis and subsequent support for patients with dementia.

Intermediate Care

Review patient flows across health and social care and develop pathways to support optimal independence.



Reducing inactivity

Reduce levels of inactivity across Basildon as part of a Sports England pilot.

These priorities reflect the findings of the Joint Strategic Needs Assessment and align with the Joint Essex Health and Wellbeing Strategy.

Implementation of the Aligned Team model will transform the way services are integrated to better support the populations they serve. The Aligned Teams will operate on a Primary Care Network footprint and cover community health, mental health, primary care, social care and third sector provision with in-reach from secondary care services where appropriate. This model requires significant cultural change in the way services are delivered in order to risk stratify the population, proactively care plan and support patients and carers to better manage their own health and wellbeing.

The integration of services at a neighbourhood level incorporates a model for social prescribing that has been implemented across the Basildon and Brentwood footprint which has helped to provide signposting and support to patients on how to access alterative services.

Dementia has been recognised as a priority where each partner within the Alliance has a role to play in improving the initial diagnosis for patients with dementia and then the subsequent care and support provided to enable individuals to remain as physically and emotionally health for as long as possible.

Partners within the Alliance have commissioned an external review of Intermediate Care Services. The aim is to understand where our intermediate care offer can give people better outcomes and help more people stay at home. A case review and patient flow review is underway to establish the difference between one 'ideal' pathway for patients and the current provision. Through the Alliance partners will work together to redesign and integrate services so that care provided is seamless and people receive effective short term care in the community leading to the most independent long term outcome.

Essex is one of 12 pilot areas selected by Sport England with Basildon being targeted as an area with a high level of physical inactivity and higher levels of poverty and social immobility. Reducing inactivity will be a whole system approach focused on an asset based community development approach which is working with communities to harness their strengths, capacity and knowledge.

Outcomes:

By working together, we want to make a difference to the way in which services are planned, purchased and delivered. We have defined a small number of indicators to help illustrate that our new ways of working are having impact, these are:

// A reduction in non-elective readmissions for patients aged 75+ for medical reasons

// A reduction in falls-related admissions

// A reduction in the rates of physical inactivity

Whilst the initial priorities are focused around our elderly population, the Alliance Forum will be considering the needs of all age groups including children and young people.

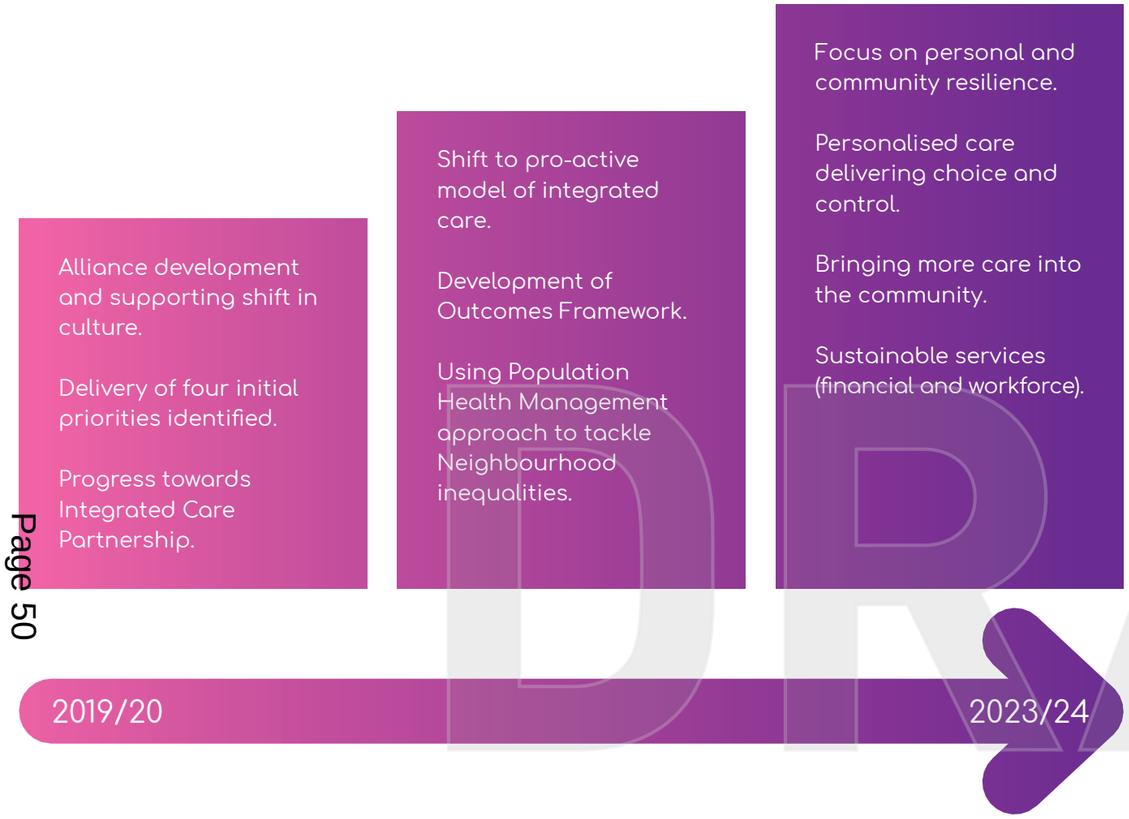
Our 5-Year Plan

Over the next five years the Alliance Forum will transition into an Integrated Care Partnership that will support the delivery of the ambitions set out in this strategy. In the first years the focus will be on delivering the agreed priorities outlined above. It is recognised that a significant change in culture is required to deliver the transformation programme and that will not happen overnight.

The next step change will be as we mature as an Integrated Care Partnership and move towards the development of an outcomes framework that measures how we are performing and improving the health and wellbeing of our population. The Alliance Forum will adopt a Population Health Management approach using health and social care data to have a greater understanding of people's needs to target interventions and deliver care to achieve maximum impact.

Towards the later years the Integrated Care Partnership will establish a comprehensive model of personalised care that supports people of all ages and their carers to manage their physical and mental health and wellbeing. This will build upon community resilience and the asset based development approach that has been adopted in the earlier years.

The Integrated Care Partnership will work with the ICS to ensure that the investment in system wide estate and digital technologies will enable more care to be brought into the community and integrated with the established teams. The workforce expansion and development to support the new models of care will accelerate throughout the five year period.



Page 50

How we will deliver this

The Alliance Forum will have clear oversight of the delivery of our agreed priorities through a shared work plan, with each scheme being led by the most appropriate organisation. The focus will be on the integration of health and social care services to support a shift away from reactive to pro-active care. Combined with the development of the asset-based management approach that build individuals and community resilience, the transformation in culture will start to impact.

The Alliance recognises that the traditional approaches to contracting and commissioning and individual organisational accountability will not deliver the change required. Over time the Alliance will adopt a collective approach that is outcome driven for both operational staff and senior leaders.

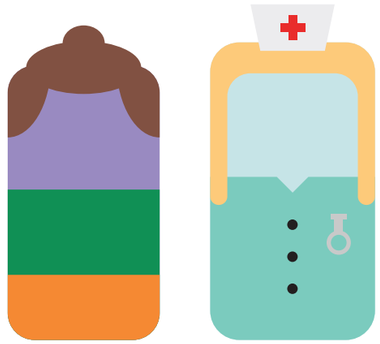
The Alliance Forum supports 'doing things once' where it makes sense to do so. This would include the development of a service operating model that would define standards and outcomes. Nonetheless, there are likely to be some specific nuances in the delivery of the service offer as a result of taking a targeted Population Health Management approach to reducing inequalities in certain wards within the population of Basildon and Brentwood.

Engaging with our Community

The priorities and approach the Alliance is seeking to take is driven by significant engagement with communities and stakeholders undertaken by the CCG, Essex County Council, Basildon Council and Brentwood Council. There are very active patient participation groups, residents groups and service user groups in existence and the Alliance will ensure these are part of the design and implementation of service change locally.

Our Work with the System

The organisations represented within Basildon and Brentwood Alliance Forum work at a system level on cross-cutting issues such as developing our approach to population health management and prevention, digital transformation, ensuring best use of resources, workforce planning and transformation.



6.4 South East Essex

Our Population:

South East Essex (SEE) comprises three main areas – Southend, Castle Point and Rochford with a combined population of c370,000.

The SEE local system is under intense pressure as a result of a multitude of issues including but not limited to a growing population, reduced funding for adult social care, a plateauing of funding for the NHS, an increase in individuals experiencing problems with their mental health, multiple long-term conditions, social circumstances (eg. housing, employment etc) and an increase and variable ask of public services. These are challenges that are faced all across the country and, in South East Essex, the circumstances are no different.

Moving forward SEE will see a growth in population of 6%, or 20,000 people, over the next 10 years (2018-2027); this coupled with funding pressures and lifestyle choices, will under the current model of care and support, lead to an exponential and unmanageable demand for public services.

SEE as an area is one that contains a collection of smaller communities, each with their own specific care needs based upon the demographic of the population.

It also has a complex and varied health profile as summarised within Public Health England's Local Authority Health Profiles 2018.

	Castle Point	Rochford	Southend-on-Sea
Health in summary	The health of people in Castle Point is varied with the England average. About 15% (2,100) of children live in low income families. Life expectancy for both men and women is similar to the England average.	The health of people in Rochford is generally better than the England average. Rochford is one of the 20% least deprived district/ unitary authorities in England, however about 10% (1.300) of children live in low income families. Life expectancy for both men and women is higher than the England average.	The health of people in Southend-on-Sea is varied with the England average. About 19% (6,300) of children live in low income families. Life expectancy for men is lower than the England average.
Health inequalities	Life expectancy is 6.6 years lower for men and 3.6 years lower for women in the most deprived areas of Castle Point than in the least deprived areas.	Life expectancy is 3.9 years lower for men and 5.4 years lower for women in the most deprived areas of Rochford than in the least deprived areas.	Life expectancy is 11.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived areas.

SEE, like many other areas, is a complex landscape of health and social care commissioners, providers and third sector organisations. SEE is rich in community assets which currently work, some through partnership, some through silos, in support of communities and individuals. The area is diverse on many fronts: poverty, affluence, ethnicity and age but is rich in terms of its physical assets. The challenge for SEE is to ensure that these are used to support the health and wellbeing of our residents. The SEE area also forms part of the Mid and South Essex Health & Care Partnership planning footprint.

The complex nature of SEE aligned with increasing demand for services, unaligned workforce cultures, reducing community resilience and decreasing resource means that we have to deliver support, preventative interventions and integrated services on a population needs basis.

Our Partnership

The local health and care work is overseen by the South East Essex Partnership Group, chaired in rotation by a senior executive from either Southend on Sea Borough Council, Essex County Council or either of the two CCGs. The Partnership Group is a collaboration between organisations working to support the population in SEE and comprising the following partners:

- // Southend CCG
- // Castle Point & Rochford CCG
- // Southend Borough Council
- // Essex County Council
- // Castle Point Borough Council
- // Rochford District Council
- // Essex Partnership University Hospitals NHS Foundation Trust (EPUT)
- // Southend University Hospital NHS Foundation Trust (SUHFT)
- // Southend Association of Voluntary Services (SAVS)
- // Castle Point Association of Voluntary Services (CAVS)
- // North East London NHS Foundation Trust (NELFT)

The area is covered by nine primary care networks (PCNs), which have formed this year with the aim of building on the strong foundations built informally between locally

"The development of a long-term plan for mid & south Essex represents a significant opportunity for the south east Essex system.

With the plan focused on prevention, health inequalities and local people managing their health, there is a clear link with the strength and community based approach we are collectively delivering in south east Essex.

We are very excited for the future and keen to explore the benefits from the close working relationships we have invested and built over the course of the past few years. The engagement across south east Essex to develop the 'Living Well in Thriving Communities' strategy was substantial and we are now beginning to see the benefits of this work."

Simon Leftley, Deputy Chief Executive (People), Southend-on-Sea Borough Council and Chair of the South East Essex Group Partnership.

integrated teams and primary care providers. The PCNs in SEE represent a significant opportunity to further integrate local teams with primary care, to respond to the local needs of our populations and build upon the community assets within our localities.

There is a direct line between both the Southend Health and Wellbeing Board, the Essex Health and Wellbeing Board and the partnership group. The group is mandated on behalf of both Boards to develop, evolve and implement the agreed locality strategy.

The implementation of the locality strategy operates through an approach of partnership working, integration and collaboration. The arrangements that are evolving are built on this principle and it is clear that it will require organisations and interests, to be represented in multiple forums. The group has the task of oversight and ensuring that the key challenges to implementation of the locality strategy are addressed. Co-design and co-production are principles that run throughout and the group supports each individual organisation represented to report separately into governance channels.

Our Priorities

There is a desire from all partners to invert our existing model of care, for future solutions to be driven by the lived experiences of the residents within an area. The desire includes the mobilisation of all the assets at our disposal (within local authorities, health and third Sector) which can be used to engage communities and empower a supportive functionality and ensure public services are designed to support this approach.

It is the ambition for the system to move from a reactive model of care and enable an improved focus on prevention, self-care, personal responsibility, empowerment and wider community resilience. The model will articulate how the support individuals require can be delivered against this backdrop that is person centred, outcome focused, integrated and that provides the best possible outcomes for the individual.

Traditional top-down approaches to change, or transformation, that rely on an overarching system (or national) view that is then broken down into sub-systems (local views) are not considered as the best option for maximising the collective power of individuals, communities and the third

> "Health and care partners across south east Essex are collaborating across organisational boundaries to unlock the potential within the community and better understand how local residents can be supported to keep safe, well and happy in their own homes.
>
> The development of our local Primary Care Networks offer a positive foundation for strengthening and re-designing community services to meet local needs. We want to proactively support people at risk of deteriorating ill health, focus on what individuals can do and support them to achieve their goals while supporting local staff to work in partnership with shared information to provide joined up care."
>
> **Dr Sunil Gupta**, Chair, Castle Point & Rochford Clinical Commissioning Group

and statutory sectors. By focusing on the deficits, rather than the assets, top-down approaches can sometimes be criticised for undervaluing the importance of local knowledge and assets and, as a result, the differentiation between local and systemic/national issues becomes misunderstood. This can be problematic, particularly when thinking about improving health and wellbeing, as it can cause us to think that the wider perspective is all that matters and prevent us from understanding local needs. Place-based working is a grass roots, person-centred, approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight.

By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective, taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved. Through the above approach and by strengthening our local partnership the following priorities have been agreed;

// **Strengthened GP services.** The provision of primary care services is diverse and varied. With the evolvement of the PCNs and locality working our plan is to invest in and improve GP services so that outcomes are improved for residents and patients. Patients, in the first instance will be encouraged to take responsibility for themselves and access GP services only when needed. GPs will work in partnership with partners to ensure access to front line services will be dictated by need rather than availability. An outcome for patients will be that they are able to access the right care at the right place at the right time.

// **Appropriate access to secondary care.** We will invest in the community, in primary care, in social care so that our residents will only need access to secondary care services when it is absolutely necessary.

// **All age mental health** is an increasing issue for the SEE population. We will invest in mental health services, build partnerships across organisation so that patients who have a need for mental health interventions receive the best possible outcomes.

// **Supporting self-care & prevention** through Population Health Management. By understanding further the needs of our local population, integration and local working can be tailored. Through sharing data and working in partnership we can further understand the impact of the wider social determinants (eg poor housing, income, diet, environment etc) on an individuals' health and wellbeing. The impact of living close to or having better access to parks or open spaces can be better understood. This understanding (as examples) will influence who and what we invest our limited resources in.

Our 5-Year Plan

It is collectively agreed that the current approach to commissioning, delivery and the subsequent monitoring of success is not conducive to supporting the development of a locality approach. Providers often have conflicting priorities as a result of different approaches to commissioning, and no ability to obtain a system view of current and future priorities.

It is considered that a move to measuring outcomes will address the first issue – and the system is in the process of identifying how an outcomes framework may be structured.

For this to be successful all parties need to agree the key outcomes the system wishes to achieve, and commission and provide services that ultimately contribute to the delivery of these.

The SEE plan to deliver our agreed strategy is across two levels:

Firstly, we will work at a locality level supporting the development of locality teams. We will support the development of a culture built through partnerships and relationships. Integrated working will be actively encouraged, safe spaces will be created through which operational staff will be able to try different initiatives, learn and evolve. The community and community assets are at the centre of this plan as is a strength based approach. The initiatives developed will be in partnership with our communities, they will directly respond to a need and will place the person at the centre. Operational relationships across the entire system will be challenged, the wider determinants of health and wellbeing will be a major consideration. Most importantly, the learning from each initiative will be understood and used to evolve the next steps.

Examples within this first level that have already been delivered are: the development of a community group to address social isolation and loneliness (West Central Locality); regular multi-disciplinary team working (all localities); the development of the 'hub' concept (East Central and East Localities); assistive technology and care homes (West Central Locality); dementia navigators (all localities).

Future examples include the development of a community based asset around the new St Luke's Primary Care Centre (East Central Locality).

Secondly, our senior leaders will be challenged to work in partnership at both an individual and organisational level. This will be achieved through the development of outcomes, a plan to further pool budgets, work in true partnership with providers and strengthen relationships with the community and voluntary sector. Our leaders will listen to communities, residents, patients and operational staff. Outcomes will be 'made real' for our leaders so that they can understand the impact of their collective decision making. However, a risk has been identified with the merging of the CCG and the engagement of senior leaders within the SEE system.

How we will deliver this

The model of care designed for SEE is one that focusses on enabling people to remain independent. It is a model that moves the focus to pre-emptive and pro-active care and ensuring communities and individuals have access to the necessary assets to enable this to happen.

In addition to this ambition for the whole population it fundamentally focuses on the community as consisting of four distinct cohorts

1. Those that do not require care or support at this point in time, nor are they expected to require care or support over the next five years
2. Those that, based on a variety of factors are likely to require care and support within the next five years, and the expectation that they are identified and provided access to solutions that either defer or delay the requirement for care
3. Those that, despite of the best intentions of the individual, their community and support network do require the support of formal services – in this instance the system collectively works to ensure they continue to live well with care and/or support in place and return to living an unsupported healthy and active life in a safe and timely manner, and
4. Those that will always need care and support who will receive services that enable them to live well regardless of the complexity of need

Whilst the 'Living Well in Thriving Communities' model has a focus on personal and community resilience and the strengthening of support available within the community (primary, community and through social care), there is no denying that people will continue to need a level of care and support that is either best provided, or overseen, by the clinical/medical expertise available through an acute provider. The model of care however places an emphasis on both timely – and where possible pre-emptive - intervention and the pro-active return of individuals to their normal place of residence with any required on-going care and support delivered outside of a hospital ward.

For this to be successful there would be an expectation that those responsible for delivering support within the locality setting link with acute colleagues to ensure the care provided is seamless, and the drive is to ensure the individual returns to their normal place of residence in a safe and timely manner.

As individual organisations each partner has already stated their own vision and values. Whilst these are specific to each individual organisation and would have been developed through wide organisational and stakeholder engagement, all organisations have common themes running through their values. Using these individual organisational values it is possible to extract a number of key principles that the system wishes to work to:

// It is accepted that the combined strength of the system is greater than the individual strengths of the organisations that make it. As such a principle of collaboration shall be adhered to across SEE to address the challenges and deliver the model as described in this document

- Previous attempts to redesign the system have failed in part as a result of what is sometimes referred to as the 'fortress mentality' – in order to overcome this the partners will be open and honest in the interactions with each other and the populations which they serve
- Underpinning both of these is a need to be compassionate and supportive – not only towards the populations that they serve, but also to individual organisations' positions. The system has a greater chance of overcoming challenges together by accepting them as system challenges, as opposed to separate organisational ones

We will ensure that where it makes sense to 'do things once' the system will support this. The expectation is that strategic direction will be defined once across the system ensuring that there is a single approach to: (a) defining the model and ensuring consistency in model development where this makes sense; (b)where gaps in interventions or functions are identified within localities and where this gap exists across multiple localities a single approach will be strived for; (c) standard operating procedures for functions such as MDT's or social prescribing; (d) agreeing locality population health and wellbeing outcomes; and (e) developing and delivering an approach for the definition, extraction and analysis of information needed to support locality development.

It is acknowledged that whilst we can simplify need and challenges across the wider footprint each locality will have its own specific nuances based upon the local population. These include;

- Health behaviours such as tobacco use, diet and exercise and alcohol and drug use
- Physical environment such as air and water quality, housing and transport
- Social and economic factors such as education standards, employment levels and income
- Access to and quality of clinical care

Collectively, whilst these contribute to the length and quality of life of an individual they also contribute to an individuals' ability and appetite to engage with their own health and wellbeing and take responsibility for their own independence.

Engaging with our Community

The development of Locality based models of care, which focus on prevention, personal empowerment, community resilience and the underlying principle of services and interventions being developed around the needs of the population, relies heavily on the assumption that local people will be involved in all levels of developing, implementing, reviewing and assessing the new models of care.

To support the development of localities the system needs appropriate resource from all organisations working to implement an engagement strategy built on:

- The principles of co-design and co-production - involving, collaborating and devolving – and evolution from current approaches to engagement, and
- A whole system approach, across locality, communications and engagement to offer a place based offer for the locality and where appropriate and specific locality focus to meet separate needs and requirements.
- Working in partnership with voluntary sector and communities to build upon what is already strong within localities.
- Working with residents on a good life model, helping people to stay strong, preventing the need for a service in their lives.

It is anticipated that shared resources are identified to address and manage these requirements and that a joint plan is developed and implemented to support the wider transformation of the system

Our Work with the System

The organisations represented within SEE work at system level on cross-cutting issues such as developing our approach to population health management and prevention, digital transformation, ensuring best use of resources, workforce planning and transformation. We need to keep building and working on a shared purpose ensuring that behaviours and values are consistent across the system.

7. Our Current Challenges

Organisations within the Mid and South Essex Health and Care Partnership are facing significant pressures, both in terms of rising demand for services, shortages in staff and financial challenges.

Workforce

Securing a sufficiently skilled workforce is a challenge for all partners in our system. In the NHS, vacancy rates are high, and this is creating pressures both in relation to service provision and finance (the locum /agency staff rate of 14% is higher than the average across the East of England). We are in close proximity to London, and trained, experienced staff are often attracted to work there; this is exacerbating our workforce pressures.

In social care, there are significant workforce challenges, particularly within the domiciliary care market, where there is a high turnover of staff and a number of provider failures. Attracting nursing staff and managers to work in care homes is also very challenging. It is often difficult to attract younger workers into the care market when they can obtain similar or higher salaries in the private sector.

See section 28 and Appendix 4 for further detail.

Performance & outcomes

We face significant challenges in performance against NHS Constitutional Standards, in particular, demand for urgent and emergency care which impacts significantly on waiting times for cancer and elective care,

It is of concern to us that our cancer outcomes are not where we would want them to be and this will be a major area of focus for us in the coming months.

In general our performance against mental health standards – including access to talking therapies, early intervention for first episode psychosis and children and young people's mental health – are in line with constitutional standards requirements, but we know that we have further to go to improve services for residents experiencing mental health conditions.

Part two of this document describes our work to improve performance and outcomes in more detail.

Demand

Demand for our services is rising – our primary care strategy (June 2018) identified that as a combination of increasing demand and a lack of primary care capacity we are approximately 20,000 GP appointments short per week. As well as impacting patients who may not be able to access the support they need, this lack of capacity undoubtedly places additional demand on other services within the system, as a significant proportion of patients looking for a GP appointment will attend A&E. We estimate that if we do nothing to address capacity issues in primary care, the gap could grow to 60,000 appointments per week, with the attendant impact on patients, carers and services. Our work through Primary Care Networks and developing our place-based plans are geared towards addressing these challenges.

Local authorities

The scale of the challenge facing social care is creating an uncertain service and financial environment within local authorities. Demographic pressures, growing public concern and a system at 'tipping point' contribute to this uncertainty whilst increasing financial pressures solidify the issue.

Council funding for social care is derived from the remaining revenue support grant received from central government, from locally generated incomes such as council tax and business rates, and from user charges. Current national policy is to end the revenue support grant over the next few years and for Local authorities to retain 75% of business rates raised. In addition, with the Government only recently announcing a one year spending review for 2020/21 there remains continued uncertainty with Government funding for social care. This policy presents a risk to local authorities as they may find themselves with revenues that differ significantly from the social care spending needs.

Additional funding has been available via the Better Care Fund, an Improved Better Care Fund grant, winter pressures money and the ability to supplement council tax with a social care precept alongside recent one-off social care grants. However, the difficulties facing social care remain and the Government has yet to provide the full funding and certainty of funding requirements. In addition, the thrust of Government policy for local authority funding is for local authorities to enter an era of financial self-sustainability, which will bring imminent challenges given the demands and cost pressures of social care.

Challenges around the increasing demands of workforce, provider stability, recruitment and retention remain despite proactive work by the local authorities to address concerns.

The task set by national policy is to consolidate and integrate services across health and social care. With no certainty around the future funding for social care local authorities have identified high risk to committing funding over the long term.

NHS Finance

The NHS in mid and south Essex has traditionally been a financially challenged system and this has impacted on our ability to provide investments into delivering high quality healthcare for our population. We have agreed a delivery plan to meet allocated system control totals over the next five years. These plans are not without challenge, however, it is only by working together, and making best use of the wealth of data we collect, can we reduce duplication and drive efficiencies in the system. Part 2 of this document and Appendix 5 provides further detail on NHS financial plans.

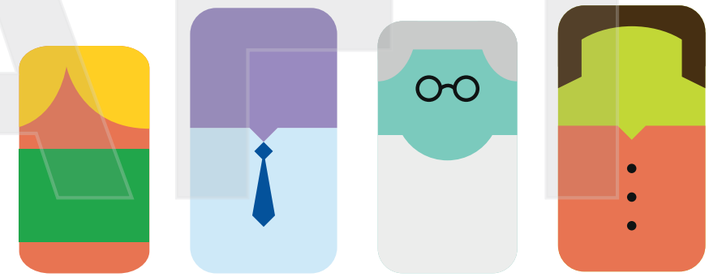
Addressing challenges together

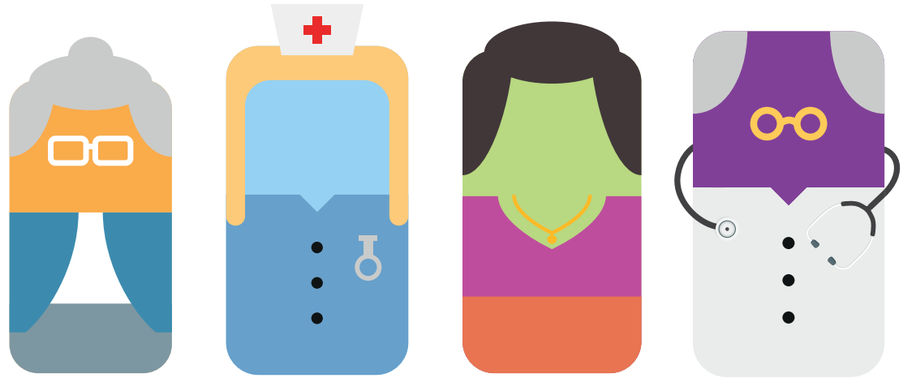
Through the Better Care Fund (BCF) NHS and local authority partners are working together to address the challenges on each sector:

// Thurrock's Better Care Fund Plan reflects the vision for and progress made on delivering a redesigned place-based health and care system. The pooled fund now totals £48m of joint health and care funding, with the plan's schemes designed to shift activity away from the acute sector. This includes a strong focus on prevention and early intervention as well as ensuring, as far as is possible, that the current adult social care market can be stabilised. Governance arrangements for the BCF Plan are through Thurrock's Integrated Care Partnership and ultimately through the Health and Wellbeing Board.

// The challenges in Southend are significant and demand for services continues to increase. The Southend BCF plan continues the work of integration, community asset building and locality development and builds on all the successes and learning from previous years. There is a strong focus for the Southend BCF on strengthening primary care through the development of Primary Care Networks, investing in the community and alleviating pressures within the acute environment. As noted elsewhere in this strategy, Local Authority finance is uncertain so the challenge for the BCF has been to find balance between sustainability and investment at pace. The Southend BCF plan is further underpinned by the close partnership held with partners across mid and south Essex.

// The Essex BCF plan is worth a total of £154 million in 2019/20 and aligns to the wider integration landscape across Essex. The Essex health and social care landscape is particularly complex, with five CCGs and three Health and Care Partnerships that overlap Essex borders. The BCF supports local delivery of Long Term Plan aspirations and forms the foundations for integrated working. At a pan-Essex level the focus is on prevention; early intervention and enablement, safeguarding, and care market quality and sustainability. Individual CCG locality-based pooled funds channel funding according to local priorities. The Essex Health & Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning and acts as the final point of governance for the Better Care Fund.





Part Two: Our Delivery Plan

8. Delivering on NHS Long Term Plan Commitments - Introduction

This part of the strategy outlines how the Partnership will deliver on the foundational commitments in the NHS Long Term Plan (LTP).

The LTP set out a number of criteria against which plans would need to align.

Our plans are:

// **Clinically-led** – senior clinicians are involved in leading the development of all of our plans – through individual clinical transformations programmes, PCN Clinical Directors, provider and commissioner clinical leads and, at system level, through the Clinical Cabinet. All of our change programmes have clear quality impact assessments and "check and challenge" through the various clinical fora. Further information on our Clinical Cabinet and plans for future clinical leadership arrangements can be found in section 33.

// **Locally-owned** – we have engaged with our communities over a long period of time and this engagement continues through individual statutory organisations, through pathway and programme groups, and via the system-wide Service User Advisory Group, The feedback received from all these sources has helped to shape our plans (see section 2)

// **Realistic workforce planning** –within the current workforce restraints, individual organisations have set realistic workforce plans to enable the safe delivery of current and transformed services. Our workforce plans have been triangulated with finance and activity plans, and we have placed great focus on retaining and developing our existing staff alongside the development of new roles to meet the changing needs of our population. See section 28.

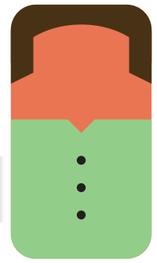
// **Financial balance** – our plans observe the business rule set out in the NHS LTP Implementation Framework. As part of our plans to achieve Integrated Care System designation, we recognise that we have further to go in relation to maturing our financial management across the system and this work is underway.

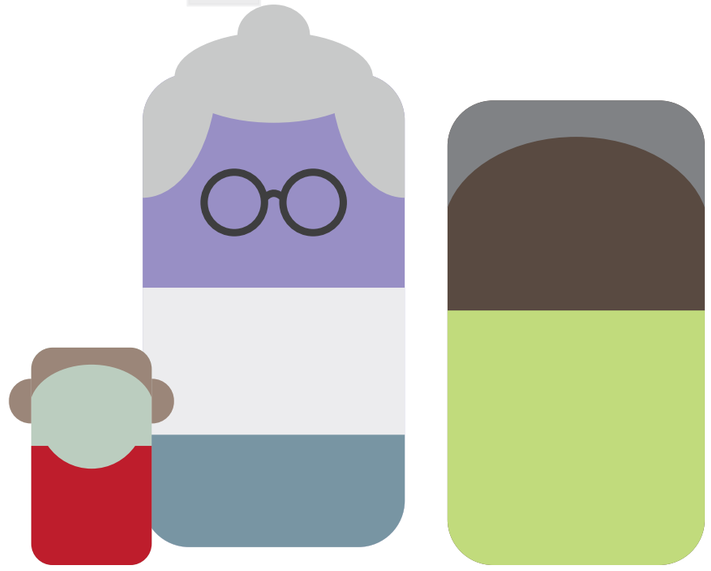
// **National standards and LTP commitments** – as a system we are committed to delivering the requirements of the LTP – and we set out below how we will do this.

// A focus on **reducing inequality and unwarranted variation** – as a partnership we are committed to reducing health inequalities. Our strategy has described how we will do this through our focus on creating opportunities, supporting healthy lifestyles, bringing care closer to home and transforming our services.

// **Engaging partners** – our plans are a collaboration of partners involved in delivering health and care services in mid and south Essex,

// **Focussed on innovation** – we place great emphasis on innovation in our system. Our work on innovation is summarised in section 31.





9. Prevention and addressing health inequalities

Clinical Lead: **Mike Gogarty** (ECC), **Ian Wake** (Thurrock), **Krishna Ramkhelawon** (Southend), Directors for Public Health
Senior Responsible Owners: **CCG Accountable Officers**

Prevention is about transforming life outcomes, and not simply about stopping bad things from happening. An estimated 40% of all ill health is preventable. By reducing the prevalence of the risk factors, we will reduce the burden of ill health. We know that prevention is best achieved through improving material wealth with a focus on employment and education, addressing social isolation and tackling unhealthy lifestyle choices. We are committed to using evidenced based clinical and non-clinical interventions and planning and infrastructure that influence life outcomes from birth.

Our Commitments

With an ageing and growing population, it is imperative that we find ways to reduce avoidable demand on our statutory services. Prevention requires actions across the Partnership. It cannot be done by any single organisation. The aims of our prevention programmes are to:

- Improve the health and wellbeing of our population
- Support people to be in good health for longer (improving healthy life expectancy)
- Target interventions to improve self-management for people with long-term conditions
- Develop our staff to work in different ways – promoting wellness
- Develop our digital capability to support residents to live well

9.1 Giving children and young people the best start in life

Every child and young person, regardless of the circumstances into which they are born, should have the opportunity to maximise their potential and future life chances.

Our Commitments

We are focussed on ensuring that mid and south Essex is a place where children can flourish and achieve their full potential in life.

We know it makes strong sense to invest in the early years from an economic perspective as the long-term savings that can be generated are considerable.

Current Work & Future Plans

Thurrock

Brighter Futures Thurrock represents an integrated children's partnership which brings together – Healthy Families, the Prevention and Support Team and Children's Centres. The ambition for Brighter Futures is to ensure children and families achieve good outcomes through universal provision and when needed through effective early help. This model will be underpinned by a Children's Prospectus from 2020/21. This high level strategic document will seek to clearly articulate Thurrock's vision for the health of its young people.

Local evidence points to key challenges for the under 5's - these include immunisation, obesity, breastfeeding initiation and maintenance, communication and language, outcomes at the two to two and half year child development check within health visiting and early years, oral health and accident and minor illnesses. A wellbeing offer for the 0- fives is being co-produced in Thurrock to address these needs, thereby providing an equitable evidenced offer to residents based on need.

Childhood immunisations trends in Thurrock have experienced a downward trend since 2010, specifically MMR1, MMR2 and PCV. In response the public health team have developed a child immunisations recovery plan, 2019 -21. This was prepared in partnership with NHSE and overseen by the Essex Vaccination Committee. Implementation commenced in June 2019. The plan aims to

- Improve understanding of performance at a smaller area level
- Understand the barriers and opportunities underpinning vaccine uptake.
- Improve access to vaccinations for children
- Ensure proactive messages about childhood vaccination are promoted in line with local social research and national evidence

A Better Start Southend
our children our community our future

A Better Start Southend is a 10-year test and learn programme funded by The National Lottery Community Fund, awarded £40m in 2015 to transform children's lives in Southend-on-Sea. Working with key Partner organisations across health, social care and education, and with local people - parents, carers and volunteers - engaged at every stage, ABSS is helping shape innovative services for young children and families for years to come. With a focus on **diet and nutrition, communication and language** and **social** and **emotional development** as well as cross cutting themes of **system change** and **community resilience**, ABSS is piloting inventive projects including breastfeeding support groups and 1:1 advice, healthy eating programmes (HENRY), maternal mental health initiatives and family support workers - as well as projects supporting speech and language development and building economic independence of families through work skills programmes.

Focussing initial 'test and learn' projects in six of Southend's most deprived wards, the programme aims to share the learning across a wider geographical footprint and will work with partners to that end. Data analysis, research and evaluation is undertaken by specialist data teams and higher education partners.

For more information visit
www.abetterstartsouthend.co.uk

Essex County Council

ECC has commissioned a partnership of Virgin Health and Barnado's to deliver a focussed, evidence-based and needs-driven approach to the Best Start in Life. This was informed by ethnographic research into the needs of local young people and families.

The council and partners recognise the central importance of evidence-based parenting support in ensuring school readiness especially within deprived populations and high risk groups and a set of outcome based KPIs have been agreed to ensure progress in this area.

In some areas there are unacceptable levels of child poverty and the system is adapting the Healthier Wealthier Child model from Glasgow using links between midwives and health visitors and local Citizens' Advice Bureau (CAB) to ensure young families can access all the support, advice and benefits they need.

Southend

Childhood immunisation in Southend is generally improving with the transfer of the Health Visiting service in-house. The council is closely aligned with the A Better Start Southend (ABSS) programme, and is developing a new framework for the commissioning of the 0-19yrs service with a focus on serving the most disadvantaged communities better and to bring about incremental behaviour change through engagement and co-design of support services.

ABSS's mission is to achieve system change such that by the conclusion of Lottery Funding, local partners have embedded a sustainable system. The aim is to shift the focus away from traditional service commissioning towards greater levels of community and practitioner ownership, recognising the social capital we can build will be key to sustainability of services and the local approach.

9.2 Flu Immunisation

An effective flu immunisation programme will prevent vulnerable people from becoming unwell.

Our Commitments

We commit to working with existing networks to:

// To increase public awareness of the need for the vaccine, its benefits and to dispel myths

// Support primary care networks to offer the vaccine – eg. offering flu clinics outside normal hours, using GP-online to book appointments etc.

// Regularly monitor uptake data, to have a better understanding of practice/ group variation etc. in order to give support.

Current Work & Future Plans

Essex

Supports public awareness of winter health through its pubic facing website that signposts to NHS information on seasonal flu immunisation and other ways to stay healthy. In addition the council is promoting the uptake of seasonal flu immunisation among public facing social care staff.

Southend

The 2019/20 Flu plan for Southend-on-Sea aims to increase the uptake of the vaccination in key vulnerable groups through collaboration across healthcare and public sector organisations in the borough to optimise resources and increase public awareness. The key aspiration of the plan is to achieve 75%+ uptake in adult vaccinations, 48%+ uptake in pre-school children, and 65%+ in school age children. Additionally, key vulnerable groups such as homeless/rough sleepers are being prioritised for service outreach and the LeDeR Programme has identified people with learning disabilities as a key group to prioritise.

A key component of the flu vaccination plan is the vaccination of healthcare staff and of public-facing staff in the local authority and partner organisations. The plan has widened access to the staff vaccination programme to key staff members in, for example, housing services and the voluntary sector.

Thurrock

The overarching strategy of the 2019/20 Thurrock Flu action plan is to work with existing networks including GP surgeries, extended access health hubs, pharmacies and community nursing, to offer the flu vaccination to a wide range of our population, particularly those aged 65+ and our 'at risk' population aged 64 years old and under. The work involves collaboration with staff working in care homes, healthcare workers, carers, and those who come into contact with vulnerable groups.

9.3 Cardiovascular Disease (CVD) Prevention

The most recent modelled prevalence of cardiovascular disease published by Public Health England highlighted a gap between the registered prevalence in the area for hypertension, atrial fibrillation and diabetes. These are major risk factors for premature death and disability and yet are relatively simple to address to enhance prevention. However, there is still a substantial variation in rates of early diagnosis and optimal treatment.

High quality primary care is central to improving outcomes in CVD because this is where much prevention, diagnosis and treatment is delivered. Improving primary care management of cardiovascular and cardiovascular-related conditions can prevent both adverse health events and costs. This underpins the need for the development of programmes that can identify patients suffering from long-term conditions at the earliest onset.

Long term conditions disproportionately affect certain groups of people such as, vulnerable individuals, those in the BME groups, areas of high deprivation or those with a disability. One of the factors identified to contributing to the highest level of inequality is due to low capacity in primary care. To tackle this unfairness, public health is looking at bringing screening services closer to the community and contributing to creating more efficient screening and diagnosis pathways in primary care.

Our Commitments

// Bring screening services closer to the community.

// Target groups of vulnerable people to decrease existing inequities.

// Create efficient, evidenced based pathways for screening, referral and diagnosis.

// Educate on and promote high quality management of cardiovascular disease.

// Work collaboratively with the voluntary sector to better understand the needs of the population and create programmes and interventions that are tailored to specific population groups.

Current Work & Future Plans

Thurrock

// NHS Health Checks provide a systematic way of identifying patients either at high risk of, or with undiagnosed cardio-vascular disease and then providing referral to lifestyle modification programmes or where necessary clinical management. NHS Health Checks in Thurrock are provided either by the GP practice or by the Thurrock Healthy Lifestyle Service. There is an ambition to reach a 60% conversion from invites to completed checks. Last year the service achieved 48%. Improvements have been made through new software that enables consistent delivery of the health check and ensures data is transmitted back onto the clinical systems. In 2018 a localised best practice guide was produced to help GP practices deliver the NHS Health Check programme to a high standard.

// The Thurrock the Hypertension Detection project commenced in April 2017, as a 3 year programme to address the high level of under-detection of hypertension. The overarching outcome of the project is to achieve a 10% increase in hypertension register completeness in Thurrock by 31st March 2020 compared to the 31st March 2017 baseline. The series of detection streams being implemented as part of the overall project includes;

  // Community Pharmacy detection (Jun. 2017 – Mar. 2018)

  // GP waiting area detection (Since Feb. 2018)

  // Smoking Cessation clinic detection (Since Jul. 2018)

  // Community hub detection (Since Aug. 2018)

  The programme has been highly successful, delivering a 6% increase in register size in its first year.

// Diabetes Detection Programme – a series of pilot projects which commenced with a Diabetes Detection in Dentistry is underway. The purpose of Thurrock Diabetes Community Detection is to develop work streams to act on the low case finding rates for diabetes mellitus (type 2), aiming to increase the detection rate of people living with diabetes who are asymptomatic and are at risk of serious health implications if undiagnosed. Additional to early diagnosis, pre-diabetic range is also being considered, with high risk patients being referred into the National Diabetes Programme for healthy lifestyle education. It is intended that the projects will also increase the number of people receiving appropriate care and treatment to prevent disease onset.

// CVD Upskilling - Public health have developed and implemented a number of work streams focused on the improvement in detection and management of patients with long term conditions. These work streams also carry with them a significant financial investment. To ensure the effectiveness of the initiatives and achievement of outcomes it is acknowledged there is a need to upskill the practices and clinicians who will be delivering the required activity. A focused training programme incorporating up to date guidelines and evidence-base, aimed specifically to address the needs of front line primary care was procured. The CVD Upskilling programme encompasses six Modules of training, with the aim of supporting primary care services to achieve the stated outcomes of ensuring appropriate practice based investigations and diagnosis, on-going CVD management and onwards referrals. The first round of training was completed in March 2019 with resoundingly positive feedback. The second cohort of clinicians commenced in October 2019.

// Stretched QOF – this contract with primary care commenced in July 2018 to incentivise GP practices to achieve above the maximum Quality and Outcomes Framework threshold for selected CVD, mental health and respiratory indicators. In doing so, this seeks to provide interventions to an increased number of patients eligible, improving the management of long term conditions in primary care leading to the following outcomes:

  // Reduction of non-elective hospital activity from patients with long term conditions.

  // Reduction in the number of patients having a major health event that results in a new or increased need of adult social care packages (e.g. stroke)

  // Improvement in the health and wellbeing of patients with a long term condition (LTC).

In 2018/19 the programme delivered a significant increase in performance across 18 of the 19 QOF indicators selected, with performance in CVD indicators in Thurrock now significantly better than the England mean. In 2019, the contract was updated to reflect the new QOF indicators and clinical threshold targets as indicated in the Long Term Plan.

Essex

// Health Checks: Essex County Council remain one of the top performing county councils for health checks and have an ambition to increase uptake in the most deprived groups such that 25% of checks are within the most deprived quintile. Additionally the Council continue to commissioning senior health checks, recognising the higher absolute risk and lower numbers needed to treat in the 75 to 84 age group.

// Hypertension: Essex completed a hypertension detection and management project in 2018. Our consideration of published evidence and local data suggest further specific initiatives in this area in Essex are not currently a priority although we would still expect primary care to identify and manage people with high blood pressure and wider cardiac risk in line with national guidelines.

// Diabetes prevention - Essex are keen to work with primary care colleagues to ensure people who may be at risk of diabetes are referred for lifestyle advice including weight loss. Local review of literature and a desire to simplify systems suggests a model simply based on weight is best to identify the most people at risk of type 2 diabetes and there is ample capacity in lifestyle and weight loss support services to support referrals.

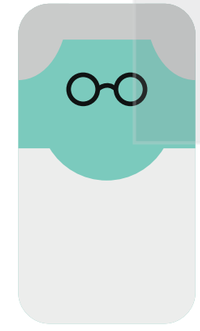
// Atrial fibrillation - Essex have run several initiatives over recent years to work with practices to ensure people with AF receive optimal stroke prevention management. There is however further scope for improvement in this area and therefore the AF work highlighted in section 21 is welcomed.

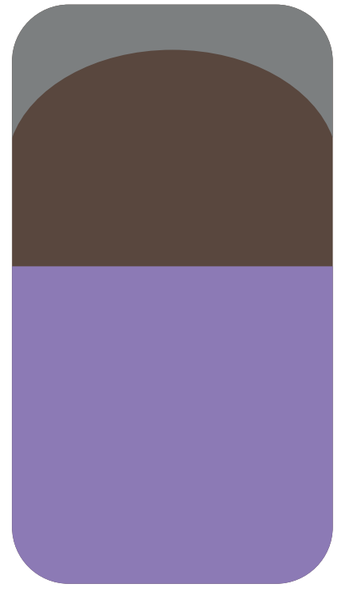
Southend

Southend-on-Sea met its targets for provision of NHS Adult Health Checks in 2018/19 and has sought to build on this for 2019/20, working with the new PCNs to better target people in areas of higher deprivation and provide more flexible access out of hours service through community hubs. In addition, a plan has been developed for provision of a dedicated service to increase access to physical health checks for people with significant mental illness.

A local incentivised scheme for PCNs has been developed to support prevention interventions across the life course. This provides an extended QOF for a set of prevention areas to be prioritised according to key areas of PCN need from childhood through to older age populations. This extended QOF service includes work to reduce risk factors for CVD through identification and optimised management of atrial fibrillation (AF) and hypertension. This will be in place from January 2020.

Additionally, surgery pods are in place in a number of GP practices in Southend with a plan agreed to roll this out across all practices. These pods are also in place in care homes across the borough. There is scope to enhance these pods to enable further identification of AF through additional software.

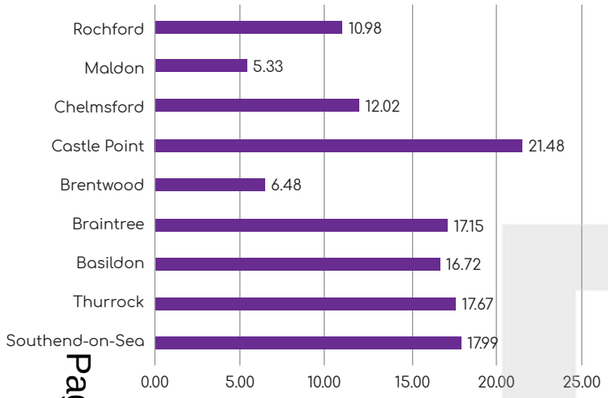




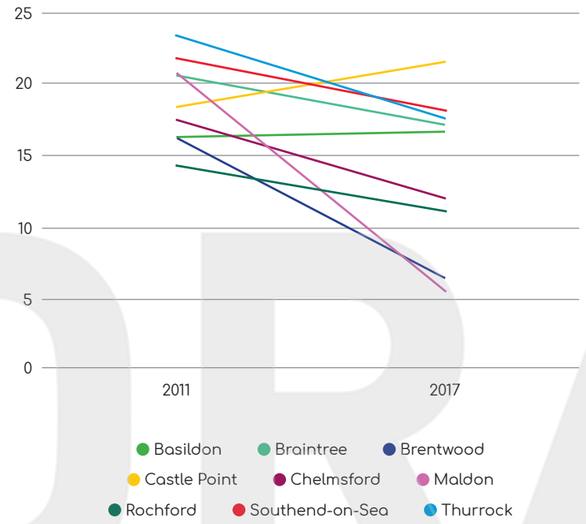
9.4 Tobacco Control

The proportion of current smokers among residents aged over 18 has mostly decreased across mid and south Essex since 2011. Helping people to stop smoking remains a key way to prevent avoidable early ill health.

Proportion of current smokers, 2017



Trend in proportion of current smokers 2001-2017



Our Commitments:

All partners are committed to working together to take a more proactive approach around smoking cessation for staff, patients and visitors. We will achieve this by preventing people from starting to smoke, supporting more people to quit and tackling health inequalities by targeting key groups. Specific points of action will be:

- // To ensure smoke free environments within our own institutions and focus more on identifying smokers and supporting them to quit.
- // Using the Anchor Institution programme to support the smoke free agenda, particularly through work with hospitals as major employers.
- // Through our Places we will target interventions in particular areas of high smoking prevalence
- // Through our maternity services transformation work, ensuring additional support is available for pregnant women to quit smoking, both in order to reduce health inequalities and the adverse impacts on the health and development of foetuses and infants.

Current provision & future plans

Community smoking cessation services exist across our three local authority areas. These services offer lifestyle advice and support for stopping smoking:

Southend

Has launched a new Harm Reduction Strategy which will tackle the issues inter-twinned with gambling, tobacco control and smoking and drug and alcohol misuse. This will drive the smoke-free work across a number of partnerships. The council is actively working with local vaping shops to support smokers to quit tobacco smoking, as well as moving to appoint a dedicated public health midwife to better support pregnant smokers. The Smoke-free School Gates campaign is working with primary schoolchildren to encourage their grown-ups to stop smoking at the school gates.

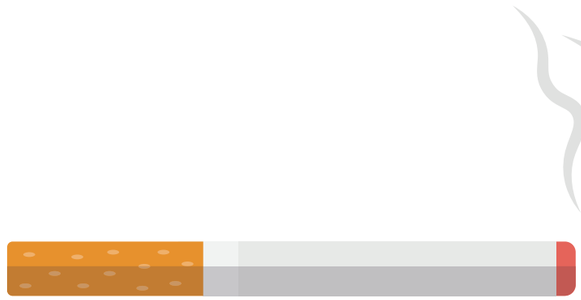
Thurrock

Public health officers have been working with EPUT, BTUH and secondary care datasets to support the implementation of smoke free sites set out in the Tobacco Control Plan for England (2017-2022) and the NHS Long Term Plan's Ottawa/CURE model in acute settings. This includes brief advice, screening and referral to community smoking cessation services but also smoking cessation support for inpatients.

Collaborative working with Trading Standards is restricting the supply of 'pocket-money-priced' illicit and counterfeit tobacco. Test purchases and tobacco detection dogs are just two of the enforcement measures implemented. Since 2017, the council's Trading Standards Team has conducted numerous covert operations across the borough, seizing tens of thousands of counterfeit and smuggled cigarettes and numerous kilos of hand rolling tobacco. The Council has taken enforcement and legal action against all itinerant traders.

Essex

Alongside more traditional interventions, piloted the use of vape vendors in supporting complete switch from tobacco to ecigs. This followed recognition that many people chose to try and substitute tobacco with vaping rather than approach traditional smoking support services. The approach has been recognised by Public Health England and shared as good practice. Trading Standards, part of the Public Health team in Essex, have too made considerable inroads into tackling illicit tobacco.



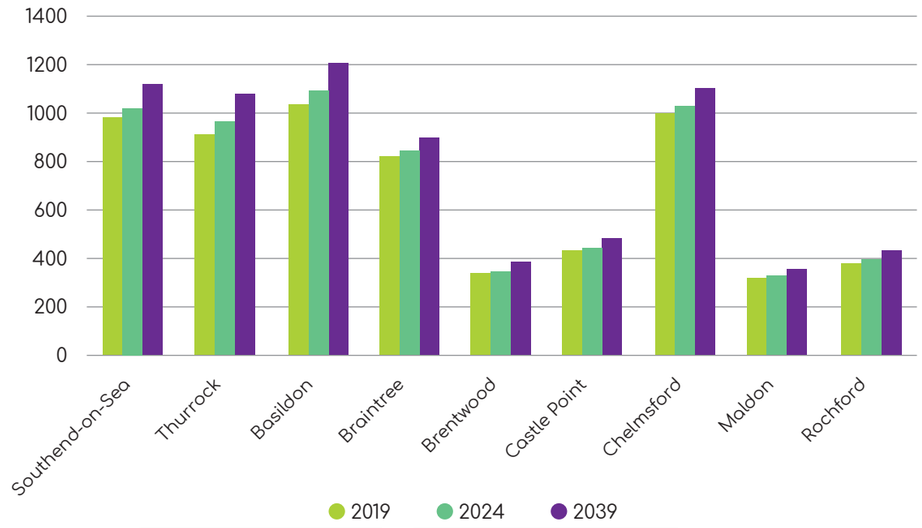
9.5 Alcohol Use

Alcohol is a significant cause of harm across mid and south Essex, resulting in high numbers of hospital admissions, ambulance call outs and GP attendances.

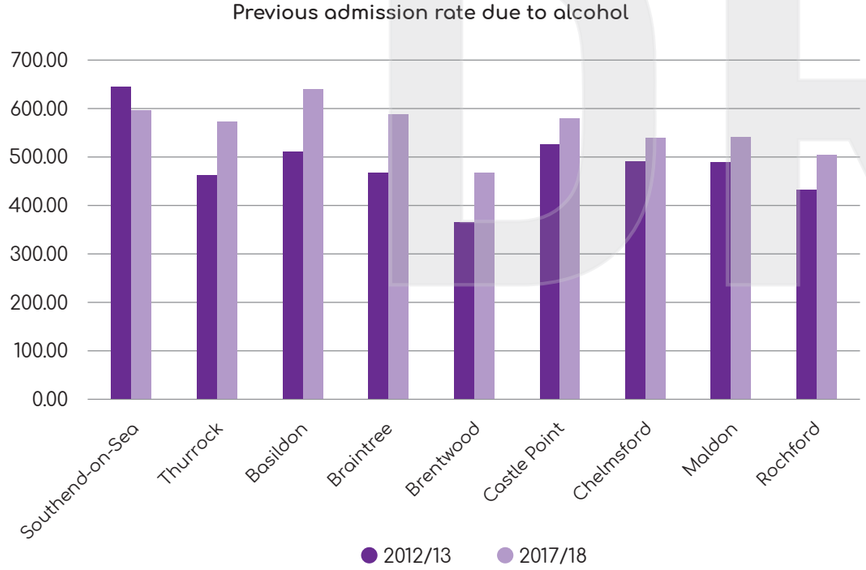
Through the narrow measure of alcohol related hospital admissions per 100,000 population (which includes only those admissions where alcohol is directly attributable), Basildon had the highest rate of all local authorities across mid and south Essex and the largest increase over the previous five years. This contrasts with Southend-on-Sea which had the second largest rate for 2017 but was the only local authority to show a decline (-47) in hospital admission rates since 2012/13.

Based on population estimates, the number of alcohol-related hospital admissions is likely to increase, with Basildon and Thurrock forecast to have the largest percentage increase over the next five-20 years.

Projected count of alcohol-related hospital admissions*



Previous admission rate due to alcohol



Our Commitments:

// We will take a more proactive approach to alcohol management including identification of individuals with alcohol dependency, and support for people to reduce/abstain to prevent ill-health.

// All organisations will take action to minimise the impact of alcohol on the most vulnerable including the children of dependent and harmful drinkers.

// All local authorities seek to increase the number of dependent drinkers receiving treatment.

// Specific actions will target areas with high prevalence of alcohol related harm through place-based plans.

Current provision and future plans:

// Across the system we have some excellent community alcohol support services including preventative and treatment services being provided across community, primary and secondary care, but the service offer is not consistent and funding arrangements require review. Better alignment across the partnership footprint between service providers could ensure we manage differential access and share learning and good practice.

// The LTP highlighted alcohol treatment teams (ACTs) as being an effective approach to preventing alcohol-related harm. Currently the local authority Public Health teams fund two roles in each hospital – an Alcohol Liaison (nurse) Service and an A&E Liaison Service. Discussions are on-going about how to enhance the hospital-based services, focused on linking with mental health workers and improving links to community drug and alcohol services and having more liaison support workers covering longer hours, including events and weekends

// The charity Open Road provide weekend support in the city centre in Chelmsford to keep those affected by alcohol safe and away from A&E services, this model is being reviewed across the footprint. Southend has started this review, following the decommissioning of a similar service in 2017-18.

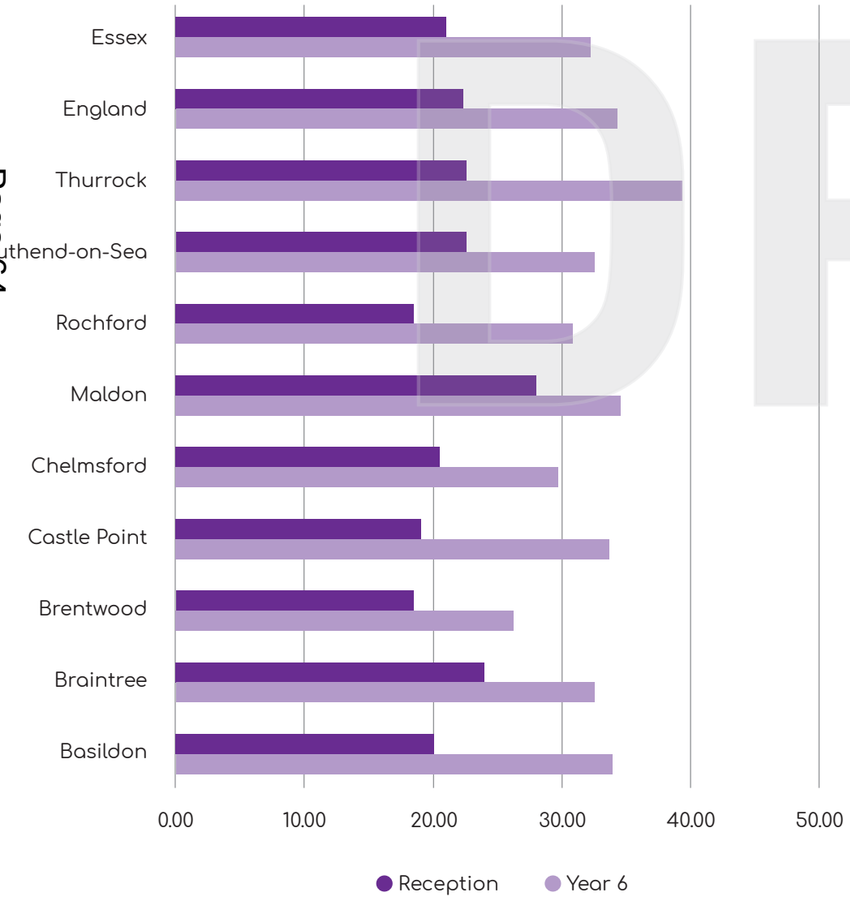
9.6 Obesity

Children

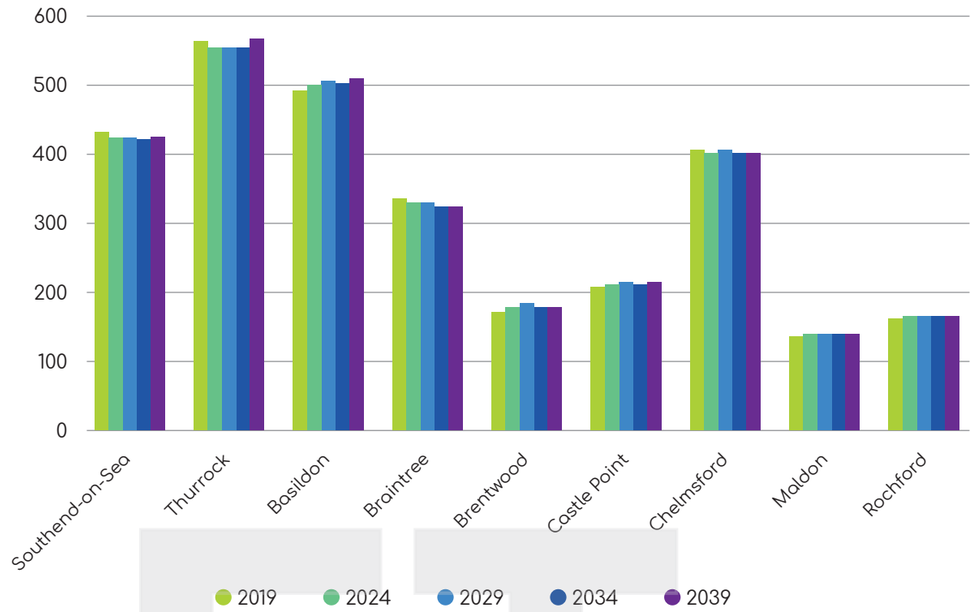
Being overweight is partly responsible for more than a third of all long term health conditions.

If the proportion of overweight or obese children remains the same, due to projected population increases, the total number is likely to increase across the footprint. It is forecast that Southend, Thurrock and Basildon will consistently have the highest count of overweight or obese children in reception.

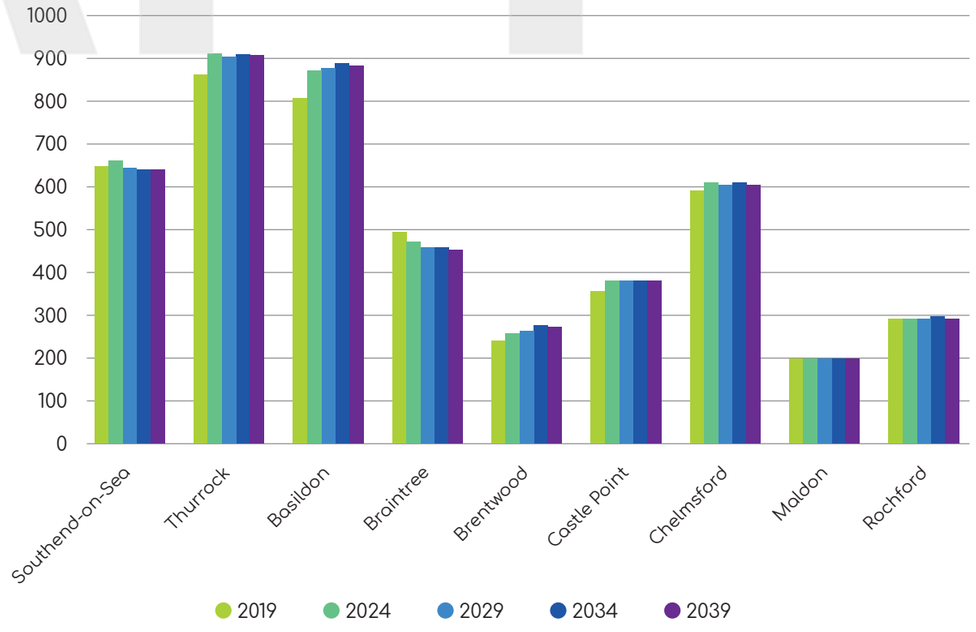
Proportion of children ocerweight or obese in Reception and Year 6 (2017/18)



Projected count of children overweight or obese in Reception*



Projected count of children overweight or obese in Year 6*

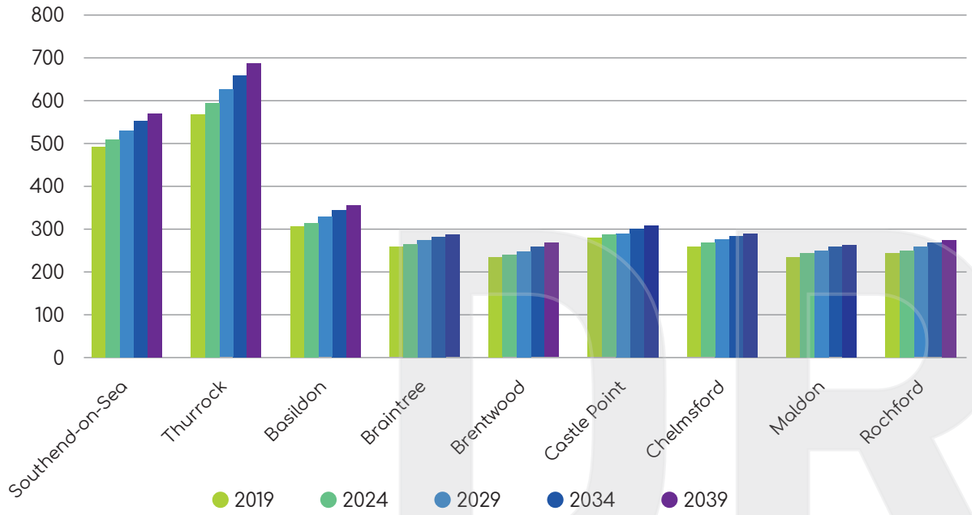


Adults

The proportion of overweight or obese adults was the highest in the Basildon district, however, the proportion in all but three local authorities was higher than across England.

It is forecast that Basildon, Southend and Thurrock 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.

Projected count of children overweight or obese adults*



Basildon and Thurrock had the lowest proportion of adults that were physically active, lower than the Essex and England average. Basildon also had the lowest proportion of adults meeting the recommended "five a day" fruit and vegetable target, lower than the Essex and England average.

Our Commitments

// We recognise that active and health lifestyles contribute to improve physical and mental health. We commit to supporting our residents to make the best choices about their diet and physical activity levels.

// Our local authorities have committed to a "health in all policies" approach.

// We will ensure access to commissioned weight management services across the footprint for both adults and children, in accordance with NICE guidance.

// Increase uptake of the Diabetes Prevention Programme and target groups that are at higher risk.

// Work together on whole system approaches to encourage healthy lifestyles and weight management.

// Use the Anchor Institution approach to create healthier working environments, particularly active travel, physical activity opportunities and reduced access to high sugar food and drinks.

Current Provision & Future Plans

Currently it is estimated that 22% of the population of Essex is classified as inactive.

Southend

A new wellbeing service was commissioned in 2019 in Southend. The main remit is to enable community-led Tier 1 service development, building on some existing initiatives and more collaboration with other existing 'Tier 2' providers locally. The services work with the PCNs to develop a wider offer for the Exercise Referral Programme, which currently only offers gym-based sessions. PCNs would like a mix of community-led initiatives as well as dedicated low to moderate impact activities – such as yoga, Pilates, TaiChi, swimming, etc. Southend plans to launch this new service in 2020. The council is reviewing their offer for Strength and Balance exercise programmes, expanding from fall prevention to healthy ageing.

Southend Council is also promoting the Daily Mile in schools and will shortly add this to the menu of interventions as part of the Enhanced Healthy School programme. The dedicated investment through A Better Start Southend programme, is enabling more alignment between physical wellbeing activities and the diet and nutrition component in looking at obesity.

The Southend Physical Activity Implementation strategy is entering its final year, and most of the key actions are already in place or in development including tackling obesity through planning and development and adopting Sport England's "10 Principles of Active Design".

THE DAILY MILE

65,000 primary school children across Essex & Southend are participating in the Daily Mile programme. Active Essex is one of ten partnerships to receive funding to employ a Daily Mile coordinator to embed the programme across our schools.

Essex

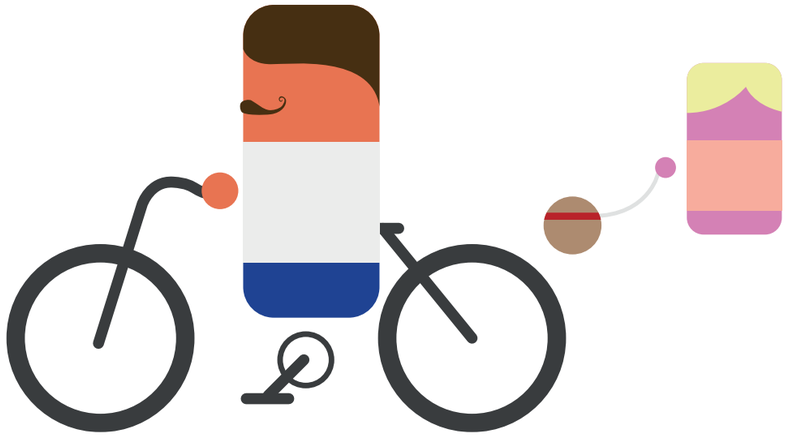
The limited range and impact of traditionally commissioned tier 2 services led to a service redesign, led by the tier 2 provider, to transform the service to be one of community- led peer support weight loss groups. These have delivered a 30% increase in activity in the first year at half the cost, with weight loss levels in individuals comparable with the National Diabetes Prevention Programme. This work has led Essex to rethink how best to prevent diabetes locally, including an approach to optimising referral of anyone who is overweight into the service.

A second approach, highlighted as best practice in the NHS Green paper , is a whole system approach to childhood obesity developed on the evidence based EPODE model piloted in a local authority. The schools benefitting from the whole system interventions showed weight loss over the pilot while control areas saw a gain. The model will be rolled out subject to continued gains in the upcoming NCMP results.

ActiveEssex

Essex has been awarded a £10.68m National Lottery grant from Sport England to increase physical activity and tackle the inequalities that prevent nearly 400,000 people from enjoying the benefits of an active lifestyle. The programme has seen 20 action research projects across the county and involves almost 1500 stakeholders and community groups. The plans include:

// Getting local people involved, who want to create activities in their areas
// Creating active parks, coastal paths and new walking and cycling routes
// Easy access to small grants and support for community projects
// Investing in successful voluntary groups and charities to scale up their activities
// Training people in voluntary as well as paid roles, creating thousands of new volunteers, leaders and coaches
// Brightening up buildings, streets and parks to make them attractive places to be active
// World class measurement and evaluation which will be shared UK-wide



Thurrock

Whole Systems Obesity Strategy

In 2017/18, 69% of the adult population were overweight and obese in Thurrock. This prevalence is statistically significantly greater compared to England (62%) and is the highest in the East of England. Prevalence of childhood obesity in Thurrock at reception and year six are 10.7% and 25.3% respectively (2017/18). The year six prevalence is also statistically significantly greater than England's prevalence.

In 2019/20, a Whole Systems Obesity Strategy has been developed as the strategic driver for preventing and reducing obesity in Thurrock. There are five goals within the strategy:

// Enabling settings, schools and services to contribute to children and young people achieving a healthy weight
// Increasing positive community influences
// Improving the food environment and making healthier choices easier
// Improving the built environment and getting the physically inactive active
// Improving the identification and management of obesity

Thurrock Exercise on Referral (EOR)

EOR is a prescribed exercise programme offering specific programmes for people with long term conditions including obesity, COPD, Parkinson's, low level mental health, diabetes, back pain, cardiovascular conditions (e.g. high blood pressure), stroke and cancer. The programme is 12 weeks long and includes twice weekly sessions. Impulse Leisure is the provider of the service and it is offered at the three leisure centre sites across Thurrock. The programme has physical, mental and social benefits. Being in the group provides a social opportunity useful for sharing ideas and tips around self-management.

9.7 Air quality

Air pollution contributes to a number of conditions, including lung cancer, heart disease, stroke and lung diseases, such as asthma and is a significant contributor to health inequalities.

Our Commitments

// Work in partnership to encourage and support staff to use travel modes such as cycling, public transport or walking. Some organisations already offer incentives and subsidies for using public transport (eg, the acute hospitals offer discounts on bus travel) and we will seek to map what is on offer and share good practice.

// Support and encourage service users to use sustainable travel methods.

// Reduce business mileage through increased use of video- and tele-conferencing, Webex and other on-line means.

// Use of low emission vehicles for business wherever possible. Southend boasts the only electric car-club scheme in this area for use by council employees and other local residents/businesses.

Future Plans

Southend

Will be looking to explore opportunities in the creation of Park & Ride schemes that could better serve the airport and encourage the use of the excellent train service to access its beaches.

Southend recognises the need to invest in new technology to help better measure peaks of poor air quality and is looking to pilot an Internet of Things project with the support of Public Health England. Southend will also be exploring policy options to help alleviate high air pollution in its Green City policy development.

Essex

Through its Essex Design guide, Essex County Council is setting the expectation that the substantial new development that is taking place in Essex supports active transport and access to the natural environment.

Essex Air, a collaboration of all upper and lower tier local authorities in Greater Essex, is developing its public facing website to improve the information to the public to provide clear information on air quality in their local area.

9.8 Anti-microbial resistance

The NHS Long Term Plan sets out an ambition to drive progress in implementing the Government's five-year national action plan, Tackling Antimicrobial Resistance, to reduce overall antibiotic use and drug-resistant infections.

Our Commitments

// To achieve the measures of success within our remit as set out in the Tackling Antimicrobial Resistance 2019–2024; the UK's five-year national action plan

// To optimise system wide use of antimicrobials

// To establish a:

1. single system-wide antimicrobial stewardship committee
2. system wide antimicrobial stewardship strategy
3. surveillance system for data review and analysis
4. system to promote the antibiotic guardian pledge

// Provide system wide leadership to providers on the delivery of national Commissioning for Quality and Innovation (CQUIN) indicators.

Current Work & Future Plans

// There is a newly appointed senior responsible officer for AMR, who will provide system leadership to ensure the delivery of the 5-year national action plan.

// Focus to date includes;

// Establishment of system- wide governance structure with a single overarching Antimicrobial Stewardship Committee to provide system leadership for preventing and reducing rates of healthcare associated infections (HCAI) and the AMR agenda.

// Provision of system wide leadership to:

1. Reduce total antibiotic consumption by 1% from the 2018 baseline by the end of Q4 2019/20
2. Deliver the two NHS Improvement Commissioning for Quality and Innovation (CQUIN) indicators:

// Improving the management of lower urinary tract infections in older people

// Improving appropriate use of antibiotic surgical prophylaxis in elective colorectal surgery

Our work plan for the coming two years is to:

// Establish a single Primary care antimicrobial prescribing formulary across mid and south Essex

// Establish a single secondary care antimicrobial prescribing formulary across mid and south Essex hospitals

// Standardise the implementation of the national PHE target antibiotic campaign on an ongoing basis

// Monitor antimicrobial prescribing data and local antibiotic key performance indicators (KPIs) eg. Prescribing of broad spectrum antibiotics. to address areas of improvement by educating and training all prescribers on appropriate use of antibiotics by promoting use of the target antibiotic toolkits

9.9 Public Mental Health

Essex County Council

It is recognised that, regardless how much the system invests in mental health services, it will be impossible for funded services to identify and intervene with all people who may be at risk of mental health issues. One of the solutions includes developing local social media Facebook groups to enable people to be able to identify and the address the issues that are important to them within their own communities. The system will support them with training and with small microgrants.

The system is growing in coverage with Facebook groups being identified and supported by an independent social media expert. Work to date includes widespread community based mental health first aid training, online suicide training and domestic abuse training as well as action around social isolation, weight loss support and physical activity.

A second key route to communities in many parts of Essex is via the parish councils. A dedicated public health practitioner post has been employed by the Association of Local Councils and charged with engaging parishes in the work described above.

The system is also working with employers to ensure a strong workplace health approach. The Joint Health & Wellbeing Strategy for Essex has specific targets on helping people with mental health issues to be employed and retained in the workplace.

Essex has seen a rise in suicides and specific action has been initiated to tackle this including widespread roll-out of training to communities, with particular focus on those who may be in contact with those at higher risk. This has led to work through local districts with barbers, taxi drivers and pubs who are most likely to see people who may be less likely to recognise their own risk. There is also work with debt agencies, housing and Job Centres to ensure those at risk through debt and lack of employment can best be identified. This is being supported by a social media campaign "It's never too late, Mate".

Loneliness is a key challenge and the system is developing a series of local and system-wide approaches to tackle this. This has included the launch of the United in Kind social movement and the development of a systematic approach to identify and tackle loneliness across Essex. This requires active (but very limited) intervention through primary care and is built around a care navigator model embedded in a large local community organisation. The new opportunity open to PCNs through social prescribers will be aligned with existing related systems to ensure the optimal gain to local people from these new roles.

In addition to issues around access to work and the impact of this on health and life expectancy, people with mental health issues often suffer poor lifestyle choices. Improved physical activity will both help address mental health issues and improve wider health outcomes. As a national Sport England LDP pilot one area of specific focus is improving physical activity in people with mental health issues using a whole system approach.

The system is also working with employers to ensure a strong workplace health approach. Working Well provides targeted and tailored interventions within the workplace to support employers to improve and maintain the mental and physical health of their employees. The programme offers a broad range of approaches including Mental Health First Aid training, smoking cessation, stress awareness training, as well as increased physical activity.

This is now also supported by the Working Well Accreditation programme, and a monthly newsletter is provided to organisations which gathers feedback on mental health first aid interventions carried out by the Mental Health First Aiders. This programme is currently working with 165 businesses county-wide and has partnered with the Chambers of Commerce and the Federation of Small Businesses to increase reach.

Southend

The Southend 2050 vision places health and wellbeing at the heart of planning across all areas of local authority business, and recognises the benefits of a "health in all policies" approach to addressing the wider determinants of mental health. The vision and strategy seeks to develop systems and a planned environment within the borough that enables residents and communities to optimise their life opportunities and resilience and improve their wellbeing.

Priority areas of work for promoting wellbeing and preventing mental ill health are the development of a multi-partner social prescribing system across the borough, development of population health management approaches to identify optimal use of mental health resources, and a new system for increasing access to physical health checks for people with significant mental illness. The Public Health team manage and deliver/commission a significant programme of interventions and systems for children and young people to build personal resilience and support them in times of emotional wellbeing need, both inside and outside school. The A Better Start Southend programme supports parents in areas of high deprivation with developing healthy relationships with their young children, recognising the importance of this for the rest of the life course.

The council is also reviewing its offer to local businesses in regards to mental health and wellbeing as part of a refresh of the Public Health Responsibility Deal, with a focus on micro-businesses which make up 86% of all local enterprises.

Thurrock

Adults and Older People

// Thurrock is involved in a number of initiatives around improving the mental health and wellbeing of its population and preventing onward service use. Thurrock's overall commitment to this approach can be seen in the recent signing of the Prevention Concordat for Better Mental Health, which was submitted in July 2019 by Thurrock's Health and Wellbeing Board – demonstrating the extent of partnership agreement towards this aim. Some examples of specific work programmes currently underway or planned to commence include:

  // Mapping where residents with poor mental health are currently being seen by non-specialist services, in order to roll out improved opportunities for case finding/early identification and better pathways to support options such as the Recovery College

  // The housing service have recently employed a mental health practitioner to improve staff skills around identifying and supporting those with mental ill-health, and to increase awareness of wider support options available

  // We are supporting national initiatives, such as promoting Every Mind Matters, but have also invested in Mental Health First Aiders across the borough. We plan to evaluate the success of this in 2020.

  // We will complete a worklessness and health Joint Strategic Needs Assessment which will include recommendations on ensuring the mental health needs of those in employment are met, and also that those with poor mental health who are out of employment can be supported.

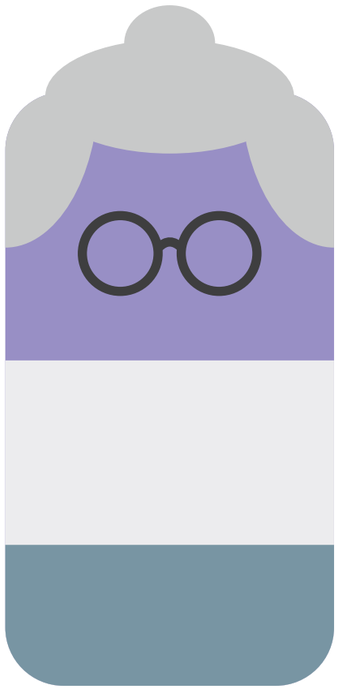
  // Several organisations are screening their patients for likely anxiety or depression, with an onward referral pathway to the local IAPT service if required. This is underway in a handful of GP practices for diabetes patients in the first phase, and will be further rolled out to more practices during 2019/20. It is also being undertaken in the Healthy Lifestyles Service and the community diabetes team.

// Thurrock is also undertaking a number of initiatives which will aim to reduce inequalities in those groups identified to have poorer mental health. The Public Health team undertook Joint Strategic Needs Assessments for Adult Common Mental Health Disorders and for Children's Mental Health and Wellbeing in 2017. Both documents profiled key groups at high risk of poorer mental health. Public Health intelligence has informed the way data is being collected for several clinical services – such as EIP, IAPT and Recovery College, as the services are now monitoring more information on different population groups. This is monitored as part of monthly contract review meetings – particularly for BAME and older people's referrals.

// As part of the work to transform the mental health of those with serious mental illness, Thurrock is developing a new model of care at locality level – piloting in Tilbury. Fundamental to this is the mapping of all services and organisations which might support those with poor mental health – even if that is not their primary remit; understanding current demand, capacity and service interfaces. This will aim to improve the future offer of support and ensure services that support employment, housing, social care and other wider determinants of health are aligned appropriately with clinical treatment models – recognising that aspects such as homelessness and unemployment are key drivers of poor mental health.

// To improve the mental health of those with physical LTCs, Thurrock is rolling out a new programme of serious mental illness Physical Health Checks for 2019/20, with the ambition for 60% to have had this by March 2020. The other programme of work for those with LTCs relates to depression screening – completion of the PHQ9 and GAD7 screening tool is being trialled in a handful of GP practices for Diabetes patients, and will be further rolled out to more practices during 2019/20 and evaluated for impact. Depression screening will also shortly begin in the Council's Sheltered Housing tenancy reviews – this will aim to improve identification and referrals from older people. If successful, this approach will be further rolled out to more front line staff.

Thurrock's Mental Health Transformation Board agreed the need to have an Outcomes Framework for Mental Health, which focussed on system-wide outcomes rather than service-specific targets and will incorporate information around inequalities.



10. Giving People Control – Personalised Care

Underpinning all of our work is the commitment to give our residents control of their lives and, if health and care services are required, to ensure these are personalised and support the principles of the comprehensive model for personalisation. We acknowledge that the move to a system built on principles of proactive and personal care requires a shift in the cultural mind-set of all those that play a part. Personalisation will not be seen as a "nice to do", but as a fundamental element of our new operational model, irrespective of the age or need of the individual. As a system we will ensure that the flexibility in service provision is available for those groups of patients who may need adjustments to the universal offer, groups like people with a mental health need, children and those approaching the end of their life.

All transformation will be measured against the nationally defined comprehensive model for personalisation, from the simplest level of personalised care – choice – through to the ability to implement personal budgets where these are appropriate to meet the needs of individuals not met through universal service offerings. Achieving this requires a level of cultural change across the system that has not been previously delivered.

Through a programme of organisational and cultural change over the next four years, we commit to supporting:

- // the public to understand the personalisation agenda
- // providers of health and care to become flexible in service provision, enabling shared decision-making at all points in a patient journey, and promoting the self-care agenda through enabling both individual and community resilience
- // commissioners of services to ensure that services are contracted in a way that enables the delivery of the personalisation agenda, including a movement to commissioning for outcomes that matter to the individual, and does not discourage local innovation amongst providers to flex services to better meet the needs of residents.

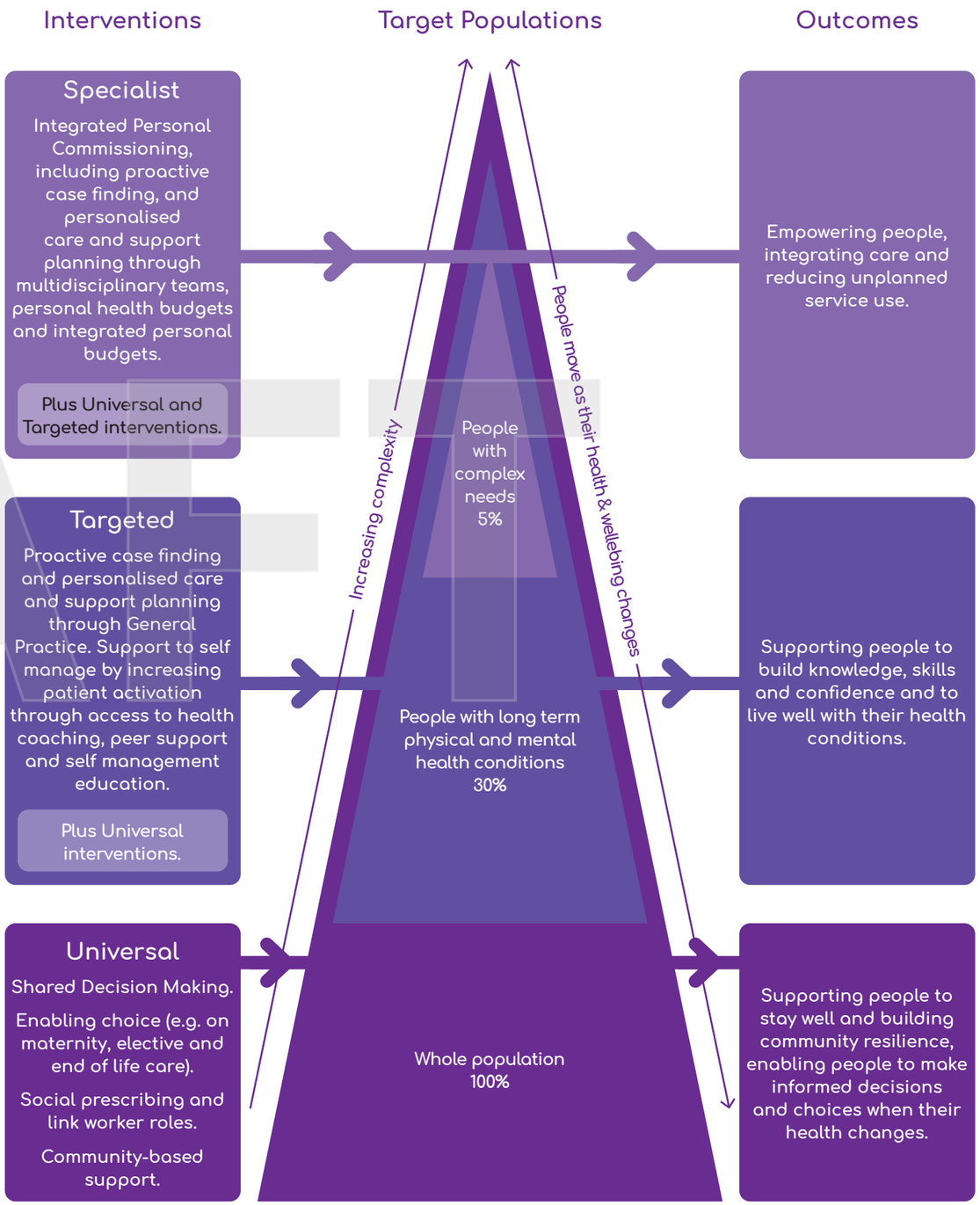
Our commitments

In order to ensure we embed personalised care across the Partnership, we will:

- // By April 2020 create a Partnership-wide Personalised Care Pledge; underpinning a cultural transformation programme across all key partners
- // Ensure the six components of personalisation become "business as usual" for all partners within the system, underpinning both the approach to commissioning and provision and the messages shared with the local population
- // Identify personalisation champions within the system
- // Develop the infrastructure across the system to ensure personal health budgets are available for those individuals that would benefit from them

Comprehensive Model for Personalised Care

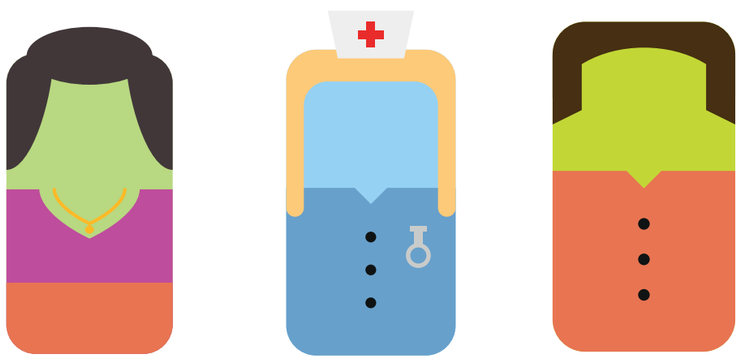
All age, whole population approach to Personalised Care



Personal Health Budgets and Integrated Personal Budgets

The CCGs are active in ensuring the roll out of Personal Health Budgets (PHBs) across their areas. This includes Personal Wheelchair Budgets, Continuing Healthcare (CHC) and Children's Continuing Care on a 'right to have' basis. Whilst we accept the PHB target the local view is that PHBs should be utilised, not to hit a specific target, but to improve patient outcomes where an individual's needs are either uniquely different, or not being met through the universal service offer to the whole population.

In accordance with NHS England's PHB work programme, the CCGs have developed clear activity improvement trajectories to meet the national target of 200,000 by 2023/24. The development of a system-wide pledge for personalised care will facilitate standardisation of good practice across the region.



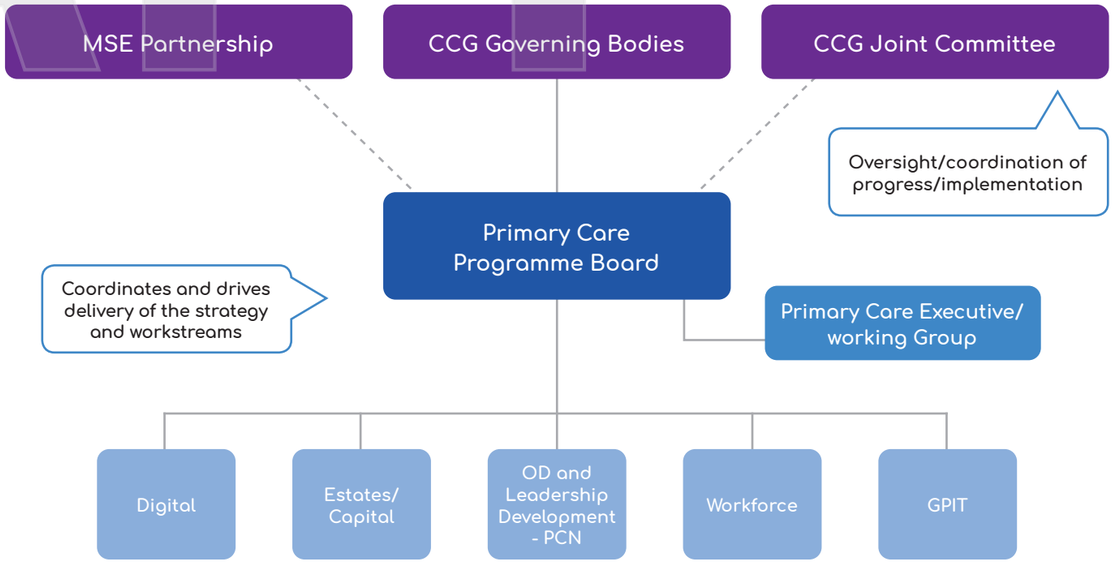
11. Transforming "Out of Hospital" care

Clinical Lead: **Dr Jose Garcia**, Chair, Southend CCG & Chair of the Primary Care Programme Board
Senior Responsible Owner: **Caroline Rassell**, Accountable Officer, Mid Essex CCG and Lead Accountable Officer for Out of Hospital Care

We developed our single Primary Care Strategy in June 2018, focusing on ensuring general practice is sustainable and able to fulfil its role as a foundation for future models of care. The strategy recognised that the 'full population' registered list of general practice makes them an essential partner in any move to population health and population health management.

The Primary Care Strategy focused on creating capacity and managing demand through both individual practice support and transformation, as well as collaboration both between practices and between practices and the wider system through our neighbourhoods. This direction of travel was later supported through the NHS Long-Term Plan and nationally negotiated GP Contract Reforms, the latter delivering a contractual vehicle, the Network DES/Primary Care Network Contract, that is being used to accelerate local plans.

Developments in primary care, including the maturity of primary care networks, are overseen by the Primary Care Programme Board:



11.1 Primary Care Networks

Primary care networks (PCNs) will form the vehicle for delivering collaborative working amongst front-line staff. Through PCNs we will deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. We will move to a GP-led model of care focused on improving population health and wellbeing, and supporting provider sustainability. PCNs will be the foundation stone on which local places will thrive and the key provider vehicle for delivering local services.

We see PCNs as more than just a collaboration amongst practices. At their core they will support collaboration amongst those who positively impact on their population's health and wellbeing. This includes other significant incumbent providers of health and care, education providers, major employers, the third sector and community groups. PCNs are seen as a vehicle to bring together the wider network of primary care providers - community pharmacists, optometrists and dentists.

PCNs are led by clinical directors who will provide leadership for networks' strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of network services. We will nurture and support the clinical directors to ensure they are able to fulfil the requirements placed upon them.

With 28 primary care networks it is accepted that they will vary in terms of stability and maturity in the short to medium term. They are however seen as fundamental building blocks in the success of the local health and care system, being the core out of hospital 'delivery units'.

The National Ageing Well agenda, with a focus on anticipatory care and enhanced health in care homes, as well as urgent community response, will only deliver the ambitions where PCNs take a leading role in the care of older people in the community – irrespective of where they live. We envisage, as a minimum that through the national service specifications PCNs will deliver the medical requirements of two of these three programmes of work. This is expected to be implemented through national negotiations from 2020/21.

Through PCNs public health initiatives will be prioritised for their local populations, including maximising uptake of screening and vaccination programmes for people of all ages and all needs.

A move to more person-centred care will see PCNs be the launch pad for whole-system delivery of

- // Shared decision making with anyone who has a health, care or social need including implementing the legal right to choice, and
- // Personalised care and support planning for those living with a long-term condition

Through these two principles PCNs will enable

- // Improvements in self-care and the resources available to support this
- // Links between individuals and other, non-medical, interventions through social prescribing
- // and for those with exceptional needs, pathways into more bespoke support arrangements through enablers such as personal health budgets

PCN Maturity

Following release of the national PCN Development Prospectus and the PCN supporting self-assessment/maturity matrix tool we have worked with the clinical directors to identify their, and their PCNs, short—term development requirements.

As a system we are committed to all PCNs achieving level three maturity by 2023/24.

PCN Development Programme

A comprehensive development plan for each PCN will be in place by the end of 2019/20. This plan is expected to be detailed over the short-term, indicative longer-term and flexible enough to meet changing priorities of the PCN over a longer period. We will use the national tools and support where appropriate, and as a minimum the national allocation - £878k in 2019/20.

PCN development will be evolutionary and take account of both the original position of PCNs, and the desired end state. It is accepted that sustainable change will not be achieved through a short-term, rapid, development programme, but one that supports all partners to embed cultural change, new ways of collaborative working and collective ownership.

Meeting the Funding Guarantee

We commit to meet the local requirements of the real terms increase in funding that covers primary care, community health and continuing health care (CHC) spend by 2023/24.

11.2 PCN Service Developments

We will work with PCNs to ensure they are able to fully deliver services to their population in line with the requirements included within the seven nationally negotiated service specifications.

Service Specifications		

From 2020/21:
// Structured Medicines Review and Optimisation
// Enhanced Health in Care Homes
	From 2020/21 onwards:
	// Anticipatory care requirements (for high need typically multi-morbidity patients, jointly with community care)
	// Personalised Care
	// Supporting Early Cancer diagnosis
		From 2021/22 onwards:
		// CVD Prevention and Diagnosis
		// Tracking Neighbourhood Inequalities

Improving anticipatory care

As part of the Ageing Well programme, anticipatory care will support the move from a reactive, hospital-centric, health and care offer to one of prevention, empowerment and community and personal resilience. The principles of anticipatory care underpin the future models and focus on maintaining wellbeing. This will be underpinned by our Population Health Management work stream.

The expectations of the national service specification are due to be implemented across community providers and general practice from April 2020. The system commits to ensuring the work to date continues, and the national requirements are considered the minimum offer for our population.

We have developed a risk stratification tool to assist PCNs in identifying and managing high risk and rising risk patients in a structured way and this will be rolled out to all PCNs in the coming months to enable a proactive and targeted approach to supporting patients.

Anticipatory care will also encompass supporting maximum coverage of screening opportunities – including supporting early cancer diagnosis -, annual health checks for those who would benefit from it, and ensuring that there is sufficient support for carers, on whom the system relies so much.

Personalised Care

With improvements in anticipatory care, patient identification and holistic care planning driven by a more diverse workforce, PCNs will provide greater emphasis upon personalisation and a move to service delivery in line with the Comprehensive Model for Personalised Care.

Enhanced Health in Care Homes

As part of the Ageing Well programme, the CCGs have been working to improve the offer to residents of care homes. With over 8,000 care home beds a significant proportion of our most vulnerable residents live within a care home setting.

We have prioritised work to implement the Enhanced Health in Care Homes (EHiCH) Framework. This is delivered through a partnership approach to co-ordinate the implementation and delivery of a single plan across mid and south Essex. The expectation is to increase the support to care homes through the EHiCH model by 2022/23, implementing all elements of the framework across the full footprint.

Good progress has already been made across the seven domains within the EHiCH Framework. Local and system level priorities have been identified, with plans being developed to reach full achievement by 2022/23.

Structured Medicines Review and Optimisation

Across the system practices and PCNs have already appointed clinical pharmacists to their primary care teams. The roles and functions of these vary across the patch, but a key commonality is their focus on medicines review.

PCNs will work to ensure that structured medication reviews are provided as a minimum to the defined set of patients as clarified in the specification. The system acknowledges that the introduction of this service coincides with the cessation of Medicines Use Reviews under the Community Pharmacy Contract.

Crisis Response

Across the footprint community-based crisis response has been a key pillar of the evolving models of care, and is seen as an essential component of any future model at place level, providing a safety net for when the proactive and anticipatory models breakdown and ensuring that solutions are not reliant on acute attendance and admission.

Across the footprint we already commission:

// 100% population coverage for access to community crisis response within 2 hours as part of the commissioned community offer

// 100% coverage of the population for reablement care within two days of referral

Supporting people to stay at home – Admission Avoidance

We know that our ambulance service is stretched and that people who call for an ambulance who are not suffering a life-threatening condition can experience a significant wait for a response. We also know that, for older patients, waiting a long period of time for an ambulance and then being conveyed to hospital often results in admission. Our community providers are working closely with East of England Ambulance Services Trust to support people who have called an ambulance, where the call has been allocated a category two, three or four response. Where clinically appropriate, community teams are able to intervene and visit these residents to assess their needs and provide any immediate care and support. This scheme is aimed at preventing an ambulance conveyance to hospital. The evaluation of the scheme will be published by the end of 2020; early indications are that the scheme has been successful in supporting people to stay at home and has supported closer collaboration between our community providers and the ambulance trust.

11.3 Digitally Enabled Primary Care

Governance

A primary care specific digital transformation working group has been set up to deliver the digital commitments outlined in the NHS Operational Planning and Contracting Guidance 2019/20, GMS contract for 2019/20 and GMS contract framework.

This group provides a centralised strategic approach to delivering digital transformation in primary care that is clinically-led and locally owned ie. by PCNs, GP practices and patients

This Primary Care Digital Working Group links closely with the Partnership Digital Board to ensure alignment of all digital programmes (see section 29).

As described in the Primary Care Strategy we know that the use of digital and other technologies will be a key enabler for our future model of care. These have the potential to help with the better management of demand, creating capacity in general practice, reducing bureaucracy and supporting practices to operate at scale.

We have identified a number of potential solutions which, taken together, would help practices reduce their workload and close the gap between demand and capacity.

One of the key design principles of our future operating model is to adopt a "digital first" approach. We know that the use of digital and other technologies have the potential to support patients and help with the better management of demand, creating capacity in general practice, reducing bureaucracy and supporting practices to operate at scale. The primary care digital work stream has identified three domains and five local priorities that will start to move primary care towards a new operating model that makes 'digital first' a reality. Plans are in place to deliver these priorities:

Manage Demand	// Digital triage - including on-line consultations // On-line patient awareness and education
Create Capacity	// Call-centre/administrative hubs // Supporting isolated individuals
Operate at Scale	// Connectivity - GPs and patients, anywhere

The primary care digital working group will ensure delivery of all national "must do's" that are primary care specific commitments, as well as identify other local priorities.

11.4 Mid and South Essex - Primary Care Workforce

To drive transformational change in the primary care workforce, a system-wide primary care workforce team has been established along with a dedicated primary care training hub. There have been a number of developments which support the aspirations set out in the Interim NHS People Plan. Examples include:

// A focus on general practice nursing as a priority and developing new models of working collaboratively with stakeholders locally and nationally towards integrated care.

// We have increased the wider workforce by almost 12% including the employment of 13 emergency care practitioners, a move designed to reduce the pressure on the GP workforce

// Information booklets for practices have been developed for new roles including the emergency care practitioner.

As we support the development of PCNs and the full uptake of the additional roles reimbursement scheme we expect to see significant increases in the numbers and types of staff working within primary care.

Whilst PCN's will develop the staffing model that best meets the needs of the local population, assuming PCNs grow the workforce in line with the national assumptions around role types and staff numbers it can be assumed that almost 500 additional posts will be created within primary care as part of the PCN workforce:

WTE - per 50,000 PCN	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical Pharmacist	1	2	2	3	4
Link Worker	1	2	2	3	4
Physiotherapist		1	2	3	4
Physician Associate		1	2	3	4
Paramedic			1	2	3
	2	6	9	14	19

Health and Care Partnership

Clinical Pharmacist	26	52	52	78	104
Link Worker	26	52	52	78	104
Physiotherapist		26	52	78	104
Physician Associate		26	52	78	104
Paramedic			26	52	78
	52	156	234	364	494

Volunteers

The valuable contribution that volunteers make in health and social care sectors is well known. The Kings Fund report, 'Volunteering in General Practice' (2018) identifies specific ways in which volunteers can engage and support general practice. There are over 300 volunteering NHS role - types within our footprint and we have well established volunteering programmes across our provider trusts and partner organisations.

A Digitally-Enabled Workforce

Whilst focus rightly remains on ensuring sufficient numbers of staff are in post, and existing vacancy rates are improved, future models will require a workforce that has enhanced non-clinical competencies, particularly in relation to their use of technology.

We will support, empower and train the workforce to embrace digital tools and innovation as enablers to support them to manage and conduct their roles more efficiently, and with higher level of quality. We will improve the digital capabilities of everyone in the primary care workforce and support positive behaviour change to recognise the potential that digital transformation can bring.

12. Improving our Hospital Services

Clinical Lead: **Dr Celia Skinner**, Group Medical Director, Mid & South Essex University Hospitals Group
Senior Responsible Owner: Clare Panniker, CEO Mid & South Essex University Hospitals Group

Following a public consultation Your Care in the Best Place, and detailed review of plans by the East of England Clinical Senate, the CCG Joint Committee approved all recommendations relating to the reconfiguration of hospital services in June 2018.

The changes were aimed at improving access to, and quality of, specialist hospital services, and dealing with the significant workforce challenges in the acute sector. The changes were based on five principles:

1. The majority of hospital care remains local (outpatient appointments diagnostics, day case surgery and maternity), and each hospital will continue to have a 24 hour A&E department that receives ambulances.
2. Certain more specialist inpatient services to be concentrated in one place.
3. Access to specialist emergency services, such as stroke care, will be via the local (or nearest) A&E, where patients will be treated and, if needed, transferred to a specialist team, which may be in a different hospital
4. Elective and emergency care should, where possible, be separated.
5. Some hospital services should be provided closer to home.

The proposals were referred to the Secretary of State for review by the Health Overview and Scrutiny Committees of Southend and Thurrock Councils. Following review by the Independent Reconfiguration Panel, the Secretary of State has advised that the agreed changes can go ahead. Over the coming three years, these plans will be implemented as follows:

Clinical Reconfiguration Programme

2019/20	2020/21		2021/22	
Q3/4	Q1/2	Q3/4	Q1/2	Q3/4
Vascular Emergency	Vascular Emergency	Urology	Stroke	
Hip and Knee (ASA 1,2)	Hip and Knee (ASA 3)		Respiratory	
Spine	Hands, Wrists, Ankles		General Surgery	
Interventional Radiology			Renal	
Cardiology (Broomfield only)	Cardiology (Southend)			
Opthalmology (Braintree)				

These changes are supported by the £118m capital award, secured in 2017. This capital funding will support the following schemes:

Basildon Hospital	Broomfield Hospital	Southend Hospital
New endoscopy suite	Critical Care expansion	Purpose built (2 ward) elective surgical care block
Emergency care expansion	Emergency care expansion	Emergency care expansion
Critical care expansion	2 new inpatient wards	New theatres
Onsite helipad		Creation of new paediatric assessment unit
New renal ward		New endoscopy suite
New theatres		4th LINAC bunker
		Refurbished ophthalmology unit

Hospital merger

The three acute hospitals in mid and south Essex will merge in April 2020, reflecting significant work over the past three years to consolidate the clinical and corporate strategies, create a single executive team and Chief Executive. The key principles of the three hospitals working together are given below:

Working together as one team means we can do better

- Specialist centres of care leading to faster specialist access, diagnosis and treatment to improve patient outcomes **and** to attract clinical staff.
- Standardised model and approach to care based on best practice - reducing variation through the use of protocols, again leading to better care and outcomes for patients.
- Standardised model and approach to corporate services based on best practice and using modern technology, better service to the front line and reduced costs.

In turn, these things are enabled by a number of other activities

- Merger - single systems, policies, procedures - clarity of management decision making.
- Infrastructure improvements - particularly in IT, informatics and estates.
- Capacity and capability building - organisational development, strategy unit, change management, communications and engagement.

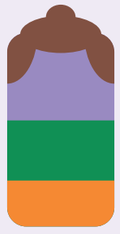
13. Reducing pressure on emergency hospital services

Clinical Lead: **Dr Eddie Lamuren**, Group Clinical Director (Emergency Care),Mid & South Essex University Hospitals Group
Senior Responsible Owner: **Hospital Site Managing Directors**, Mid & South Essex University Hospitals Group

We have three established sub-systems for urgent and emergency care (south east, south west and mid Essex). These sub-systems currently have their own delivery boards, where partners work together to deliver improved urgent and emergency care services.

The urgent care system is under significant pressure and this impacts on our responsiveness to deliver elective and cancer services. All partners are working hard to address urgent care pressures.

How will urgent care services be delivered in future?



You

Individuals with an urgent care need can access a range of support including on-line (www.nhs.uk), and through NHS 111, where they can obtain advice, check symptoms and figure out the best course of action.

NHS 111 will provide advice, support and the ability to book appointments with the right professional.

Patients will be able to access on-line advice and consultations with the GP practice.

Neighbourhood

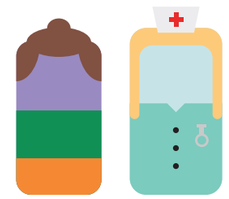
PCNs will be able to offer extended hours appointments in the evenings and at weekends. They may also offer extended home visiting for patients who need it.

PCNs will use risk stratification tools to proactively identify patients who may be at risk of deterioration or ill health, and intervene early so that they can get the proactive care and support they require, reducing the need for an urgent response.

Community providers and the ambulance service will work together to avoid, wherever possible conveyance to hospital for patients who could be seen within their homes by community teams.

Place

Some urgent care services may be provided at place level, for example, minor injury services.



System

At system level, we will work together to:

// Reduce the pressure on emergency hospital services.

// Undertake workforce planning and development to support urgent care services

// Coproduce communications and engagement with residents about urgent care services, particularly at times of pressure, eg winter

// Identify and promote on-line and digital channels that will help patients to self-care and find the right support.

13.1 Integrated Urgent Care Service

We have a comprehensive NHS 111 service covering the entire mid and south Essex population. This includes a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services.

As part of the national pharmacy contract reforms, from October 2019 NHS 111 will be able to refer minor illness and urgent medical supplies to community pharmacy. The Community Pharmacy Consultation Service provides the opportunity for community pharmacy to play a bigger role and to become an integral part of the NHS urgent care system.

13.2 Same Day Emergency Services

All three hospitals offer a same day emergency service for 12 hours/day, 7 days/week. These services provide fast access for patients to diagnostics and treatment and reduce admissions to hospital.

13.3 Older People's Service

Our three hospitals have worked to develop assessment and treatment units specifically to meet the needs of older people. At Broomfield, the operating hours of the Frailty Ambulatory Service is 08.00-20.00 Mon-Fri. A move towards a 7 day service will be reviewed in April 2020. The community admission avoidance service operates 7 days per week.

At Southend the Frailty Service currently operates Monday-Friday 09:00 to 17:00 (a total of 40 hours per week). An extension to the operating hours is being overseen by the Frailty Steering Group. A business case is being developed in support of additional staff to facilitate achieving the 70 hours target by December 2019.

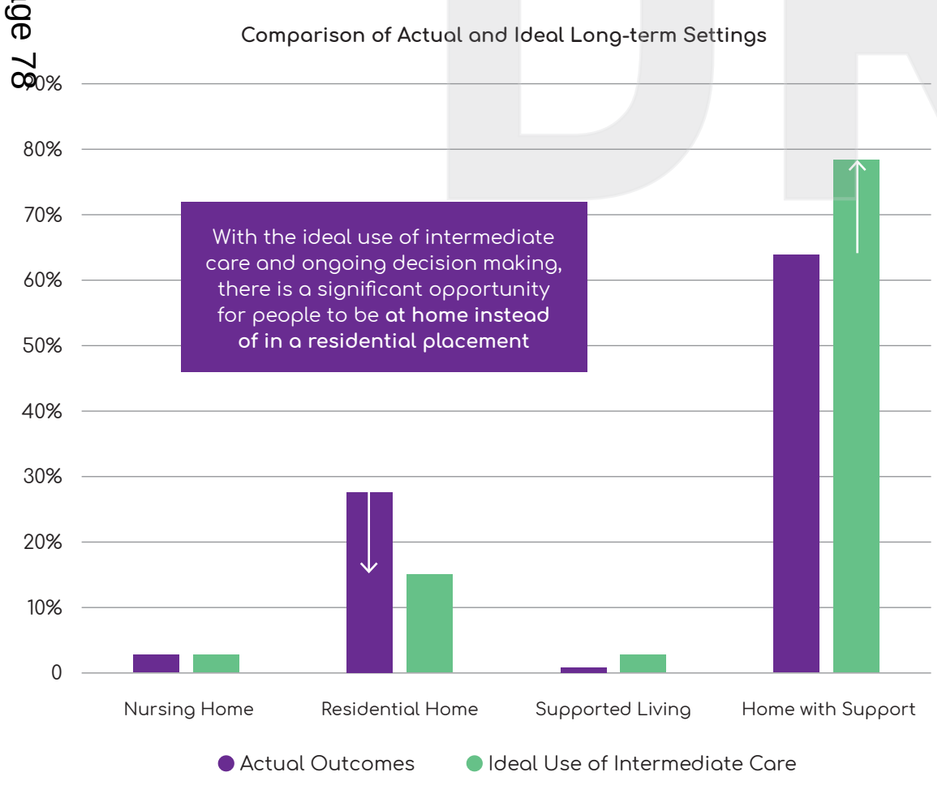
Basildon offers a full 7-day frailty service.

The Ageing Well programme, described above, will see an increased role for primary and community services in identifying and supporting older people to maintain independence and stay at home for longer.

13.4 Discharge Processes

Due to good partnership working between local authority and NHS partners, our Delayed Transfer of Care (DTOC) rate across the three acute hospitals (1.4%) falls well below the target of 3.7%.We expect to maintain this low rate moving forward.

Across Essex, we are working to better understand our reablement and rehabilitation processes and improve on these for our residents. This work has taken an embedded approach to work with discharge teams, patients, families and carers to understand the realities of the discharge process and its outcome. The work is on-going, however, interim findings suggest that if the system could make optimum use of intermediate care and on-going decision-making, there is a significant opportunity to reduce the use of residential placement and for people to be cared for at home (along with their individual wishes).



14. Improving our cancer services

Clinical Lead: **Dr Donald McGeachy**
Senior Responsible Owners:
Michael Catling, Director of Cancer Services, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team

With almost 7000 new cases of cancer confirmed across mid and south Essex in 2017, our cancer services are under significant pressure. Our screening rates for breast, bowel and cervical cancer are below the required standards which impacts on our early detection and survival rates.

Performance against the 62 day waiting time standard has been challenging for the system. Significant work has been undertaken by the Cancer Alliance and the acute hospitals to improve the situation. We now expect to be compliant with this standard by March 2020.

We recognise that, as well as improving on waiting times for diagnosis and treatment within the hospital setting, the whole system has a responsibility to prioritise prevention, screening early diagnosis and treatment. We are shifting focus to our places, with the intention of improving access, early diagnosis and outcomes for our population – this work will be underpinned by the incorporation of faster translation of innovation and research into practice.
We know that cancer incidence increases with deprivation. Our place-based plans provide a real opportunity to focus on reducing health inequalities and prevention activities, and also to significantly enhance the uptake of screening programmes locally to improve on early diagnosis and treatment. We are also ensuring that:

// Primary care networks will support practices in using the latest evidence-based guidance to identify people at risk of cancer; recognise cancer symptoms and patterns of presentation; and make appropriate and timely referrals for those with suspected cancer.

// Our Macmillan GPs work with PCNs to identify and target variation in screening and referrals to promote early diagnosis

We have been successful in our bid to have a Rapid Diagnostic Centre, which is planned to commence in January 2020, as follows:

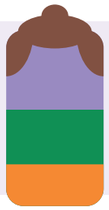
// Cohort 1; A&E referrals across all three hospitals

// Cohort 2 & 3: Upper and lower gastrointestinal referrals

// Cohort 4: Tele-dermatology (piloted by three Primary Care Networks initially)

Thurrock CCG has been selected to participate in the National Targeted Lung Health Checks programme. This is due to go-live in early 2020. While focussed on the population of Thurrock, we will rapidly take the learning from this programme and seek to embed the improvements across the Partnership.

How will cancer services be delivered in future?



You

Individuals will be supported to maintain healthy lifestyles, with support to reduce the risk factors that can lead to cancer.

Neighbourhood

PCNs will be focussed on prevention and ensuring we meet standards for screening programmes for breast, cervical and bowel cancers.

By working together, practices will be able to offer faster access to appointments ensuring fast onward referral, where required, for tests and treatments.

Patients diagnosed with cancer will receive personalised support throughout their treatment and afterwards

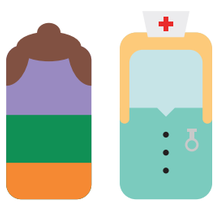
Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, on welfare advice and support groups

Place

Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally.

Our places will be focussed on measuring success against activities aimed at improving our cancer offer, for example, monitoring screening uptake, using data to target additional support and interventions where required.

Places will also be focussed on joining up health and care services, reducing fragmentation that patients and their families might encounter.



System

At system level, we will work together to:

// Reduce unwarranted variation in access, quality and outcomes.

// Undertake workforce planning and development to support cancer services

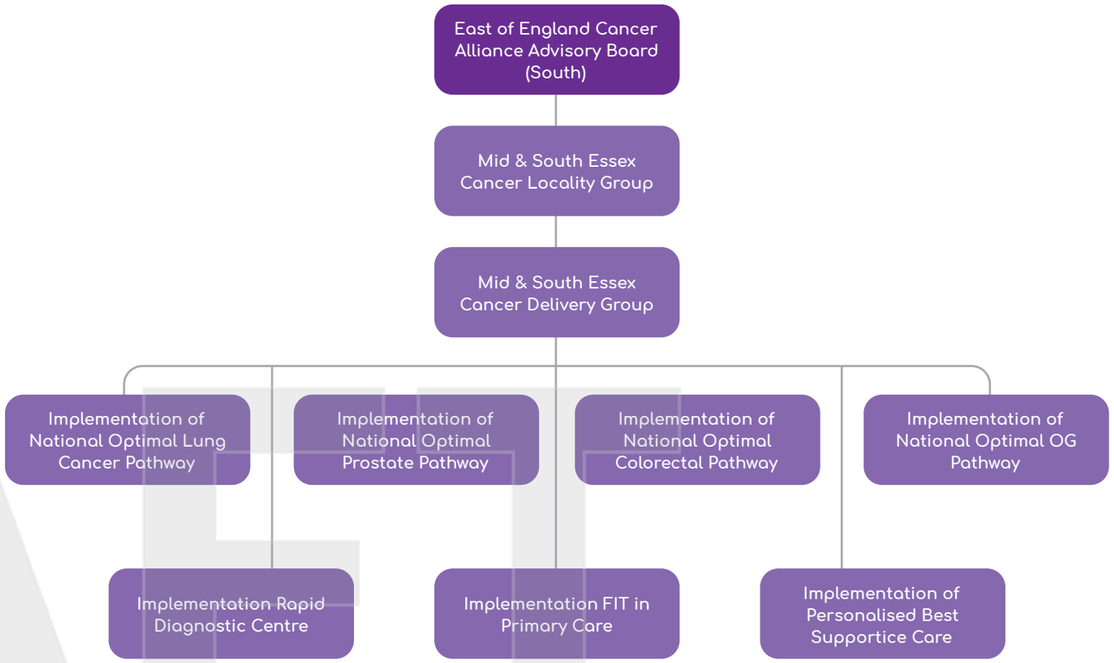
// Coordinate communications and engagement, eg through public health messages

// Coordinate research & innovation opportunities to improve cancer care for our patients

// Identify appropriate digital solutions that will help patients manage their condition

We have established clinical leadership and a cancer board to oversee the improvement and transformation plans we have in train, working closely with the Cancer Alliance. An overview of the governance and work programmes is as follows:

Mid and South Essex Governance - Cancer Transformation Programme



Our Commitments

We commit to deliver the two national ambitions for cancer to improve the outcomes for our population.

// **Survival Rate: Ambition 70% of cancer patients will survive five years or more**

The LTP survival ambition aims to place England among the best countries in Europe for cancer survival. The East of England Cancer Alliance five-year survival rate is currently 53.5%, the Partnership's ambition reflects the national plan of achieving 70% survival at 5 years. We are actively pursuing opportunities to improve breast, cervical and bowel screening processes as a means to achieve this ambition as earlier detection improves survival rates.

We have has successfully rolled out FIT to our practice population and this will expand to incorporate the national FIT screening programme.

We will also ensure the continued roll out of cancer care reviews and holistic needs assessments for relevant pathways. This enables people with cancer to have a regular review and a personalised care plan ensuring that they are able to access advice and support, or reach back into services without of delay should they identify a concern. We have undertaken this work in partnership with Primary Care, building on the Quality Outcomes Framework to ensure that there is a planned review to support the patient and their wider network following a cancer diagnosis.

// **Early stage diagnosis: Ambition to diagnose 75% of cancers at an early stage;**

Across England, 53.7% of cancers are diagnosed at stage 1 or 2. Across the East of England Cancer Alliance, 54.6% are diagnosed, with the highest CCG early diagnosis rate at just over 60%. However, currently only three cancers have early diagnosis rates above 75% (breast, melanoma, uterine), with some remaining below 30%.

We will be focussing on the skin pathway (as part of the Rapid Diagnostic Centre work) to incorporate, at primary care network level, the use of Tele-dermatology (based on the Anglian Health Science Network experience). This will improve screening, access and early diagnosis ensuring patients access the right pathway, first time while also releasing capacity within this significantly challenged specialty.

We are working to deliver the national optimal pathways in order to standardise delivery across the system ensuring equity for the population. Interdependency with networked sites (London and East of England) is essential and this is being mapped within each pathway to ensure that delays and flow is understood and risks mitigated.

Our cancer programme is underpinned by a number of key enablers these include:

Cancer Alliance Transformation monies – these monies have supported a number of key programmes and the recruitment of staff to facilitate care and pathway improvements (eg. the cancer care navigator role).

Patient Leadership – from the Cancer Board through to individual pathways, patient representation is paramount. Our patients have supported and driven the focus and direction of our work.

The Thurrock patient group is actively progressing experience and engagement to improve reach and awareness of cancer programmes within the local population, this work will be evaluated, and rolled out across the Partnership.

Workforce:

Workforce is a key challenge for cancer – through work commissioned by HEE and the Cancer Alliance, the three hospitals have undertaken strategic workforce planning. The key findings of the work were that:

// There is currently a workforce gap, with specific concern in oncology, cancer nurse specialists and chemotherapy.

// Incident of cancer is likely to grow by 25% over the next decade and will impact on the workforce,

// There are opportunities to leverage the scale of the hospital reconfiguration and merger to mitigate some future pressures

The current priorities for workforce transformation are:

// Clinical nurse specialists – the scope of CNS roles across the group differs and there is an opportunity to standardise and, in so doing , support CNS to work at the top of their competence, thus increasing capacity in the workforce

// Oncology and chemotherapy staff require specific focus – services currently rely heavily on locum and agency staff. The hospitals will focus on retention and staff development in the knowledge that there is currently a national shortage in both roles.

Transparency of system metrics and reporting – we are working with the Cancer Alliance to develop and test a new dashboard enabling the system to understand performance and other measures that reflect the progression of the Cancer Plan , this is supported by sharing of information and data including Right Care/GIRFT. We will develop and roll out a dashboard for the four National Optimal Pathways (breast, lung, urology, and colorectal).

Our cancer transformation plan can be found at Appendix 6

Transforming Cancer Services 2019-2024

Mid and South Essex Approach in Partnership

- Reduce growth in the number of cancer cases
- Improve survival rates
- Improve care, treatment and support
- Improve quality of life following treatment and end of life
- Improve effectiveness and efficiency
- Improve patient experience

Redesign pathways to improve one and five year survival and reduce variation

Improve early diagnosis through FIT, TLHC and RDC

Improve education on preventative cancer and increase uptake in cancer screening

Our outcomes:

2019-2024:

// Improve 1 year survival rates - 77%

// Meet 62 day performance standard - 85%

// Work towards definitive diagnosis of cancer or rule out cancer within 28 days - 95%

// Improve screening to match national standards -

// Meet 2ww GP waiting standard for all cancer - 93%

// Improve patients diagnosed earlier - Stage 1 and 2 - 69%

// Design and implement best practice pathways to improve patient experience and meet the needs of patients living with and beyond cancer

One-Year Survival from Cancer

East of England has been used as a proxy as data is not available for the new Cancer Alliance boundaries. Cancer Alliance will need to adjust for demographic makeup of the new boundaries.

	Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
One-year cancer survival rate (%)	72.60%	74.1%	74.4%	74.7%	75.1%	75.6%

→ By 2028 = this should be around 79%

Proposition of cancers diagnosed at stages 1 or 2

East of England South Cancer Alliance

	Baseline 2017	2019/20	2020/21	2021/22	2022/23	2023/24
Numerator	8,592	9,513	10,045	10,428	10,818	11,114
Denominator	15,650	16,679	17,053	17,428	17,803	18,184
Early stage %	**54.90%**	**57.0%**	**58.9%**	**59.8%**	**60.8%**	**61.1%**

→ By 2028 = this should be 75%

15. Improving our mental health services

Clinical Lead: **Dr Milind Karale**, Medical Director, EPUT
Senior Responsible Owner: **Mark Tebbs,** Director of Mental Health Commissioning, Mid & South Essex CCGs

Our vision for mental health is to:

// Improve urgent and emergency care mental health – **crisis response and care**.

// Integrate social care, mental health and physical health – **parity of esteem and care closer to home**.

// Promote good mental health and preventing poor mental health – **early intervention and prevention**.

It is clear that in order to deliver on this vision, partners need to work together, focusing on the wider determinants of health to enable the best possible outcomes for our residents. The mental health transformation programme is an extensive undertaking with significant interdependencies and interfaces involving CCGs, local authorities, Essex Police, the ambulance trust, mental health providers, acute hospitals, Healthwatch and many community and voluntary sector partners. A joined up collaborative approach and governance framework has been agreed to enable us to expedite projects at pace and facilitate decision making both as a collective, and through individual governing bodies.

The NHS has made significant additional funding available for mental health services, and has committed that funding will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.

Our key transformation programmes are:

// 24-7 community mental health emergency response and crisis care – assessment and home treatment;

// Transforming the model of care for dementia;

// Transforming the model of care for personality disorders;

// Integrated primary and community care mental health.

The full transformation plan can be found at Appendix 7.

Current Provision

Our Mental Health Partnership Board has overseen the development of a 'Costed Delivery Plan' to help us to understand how we could best use the additional investment to efficiently and effectively deliver on the LTP commitments.

The work highlights a system with lower than average investment in mental health, significant reliance on inpatient services, a workforce challenge and lack of defined structure between system and place.

Through our focus on the wider determinants of health, our primary care networks and place-based plans, we want to ensure the system rebalances in favour of prevention, early intervention, resilience and recovery.

Key issues for mid and south Essex

- // One in five people suffer from a mental health condition, many with depression/anxiety;
- // While depression rates are high, not all patients are diagnosed in primary care and rates of diagnosis vary widely across GP practices and CCGs;
- // The system currently spends £253m on mental health and related services in primary care and social care;
- // Secondary care mental health services represent £103m of overall spend with approximately 17% directed at inpatient mental health support;
- // In 2018/19 we spent c. 12% less per head than national median, though this could be reflective of the relatively lower mental health prevalence in the area;
- // Mental health services are delivered by approximately 2,200 staff across different care settings, with 30% delivering inpatient care;
- // We have proportionately fewer adult consultant psychiatrists and registered nurses as a proportion of inpatient beds;
- // Inpatients are likely to spend longer in hospital than national benchmarks;
- // More patients are likely to be readmitted as an emergency, while patients receive fewer community contacts than the national average.

Our Commitments

15.1 Urgent and Emergency Care (UEC) Mental Health

People facing a mental health crisis should have access to care seven days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. To deliver responsive options and maximise patient experience and outcomes we are implementing a comprehensive Urgent and Emergency Care Mental Health transformation programme.

Liaison Mental Health

BTUH and SUHFT received UEC wave 1 transformation funding in 2017 to pump prime and accelerate existing plans and expand existing mental health liaison services so that they operate at the 'Core 24' standard. The service commenced mobilisation in April 2017 and formally launched in July 2018. The service which is delivered by a multi-disciplinary team comprising of medical staff, nurses, psychologists and support workers, aims to see patients in A&E within one hour and to discharge patients from the A&E department to the clinically appropriate pathway within four hours. It provides an assessment, diagnosis, treatment and risk management model.

MEHT has just been successful at the UEC wave 2 transformation bid to enhance the current service. The ambition is the 'Core 24' service will commence mobilisation in December and be fully operational by April 2020.

Investment has been committed as part of MHIS for sustainability of all 3 services.

Adult and Older Adult Crisis

The current CRHT service offer only covers 12 hours a day, seven days and does not support access for self-referrals. Access is purely through health professionals and the home treatment function operates only to 8pm.

To deliver the national mandate and provide a fit for purpose, 24-7 responsive and high standard service, a business case has been developed for additional investment to resource a new service model to meet the needs of people in a mental health crisis by providing a responsive 24-7 community crisis service via NHS 111, offering access via self-referral and promoting intensive home treatment to minimise the need for inpatient services.

We were also successful in receiving national transformation funds to establish three crisis cafes that will be located in the following areas:

- // Thurrock – covering Thurrock, Basildon and Brentwood.
- // Southend – covering Southend, Castlepoint and Rochford
- // Chelmsford – covering Chelmsford, Braintree and Maldon.

The cafes will be operated by the voluntary sector and will provide more suitable alternatives to A&E for many people in a mental health crisis who do not have medical needs. The service specification of the new Mental Health Emergency Response and Crisis Care service is being co-produced with all stakeholders, ensuring users, carers and families play a key role in shaping the model of delivery. The ambition is the new service will be fully operational by April 2020.

Acute Care (including Out of Area Placements (OAPs))

EPUT has undertaken a comprehensive exercise to repatriate patients placed out of area in the last year. Work continues to minimise need for OAPs and eliminating adult OAPs:

- // Assessment Unit opened in the north serving Mid Essex reducing need for OAPs
- // The Assessment Unit has been funded from the reduction in Out of Area Placements
- // On trajectory to deliver against set system level plans

Improving therapeutic offer by:

// Review of trust's estates to eliminate dormitories and deliver on commitment to provide single bedroom accommodation across by 2020

// Developing quality improvement programmes of work focusing on workforce, technology, engagement and service user participation and environment.

// Define the training and pathway requirements to implement the enhanced therapeutic offer inpatient services.

15.2 Community Serious Mental Illness services for Adults and Older Adults

Implementing the Five Year Forward View for Mental Health describes the ambition that by 2020/21, community mental health services for adults of all ages will be better supported to balance demand and capacity, deliver responsive access to evidence-based interventions, integrate with primary care, social care and other local services and contribute towards continued efficiency within the mental health system.

Early Intervention in Psychosis (EIP)

We have 3 EIP teams serving mid Essex, south west Essex and south east Essex. They have all received the 2018-19 national NCAP spotlight audit rating at level 2 (Needs Improvement). The ambition was for all teams to meet level 3 compliance by 2019-20. Action plans are being developed to ensure compliance in the next audit which has now commenced with reports published by summer 2020.

In summary the highlights indicate a system with lower than average investment in mental health, significant reliance on inpatient services, a workforce challenge and lack of defined structure between system and place. Our five-year mental health plan will endeavour to demonstrate how the system rebalances in favour of prevention, early intervention, resilience and recovery through implementation of the MHFYFV and NHS LTP requirements to 2023-24. A robust engagement plan has been developed to run over Q4 2019/20 to ensure the implementation work plan is informed by locality detail.

Individual placement services (IPS)

Rates of employment are lower for people with mental health problems than for any other group of health conditions. IPS is an evidence-based approach to providing employment support for people experiencing serious mental health problems, shown to be twice as effective as vocational rehabilitation, and associated with reduced utilisation of other services, including use of inpatient admissions. IPS is based on eight principles, with increased fidelity to these principles correlated to better outcomes for service users.

We have three IPS services covering Essex, Southend and Thurrock. All services have received transformation funding in the last two years and are on trajectory to deliver the yearly defined targets. The Essex service is classed as a national Centre of Excellence and Southend will be seeking re-accreditation in 2019-20. Thurrock is the youngest service with an ambition to be accredited as a Centre of Excellence by 2022-23.

Serious Mental Illness – Physical Health Checks

People living with severe mental illness (SMI) face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15–20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. Every CCG has put in place a plan to ensure people on SMI registers not known to secondary care mental health receive robust physical health checks and follow on interventions. The plans are centred on:

// Validating registers to enable clarity on performance against trajectories.

// Promotion campaigns through coproduction and outreach activities

// Public health programmes e.g. 'Every Contact Counts'

// Primary care training sessions

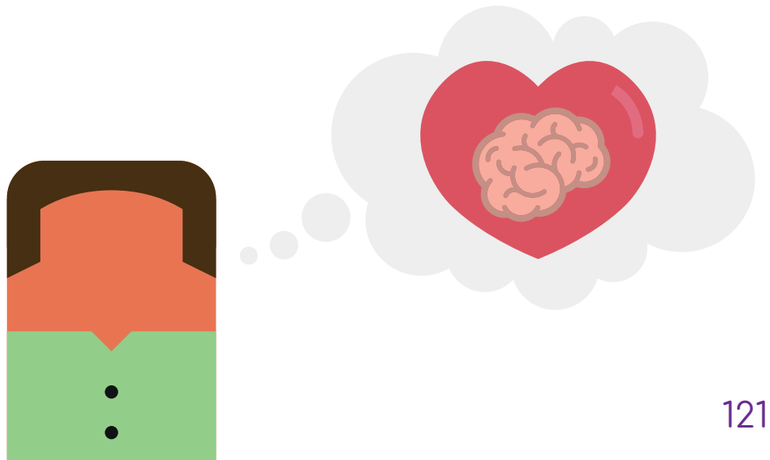
// Monitoring and contract arrangements

There is a system wide steering group in place to facilitate interface with EPUT, standardise processes between secondary and primary care and share good practice.

We currently average 25-30% of people with SMI accessing physical health checks and our ambition is to meet 60% by end Q4 2019/20. The validation of registers alone is likely to give an improved status. All CCGs have committed funds through Locally Enhanced Services initiatives to ensure both the validation is completed and checks are undertaken. We are working to embed SMI-PHCs as a function of the integrated primary and community care mental health teams.

Integrated Primary and Community Care Mental Health

Work is in progress through co-production in all CCGs to define and implement an integrated primary and community care mental health offer for the PCNs. This will provide additional mental health workforce integrated in primary care to deliver a wrap-around mental health service that supports primary care to respond to mental health needs at the earliest presentation, manage need in the least restrictive environment and provide a seamless interface with crisis response and secondary care mental health. The ambition is for the 28 PCNs to have a mental health service offer by 2023-24.



15.3 Community CMI for Adults and Older Adults

IAPT

Nine out of ten adults with mental health problems are supported in primary care. IAPT services across mid and south Essex are commissioned on CCG footprints. The ambition is that all services will continue to deliver against the access, recovery and waiting time's targets. To achieve these the focus is on building workforce capacity through training. Health Education England will fund places and 60% salary support over the next two years whilst CCGs meet the remaining 40%; CCGs will pick up the total responsibility from 2021-22.

Thurrock has embedded therapists in primary care and fully commissioned a bespoke IAPT/long-term condition pathway. The other areas are at different stages of fully operationalising these two requirements. The expectation is that CCGs will be largely compliant in 2020-21. All services are working closely with PCNs to maximise case finding to ensure unmet demand is identified and supported e.g. through social prescribing to access services.

15.4 Perinatal

Integrated model

Mental health and maternity executive leads have identified dedicated resources to lead the further development and expansion of the Specialist Community Specialist Perinatal Mental Health Service in line with increased investment to deliver the ambitions of the LTP. As an aligned resource with the LMS; the scope of work includes the requirements of Better Births implementation in regards to supporting emotional wellbeing and identifying mental health concerns at an early stage, ensuring that wellbeing and mental health is a golden thread running through all services involved in providing care for women and their partners through preconception, antenatal and post-natal care.

High level implementation plans which describe the anticipated phases the have been approved through Mental Health and LMS Governance structures. Firstly, we have committed to using a co-production approach to underpin and inform future investment and design. This will be completed in collaboration with the Maternity Voices Partnership and patient representative groups through commissioning a series of events reflecting both the localities and three acute maternity interfaces. The engagement events will form part of a wider needs analysis to understand demographic variations and features, current referrals and access to specialist services. The access target of 4.5% is being achieved; however there are current variations across localities to address to ensure equity and reduce any resulting health inequalities. Workforce will be considered as part of the Workforce Action Board and LMS Group and include a training needs analysis.

The access target of 10% by 2023/24 will be delivered with further investment to the specialist service expanding and remodeling to align with maternity and locality systems. The phasing of performance against the access targets will be achieved through the development of key areas including:

// Enhancing the evidenced based psychological offer whilst strengthening the multidisciplinary approach of the specialist team.

// Expanding the model from the current pre conception advice offer working closely with primary care networks.

// Extending the service offer for women to 24 months and including assessment/ signposting for partners.

// Developing maternity outreach clinics, through coproduction; these are anticipated to be delivered in pilot sites and rolled out across the system as a test and learn approach. The area would be interested in becoming a pilot site for targeted maternity outreach clinics.

A wider system audit will evaluate key touch points across services including Maternity, IAPT, Health Visiting, Children's Prevention and Support Services and GPs. The aim is to understand unwarranted variation to enable development of a system wide action plan to deliver quality and effective care for women, partners and their families. Key partners will include the voluntary sector to understand the offer across localities and explore opportunities such as prevention of social isolation and peer/support networks for partners.

15.5 Dementia

We know that the population is growing but also ageing rapidly with projection that people aged 75-84 will increase by 28% over the next five years. As of September 2019 the system was achieving a dementia diagnosis rate of 66.2% (range 59.6% Mid – 71.9% SE) against the 67% target.

A transformation programme is currently being implemented to invest more in a community based Dementia model with a focus on early diagnosis. The programme will comprise:

// **A community model** that is optimally provided with system partners in primary care, to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings.

// **A dementia in-patient model** for those with the most complex needs whose care and treatment cannot be safely provided within the community. In-patient stays for assessment and treatment will be planned, purposeful and time limited with the outcomes of the admission agreed with patients and carers at the point of admission.

The model has been collaboratively developed with EPUT clinical leads and frontline staff, carers by experience, CCGs, local authority commissioning colleagues and third sector partners. Model testing has been undertaken in each CCG as opportunities have arisen. A full test of the model has been undertaken in south east Essex, arising from a requirement to reconfigure dementia inpatient beds in order to provide preparation for winter pressures.

A small augmentation to the South Essex Dementia Intensive Support Service, alongside operationalising the proposed integrated model and new ways of working resulted in a significant reduction in admission to dementia beds. The reduction in admission to inpatient dementia beds has been sustained and provides evidence for the effectiveness of the model. This has enabled reaching and maintaining diagnosis rates above 70%.

The plan is for the model to be rolled out fully across the system with any efficiencies realised through a reduction in inpatient use being re-invested into the community services

15.6 Suicide Reduction & Bereavement

Suicide is rising, after many years of decline. We have identified reducing suicide and self-harm as one of three key priorities for mental health. Suicide is a significant inequality issue. People in the lowest socioeconomic group and living in the most deprived areas are ten times more at risk of suicide than those living in the most affluent group living in the most affluent areas. Suicide is the leading cause of death in males between the age of five and 49.

Suicide Reduction

Southend, Essex and Thurrock have a suicide prevention strategy overseen by a steering board comprised of local authority and NHS senior responsible officers; the board will be listening to the voice of people with lived experience of a death by suicide and linking into organisations such as the Samaritans and SOBS to further enable this.

Organisations across Essex have invested in both suicide awareness and Mental Health First Aid training establishing nominated first aiders. EPUT has a suicide reduction strategy in place.

We are not in receipt of current waves of transformation funding from the Suicide Reduction Programme or suicide bereavement support. (See also section 9).

Bereavement

Under the Southend, Essex & Thurrock Suicide Prevention Plan an established bereavement working group is mapping the availability of national and local resources to establish a single point of local online presence, The group is also designing a pathway for responding to suspected and confirmed death by suicide including establishing the point of entry (ongoing discussions with Essex Police and the Essex Coroner).

15.7 Mental health data

Commissioners and providers ensure data quality is proactively reviewed, national guidance is adhered to and the breadth of data submitted to the MHSDS accurately reflects local activity. This is undertaken as part of contract monitoring and it means:

// All providers being compliant with MHSDS v4 Information Standards Notice (ISN) from 1 April 2019; EPUT is compliant with MHSDS V4 and have been successfully submitting since May 2019.

// All providers submitting interventions to the MHSDS using SNOMED CT codes. Action plan is currently being implemented in line with Trust CQUIN to ensure SNOMED codes are implemented within EPUT from Q3 2019/20

15.8 Digital Mental Health

// EPUT has a robust, published IM&T Strategy through to 2022.

// Digital maturity - the second digital maturity assessment placed EPUT between the second and third quartiles, plans in place to improve

// EPUT already offers a range of self-management apps, digital consultations and digitally- enabled models of therapy

// Digital clinical decision making tools

// EPUT's IM&T Strategy includes full interoperability to national standards (FIHR and Snomed) supported by the Tiani Health Information Exchange (HIE).

// EPUT's IM&T Strategy is fully funded for all planned projects and therefore additional financial resource is not required at this point.

IAPT providers

All IAPT providers (including EPUT) are compliant with the new data quality requirements and monitoring is via the Information Assurance Framework and contract arrangements.

15.9 Mental Health Investment

The system commits to the mental health investment standard. Further detail can be found in Appendix 5.

16. Children and Young People's Mental Health

To deliver the LTP requirements for Children and Young People (CYP), partners are working closely with West Essex CCG, the lead commissioners for CYP mental health services. The work being undertaken is summarised below:-.

0-25 Pathway

- Transforming our CYPMHS to move to a 0-25 years' service offer, this will be achieved by:
  - Increasing access age range for 18-25yrs into our service
  - Increasing wider CYPMHS delivering within the CCG's offer provision to 18-25yrs
  - Delivering more lower level mental health intervention to CYP 0-25yrs
- Working with Adult commissioners/providers and NHS England to count the 18-25yrs cohort towards the access target.

Eating Disorders

- Utilise the CYP Eating Disorder (ED) funding investment to support ensuring full staffing to the specialist CYPED service
- Work with the voluntary and community sector to deliver an early intervention service offer around CYPED to support; awareness, self-referral, professional awareness and sign-posting

Comprehensive 0-25 support offer

- Transforming our CYPMHS to move to a 0-25 years' service offer, this will be achieved by:
  - Increasing access age range for 18-25yrs into our CAMHS service
  - Increasing wider CYPMH Service offer to deliver provision to 18-25yrs; achieved by service redesign and roll-out/ embedding of current pilots
- Working collaboratively to ensure we offer an 'every age' service offer to 0-25years population in need of mental health support, this will be achieved by:
  - Children's and Adults mental health commissioners aligning service offers and agreeing that the 18-25years cohort have choice of access based on need.
  - Working with providers to ensure alignment and patient choice of access is available and delivered on clinical and patient suitability

Mental Health Support Teams (MHSTs)

We will train and roll out MHSTs in the current phases, and will apply for further funding as this comes available. We are working towards the national and regional targets to deliver MHSTs across the region by 2023/24.

- Ensure MHSTs activity is submitted to MHSDS and counted towards the access target., this will be achieved by:
- Ensuring the delivery providers have access and can submit data to MHSDS

24/7 Crisis Provision

We already have in place a 24/7 crisis provision for CYP for crisis assessment and brief response. The service is currently mobilising a wider service offer to include intensive support and home treatment functions. This will be fully mobilised by April 2020.

We plan to evaluate the new model in 2021 and ensure continuation of a 24/7 crisis provision for CYP which offers crisis assessment, brief response, intensive support, home treatment functions and better alignment with A&E, acute hospitals, Tier 4- admissions and admission prevention

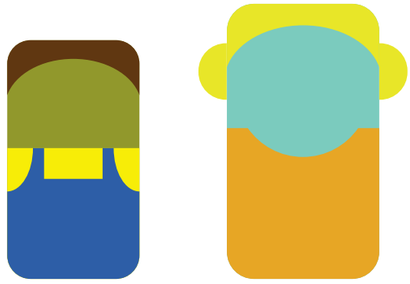
Local Transformation Plan

The Southend, Essex & Thurrock Local Transformation Plan is in year five (2019/20) was refreshed and published by 31st October 2019. The LTP will be refreshed for its final year in 2020/21 with sustainability aligned to the NHS LTP

CYP mental health plans align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services and health and justice, from 2022/23

Southend, Essex & Thurrock will work towards aligning CYPMH plans by 2022/23 by joining CYP work stream plans and moving towards a CYP system wide strategy.

Children's mental health has been a key transformation plan for Thurrock's Health and Wellbeing Board. Following recommendations from the Children and Young People's Mental Health JSNA product developed by the Public Health Team in 2018 which focused on prevention by exploring risk and protective factors, Thurrock has just recently implemented a School Mental Wellbeing Service (SWS). This is a partnership approach between Thurrock Council, Thurrock CCG and local schools and academies with a main focus to strengthen and improve the emotional wellbeing and mental health of school aged children and young people, as well as supporting families and school staff. The programme represents a £1M investment in the mental health of our children and young people. The service is a universal offer with an ambition to provide a whole school approach to emotional and mental health needs of children and young people in school and enabling mentally healthy school environment.



17. New Models of Care in Mental Health – Provider Collaboratives

In line with the NHS Long Term Plan, mental health providers are collaborating to deliver new models of secondary care. The anticipated benefits for patients include:

// Care closer to home

// More consistent and high quality care through standardising our approaches

// Greater influence from patients on the design of care at both service and individual level

// More 'joined up' care with close working between NHS providers and private sector partners

The following trusts have formed an aspiring East of England Collaborative:

// Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

// Central and North West London NHS Foundation Trust (CNWL)

// East London NHS Foundation Trust (ELFT)

// Essex Partnership University NHS Foundation Trust (EPUT)

// Hertfordshire Partnership NHS University Foundation Trust (HPFT)

// Norfolk and Suffolk NHS Foundation Trust (NSFT)

In early 2019, NHSE invited applications from trusts to form new care model collaboratives in respect of the following services:

// Low and medium secure mental health services including those for patients with a learning disability

// Specialised eating disorder services

// Child and adolescent mental health services

The designated lead providers are EPUT for low and medium secure services, HPFT for CAMH and CPFT for Eating Disorders.

Community Forensic Services

The collaborative agreed that EPUT as lead provider of low and medium secure services would submit an Essex-focused bid to set up community forensic services on a pilot basis during 2019/20 and 2020/21. Negotiations continue between EPUT and NHSE in this respect.

18. Improving our planned care services

Clinical Lead: Pathway specific clinical leads in place
Senior Responsible Owners: **Jane Farrell,** Managing Director, Broomfield Hospital
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

Current Provision & Future Plans

We are taking steps to address long waits for treatment, but have significant capacity constraints as a result of the demand for urgent care services. One of the key principles of our hospital reconfiguration programme was to separate, where safe and possible, the provision of planned care from emergency care so as to protect planned care capacity, particularly over times when the system experiences more pressure than usual on the emergency care pathway, eg winter, bank holidays, etc.

An Elective Care Programme Board has been established (July 2019) to oversee the redesign of system-wide pathways to support delivery of planned care standards (as identified through use of Right Care and Model Hospital data).

Our Commitments

// We will reduce the number of 52 week waits to zero by focussing on the longest waiting patients waiting over 40 weeks.

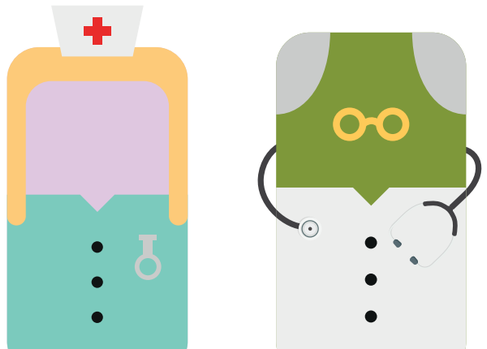
// We will implement the national tools and functions aimed at supporting planned care, including advice and guidance, apps for appointments, capacity alerts and triaging at point of referral to reduce demand for elective services.

// We are considering the use of new models of care including first contact practitioners and non-acute models of care, self-management, etc.

// We will redesign our outpatient services to ease pressure on planed care pathways and ensure we are using the most appropriate ways of managing elective care demand.

// We are focussing on an initial set of pathways to conduct detailed, system-wide demand and capacity assessments; these are ophthalmology, dermatology, neurology, urology, orthopaedics and gastroenterology. Collectively, these pathways account for over half the waiting list across the three hospitals. We will have national assistance from the Intensive Support Team on this demand and capacity work.

The system recognises that this programme cannot solely be focussed on hospital provision and a whole pathway approach is required to ensure that models established are fully utilised across mid and south Essex by all sectors.



Backlog Clearance

Waiting lists have grown over recent years and we have a large number of patients waiting over 18 weeks for treatment. The trusts and CCGs are discussing how best to achieve the commitments in the LTP, within the context of the currently available capacity and the financial challenges faced by the system.

Long Waits

We are committed to reducing the number of patients waiting over 52 weeks for treatment to zero by April 2020. We have clear plans in place to ensure this.

Currently Mid Essex Hospital is not reporting on elective care data; the hospital expects to return to reporting in April 2020.

First Contact Practitioners

Nationally, over 30 million working days are lost due to musculoskeletal (MSK) conditions every year, and they account for 30% of GP consultations in England. NHSE have identified the First Contact Practitioner (FCP) service as a High Impact Intervention for elective care transformation. CCGs in south east Essex were identified as a pilot site and in September 2018 the CCGs commissioned a FCP pilot, which aimed to introduce physiotherapists into Primary Care to address the MSK workload in general practice. This was based on the learning from National best practice, and focussed on embedding clinicians from within the main local provider; in this case Southend Hospital.

Since January 2019 there have been 2.5WTE FCPs working within one of the PCNs. The scheme had been very successful, with 96% of appointments being filled; only 1% DNA rate; and nearly 80% of all appointments being discharged with no onward referral (to either GP or hospital). This success enabled the south east CCGs to commission a second test site in another PCN, which is due to mobilise in December 2019.

Thurrock is also piloting direct access to MSK FCPs. As of April 2020, Thurrock will have one FCP operating within each of its four PCNs. The model will see full MSK assessment, triage and physiotherapy services provided across 7 sites in Thurrock, offering extended access appointments 7 days per week, including evenings and weekends. The service will include direct access to diagnostics, including ultrasound and MRI as well as scan-guided procedures. Through this work, we expect to deliver faster access to MSK and physiotherapy services for patients and a reduction in the use of hospital services. This brings care closer to home for patients in Thurrock as part of its overall place-based strategy.

The impact and learning from all 3 of the pilot sites with be measured, analysed and shared across the Health and Care Partnership to inform future commissioning decisions.

Evidence Based Interventions

There is a single policy for most evidence based interventions which reflects national guidance and provides equity for our patient population. The policy also supports the management of demand through patients not being listed for those procedures with little clinical evidence for them to be undertaken. There is a consistent full individual funding request process in place.
This is overseen by the CCG Joint Committee.

How will planned care services be delivered in future?

You

Individuals will maintain healthy lifestyles, with support, where required, to reduce key risk factors that lead to ill health and the need for planned treatment.

Neighbourhood

By diversifying the workforce within PCNs, people will get swifter access to the right health or care professional to get help with a developing condition –this might be a physiotherapist, a pharmacist, and specialist nurse or a GP.

When thinking about treatment options, patients will receive personalised support to enable shared decision-making.

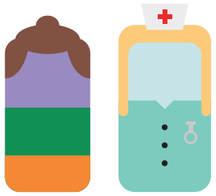
Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, community groups, exercise classes, and support groups.

Place

Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally.

Similarly, rehabilitation and reablement services will be available to support patients to return to full health after having had an operation or treatment.

Patients that require bed-based rehabilitation and support will usually be able to receive this at place-level, and support to get them home will be provided by discharge teams, social care and health care practitioners working together.



System

At system level, we will work together to:

// Reduce unwarranted variation in access, quality and outcomes for our elective care services.

// Identify appropriate digital solutions that will help patients manage their condition.

// Make best use of our estates and infrastructure to deliver care closer to home.

19. Improving our cardiovascular services

Clinical Lead: **Dr Rebecca Morgan,** GP Lead
Senior Responsible Owner: **Karen Wesson,** Director of Commissioning, Mid & South Essex CCGs, Acute Commissioning Team

Section 9 above on prevention highlights the work we are doing in partnership to prevent cardiovascular disease across our three local authority areas.

As a partnership we have agreed to take atrial fibrillation (AF) as a focus area to support the cardiovascular disease (CVD) programme of work, following successful work in Thurrock. In May 2019 the CCGs agreed a programme to:

- // Review patients currently on AF medication to ensure that they are medicated appropriately,
- // Review patients on the AF GP practice register that are not currently medicated, and
- // Case find new patients.

To progress this work, the system has secured support from our Academic Health Science Network partner, UCLPartners, to provide programme management support using the experience they have gained from similar projects across London. We have also appointed a GP lead for this work, funded through the GP Retention Intensive Support Site.

The UCLP programme manager and clinical lead are working closely with commissioning leads, primary care teams, medicines management, locality pharmacists, GPs and public health to improve the detection and protection of AF patients across mid and south Essex.

Locally, our places, working with local authorities will be implementing wider prevention programmes according to local need.

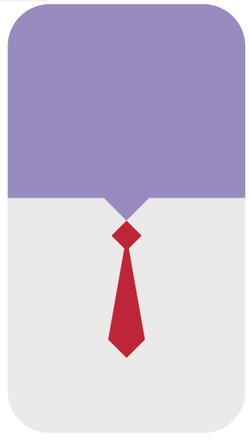
20. Improving our cardiac services

Clinical Lead: **Dr Stuart Harris,** Group Clinical Director, Cardiovascular, Mid & South Essex University Hospitals Group
Senior Responsible Owners: **Tom Abell,** Deputy Chief Executive, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

Our STEMI and NSTEMI pathways operate within a networked model with the Essex Cardiothoracic Centre (CTC) in Basildon. Opportunities to improve these pathways have been identified and were subject to East of England Clinical Senate scrutiny, public consultation and Secretary of State approval.

Our revised pathways will accelerate access to the CTC for NSTEMI patients to increase the proportion of patients who undergo angiography within the 72 hour target and reduce duplication in diagnostics between receiving hospital and the CTC, thereby reducing length of stay by two to three days for these patients.

This new pathway is scheduled for implementation during 2020. In advance of this a pilot of the new pathway will be undertaken with a seven day cardiology service being implemented at Basildon Hospital and NSTEMI patients being accelerated to Basildon from Broomfield Hospital. An evaluation of this service will be undertaken during February and March 2020 to inform the implementation of the system wide model.



21. Improving our stroke services

Clinical Lead: **Dr Indi Gupta,** Group Clinical Director, Specialist Medicine, Mid & South Essex University Hospitals Group
Senior Responsible Owners: **Tom Abell,** Deputy Chief Executive, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

We have a comprehensive stroke work programme that is developing a standardised stroke pathway - from prevention to rehabilitation care - for the population of mid and south Essex, informed by NHS Right Care and other nationally recognised models. The work covers the following key components:

21.1 Prevention

As above, AF is a particular focus for the system as are the activities described in the prevention section, above.

21.2 The acute stroke pathway

The future acute stroke care pathway has been agreed through the 'Your Care in the Best Place' proposals which were subject to East of England Clinical Senate Scrutiny, approved by the CCGs in July 2018, and by the Secretary of State in June 2019 following referral by Southend-on-Sea Council.

The future acute stroke pathway will see all three hospitals continuing to receive suspected strokes with optimised scanning and initial treatment (thrombolysis) with confirmed strokes then being transferred to a new acute stroke unit at Basildon Hospital for up to 72hours for intensive care and support following which patients will be stepped down to either an Acute Stroke Unit at their local hospital, or home supported by early supported discharge services. The full model is planned to be in place by 2022. In line with the consultation the trusts have commissioned UCL to undertake an evaluation of the new model of care.

In advance of the full pathway changes the trusts are standardising initial assessment and diagnosis procedures with the three A&E departments, including the introduction of rapid access to MRI scanning for suspected strokes to improve treatment decisions and to support earlier referral for mechanical thrombectomy.

These service changes are being overseen by Stroke Project Board, led by Dr Indi Gupta, Group Clinical Director for Specialist Medicine, with clinical representatives from the three hospitals and community services. This board reports to the group wide Clinical Programme Board which in turn reports to the trust executive and Partnership Board.

The hospital group also currently provide a 'best endeavours' mechanical thrombectomy service at Southend Hospital. This service is currently under internal review to ensure it is safe and effective, alongside ongoing work with NHS England SpecialisedCommissioning on their proposed future network arrangements for thrombectomy services for the population of mid and south Essex.

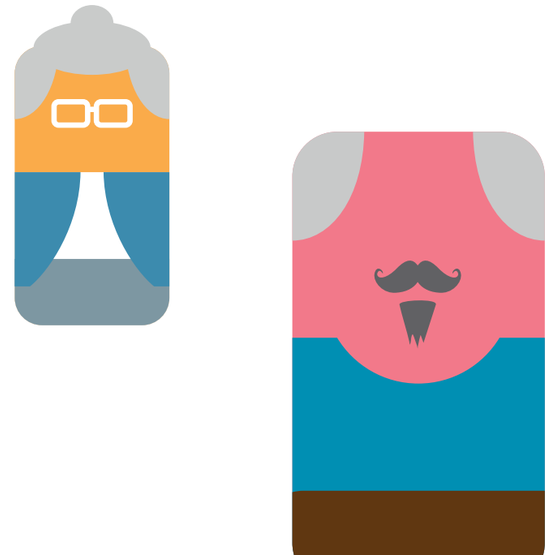
The system is committed to working with NHSE on Integrated Stroke Delivery Networks, in line with national clinical guidance on stroke treatments.

21.3 Acute/community pathway

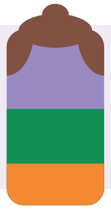
The five CCGs commission early supported discharge (ESD) via their local community providers and each provide services in a different way. At present, none of the services are commissioned to the National Clinical Guidelines for Stroke standards. The CCGs are currently undertaking a gap analysis to understand the future commissioning model for ESD with a view to offering a standardised service offer for the population. This has included criteria for bedded and non-bedded ESD services, multidisciplinary input, staffing, non-clinical and clinical follow-ups and six monthly reviews. A new pathway is currently being developed and will be reviewed by the Clinical Cabinet before a full business case is developed.

21.4 Rehabilitation

Across the seven CCGs in Essex, a neuro-rehab navigator role has been introduced. This has facilitated improved patient flow and reduced delays in acute inpatient beds. In addition, a procurement process has been undertaken for a provider of Level 2B inpatient and outreach neuro-rehabilitation. This will go through relevant governance processes in Q3 2019/20 with a view to commence mobilisation January 2020.



How will our stroke services be delivered in future?



You

Individuals will maintain healthy lifestyles, with support, where required, to reduce key risk factors that can lead to a stroke.

Neighbourhood

Our PCNs will be focussed on prevention, offering screening and health checks to those who may be at risk of developing conditions that may cause a stroke.

People will get swifter access to the right health or care professional to get help with a developing condition –this might be a pharmacist, and specialist nurse or a GP.

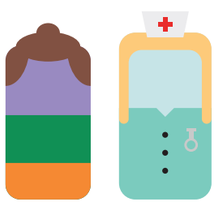
Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, community groups, exercise classes, support groups,

Place

Early supported discharge and bed-based rehabilitation services following a stroke will, where possible, be provided at Place level. Services will be provided to a consistent set of standards, focussed on improving outcomes for patients and supporting their carers.

Support to get people home will be provided by integrated discharge teams - social care and health care practitioners working together.

Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally. This may include 6-month and 12-month follow-ups post-stroke.



System

We will implement the new acute hospital stroke pathway to improve outcomes for patients who experience a stroke. The new pathway will reduce unwarranted variation in access, quality and outcomes for stroke services. Our neuro-navigation role will ensure patients get the right care for neuro-rehabilitation as close to home as possible

We will identify appropriate digital solutions that will help patients both reduce risks of having a stroke and support rehabilitation for stroke survivors.

Our estates strategy will support us delivering as much stroke care closer to home as is safe and possible.

22. Improving diabetes care

Clinical Lead: **Dr Sammi Ozturk,** GP lead
Senior Responsible Owner: **Tricia D'Orsi,** Chief Nurse, Castle Point & Rochford and Southend CCGs

We are committed to improving the quality and consistency of services to deliver best outcomes for people living with diabetes or at risk of developing the condition. Building upon existing best practice there is significant potential to improve services in both traditional and innovate ways and contribute to national targets in the following areas:

// Prevention and Early Identification
// Structured Education
// 8 care processes and treatment targets
// Diabetes foot pathway

Our Commitments

We are committed to achieving an improvement in outcomes for people at risk of developing, or living with diabetes. Our commitments include:

// Prevention of the onset of type 2 diabetes
// Promotion of awareness and earlier detection of type 1 and type 2
// Reduction of the occurrence of diabetes related complications
// Reduction of the impact of diabetes among hard to reach groups
// Using evidence, research and data to strengthen our approach to prevention and care
// Improvement of health care education

Current Provision & Future Plans

From 2017/18 data, the number of patients diagnosed with diabetes across the five CCGs is as follows:

2017/18 Data	Number of Registered Diabetes Patients		Population Prevalence % (17+)	
	Type 1	Type 2	CCG	England
Basildon & Brentwood	1,150	12,550	6.4	6.8
Castgle Point & Rochford	850	9,845	7.2	
Mid-Essex	1,915	17,885	6.4	
Southend	770	8,565	6.7	
Thurrock	620	7,320	6.7	

22.1 Our ambitions:

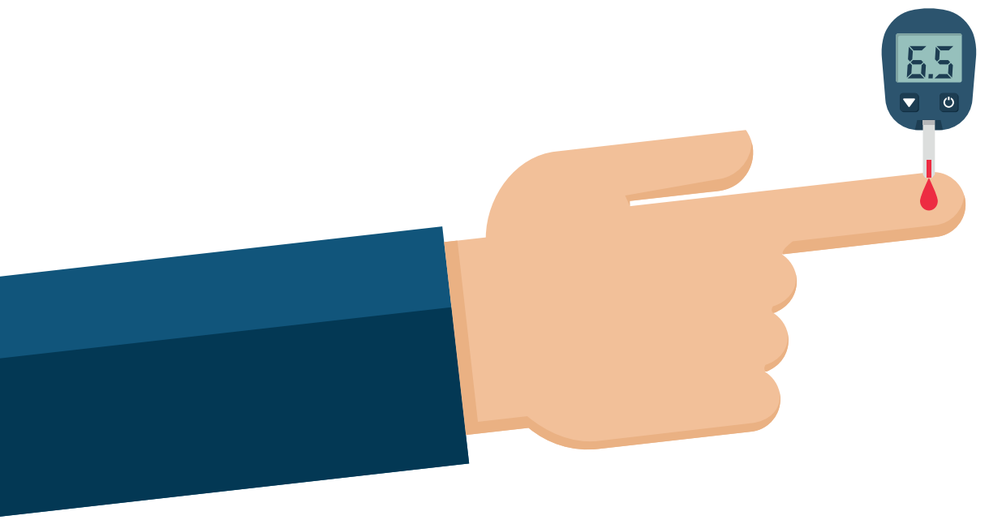
We are aiming for improvements in care processes for type 1 (from current 25% to 40% to bring us in line with national performance) and for type 2 (from current 35% to 60% to bring us in line with national performance).

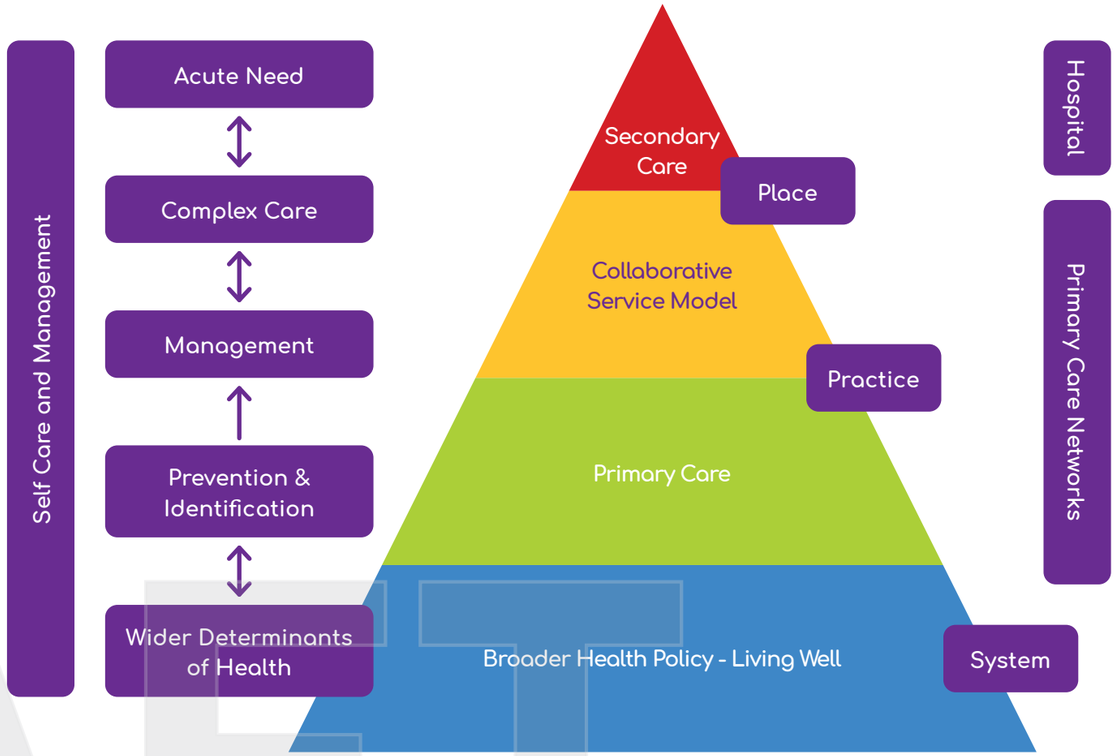
We are also aiming for a 50-60% conversion rate (referral to intervention) for the National Diabetes Programme.

In order to achieve these ambitions, we have developed a diabetes framework which will be delivered within a model of care based on four tiers: broader determinants, including prevention; PCN (neighbourhood level); community care via a collaborative service (PCN/place-based) and hospital care. According to their individual needs, a person with diabetes may receive care in all of these settings. The majority of diabetes care is currently provided in primary care and community settings; and around 80% of care will be provided in these settings in future.

The collaborative service will be provided by a comprehensive diabetes skilled multidisciplinary team. Collaborative care by its definition requires all professionals involved in a person's care to work in partnership, including generalists, specialists, other health professionals and support staff, with the person living with diabetes and his/her family at the centre of their care. The workforce will be upskilled within the collaborative service to provide more specialist care in the community.

Where appropriate we will agree a mid and south Essex approach to elements of the model such as addressing the wider determinants of health. All tiers will be underpinned by a population health management approach with self-care and management being a fundamental component throughout.





As part of our improving diabetes care journey, we need to identify and support current workforce capacity and competency to deliver the future model of care. Implementing a new model of care to support diabetes management will include staff training and development needs.

The skills required to support effective diabetes care include many that are generic to all long term conditions, as well as others that are specific to diabetes.

This will involve:

- // acknowledging the philosophy and principles of support for self-management
- // identifying accountable leadership
- // identifying the population involved (risk stratification)
- // identifying the capacity of individuals to engage in the necessary processes and supporting them to do so
- // identifying the multidisciplinary teams involved and the roles and responsibilities of each team member in order to ensure that care is personalised and co-ordinated
- // using available evidence-based and quality-assured training
- // identifying robust metrics, data collection methods, analysis and feedback to drive improvement.

The diabetes framework will be implemented through the development of a competency framework which will identify the skills required to support individuals at differing stages of their diabetes experience. This will then inform necessary investment for continuing professional development across the primary, social and secondary care interface.

22.2 Digital Solutions

The MyDiabetes App has a number of embedded functions such as expert written information, structured education, blood glucose level (HbA1c) log and monitoring, programmes of simple activities and diet plans, and access to a pool of clinical specialists for advice and support in understanding Diabetes, the associated risks, and self-management of the condition.

MyDiabetes will be used by newly diagnosed Type 2 diabetes patients and provides a lifetime licence for the patient once registered; therefore the patient has access to the app, dipping in and out of the embedded functions as and when required

We will undertake a 6 to 12 month pilot (100 licences per CCG area) in addition to the face to face structured education courses currently provided.

22.3 Our Deliverables

Key Milestone Deliverables	Timeline
Health and Care Partnership five year Diabetes framework finalised and approved	Nov-19
Review and redesign Health and Care Partnership foot pathways community through to acute	Dec-19
Governance structure established (in line with existing forums)	Jan-20
Prevention/self care programmes identified across the wider health system	Feb-20
Benchmarking (gap analysis) against the framework completed	Feb-20
System-wide and CCG priority areas agreed and plans developed	May-20
Framework changes to service pathways implemented	Jun 20 - Mar 22
MyDiabetes app distributed to 100 Type 2 diabetes patients within each CCG (initial pilot) as part of the existing structured education pathway	May-20
NDPP referrals increased in line with yearly IP allocation	Aug 20 - Jul 24
Improvement in variances across practices in care processes and 3TTs	Mar-21
Diabetes workforce competencies developed based upon national guidelines	Sep-20
Workforce training needs identified	Mar-21
Collaborative working across PCN/Place - community and specialist	Apr 22 - Mar 23
Care model developed and procured (subject to PCN maturity)	Apr 23 - Sep 24
Care models implemented	Mar-25

23. Respiratory disease

Clinical Lead: **Various**
Senior Responsible Owner: **Terry Huff**, Accountable Officer, Castle Point & Rochford and Southend CCGs

Redesigning respiratory services is one of our transformation priorities.

Our vision is ultimately to improve the respiratory health and well-being of the population of mid and south Essex from the start to the end of their lives.

Our respiratory plans will initially focus on a defined scope of adult chronic respiratory disease before expanding to include acute and paediatric services

All CCG's have already implemented or planned initiatives to improve respiratory services and patient outcomes. Our programme will review and revise these initiatives to create a system-wide offer that meets national standards and LTP commitments, with a focus on ensuring prevention and self-care, ensuring as much care as possible is provided close to home.

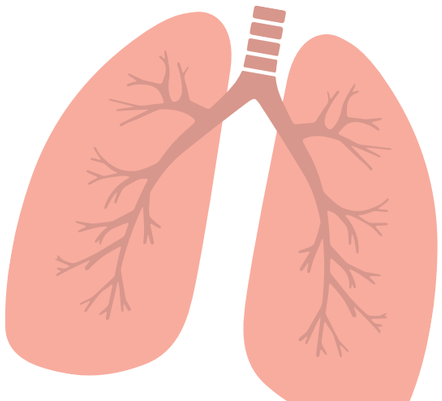
Programme objectives:

// To create a consistent approach to respiratory care across mid & south Essex.
// To increase early and accurate diagnosis of respiratory disease.
// To promote better medicine management.
// To improve education and support GPs to enable them to manage patients.
// To comply with the requirements of the National Spirometry Register using targeted funding as it becomes available.
// To promote self-management, including the MyCOPD app, to enable greater patient control of their own care.
// To increase the uptake and completion of pulmonary rehabilitation programme, using targeted funding as it becomes available.
// To reduce avoidable admissions for community acquired pneumonia.
// To reduce hospital outpatient activity.
// Deliver high quality integrated care in line with best practice guidelines

In order to achieve our vision, the respiratory Programme aims to support;

1. Prevention of respiratory ill health

We will increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks of poor respiratory health. We will ensure that the activities of individual services and agencies support this aim.



2. Earlier detection of respiratory diseases

We will ensure people are aware of the signs and symptoms of respiratory diseases in order to encourage positive health-seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

3. Primary Care and Community based support

We will provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

4. High Quality Hospital Services

We will ensure that pathways and services are in place so that people who need them receive prompt, effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.

5. Promoting Self Care and Independence

We will make sure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate, personalised information, support and interventions to help them.

6. Develop the workforce to support quality provision of respiratory care

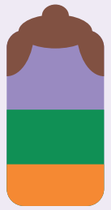
We will implement an agreed competency framework for healthcare professionals involved in managing respiratory disease and support this with a flexible educational programme that is accessible to all healthcare professionals.

Our Expected Outcomes

Through working together on a system wide approach we expect to:

- // Reduce the prevalence of respiratory disease
- // Reduce the burden of respiratory disease
- // Reduce variation of care across the system for respiratory disease
- // Increase the number of patients accurately diagnosed with COPD and Asthma at an earlier stage of disease
- // Reduce reliance on secondary care services
- // Improve patient quality of life
- // Provide proactive care delivered by the right person at the right time

How will respiratory services be delivered in future?



You

Individuals will be supported to prevent the on-set of respiratory disease and self-manage their condition, including education programmes and support with healthier lifestyles. A range of digital tools (eg MyCOPD, asthma), will be available

Individuals with respiratory disease will have personalised care and management plans, and be at the heart of decision-making about their care.

Neighbourhood

Diversifying the workforce within PCNs will mean that patients get access to the right care professional for their needs to obtain education, advice and guidance – this could be from a pharmacist, a specialist nurse, therapist or GP.

PCNs will support practices to undertake proactive case finding and risk stratify patients to ensure that those at high risk receive the right care and support.

Structured medicine reviews and education will be undertaken.

PCNs will adopt consistent management approach for community acquired pneumonia – ensuring swift diagnosis and treatment.

Community teams will be aligned to PCNs, providing pulmonary rehabilitation, community clinics (including oxygen assessment clinics). Psychology services, nebuliser trials, home support and where required, palliative care support & end of life care co-ordination

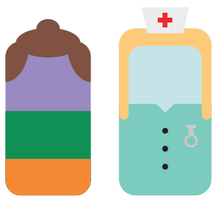
Place

At place level we will look to provide a respiratory diagnostic / assessment unit/HOT clinics and in-reach into acute services, along with supported early discharge from hospital.

We will offer flu immunisation at Place-level, with a focus on the most vulnerable.

We will bring as much care close to home as possible to prevent patients having to travel wherever we can.

We will offer effective smoking cessation services and ensure that all health and care professionals can offer brief advice on smoking cessation.



System

We will develop a single service specification for respiratory services and simplify points of access for patients.

The shared care record will assist health and care professionals to support people living with respiratory conditions.

We will develop and a workforce competency framework and deliver education programmes to our staff.

24. Redesigning Outpatient Care

Clinical Lead: **Specialty-specific leads in place**
Senior Responsible Owner: **Tom Abell**, Deputy Chief Executive, Mid & South Essex University Hospitals Group

Outpatient redesign has been identified as one of our key transformation priorities.

As part of the acute reconfiguration arrangements, we planned a significant reduction (274k fewer) outpatient appointments would need to be delivered in alternative ways to ensure sustainability of all services and while bringing as much care as possible closer to where people live. To deliver this reduction, we will need to work in different ways including taking a 'digital first' approach, reducing face-to-face appointments and bringing hospital clinicians into the community to support delivery of this service.

In planning our future estate requirement, we are mindful that we want to move as much care closer to where people live as possible to prevent people having to travel to hospital. Additionally, in planning the future estate as part of the capital business case for hospital reconfiguration and integration plans, we have a need to "right size" our outpatients departments. Our approach to this will use the latest technology and adoption of proven innovations to deliver new ways of working to support personalisation and choice for patients, while improving the capacity and utilisation of our services.

Our outpatient redesign programme has the following key objectives:

// Reduce overall outpatient appointments
// Reduce % of face to face outpatient appointments
// Reduce variance across our three hospitals, optimising our administrative processes
// Optimise Outpatient experience
// Enhance Outpatient data analytics to enable continuous improvement
// Adoption of a 'digital by default ' approach

As well as taking a pathway approach to improvements (pre-OPD, OPD delivery, Follow-up), we are focussing on three key specialities as part of the NHS England Outpatient Transformation Programme (dermatology and rheumatology across the three hospitals, and urology at Southend Hospital). This work will involve commissioners, newly formed primary care networks and other community providers, also linking closely with our digital transformation and estates programmes.

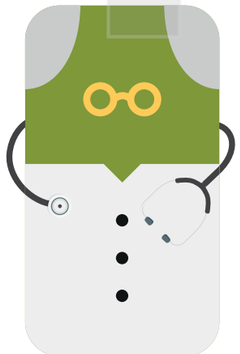
Health and Care Partnership Outpatients Transformation Programme (in scoping)

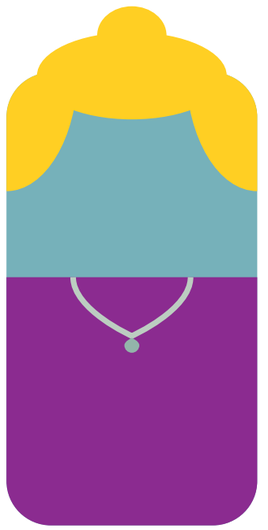
Pre-OPD Appt	OPD Delivery	OPD Follow Up	NHSE Programme

Current State Mapping			// Outpatient pathway transformation for Dermatology (group), Rheumatology (group) and Urology (SUHT)
			// Intention is to pilot potential technologies
			// Supported by the NHSE Elective Care Transformation Programme
			// 100k funding

Target Operating Model			

// Robust advice and guidance approach
// Effective triage
// Joint access policy
	// Streamlined booking process
	// Efficient use of estates
	// Pre-appointment data
	// One stop clinics
	// Reduction in F2F outpatient appointments
		// Risk stratified clinics
		// Alert system
		// Patient let follow up for LTC
		// Planned time for consultatns to forward view case load
		// Self monitoring	





25. Children & Young People

25.1 Maternity & Neonatal

Clinical Lead: **Teresa Kearney,** Chief Nurse, Basildon & Brentwood CCG
Senior Responsible Owner: **Karen Berry,** Senior Maternity Commissioner, Basildon & Brentwood CCG

Positive, healthy pregnancies and births, and good early development have wider societal impacts for our population.

We aim to ensure that children and their families have the best quality of care throughout pregnancy and early life and that parents are given choice and control of their care and support.

The Maternity & Neonatal Long Term Plan commits to include the Better Births programme with Maternity and Neonatal ambitions. The mid and south Essex Local Maternity Service Transformation (LMS) programme has clear governance processes and a robust link is being developed across the system with interdependent programmes. We have established a Local Maternity System Transformation Board comprising representatives from commissioners, hospital providers, community services and patient representatives. A full report on our maternity and neonatal transformation programme can be found at Appendix 8.

Context

Across mid and south Essex, our maternity services deliver approximately 12,305 births/year. The acute hospital merger will provide the opportunity for our Maternity and Neonatal services to become standardised. There are two standalone midwifery units and three co-located midwife- led units.

Each acute hospital unit has a level 2 Neonatal unit. Our intensive care pathways operate as follows:

Southend Hospital / BTUH - The Royal London Hospital

Mid Essex - Cambridge University Trust and are part of the Cambridge Cluster hospitals

A capacity and demand analysis of mid and south Essex (2018) suggested birth rates in Essex were expected to remain steady over the next few years with a small expected increase in Basildon in 2020 and steady thereafter. Given the amount of cross border activity it is not immediately clear where this expected increased activity will have most impact. The information available suggests it is most likely to impact on BTUH and MEHT. Given the small increase in birth rate indicated, the requirement for additional staff does not appear to be significant at this time. However, we are aware there are significant housing developments within the area and the impact of these . Therefore, ongoing monitoring of the impact of this as well as increases in maternity bookings will be required by the Heads of Midwifery to ensure that any increase results in an by establishment uplift.

Saving babies lives care bundle version 2

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one and address the issues identified in the SPiRE evaluation. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy,
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth

Our current work and future plans

We are committed to delivering against the requirements of the Saving Babies' Lives Care Bundle. A deep dive performed in 2018 demonstrated the gaps in our compliance and we have clear plans in place to close these gaps (see Appendix 8) We are committed to making significant progress on the "halve it" ambition of halving rates of stillbirth and neonatal death, maternal death and brain injuries during birth by 50% by 2025:

Stillbirth rate

		Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
Numerator	The number of stillbirths during a calendar year	60	51	49	46	44	42
Denominator	The number of live births and stillbirths occurring during a calendar year.	13,987	13,987	13,987	13,987	13,987	13,987
Rate	Rate per 1,000 live births and still births	4.3	3.6	3.5	3.3	3.1	2.9

Neonatal Mortality rate

		Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
Numerator	The number of stillbirths during a calendar year	14	12	11	11	10	10
Denominator	The number of live births and stillbirths occurring during a calendar year.	13,927	13,927	13,927	13,927	13,927	13,927
Rate	Rate per 1,000 live births and still births	1.0	0.9	0.80	0.8	0.7	0.6

Improvement Programmes

All three maternity units in our LMS are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme.

Southend Hospital Maternity participated in Wave 2, specifically to improve the early recognition and management of deterioration during labour and early post-partum period. They completed a Quality Improvement piece of work on early identification and treatment of Sepsis.

Basildon Hospital Maternity are in Wave 3 and are undertaking a Quality Improvement initiative focussed on improving the proportion of smoke free pregnancies, this has included Carbon Dioxide monitoring at each point of contact. The LMS financial plan has supported the initiative for smoking cessation.

Mid Essex Hospital Maternity participated in Wave 3, the focus was on improving early the early recognition and management of deterioration during labour and early post-partum period. Their quality improvement project is in the management of post-partum haemorrhage.

The LMS are reporting the use of Magnesium sulphate for women in suspected labour under 27 weeks. They are exception reporting when this is not carried out, or when unable to transfer women to a tertiary unit prior to 27 weeks.

All three Maternity units are using the perinatal Mortality review tool to review all stillbirths and neonatal deaths. Learning from these is shared via a safety newsletter.

All three units take part in the National Neonatal Audit Programme (NNAP). The 2018 data results are available at Appenidx 8.

Term babies admitted to the Neonatal unit are being reviewed locally to enhance learning and ascertain if the admissions could have been avoided, also consideration is given as to whether babies could have been cared for under a transitional care pathway which would reduce the likelihood of them being separated from their mothers. All three sites have an Avoiding Term Admissions to NICU (ATAIN) action plan, In addition to this there are action plans for each unit to introduce a transitional care service.

The LMS has considered the use of placental growth factor testing. This will be kept under review but not instituted at present.

Choice and Personalisation

Better Births state that all women should receive personalised care, centred on the woman, her baby and her family, based around their needs and decisions, where they have genuine choice, informed by unbiased information. The LMS is working to ensure that:

- All women have a personalised care plan by 2021
- All women can make choices about their maternity care, during pregnancy, birth and postnatally
- More women can give birth in midwifery settings (at home and in midwifery units)

MSE Personalised Care and Support Plans are now completed; Maternity choices are available on each of the trust websites. The Maternity Direct App has gone live at BTUH, it will be developed to be available for all women to download and is a platform for health information for those who are able to download the app. The chat and appointment functionality will be available at BTUH, but not currently at Southend or MEHT, until IT integration has been achieved.

At present all Maternity units are using personalised care plans and these are given at booking ensuring the majority of women have a personalised care plan.

Continuity of carer.

At present, we are offering 12.9% of women the opportunity to have the same midwife throughout pregnancy, during birth and postnatally, against a requirement of 20%. We will continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2020 we progress towards 35% of women are being placed on a continuity of carer pathway and in March 2021, Most women will receive continuity of carer.

Our work will be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes. By 2024 75% from Black/Black British and Asian/Asian British communities and women from the most deprived areas will receive continuity of carer.

Perinatal mental health.

Mental health and maternity executive leads have identified dedicated resources to lead the further development and expansion of the Specialist Community Specialist Perinatal Mental Health Service in line with increased investment to deliver the ambitions of the LTP. As an aligned resource with the LMS; the scope of work includes the requirements of Better Births implementation in regards to supporting emotional wellbeing and identifying mental health concerns at an early stage. Ensuring that wellbeing and mental health is a golden thread running through all services involved in providing care for women and their partners through preconception, antenatal and post-natal care.
See section 15 and Appendix 8.

Maternal Smoking.

We are committed to reducing maternal smoking and aim to unify smoking cessation services available to women and their partners across the footprint. Smoking at time of delivery for 18/19.

Workforce

Workforce profiling has included Birth rate + reports from all three sites. This has demonstrated a midwifery workforce deficit of 30 WTE and a deficit of maternity support workers (MSW) of 14.5 WTE. All three Trusts provide maternity workforce statistics and use this information to support future planning of workforce numbers and skill mix. Reporting of workforce information will be aligned across the three Trusts.

Postnatal Care

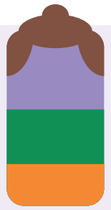
All three sites are providing personalised care planning which includes postnatal planning in the antenatal period. Two sites have clear pathways for timely referral for women who experience issues with their pelvic health. We recognise that there needs to be greater emphasis on access to emotional and mental health support, and this is included in the perinatal mental review.

Infant feeding

Currently, only Mid-Essex have a tailored feeding strategy and so we will develop a tailored feeding strategy ideally across the system. Breast feeding support has diminished across the LMS and the Maternity Voices Partnership are looking at ideas to improve our service to women.

BTUH and SUHFT have infant feeding midwives with baby friendly accreditation initiative (BFI) whilst MEHT currently have a vacancy for this position and need to re apply for BFI.

How will maternity services be delivered in future?



You

Pregnant women will be supported to maintain healthy lifestyles, with support where required to reduce key risk factors. Eg smoking in pregnancy

Women will be able to access support and advice through the Maternity Direct App.

Neighbourhood

Swifter access to the right health and care professional through primary care networks.

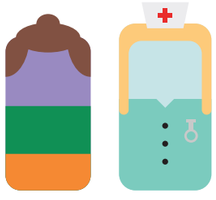
Women will receive personalised support to develop care plans.

Close work with community and voluntary sector organisations will aide women and families in accessing a range of support services pre- and post-natally eg new mum groups, breastfeeding support.

Place

Where safe and possible, a range of outpatient appointments and diagnostic tests will be available closer to home.

Immunisations offered through place-based arrangements.



System

At a system level organisations will work together to further develop digital channels for accessing information, advice and support/

We will continue to develop and improve our maternity services, ensuring full adoption of the Better Births principled across our three maternity units and ensuring continuity of carer in line with LTP commitments.

25.2 Children and young people's mental and physical health services

Clinical Lead: **Dr Sooraj Natarajan**

Mid and south Essex has a child population of circa 270k and although there are similarities in the health needs, there are also significant variations linked to demographics and wider health determinants. The joint strategic needs assessments undertaken across the footprint have informed commissioning priorities and will continue to support collaborative working across heath and care partners.

Children and Young People Partnerships

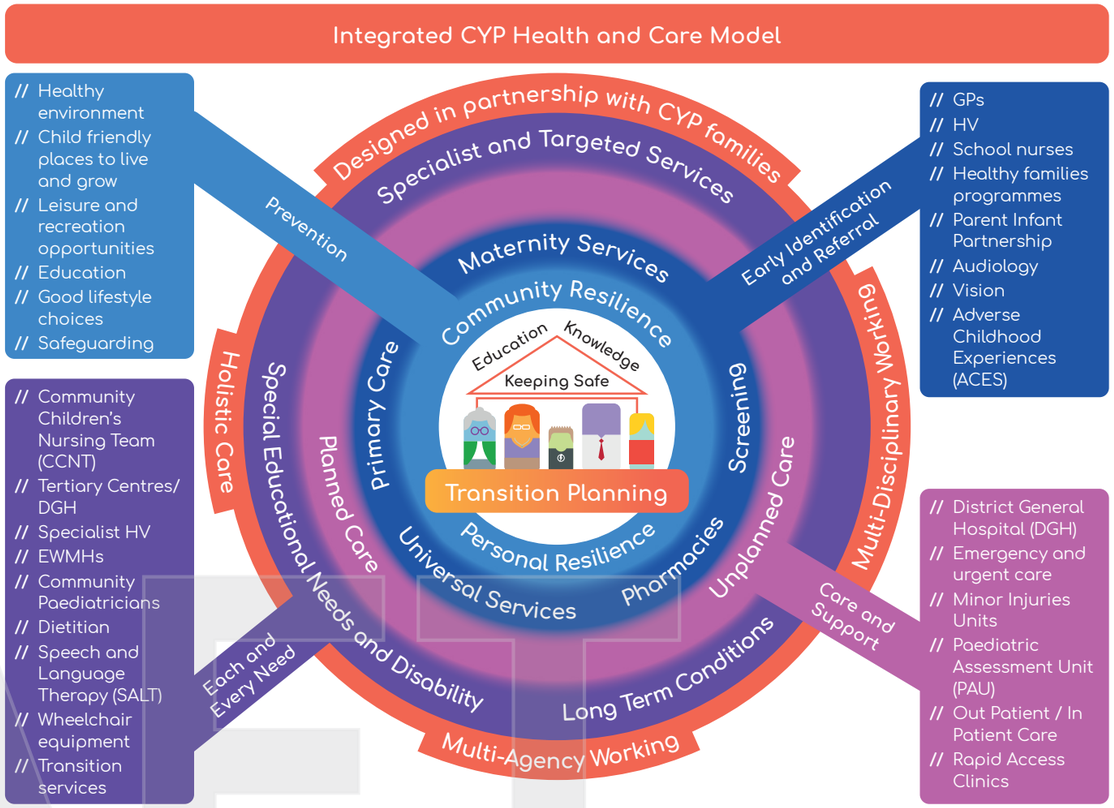
Children and Young People (CYP) Partnerships are currently aligned with the individual council and unitary footprints. This includes Essex Children's Partnership Board, Thurrock Brighter Futures Board and Southend Success for All. These three partnerships will have oversight of presenting health inequalities and local needs; each reports to the relevant Health and Wellbeing Board. The delivery of the Families and Children Act in relation to Special Educational Needs and Disabilities (SEND) remains accountable on the local authority footprints supported by the SEND Partnership Boards. Safeguarding for CYP also has locality accountability; however Southend, Essex and Thurrock work in collaboration to have a consistent approach underpinned by the single Safeguarding and Child Protection Procedure.

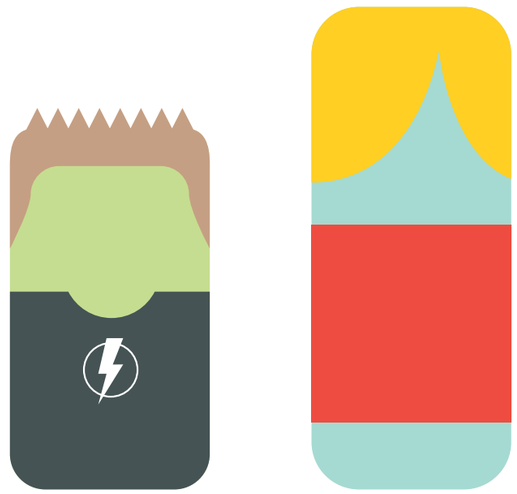
Clinical leadership

To support the work across mid and south Essex there is a well-established Paediatric Clinical Engagement Group (PCEG) which brings together universal health and prevention services, children's acute and community services. The PCEG has strong clinical leadership and is chaired by the CYP GP Lead.

PCEG and the primary care networks will work closely together to support integration across the health and care system for CYP with long term conditions including asthma, epilepsy and diabetes. This will include the ongoing and transfer of care to adult services and integration with education and wider settings who provide care for this group of children.

The PCEG has developed an overarching model to illustrate the integrated approach for children and young people (see below). The model illustrates the importance of taking a whole family holistic approach to prevention and early intervention and the potential benefits to be realised by maximising integration.





26. Learning Disability and Autism

Clinical Lead: **Tricia D'Orsi**, Chief Nurse, Castle Point and Rochford and Southend CCGs
Senior Responsible Owner: **Simon Leftley,** Deputy Chief Executive, Southend Borough Council, Chair of Transforming Care Partnership

We will deliver the Long Term Plan commitments to improve services and outcomes for people with learning disabilities, autism or both, through working across the existing Essex Transforming Care Partnership (TCP) that was set up in 2016.

The Essex Transforming Care Partnership consists of Southend CCG, Castle Point & Rochford CCG, Basildon & Brentwood CCG, Thurrock CCG, West Essex CCG, Mid Essex CCG, North-East Essex CCG, Essex County Council, Southend-on-Sea Borough Council and Thurrock Council. The Partnership covers all of the mid and south Essex footprint, but also sits across Hertfordshire and West Essex and Suffolk and North Essex.

Since its conception the Essex TCP has successfully delivered against the national Transforming Care agenda. Key achievements include:

- Reducing admissions to adult learning disability in-patient facilities by over 50%;
- Reducing overall learning disability adult in-patient numbers by 34% and exceeding the targets within the national Transforming Care programme;
- Delivering a transformed local service model in line with "Building the Right Support" - the national service model for learning disability - through a new 7 year contract with Hertfordshire Partnership University NHS Foundation Trust (HPFT)
- The establishment of a Pooled Budget underpinned by a Section 75 agreement across the partners;
- The establishment of an integrated learning disability commissioning function funded by all partners and hosted by Essex County Council.

Since the publication of Valuing People in 2001 it has been clear that the wider determinants of health for people with learning disabilities – housing, employment, and healthy living are influenced best by Local Authorities. Those areas that achieved the greatest successes in reducing health inequalities have had strong partnerships between CCGs and Local Authorities. The Essex TCP has a senior responsible officer in place (Simon Leftley, Deputy Chief Executive, Southend Council) and the commissioning infrastructure to deliver the commitments within the Long Term Plan.

The Essex TCP also sees opportunities of working across all three Health and Care Partnership footprints. The areas that offer the greatest benefit for operating at this larger scale are low volume and high cost niche services where it makes sense to commission collaboratively. For example:

- We are already working with the Suffolk TCP to explore opportunities around co-commissioning assessment and treatment services. Both Essex and Suffolk are looking to remodel their assessment and treatment units and doing this together would deliver improved economies of scale;
- We are working with Hertfordshire, Suffolk and Norfolk to explore how we can commission low volume high cost in-patient beds to achieve the best value and ensure consistent quality standards.

The Essex Transforming Care Partnership has recently extended its terms of reference to address the wider health inequalities that people with learning disabilities and autism experience. In 2019/20 we will publish the first Health Equalities strategy bringing together the learning from Transforming Care, LeDeR, STOMP / STAMP and annual health checks into a coherent programme of work across the partnership.

The partnership has invested in a commissioning structure to deliver Learning Disabilities Mortality Reviews (LeDeR). Through the appointment of two permanent LeDeR reviewers, a LeDeR co-ordinator, a number of interim workers to address the backlog, and our existing reviewers within the local health and social care system, we will ensure reviews are undertaken within six months of the notification of death. The Essex TCP was one of the first areas to produce an annual LeDeR report and has an active steering group to address the identified themes from the reviews.

The Partnership also has steering groups for the Stopping Over Medication of People with a learning disability or autism and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to ensure a consistency and efficiency across all seven CCGs.

Co-production has always been central to the work of the Essex TCP and experts by experience have been involved in shaping all aspects of the programme from co-producing the service model and specification to being full members of the board. Within the new commissioning structure two posts have been created for a person with a learning disability and a family carer and they will have responsibilities for developing systems to monitor the quality of care, support and treatment, and that local services are making reasonable adjustments.

The Partnership has already had considerable success in reducing adult inpatient usage and has plans to exceed its targets for both 19/20 and 20/21. The Partnership has also reduced the length of stay in adult in-patient services and actively uses the 12 point discharge plan to ensure people do not have to stay in hospital any longer than they need to. We will continue to actively monitor the use of seclusion, long term segregation, and restraint through our quality monitoring on in-patient services and through the Care and Treatment Review process to ensure these interventions are minimised and only used where absolutely necessary. We will also ensure that the providers we commission services from (both NHS and Independent Sector) meet the Learning Disability Improvement Standards.

The achievements in reducing adult in-patient services have been delivered through our new service model that went live in November 2018 that includes an enhanced community support service available seven days a week and a community forensic service. The Partnership has utilised capital to deliver housing solutions to discharge some of our long-term inpatients and we have a housing strategy in place to further reduce inpatient numbers.

The new seven year contract which covers the Partnership as a whole consists of the core services described in Building the Right Support, and a Local offer in which CCGs can tailor local services through their place plans to meet the needs of their populations. A key component within the place plans is improving the uptake of physical health checks to meet the target of 75%.

Our Priorities

A real focus of the Partnership over the next eighteen months will be children and young people with learning disabilities and autism. The Accelerator Pilot that was implemented in 2018/19 has illustrated how multi-disciplinary working and a person-centred offer can reduce crisis for children and young people with learning disabilities and their families. The current children's LD service that operates in north, mid and west Essex is being extended in 2019/20 to cover the Partnership as a whole to embed the learning from Accelerator Pilot. The Partnership will also be extending the model to include children and young people with autism and trial the use of keyworkers with access to flexible support including Personal Health Budgets in preparation for a roll out of the keyworker model in 2020/21. The Partnership with its local authority footprints also provides the best framework for testing the model for taking eye, hearing and dental services to children and young people in residential schools from 2021/22. The Health and Care Partnership is also reviewing its neurodevelopment pathways to ensure that C&YP with autism receive the support they need pre and post diagnosis; so that a diagnostic assessment is not just a Gateway to services but forms part of the overall support offer for this cohort.

The model for Children and Young People will align with the SEND plans for each of the three local authorities. The Partnership is also in the process of retendering for its CAMHS services (also on a TCP footprint) which provides an opportunity to ensure that the social care, education, and mental health offer for children and young people with autism are fully aligned to meet local need and reduce the need for in-patient admissions.

26.1 Special Educational Needs and Disability

The Children and Families Act 2014 requires Local Authorities and CCGs to work together to support the health element of services for children and young people with Special Educational Needs and Disability (SEND), enabling children and young people to have more say over what support and services are offered in the local area and the help they need to prepare for adulthood. Local Authorities publish information about the range of support available in their area for children and young people aged 0 to 25 years with SEND. This information is known as the 'Local Offer' and covers education, health and social care support and services.

Children and young people's needs are met from a range of NHS services, some are universal, such as GPs and health visitors and some are more specialised and may need an assessment or referral from a health or social care professional – these include, but are not limited to, speech and language therapy, community paediatrics, physiotherapy, specialist children's nursing, continence services, emotional health and wellbeing services, continuing health care assessments and packages of care.

Ofsted and the Care Quality Commission are tasked with inspecting local areas on their effectiveness in fulling their duties under the Children and Families Act.

Following recent inspections, our three local authorities have each been given a Written Statement of Action, detailing where improvements must be made to SEND services and the local offer. The CCGs and local authorities are keen to commit to being joint and active members of an improvement board and have further committed to reducing inequalities within joint commissioning arrangements, recognising the need to work to agreed outcomes. Work has already commenced to this effect with commissioners working with officers from the local authorities. The work includes:

- // The development of a joint outcomes framework
- // Undertaking a gap analysis against best practice for a universal 0-25 service to support early intervention. This is likely to lead to a jointly commissioned service for higher level needs for the specialist service.
- // Education Health and Care Plans and inclusion of health and social care - a working group has been established to oversee this

The Improvement Board will feed into the SEND strategic governance group.

27. System financial plans

Clinical Lead: **Various** (depending on efficiency plan)
Senior Responsible Owner: **Chief Finance Officers**

27.1 Five-year System Control Totals

Mid and south Essex has traditionally been a financially challenged system and this has impacted on our ability to provide investments into delivering high quality healthcare for our population.

Our five year financial planning is predicated on two initial high level aims:

// To achieve the control total set for the system as a whole by the end of the planning period

// To ensure that our financial planning is both credible and an enabler for the delivery of the commitments set out in the NHS Long Term Plan

Further to these initial challenges, we continue to explore further opportunities that will also allow us to:

// Achieve the control totals for each year across the planning period; and

// To achieve the control totals set for each individual NHS organisation

The starting point for planning is the published CCG allocations for the next five years that set out the funding available to deliver the ambitions of the Long Term Plan and ensure quality healthcare is delivered for our population. This funding amounts to £1.64bn in 2019/20, rising to £1.91bn in 2023/24 which equates to annual increases in funding of between 3.5% and 4.2% p.a.. Together with social care resources (circa £0.6bn) across our system our population will benefit from £2.5bn spent on care.

Our financial plans show the following position:

Summary by Organisation (£m)		2019/20	2020/21	2021/22	2022/23	2023/24
Net system position by organisation						
Mid-Essex	£000s	4.0	0.0	0.0	0.0	0.0
CPR	£000s	0.6	0.0	0.0	0.0	0.0
Southend	£000s	0.6	(0.0)	0.0	0.0	0.0
B&B	£000s	3.8	0.0	0.0	0.0	0.0
Thurrock	£000s	0.5	-	-	-	-
Total CCGs	£000s	9.5	0.0	0.0	0.0	0.0
Total MSE Group	£000s	(109.3)	(87.6)	(79.9)	(76.0)	(73.0)
EPUT	£000s	(0.4)	(0.0)	0.6	1.3	1.9
Underlying system position	**£000s**	**(0.4)**	**(0.0)**	**0.6**	**1.3**	**1.9**
National support (MRET/PSF/FRF		34.5	-	-	-	-
Net reported system position		**(65.7)**	**(87.6)**	**(79.3)**	**(74.7)**	**(71.1)**
System issued control total		(39.6)	(81.9)	(78.2)	(74.7)	(71.1)
Surplus / (Deficit) to control total		**(26.1)**	**(5.7)**	**(1.1)**	**0.0**	**0.0**

This plan is not without its challenges however, particularly around the level of financial efficiencies required (totalling over £300m between the CCGs and provider trust programmes alone by 2023/24 on an anticipated annual allocation of £1.9bn). The key components of this include:

// Demand management of £157m across the health economy delivered by commissioners in partnership with providers through a range of efficiency programmes previously known as QIPP.

// Financial benefits of £19.4m across corporate and clinical areas as a result of the clinical reconfiguration work that can be enabled by the capital programme. In the event the capital programme is not approved these efficiencies would be at risk.

// Cost efficiency programmes or CIP within the acute providers of £124m, which is equivalent to 4% of the cost base in each of the three providers in 2019-20. For 2020/21 we have planned on 3.0% efficiencies, reducing to 2.2% across the group by 2023/24.

// financing of deficits. In the event the merger does not proceed these efficiencies would be at risk.

// Due to the risks associated with delivering significant and concurrent cost reduction programmes as well as the dependency of certain benefits on the merger and estates programmes that have not yet received final approval, the baseline position includes a reserve of approximately 2% of the annual allocation by 2023-24.

// There are also efficiencies being delivered in the other members for the purposes of developing SDP reporting including £21m by EPUT.

Our submission is compliant against the control total trajectory set by NHSE and NHSI in the years up to 2023/24 as a system. See Appendix 5 for further detail.

27.2 Efficiency plans

In order to deliver the required efficiencies, the system needs to deliver some £300m savings over five years. This level of efficiency cannot be delivered through usual transactional savings programmes - it requires the whole system transformation described in this strategy and delivery plan. We know that we are likely to have significant investment requirements to enable this level of saving including, but not limited to:

- // Further investment to improve mental health services
- // Further investment in primary and community care over and above the funding made available through the LTP.
- // One-off funding to deliver elective care standards (subject to available capacity)
- // Investment in prevention activities
- // IT investment –funding to bring the basic infrastructure up to standard to support digital transformation plans
- // Double-running/additional support for workforce costs
- // Investment in community schemes

Partners are working together to address the significant efficiency challenge. The NHS Efficiency Map provides helpful guidance for systems, under three key areas of focus:

Enablers for Efficiency – ensuring	Service Efficiency – focussing on	System Efficiency – working together to focus on
System leadership	Workforce optimisation	Urgent and emergency care
Board capability & governance	Clinical support services	Long-term conditions and frailty
Management capability & capacity	Clinical quality and efficiency	Integration of services
Use of evidence and best practice	Procurement	Integration with social care
Controls and reporting	Estates	Right Care opportunities
Digital maturity	Corporate Services	Focus on prevention and self-care
	Focus on productivity	
	Model Hospital	
	Patient Flow	

Partners will work together, through the System Finance Leaders Group, to develop options for transformation including investment requirement.

28. Supporting our staff

Clinical Lead: **Various**
Senior Responsible Owner: **Sally Morris**, Chief Executive, Essex Partnership University Foundation Trust & Chair of Local Workforce Action Board

Our staff is our most important asset; the lack of available personnel to fill vacant posts is also our biggest risk. All of the transformation programmes we are undertaking are aimed at making the best use of the available workforce, and supporting them to achieve fulfilling careers in our system.

We are supporting a range of innovative programmes to attract new staff and retain the existing and by Q4 2019/20 we will have developed our first joint health and care workforce strategy, with key ambitions for the future. All NHS and local authorities within the mid and south Essex footprint are collaborating on this and we see the development of the strategy as an important milestone in our work together.

In line with the themes of the Interim People Plan the Local Workforce Action Board (LWAB) will support the system to ensure we focus on:

- // **Making our system the best place to work** - offering greater opportunities for flexible working and ensuring that we take positive action to have greater representation of BAME staff on our senior leadership teams.
- // **Improving leadership culture** – executives and chairs in mid and south Essex have been supported by a bespoke development programme enabling those senior leaders to support the cultural values of our Partnership, demonstrating compassionate and inclusive leadership at all levels in our workforce.
- // **Delivering a holistic approach to workforce transformation and workforce growth** – we are developing a greater variety of new hybrid roles (especially on integrated services with local authority and NHS organisations), working closer with social care to develop joint approaches to role development. We are up-skilling staff and developing new roles such as trainee nurse associates and physician associates to resource the establishment of primary care networks.
- // **Change the workforce operating model** – the LWAB has commissioned a bespoke system that will provide quarterly system workforce reports. This will enable us to have far greater access to data to monitor workforce themes such reasons for leaving, attrition rates, and the level of vacancies by staff group.

As part of our responsibility of being a good employer and understanding how we can improve access to opportunity and embrace the opportunities that come from a diverse workforce, partners at the MSE Group of trusts have begun some work to gain insight into the workforce and the needs of key populations within. MSE has developed methodologies for organising workforce information by key characteristics and social factors that have potential to contribute to hindrances for some groups in accessing opportunities for development, new experiences or more varied roles. We can use this information to pick up patterns or trends which might need addressing. This is already helping us to identify where data capture can be improved, identify areas for targeted staff engagement and build upon important factors such as action in response to the NHS annual staff survey. We hope to build on this through co-development of plans with staff directly, and for specific work streams such as the NHS Hospital as an Anchor programme.

For our workforce, the Partnership Board as approved the following key priorities for 2019/20:

Retention & Recruitment

// A systematic review of the current retention plans to develop a consistent system approach to retention initiatives. This includes identifying reasons for leaving, reviewing attrition rates and reasons, identifying the main areas of concerns in the nursing workforce initially (other staff groups to follow) and reviewing the use of resources such as application of the NHSI retention tools

// Development of a rotational roles scheme across the system; this will be led by the Directors of Nursing network to develop a system approach to offer greater flexible career opportunities and reduce contractual/employment issues for rotational roles.

// Development of a system approach to return to practice, which we will implement and monitor over a 12-month period.

// Review and streamlining of current recruitment practices, building on the national NHS Employer streamlining hub approach.

// Introduction of alternative workforce roles including physician associates, AHP associates and Advanced Clinical Practitioners. Partners will collaborate on workforce planning for these new roles.

// Further development of the Nurse Association partnership, supported by £240K investment (19/20) from HEE to manage the pipeline and enable 130 additional trainees.

// Explore ways to develop technology enhanced education and training.

Mid & south Essex Career Framework

We will develop a virtual "School" that will include the following:

// A system career framework to support development through level one - level five apprenticeships with a whole career pathway. This will better clarify the career pathways and options for nursing staff in order to deliver on the ambition that all staff have the opportunity of embarking on a 'career and not just a job' recognising the investment in time and training that this will require.

// Mid and south Essex cadet scheme via engagement with schools through to work-based placements – promotion of careers through 'chat' sessions, podcasts of 'A day in the life of', intensive simulation training for schools and colleges.

// Develop the mid and south Essex passport – offering greater flexibility and career development opportunities across the system.

// Working with Essex Skills Board, Essex Primary Care Careers, Skills for Care to promote health and care careers enabling more joint role development.

// Roll out of the mid and south Essex newly qualified nursing preceptorship programme and dedicated web site.

// Leadership development programmes - targeted on broadening diversity and inclusion in senior roles; link to the new leadership compact agreement to develop and embed cultures of compassion, inclusion and collaboration in the system.

// Link with the Training Hubs for Primary & Community staff – refine and identify savings as a system on continued professional development courses.

// Create leadership alumni networks (join up existing organisations/local authority).

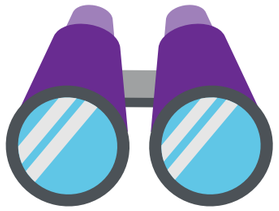
// Develop the Partnership talent academy to support the High Potential Pilot programme and system talent management approach

29. Digitally enabled care

Clinical Lead: **Various** depending on project
Senior Responsible Owner: **John Niland**, Chief Executive, Provide CIC & Chair of the Partnership Digital Board

29.1 Our Digital Vision

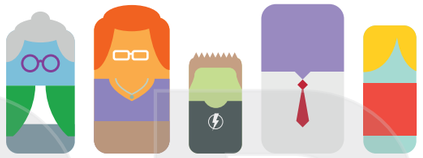
Taking a "digital first" approach is a fundamental part of the design principles we have adopted for our system. Our vision is as follows:



Our Shared Vision

Health and Social Care organisations in Essex share an ambition to **improve the services they deliver and the wellbeing and lives of the people they serve**.

They will work together with each other and with the local population to **organise around the needs and locations of people, rather than boundaries of organisations**. They way that technology is used will be improved, with **connected systems and better sharing of information** to allow **Health and Social Care professionals to be more responsive**.



What this will mean for local people

Digital services will provide patients and users with the **ability and convenience to manage their own information and needs if they want to** - just like they can in other parts of their lives (e.g. online banking).

People will be **encouraged to be more responsible, active and healthy** and they will be **provided with technology that helps**, like Health Apps and the ability to use information from wearable devices.

Information will be combined and used intelligently to identify needs or issues so that where possible **services can be targeted proactively** rather than treating problems after they occur.

What this will mean for our workforce

The Health and Social Care workforce in Essex will be a critical part of this plan. Without their involvement and buy-in new technology will fail and no improvements will be achieved. They will be **included, educated, equipped and enabled** to be successful - with technology being put in place that **allows them to focus on caring for patients and citizens**.

New services will be **designed with users in mind**, making the systems intuitive to use and training and adoption less of a hassle. The importance of the **safety of the people being cared for will not be overlooked.**

How will we work together & with others

These changes will be forward thinking and made collaboratively, **listening to people in the region** and being honest and practical about what can be done.

We will **recognise that some centralised coordination is essential, and respect the decisions that are taken.**

We will **work with clinicians and patients to co-produce plans and services**, working with or convening clinical or citizen groups where required.

Essex will become known as a **leading region for working with the vibrant marketplace of Health and Social Care innovation**.

New approaches will be welcomed, trialled and adopted. The Essex teams will work with neighbouring systems to ensure that the flow of information follows the flow of people.

How we will work to deliver the vision

Working across the different Health and Social Care organisations in Essex at the same time to improve technology will be hard, and careful prioritisation and management will be needed.

Initial focus and investment will go into a number of fundamental technology foundations, on which other solutions and changes ill be built. Teams will be set-up to deliver these changes that follow the approaches to technology that are successful in the private sector (e.g. agile).

These **teams will have multiple skills and people, and an experimental mind-set** that will quickly work out the best way of doing things. Where investments are made the teams will be held accountable to make sure that the **expected benefits are delivered**.

29.2 Our Current Position

As a result of the financial and operational challenges faced across the footprint, the development of technology and digital maturity has been variable and limited to single organisations. We have been without a wider strategic framework for digital for some time.

The system has recently completed a maturity matrix which identified a very low level of digital maturity across the system – including our approach to investment in digital infrastructure. The results of this assessment will help us to set our two and five year strategy for digital transformation which will establish our overarching strategy, resource requirements and our project pipeline. We expect to have the strategy finalised by Q1 2020 following a further evaluation of the technical landscape to be completed as part of Shared Care Record programme.

29.3 Digital Roadmap

The development of the revised digital roadmap in 2018 created a sense of direction and identified nine areas for digital developments

1. Shared Care record
2. Right information right time
3. Joined up hospitals and wider Health and Care Partnership
4. Data quality and standards
5. Staff digital collaboration
6. Patients and citizen collaboration
7. Mobile IT and identity that 'just works'
8. Operational intelligence
9. Patient and citizen population intelligence

These were later distilled to three priorities for immediate attention:

// Integrated Shared Care Record

// Provider digitisation

// Population health data

29.4 Integrated Shared care record

We have received national funding through the Health Sector Led Investment (HSLI) programme. All system partners agreed that this funding should be used to develop and implement an integrated shared care record, which would provide a central, consolidated digital view of service user/patient information, and make this accessible to health and social professionals across the Partnership to better support the delivery of safe, high quality care and support.

The shared record agreement is the first Partnership-wide digital project to be initiated and has been the catalyst for more collaborative digital governance and planning at a system-wide level.

A detailed implementation plan is under development, with the expected implementation dates for the Shared Care Record as follows:

Stage	Dates
Programme goverance and plan	September 2019
Integration technical review and planning	January 2020
Health Info Exchange (HIE) connectors developed	February 2020
Data sharing agreements in place	February 2020
Local APIs developed	Fubruary 2020
Local Portal enhanced	March 2020
HIE links live	March 2020

It should be noted that this will be the very early stages of the programme to establish initial data sharing using technology already available; further developments and expansion will be required to realise the full vision of the Partnership. It is intended that the development of the Digital Delivery Strategy will further develop and inform these plans.

29.5 Provider digitalisation

The three acute trusts have a detailed digitalisation plan initially focused on technology linking across the three sites and wider partners.

The public consultation conducted in 2018 on acute service improvements, and the acute merger business case, all highlighted the need for technology to support the following ambition:

// Build stronger neighbourhoods to deliver a broader range of primary and community services

// Reduce the number of non-elective admissions into acute hospitals

// Reconfigure acute services

// Redesign clinical pathways to deliver improved outcomes

// Support corporate services transformation

// Support digital transformation in the wider health economy

To support these themes, the acute hospitals have adopted the following guiding principles as part of their "digital vision":

// Rationalise, centralise, consolidate and standardise digital processes

// Remove physical boundaries

// Use of mobile, Wi-Fi, shared infrastructure

// Data capture and (cyber) security

// Information recorded digitally and captured once but used multiple times
// Safe and secure but shared patient information
// Patient pathway information capture, single version of the truth
// Single consistent view of patient information within a patient-centric context
// Supporting innovation and new ways of working
// Speed of change, flexible approach
// Reducing the burden on clinical staff, releasing time to care
// Where appropriate tasks that can be performed by more untrained staff
// Tasks should be automated
// Seamless communication
// Patients are able to do and take more responsibility for their own health needs

In delivering the digital vision, the digital experience for both staff and patients should be much improved, this work will also underpin the Integrated Shared Care Record as information must be available electronically as a pre-requisite. Further information on mental health provider digital plans can be found in section 15.

Population Health

Further detail on our work on population health management can be found in section 35.

29.8 Region-wide Work – East Accord & the Local Health and Care Record (LHCR) Board

The East Accord, which is a collaboration of digital leaders from across the East of England region are working together to develop an information sharing environment that improves the lives of people in the East of England with the following agreed principles:

// Adopting standards that move towards intuitive and flexible technology that joins up effectively
// Designing safe, secure and useful ways of sharing information to build trust among our partners and people
// Demonstrating digital leadership, creating the conditions for genuine transformation
// Collaborating by default
// Acting as ambassadors and advocates of best practice

The Accord links closely with the Local Health & Care Record Board (LHCR). Both have focused on core activities that can be developed once and used across the region – this includes development of core data standards and a common approach to information governance and information sharing. The work will mature in during 2019/20 to support the formal development of a wave three LHCR application for transformation funding. This will be a multi-year, multi-million-pound accelerant to our local health and care record programmes,

Fundamentally the LHCR approach in the East is about progressing collectively so that:

1. Our residents and staff have easy access to relevant information
2. Our residents and staff are provided useful information
3. Information provides value to our residents, our staff and the wider public sector

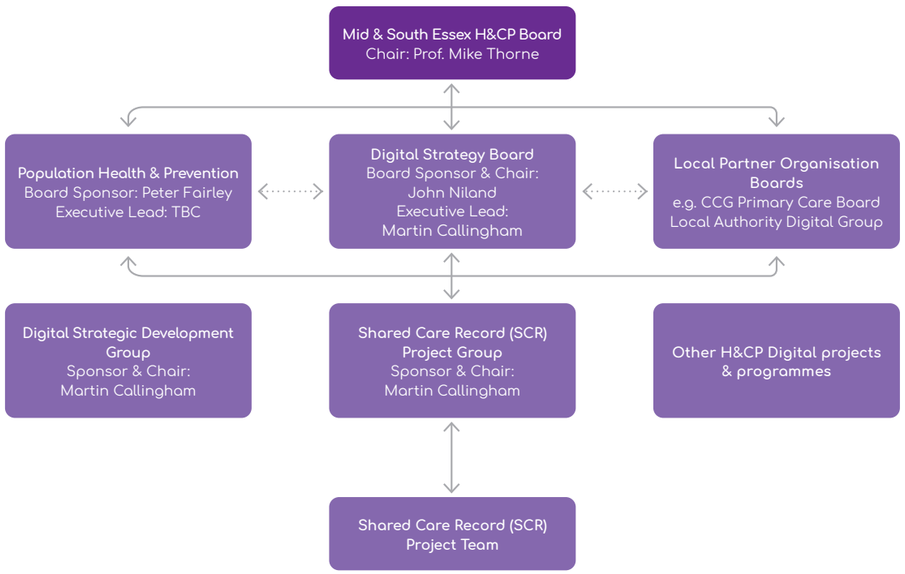
We commit to the requirements identified in the LTP for Local Health and Care Records, with the following specific commitments identified:

// Protecting patient's privacy and give them control over their record
// Ensuring that Patients' Personal Health Records hold a care plan that incorporates information added by the patient themselves or their authorised carer
// Ensuring LHCR platforms provide open and free APIs for developers to create new solutions
// Moving care plans and Summary Care Record (SCR) to the individual's local health and care record over the next 5 years
// Ensuring that, by 2024 LHCRs will cover the whole country

29.9 Digital Governance

We have established a Digital Board to oversee digital programmes in the broadest sense (health and care).

Through increasing collaborative working, based on shared objectives, our digital board is progressing and, through alignment with the LTP, our digital priorities are being developed. The governance for the Digital Board is given below:



29.10 Digital Deliverables

Below are the deliverables defined so far as part of the Partnership digital programme, these will be further developed and enhanced as the Digital Board develops and identifies its delivery strategy.

Activity	2019/20	2020/21	2021/22	2022/23
Digital strategy completed		Q1		
Shared Care record - Stage 1 complete	Q4			
Shared Care record - Stage 2 complete		Q3		
Digital Maturity Assessment - Ongoing	Q3	Q1 & Q4	Q2 & Q3	Q1 & Q2
Review of Digital Landscape	Q1			
LHCR Governance & Engagement established	Q3			
Provider Digitisation to support the accute hospital merger	Q4			

See also the Primary Care Digital Transformation in section 11.3

30. Estates

Clinical Lead: **Various**, depending on specific programme.
Senior Responsible Owner: **Kerry Harding**, Director of Estates, Mid & South Essex CCGs

Our first system-wide estates checkpoint with NHS England/Improvement was completed with full input from local authorities, providers, and commissioners. We will now produce a full system-wide estates strategy, incorporating individual estates strategies from across partners, ensuring we are able to see clear linkages between them and identify how, as a combined ambition, our estate will facilitate new models of care, best value for money and improved patient outcomes.

We are using our clinical strategy to drive forward estates provision. We have developed a clear governance structure for estates, which has the mid and south Essex Estates Forum at its heart. This forum is attended by representatives across the system including public health and One Public Estate (OPE), as well as digital and workforce leads. The forum is the vehicle for sharing information about proposed and live projects, providing a clear understanding of the work that is being developed across the system and giving the opportunity for projects to evolve to include wider system input. The objective to working in this way is to reduce duplication, promote shared use of buildings and joint projects, and ensure that we look to use current public assets before building new, maximising value for money and sustainability.

The pipeline of estates projects has been developed from the forum and is updated as a live document by all participants. This provides an overview of estates projects either current or identified within individual strategies as requirement for the next 15 years. This transparency has supported the development of joint projects to reduce the overall capital and revenue implications, whilst at the same time supporting new models of care. The information within the pipeline also forms the basis of individual Infrastructure Delivery Plans to support local authority Local Development Plans.

We have developed a robust prioritisation process to enable us, as partners, to consider estates developments in the round and ensure that priority is given to projects that will support the overall aims and priorities of the Partnership.

We are taking an innovative approach to utilise funding streams to address some of our fundamental challenges – such as negotiating S106/CIL funding to support digital/IT initiatives and to cover one-off recruitment costs. We are also currently exploring the possibility of securing funds to pay off university fees for newly qualified clinical staff to support recruitment and retention across the system, so that we can encourage clinical staff to stay in mid and south Essex and develop their careers. We are also utilising traditional S106 capital contributions to new builds to offset future revenue implications.

Our estates plan supports our operating model as follows:

- Increase the availability of services outside of the acute hospital setting
- Develop sustainable and resilient primary care based around 28 PCNs and extend primary care access by:
  - increased operating hours and seven day working to improve access and maximise estate utilisation
  - expanded the range of providers (additional professional groups) working in general practice
  - offer improved access to 'alternative' community-based provider services – e.g. MSK, pharmacy, third sector, dental services.
- Integrate primary, community, out of hospital and social care services within neighbourhoods to provide more care closer to where people live
- Place a greater emphasis on prevention and encouraging people to take more responsibility for their own health and wellbeing to include increase in social prescribing
- Support the reconfiguration of mental health inpatient estate to remove dormitories
- Support the digital strategy including developing systems to provide the option for every patient tom access digital GP consultations by 2024
- Continued liaison with public health colleagues to deliver and implement objectives to ensure that preventative care is available to the population and that planning policy reflects our agenda to encourage our communities to live well and take greater responsibility for their own health and wellbeing
- Ensure every Place has adequate and appropriate provision, based on its demographic and need, of the following services:
  - Screening and diagnostics
  - Diabetes prevention, treatment and management
  - Treatment and management of respiratory conditions
  - Children's health services
  - Learning disability and autism services
  - Mental health services for children and adults
  - Healthy ageing services
  - Maternity services

31. Innovation

We have an extensive programme of innovation activity, supporting local innovators and entrepreneurs, helping adopt approved innovations developed externally, and matching local transformation and improvement needs to new models of care.

Our Partnership-wide Innovation Advisory Group is chaired by Professor Tony Young, a consultant urological surgeon from Southend Hospital, and Chair and Director of Medical Innovation at Anglia Ruskin University. Professor Young also leads the NHS Clinical Entrepreneurs Programme and is the National Clinical Lead for innovation at NHS England.

Our innovation programme includes:

- The MSE Innovation Fellowship for local staff members and NHS Clinical Entrepreneurs to receive mentorship, training and support to take forward ideas under the themes of workforce improvement or enhancing patient safety. The scheme will have its second intake in October 2019, and includes mentors from across primary, community and acute sectors.
- Developing local products which meet local needs, such as SMART mortality reporting and quality improvement tool, and the development of the Maternity Direct secure chat service.
- A range of innovation challenges for local staff, as well as support for budding ideas through Health Enterprise East and Invest Essex, with the clinical check and challenge via the Clinical Cabinet.
- Providing direct advice to members of staff with innovative ideas, their development and adoption, with the first dedicated Innovation Programme Manager appointed in November 2018, further expansion of the support team planned in late 2019.
- Promoting and signposting staff to innovation opportunities including new proven products, processes and care pathways, working with Academic Health Science Networks and connecting staff to successful innovators in other provider organisations and signposting staff to regional and national innovation competitions eg. Health Enterprise East's MedTech Accelerator, national Life Sciences Innovation Fund and recent bids from radiology and stroke services.
- We continue to act as a partner in the NHS England Clinical Entrepreneur programme, now entering a fourth year. This programme has provided selected clinical entrepreneurs with honorary contracts with partnership organisations, to provide them with a real world test-bed site to help develop their innovations.
- We have developed a Ways of Working agreement with the wider health care industry, agreed in March 2019, to help support innovation and bring in additional resources for transformational improvement locally. This has been recognised as national good practice by the AHSN Network and ABPI.

maternity direct

The hospitals have recently launched Maternity Direct+ – a secure telemedicine chat app which connects an NHS midwife with a pregnant woman for non-urgent queries and stores their text chat in the patient record. The aim of the app is to support pregnant women, enable midwives to answer straightforward queries, thus reducing unnecessary visits to the unit and to A&E, and to differentiate routine queries and those which require further attention.

32. Research

Partner organisations are active members of the NIHR Clinical Research Network for North Thames, one of the best recruiting networks in the country.

The merger of our acute providers in April 2020 will improve set up and facilitate recruitment to research studies across a combined patient population of 1.2m. This will attract commercial research activity and associated financial benefits. Research active clinical staff will be able to recruit patients to research studies from whichever site they are working and patients will have an equal opportunity to participate. This increases the research opportunity for patients, increases income to the trusts and encourages recruitment and retention of high calibre research staff.

As founding partners in the UCLPartners Applied Research Collaborative (ARC) we have helped to inform the areas of focus within the ARC. Through the hospitals' Strategy Unit and the Clinical Cabinet, we will ensure relevant findings are tested and disseminated, as well as having the opportunity to influence the portfolio to support population health.

33. Clinical Leadership

Ensuring the safety and quality of our services is core to our work. It is important that our clinicians and professionals working across the system drive our transformation plans and have confidence in them.

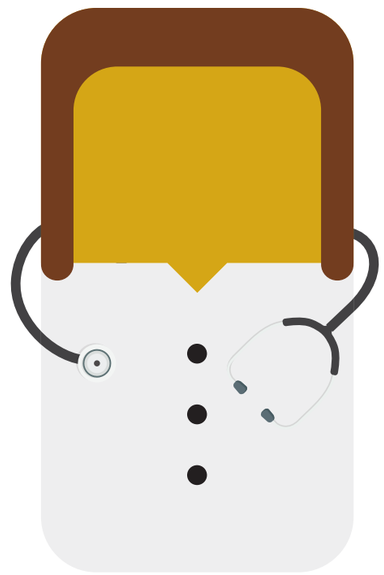
The Clinical Cabinet is a forum of senior clinical representatives from across the system. The Clinical Cabinet oversees and reviews clinical pathway changes that are being considered across the system, ensuring that changes have clinical and professional buy-in and maintain the golden thread of delivering the highest standards of quality and safety

The Cabinet is multi-disciplinary in nature and comprises senior nurses, GPs, consultants, allied health professionals (including therapists, pharmacists, and paramedics), from across the system who are involved in delivering health and care services to the population. In recognising the critical role that allied health professionals play in delivering health and care services, we will be establishing a Partnership AHP Council in the coming months. The Council will provide an important focal point for developing new models of integrated care.

The cabinet played a critical role in developing options for acute hospital service change, and crucially offered local "check and challenge" to the proposed changes that were later supported by the East of England Clinical Senate and the CCG Joint Committee. It continues to play a role in supporting the implementation of acute hospital service improvements.

Each of our clinical programmes (diabetes, stroke, mental health, maternity, cardiovascular etc) has a designated clinical lead, and each programme feeds in to the Clinical Cabinet to provide the clinical "check and challenge" of plans as they develop.

As we move to the next phase of our development - Integrated Care System designation - the cabinet will be considering its future composition in order to ensure broad clinical and non-clinical, professional representation, including Clinical Directors of our Primary Care Networks.



34. Approach to Quality & Safety

The programme of transformation across mid and south Essex presents clear opportunities for health and social care organisations to work together to address current quality challenges. We recognise that each organisation has its own statutory duties in relation to ensuring the quality and safety of services.

Our approach does not seek to replace these duties, rather it aims to deliver:

// A streamlined and efficient approach to quality measurement and monitoring
// Opportunities to increase the voice of patients/residents in defining, measuring and evaluating the quality of services
// A better understanding of quality variation across integrated pathways, rather than looking at quality in silos
// The structure, process and guidance needed by teams working on new models of care to ensure regulatory compliance
// Better use of data, including the effective triangulation of multiple sources of data and quality surveillance that focuses on early warning and prevention rather than multiple investigations after the event
// Agreement on the approach to defining, measuring and monitoring quality which will be required under new contractual arrangements.

Clear quality and health inequality impact assessments are undertaken for all change and transformation programmes.

35. Population Health Management & Prevention

Our approach to population health management and prevention is to make better use of the wealth of data that partners in the system collect and to use this intelligently to understand our population and plan/target interventions appropriately. Collecting, collating and analysing data can be achieved at system level, enabling the targeting of interventions locally where these have most impact.

Population health management will:

// Support front line teams to design and deliver care and support to meet individual needs.
// Enable our PCNs to work with local partners to deliver personalised care
// Support NHS and local authority commissioners to better predict need and design services to meet needs more appropriately.

Our Vision:

We want to support the population to manage their own health, to prevent avoidable illness and improve their health and wellbeing. We will do this through intelligent use of data analytics to understand how timely access to health & care services along with the wider social & environmental context can have an impact. We will target evidence-based clinical and non-clinical interventions to address inequality & inequity, leading to better lives for all.

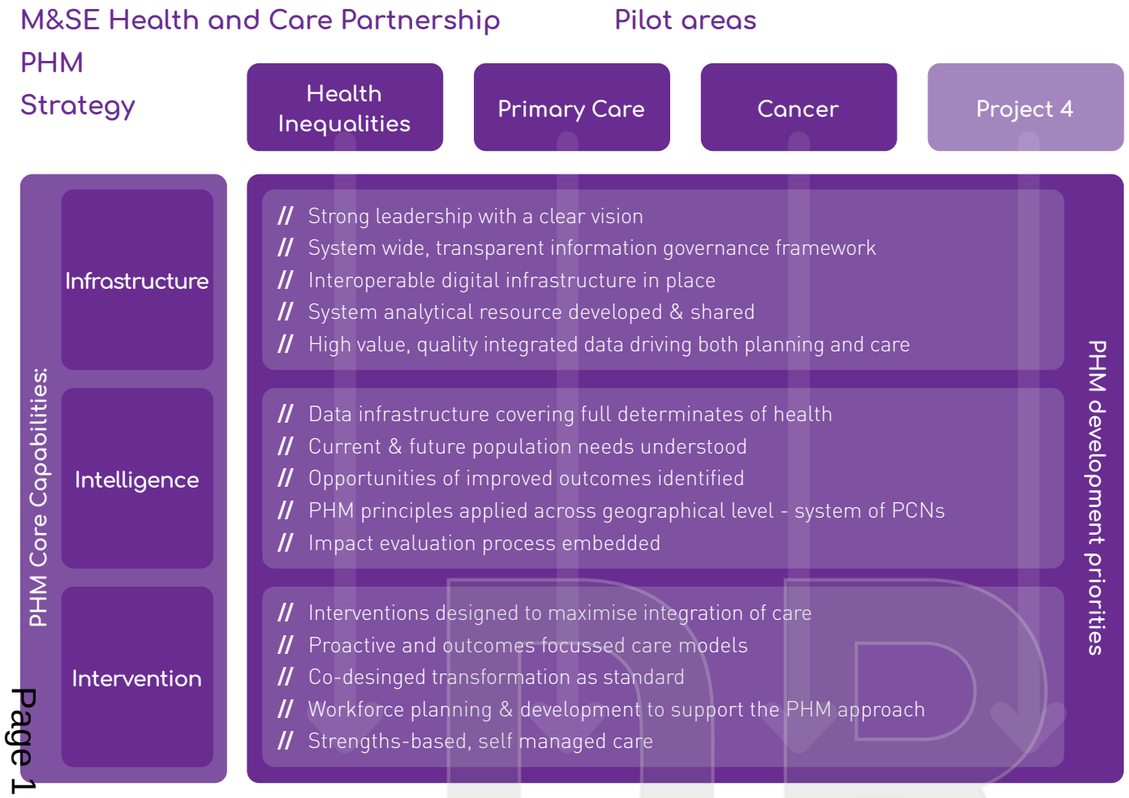
Capabilities for Population Health Management

There are three core capabilities required for an impactful population health management programme:

// **Infrastructure** – the basic building blocks including a defined population, digitalised providers and linked records, digital infrastructure and information governance processes
// **Intelligence** – building the capacity and capability within the system to support analytical requirements and provide system-wide insight. Using this intelligence to make best impact and report on progress for the system.
// **Interventions** – using proactive clinical and non-clinical interventions to prevent ill-health, reduce risk and address inequalities. This will support us to realign our workforce, target assistive technologies and digital tools to support patients and being able to use information to build aligned incentives.

We are developing our system-wide Population Health Management & Prevention Strategy and this will be approved by the Partnership Board in December 2019.

Our strategy uses the framework of the 3 core competencies, with key priorities within each. We will use specific areas/conditions to test and learn our approach.



We are working with colleagues across the region to develop our approach and ensure we make best use of resources.

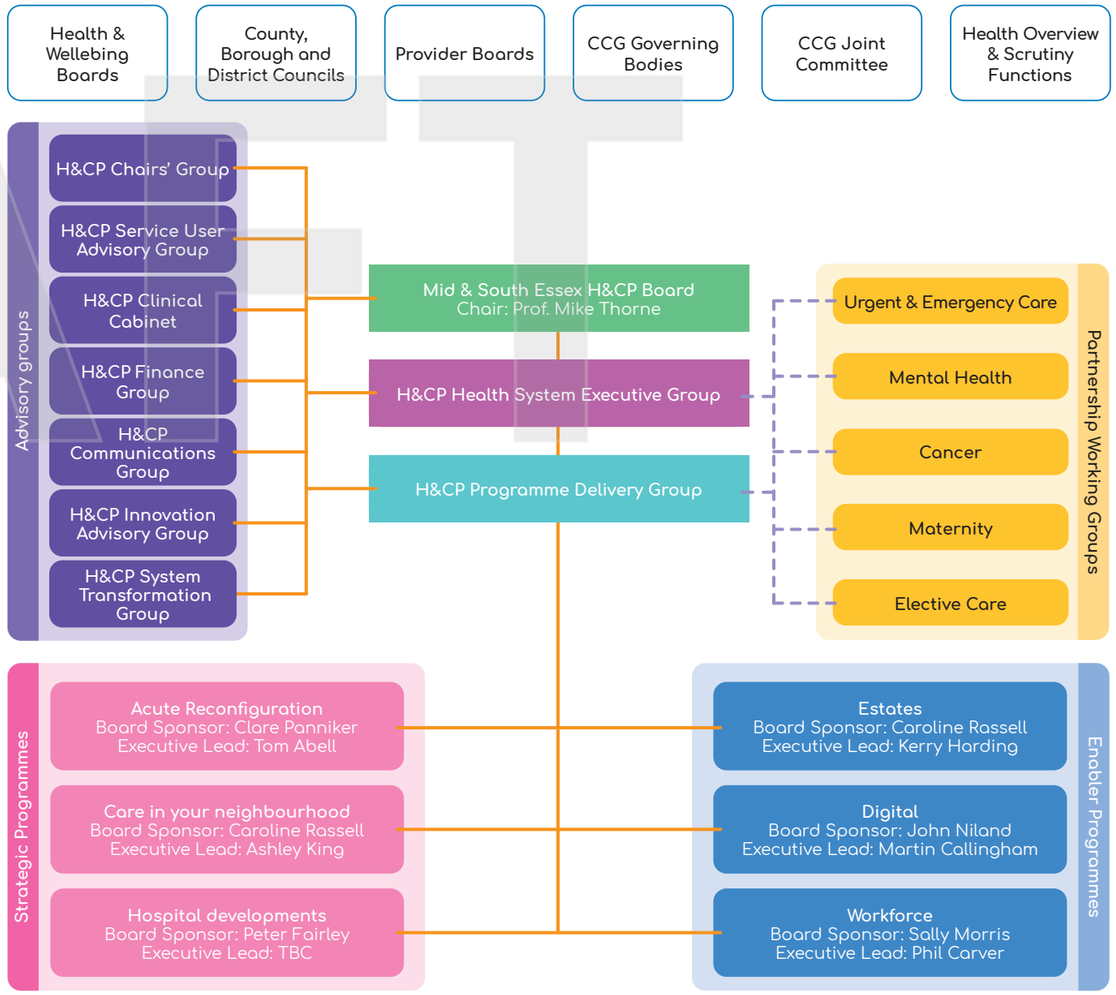
Population Health Approach in Action

The strategy unit of MSE University Hospitals Group is working with partners in south east Essex to combine CCG and hospital data to understand more about the south east population by looking from both perspectives at demand. We are focusing on respiratory (specifically COPD) as a proof of concept to build up an understanding of the pathway of patients with COPD prior to an admission to hospital, and identify the significant factors that drive admission. In doing this we hope to understand more about the needs of the population and how to respond more preventatively to these to avoid escalation of COPD in the future where possible. All data will be presented at a locality level.
By combining data from multiple sources we can begin to develop predictive models, allowing us to predict hospital admission beforehand and understand when and how to intervene. There are limitations to these models, largely based on data availability, rules regarding sharing, and also some topics do not lend themselves as easily to prediction, so this is part of our exploration. By doing this we can start to use data more intelligently as a predictive tool that allows us to focus on prevention rather than reacting to growing demand. The technique may also help us to support patients effectively to reduce escalation of conditions by focusing on preventative action in a more targeted way.

36. Building our Integrated Care System

36.1 Existing system governance arrangements

At present, the Mid and South Essex Health and Care Partnership Board comprises chief executives of provider organisations, accountable officers from the CCGs, lead officers from the three local authorities and a number of representatives from advisory groups and partner organisations. The Board has no decision-making authority as this resides within individual organisations. An overview of current governance and key programmes is given below:



It is an immediate priority of the newly appointed independent chair to review the governance and delivery structure for the Board to enable development to an Integrated Care System.

36.2 ICS development plan

In line with LTP requirements, partners are committed to the Mid and South Essex Health & Care Partnership achieving Integrated Care System designation by April 2021. We will draw upon learning and published research to ensure that we use experiences from other systems who are further along this journey.

36.3 Benefits of ICS Designation

We believe that achieving ICS designation will provide the following benefits:

- Put our residents first, delivering person-centred care, close to home, and give them confidence that the changes we are making work well for them.
- Support system partners to collaborate and to take decisions together.
- Create a willingness for partners to invest outside of existing organisational boundaries to support transformation and develop essential social infrastructure;
- Support communities to thrive, through improved education, employment and economic growth, attracting investment to our area.
- Enable a collaborative approach to improving our performance and outcomes against national standards, demonstrating real impact for our population,
- Commission against consistent standards and outcome measures, rather than traditional methods of commissioning and contracting.
- Enable us to use our collective workforce resources more wisely, and support our staff to work in different ways with a "system" ethos.
- Safely and securely share information and records across the NHS and local authority partners – and use the vast quantity of data we have to effectively target resources and interventions.
- Reduce waste, duplication of effort and resource to unlock efficiencies.
- Streamline decision-making and governance processes.
- Support financial stability and joint decision-making on investments, while holding the system to account for effective delivery.
- Take a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues.

36.4 Our plan to achieve ICS designation

In July 2018, we undertook a self-assessment against a number of criteria set out by NHSE/I. Through this self-assessment, we identified that our key areas for development were;

- Our relationships with and between wider system partners, particularly our Health and Wellbeing Boards and Integrated Care Partnerships at Place level as these develop.
- Our leadership – to ensure streamlined decision-making and closer collaboration of partners.
- Our commissioning approach – with the streamlining of NHS commissioning functions under the direction of a single accountable officer and executive team for the five CCGs in mid and south Essex.
- Our governance – to ensure that decisions are taken at the right level, by the right partners, to support good governance and stewardship of public money, while also supporting the integration and collaboration of services in an "organisationally agnostic" manner.
- Our methods of ensuring a strong user "voice" in local plans, and ensuring that insight gained from local co-production and engagement work is used at system level.
- The need to progress to a population health based system that encourages partnership working for a defined population, has access to, and uses population-level data to understand needs, focusing on prevention and the wider determinants of health.
- Developing an outcomes focussed approach in everything we do.
- Our ability to self-regulate – particularly on matters of operational performance and sustainability – ensuring we can hold ourselves to account for the performance of our system and that we take the appropriate steps to ensure sustainability of our services.
- Our financial strength – both to ensure our plans support bringing the system into financial balance, and also to ensure we have robust and aligned mechanisms to take decisions about public money at a system level, where appropriate.
- The efficiency of our work – reducing duplication and consolidating "back office" functions to support the system.
- Defining the transformation resource requirements, ensuring we have the right resources in place to deliver on our transformation plans.

36.5 System architecture & leadership

At present, partners operate in a complex system and this creates challenges for effective and streamlined decision-making. There will be, however, significant change to our current system architecture that will help to simplify the system:

// In April 2020, our three hospitals will merge, creating a single organisation with a consolidated clinical strategy. This will streamline functions and decision-making across the hospital group and release significant efficiencies which will be reinvested in our new operational model.

// Early in 2020, our five CCGs will appoint a single accountable officer to operate across the five organisations.

// It is our intention for this joint accountable officer to also be the lead executive for the Health & Care Partnership.

// All five CCG Governing Bodies have agreed to commence work on a merger application to be made in September 2020. This will be subject to wide stakeholder engagement in the coming months, particularly with member practices.

36.6 Developing our approach to strategic commissioning

Effective commissioning at the right level across the ICS will be vital to create an environment in which our system is focussed on outcomes, our places and neighbourhoods are able to flourish and the benefits of integrated care can be realised.

This will require significant changes to the way in which we commission services, involving co-design with our communities and a much greater focus on prevention and population health. Statutory commissioning organisations will need to work differently with providers in order to have maximum influence on the health and wellbeing of our population. We must better involve community and voluntary sector organisations and develop asset-based and outcomes-focussed commissioning frameworks.We also needto ensure that we commission at the most appropriate level across the system.

As described above, our CCGs will have a single accountable officer and executive team – and will be required to deliver 20% savings on running costs. The single AO will also be the executive lead for the ICS and will play a significant role in supporting the Independent Chair to deliver the agreed ICS objectives and build relationships with internal and external stakeholders. The AO will also play a key role in the development of our four Integrated Care Partnerships, supporting them to ensure effective local delivery.

Early in 2020 we will appoint the Joint Accountable Officer and Health and Care Partnership/ICS Executive Lead. During 2020/21 they will:

// Consider the resource required to support ICS development. Their priority will be to ensure capacity to support system moving forward by refocussing resource currently within five CCGs to a system-wide purpose

// Appoint to the joint executive team for the CCGs.

// Prepare an application for CCG merger in September 2020, which will be subject to agreement by CCG Governing Bodies and approval by NHS England. If approved, CCGs will merge in April 2021.

// Continue to operate with 5 CCGs, but as an interim measure towards greater collaborative working, consider whether the current CCG Joint Committee arrangements can be expanded to enable more decisions to be made once across the system.

// Develop a plan for the movement of delegated commissioning so that by April 2021, the five CCGs have taken on this function While there are no current plans to take on commissioning of pharmacy, optometry and dentistry services, we will continue to work in close partnership with NHSE/I to ensure we are obtaining maximum impact from these services for our populations at neighbourhood and place level.

// In line with strategic commissioning plans, continue to work in partnership with NHS Specialised Commissioning with the longer-term aim to be more involved in the commissioning of specialised services provided across mid and south Essex. Some work has already started, for example, in relation to mental health provider collaboration.

// Continue to work with Specialised Commissioning on health and justice commissioning, particularly on pathways into and out of detention and links with children and young people's mental health.

36.7 System performance oversight and intervention

As we become an Integrated Care System, we will need to develop our approach to self-assurance and regulation against national standards. Our Health and Wellbeing Boards will play a role in holding the ICS and our Places to account for delivery of our plans and our ability to positively impact outcomes for our population.

Health Overview and Scrutiny Committee (HOSC) functions continue to play an important role their statutory role in scrutinising major service change. Where changes span the three local authorities, a Joint HOSC will be formed.

36.8 ICS financial framework

The NHS has set control totals for organisations within the system. Partners are collectively responsible for meeting the allocated total and are plans are geared towards achieving this.

Our finance leaders are developing a financial framework for our ICS, which will require strong leadership and an approach to system-wide understanding and management of financial risk. The framework will also identify a system-wide approach to managing investment decisions, with priorities agreed by the Partnership Board.

We expect this framework to be in place by the end of Q4 2019/20, with regular reports to the Partnership Board.

36.9 On-going engagement with partners, public and patients

Understanding the views of our population will help us to explore ideas such as the smarter use of technology, providing care in different settings closer to home and support the Partnership to seek ways to reduce health inequalities. Feedback is important to ensure we have taken in to consideration the needs and expectations of as many of our partner organisations and our local population as possible.

We will want to hear the views of and work with our staff, patients, and communities and have set as one of our design principles the commitment to use the insight gained from our engagement work to inform what we do.
We have embarked on work to co-design our engagement strategy through a series of Engaging our Communities workshops.

Through this work we are talking to and working with service users, voluntary and community sector colleagues, our Healthwatch organisations, charitable and support groups, youth councils and engagement professionals working in our system.

These conversations and workshops aim to develop an overarching engagement framework which sets out the opportunities at neighbourhood, place and system for involvement and community engagement and where appropriate to be more formally consulted about proposals for change.
At system level we will seek to build on existing good practice, avoid duplication and add value to ensure the voice of local people is recognised.
The framework will seek to demonstrate that different approaches will be needed taking into account the types of changes, but also recognise that we need to widen the scope of input across our population and offer varying methods of engagement.

Our work to develop a system wide citizens' panel, called Virtual Views, is part of this work and will help to seek and understand the opinions of a demographically representative, statistically significant sample of mid and south Essex residents.

We also want to go further and ensure co-production and co-design defines the way we work as a Partnership across all our levels.

Co-production supports the basis of our five year strategy by helping seek the solutions to keeping people well together, and by ensuring our services truly reflect the needs of local people.

To achieve this we will learn from the work already underway particularly in our local authorities through Asset Based Community Development (ABCD), This approach is based on the premise that communities can drive the development process themselves by identifying and mobilizing existing, but often unrecognised assets.

We will also seek to support our teams and residents through offering development sessions and training to ensure over time this becomes our norm.

36.10 ICS Development timeline:

Activity	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2
LEADERSHIP								
Appointment of Independent Chair	✓							
Central resource infrastructure agreed			■	■				
Review of clinical and professional leadership		■						
Implement new model for clinical and professional leadership			■	■				
RELATIONSHIPS & GOVERNANCE								
Secure resources to support for system governance review	✓							
Review of governance arrangements at system level to include decision-making, accountability, self-regulation.		■	■					
Agree relationships between "place" and "system" to enable places to deliver		■						
Test governance arrangements with stakeholders				■				
Agree framework for service user input		■						
Implement Citizen's Panel			■					

Activity	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2
FINANCIAL MATURITY								
Agreement of 5 year control totals	✓							
Review of finance oversight arrangements (NHS)		■	■					
Test and agree finance oversight arrangements with regulators				■				
Delivery of agreed financial recovery plans		■	■	■	■	■	■	■
SELF-REGULATION – QUALITY, SAFETY & OPERATIONAL PERFORMANCE								
Agree system-wide objectives with regulators (care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance)		■	■					
Run assurance processes in shadow form (with regulators)				■	■	■		
Evaluate self-regulation approach and agree future arrangements with regulators							■	■
PROVIDER DEVELOPMENTS								
Acute trust merger		■						
Mental health provider collaborative (new care models)		■						
GPs/PCNs deliver new service specifications			■	■	■	■	■	■

Activity	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2
STRATEGIC COMMISSIONING								
CCGs agree to progress single AO & Executive Team	✓							
Appointment of Single AO for CCGs & Executive Lead for ICS		■						
Appointment of CCG Executive Team			■					
Engagement on future commissioning landscape			■	■				
CCGs to submit merger application					■			
CCG merger (subject to approval from NHSE/I)							■	
POPULATION HEALTH								
Population health strategy approved by Health and Care Partnership Board required to deliver including resources		■						
Agree and adopt Health and Care Partnership-wide outcomes framework		■						
PCNs supported to develop population health approach			■	■	■	■	■	■
WORKFORCE DEVELOPMENT								
Joint Health & Care Workforce Strategy agreed, organisational development needs		■						
Agree retention & recruitment strategy								
Implement Partnership "School"								
DIGITAL								
System Digital Strategy agreed		■						
Early implementation of Shared Care Record			■					
Digital maturity assessment		■		■		■		■

37. Arrangements for Ensuring Delivery

This section sets out the practical steps needed to deliver our five Year Strategy and LTP commitments. It includes programme resources, governance, risk management.

37.1 Programme management and resources

The Partnership will implement a robust programme management and governance structure which ensures accountability through clear allocation of roles and responsibilities, and provides assurance through regular reporting, enabling quick identification and addressing any issues as they arise.

37.2 Governance Structure

In order to deliver the requirements of the LTP and achieve ICS designation, detailed work will be undertaken on our governance structure at system level, and our governance arrangements between system and "place". This will include a review of the current Partnership Board, work programmes and advisory mechanisms.

37.3 Programme roles and responsibilities

An executive delivery group has been established , chaired by the Programme Director. Its membership includes the executive lead for each current work stream to ensure that colleagues are aware of developments. The programme meetings occur bi-monthly and the outcome, in the form of programme overview plans are submitted to the Partnership Board for information.

Once governance arrangements are agreed, we will review existing Executive Delivery Group arrangements to ensure that agreed priority programme achieve their objectives in full and on time.

37.4 Approach to risk management

The Partnership approach to risk management is designed to ensure that the risks and issues are identified, assessed, and mitigation plans developed in a risk management plan. All risks will have a responsible owner identified.

Each specific programme has its own risk log and items elevated to Partnership level are those significant risks that require partners to address together.

The overarching risk management policy is based on an iterative process of:

- // Identifying and prioritising the risks to the achievement of the programme aims and objectives;
- // Evaluating the likelihood of those risks being realised and the impact should they be realised;
- // Managing the risks efficiently, effectively and economically.

The key risks for the Partnership are as follows:

Risks	Mitigations
Partners do not agree the core vision for the Partnership	Partnership Board clarifies and agrees the core vision for the Partnership.
The system does not manage demand for services effectively	Focus on prevention and wider determinants of health – work to agreed outcomes framework to monitor progress, Aligned plans across partners to reduce avoidable admissions, improve performances and reduce length of stay. Teams aligned to PCNs to ensure community capacity to meet demand.
Failure to attract and retain an appropriately skilled health and care workforce.	Address workforce needs by developing new roles, and career opportunities for current staff. Work with partners to address eg housing and education needs. Exploit partner organisations as Anchors programme – seek to raise educational attainment and aspiration and attract staff to public sector roles.
Financial risks are not managed appropriately	System finance leaders developing ICS financial framework which will describe how control totals and risk will be managed collectively. Partners support resolving system challenges together.
System governance does not provide for effective transparency and accountability to the public	Develop system governance framework with openness and transparency at the center. Publish information about allocation of resources and expected outcomes.
Access to treatment (including cancer, elective care and emergency care) is below standard and does not provide good care for our residents	Integrated programme agreed to tackle prevention, early intervention and diagnosis, waiting times for treatment and support post-treatment. All partners in the system are involved and engaged.

The Programme Office maintains the Risk Register for the Programme. Project risk registers are maintained by the project manager/work stream leads and risks escalated where necessary via reporting.

Appendices

1. Mid & South Essex Health & Care Partnership Profile
2. NHS Long Term Plan Engagement; report of Thurrock Healthwatch
3. Mid & South Essex Outcomes Framework (draft)
4. Mid & South Essex Workforce Plans
5. Mid & South Essex NHS Finance Plans
6. Mid & South Essex Cancer Transformation Plan
7. Mid & South Essex Mental Health Plans
8. Mid & South Essex Local Maternity Services
9. Mid & South Essex NHS Estates Strategy

Glossary of Terms

#

111 The NHS 111 service is a free-to-call, non-emergency medical helpline, available 24 hours a day, to be used for health information, advice and access to urgent care.

A

A&E Accident and emergency

Academic Health Science Network (AHSN) Created by NHS England to work with local health and care systems to select, encourage, develop and deliver innovative solutions that improve patient care and aid economic growth across our region

Acute care health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or recovery from surgery

Acute medical unit The first point of entry into hospital for patients who have been referred as emergencies by their GP or who require admission from the A&E department.

Advanced Nurse Practitioner (ANP) The role includes assessing the patient, making differential diagnosis and ordering relevant investigations, providing treatment (including prescribing) and admitting/discharging patients.

Agenda for Change The main pay system for staff in the NHS, except doctors, dentists and senior managers. Abbreviated to AfC and also know as NHS Terms and Conditions of Service

Allied Health Professionals (AHPs) AHPs is an umbrella term for therapists, chiropodists, dietitians, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists, psychologists, psychotherapists, radiographers, and speech and language therapists among others.

B

BAME Black and minority ethic

Better Births policy to improve maternity provision and services

Better Care Fund (BCF) A local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems.

C

CAMHS Child and Adolescent Mental Health Services

Care Quality Commission the body which regulates health and care services in England to ensure they are safe, effective, compassionate and well led.

CIC community interest company with the objective of benefiting society rather than financial gain

Clinical Commissioning Group (CCG) Clinically-led statutory NHS body responsible for the planning and commissioning of health care services for their local area.

Commissioning The process of planning, agreeing and monitoring services. Commissioning of health services can take place at the local level by CCGs, or at a nation-wide level by NHS England. Local authorities also commission social care.

Co-morbidity Co-morbidity is the simultaneous presence of two or more health conditions or diseases in the same patient.

Continuing Healthcare NHS continuing healthcare is health and social care outside of hospital that is arranged and funded by the NHS. It is available for people who need ongoing healthcare and is sometimes called fully funded NHS care.

Consultation Public bodies have a duty to consult people when changing commissioned services. The decision to consult is usually triggered when there is a legal requirement to do so and this depends upon the level of service change.

COPD chronic obstructive pulmonary disease

Co-production Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Fundamentally, co-production recognises that people who use services (and their families) have knowledge and experience that can be used to improve services. The Social Care Institute for Excellence describes co-production as "people who use services and carers working in equal partnerships with professionals toward shared goals."

D

DASS Director of Adult Social Services

Deprivation lack of the basic resources considered necessary for well being

DHSC the government's Department of Health and Social Care

Discharge to Assess Short term funded support to enable discharge from hospital, whilst still requiring some level of care

DPH Director of Public Health

Domiciliary Care Worker A domiciliary care worker is someone who visits a person's home to help them with general household tasks, personal care or any other activity that allows them to maintain their independence and quality of life at home.

E

Elective care Treatment that is scheduled in advance as it does not involve a medical emergency.

Enabler A person or system that makes something possible. In the NHS enablers are the systems and processes that help achieve change and improvement.

End of Life Care care provided in the last months or weeks of life to provide relief and support prior to death

Engagement a term commonly associated with many forms of patient, service user or public involvement. It describes processes, both formal and informal, through which commissioners may invite local communities to become involved in discussion about the shape of their local services.

Equality Impact Assessment (EIA) A process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people.

Estates Strategy Supports the delivery of the system's overall strategy and vision for estates.

F

FIT Bowel Cancer screening The faecal immunochemical test (FIT) is an improved screening test that detects hidden traces of blood that could indicate bowel cancer or pre-cancerous growths known as polyps.

Frailty a collection of symptoms including weakness as a result of being older

G

Global Digital Exemplar An internationally recognised NHS provider delivering improvements in care quality through world-class digital technologies and information.

General Medical Council (GMC) The GMC works to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

General Medical Services Contract (GMS) The GMS contract is the contract between general practices and the NHS for delivering primary care services to local communities. It is a nationally negotiated contract that sets out the core range of services provided by family doctors (GPs), their staff and a national tariff.

Governance The way that organisations ensure they run themselves efficiently and effectively, and the way organisations are open and accountable to the people they serve for the work they do.

GP general practitioner

H

Health and Wellbeing Board a statutory formal committee of the local authority that promotes greater integration and partnership between bodies from the NHS, public health and local government. It produces a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

Health Education England Health Education England is an executive non-departmental public body which provides national leadership and coordinates education and training within the health and public health workforce within England.

Health inequalities Differences in health status between different population groups, or in the personal, social, economic, and environmental factors that influence health status.

Health Overview and Scrutiny Committee (HOSC) Reviews and scrutinises matters relating to the planning, provision and operation of local health services. A Joint Health Scrutiny Committee oversees matters that span the Mid & South Essex Health and Care Partnership.

Healthwatch Local organisations which listen to the needs, experiences and concerns of people who use health and social care services to make sure that service commissioners and providers put people at the heart of care. Healthwatch Thurrock, Healthwatch Southend and Healthwatch Essex work across mid and south Essex.

I

IAPT Improving Access to Psychological Therapies A service providing evidence-based treatments for people with anxiety and depression.

Inpatient resident attending hospital who is required to stay in overnight or more to receive treatment or care

Integrated Care System (ICS) A partnership of NHS organisations, local councils, the voluntary sector and others in a geographical area, who take collective responsibility for managing resources, standards, and improving the health of the population they serve.

J

Joint Strategic Needs Assessment (JSNA) This looks at the current and future health and care needs of local populations to inform and guide the planning and social care services within a local authority area.

K

L

Learning from Deaths Review (LeDeR) National programme to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

LOS: Length of stay – The time a patient will spend in hospital

Local Medical Committee (LMC) represent the interests of NHS general practitioners in a defined location

Local Pharmaceutical Committee (LPC) represent the interests of NHS pharmacists in a defined location

Local Workforce Action Board (LWAB) Support Health and Care Partnerships across a broad range workforce and HR activity, and the local delivery of the Health Education England Mandate and other key workforce priorities in line with national policies.

Long Term Condition a condition that cannot be cured; but can be controlled by medication and other therapies such as diabetes

M

Magnetic resonance imaging (MRI) An imaging technique that uses powerful magnetic fields and radio waves to provide detailed cross-sectional or three-dimensional images of the body.

Model of Care A model of care is the overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice and defined standards which broadly define the way health services are delivered.

Mortality Rate Mortality rate, or death rate, is the rate of actual deaths to expected deaths.

Multi-disciplinary team A team of professionals from one or more disciplines, which can include social care as well as health, who together make decisions regarding recommended treatment of individual patients. Such teams may be organised for a specific condition, e.g. cancer, or in a specific setting, e.g. a hospital.

MyCOPD An app helps people with COPD (chronic obstructive pulmonary disease) to better manage their condition.

MyDiabetes An app that helps people with diabetes to better manage their condition.

N

National Institute for Health and Care Excellence (NICE) Evidence-based guidance for clinicians, commissioners and providers of health and care.

Neighbourhood integrated care across a range of services around populations of between 30,000 and 50,000. These services typically include general practices, community teams, some mental health services and adult social care.

NHS England/Improvement (NHSE/I) Sets the priorities and direction of the NHS in England, and encourages and informs the national debate to improve health and care. It commissions some NHS services directly, and delegates authority to CCGs to commission other services.

NHS Long Term Plan The plan for the transformation of NHS services in England over the next 10 years, to improve quality of care and the health outcomes of the population.

NMC The Nursing and Midwifery Council. A regulatory body that maintains a register of nurses, midwives and health visitors

O

Outcome the result of treatment, surgery or support from health and care services

Out of hospital care A form of care that is available outside of major hospitals, often referred to as primary and community care. 'Primary care' is the advice and treatment you receive from your local GP.

Outpatient resident attending a planned hospital appointment for treatment or care but not staying overnight

P

Pathways A patient pathway is the route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a treatment centre until the patient leaves.

Personal Health Budget (PHB) An amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioner. It is a different way of spending health funding to meet the needs of an individual, and gives the individual greater choice and control over their care.

Personalisation Shifting the culture and practice of care so that services are better coordinated and centred around the individual.

Perinatal status immediately following the birth of a child

PHE Public Health England.

Population health management Collection and analysis of data on patients and the public, to help improve planning and management of health and care services in the local system.

Prenatal stage of pregnancy before giving birth of a child

Primary care Primarily GP practices, but also includes community pharmacists, dentists and opticians.

Primary Care Networks (PCN) Groups of GP practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas.

Providers Acute, ambulance, community and mental health services that treat patients and service users in the NHS; social care providers including local authorities, care homes and home care organisations; and community and voluntary organisations.

Public Health Public health is concerned with improving the health of the population rather than treating the diseases of individual patients.

Q

Quality, Innovation, Productivity and Prevention (QIPP) transformation programme for the NHS, involving all NHS staff, clinicians, and the voluntary sector aimed at improving the quality of care the

Quality and Outcomes Framework (QOF) Indicators of the overall achievement of a GP practice through a points system. Practices aim to deliver high quality care across a range of areas for which they score points.

Re-ablement Services to maximise people's long-term independence, choice and quality of life, while at the same time attempting to minimise the need for ongoing support.

Reconfiguration Changing the arrangement, structure or model of organisations or services.

Referral to Treatment (RTT) The framework for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently.

Residential Care Residential care refers to long-term care provided to adults or children in a residential setting rather than their own homes. Some residential settings are designed to meet a specific care need e.g. those living with dementia or a terminal illness.

Rightcare NHS programme to improve spend and outcomes in care, by diagnosing the issues and using evidence to identify opportunities for improvement, developing solutions and delivering improvements for patients, populations and systems.

Risk stratification Identifying patients who are at high risk of an adverse event so that they can be offered preventive care and support to avoid health problems.

S

Secondary care Either planned (elective) care such as surgery or an operation, or urgent and emergency care provided by a hospital.

Self care or self management All the actions taken by people to recognise, treat and manage their own health, either independently or in partnership with the healthcare system.

Skills for Health Skills for Health provide workforce solutions designed to improve healthcare, raise quality and improve productivity and financial performance. Skills for Health is a not-for-profit organisation for the whole UK health sector.

Slope Index of Inequality (SII) A measure of the difference in life expectancy between the most and least deprived sections of the local population.

Social Care Social care is the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

Social Prescribing Social prescribing is a means of referring patients to a range of local, non-clinical services which are typically planned and delivered by voluntary and community sector organisations.

Sustainability and Transformation Partnership (Health and Care Partnership) Created in 2016, to bring local health and care leaders together to plan around the long-term needs of local communities. England is divided into 44 Health and Care Partnerships, including our area, mid & south Essex.

System unified health and care commissioners and providers operating to deliver what cannot be achieved in neighbourhoods and places, to improve and transform care, to provide oversight and accountability at ICS level.

T

T&O Trauma and orthopaedic. Covers injuries and conditions relating to bones, joints, ligaments, tendons, muscles and nerves

Tertiary care Treatment given in a regional hospital that provides highly specialised care, for example in cardiac surgery or cancer care

Third sector The third sector encompasses the full range of non-public, not-for-profit organisations that are non-governmental and 'value driven'; that is, motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

U

Urgent and emergency care (UEC) Services the NHS provides if you need urgent or emergency medical help

V

VCS Voluntary and Community Sector

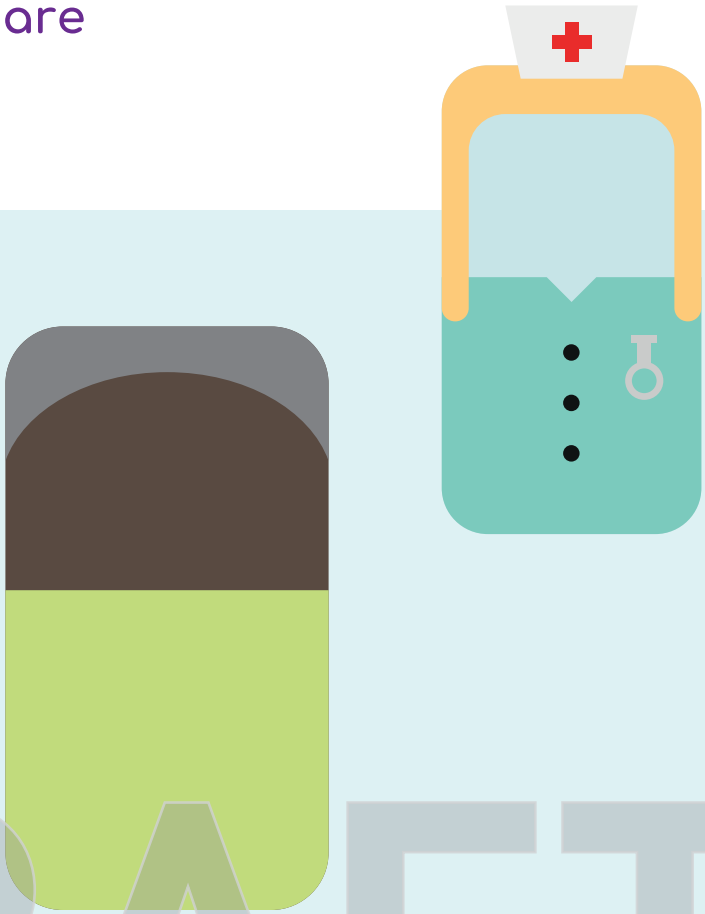
W

WTE: Whole time equivalent: A way to measure an employees' hours of work for example 1WTE equals a person working full time hours

Y

Z

Mid and South Essex
Health and Care
Partnership



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Mid and South Essex
Health and Care Partnership
c/o Basildon Brentwood CCG,
Phoenix Court, Christopher Martin Road,
Basildon, Essex SS14 3HG

Working together for better lives

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Mid and South Essex
Health and Care
Partnership

Our 5 Year Plan for Improving Health and Care

Working together for better lives

Mid and South Essex
Health and Care
Partnership

Introduction

The way we live and the lifestyles we lead have changed a great deal over the years.

Our population is growing, new technology is being developed and research into the things that affect our health and wellbeing is providing new answers.

We are living longer, but not all of those extra years are spent in good health and some of our communities experience significantly poorer health than others. Our health and care staff are also under a great deal of pressure coping with increased demand for our services.

All of this means that the support and help we sometimes need to lead a happy and healthy life must change and adapt too.

We want our residents to have a good quality of life, from education and employment opportunities, to making better choices about being active and what they eat.

So we are changing the way we work together and our five year plan sets out our goals, priorities and the actions we want to take to play our part in improving the health and wellbeing of people living in our cities, towns and villages right across mid and south Essex.

It also explains our how locally we will deliver the commitments set out in the national NHS Long Term plan (**www.longtermplan.nhs.uk**)

But our plan isn't just about the NHS because we need to think wider than that. We have linked up with our local councils and social care teams, look at housing, our environment and air quality as well as how we can prevent poor health in to first place.

Our Partnership

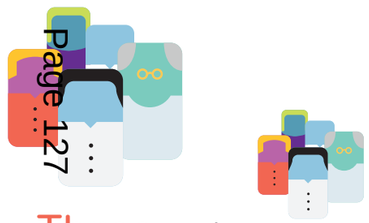
Our five year plan has been written by the Mid and South Essex Health and Care Partnership, which brings together all of the health and care organisations working to support healthier communities in our area.

Our Partnership includes local GP practices, our hospitals, community care, social services and mental health teams.

Together we are committed to finding lasting solutions to the common challenges that can prevent us from delivering the best possible care and support services to the 1.2 million people who live in mid and south Essex.

This document is a summary of our plans over the next five years and the full document is available to read on our Partnership website.

You can find out more about us and our plans at **www.msehealthandcarepartnership.co.uk**



Over **150** GP practices, operating from over **200** sites, forming **28** Primary Care Networks.

Five clinical commissioning groups

Three main community and mental health service providers

Mid Essex
390k population

9 Primary Care Networks:

3 - Chelmsford

2 - Braintree

2 - Maldon/ Chelmsford

1 - Maldon/Braintree

1 - Braintree/Chelmsford

Basildon & Brentwood
276k Population

6 Primary Care Networks:

5 - Basildon

1 - Brentwood

Thurrock
176k Population

4 Primary Care Networks:

Tilbury & Chadwell

Grays

Purfleet

Corringham

South East Essex
370k Population

9 Primary Care Networks:

2 - Castle Point

2 - Rochford

5 - Southend

Our Population

Our public health teams have created a Mid & South Essex Population Profile to describe our population in detail. The following headlines provide an overview for our area - but mask sometimes significant differences across the areas. The details contained within the profile pack, along with the Joint Strategic Needs Assessments and strategies of our three top tier Health & Wellbeing Boards, has helped to define our priorities.

// In 2017 1 in 12 people were aged over 75; this is estimated to increase to 1 in 9 by 2024 and to 1 in 7 by 2039.

Demography

// Over the next 5 years the largest increase is forecast among 75 – 79 year olds. By 2034 the largest increases are forecast for the 90+ years population.

90+

5.22%

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

14.70%

// The life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females, but there is still variation even within boroughs/districts.

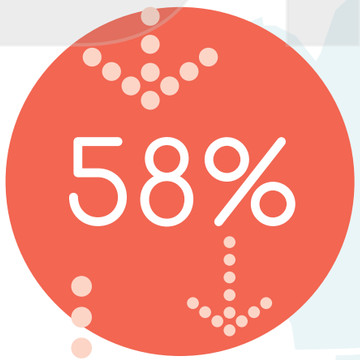
Education, Employment & Prosperity

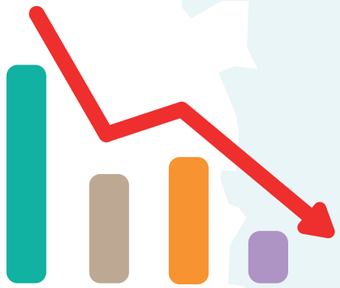
// Deprivation has increased across the 1.2m population

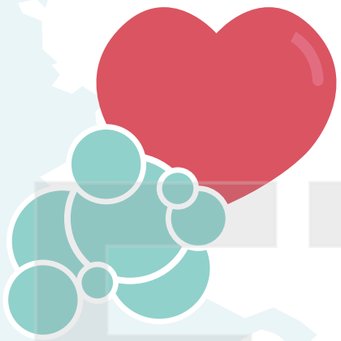
// Overall Essex is performing worse than national comparisons for reading and maths scores creating a disadvantage for future schooling and ultimately skills for work

// The productivity gap is increasing between mid and south Essex and national comparators.

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







Health Behaviours & Outcomes

// There are high and increasing proportions of overweight or obese adults.

// There are increasing numbers of overweight or obese children in early years schooling

// Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease

// More people in this area die from cancer, heart disease and liver disease than expected

// More people are being diagnosed with dementia

// Mental health conditions are increasing in adults and children and in some areas suicide rates are increasing

Our Vision

A health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident making informed choices in a strengthened health and care system

This means:

Healthy Start – helping every child to have the best start in life

// supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.

// supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide

Healthy Places – creating environments that support healthy lives.

// creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – which spring from participation

// making sure everyone can participate in community life, empowering people to improve their own and their communities' health and wellbeing, and to tackle loneliness and social isolation

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives

// helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home

// from advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

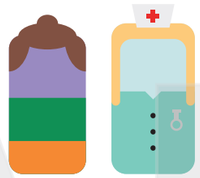
Our Ambitions

The health and wellbeing of people in some of our areas is much poorer and on average people die younger there than in other areas. As a Partnership our aim is to change this.

We have set four ambitions to help us reduce inequality, achieve our aims and deliver our vision:

1. Creating Opportunities

For our communities to thrive we need good education, opportunities for employment, decent housing and a vibrant local economy. Our Partnership represents some of the largest employers and purchasers of goods and services locally, so we have an important role to play. By working together, we can harness these opportunities for the benefit of local residents.



2. Supporting Health and Wellbeing

By working in different ways and in closer partnership with our communities we can do more to prevent the things that can cause us to have poor health and mental illness. Up to 40 per cent of ill heath can be avoided so by getting a grip on issues sooner we can stop them become bigger problems in the future.

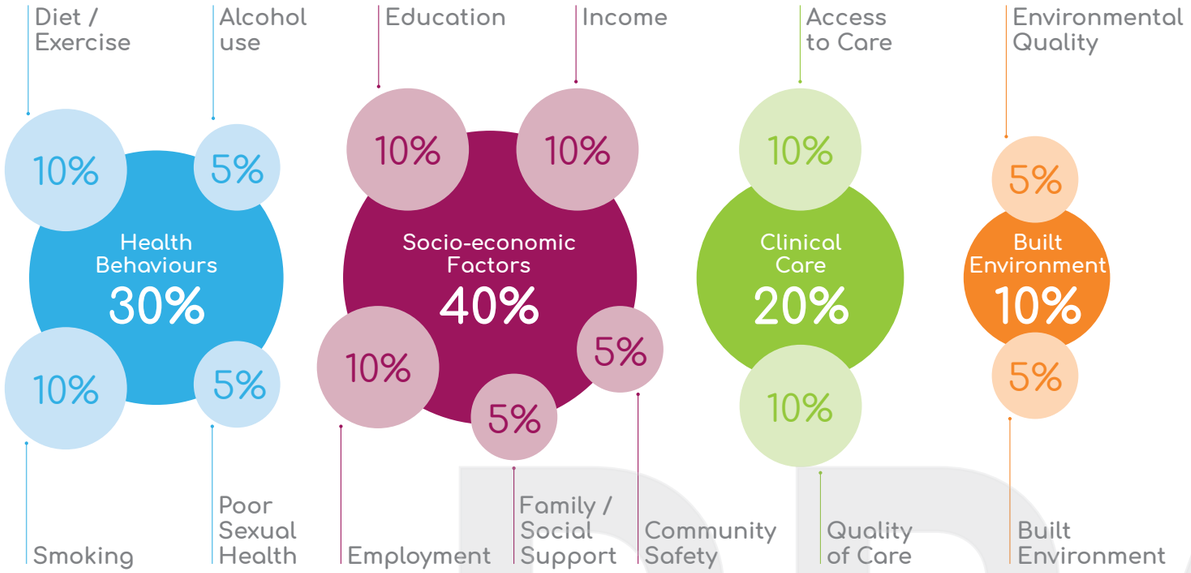
3. Bringing Care Closer to Home

Joining up our different health, care and voluntary services means we can bring services closer people's homes –whether that is through support on-line, or by bringing health and care services into the community such as some hospital outpatient appointments, tests like x-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.

4. Improving and Transforming Our Services

We want to make sure our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can. Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical advances and new ways of working to treat people at an earlier stage and avoid more serious illness.

Why We Need To Change



SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

We are helping more people than ever before

We need to change how local NHS and care organisations work together to care for people. The way we currently work together is too disjointed and this puts pressure on our staff and services. We need to be better at planning together so that we can make sure there aren't gaps in services, that there isn't any duplication or waste, and so that people who need care, can get it easily.

If we don't do anything, the pressure on our services will only increase, and we will not have enough money or staff to keep caring for people in the same way we do now.

Our population is growing

Our population is growing, people are generally living longer and the type of care that people need is changing. The number of people living in mid and south Essex will grow by over five per cent in the next five years and by more than 14 per cent in the next 20 years. Not all of these extra years are spent in good health either. As people get older, they are more likely to have several different health conditions at once. This has a real impact on day-to-day lives and can mean more support is needed to remain independent, as well as more care from a range of different professionals.

Supporting our staff

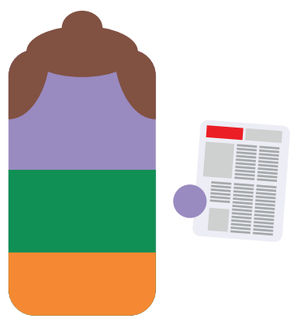
Across health and care recruiting people to work in a wide range of jobs is becoming more difficult and puts added pressure on our staff.

From nurses and social workers, to therapists and consultants across our area we have a large numbers of vacancies.

Its not just about how we attract new staff, we also want to make the working lives of our staff and for those in caring roles better for people. We want to develop more flexible careers and opportunities for training more fulfilling roles and a better work/life balance.

Technology is changing how we live and work

Too much of our technology is out of date and often our computer systems don't "talk" to each other and at the same time new technology is changing what we can do to look after ourselves, as well as how health and care services can treat and support people. We need to make the most of the opportunities that new technology offers so that we can provide the type of care that people now need, reduce the pressure on our services, make it easier for our staff to get the information they need to care for people, and so that people don't have to repeat their story as often.



What you have told us

We've heard from and spoken to lots of local people, organisations and health and care professionals to help develop our plan.

Here's a summary of what we have heard and how we are responding:

We should do more to keep people healthy and well, and prevent people from getting ill.

Our approach to prevention will have a focus on children and young people, together with support for parents and carers, on building active and involved communities.

We have committed to addressing the wider determinants of health, such as housing, education and income through our Partnership recognising it takes everyone to join forces and tackle inequalities if we are going to make a real difference.

People don't want to have to repeatedly tell their story to different health and care professionals.

Our plan describes how we will better coordinate different professionals and services supporting individuals, working with them to shape their care, in locally based teams. We are also developing a shared care record which will enable all professionals to access to vital information when they need to improve how we join up the care we provide.

We aren't making the most of the opportunities that new technology offers to improve people's care.

From the success we have already seen in projects across mid and south Essex we know that investing in technology it will help to reduce the pressure on our services and are committed to focusing on digital transformation across health and social care to benefit both our residents and staff.

Recruiting more people to work in health and care, and supporting our workforce must be a priority.

Our plans are nothing without dedicated teams delivering high quality person-centred care. Ours plans sets out how we will recruit new people to work in the health and care sector, as well as do much more to retain our existing NHS and social care workforce.

People have difficulty in being able to get an appointment at their GP surgery.

We have and are continuing to invest in primary and community care so that different health and care professionals work together in teams based around groups of GP practices. This is as a real opportunity to make sure our residents get the right care they need by the most appropriate professional, at the time they need it.

Improving mental health care needs to be a priority area.

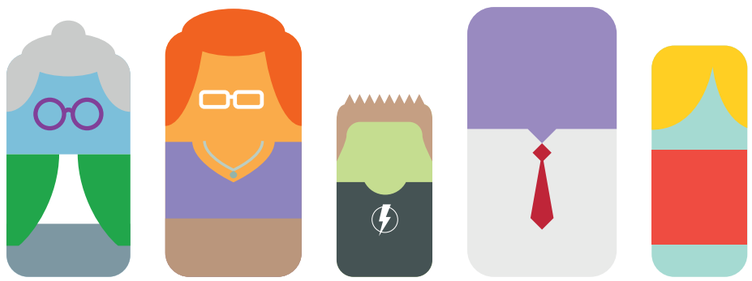
We want people of all ages to be able to get the help and support they need quickly and easily, so that their mental health needs are treated early. We are increasing our focus on prevention and wellbeing, as well as providing appropriate support for people in crisis and effective inpatient care.

We should work more closely with local community groups, voluntary organisations and faith groups.

Our plan is centred around linking up everybody in our communities to help keep people healthy, well and active, to support people when they're ill and care for people when they need help.

It's important we consider travel and transport to and from health services and activities which keep people healthy and well.

We recognise transport can be a barrier to people getting to services and the care they may need. Our plan aims to ensure our services join-up in the very heart of our communities to make support available closer to where people live. And if they need to travel for very specialist care, support is in place for those who need it.



Our five year plan

Our five year plan sets out our goals, priorities and the actions we want to take to play our part in improving the health and wellbeing of people living in our cities, towns and villages right across mid and south Essex.

Starting with you, your family and social networks, the first section of our plan describes how we will make it easier find out about ways to prevent you from becoming unwell and where you can get support to make the changes you need to improve your health

If you have a long term condition such as diabetes or breathing problems, you will be able to work together with range of health and care professionals to explore the support you need to manage your health and prevent more serious illness developing.

To do this we are setting-up teams comprising different health and care professionals to provide joined up care. These teams will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists and colleagues from the voluntary sector, working together in Primary Care Networks.

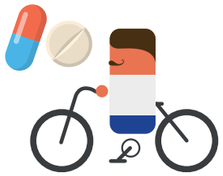
Supporting Primary Care Networks will be four "Place", partnerships covering the areas South East Essex, Thurrock, Basildon and Brentwood and Mid Essex.

These will bring together groups of Primary Care Networks, with local council teams, community service and mental health providers, the hospital teams serving that location and voluntary sector partners to ensure the health and care needs of their local population are met.

We have also set out our ambition to become a fully Integrated Care System for our 1.2 million residents, by 2021 as set out in the NHS Long Term Plan. This will bring significant benefits to our area through more funding and joined up planning to avoid wasteful duplication.

As well as explaining how we will work together we also set out in our plan how we will deliver over the next five years the commitments set out in the national NHS Long Term Plan for improving care for major health conditions (**www. longtermplan.nhs.uk**)

We set out the actions we're taking to improve care for conditions such as cancer, mental health conditions, cardio vascular disease, diabetes and for people at key points in their lives, for example having a baby or at the end of their life.
These include:



Prevention

// Providing information and support for people to look after themselves including on-line and digital options.

// work on reducing childhood obesity through the adoption of the "Daily Mile" across our schools

// increasing physical activity in adults, linking with Sport England and Active Essex

Cancer

// introducing a new test to help detect and diagnose bowel cancer earlier, so we can treat people quicker and improve their health outcomes

// setting up a Rapid Diagnostic C entre for patients with non-specific symptoms which could indicate cancer

// becoming a pilot area for the National Targeted Lung Health Check to support earlier diagnosis of lung cancer

Mental Health

// creating safe places for people to walk-in such as community cafés, where they can find emotional support when they feel their anxieties or other mental health problems are escalating

// setting-up mental health support teams in schools to provide therapy and support to children and younger people

// improving how we support people with a personality disorder at an early stage, so that they can manage their condition and are less likely to need to go to hospital

Cardiovascular disease

// focusing on atrial fibrillation (irregular and often abnormally fast heart beat) to improve earlier detection and treatment to prevent stroke.

// reviewing existing patients to ensure their medication is appropriate

// improving access to specialist care at the Essex wide Cardiothoracic Centre with more patients requiring an angiography being seen within 72 hours.

Diabetes

// rolling-out the NHS Diabetes Prevention Programme to provide personalised support to people to reduce their risk of developing diabetes

// reducing the impact of diabetes among harder to reach/less engaged groups

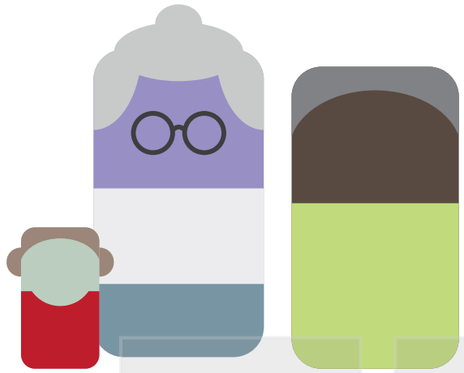
// piloting the MyDiabetes app with 500 newly diagnosed Type 2 diabetics to support them to understand and better manage their condition and reduce the risk of more serious complications developing

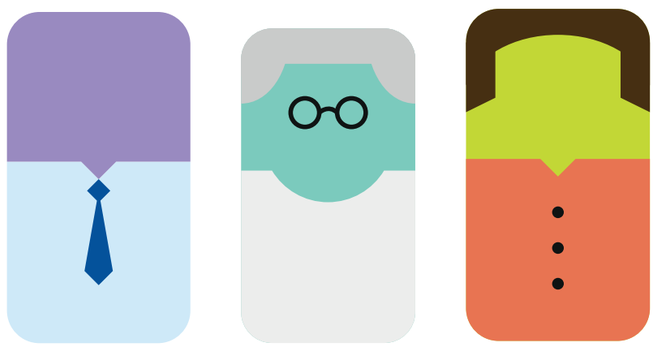
Maternity

// launching the Maternity Direct App to allow mums-to-be to speak online with an NHS midwife about non-urgent concerns at anytime

// creating personalised care plans to support women to have choice and opinions about the care they receive

// reviewing our current mental health services to support women both before and after birth to make it easier for those in need to access support.





Place – Based Plans

Our "place based" systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

Basildon & Brentwood

Predicted population growth

Age Band	2020	2041
0-14	19.23%	20.82%
15-24	16.48%	19.30%
30-64	46.03%	49.81%
65-89	17.30%	23.83%
90+	0.97%	2.12%
Total	269.4	312.2

PARTNERSHIP:

Basildon & Thurrock University Hospitals NHSFT

North East London NHSFT

Basildon & Brentwood CCG

Essex Partnership University NHSFT

Essex County Council

Brentwood Borough Council

Basildon Council

Community Voluntary Sector

Primary Care Networks – 6

PRIORITIES:

1 Implementation of the aligned team model
2 Support patients and carers to better manage their own health and wellbeing
3 Support residents to access alternative services

PRIORITIES:

1 Transform community and primary care services
2 Develop strong and resilient communities
3 Transform how residents with long-term conditions are managed in the community
4 Reconfigure the out of hospital estate

PARTNERSHIP:

Basildon & Thurrock University Hospitals NHSFT

North East London NHSFT

Thurrock CCG

Essex Partnership University NHSFT

Thurrock Council

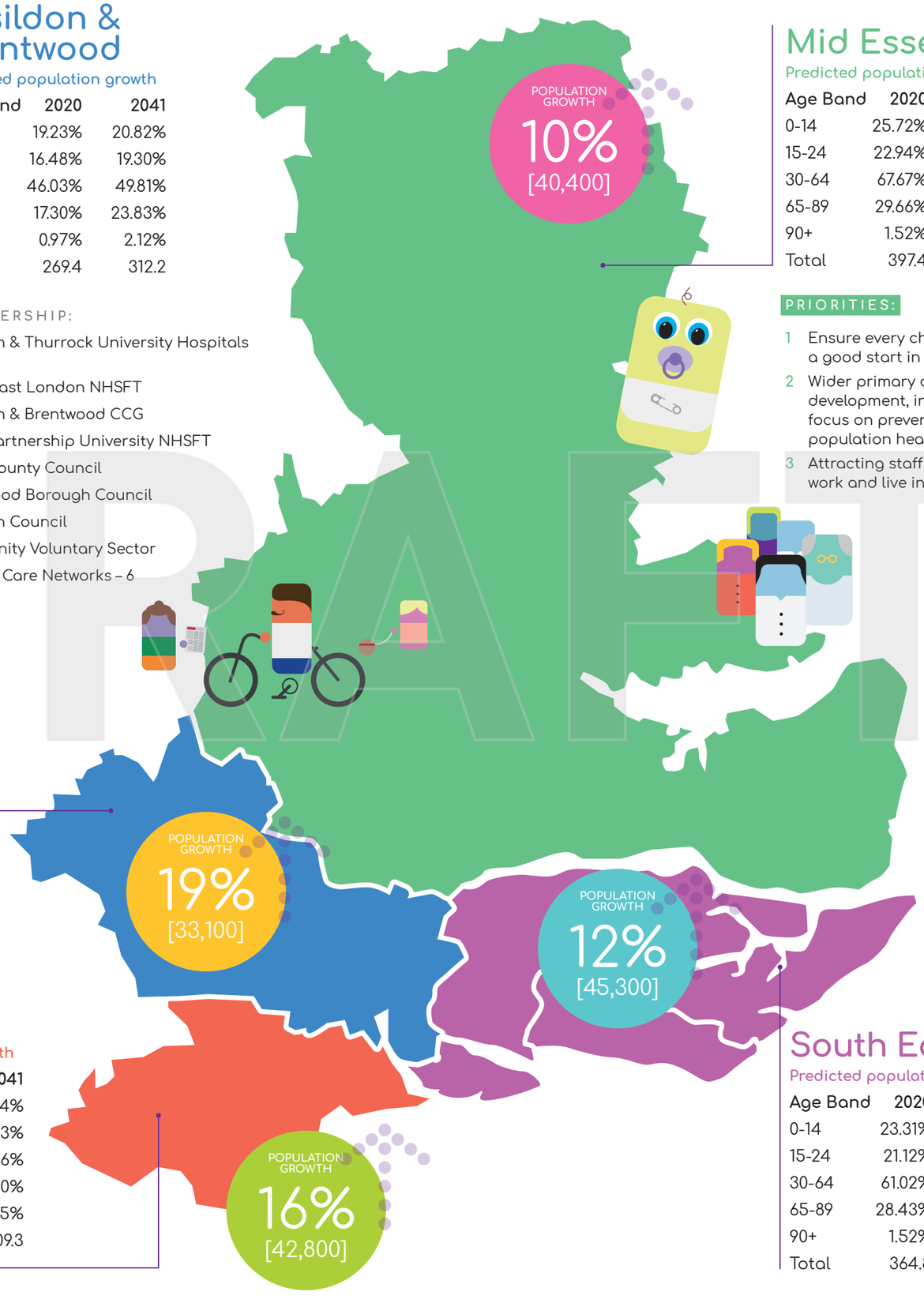
Community Voluntary Sector

Primary Care Networks – 4

Thurrock

Predicted population growth

Age Band	2020	2041
0-14	14.29%	15.14%
15-24	11.28%	14.03%
30-64	30.59%	34.26%
65-89	8.87%	13.40%
90+	0.37%	0.85%
Total	176.2	209.3



Mid Essex

Predicted population growth

Age Band	2020	2041
0-14	25.72%	25.45%
15-24	22.94%	24.72%
30-64	67.67%	67.41%
65-89	29.66%	40.91%
90+	1.52%	4.01%
Total	397.4	437.8

PRIORITIES:

1 Ensure every child can have a good start in life
2 Wider primary care network development, including a focus on prevention and population health
3 Attracting staff to want to work and live in mid Essex

PARTNERSHIP:

Mid Essex CCG

Essex County Council

Chelmsford City Council

Braintree & Witham District Councils

Maldon District Council

Provide CIC

Mid Essex Hospital

Farleigh Hospice

Community Voluntary Sector

Anglia Ruskin University

Essex Partnerships University NHSFT

Primary Care Networks - 9

PRIORITIES:

1 Strengthened GP services
2 Appropriate access to secondary care
3 Improve outcomes for all-age mental health
4 Support self-care and prevention for all

South East Essex

Predicted population growth

Age Band	2020	2041
0-14	23.31%	23.90%
15-24	21.12%	23.42%
30-64	61.02%	62.40%
65-89	28.43%	38.90%
90+	1.52%	3.60%
Total	364.8	410.1

PARTNERSHIP:

Southend CCG

Castle Point & Rochford CCG

Southend Borough Council

Essex County Council

Castle Point Borough Council

Rochford District Council

Essex Partnerships University NHSFT

Southend University Hospital NHSFT

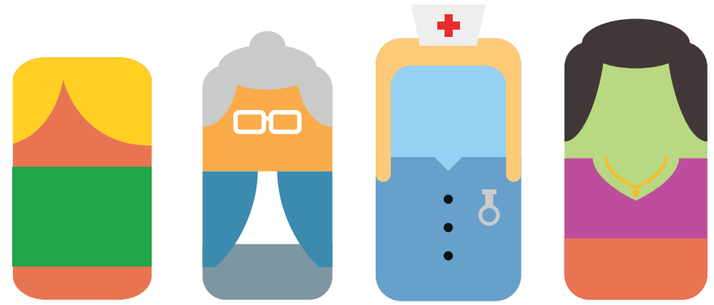
Community Voluntary Sector

North East London NHSFT

Primary Care Networks - 9

How will we know if we've made a difference?

Linked to our ambitions we have developed a set of outcomes we can measure to keep us on track in the key areas we believe, by working differently we can make a difference.



This plan for is for the next five years but we know that some of our ambitions and goals will take longer, particularly how we tackle some of the wider causes of poor health and wellbeing such as education, employment and income opportunities.

We all have a role to play in how we work together to do that – as public services, as individuals, families and communities - all taking responsibility to think differently about our health and wellbeing.

We believe that together we really can make a difference.

	How will we know we've made a difference?	What metrics will we use to track progress?
Reducing Inequalities	Inequality will reduce and our residents will enjoy longer, healthier lives.	// Slope Index of Inequality // Healthy Life Expectancy measures

Creating Opportunity	Our children achieve good development and educational attainment.
	
	Employment will rise.
	
	Homelessness will reduce and we will have good housing stock.
		// School Readiness
		// Percentage of people in employment
		// Educational attainment
		// Statutory homelessness
		// Number of non-decent dwellings
		// Air quality

Health & Wellbeing	Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.	// % of adults classified as overweight or obese.
		// Reception and year 6 prevalence of overweight children
		// % of adults physically active
		// Smoking prevalence
		// Admissions for alcohol related conditions
		// QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol.
		// % of people self-caring after reablement
		// Patient Activation Measures

	How will we know we've made a difference?	What metrics will we use to track progress?

Moving care closer to home	Our residents report good access to and experience of primary and community services.	// Patients reporting good overall experience with practice appointment times and good experience of making an appointment.
		// Patients reporting a positive experience of their GP practice.
		// Delayed transfer of care
		// A&E attendances conveyed by ambulance

Transforming our services	Our residents have consistent, timely access to safe, high quality health and care services.
	
	The outcomes from our services are improved.
		// Breast and bowel screening uptake
		// Cancer waiting times
		// Elective waiting times
		// % of residents with high self-reported happiness
		// Reduction in depression cases
		// Reduction in self-harm
		// Reduction in suicide
		// Treatment and recovery rates for IAPT services
		// Physical health checks for patients with serious mental illness
		// Mental health admissions to hospital

Mid and South Essex
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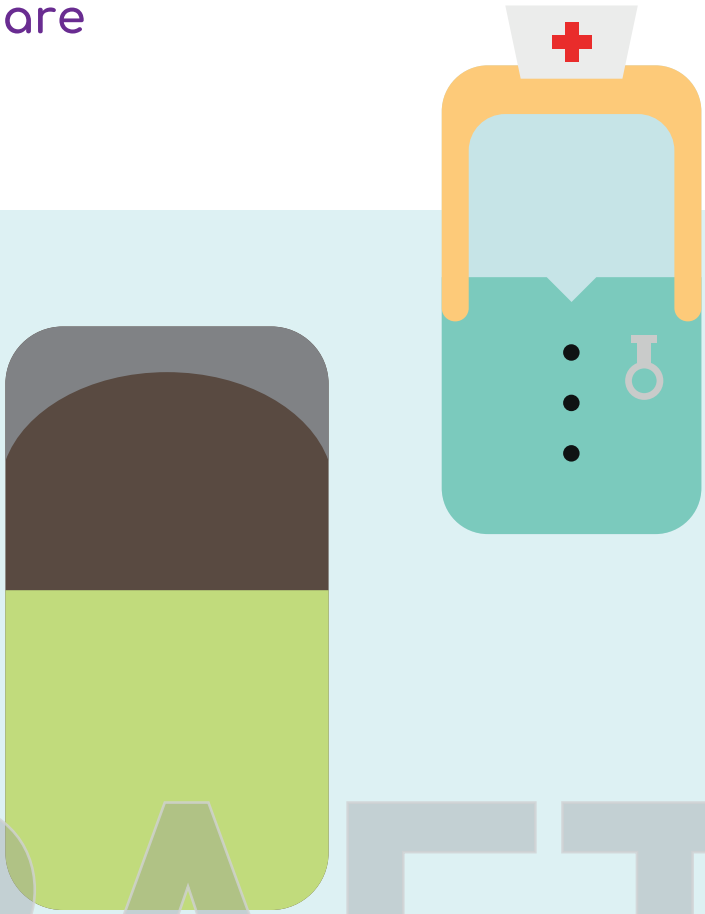

Call 01268 594534

or email btu-tr.midsouthessexstp@nhs.net

Mid and South Essex
Health and Care Partnership
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Basildon, Essex SS14 3HG

Working together for better lives

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31 January 2020	ITEM: 6
Health and Wellbeing Board	
Sexual Violence and Abuse Joint Strategic Needs Assessment	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Maria Payne, Strategic Lead for Public Mental Health and Adult Mental Health System Transformation Sareena Gill-Dosanjh, Public Health Programme Manager	
Accountable Head of Service:	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

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

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

1. Recommendation(s)

1.1 That the Board endorse the report and approve it for publication.

1.2 The Board support to the next steps proposed, i.e. holding a Thurrock Sexual Violence and Abuse summit and implementation of the recommendations.

2. Introduction and Background

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

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

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

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

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

3. Issues, Options and Analysis of Options

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

4. Reasons for Recommendation

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

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

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

5.2 A draft version of this document has been shared at multiple forums including Brighter Futures Board, Directors Board, Community Safety Partnership and the Violence Against Women and Girls (VAWG) Strategic Group. Audiences were in support of the document and have provided comments regarding how to take the recommendations forward.

5.3 An overview of this needs assessment and its findings was presented at Health and Wellbeing Overview and Scrutiny Committee on 7th November and was well received by its members.

5.4 It is intended to launch this needs assessment to a wider audience at a summit in spring 2020 in order to invite further discussion on the report's findings and taking the recommendations forward.

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

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

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

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead, Corporate Finance

The report looks at potential unmet needs of survivors of sexual violence and abuse. Whilst exact costs have not been calculated, the report indicates that there may be future increases in demand for specialist services; but it also

includes a number of potential areas for future financial savings if the impacts of sexual violence and abuse were mitigated.

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

7.2 **Legal**

Implications verified by: **Lindsey Marks**

Deputy Head of Legal Social Care and Education.

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

7.3 **Diversity and Equality**

Implications verified by: **Becky Price**

Team Manager - Community Development and Equalities

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

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

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

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

- Detailed references are given in the main report.

9. Appendices to the report

- Sexual Violence Joint Strategic Needs Assessment
- Sexual Violence Joint Strategic Needs Assessment Appendices

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Public Health

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Public Health Programme Manager
Public Health

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Sexual Violence and Abuse: A Thurrock Joint Strategic Needs Assessment

October 2019

Authors:

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Katie Powers, Public Health Graduate Trainee

Contents

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Editor:

Ian Wake, Director of Public Health

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

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

Notes to the reader

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

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

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

Executive Summary

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

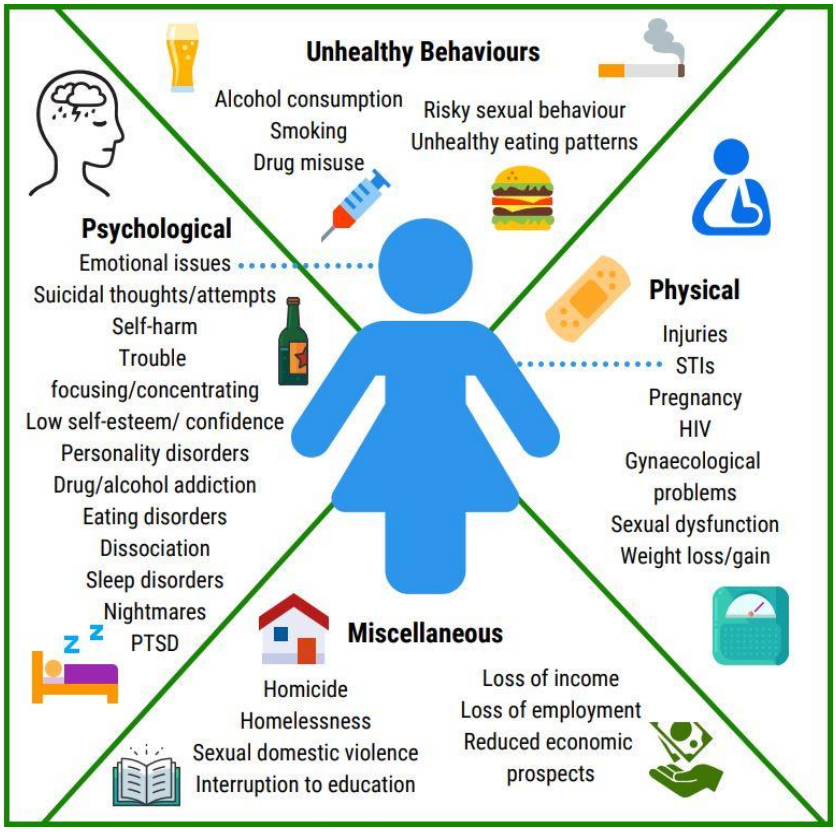
This needs assessment sought to further our understanding of the nature, prevalence and types of sexual violence and abuse occurring locally. This understanding will enable us to ensure that efforts are made to prevent these horrific crimes happening in the first place and ensure survivors are appropriately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

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

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

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

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



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

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

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

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

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

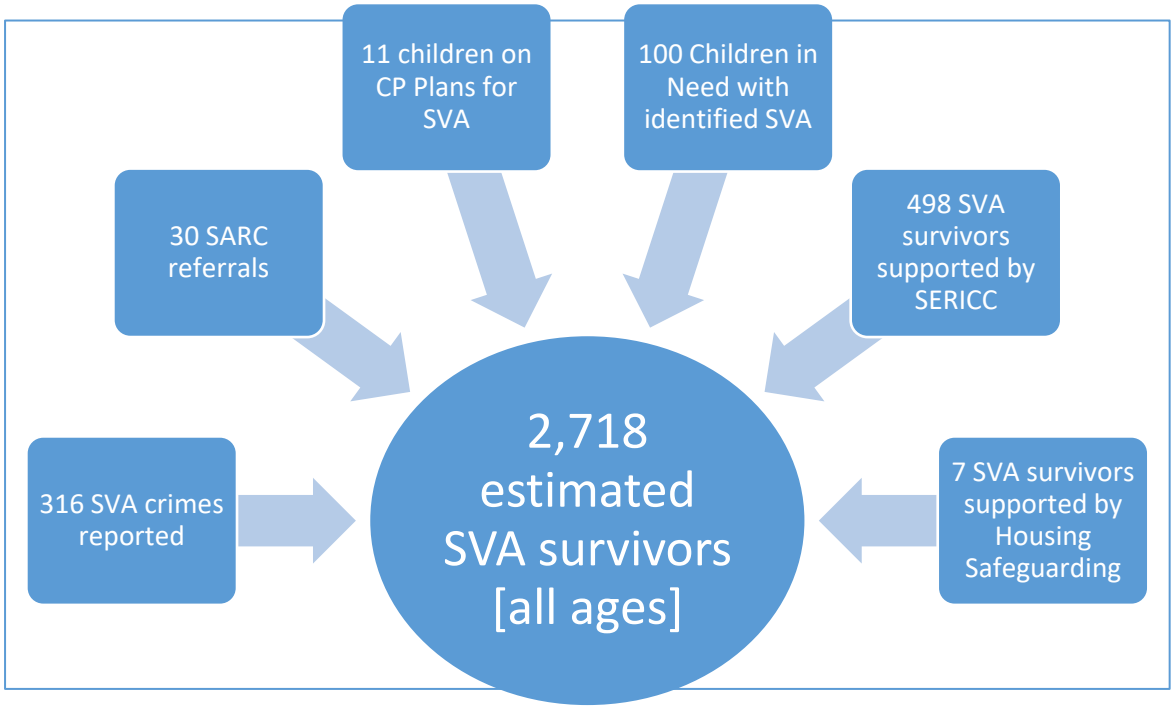
- **Young (over half were aged < 17 years)**
- **Female (over three quarters were female)**

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

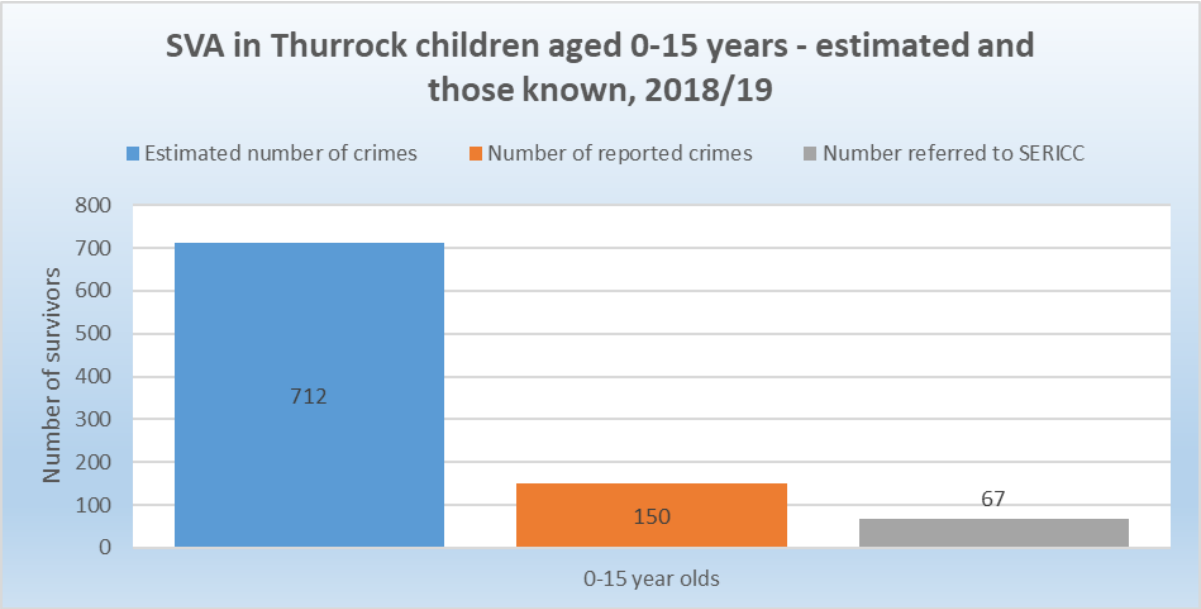
Sexual violence and abuse can occur in a number of different contexts. Crimes related to SVA often represent an exertion of power from the perpetrator over the survivor and may be used as forms of punishment, blackmail and to instil fear within a victim. Victims may also by sexually abused or exploited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

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

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



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



User Voice

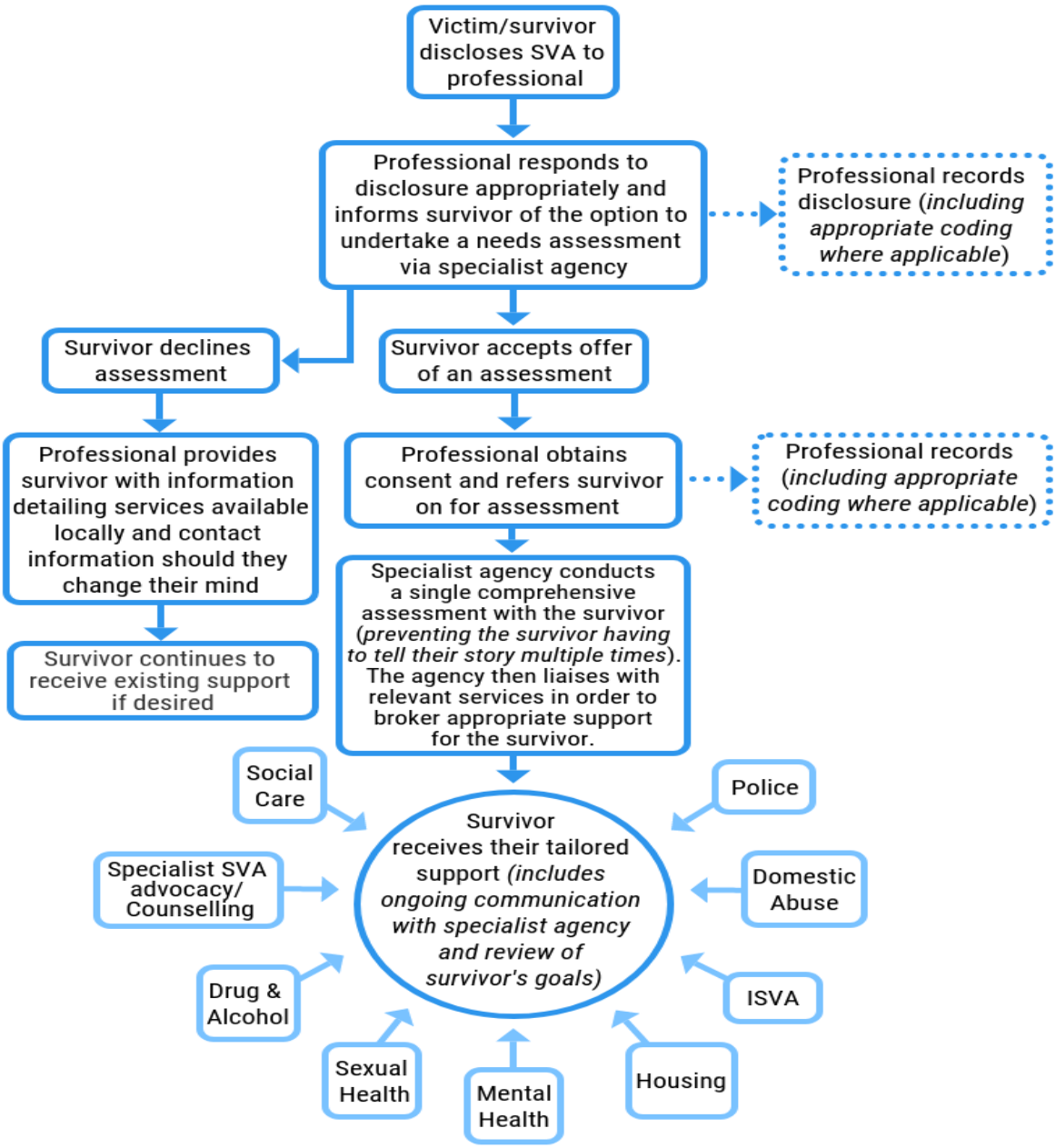
Local victims/survivors spoke of the experiences of fragmented pathways, poorly handled disclosures, difficulties navigating the landscape of numerous providers and to their frustration, often having to repeat their traumatic experiences to multiple members of staff across various services. victims/survivors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

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

A new integrated model of care for victims/survivors.

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

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



Key issues and recommendations

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

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

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

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

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

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

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

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

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

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

Chapter 1: Introduction

1.1 What is sexual violence and abuse?

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

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

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

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

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

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

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

1.2 Why is it an important issue?

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

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

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

1.3 How this needs assessment was conducted

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

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

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

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

Chapter 2: National Context and Legislative Framework

2.1 Legislative framework

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

2.2 National strategies and guidance

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

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

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

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

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

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

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

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

2.3 Safeguarding responsibilities

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

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

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

2.4 Commissioning responsibilities

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

Figure 2: Commissioning Responsibilities

NHS England

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

Clinical Commissioning Group (CCG)

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

Police and Fire Crime Commission (PFCC)

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

Local Authority

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

Ministry of Justice

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

Home Office

- National Services for victims of child sexual abuse

Chapter 3: Incidence and prevalence of Sexual Violence and Abuse

3.1 National prevalence

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

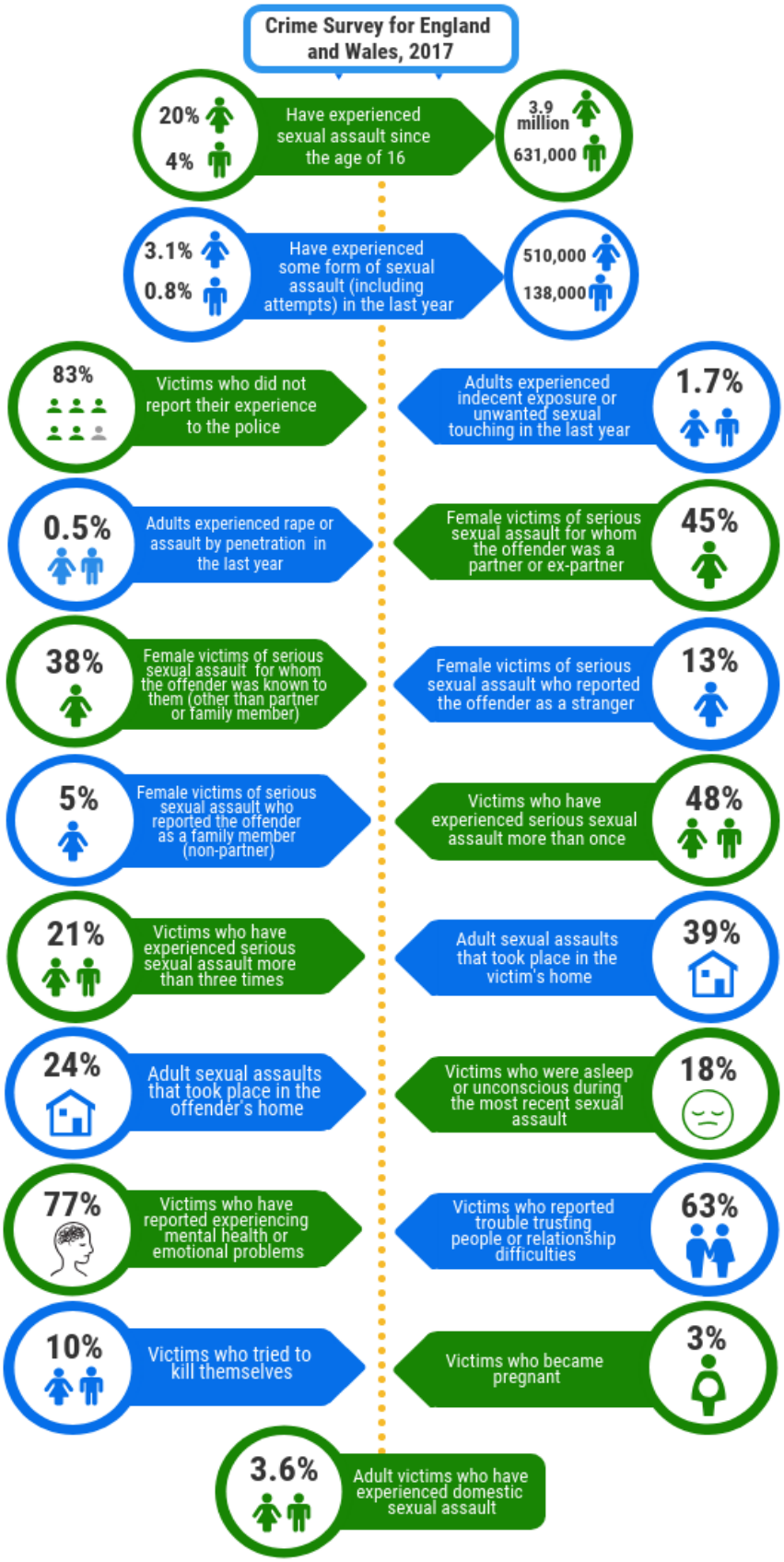
The CSEW estimates that 3.1% of women (510,000) and 0.8% of men (138,000) aged 16 to 59 experienced sexual assault in the last year, and 20% of women and 4% of men have experienced some type of sexual assault since the age of 16, equivalent to an estimated 3.4 million female victims and 631,000 male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

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

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

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

Figure 3: Key findings from the CSEW (2017)

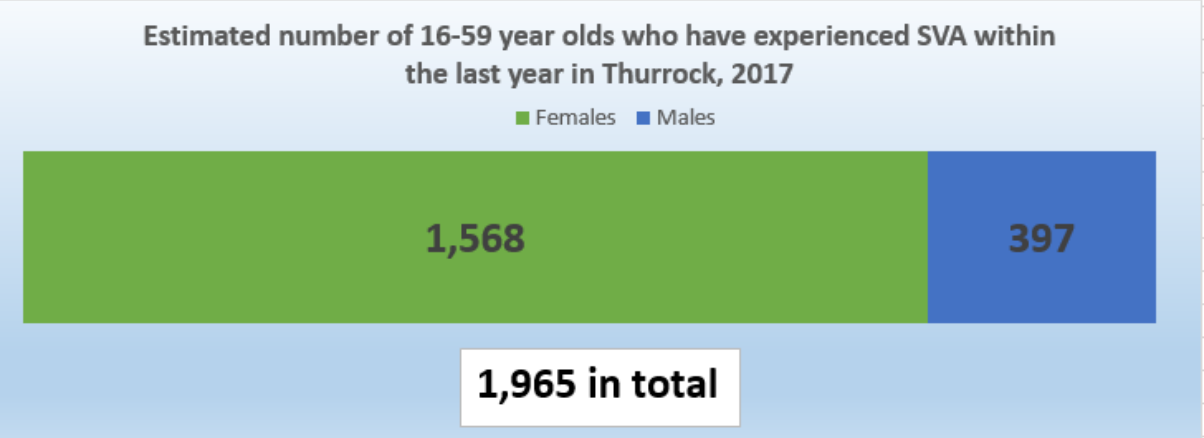


3.2 Estimated local incidence and prevalence

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

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

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

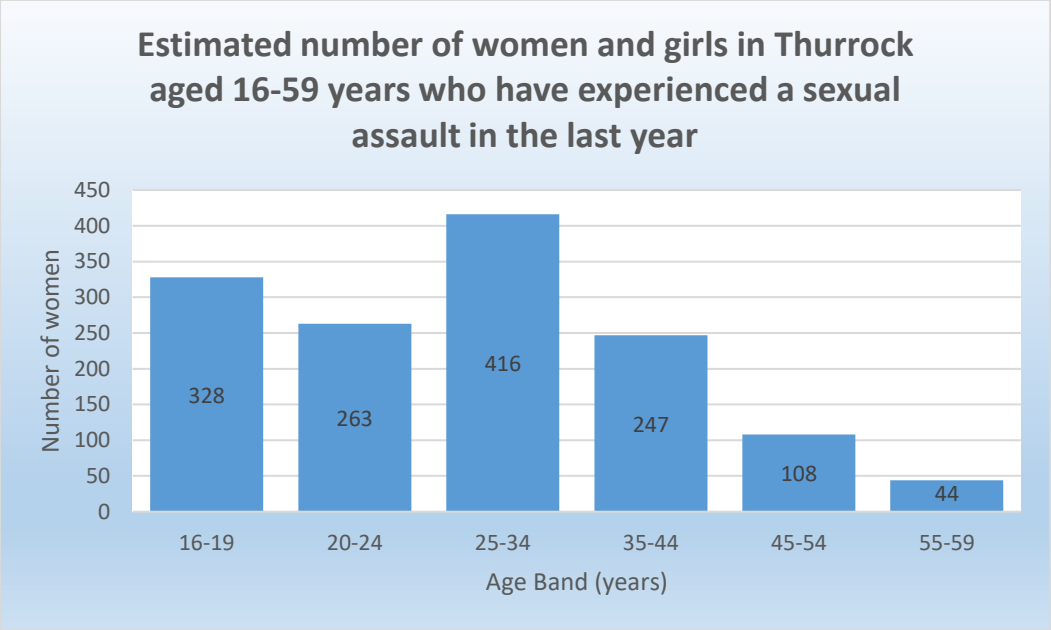


The above estimates are to be used with caution as they only include individuals aged 16-59 years old; however the number of victims/survivors in the 0-15 and 60 and over categories can be estimated using the crime data reported to Essex Police. Police data from 2018 shows that there were a total of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

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

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

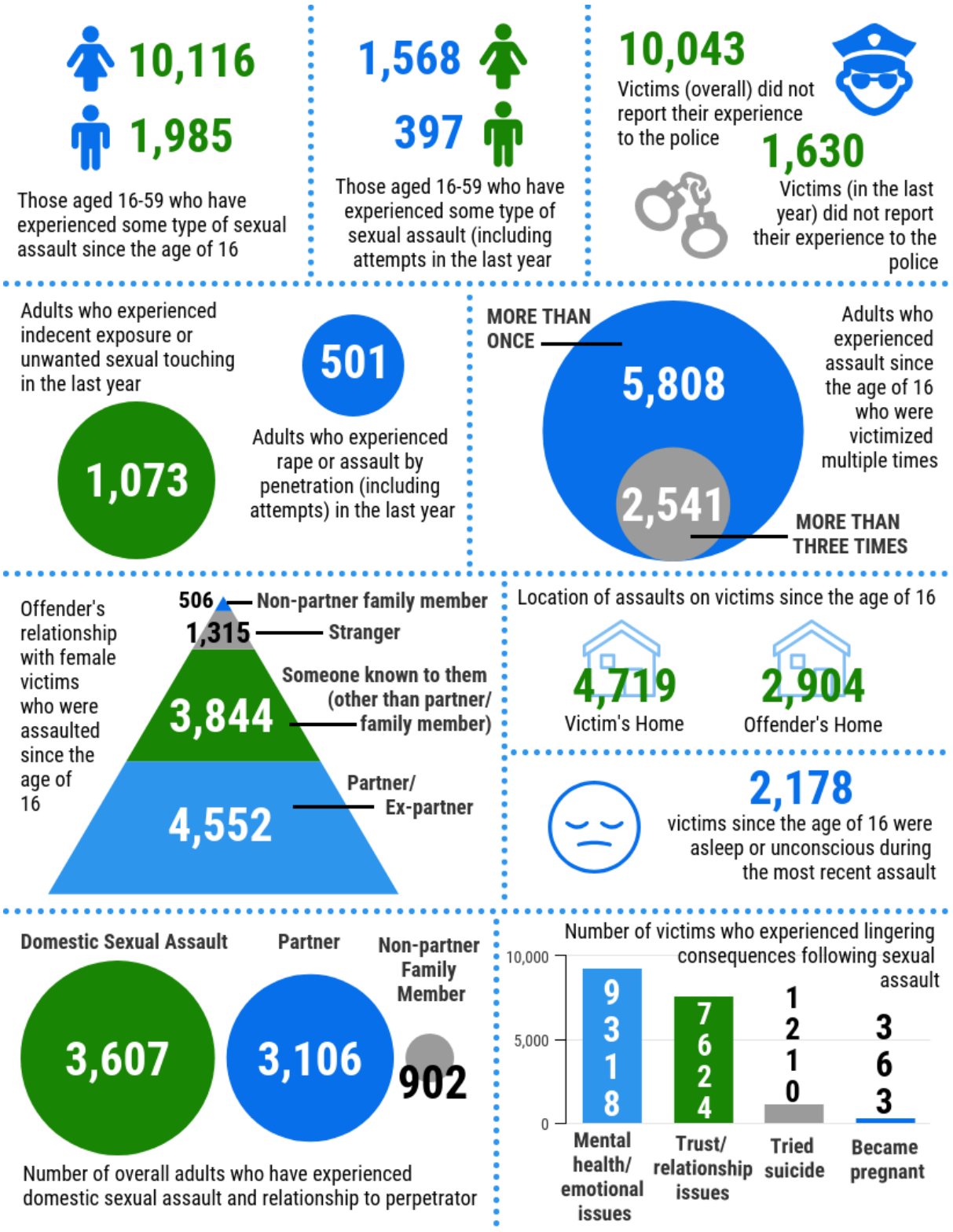
Figure 6: Number of Thurrock women and girls who experienced sexual assault in the last year



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

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

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


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

3.3 Implications of local data

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

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

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

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

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

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

3.4 Barriers to determining accurate local data

3.4.1 Data recording

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

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

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

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

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

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

3.4.2 Data sharing

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

3.4.3 Recommendations to address known issues with data collection

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

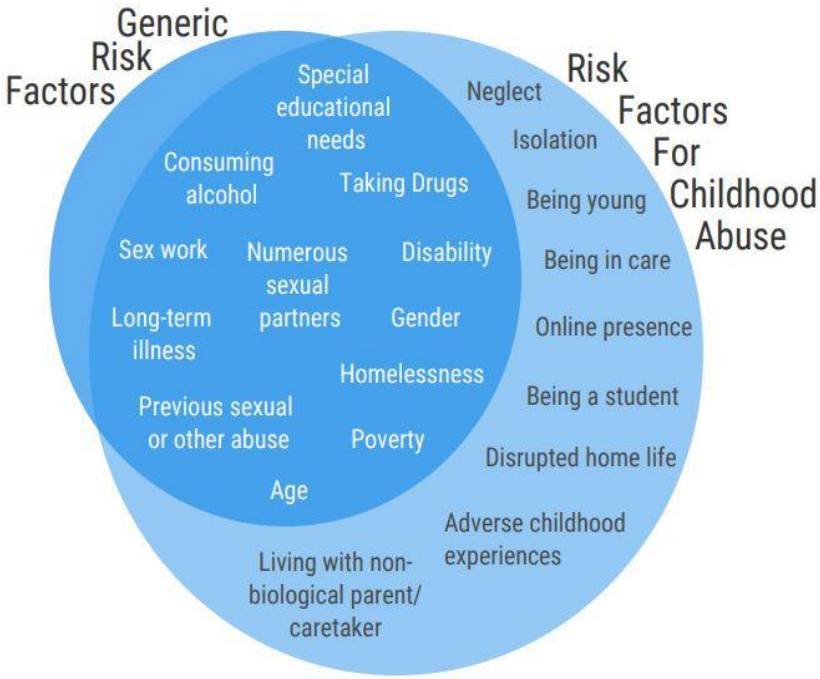
Issue Identified	Recommendation to address this	Responsibility
Recommendations around improving data		
Locally there are low levels of reporting of SVA crimes to the Police. Although this is observed nationally, the Thurrock rates are lower than comparable authorities (see chapter 7 for further information)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

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

4.1 Risk factors

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

Figure 8: Risk factors for SVA[9]



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

Gender

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

Age

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

Vulnerabilities

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

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

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

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

4.2 Associated links with SVA

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

Domestic Violence

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

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

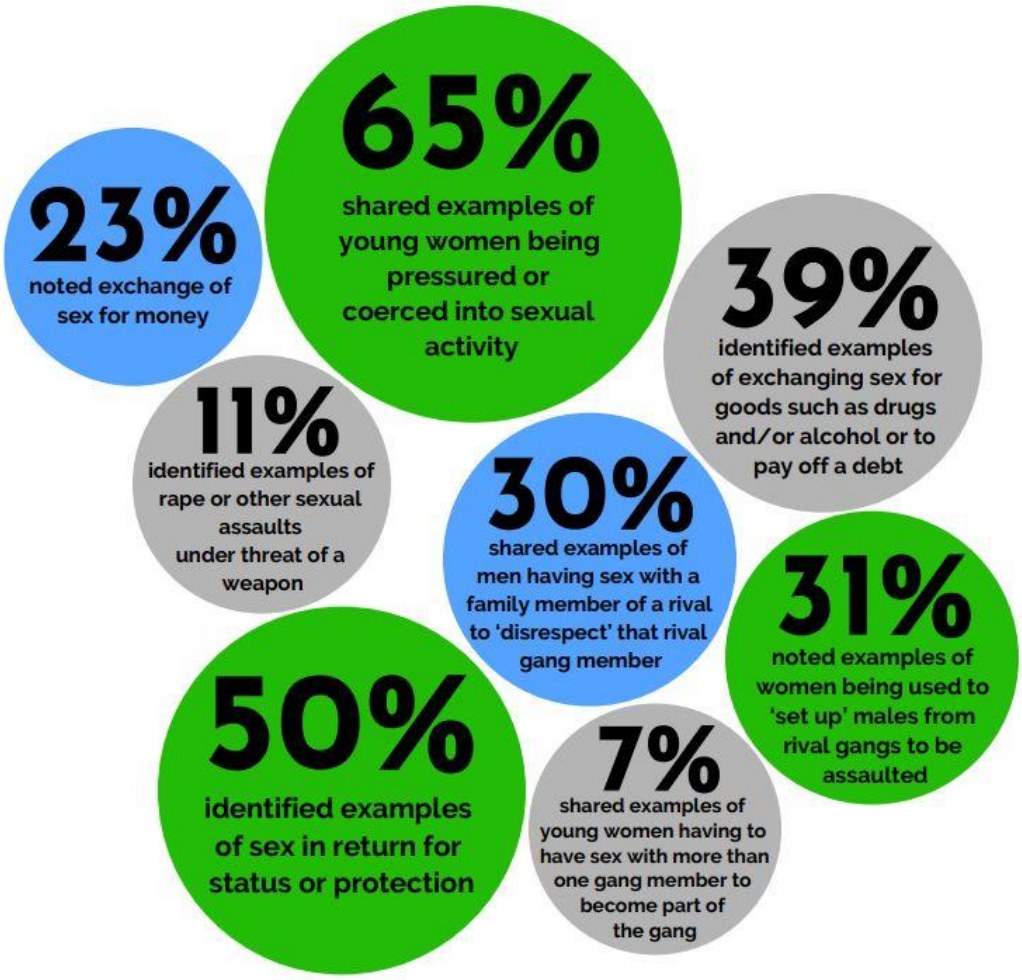
Substance Misuse

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

Gangs

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

Figure 9: Key findings from research regarding Gangs and SVA



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

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

Trafficking/Sex Trafficking

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

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

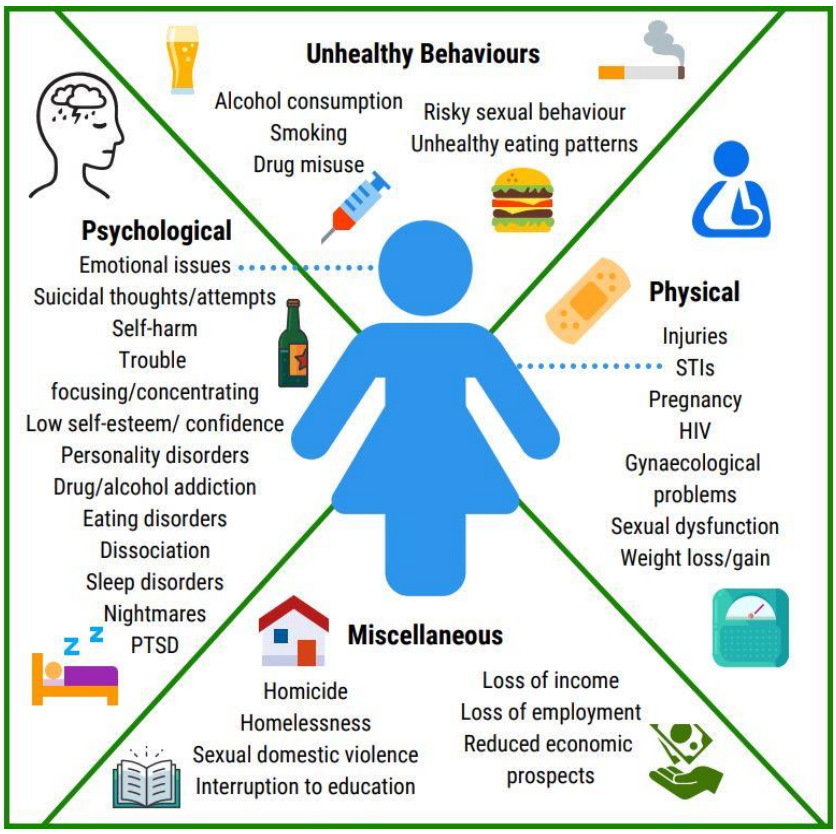
4.3 Impacts of sexual violence and abuse

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

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

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

Figure 10: Impacts of SVA on victims/survivors32



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

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

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

4.3.2 Impacts on mental health

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

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

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

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

*Referenced in section below

Borderline Personality Disorder (BPD) and SVA

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

Inpatient admissions and SVA

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

4.3.3 Impacts of SVA on relationships with family/friends

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

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

4.4 User voice on impact

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

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

4.5 Socioeconomic costs

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

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

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

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

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

Table 2: Yearly costs associated with CSA

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

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

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

4.6 Estimated socioeconomic cost of SVA in Thurrock

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

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

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

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

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

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

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

Chapter 5: Preventing Sexual Violence and Abuse

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

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

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

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

5.1 Evidence base

5.1.1 School-based Programmes

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

5.1.2 Targeted prevention

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

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

5.1.3 Prevention aimed at perpetrators/offenders

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

5.2 Local provision

Relationships and Sex Education

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

The Good Man

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

Thurrock Youth Offending Team

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

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

Prison-based support

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

Police community-based support

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

5.3 Identification of gaps

The above has allowed the following gaps to be identified:

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

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

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

5.4 Recommendations

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

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

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

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

Chapter 6: Disclosure

6.1 National evidence around disclosure

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

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

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

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

6.2 Barriers to disclosure

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

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

Figure 12: Barriers to disclosure[58, 59]

6.3 Professional responsibilities following disclosure

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

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

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

6.4 Importance of a positive reaction

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

6.5 Thurrock data on disclosure

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

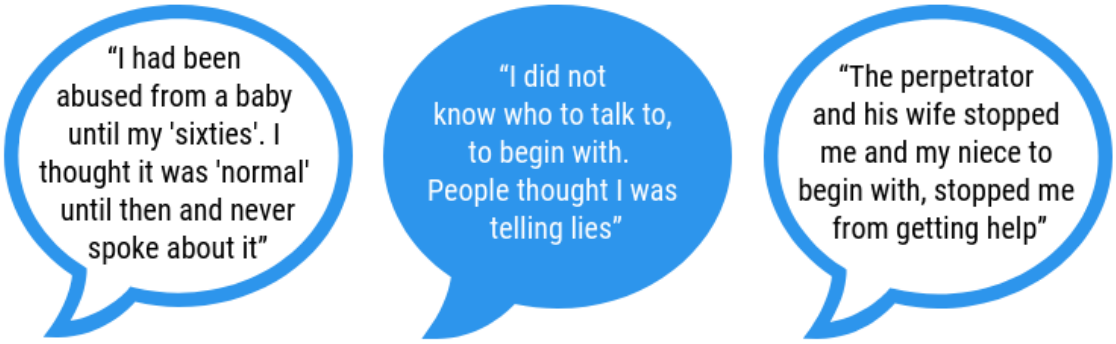
CSEW finding	Estimated number of Thurrock victims (within the last year aged 16-59)	Estimated number of Thurrock victims (ever experienced abuse aged 16-59)
31% victims told no one of their most recent experience	609	3,751
58% victims told someone close to them	1,140	7,019
30% victims told a professional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

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

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

6.6 Local engagement with survivors regarding barriers

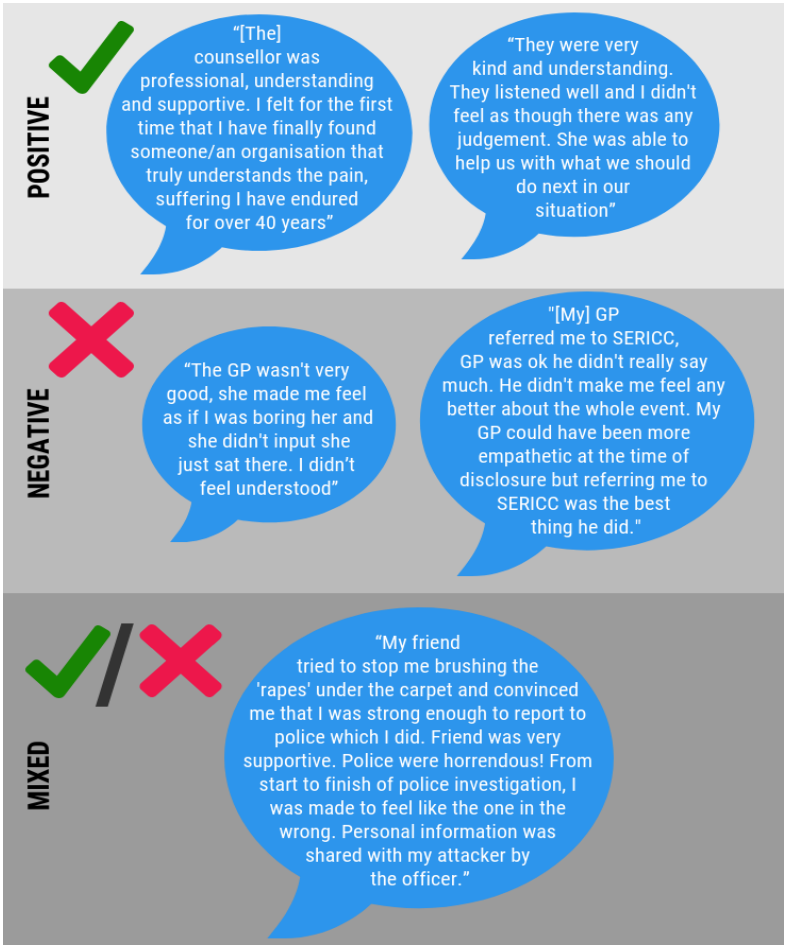
Local survivor's thoughts and experiences related to barriers to disclosure were predominately discussed during the interviews. Key barriers mentioned included; embarrassment, guilt, feeling ashamed, not wanting to be judged by others, a low conviction rate of perpetrators and a lack of confidence in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



6.7 Experience of reaction to disclosure

6.7.1 Engagement with survivors

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



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

6.7.2 Engagement with professionals

Professionals' awareness of services

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

Professionals' responses of actions following a disclosure

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

6.7.3 The REAL. Conference

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

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

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

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

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

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

6.7.4 Challenging Myths, Changing Attitudes Training

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

6.8 Recommendations to address barriers and poor response to disclosure

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

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

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

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

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

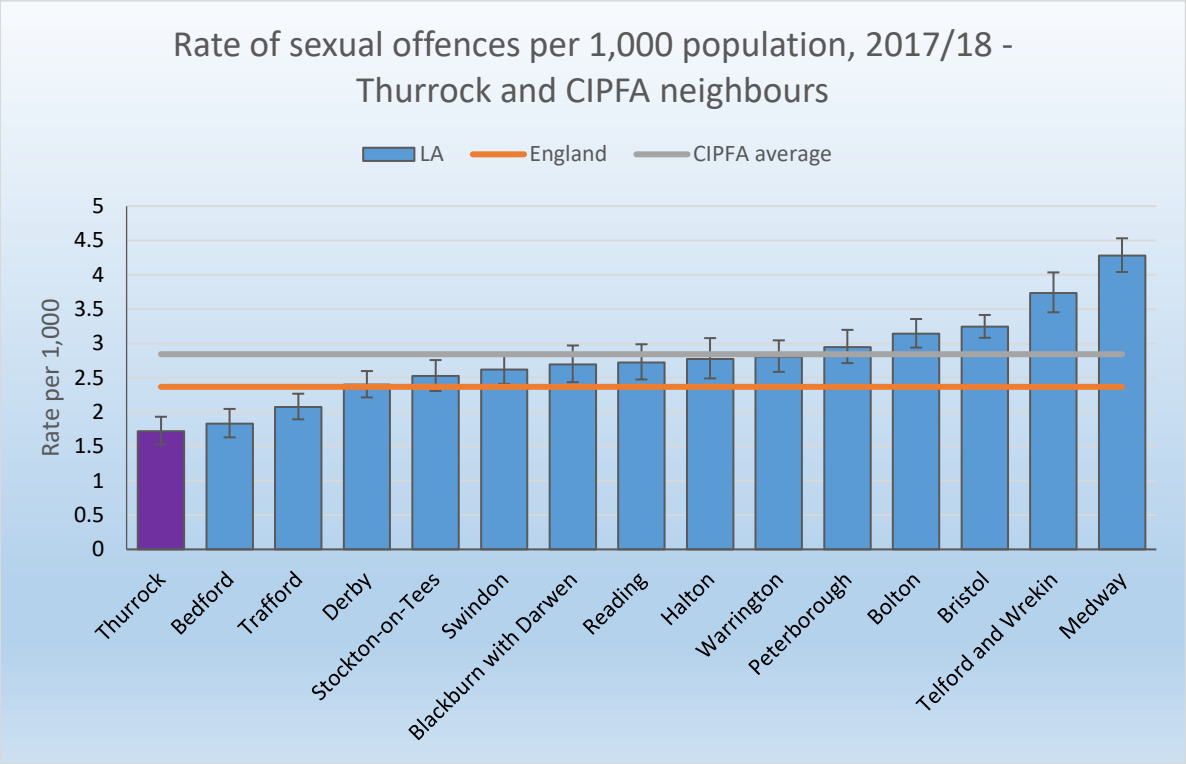
Issue Identified	Recommendation to address this	Responsibility
	Where practicable, referral forms to SVA support services should be automated or embedded into organisational information systems (e.g. the Systm One or EMIS systems in General Practice and hospital systems)	Thurrock Sexual Violence and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

Chapter 7: Criminal Justice for victims/survivors

7.1 Comparison of SVA crime with other areas

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

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



Source: Home Office and Public Health England

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

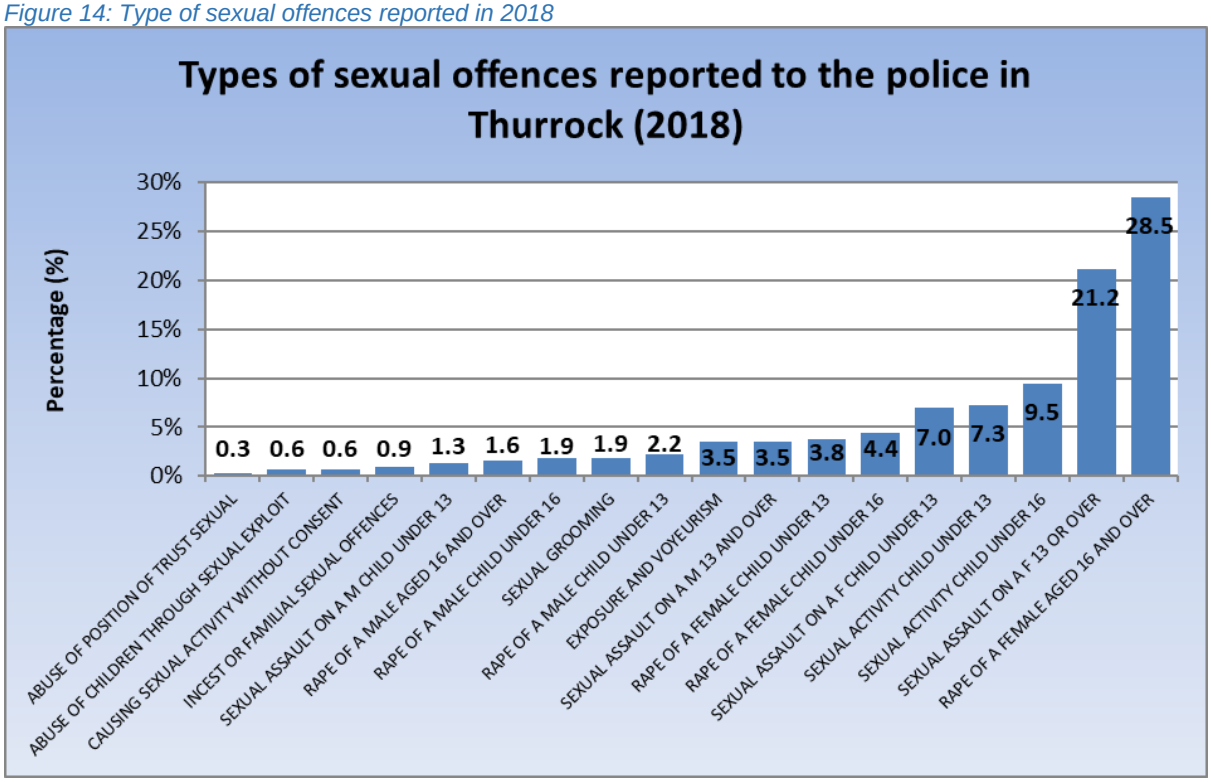
7.2 Sexual Violence & Abuse in Thurrock reported to Essex Police

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

7.2.1 Type of crime

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

Figure 14: Type of sexual offences reported in 2018



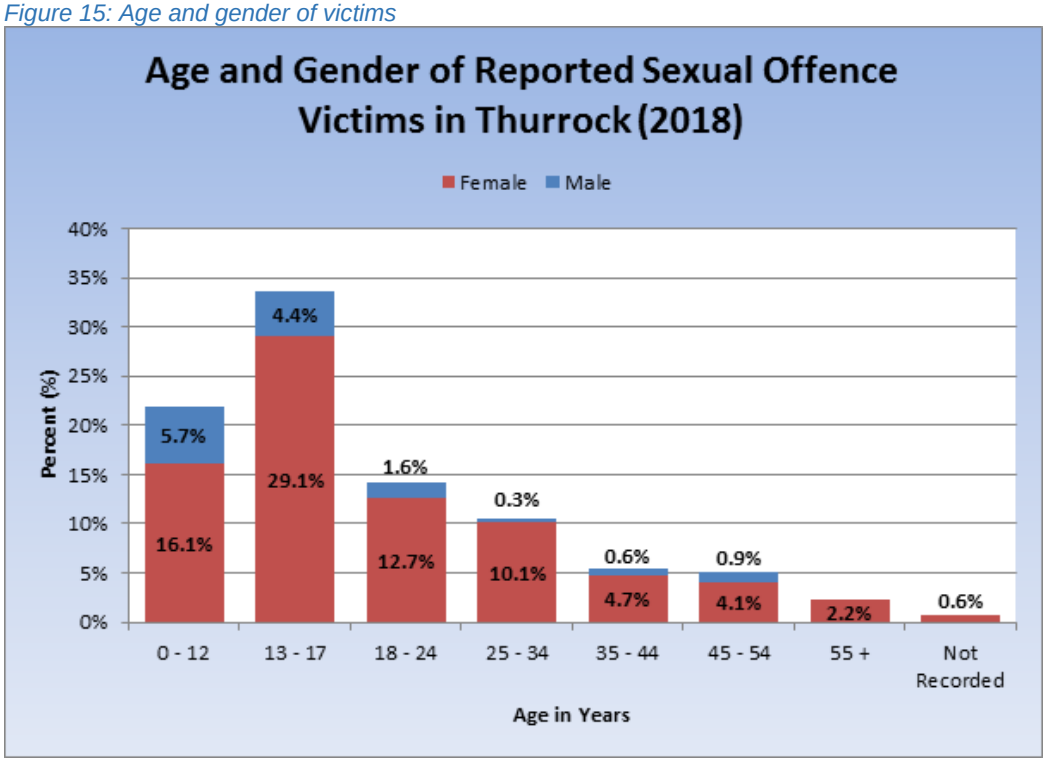
7.2.2 Sexual offences linked to Domestic Violence

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

7.2.3 Victims' Demographics

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

Figure 15: Age and gender of victims



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

7.2.4 Location

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

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

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

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

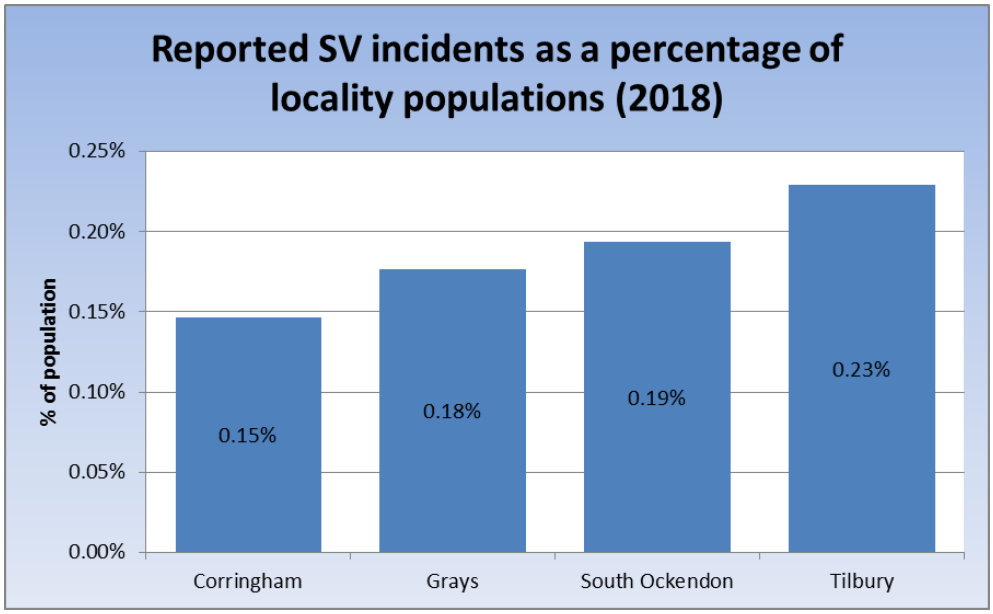
d) The victim and offender met elsewhere and the suspect has then taken them into Thurrock on the day of the offence. This may be to a dwelling, hotel or business premises.

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

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

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

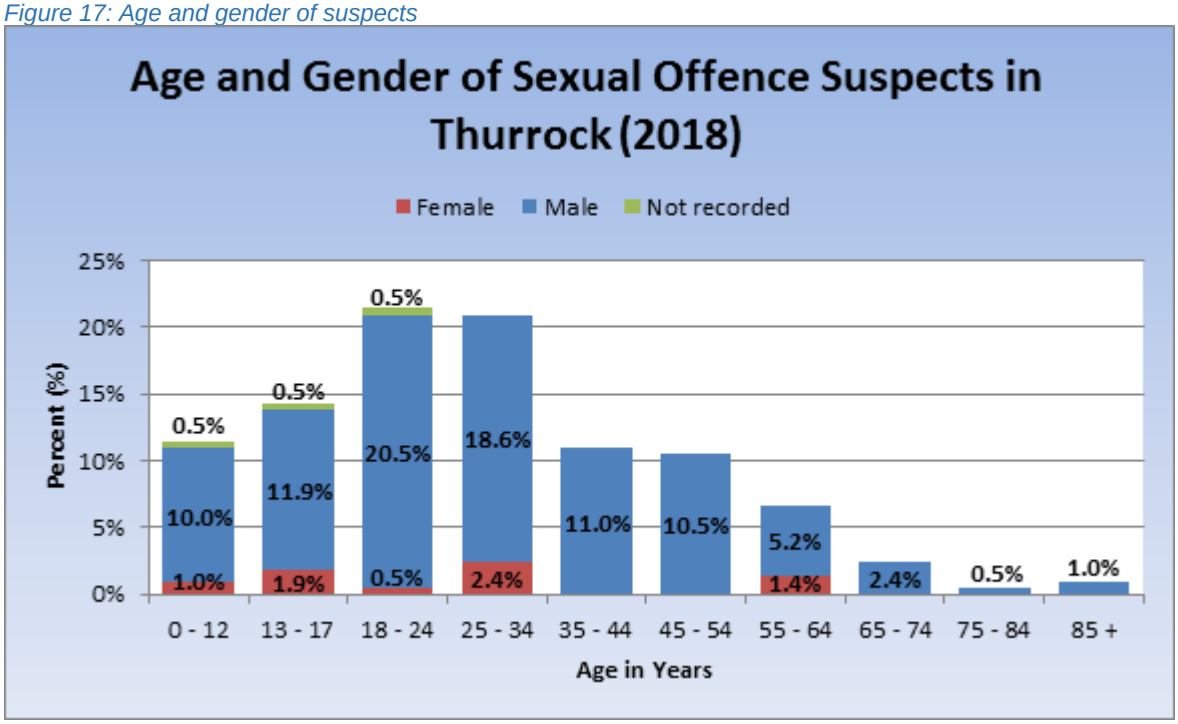
Figure 16: Locality of crimes



7.2.5 Suspects' Demographics

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

Figure 17: Age and gender of suspects



7.2.6 Repeat offences

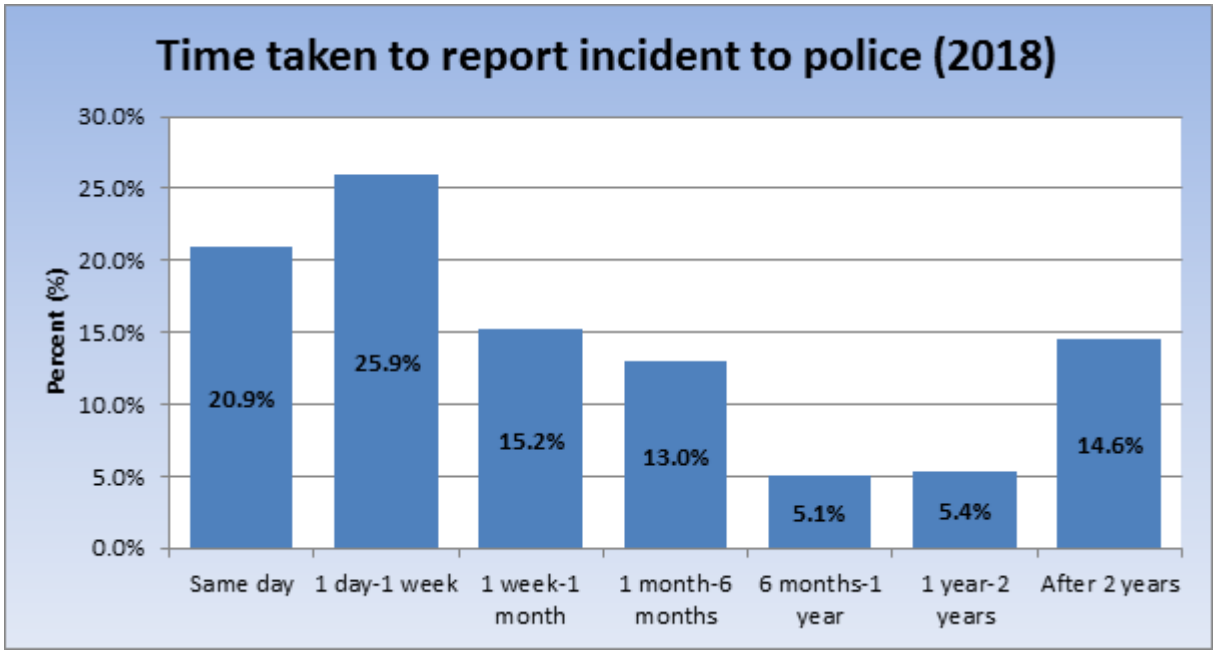
The majority (92%) of victims have reported a single incident whilst the remaining 8% have reported multiple incidents. Multiple offences may have been committed by the same or multiple different perpetrators.

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

7.2.7 Time taken to report/record

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

Figure 18: Time taken to report to the Police



7.2.8 Outcomes of police reported crime

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

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

Figure 19: Incident outcomes of SVA reported crimes

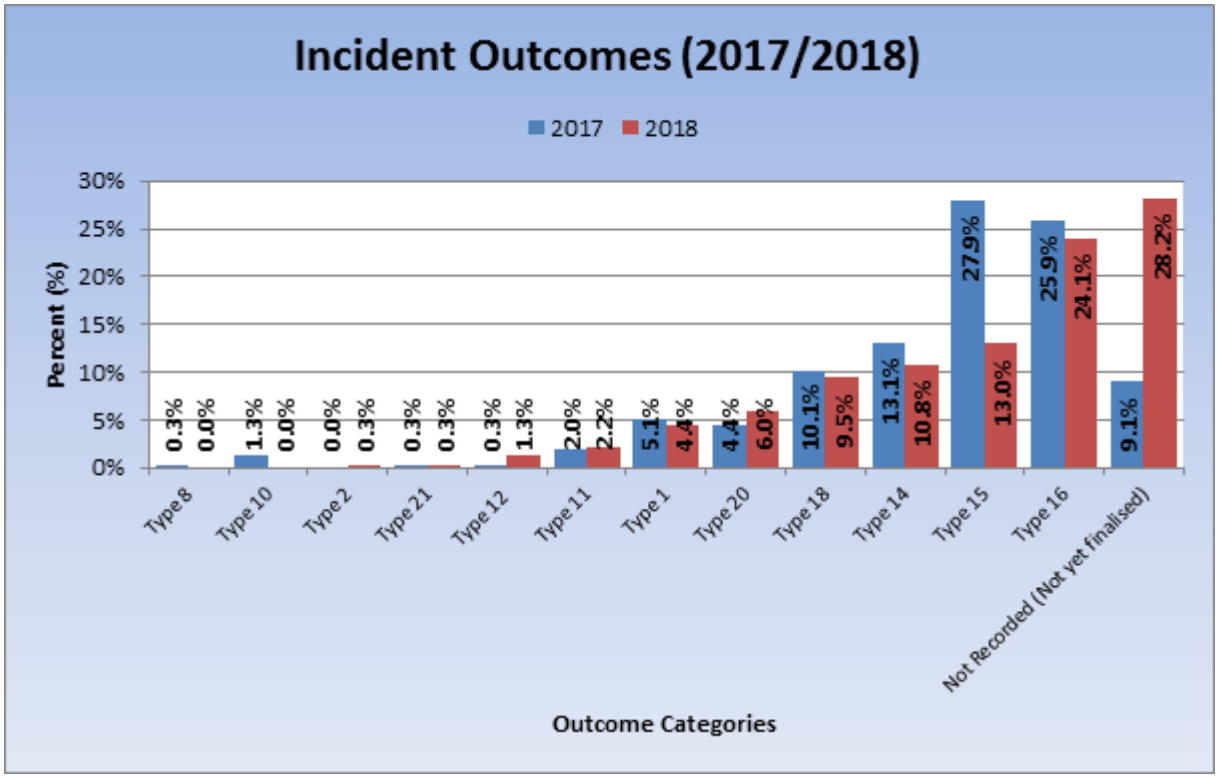


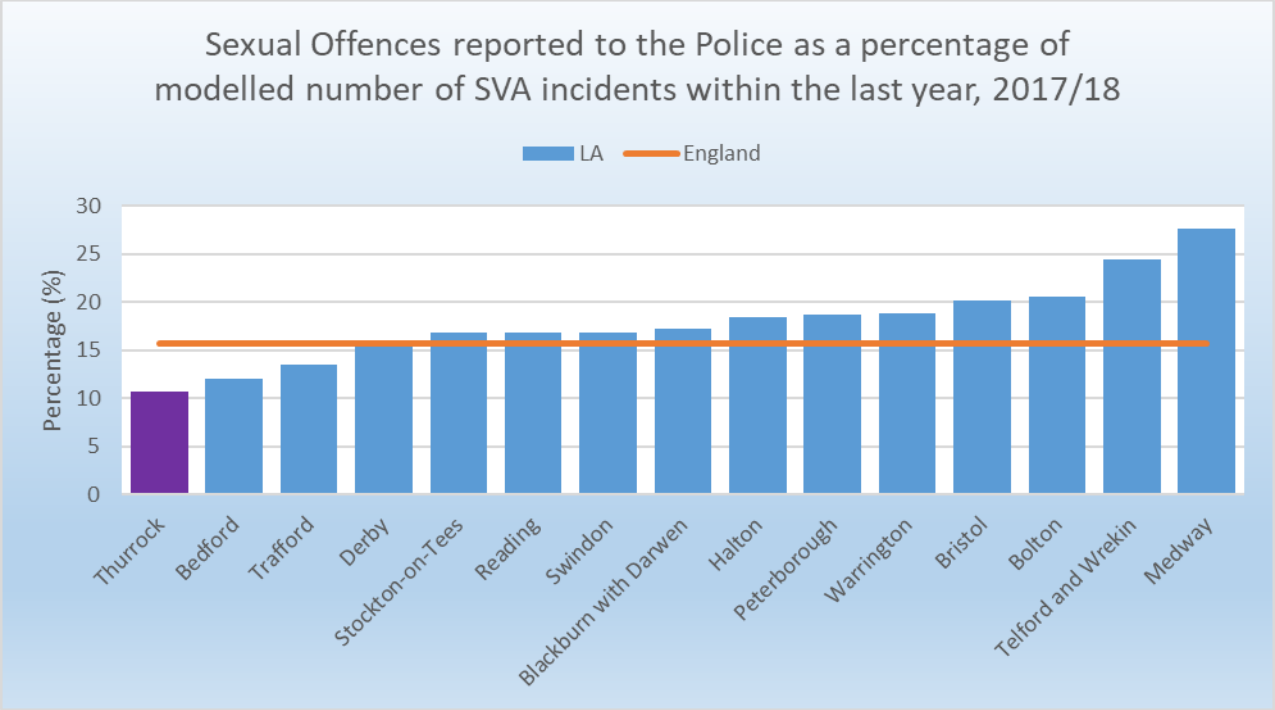
Figure 20: Definitions of outcome categories

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

7.3 Comparison to estimated number of survivors

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

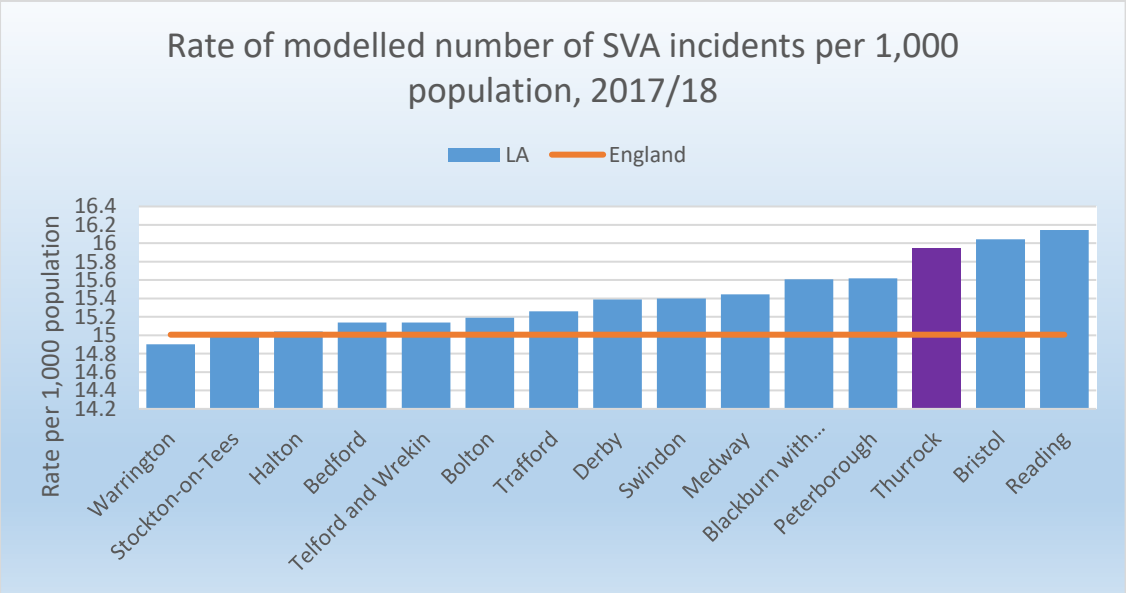
Figure 21: Sexual offences reported to the Police as a percentage of the modelled number of SVA incidents within the last year



Source: Home Office, Office for National Statistics and CSEW

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

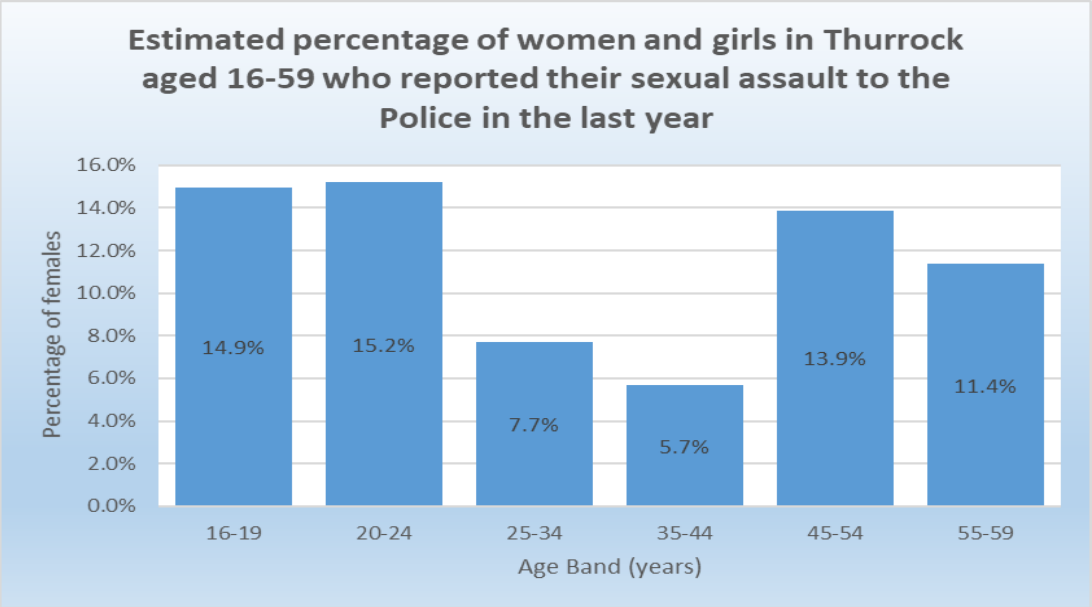
Figure 22: Rate of modelled number of SVA incidents



Source: Home Office, Office for National Statistics and CSEW

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

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



Source: VAWG Ready Reckoner and Essex Police data

7.3.1 Suspect Demographics

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

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

7.3.2 Time taken to report to the Police

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

7.3.3 Outcomes as a proportion of all estimated offences

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

7.4 User voice

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

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

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

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

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

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

7.6 Recommendations to address

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

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

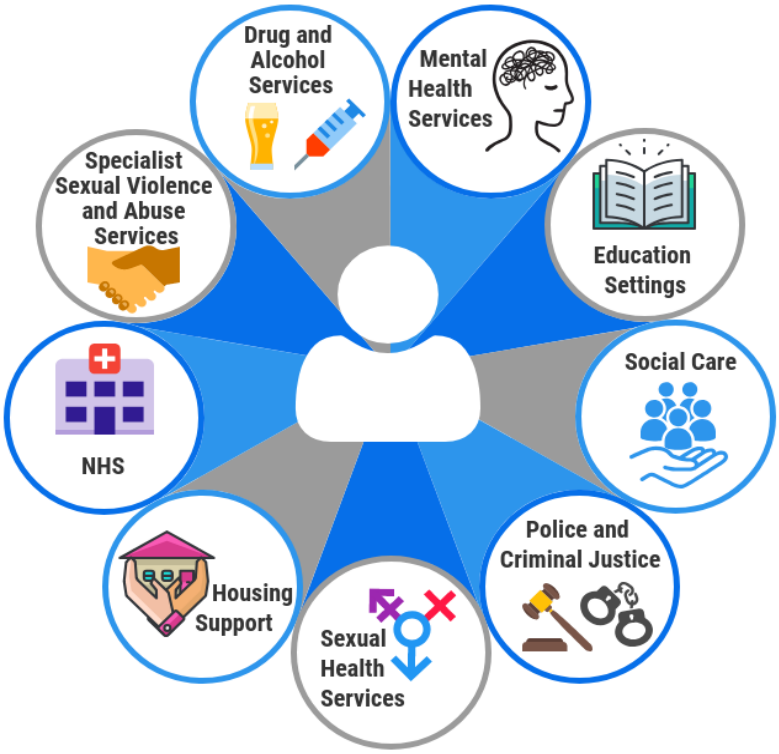
Chapter 8: Accessing Support

8.1 National evidence base

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

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

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



8.1.1 SARC Provision

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

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

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

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

8.1.2 Counselling and Advocacy services

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

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

8.1.3 Specialist SVA Counselling

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

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

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

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

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

8.1.4 Specialist Advocacy

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

8.1.5 Independent Sexual Violence Adviser (ISVA)

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

8.1.6 Pre-Trial Therapy Guidance

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

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

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

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

8.2 Description of local provider landscape

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

8.2.1 The Sexual Assault Referral Centre

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

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

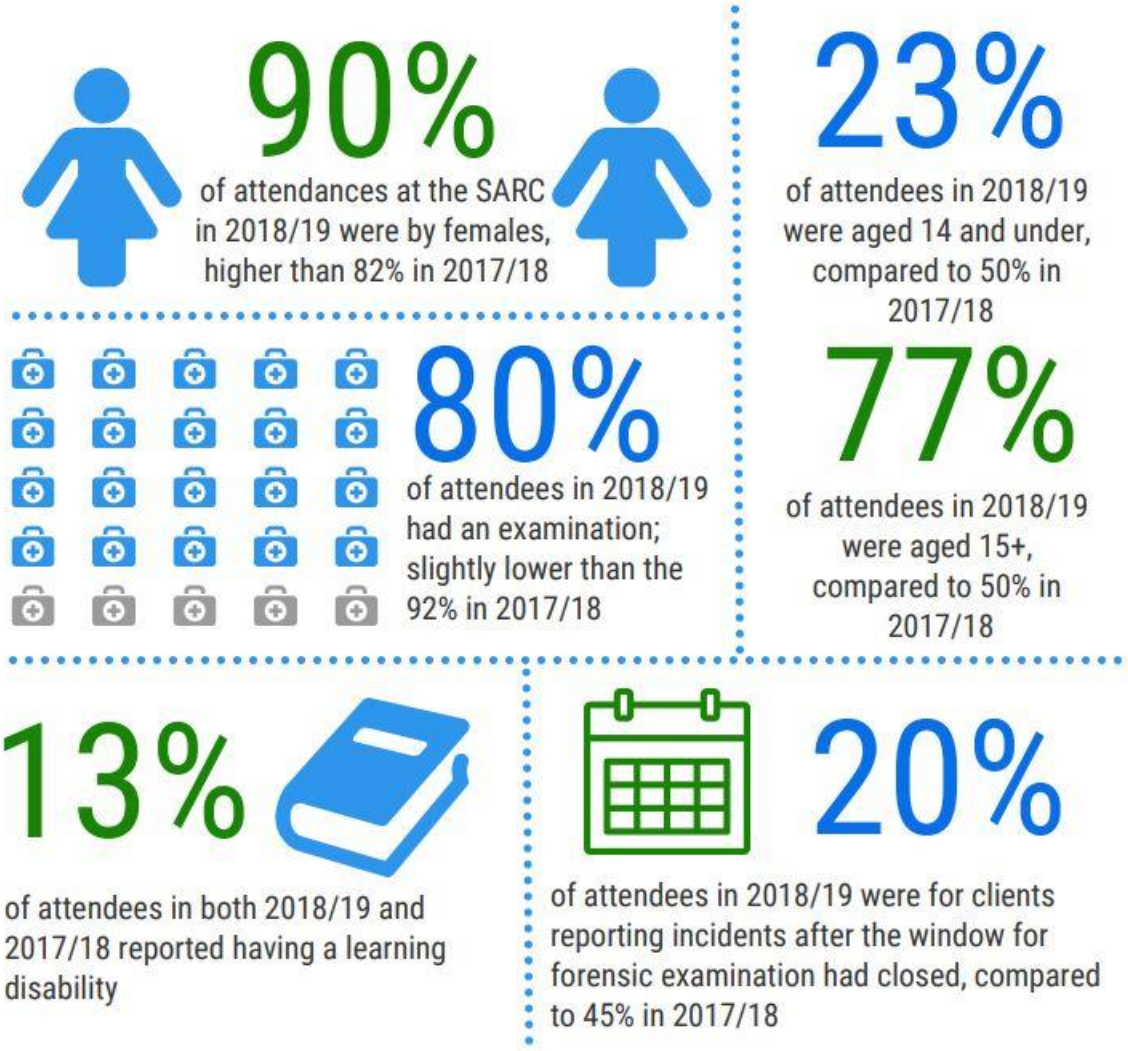
8.2.2 Attendances at the SARC by Thurrock Residents

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

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

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

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



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

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

Figure 26: Vulnerability factors of the SARC attendees

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

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

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

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

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

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

8.2.2 Specialist sexual violence and abuse counselling

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

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

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

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

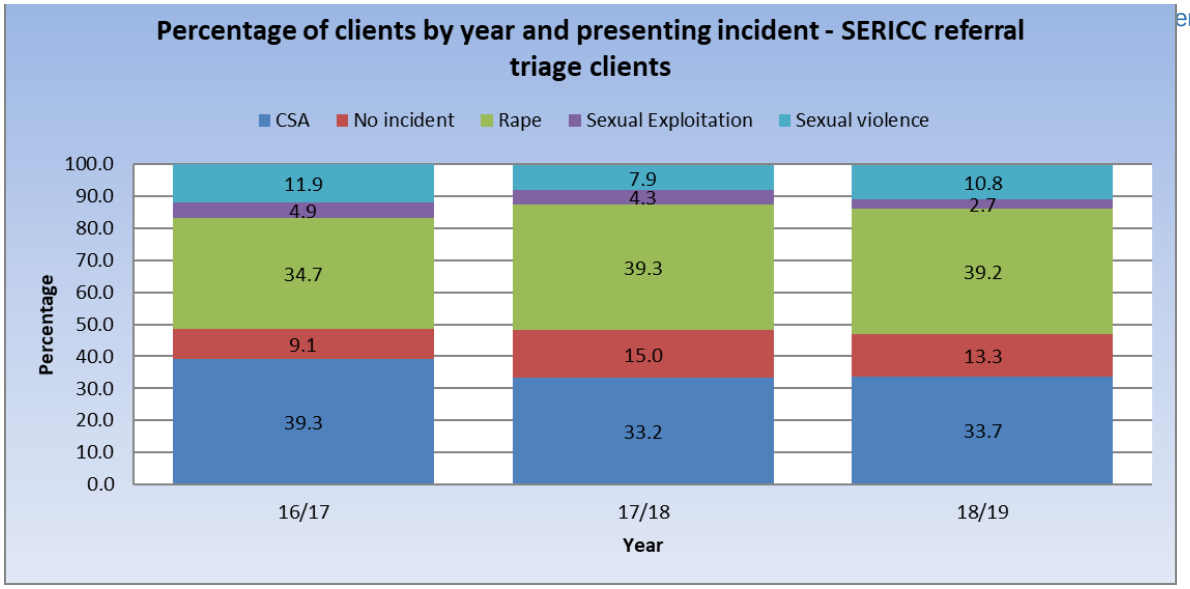
people, children, families and carers who are referred to the service. SERICC's specialist Sexual Violence Counsellors use a wide range of therapeutic approaches including; sensorimotor psychotherapy, resilience and empowerment models, mindfulness, person centred counselling, solution focussed, play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

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

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

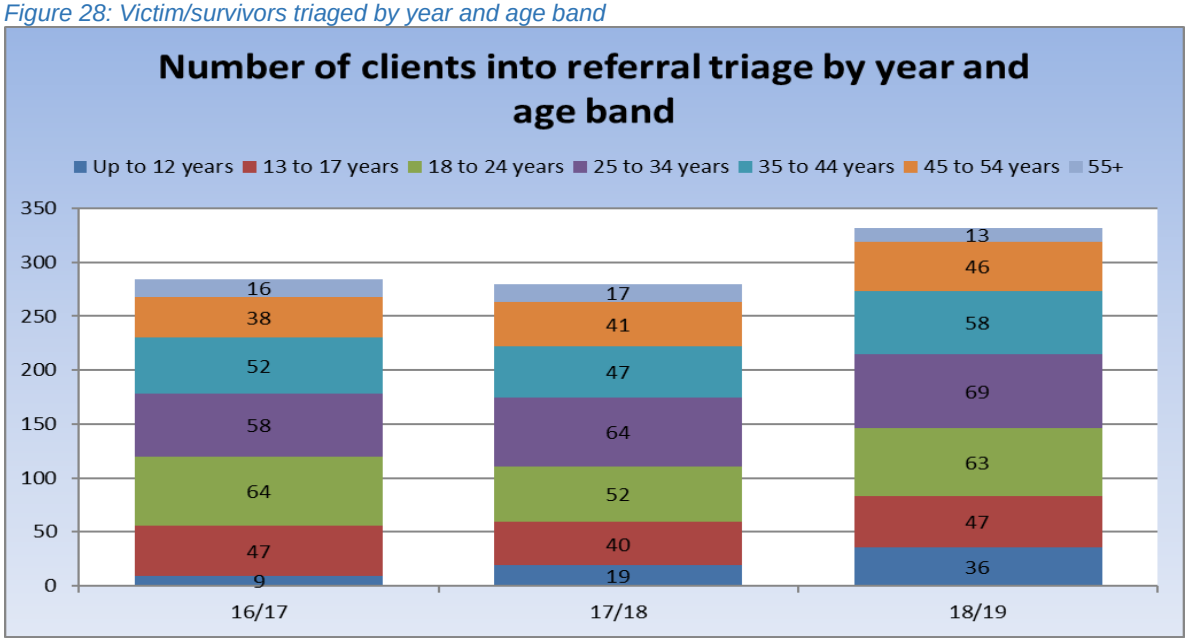
8.2.2.1 Referral Triage Activity

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



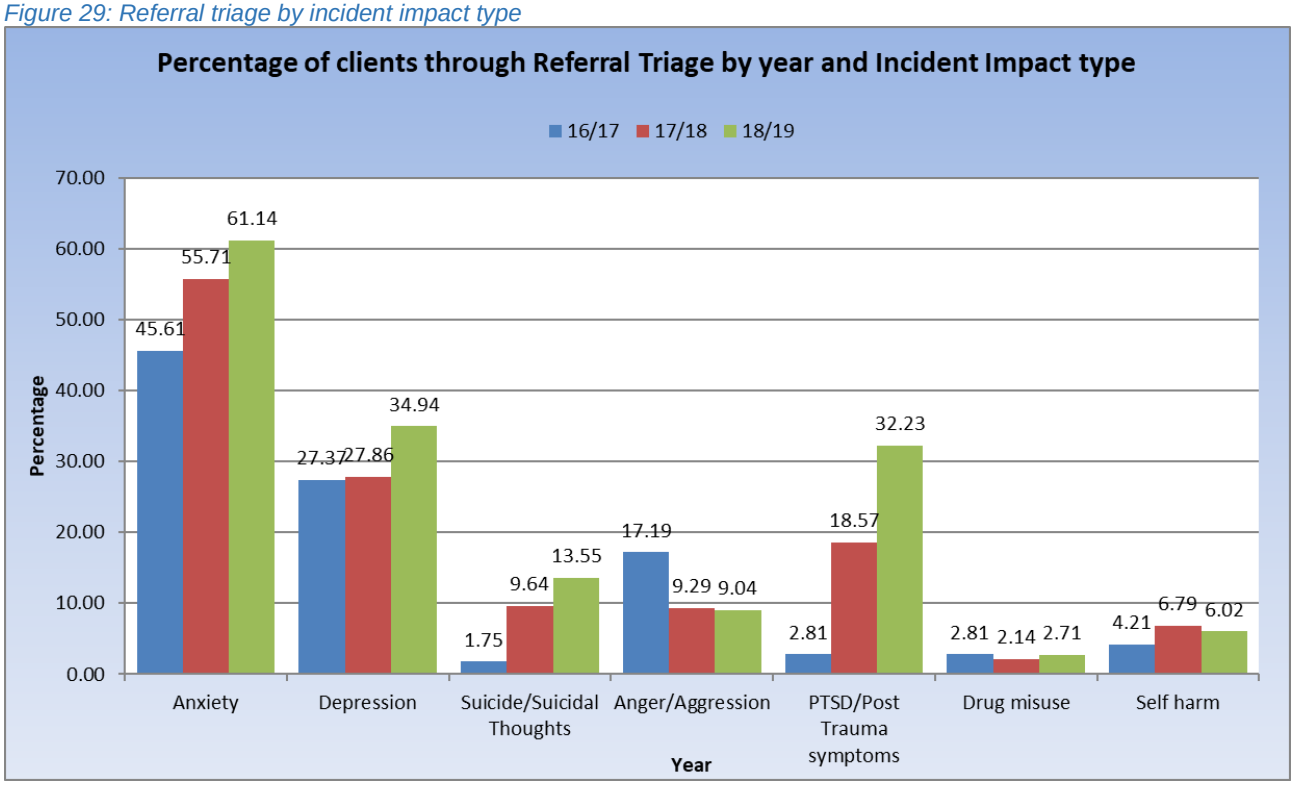
Of these victims/survivors, many were young, with 83 out of the 332 service users in 2018/19 under the age of 18 years. The number of under 12 year olds has increased year on year since 2016/17, as has the number of 45-54 year olds.

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



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

Figure 29: Referral triage by incident impact type



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

8.2.2.2 Usage of SERICC services

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

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

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

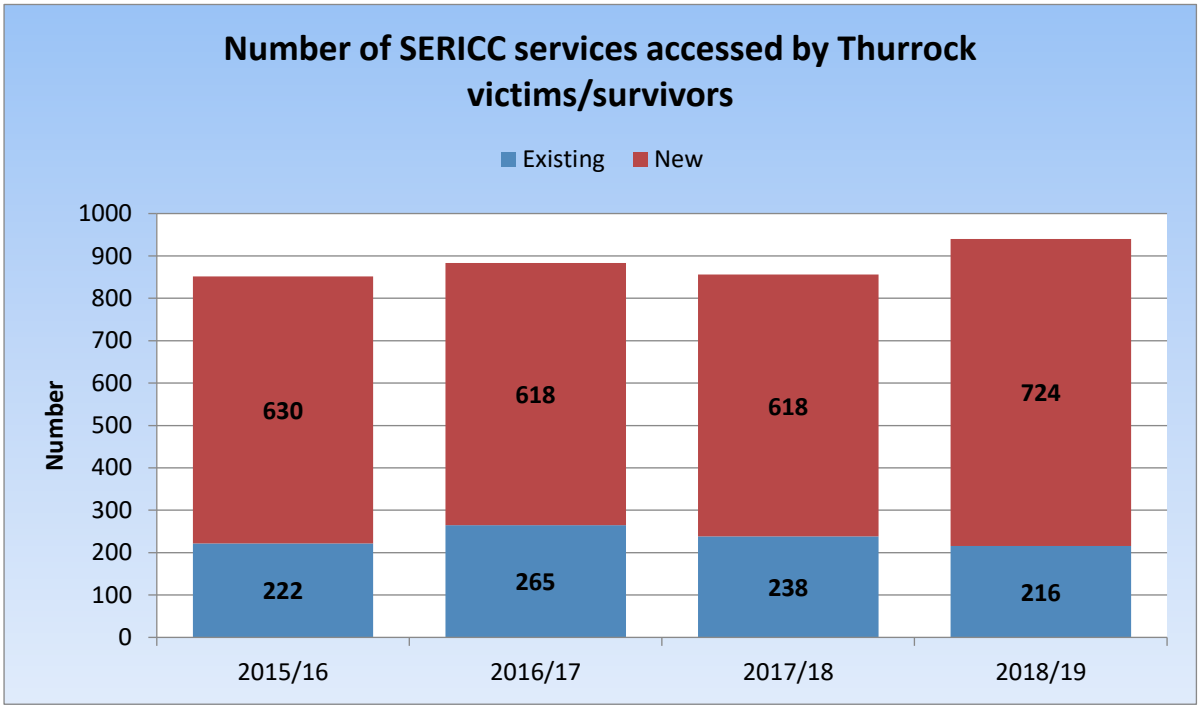


Figure 31 below shows the number of victims/survivors SERICC have supported over the last four financial years. It is to be noted that there has been a year on year increase in the number of victims/survivors accessing SERICC services, equivalent to a 20% increase over the last 4 years.

Figure 31: Total number of survivors accessing support from SERICC

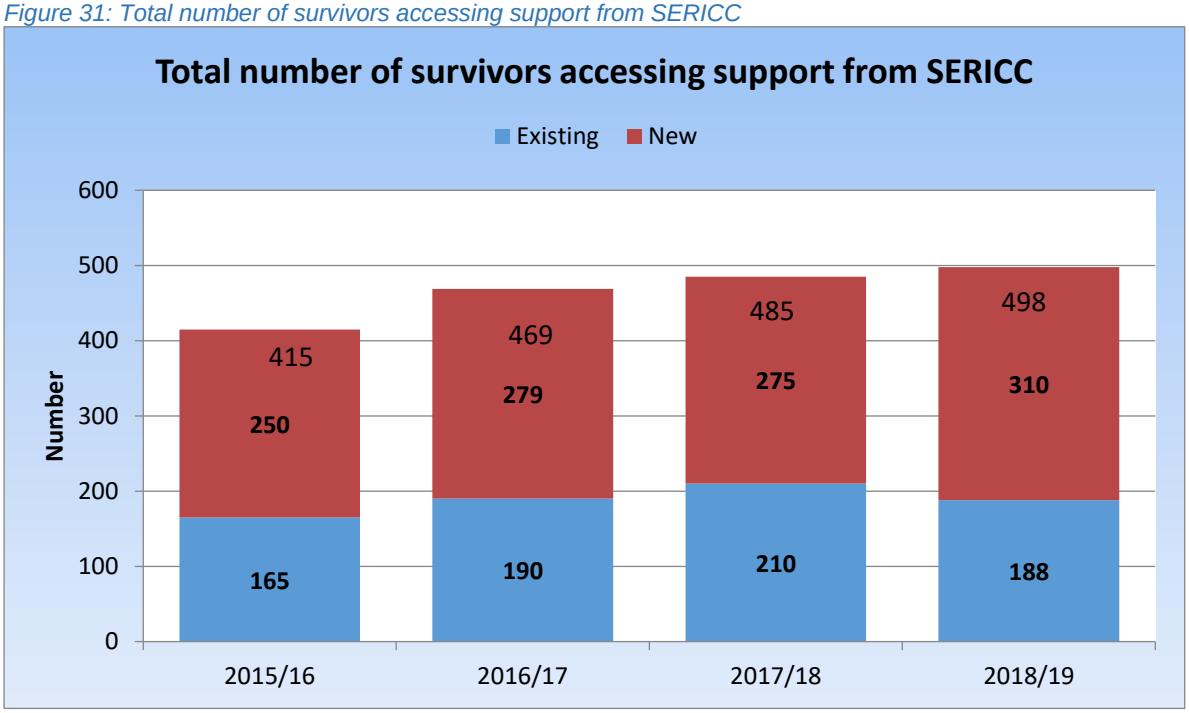


Figure 30 and Figure 31 show that the average service use per victim/survivor is different for new and existing victims/survivors for 2018/19. In 2018/19 there were 310 new survivors who accessed 724 services provided by SERICC, equating to an average of 2.33 services used per person. This was greater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

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

8.2.2.3 Waiting times for SERICC services

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

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

8.3 Non-specialist SVA specific services

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

8.3.1 General Practice

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

8.3.2 Hospital

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

8.3.3 Sexual Health Services

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

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

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

8.3.4 Domestic Violence and Abuse Services

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

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

8.3.5 Substance misuse services

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

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

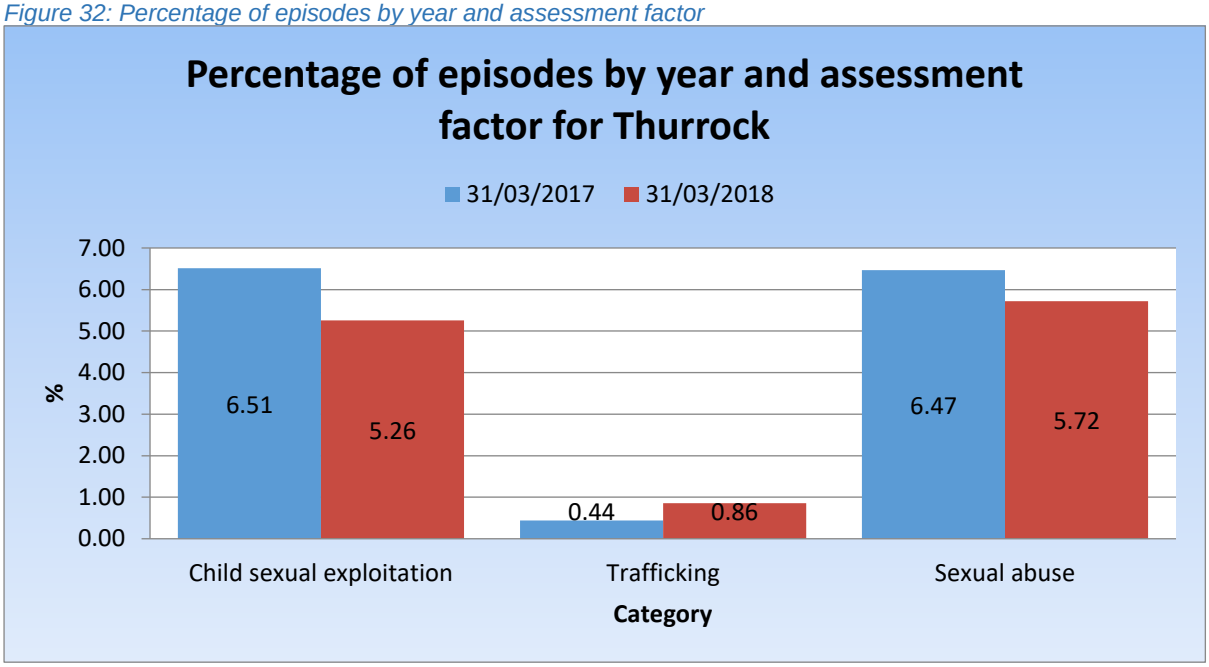
8.3.6 Children's Social Care Provision

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

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

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

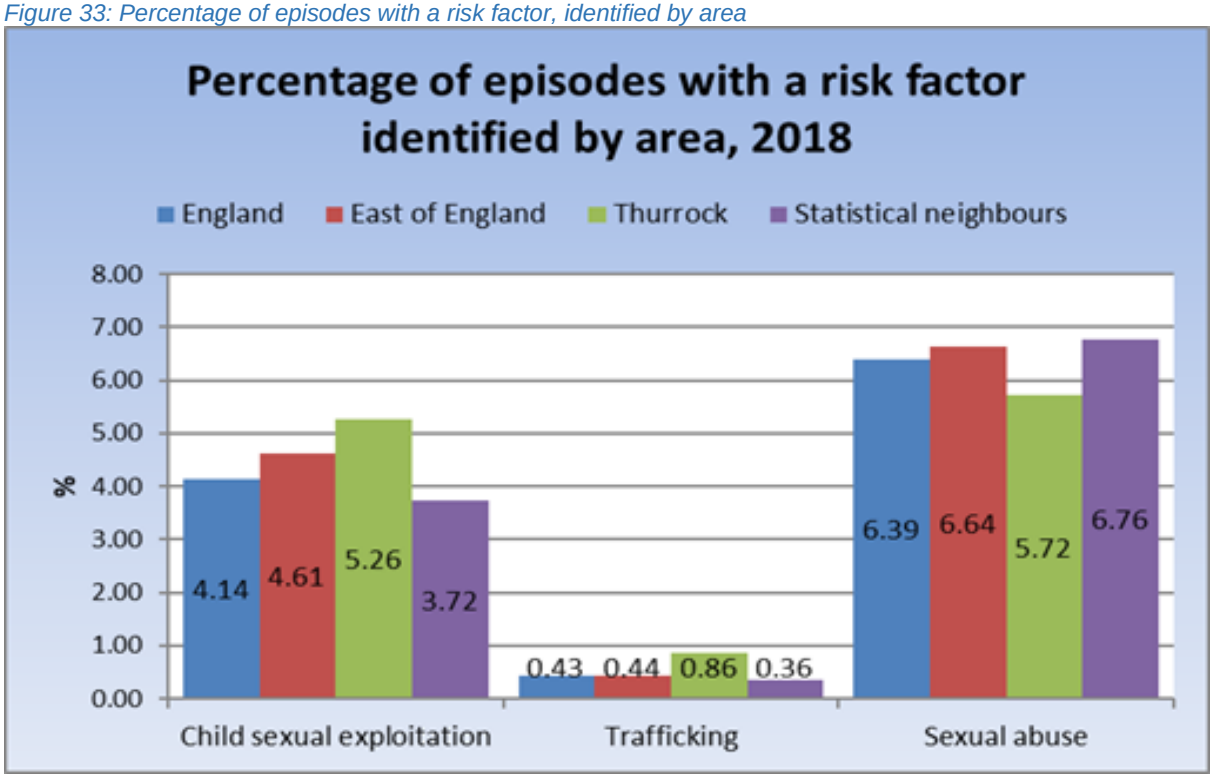
Figure 32: Percentage of episodes by year and assessment factor



Source: Children in Need and Child Protection Statistics, 2019

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

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



Source: Children in Need and Child Protection Statistics, 2019

8.4 Primary and Secondary Care Mental Health Services

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

Figure 34: Mental Health Provision for Adults

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

Improving Access to Psychological Therapies (IAPT)

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

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

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

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

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

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

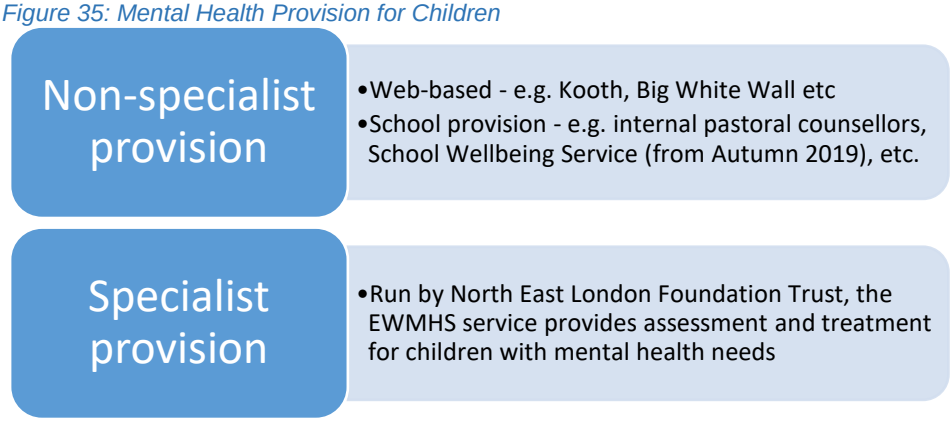
Inclusion Thurrock referred 19 patients to SERICC in 2017/18, all of whom required specialist support for issues relating to their sexual assault, but have not received any referrals directly from SERICC – although survivors might self-refer to Inclusion as that route is also available to them. Work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

Personality Disorder Service

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

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

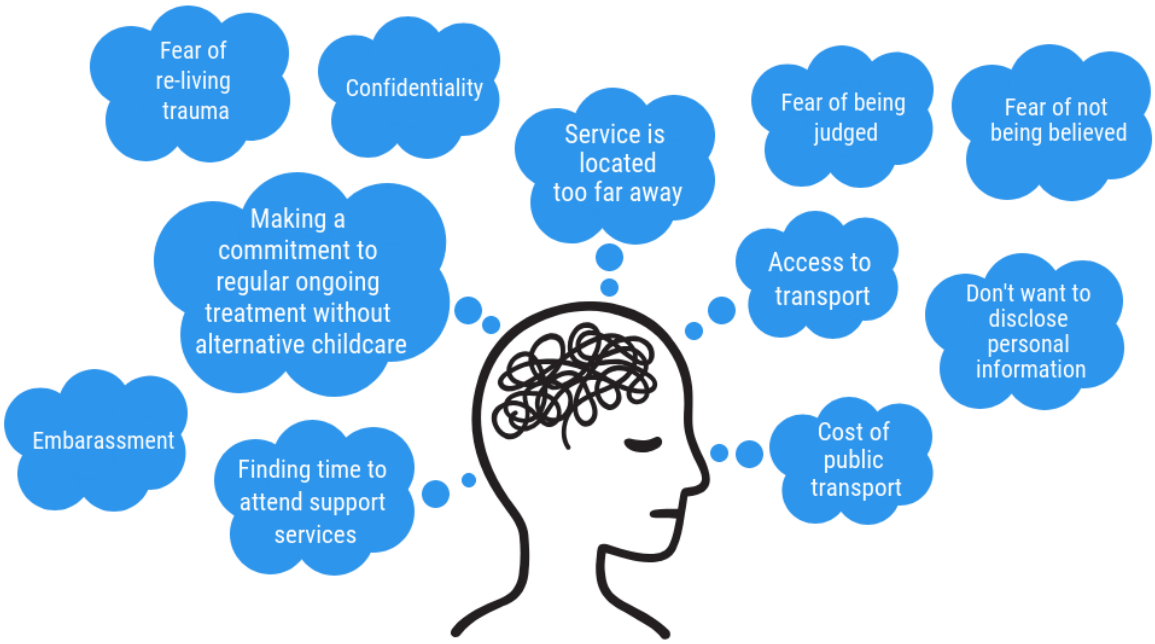
Figure 35: Mental Health Provision for Children



8.5 Barriers to accessing support

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

Figure 36: Why victims/survivors may not access support



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

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

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

8.6 Recommendations to address problems of access

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

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

Page 240

8.7 Issues on local provision

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

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

8.8 Victim/survivor voice on experience

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

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

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

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

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

8.9 Recommendations to address issues with existing overall service provision

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

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

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

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

9.1 Issues with current provider landscape

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

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

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

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

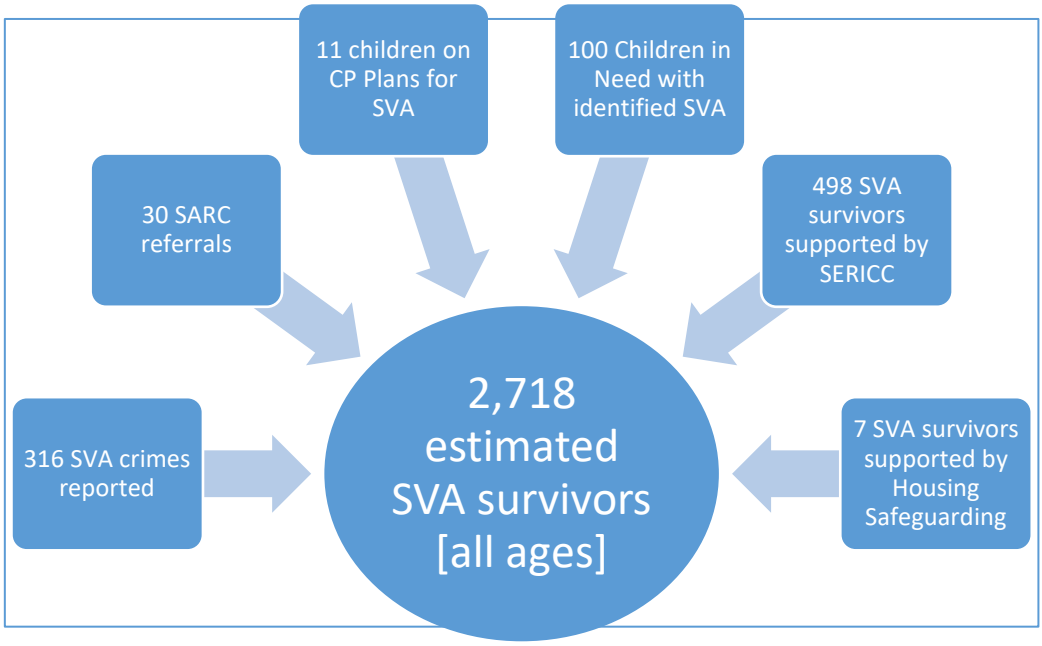
9.2 Quantifying the gap locally

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

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

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

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



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

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

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

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

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

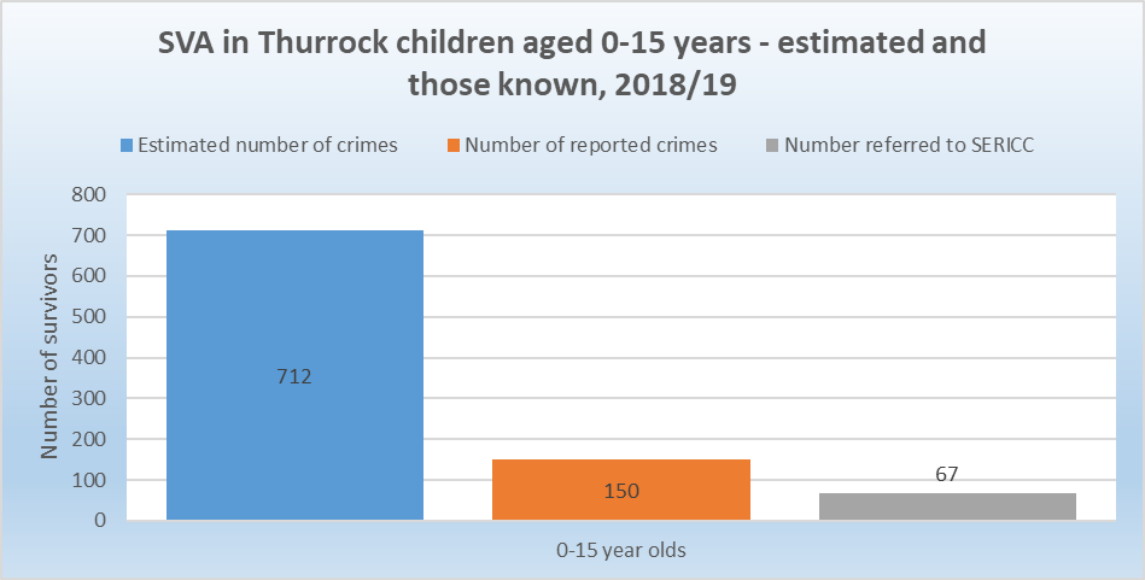
- 25% of the referrals triaged by SERICC in 2018/19 were for those aged 0-17 years – equating to 83 individuals.

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

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

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

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



Source: CSEW, Essex Police and SERICC data

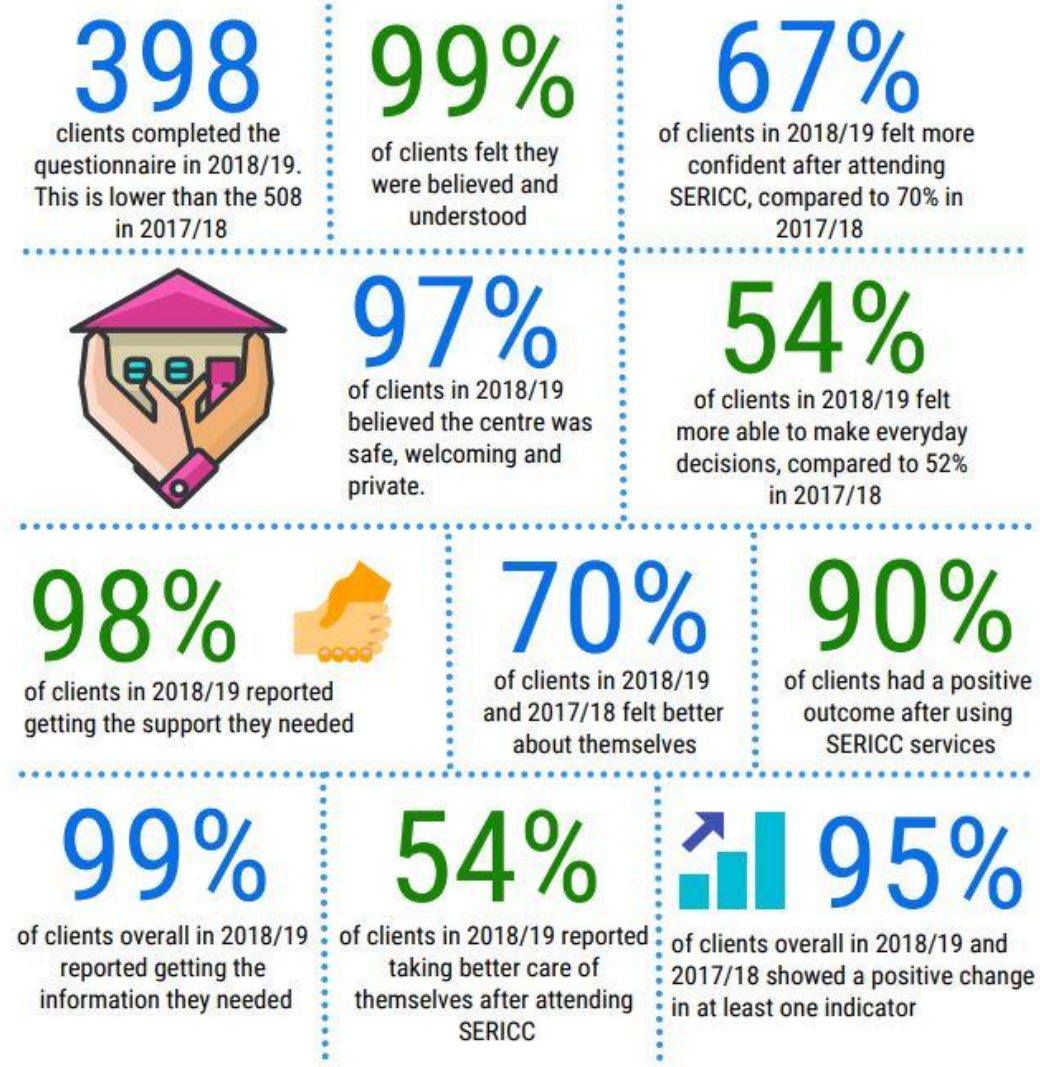
It is also to be noted, due to the low reporting rate of SVA offences to the Police, this data is not entirely representative of the type of sexual violence and abuse occurring in Thurrock. Considering the age groups of these young people, they *may* be more likely to be able to disclose and report their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

9.3 User voice

9.3.1 SERICC pre and post questionnaires

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

Figure 39: Findings from the SERICC before and after questionnaires



9.3.2 Findings from the engagement

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

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

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

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

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

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

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

9.4 Professionals views

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

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

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

9.5 Recommendations

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

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

Chapter 10: Local safeguarding and strategic focus

10.1 Local Safeguarding arrangements in Thurrock

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

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

10.2 Existing Networks and Strategic Groups

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

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

Regional groups include:

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

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

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

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

- Seek new ways of working together and promote best practice

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

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

10.3 Recommendations

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

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

Chapter 11: A vision for future service provision

11.1 High level vision and principles

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

This will only be achieved through the following:

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

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

11.2 Proposal of a new pathway of support

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

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

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

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

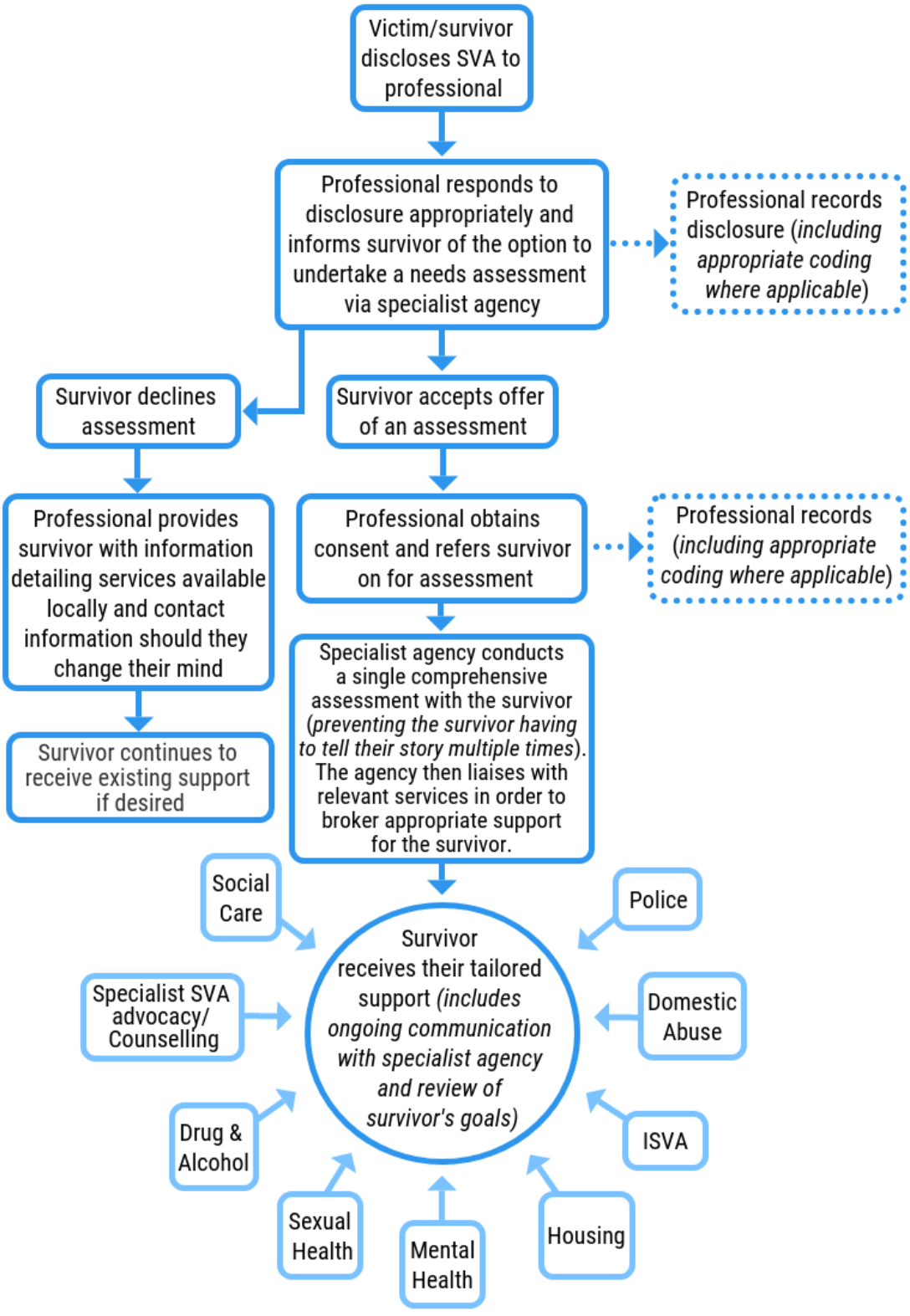
The specialist agency will maintain regular contact with the survivor whilst the survivor is accessing support from the other support services. This will enable the specialist agency to check the status of the referrals, monitor the survivor's compliance with accessing support and review the survivor's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

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

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

In theory, the assessment that a survivor undertakes should act as a survivor's '*passport*' in to services. An illustration of how this proposed pathway may look is included in Figure 40 below.

Figure 40: The proposed pathway of support



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

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

11.3 How the new model addresses issues identified

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

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

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

Appendices

See separate document.

SVA JSNA appendices.docx

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	ITEM: 7
Thurrock Health and Wellbeing Board	
Ofsted Inspection of Local Authority Children's Services (ILACS)	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Sheila Murphy	
Accountable Director: Roger Harris, Corporate Director of Adults, Health and Housing and Interim Director of Children's Services	
This report is Public	

Executive Summary

This report is to update Members of the Health and Wellbeing Board on Thurrock's outcome from the Ofsted ILACS inspection undertaken between 11th and 22nd November 2019.

1. Recommendation(s)

1.1 That the Members of the Board are informed about Thurrock's outcome from the Ofsted ILACS.

2. Introduction and Background

2.1 The ILACS inspections by Ofsted focus on the effectiveness of local authority children's services and arrangements in these four areas:

- Impact of Leaders on social work practice with children and families
- The experiences and progress of children who need help and protection
- The experiences and progress of children in care and care leavers
- Overall effectiveness

Thurrock's children's social care last Ofsted inspection was in February 2016, when children's social care was judged to be 'require's improvement'. We were notified of the ILAC inspection on the 4th November, which is the off-site week. During this week we uploaded over 200 documents, produced audit reports of case work and

the Lead Inspector conducted some telephone interviews. The onsite weeks began on the 11th November and completed on the 22 November. During that period of time there were up to six Ofsted inspectors in the service. The inspectors came and sat alongside social workers and reviewed their cases directly with them. The inspectors looked at many cases in their 2 weeks of onsite work.

At the end of the Inspection Ofsted rated services as:

- Impact of Leaders on social work practice with children and families; **GOOD**
- The experiences and progress of children who need help and protection: **GOOD**
- The experiences and progress of children in care and care leavers: **GOOD**
- Overall effectiveness: **GOOD**

Please see the attached Ofsted report in full, which was published on the 20th December 2019.

3. Issues, Options and Analysis of Options

3.1 Thurrock's Ofsted ILAC report is attached at appendix 1.

4. Reasons for Recommendation

4.1 Members of the Board are aware of the outcome of the ILAC inspection, including the areas for development.

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

5.1 None

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

6.1 None

7. Implications

7.1 **Financial**

Implications Verified by: **Michelle Hall**
Management Accountant

There are no financial Implications to this report.

7.2 Legal

Implications Verified by: **Lindsay Marks**
Principal Solicitor Children's safeguarding

There are no legal implications

7.3 Diversity and Equality

Implications Verified by: **Rebecca Price**
Community Development Officer

- None

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

- None

7.5. 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

8. Appendices to the report

- Appendix 1 – Ofsted ILACS Report 11 – 22 November 2019

Report Author:
Sheila Murphy
Assistant Director
Children's Social Care & Early Help

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Thurrock Council

Inspection of children's social care services

Inspection dates: 11 November 2019 to 22 November 2019

Lead inspector: Brenda McLaughlin
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Good
The experiences and progress of children who need help and protection	Good
The experiences and progress of children in care and care leavers	Good
Overall effectiveness	Good

Since the last inspection in 2016, when children's services were judged to require improvement, an experienced senior leadership team has driven a sustained pace of improvement in most areas. Services for vulnerable children and their families in Thurrock are now good. Although some developments are recent, strong child-centred practice is evident across all teams and services. Skilled and committed social workers and other frontline practitioners listen to children and their parents. They take time to understand children's experiences. Staff act swiftly to prevent harm and provide support early. Current senior leaders have worked diligently to develop and support a culture of continuous learning and improvement. Stability of leadership and strong aspirations to 'get it right' for vulnerable children are key factors in their success. Action to support exploited and missing children is beginning to make a difference, but changes need to embed further to ensure that risks to children are fully understood and addressed.

Children in care, adopted children and young people leaving care benefit from teams of highly committed, ambitious and determined professionals and carers, who work well together, helping them to remain safe and achieve well in life. The local authority is a highly ambitious corporate parent. There is a palpable sense that staff across all directorates want to do the right thing. Work to improve the timeliness of initial health assessments is critical and necessary, particularly for unaccompanied asylum-seeking children coming into care. Planned transitions for disabled children and care leavers need to happen earlier.

What needs to improve

- Planned transitions and closer collaboration with adult services needs to happen earlier for disabled young people and care leavers.
- Timeliness of initial health assessments when all children come into care.
- Alignment and effectiveness of systems that support children at risk of criminal and sexual exploitation and children missing from home and care, to ensure that children can tell their stories.

The experiences and progress of children who need help and protection: Good

1. Judicious, targeted investment in the newly reconfigured locality-based preventative and support service (PASS) as part of Thurrock's Brighter Futures strategy means that early help is carefully prioritised for the most vulnerable families. The pathway into PASS is clear: a 'team around the family' and well-being model takes a holistic, multi-agency perspective in addressing families' needs. As a result, children and families get the right level of help and protection at the right time, delivered by caring and skilled professionals, and this is making a difference to their day-to-day lives and protecting them from harm. Actions by managers to align performance monitoring, as well as audit programmes with children's social care, are positive developments.

2. Strong partnerships in the multi-agency safeguarding hub (MASH) serve to protect children from harm. Thresholds between early help and social care services are well understood. The co-location with children's social workers of many other professionals, such as an approved mental health professional and a specialist female genital mutilation worker, enables highly effective collaboration and timely information-sharing. Proportionate checks are undertaken, and consent is routinely sought, or appropriately overridden, to protect children. Rigorous management oversight of this work ensures that children's experiences are constantly central to timely decisions about the steps needed to help and protect them from harm.

3. Assessments using the local authority's revised model of practice are comprehensive and analytical, and are a vast improvement on those seen during the 2016 single inspection. They are thorough and updated regularly, and they clearly reflect the child's voice. Focused, purposeful direct work is planned well, is done at the child's pace, and ensures that most children understand what is happening. Staff work skilfully to understand parental and family histories and cultures, as well as the impact on parents of mental illness, domestic abuse, poverty and insecure housing. Exceptionally competent examples were seen of social workers sensitively evaluating the impact that these and other vulnerabilities have on parents, while keeping a clear focus on children's needs at the heart of their practice.

4. Appropriate action is taken to safeguard and protect children who are at immediate risk of significant harm. Strategy meetings are thorough, and most involve a good range of agencies. Interventions are proportionate to risk, and, when children and young people need to be safeguarded, actions are taken promptly to ensure that they are protected. For instance, managers took decisive action to protect children who had recently moved to Thurrock and where previous local authorities had failed to act.

5. Child protection conferences are timely. Multi-agency core groups are held regularly; most are used effectively to review and update child protection plans. However, the quality of child in need and child protection plans is not consistently good. A minority of these plans lack clarity about risks, desired outcomes or timescales. Managers are aware of this and have increased their audit activity, which is supporting improvement. Assiduous management reviews and close monitoring of children's cases where child protection plans have been in place for more than a year have resulted in the number of plans appropriately reducing from 253 in 2018 to 144 at the time of inspection.

6. Effective monthly permanence planning meetings and rigorous monitoring and tracking of cases under the pre-proceedings stage of the Public Law Outline are preventing drift and ensuring timely decisions about applications to family courts. Increased risks to children are escalated swiftly. Plainly written 'letters before proceedings' ensure that parents understand the local authority's concerns. Where necessary, care proceedings are initiated quickly to ensure that children are not subject to neglect and other damaging home conditions for too long.

7. Leaders and managers have facilitated a range of evidence-based improvements, making a discernible difference to helping vulnerable children and their families sustain change. For example, additional investment in solution-focused 'families first' child in need teams, and in 'families together' edge of care teams, is resulting in persistent relationship-based work that is making a positive difference, enabling very vulnerable young people to remain living securely with their families. This effective and authoritative practice, while recent, adds value and leads to better experiences for

children. A culture of listening to children, understanding their world and acting on their views is increasingly embedded in practice across all teams in Thurrock.

8. Senior leaders have recognised the need to strengthen the operational coordination of information and alignment of systems to monitor and assess the impact of work with vulnerable adolescents and children at risk of exploitation. Having commissioned an external review in August 2019, they have put an appropriate action plan in place to drive improvement. While information on missing children is circulated daily to managers, leaders accept that the response to children who go missing or who are at risk of criminal or sexual exploitation is not yet strong enough for all children. Return home interviews do not take place routinely. Therefore, some children do not have the opportunity to tell their story. However, social workers know children well and work tirelessly to help and protect them from harm. Safety planning for a small number of children needs to be sharper. This was an area for improvement in the 2016 inspection.

9. Effective strategic relationships with multi-agency partners have resulted in the successful disruption of known perpetrators who criminally exploit or traffic children and vulnerable adults. Gang injunctions have been issued and gang members have been constrained, imprisoned, or moved out of Thurrock. Online abuse is taken very seriously. Young people across schools and colleges have responded positively to the reintroduction of 'Walk Online' roadshows, a programme which covers broader safeguarding issues, including online exploitation, knives and offensive weapons, and the impact of gangs. The dangers of radicalisation are understood well by the local authority and partner agencies. The Prevent referral pathway is clear, simple and easy to use. A heightened level of awareness, particularly on the part of schools and colleges, is helping to protect children and young people.

10. Effective arrangements for identifying and responding to children and young people who are privately fostered helps protect them and ensure they are appropriately cared for. Private foster carers have the same access to training and support as other foster carers. Privately fostered children are seen regularly and are seen alone. Young people who present as homeless have their needs carefully considered and are very well supported to return home or to move to alternative provision.

11. The operational response to allegations made against adults who are working with children in a position of trust is rigorous. More work is needed to improve awareness-raising with partner agencies. Children and their families benefit from prompt, proportionate and effective help and protection out of hours. Communication with daytime services is good.

12. Until recently, disabled children and their families did not consistently get the right level of help and support from children's social care. Action by senior

leaders has strengthened management oversight for these children. Risks and safeguarding concerns are recognised, and children's cases are stepped up appropriately when needs change and a more intensive social work response is required. Assessments are updated routinely. Skilled social workers understand children's unique needs and find ways to communicate with them to ensure that services are attuned to their specific wishes. Work with adult services and other professionals to support young people into independence does not happen early enough. Further work is required to ensure that plans are of a reliably high standard.

13. Children who are electively home educated and those missing from school benefit from effective management oversight and interventions. Leaders quickly act where there are safeguarding issues.

The experiences and progress of children in care and care leavers: Good

14. Most children come into care either on a planned or voluntary basis or through the application of a court order when efforts to protect them at home have been unsuccessful. Children of all ages are safeguarded, and care orders for older adolescents are sought when appropriate. Children and young people benefit from help and support provided by dedicated, ambitious and determined professionals who work well together, helping children to remain safe and achieve well in life. Permanence planning for children in care is tightly managed and is effective in ensuring stability and avoiding drift. When children need alternative long-term care outside their families, joint plans are tailored carefully to their individual needs. Decision-making is timely, and prompt action is taken to ensure that children have good-quality stable homes together with their brothers and sisters.

15. Social workers know children well. While some children have experienced too many changes in staff, most children are able to build trusting relationships with new workers and their foster carers. Social workers visit regularly, and they spend time encouraging children to talk about their concerns or worries. For instance, when children are reluctant to engage with other professionals, social workers learn the relevant skills and work through the issues with the child. Respectful, tenacious work by staff who really care about helping children is helping them to recover from the trauma they have suffered.

16. Independent reviewing officers (IROs) work diligently with social workers and carers to support children to express their views. They visit children, listen carefully to what children would like to happen, and take swift action to make changes. Most review minutes are easy to read and understand. IROs are a valuable source of continuity in children's lives. They rigorously review children's care plans and provide effective critical challenge. Case recording is clear and up to date, and the voice of the child is consistently evidenced. Inspectors saw many examples of creative and sensitive work helping children

to come to understand why they cannot live with their parents or extended families.

17. Children are settled in their placements, including those who are living outside the local authority area. They are well supported by carers and other professionals and most are doing well. Children and their carers socialise and spend time doing fun things together. Faced with a long waiting time for access to child and adolescent mental health services, the local authority proactively commissions emotional help and support services. Responding quickly in this way to assist children and their carers is increasing emotional resilience. This is enabling children, particularly adolescents with complex needs, to remain settled in the same placements. Increasing numbers of young people remain living with their foster families after 18.

18. Social workers regularly update their assessments for children in care, ensuring that they are child-centred, comprehensive and analytical. Bespoke intensive support provided by the families together team enables children to return home safely to their birth families. Advocates are used effectively when children need them. Staff listen to and act on children's views and aspirations. They arrange family contact sensitively and support it well, respectfully taking account of parents' wishes. For example, when parents are in prison, staff visit and seek their advice about how they should communicate this to their children. Children regularly access a wide range of activities, such as brownies, rugby or gymnastics. Apps are being used well to help children express themselves, and there is evidence of creative and imaginative direct work, including work, in some cases, to help children understand and make sense of their life stories.

19. Routine, sensitive planning for children to enable them to live with family members is a real strength in Thurrock. Staff complete initial viability and risk assessments promptly, helping to reduce disruption and allowing children to remain within family settings with people whom they know and trust. They use connected care arrangements well to provide children with safe and effective care while parenting assessments are ongoing. Most connected carers are well supported to care for children, and a number have decided to make applications for special guardianship orders. The local authority guarantees that special guardians and children will receive support that is equivalent to that given to other care givers.

20. A significant increase in the number of unaccompanied asylum-seeking children entering care and a relatively high percentage of older children in care present specific challenges. Many of these young people have suffered neglect and trauma, some are estranged from their families and others have been known to agencies for many years. Frontline staff skilfully build relationships with these children. They work in collaboration with partner agencies to ensure that they can access personalised help and support. However, delays in completing initial health assessments are a critical issue

for this group. Although leaders are working with health colleagues to resolve the delay, the pace of change is too slow.

21. The court team is emerging from a very difficult period, during which high levels of staff turnover have had a negative impact on the quality and timeliness of applications in the family courts. Currently, good-quality parenting and connected carers assessments contribute to effective and timely permanence plans for children who are unable to live with their parents. Anonymously profiling children whose plan is for adoption before placement orders are made has proved to be highly effective in ensuring that prospective adoptive families are identified early and quickly matched with them.

22. Children and carers benefit hugely from highly experienced and dynamic social workers and senior managers in Thurrock's fostering and adoption services. Staff take great pride in their work. Foster carers and adopters are positive about the support they receive. Excellent therapeutic support is available for foster carers and adopters. Trauma-based learning is integral to the authority's extensive fostering and adoption training programmes.

23. Since moving its adoption service back in-house in 2018, the local authority has widened the adoption options available for all children who need them, not just babies and toddlers. A creative, far-reaching recruitment strategy is increasing the range of placements available to meet children's diverse needs. The assessment process is well organised and responsive. Senior managers listen to and regularly consult with foster carers. Foster carers use their expertise to influence the organisation in a positive way. Their input during training and recruitment events, initial visits and mentoring of new carers is invaluable. Extensive investment in life-story work is greatly appreciated by adopters and birth families. This work is being extended to children living with special guardians and foster carers.

24. All children in care have an up-to-date personal educational plan (PEP). This is a useful tool to ensure that the right support is provided to meet children's education needs. The virtual school is very effective in supporting the achievement of children in care, getting them the help and support they need to do well. Staff quality assure the personal education plans that schools use to support and monitor pupils' academic and social progress. Outcomes at the end of key stage 2 are strong. At key stage 4, they are improving year-on-year. Staff encourage children and young people to participate in their PEP meetings. They acknowledge their views and respond to them quickly.

25. The proportion of care leavers in education, employment or training over the age of 19 is high. However, for those aged 17 and 18, it is lower than it should be. Leaders recognise this and have recently moved responsibility for these pupils back to the virtual school. It is too early to see the impact of this change.

26. The transition from child in care to care leaver is not as seamless as it needs to be. The quality and effectiveness of early pathway planning is variable. Some young people don't have an up-to-date pathway plan. Others, who are clearly vulnerable, do not have a current risk assessment. Although personal advisers (PAs) attend 16-year-old children in care reviews, there is little evidence of meaningful involvement from the after-care team until young people are approaching their eighteenth birthdays. Capacity has been an issue. The local authority has employed four additional PAs and a senior practitioner to address this gap, but it is too soon to evaluate the impact.

27. Care leavers spoke positively and with genuine warmth about PAs who help them realise their ambitions. They have access to employment, training and apprenticeships delivered by enthusiastic staff via the inspire hub. At the time of inspection, 26 young people were attending university. Care leavers who originally arrived in this country as asylum-seekers benefit from the support they receive from a PA whose personal experience of the asylum-seeking process gives him a unique insight into the trauma, challenges and practical obstacles that young people face. Extensive corporate investments mean that all care leavers have access to customised high-quality accommodation up to the age of 25 years. There are no children under 16 in unregulated provision. PAs visit young people who are in custody regularly and they support them well when they are released from prison.

The impact of leaders on social work practice with children and families: Good

28. Effective and stable senior leadership has led to considerable improvement in the quality and impact of social work practice for children in need of help and protection, those in care and care leavers since the Ofsted 2016 single inspection. Although some improvements are recent, services are now good, with many examples of exceptional child- and family-centred practice. Good governance arrangements are firmly in place, ensuring that the senior leadership team and elected members communicate regularly and effectively.

29. The assistant director and the recently retired director of children's services (DCS) in children's social care have shown remarkably strong leadership, addressing considerable deficits in practice reported at the last inspection. Together with the unstinting support of the current interim DCS, the chief executive officer, elected members and strategic leads, they have created a culture of high expectation, support and challenge. Listening to children and acting on their views are practices that are becoming strongly embedded in practice.

30. Leaders know their communities well. They have focused on co-designing services based on what local people need. Senior leaders promote a strong ethos of participation and advocacy. They ensure that children's and

professionals' views are at the centre of their work. Strategic and corporate arrangements are congruent with this vision, providing a clear understanding and shared approach to prioritising and meeting children's needs. The senior leadership team and elected members demonstrate a collective determination to provide high-quality services that improve outcomes for vulnerable children. They are connected to frontline practice and have a good knowledge of individual children. A palpable sense about wanting to do the right thing fosters an open learning culture, and allows leaders to engage readily in internal and external reviews and challenge. For example, a review of the poor adoption performance resulted in them bringing the service back in-house.

31. Successful workforce planning and staff development in Thurrock have increased the number of frontline practitioners supporting children. This has increased capacity to sustain a good-quality service and is a substantial improvement since the last inspection. Leaders have tackled staff competence issues and have helped practitioners and managers who were resistant to raised standards to develop the requisite skills or to move on. While this has meant that some children have experienced changes of social worker, the quality of practice is stronger as a result, and recent action by managers is improving staff stability. Newly qualified social workers receive exceptional support. A strong emphasis on developing and nurturing all staff encourages more to remain in the local authority. A diverse workforce of practitioners and managers who reflect the local community is a real strength, leading to better engagement by young people and their parents.

32. The local authority takes its responsibility as a corporate parent for children in care very seriously. All directors across the council have had corporate parenting training. Work to improve support to the children in care council is positive. Elected members are ambitious for children and young people in their care and have ensured that their vision for outstanding quality services is underpinned by appropriate financial resources. This provides a sound basis for good service planning and provision. Active engagement with local and international businesses based is Thurrock is successfully securing apprenticeships and jobs for children in care when they leave school.

33. Performance management is well established and is a priority. Monthly development boards which are chaired by the DCS undertake regular analysis of data and monitor progress against priorities. The lead member also provides detailed scrutiny. Managers use weekly performance and audit information effectively in most service areas. Some of the developments are recent, and the changes, while showing positive and continuous improvement, need to embed further. There is no complacency. Instead, a strong culture of continuous learning, professional accountability and responsibility enables staff to flourish in a safe but challenging environment.

34. Staff consistently feel well supported in their work and their professional development by highly visible, approachable and involved managers at every level. Senior leaders take the time and trouble to nurture talent. There is a tangible culture of professional accountability and respectful challenge devoid of blame across teams. Morale is good. Supervision is frequent and mostly effective.

35. Social workers and managers are fittingly proud of the work they are doing in Thurrock. They know their children and families very well and speak with passion and enthusiasm about the often exemplary work they undertake with them. They work in an environment where caseloads are manageable and where leaders support them to do their jobs effectively.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

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31 January 2020	ITEM: 8
Health & Wellbeing Board	
Mid and South Essex STP Mental Health Costed Delivery Plan	
Wards and communities affected: All	**Key Decision:** Not Applicable
Report of: Mark Tebbs, MSE STP Director of Adult Mental Health Commissioning Nigel Leonard, EPUT Executive Director of Strategy and Transformation McKinsey Consultancy	
Accountable Head of Service: Mandy Ansell, Accountable Officer, Thurrock Clinical Commissioning Group	
Accountable Director:	
This report is Public	

Executive Summary

The purpose of this report is to engage with a wide range of stakeholders across the system regarding the proposed direction of travel for mental health across the Mid and South Essex STP. The proposed transformation will see changing roles across the whole system. Success will be dependent on all parts of the system changing together. It is therefore important that we have a common understanding of our starting position as well as a common vision for the future.

1. Recommendations

1.1 The Costed Delivery Plan (CDP) makes 5 key recommendations. The HWB are asked to support;

1.2 Further development of community-based and primary-care based provision, structured around the emerging PCNs and with significant investment in resources, infrastructure and change management for primary care-based teams, and providing required medical or other support to the PCNs;

1.3 Delivering NICE-compliant specialist community mental health services for people with eating disorders, complex PD, Early Intervention in Psychosis (EIP) or other needs;

1.4 Strengthening existing plans on robust community-based crisis response, personality disorders and dementia services;

1.5 Removing less complex activity from secondary care services, enabling secondary care services to provide higher quality and quantity therapeutic interventions for people who need it the most.

1.6 Developing a strategic approach to estates, workforce, digital and coproduction as key enablers to the delivery of the plan.

2. Introduction and Background

2.1 The Southend, Essex and Thurrock Mental Health Strategy sets out a clear vision for the future towards rebalancing the system in favour of prevention, early intervention, resilience and recovery. However, the system lacked a detailed planning document which described how to achieve the vision, how much it would cost and the starting position for this journey.

2.2 At the same time, the NHS Long term Plan commits us to significantly increase investment in areas such as integrated primary and community care, psychiatric liaison, community crisis care, specialist perinatal services, Improving Access to Psychological Therapies (IAPT), Early Intervention in Psychosis and Individual Placement and support (IPS).

2.3 As a system, partners agreed that it was important that we understand our baseline position so we can agree our starting point and measure improvements going forward. It is important that we address the issues and challenges within our local system as well as deliver on the national targets. It is important that we integrated care rather than just add additional teams onto existing models.

3. Reasons for Recommendations

3.1 This report makes 5 high level recommendations for the future direction of travel for mental health across the Mid and South Essex STP. Success will be dependent on all parts of the system changing together. It is therefore important that we are all committed to this direction of travel. The aim will be to develop these high level aspirations into detailed partnership working plans for 20/21 and beyond.

4 Financial / Resource Implications

4.1 None at this stage. (External Report)

5 Legal Implications

5.1 None at this stage. (External Report)

6 Equality & Diversity

6.1 None at this stage. (External Report)

8 Appendices

8.1 None at this stage. (External Report)

Mid and South Essex Mental Health Costed Delivery Plan

Strategic Context and Process

At the core of the Southend, Essex and Thurrock Mental Health Strategy was the vision to rebalance the system in favour of prevention, early intervention, resilience and recovery, and develop a comprehensive Mental Health approach across the STP (e.g. including employment, housing, direct mental health services), placing the service user and their needs holistically at the centre, through a robust STP-wide governance and transformation mechanism.

In 2018-19 Mid and South Essex STP partners came together with McKinsey to develop a Costed Delivery Plan for the STP Mental Health strategy. The Mid and South Essex STP defined clear parameters for the development of a Costed Delivery Plan and focused on:

- Developing the baseline mapping of current services across the STP in terms of spend, setting of care, numbers of patients and contacts, workforce, estates and other enablers, and providing evidence of best practice within the NHS and internationally;
- Describing what the future would look like in terms of projecting forward activity and spend, to establish the 'do nothing' picture, taking into account adherence with national policy priorities, in particular around the Long Term Plan, and defined implications for enablers (e.g. workforce);
- Modelling the impact of the existing transformational strategies, focusing specifically on the Crisis, Dementia and PD services and developing the 'blueprint' of a new, integrated Primary and Community Care model for Mental Health, centred around the newly-established Primary Care Networks (PCNs)
- Developing the high-level implementation plans for September 2019- August 2024, acknowledging the MH strategy will keep evolving and reflecting the maturity of local arrangements and governance (e.g. PCNs); and starting to address the key challenges and enablers such as workforce, digital and estates.

The plan, followed an agreed 7-step Modelling approach, using a needs-based segmentation over a 3-phase process of data collection, analysis/modelling and engagement, working closely with the programme Steering Group and STP-wide finance and operational leads through the Data Sub-Group, engaging 34 stakeholders in interviews and many clinical, financial and operational leaders in a

series of multi-disciplinary workshops, each with 40-60 attendees, and refining further the proposed approach at existing STP fora (e.g. the STP Mental Health Transformation Board).

As such, the CDP provides a robust structure and costing model already aligned with finance and operational leads across the STP, to integrate additional services as they are being developed further over the next few months (e.g. CCG Operational plans).

The Costed Delivery Plan – Population Information

Key findings from the report:

- One in five people in the STP population suffer from a Mental Health condition, many with depression/anxiety.
- While depression rates are high, not all patients are diagnosed in primary care and rates of diagnosis vary widely across GP practices and CCGs.
- The population is growing but also ageing rapidly; people aged 75-84 will increase by 28% over the next five years.
- Patients on dementia clusters 18-21 represent 22% of Occupied Bed Days compared to 10-14% national averages.
- More EPUT patients are likely to be readmitted as an emergency, while patients receive fewer community contacts than national average.
- EPUT acute patients are likely to be in hospital longer than national benchmarks, with a significant number averaging 60+ days in inpatient services.

The Costed Delivery Plan – Current Financial and Workforce Information

Key findings from the report:

- The system currently spends £253m on mental health and related services in primary care and social care.
- Secondary care mental health services provided by EPUT represent £103m of overall spend with approximately 17% directed at inpatient MH support. There is a strong training requirement for non-specialist workers regarding mental health issues such as suicide or self-harm.
- In 2018/19 the STP spent about 12% less per head on mental health services than the national median, though this could be reflective of the relatively lower mental health prevalence in the area.
- The mental health service offer is delivered by approximately 2,200 WTEs across settings of care, with 30% delivering inpatient care.

- EPUT has proportionately fewer adult consultant psychiatrists and registered nurses as a proportion of inpatient beds.
- The Costed Deliver Plan emphasises the need to turn our attention on developing an Integrated Primary and Community Care (IPCC) model. National guidance suggests a framework for these teams. The framework could provide a starting point for clinically led discussions with Primary Care Networks.
- Our clear priorities for mental health transformation need to reflect the NHS Five Year Forward View and the Long Term Plan. Although, there is not always agreement on how these priorities should be delivered for our population/localities.
- Good progress has been made on Urgent & Emergency Care, Personality Disorders and Dementia. However, workforce remains a significant local and national barrier to rapid mobilisation. We will need to evaluate these changes to understand whether they go far enough.

Costed Delivery Plan – Do nothing Scenario

The CDP's modelling analysis reveals that activity growth is likely to exacerbate current challenges under a "do nothing" scenario. This scenario would imply continuing the current trajectory of funding towards the existing Mental Health model. This is a model STP stakeholders perceive as focused on medical, rather than holistic needs of the patients, and not fully addressing the changing population demographics and emerging needs reflected also in the Long Term Plan (e.g. growing, community-based care needs).

The current model has created a 'Missing Middle' of patients whose conditions do not pass the threshold for referral into secondary care, but whose acuity cannot easily be addressed within the current primary care resources, training and systems. Such patients often "bounce" across settings of care, and health and care teams, many ultimately not accessing the care they need. As an example, in a single CCG, 60% of patients referred to first response teams did not access treatment through this mechanism, while 26% did not pursue accessing service after the first referral.

An 'as is' scenario would imply not adapting services to clinical best-practice around bringing care closer to home and empowering patients and carers and would be combined with ongoing under-utilisation of community-based capabilities and assets, including around population health management through advanced analytics and also the greater use of digital.

Costed Delivery Plan – Our Future Proposals

We are now at the stage of engaging with a wide range of stakeholders across the system. The new integrated primary and community care models will see changing

roles across the whole system. Success will be dependent on all parts of the system changing together. It is therefore important that we have a common understanding of our starting position as well as a common vision for the future. The Costed Delivery plan, therefore, proposes a number of key recommendations:

The costed delivery plan proposes that we need to rebalance the system towards primary care, community assets and community crisis care, and away from inpatient care. This was felt by clinicians and those involved with mental health services as the best option for service users as it provides care closer to home, reduces stigma, and provides a better setting than expensive inpatient services. The plan aims to avoid hospital admission where possible in favour of community and primary care provision and improve working across primary and secondary care. Work between Local Authorities and EPUT to enable patients to be discharged more quickly is ongoing but should continue at pace. Readmission rates are particularly high for older adults.

While further work is required on additional aspects of the new model, STP partners have described new ways of working, focusing on:

- further development of community-based and primary-care based provision, structured around the emerging PCNs and with significant investment in resources, infrastructure and change management for primary care-based teams, and providing required medical or other support to the PCNs;
- delivering NICE-compliant specialist community mental health services for people with eating disorders, complex PD, EIP or other needs;
- strengthening existing plans on robust community-based crisis response and dementia services;
- and removing less complex activity from secondary care services, enabling hospitals to provide higher quality and quantity therapeutic interventions for people who need it the most.

The plan proposes a strategic approach to estates, workforce, digital and coproduction as key enablers to the delivery of the plan. The plan is built upon the major commitment within the CCGs' financial plans to invest more than £30m on mental health services across the STP over the next five years.

It is proposed that these themes form the basis of the STP Mental Health Programme Board's work programme over the next five years and corresponding priorities within future contract arrangements between partner agencies.

Report Authors:

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McKinsey Consultancy

Mid and South Essex STP: Developing a Costed Delivery Plan

December 2019

DRAFT V2 FOR REVIEW

Mid and South Essex STP: Developing a Costed Delivery Plan

Nigel Leonard – EPUT Executive Director of Strategy & Transformation

Mark Tebbs – Director of Adult Mental Health Commissioning, MSE STP

Mid and South Essex STP: Costed Delivery Plan

"This is the biggest transformation of mental health care in a generation"

ental Health condition prevalence across the STP

~1 in 5 people in Mid & South Essex are estimated to have a MH condition, many of which are undiagnosed, compared with an estimated ~1 in 4 people in England

People living in areas of greater deprivation are more likely to live with an MH condition. For example:

- Southend has highest recorded levels people with a MH condition overall, including people diagnosed with dementia, with similarly high rates of depression in Basildon & Brentwood
- MH need estimated by the LTP national formula estimates that several GP practices in Southend have almost twice the level of MH need to national average, whilst all other CCGs have on average 72-80% the level of need of England on average
- East Basildon and Southend localities have highest levels of people diagnosed with psychosis
- Alcohol dependency is lower overall than the national average but drug-related admissions vary, with levels in Southend well above national average

The number of people diagnosed with depression in primary care vary widely across all CCGs and across GP practices. As few as 16 out of 100 people with depression are diagnosed in some cases. This means it is possible many people are not accessing the necessary MH support in primary care settings.

defined clear parameters for success of the Costed Delivery Plan ogramme, developed in April-September 2019

als of the plan

evelopment of the osted Delivery Plan as several omponents:

- Develop a **baseline** of current state and **evidence base of best practice**
- Describe what the **future for mental health services** could look like
- Generate **a set of modelling assumptions** to cost the potential future state
- **Describe what it will take** to deliver

Prioritised guiding principles

- Focus on **current STP MH strategy and the 4 strategic transformation priorities under development, e.g.** :
  1. Crisis services
  2. Personality Disorder
  3. Dementia Services, and
  4. Integrated Primary & Community Care Model (focused on PCNs)
- **Following an agreed**:
  - **7-step Modelling approach**
  - **Needs-based segmentation** (SMI, CMI, Dementia, mostly healthy)
  - **5-service line focus** for modelling, and
  - **3-phase, 5-6 month process of data collection, analysis/modelling and engagement**

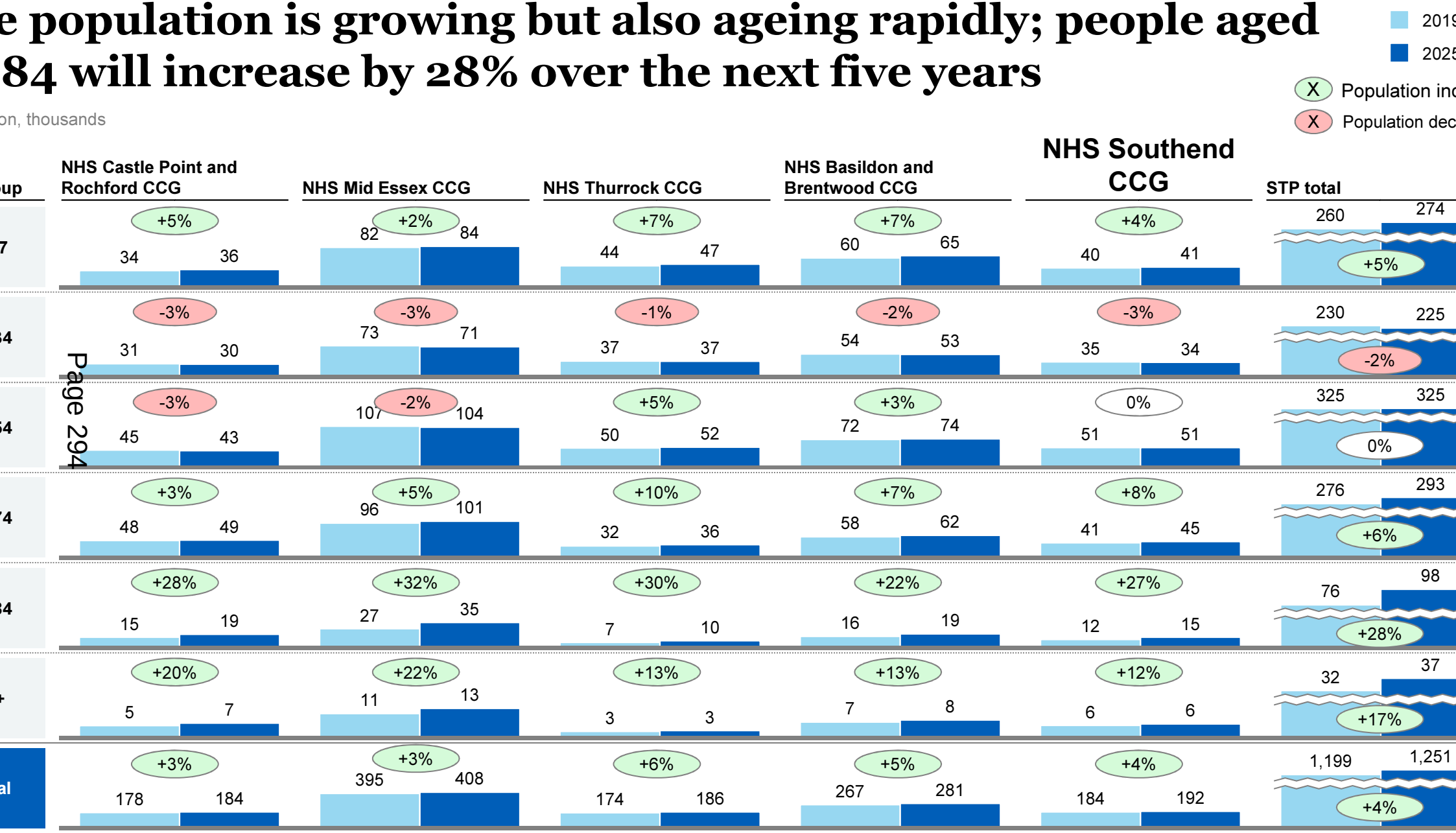
What this means for implementation

- The Costed Delivery Plan provides a **comprehensive picture of the activity an cost implications** of the **current STP strat** and the **4 core strategic transformation priorities** under development
- **For each it includes implications on key enablers** (e.g. workforce, estates, digital)
- It will also include **a high-level implementation road-map including also areas of Mental Health strategy that still need to be developed** and integrated into STP-wide Mental Health strategy and Deliv Plan going forward, such as the latest guida on LTP implementation, future developmen around CYP/CAMHS services et al.
- In doing so, it provides **a robust structure costing model** to integrate additional servi as they are being developed, **aligned with financial and operational leaders across STP** (e.g. Data Sub-Group, Steering Group

id and South Essex STP; Costed Delivery Plan team analysis; approach developed with Data Sub-Group and Programme Steering Group

e population is growing but also ageing rapidly; people aged 84 will increase by 28% over the next five years

on, thousands



ONS data

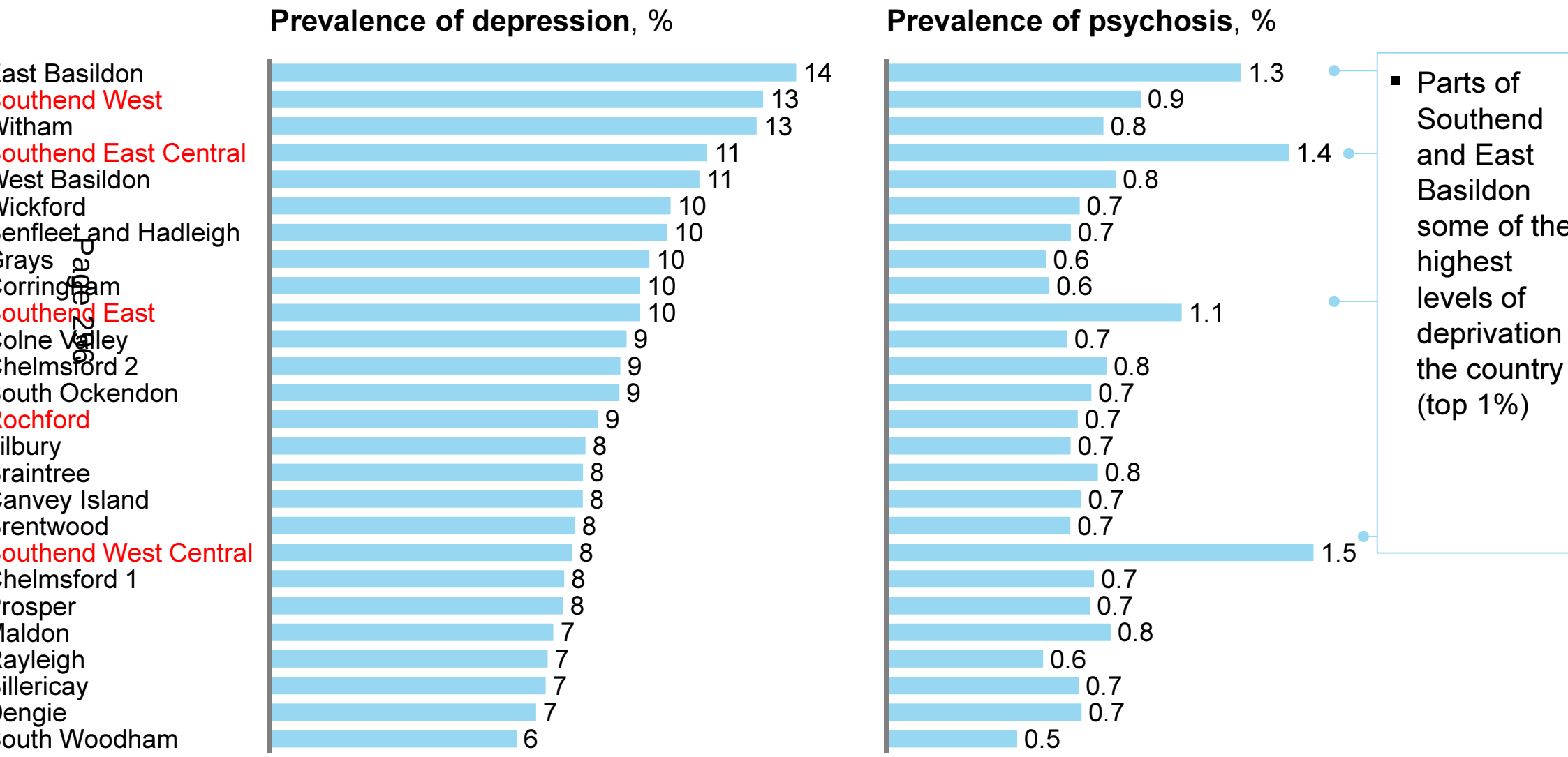
evalence and contacts will grow across settings of care over the nex e years

PRELIMIN

ategory	Unit	Estimated in 2019	Estimated in 2025	Assumptions / rationale
umber of adults ith a MH condition	Number of patients, k	178	186 (+4%)	▪ Assume prevalence grows in line with population ▪ Despite high growth in the older population, prevalence of dementia is still low and overall MH prevalence will remain at 19% (with rounding)
rimary care	Contacts per year, m	1.86	2.25 (+22%)	▪ Assume growth in line with Primary Care Strategy – 3.3% per year
nput to primary & ommunity care	Contacts	0.13	0.15 (+13%)	▪ Assume demographic growth: CMI – 0.4%, SMI – 0.9% dementia – 2.8% ▪ Assume non-demographic growth 1%
ommunity based IH support	Contacts, m	0.41	0.47 (+13%)	▪ Assume demographic growth as above ▪ Assume non-demographic growth 1%
risis	Contacts, k	34.8	38.8 (+12%)	▪ Assume demographic growth as above ▪ Assume non-demographic growth 1%

EPUT Activity Data March 2019, PC Strategy document

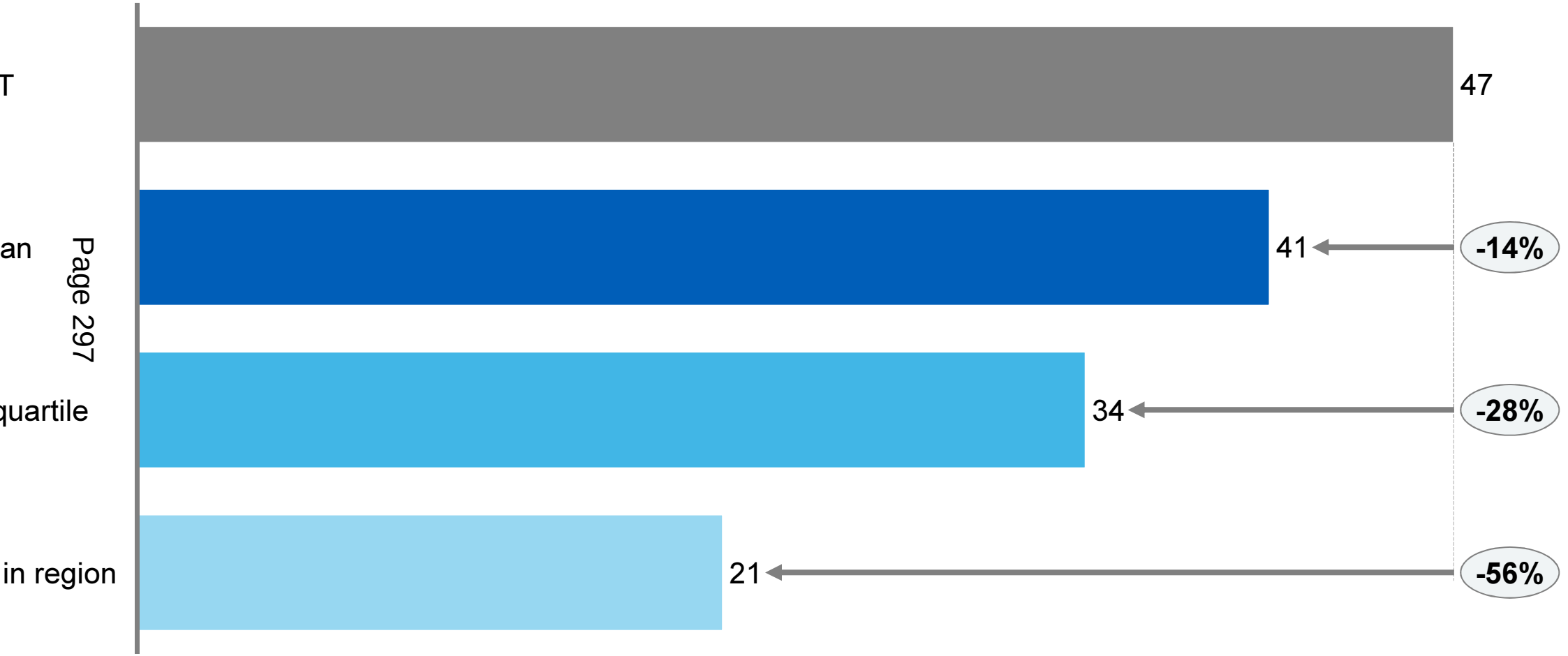
imilar pattern across localities: people in most deprived localities, for ample in East Basildon and Southend, are most likely to suffer from pression or psychosis



QOF

tients under Mental Health Act detentions are also likely to be spitalized longer than national benchmarks

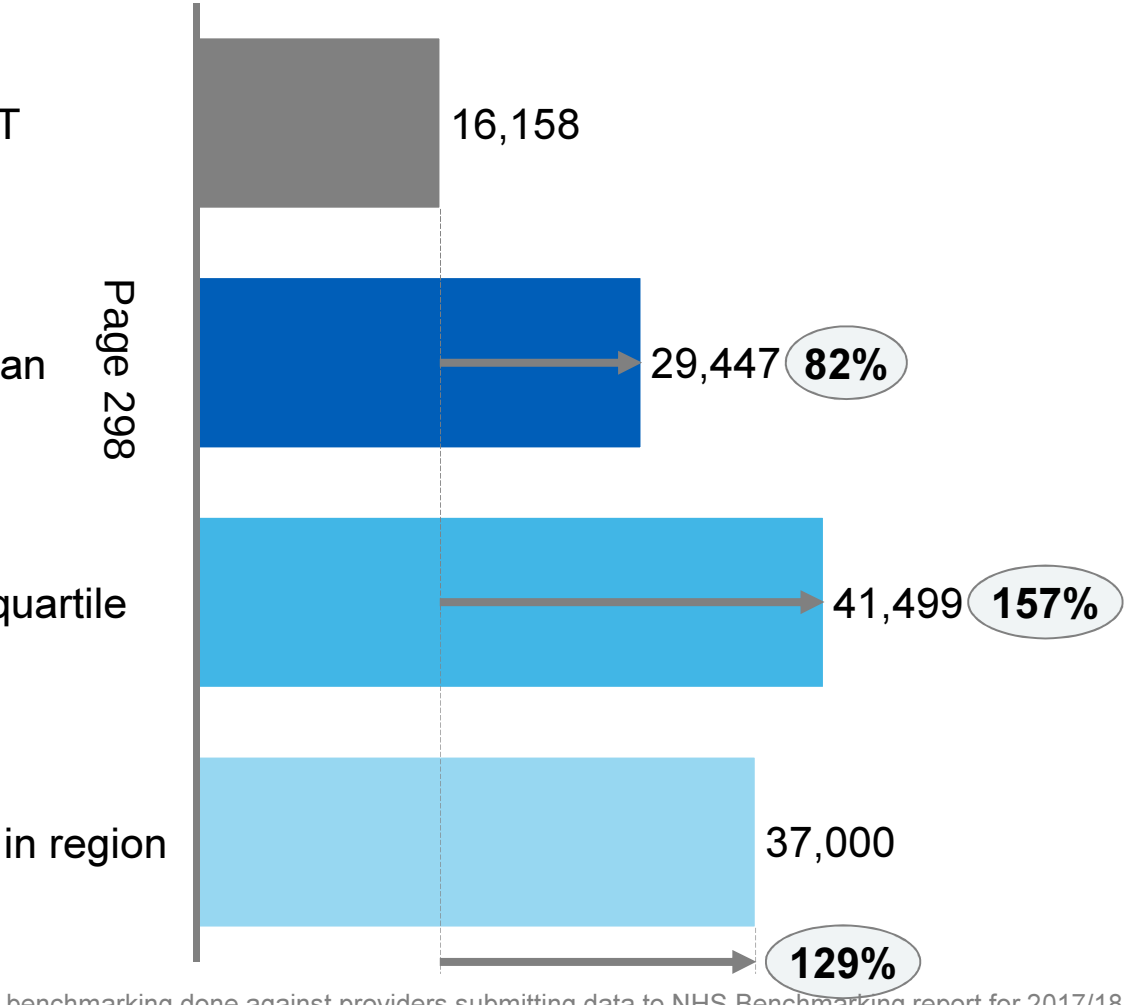
acute mean length of stay for Mental Health Act detentions



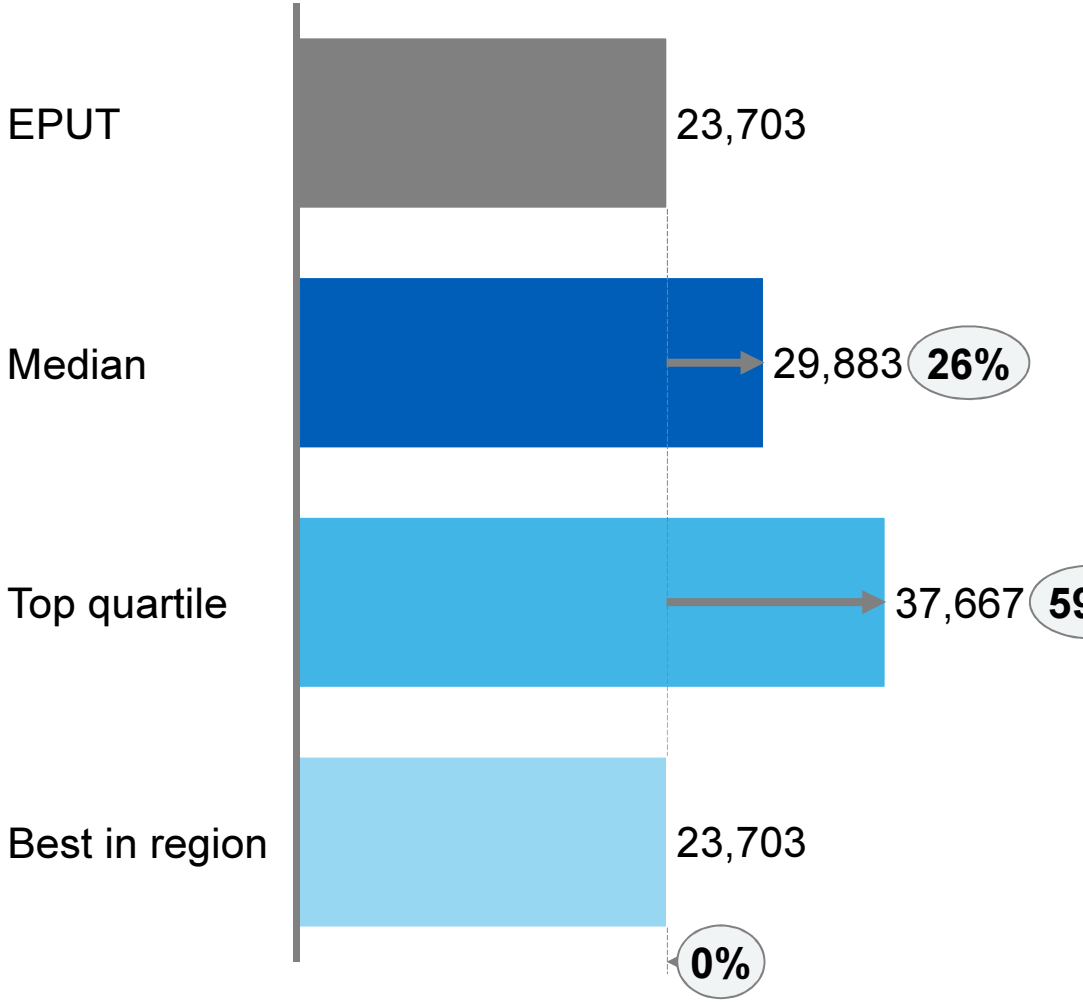
benchmarking done against providers submitting data to NHS Benchmarking report for 2017/18
marking is shown for whole of EPUT, not only the Mid and South Essex STP population
E: NHS Inpatient and Community Mental Health Benchmarking report for MH72 2017/18

while patients receive fewer community contacts than national average

r adult teams – community contacts per 100,000
tered population



Total community contacts per 100,000 registered populat



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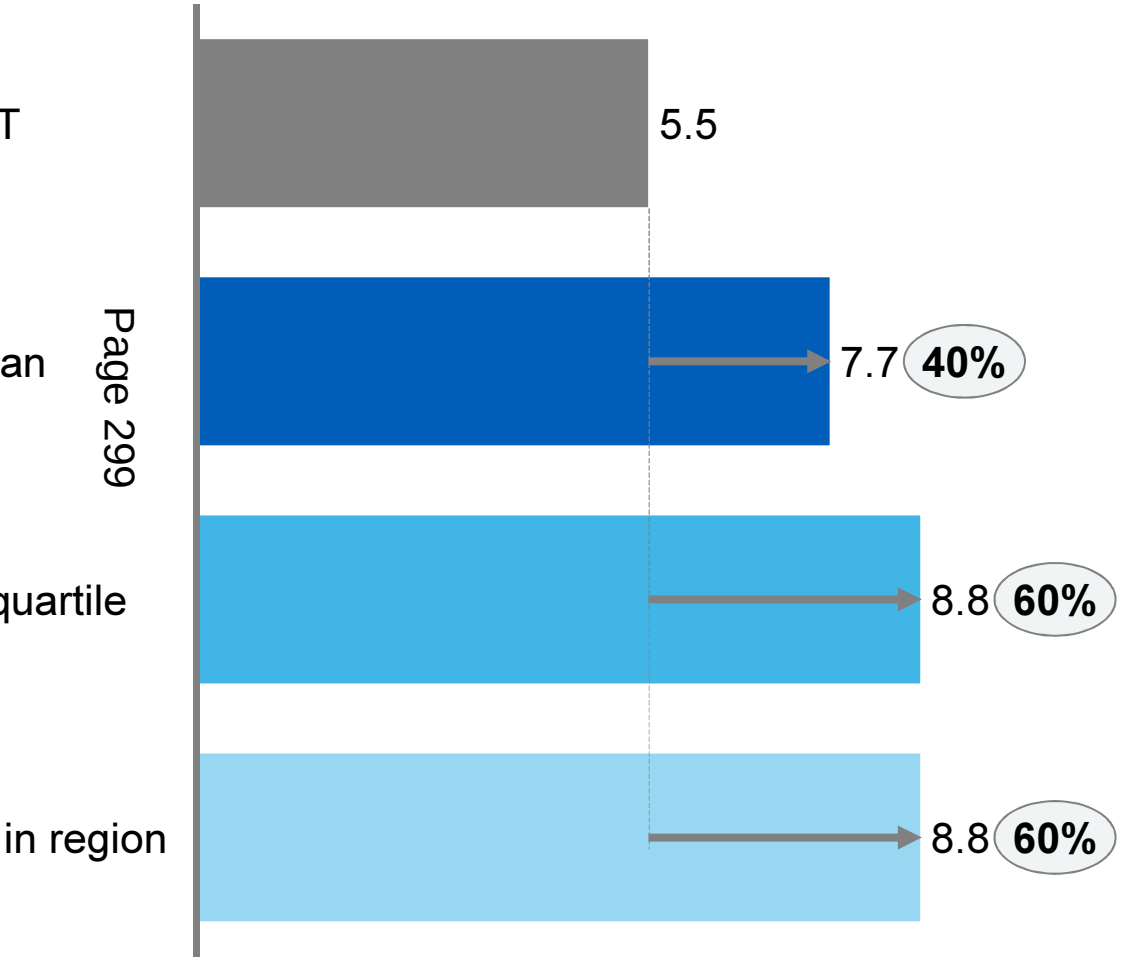
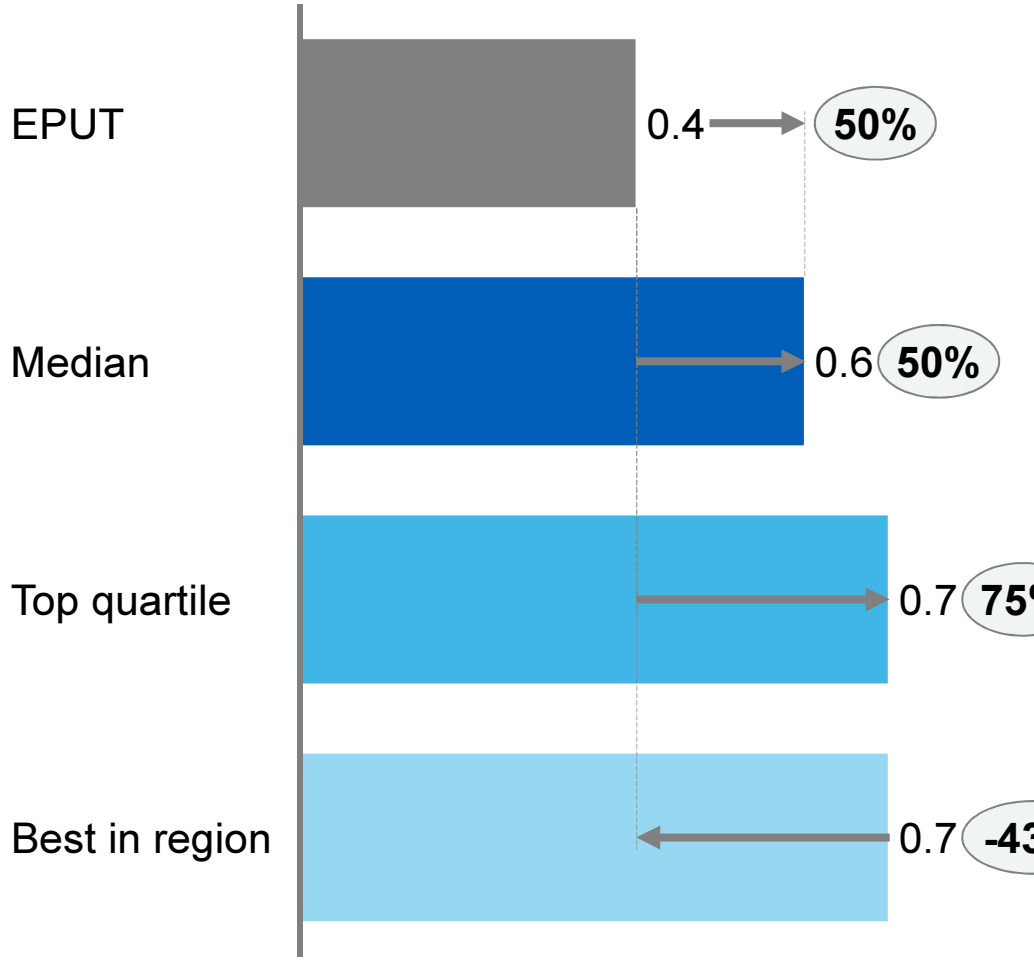
UT has proportionately fewer adult consultant psychiatrists and gistered nurses as a proportion of inpatient beds

acute registered nurses per 10 beds



Adult acute Consultant Psychiatrists per 10 beds



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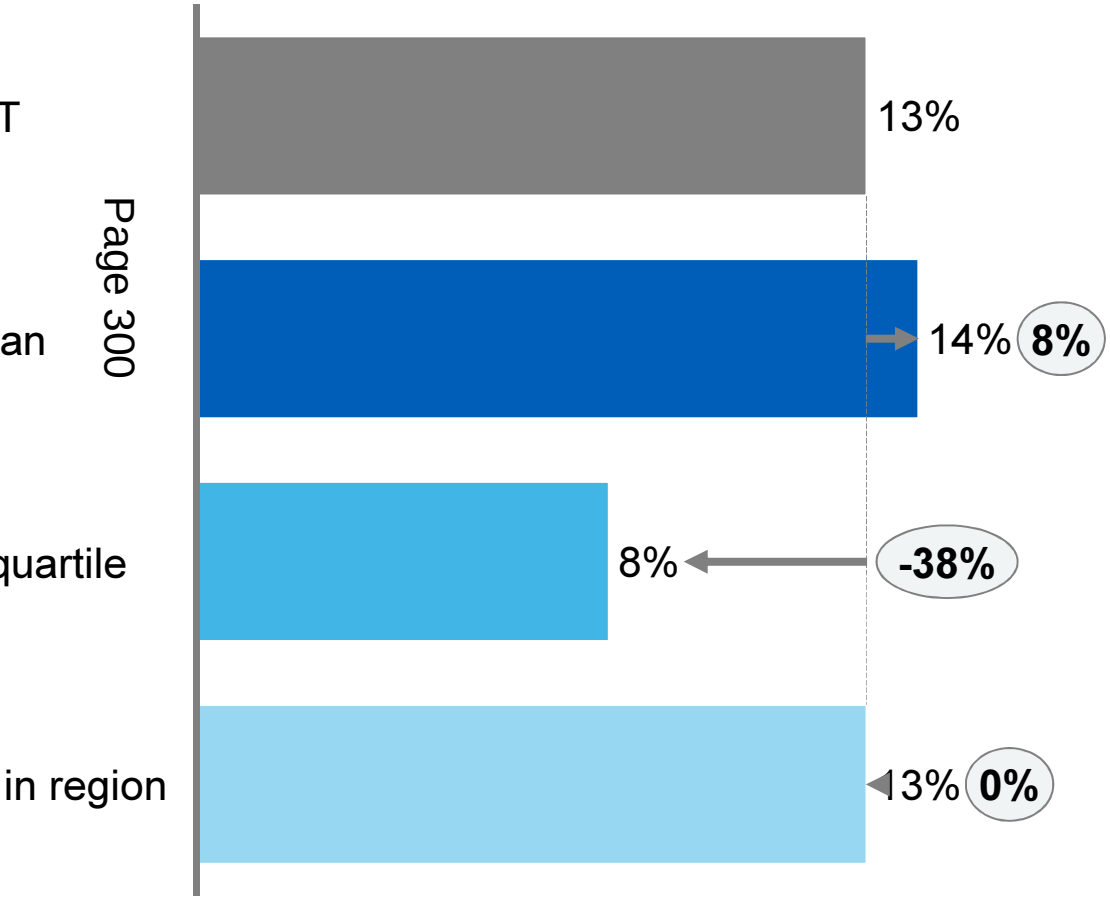
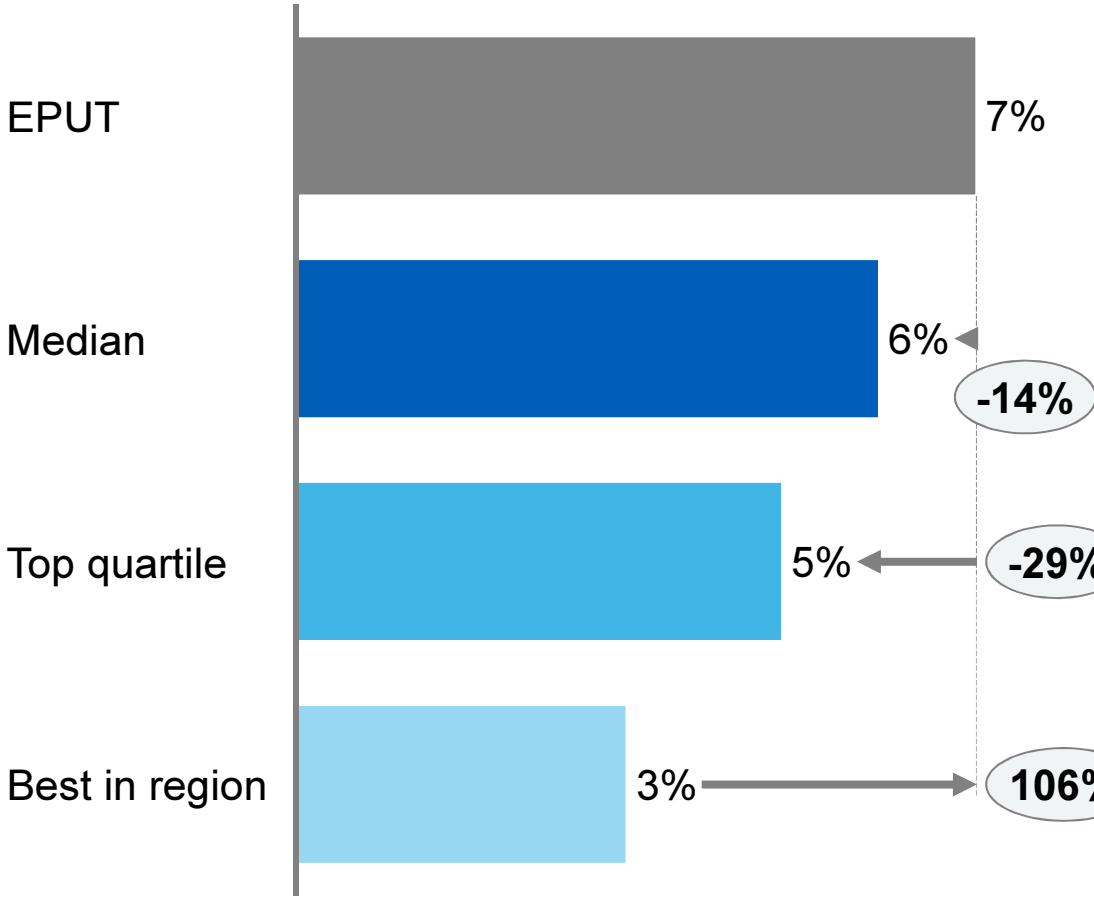
orkforce pressure poses a national challenge and EPUT is also der pressure with an overall vacancy rate of 13%, and kness/absence rate of 7%

acute WTE vacancies as % of total staffing



Adult acute staff sickness/absence %



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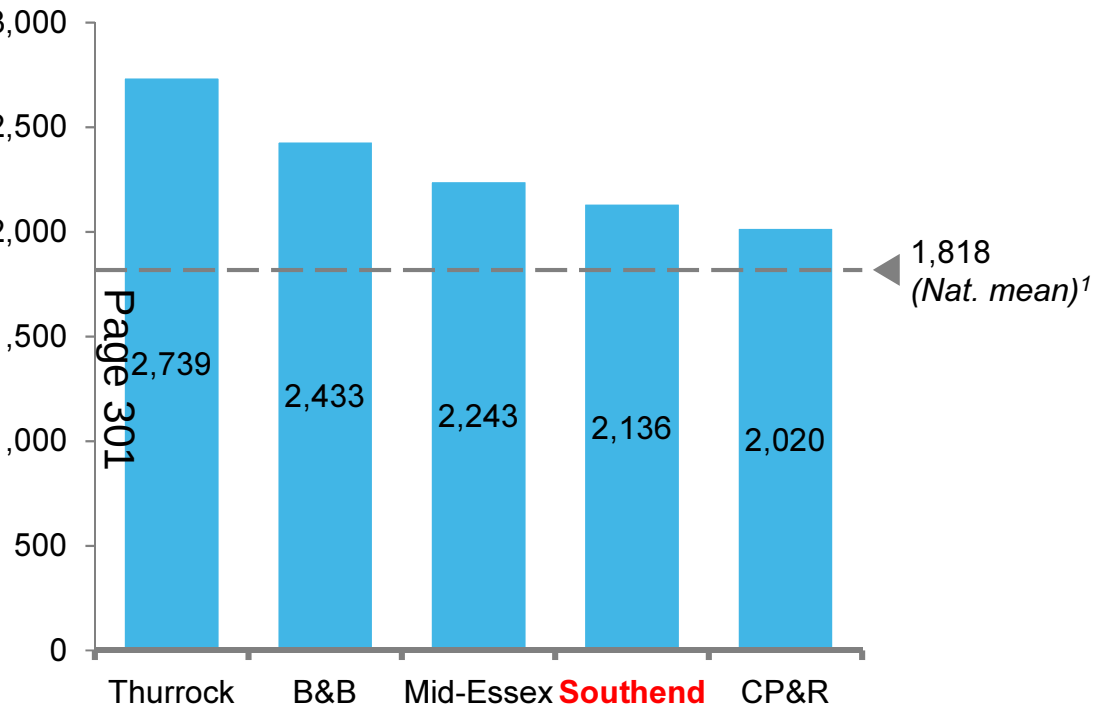
E: NHS Inpatient and Community Mental Health Benchmarking report for MH72 2017/18

ffing levels in primary care are lower than national average across all CCGs
h gaps in workforce and unmet demand in appointments set to increase

PRELIM

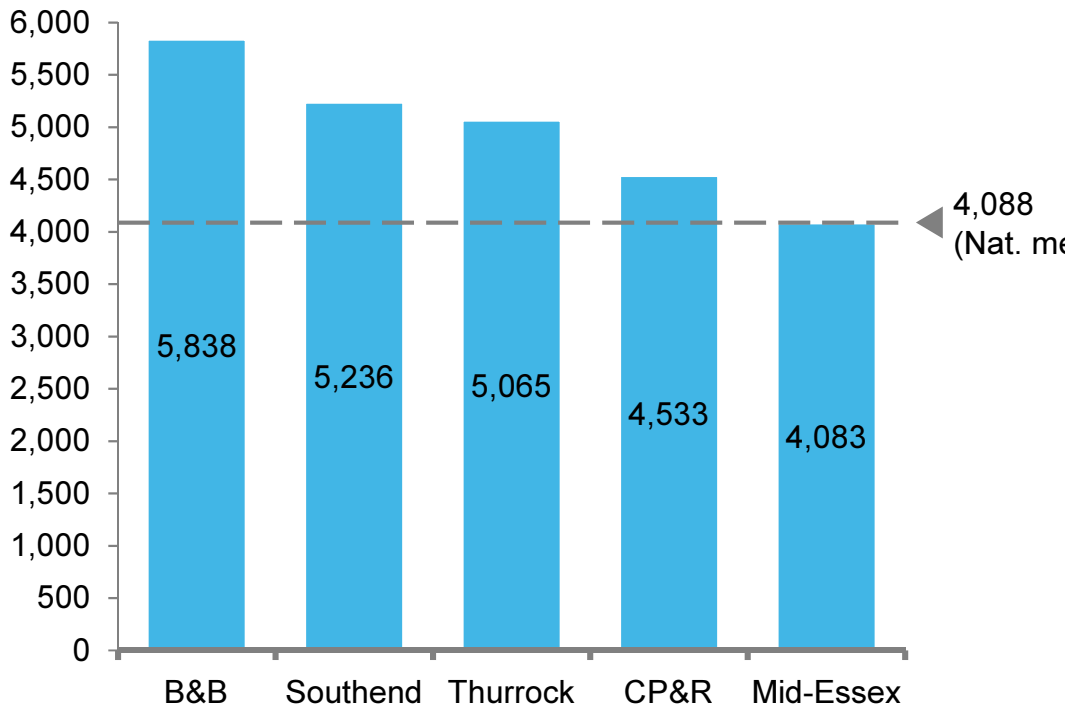
STP has fewer GPs per patient than national average



						Total
E¹	64	113	174	87	93	531
E	32	38	41	15	10	128
avg.						

g locums, but including registrars

M&SE has fewer nurses per patient than national average

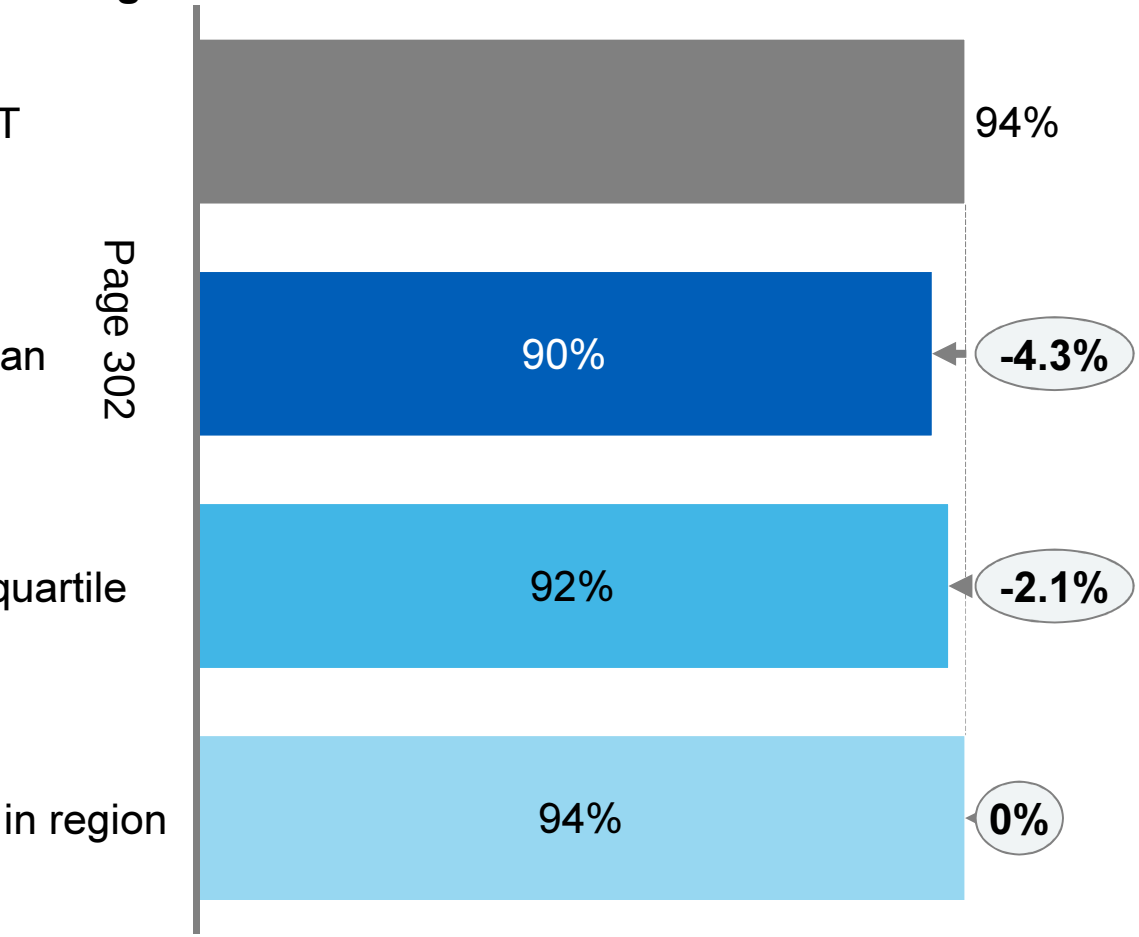


						To
	47	36	35	41	96	25
	20	10	8	4	0	4

GP data from Sep-17 MDS (unmodified) ; Nurse data from March 17 MDS (updated by CCG leads)

ients report high Friends and Family Patient Satisfaction scores, but system-e there is a concern around user access, experience and role in co-production

Friends and Family Test (FFT) Patient Satisfaction e is high…



However patients raise issues around user access and support available to individuals and families

"I decided to get counselling but did not know where to go"

There needs to be more support for the families of those affected… [so they can] better help the person"

"It should not take getting to crisis point…for a referral to take place"

benchmarking done against providers submitting data to NHS Benchmarking report for 2017/18
marking is shown for whole of EPUT, not only the Mid and South Essex STP population

E: NHS Inpatient and Community Mental Health Benchmarking report for MH72 2017/18; MH Strategy "Let's Talk"; interviews

ing forward, we have developed clear priorities for MH transformation ally, reflecting the NHS 5YFV and the Long Term Plan

ent work nationally has set ets and priorities

nary of core service commitments from 5YFV:

7 availability of crisis support service for mental health, leading to reduction and eventual elimination of out-of-area placements

grated mental and physical health services – especially in the perinatal pathway

us on prevention, with services aimed at children and young people, creating and sustaining mentally healthy communities, and support for ping people in work

nary of key Long Term Plan commitments:

w place-based MH community services integrated with PCNs

T expanded to be available for an additional 380,000 people/year

roved Urgent and crisis care (by 2023/24)

roved suicide prevention services and outcomes

te/mental health liaison services available in all acute A&Es

ppropriate out of area placements eliminated by 2021

luced ALOS to national average of 32 days

egrated Primary and Community Care model: also started defining the core functions and components of new model

PRELI

Costs and impacts mode

Not modelled – to be del by existing workforce

nents of the core model, consistent across the STP – the "80%"

Early identification and assessment	▪ Enhanced role to support GP to do rapid initial assessments – band 7 practitioner ▪ 90 minutes per assessment ▪ Whole system approach taken following assessment – what intervention needed from full range of services with support from care navigator ▪ Key enabler: MH training of all PCN staff
Care navigation*	▪ Single point of access to the full range of MH and related services e.g. PRISM services, carer support – will include social prescribing linked with 3rd sector to proactively address risk and focus on resilience-building, and link to Dementia Services ▪ Non-clinical function – band 4 / peer support / social link prescribing link worker
Regular MDT meetings	▪ MH-specific team for complex case patients by locality, tasked also with signposting to non-clinical services ▪ GP, care navigator, specialist MH input (e.g. CPN, psychiatrist, psychologist), social care worker ▪ Weekly per PCN, 3-6 hours, of which MH patients discussed for 45-90mins ▪ Uses shared care protocol to clarify roles & responsibility among wrap-around staff ▪ Key enablers of compatible information systems between primary and secondary care, digital tech to facilitate remote working (Skype/VC)
Physical health checks and medication reviews	▪ Physical health checks and medication reviews for SMI and Dementia patients ▪ Every 6-12 months by pharmacists, supported by an HCA ▪ Longer than GP appointment
Care planning	▪ Developing and agreeing an action plan with service users and families integrated with primary and secondary care services ▪ Existing secondary care activity expanded to support integrated primary care, including support from central STP care navigator
Embedded Social Care	▪ Within locality hubs; linking also to 3rd sector ▪ Existing services provided out of PCN hub sites
Consistent pathways	▪ Consistent pathways into specialist services (e.g. PD, dementia, CMHTs mapped to locality hubs) with well-documented shared-care protocols communicated with each PCN, links to PRISM services ▪ No new service offer but enables better linking of primary care with other services
Care for carers of dementia patients	▪ Providing additional support and advice on wellbeing and medical issues including health checks ▪ Development of a primary carers register ▪ Digital enablement such as SHIP in Southend

on £179 direct costs taken out in the short term; £350 taken out in longer term (90% scaling factor of EPUT bed day cost)

at this will mean for GP practices and other professionals: the new PCN model include some new workforce roles, but also different use of existing workforce

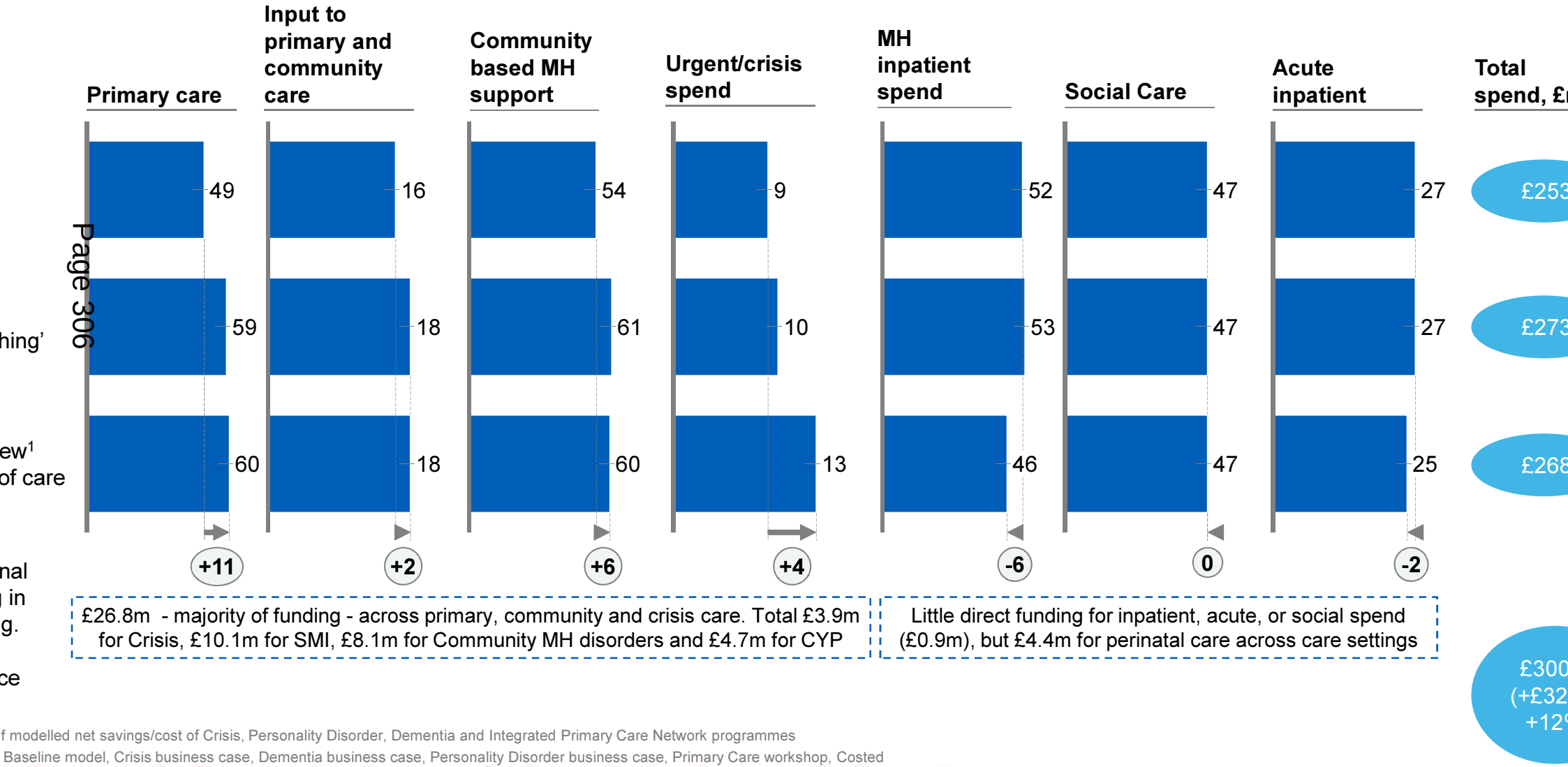
New roles | Existing

force type	How role differs from current model of care?
	▪ Shift to proactive responsibility for patient cohorts, attend MDTs, care planning
ry Care Nurse	▪ May attend MDTs, involved in care planning
al pharmacists[1]	▪ Included in baseline PCN model, n/a for MH
navigator/social prescriber[1]	▪ Single point of access to all MH services, attend MDTs, care planning, link to 3rd sector
otherapists[1]	▪ Included in baseline PCN model, n/a for MH
cian associates[1]	▪ Upskilled in MH component of role
munity paramedic[1]	▪ Increased integration with crisis services
	▪ Included in baseline PCN model, n/a for MH
ng associate	▪ Included in baseline PCN model, n/a for MH
iatrist	▪ Attend MDTs
ologist	▪ Attend MDTs
	▪ Attend MDTs, supports care planning, involved in physical health checks
5 MH practitioner	▪ Carries out early identification and assessment appointments in PCNs
support worker	▪ Link to MDT
l care worker	▪ Embedded in PCN
pist	▪ Provide care for carers

ngland expects funding to cover the additional hiring on average: 5 clinical pharmacists, 3 social prescribers, 3 first-contact physiotherapists, 2 physician associates and one community paramedic

plementing the four transformation programmes as currently designed will uce inpatient activity and increase Primary and Community-based care

osts across settings in 2019 and in 2025 under 'do nothing' scenario and under new model of care (£m)



hing'

ew[1]
of care

nal
in
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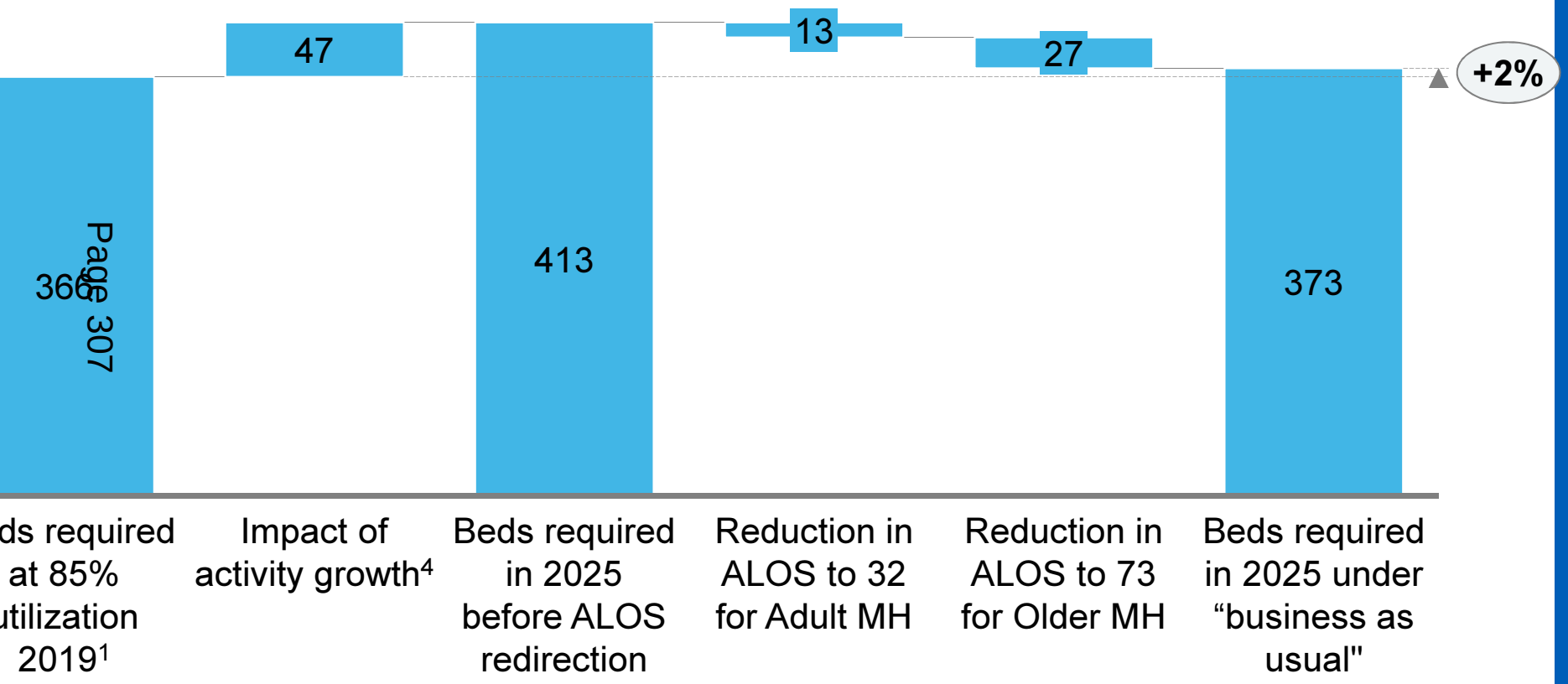
ce

f modelled net savings/cost of Crisis, Personality Disorder, Dementia and Integrated Primary Care Network programmes

Baseline model, Crisis business case, Dementia business case, Personality Disorder business case, Primary Care workshop, Costed Delivery Plan model

spite estimated demand growth in beds, average LOS reductions could set additional demand for beds

nge in bed requirement[5] under "business as usual" scenario



n "Inpatient V4" file containing occupied bed days for 18/19 broken down by type
g nursing home beds
g 85% is best practice occupancy
g growth of adult MH vs older MH in line with demographic growth and non-demographic growth assumptions used for contacts. 18-64 demographic growth 0.3%, 65+ growth 1.7% per year
uirement has been calculated using the same set of assumptions finance have used: 100% costs are based in mid and south essex

EPUT bed capacity data, inpatient data, baseline model

Assumptions

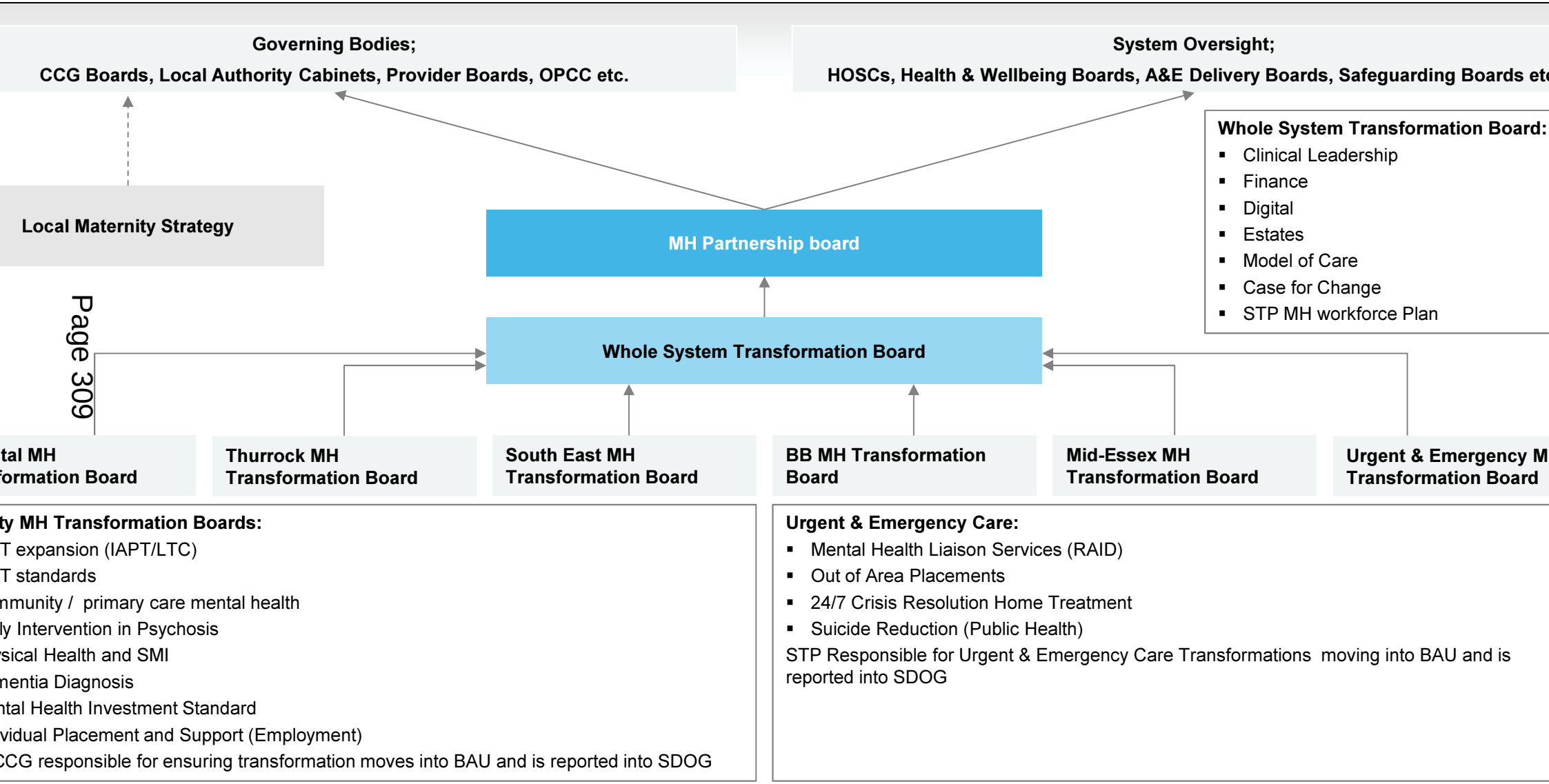
- Assume admissions grow line with other M activity
- Assume ALOS reduced to the following
  - 32 days for ad MH
  - 73 days for old MH
- "Business as usu scenario takes in account incremental expected improvements

Mid and South Essex STP: Costed Delivery Plan

- Rebalancing the system, to reduce inpatient admissions and provide improved outcomes for patients
- Coproduction and engagement is key to the delivery of the plan
- £30m to be invested by CCGs across the Mid & South Essex STP over the next 5 years
- Triangulation with the NHS 5 Year Forward View and NHS Long Term Plan
- All systems must change together to ensure success

e also set up a robust governance and oversight mechanism for ental Health Transformation

Model – Transformation Governance



Mid and South Essex STP: Costed Delivery Plan

- This is the biggest opportunity for mental health services in a generation
- Our ambitious programme will deliver significant benefits for the residents of Mid and South Essex

Questions

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31st January 2020	ITEM: 9
Thurrock Health & Wellbeing Board	
An integrated approach to Children's Partnership Working and Governance across Thurrock	
Wards and communities affected: All	**Key Decision:** Key
Report of: Teresa Salami-Oru, Assistant Director and Consultant in Public Health	
Accountable Head of Service: Ian Wake, Director of Public Health	
Accountable Director: Roger Harris, Executive Director for Adult Social Care	
This report is public	

Executive Summary

- A memorandum of understanding has been prepared to develop an integrated governance framework for children's services across Thurrock.
- The document aims to define how constituent stakeholder organisations will work together to continue to improve children's safeguarding, protection, health and wellbeing by defining responsibilities and functions at different levels of the system. It also seeks to build on the outcomes of a Children's Services visioning workshop held in April 2019.
- The memorandum of understanding has now received sign off from the Brighter Futures Children's Partnership Board and awaits endorsement from the Thurrock Health & Wellbeing Board.

1. Recommendation(s)

It is recommended that the Health and Wellbeing Board note the rationale for an integrated approach to Children's Partnership Working and endorse the Memorandum of Understanding as detailed in appendix 1.

2. Introduction and Background

2.1 The Brighter Futures Children's Partnership Board is the most senior strategic children's partnership in Thurrock. Following a visioning event led by board representatives in April 2019, the decision was taken to create a single document which articulated the shared vision and objectives of children's services stakeholders using universally understood terminology.

2.2 The resulting document set out the terms of reference for an integrated governance framework for Children's services across Thurrock and proposed that the

Brighter Futures Board developed into a Brighter Futures Children's Partnership; with place, system and community responsibility for Children and Young People's safety and wellbeing.

2.3 Having robust Children's and Young Peoples partnership arrangements underpinned by Governance systems will enable alignment and planning with the corresponding forums for adult services,promoting joint transition planning at a strategic level. Further proposals included the direct reporting of the partnership into the Health and Wellbeing Board.

2.4 The Brighter Futures Children's Partnership Board endorsed the document creation process and final product in November 2019. For further detail pertaining to the Memorandum of Understanding document please see appendix 1.

2.5 The Board is asked to note that the document is currently undergoing a sign up process from children's stakeholders as agreed by the Brighter Futures Children's Partnership Board. It is anticipated that this process will be completed by March 2020.

3. Issues, Options and Analysis of Options

3.1 There are currently no issues or options to note.

4. Reasons for Recommendation

4.1 The Thurrock Health and Wellbeing Board is responsible for developing and overseeing the implementation of Thurrock Health and Wellbeing Strategy, available at https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy

4.2 Goal 1, within the strategy is *"opportunity for all"*. Goal 1 aims, include all children in Thurrock feel and are safe at home, school and in their communities and that they make good educational progress, fewer teenage pregnancies and fewer children and adults living in poverty.
As a partnership the Brighter Futures Board will focus on achieving these and other goals as appropriate by ensuring continuity and communication within Children's services. It is therefore essential that a document which sets out an agreed integrated governance framework is endorsed by the Health & Wellbeing Board to strengthen children's stakeholder partnership working.

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

5.1 As part of the development process, the following groups were consulted,

- The Brighter Futures Partnership Board
- The CCG Board
- The Adult Health and Housing Department Management Team

5.2 The document is currently being signed by relevant parties. This process will be completed by March 2020. Parties to the Memorandum of Understanding include,

Local Authorities:

- Thurrock Borough Council (Unitary Authority)

NHS Commissioners

- NHS Thurrock CCG
- Primary Care Networks x 4

NHS Service Providers

- North East London NHS Foundation Trust
- Basildon and Thurrock University Hospitals NHS Foundation Trust
- Essex Partnership University NHS Foundation Trust

Other Partners

- Thurrock Council for Voluntary Services
- Healthwatch Thurrock
- Department for Work and Pensions
- The Essex Community Rehabilitation Company Limited
- Thurrock Adult Community College
- Thurrock Primary Head Teachers Association
- Thurrock Association of Secondary and Special School Head teachers
- The 0-11 Strategy Group and the 14-19 Strategy Group
- Community Safety Partnership

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

6.1 The Memorandum of Understanding will positively influence all policies and priorities relating to children and young people. The document facilitates a meaningful partnership working approach, which in turn will drive forward health and social care improvements.

7. Implications

7.1 7.1 **Financial**

Implications verified by: Bradley Herbert

All proposals contained within this paper will be achieved through existing budget lines.

7.2 **Legal**

Implications verified by: **Courage Emovon - Ag Strategic Lead / Deputy Head of Legal Services / Deputy Monitoring Officer**

The Council have a statutory duty for Children's safeguarding, protection, health and wellbeing. This report relates to an integrated approach to Children's partnership working in Thurrock for which a Memorandum of

Understanding has been prepared. There are no direct legal implications arising from the report, however Legal Services is on hand to advise on any issues as and when required.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Smith - Strategic Lead: Community Development and Equalities**

The Memorandum of Understanding will seek to address inequalities and promote diversity and equality through its support for the delivery of the Health & Wellbeing Strategy.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)
Not applicable

8. Background papers used in preparing the report
The Thurrock Health & Wellbeing Strategy
https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy

The format of the document presented in this report has been adapted from a Memorandum of Understanding (MOU) – An integrated approach to partnership working and governance across Mid and South Essex Sustainability and Transformation Partnership by the Director of Public Health for Thurrock

9. Appendices to the report.
Appendix 1: Memorandum of Understanding (MOU) An integrated approach to Children's Partnership Working and Governance across Thurrock

Report Author:

Teresa Salami-Oru

Assistant Director and Consultant in Public Health

Appendix 1:

Memorandum of Understanding (MOU)
An integrated approach to Children's Partnership Working and Governance across Thurrock

1. Introduction

1.1. This document sets out the terms of reference for an integrated governance framework for Children's services across Thurrock. It proposes that the Brighter Futures Board develops into the Brighter Futures Children's Partnership which will be the overarching board for Children and Young People's wellbeing services and enable streamlined feedback into one place that can communicate clearly with the Health and Wellbeing Board. It describes the context for changing the way that we work and sets out our ambitions for an integrated approach which is expected to evolve over time as the system develops new integrated ways of working. The document aims to define how constituent stakeholder organisations will work in a coordinated way to improve Children's health and wellbeing and to define roles, responsibilities and functions at different levels of the system. It seeks to build on the outcomes of the visioning workshop for Brighter Futures held in April 2019. A visual expression of how the Brighter Futures Children's Partnership interacts with partners at system, place and community levels can be seen in appendix 1.

1.2. This document has been written by Teresa Salami-Oru (Assistant Director of Public Health for Thurrock) and Rachael McCarthy (Public Health Specialty Registrar) in consultation with the Brighter Futures Strategy and Governance sub-group to be agreed by all stakeholder organisations. Further consultation work will need to be undertaken with wider system partners to gain agreement and sign up.

1.3. The format of this document has been adapted from a Memorandum of Understanding (MOU) – An integrated approach to partnership working and governance across Mid and South Essex Sustainability and Transformation Partnership by the Director of Public Health for Thurrock.

2. Parties to this Memorandum of Understanding

2.1. The members of the Brighter Futures Partnership and parties to this Memorandum are:

Local Authorities:

- Thurrock Borough Council (Unitary Authority)

NHS Commissioners

- NHS Thurrock CCG
- Primary Care Networks x 4

NHS Service Providers

- North East London NHS Foundation Trust
- Basildon and Thurrock University Hospitals NHS Foundation Trust
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- Thurrock Council for Voluntary Services
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- The Essex Community Rehabilitation Company Limited
- Thurrock Adult Community College
- Thurrock Primary Head Teachers Association (TPHA)
- Thurrock Association of Secondary and Special School Head teachers (TASS)
- The 0-11 Strategy Group and the 14-19 Strategy Group
- Community Safety Partnership
- General Practitioners

2.2. As members of the Brighter Futures Partnership, all of these organisations subscribe to the vision, principles, values and behaviours stated within this MOU and agree to participate in the governance and accountability arrangements set out within.

3. Purpose of this Memorandum of Understanding

3.1. The purpose of this MOU is to define what Brighter Futures is and the governance framework that specifies the delivery roles of stakeholders at strategic and operational level. This MOU will also articulate the Children's services relationship at system, place and community levels.

- System (i.e. Local Maternity System/STP) level
- Place (i.e. Thurrock Joint Health and Wellbeing Board, Thurrock CCG, Voluntary sector and Local Authority) level
- Community (i.e. Primary Care Network/ Children's Centres) level.

3.2. We want the governance arrangements at each level to enable partners to work in an integrated way rather than as individual organisations, coming together to meet the needs of our residents. Our proposed governance framework is built on stakeholder voice as evidenced from the visioning workshop findings.

4. Background and context at each level

System Level

4.1. *System Level* is defined at the entire geographical footprint of Mid and South Essex STP.

4.2. The Mid and South Essex STP (MSE STP) is one of 44 STPs across England. All STPs in England came together in 2015/16 as directed in the national NHS Five Year Forward View. Every STP has a plan to meet three main challenges to improve health; transform the quality of care delivery; and secure sustainable finance.

4.3. MSE covers a total population of 1.2 million residents in mid and south Essex. This geographical footprint of MSE includes the urban centres of Purfleet, Grays, Tilbury,

Basildon, Brentwood, Wickford, Southend-on-Sea, Chelmsford, Wickford, Braintree and Maldon together with rural areas and smaller villages.

4.4. Whilst life expectancy at birth for the STP population as a whole is largely in-line with England, there is considerable variation in population health outcomes between different local populations reflecting a wide diversity of need between different populations within the STP. For example, life expectancy at birth and all-cause under 75 mortality is significantly worse in Thurrock and Southend than England but significantly better in Chelmsford compared to England. As such, considering population health outcome data at STP level alone as opposed to contrasting the needs of differing populations within more local geographical footprints presents a danger that needs will be missed.

4.5. Partnership arrangements across the STP geographical footprint are complex. The STP encompasses five CCGs (Thurrock CCG, Basildon and Brentwood CCG, Mid Essex CCG, Castlepoint and Rochford CCG and Southend CCG), two unitary authorities (Thurrock Council and Southend-on-Sea Council), part of the geographical footprint of one top tier local authority (Essex County Council) and seven district and borough (second tier local authorities).

4.6. Hospital services are provided by three NHS Foundation Trusts (Basildon and Thurrock University Hospital Trust, Southend University Hospital Trust, and Mid Essex Partnership Trust) who now operate as a single hospital group (MSB Hospital Group). Secondary Mental Health Care Services are provided by Essex Partnership University Foundation Trust (EPUT) and Community Health Services are provided by the North East London Foundation Trust (NELFT).

4.7. In 2016/17 the NHS set out a national plan for the development of maternity services to 2020/21 for all women in England, called Better Births. Within mid and south Essex all the organisations involved in providing maternity care came together in a partnership called the Local Maternity System (LMS) to transform and improve maternity care in line with this national plan. The LMS's cover the same geographical footprint as the STP.

4.8. By March 2017, 44 Local Maternity Systems (LMS) were formed nationally, bringing together commissioners, providers and service users to provide local leadership and place-based planning for maternity.

Place Level

4.9. This MOU proposes Thurrock as the *Place* level geographical area which is co-terminus with the geographical footprint within Mid and South Essex covered by Thurrock Council.

4.10. Residents' views on local health services are represented through the Healthwatch organisation for Thurrock which is aligned to this proposed geography.

4.11. Thurrock has a CCG with a co-terminous boundary with the unitary authority, Health and Wellbeing Board and Healthwatch organisation, providing a logical 'place based' geographical foot print for planning, delivery and integration of healthcare, social care, public health and other local authority services.

Community Level

4.12. Communities are defined as geographies below *Place* level that are meaningful to our residents.

4.13. Communities are increasingly becoming the footprint on which service transformation and prevention activity is being planned. The NHS Long Term Plan proposes the creation of Primary and Community Care Networks (PCNs) at locality level in recognition of the increasing numbers of the population living with multiple comorbidities and the need to integrate Primary Care, Community Healthcare and community mental health provision. 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. These proposals allow an additional footprint on which to build on, expand and further integrate services, particularly with community groups and third sector assets that often operate at distinct locality level.

4.14. There are nine Centres in Thurrock that have been designated as Children's Centres. Three of these operate as Early Help Hubs and the remaining six offer a range of early years, health and local community services.

4.14.1. West locality (Ockendon, Aveley and Purfleet Children's Centres)
4.14.2. Central (Stifford and Thameside Children's Centres)
4.14.3. East (Chadwell, Tilbury, Stanford-le-hope and Abbotts Children's Centres)

5. Wider context

5.1. Goal 1 in the Thurrock Health and Wellbeing Strategy 2016-2021 is opportunity for all. Its aims include all children in Thurrock making good educational progress, fewer teenage pregnancies and fewer children and adults living in poverty. The Brighter Futures Partnership will focus on achieving this and the other goals from the Health and Wellbeing Strategy by ensuring continuity and communication within Children's services.

5.2. The NHS Long Term Plan states 'A key message from stakeholders during the development of the long term plan was that the needs of children are diverse, complex and need a higher profile at a national level. We will therefore create a Children and Young People's Transformation Programme which will, in conjunction with the Maternity Transformation Programme, oversee the delivery of the children and young people's commitments in this plan.' – The evolution of the Brighter Futures Partnership echoes this statement in the long term plan as we recognise that Children's services in Thurrock will thrive with a coordinated, high level approach.

5.3. Within the Brighter Futures Partnership Strategy issues from the prevention green paper (Advancing our health: prevention in the 2020s) will be addressed and national

and local context explored. Key issues highlighted in the prevention green paper for Children's services include childhood obesity, SEND, vaccinations, mental health services, parental ill health and health technology.

6. Values

6.1. By agreeing to this MOU, all parties are agreeing to a set of values setting out how we will work together. These are based on:

- Equality between organisations
- Mutual respect and trust
- Open and transparent communications
- Co-operation and consultation
- A commitment to being positive and constructive in outlook
- A willingness to share and learn from others
- An inclusive and proactive approach

7. Overarching Principles of the MOU

We will ensure that the Brighter Futures Children's Partnership brings together the full spectrum of partners responsible for planning and delivering health and care to the children, young people and Families of Thurrock. We agree to champion and communicate the following terminology regarding Brighter Futures:

a) The Brighter Futures Board is an executive board and will be referred to in the future as the Brighter Futures Children's Partnership encompassing all things Children's, providing strategic leadership and direction for Children's health and wellbeing at System, Place and Community level.

b) That the following boards and partnerships will adopt the Brighter Futures brand as an affix to their name i.e. Brighter Futures Children's Centres, Brighter Futures Early Help, Brighter Futures SEND improvement board, Brighter Futures Healthy Families etc. in order to further facilitate the integration of this brand within the system.

c) There is a distinct difference between Brighter Futures and Early Help. The Brighter Futures Partnership is the highest level partnership group for Children's services. Whereas Early Help is a targeted service that supports the Brighter Futures vision.

8. Process of enactment

a) Agreement of the final draft of the MOU by the Brighter Futures Board.

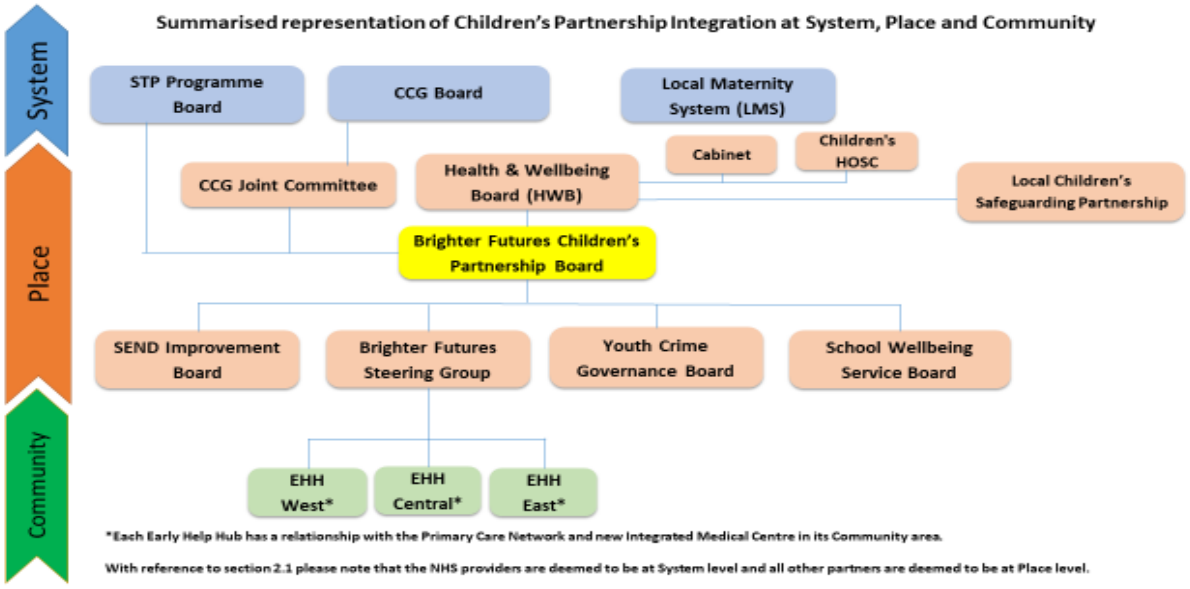
b) Presentation of the MOU to the CCG Board for note and approval.

c) Presentation of the MOU to the Health and Wellbeing Board for note and approval.

We the undersigned, do hereby agree to endorse this MOU,

This will include all stakeholders as detailed in 2.1.

Appendix 1: Summarised representation of Children's Partnership Integration at System, Place and Community



NHS Thurrock Clinical Commissioning Group

MINUTES
Integrated Commissioning Executive
31st October 2019

Attendees

Mandy Ansell – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Roger Harris – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Catherine Wilson – Strategic Lead for Commissioning and Procurement, Thurrock Council
Ian Stidston – Interim Director of Commissioning, NHS Thurrock CCG
Jo Freeman – Management Accountant, Thurrock Council
Maria Wheeler - Interim Chief Finance Officer, NHS Thurrock CCG
Tendai Mnangagwa - Head of Finance, NHS Thurrock CCG
Allison Hall – Commissioning Officer, Thurrock Council
Ann Laing - Quality Assurance Officer, Thurrock Council (substitute for Jackie Groom)
Emma Sanford – Strategic Lead – Health and Social Care, Public Health Thurrock Council (substitute for Ian Wake)
Christopher Smith – Programme Manager Health and Social Care Transformation, Thurrock Council
Les Billingham – Interim Director for Adult Social Care and Community Development, Thurrock Council
Ceri Armstrong - Senior Health and Social Care Development Manager, Thurrock Council
Mike Jones – Strategic Lead for Finance, Thurrock Council
Steve Mayo – Deputy Chief Nurse, NHS Thurrock CCG (substitute for Jane Foster-Taylor)

Apologies

Ian Wake – Director of Public Health, Thurrock Council
Sean Clark – Director of Finance and IT
Jane Foster-Taylor – Chief Nurse, NHS Thurrock CCG
Jackie Groom - Strategic Lead – Performance, Quality and Business Intelligence, Thurrock Council
Mark Tebbs – Director of Commissioning, NHS Thurrock CCG

1. Minutes of the last meeting (11th September 2019)

The minutes of the last meeting were agreed as a true record.

Matters Arising

There were no matters arising from the meeting notes of 11th September 2019.

2. BCF Plan 2017-19 Performance

AL presented the Scorecard to the end of August 2019.

Total non-elective admissions in to hospital (5.1) – performance was currently under plan.

Long-term support needs of older people met by admission to residential and nursing care homes, per 100,000 (5.2) – whilst performance was 'red', the position was recoverable. The dip in performance was in part due to a backlog of data.

Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation (5.3) – performance was 'red' by 0.1% and

therefore the position was recoverable. This indicator included people who had died at home following discharge from hospital.

Overall delayed transfers from care (5.4) – Good performance was being sustained with Thurrock being the best performing authority in its CIPFA comparator group and in the region.

CCG colleagues commented that pressure on Accident and Emergency was currently in paediatrics.

With regard to DTOC pressures, intermediate care and CHC beds were the top reasons for delays.

3. Collins House Interim Beds – Review of Target for Average Length of Stay

There was a request to change the average length of stay from 6 to 12 weeks. The beds were used as an interim solution and were not reablement beds. As such, the average length of stay was often longer than 6 weeks. If the stay exceeded 6 weeks, the social worker responsible would complete a Funding Agreement Report (FAR) and would have to state why the person required a longer stay.

ICE agreed the recommended target but with a proviso that the length of stay was reviewed periodically to ensure that people being admitted to interim beds met the criteria and were suitable.

4. BCF Plan 2019-20 Finance

There was currently a £106k surplus due to a slightly improved position created by an underspend against different lines plus some of the Fund being unallocated. It was suggested that this could be used as a contingency.

£9k had been agreed for the Voluntary Sector to cover Social Prescribing invoices (the funding gap was as a result of misaligned invoices).

A DTOC coordinator post had previously been added as a 6 month post, but this should have been 12 months and would be corrected.

Members were made aware that it was possible that an Adult Social Care precept would be applied to the 2020-21 Council Tax. This would be subject to Council agreement.

5. Bridging Service

The Bridging Service had been introduced in response to pressures on domiciliary care. As a result, an existing waiting list had been reduced, but the reliance on the service has meant an increase in hours being used.

3 options to reduce the amount spent on the Bridging Service were presented:

- Cease using the service – the implications of this option were finding 300 hours a week of domiciliary care and the possibility of a growing waiting list. Finding additional hours with a fragile domiciliary care market would be difficult.
- Use the service until the end of January – the implications of ceasing the service at the end of January were that there were likely to be additional pressures through Winter and not having the Bridging Service as an option would likely reduce market capacity.
- Use the service until the end of March – this would coincide with the review of the discharge pathway and was the preferred option.

Comments included:

- Reviewing any waiting lists
- Looking to use any unallocated Winter Pressures monies to fund the cost of the Bridging Service
- Ensuring that we planned for the end of April if this is when we were going to cease using the service
- The use of the Service reflecting the pressure and complexity of demand – there were increased hours but not an increase in people using the service
- Either increased funding was required or an expectation that waiting lists and increased DTOC were likely
- The recent analysis of residential care placements showed the increased complexity and the increased age of people entering residential care today.

Option 3 (to fund the use of the service until the end of March) was agreed and would be funded through unallocated Winter Pressures resource.

It was agreed that two papers would be brought to a future meeting:

- Residential Care Placement analysis (November meeting) – CW
- Review of the Discharge Pathway (to be advised) – CW

6. Home from Hospital (By Your Side)

CW reported that the service had been very successful, with 246 referrals (mainly via the Hospital Team). Out of the referrals, 66% of people required no further support. Some of this group were likely to have required further support had the service not been in place.

The BCF has committed to funding a recurring £35,130 but the service actually costs £70,260 to run. Whilst the outstanding amount has been covered for this year, a commitment from ICE is required to ensure that the service can continue to run.

It was agreed that the ongoing funding of the service would be considered alongside the review of the discharge pathway that was to be considered by the Integrated Care Partnership (see item 5).

7. The Better Care Fund 19-20 – update

CA updated ICE members that the BCF Plan for 19-20 had been submitted on time. A couple of additional pieces of information had been requested through the Eastern Region BCF Lead and the regional assurance process had taken place. The next stage was moderation following which plans would be recommended for sign off.

8. Future of ICE – BCF Working Group

CA presented a paper recommending the establishment of a BCF and Integrated Commissioning sub-group. This would be the last meeting of the ICE before new Integrated Care Partnership arrangements were established. As the ICP would have a broader and more strategic agenda, a sub group was required to focus on the detail of the BCF and of the development of Integrated Commissioning.

ICE agreed that the group was required and that it would report to the ICP by exception.

ES asked to be added as a member of the new group.

A date for the first meeting would be agreed where the new group's terms of reference would be discussed and agreed. This would include governance arrangements.

9. Risk Register

There was nothing to add.

Exception reporting would take place between the new BCF sub-group and the ICP.

Any Other Business

IS expressed his thanks to CA and CS for the support given to the group.