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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **5 November 2020**

Due to current government guidance on social-distancing and the COVID-19 virus the Health and Wellbeing Overview and Scrutiny Committee on 5 November 2020 will be held virtually online. The press and public will be able to watch the meeting live via the Council's online webcast channel: www.thurrock.gov.uk/webcast

Membership:

Councillors Shane Ralph (Chair), Victoria Holloway, Fraser Massey, Sara Muldowney, Joycelyn Redsell and Elizabeth Rigby

Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Alex Anderson, Tom Kelly, Cathy Kent, Sue Sammons and Sue Shinnick

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Agenda

Open to Public and Press

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1. Apologies for Absence

2. Minutes **5 - 18**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 3 September 2020.

3. Urgent Items

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

4.	**Declarations of Interests**	
5.	**HealthWatch**	
6.	**Basildon University Hospital Maternity Services**	**19 - 52**
7.	**ManKind - Male Victims of Domestic Abuse - Presentation**	**53 - 64**
8.	**Mental Health Update**	**65 - 92**
9.	**COVID Update Presentation**	
10.	**Thurrock Adult Safeguarding Board Annual Report**	**93 - 120**
11.	**Orsett Hospital and the Integrated Medical Centres - Update Report**	**121 - 128**
12.	**Verbal Update Targeted Lung Health Checks**	
13.	**Verbal Update on Detailed Fees and Charges Report**	
14.	**Work Programme**	**129 - 132**

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **28 October 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?**

Does the business to be transacted at the meeting
- **relate to; or**
- **likely to affect**

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 3 September 2020 at 7.00 pm

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Present:	Councillors Shane Ralph (Chair), Victoria Holloway, Fraser Massey, Sara Muldowney, Joycelyn Redsell and Elizabeth Rigby Kim James, Healthwatch Thurrock Representative
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Ian Wake, Director of Public Health Stephanie Dawe, Chief Nurse and Executive Director of Integrated Care (Essex & Kent) NELFT Lee Henley, Strategic Lead, Information Management Anthony McKeever, Interim Joint AO for Mid & South Essex CCGs Tania Sitch, Partnership Director Adults Health and Social Care Thurrock North East London Foundation Trust Mark Tebbs, Deputy Accountable Officer: Thurrock NHS Clinical Commissioning Group Catherine Wilson, Strategic Lead Commissioning and Procurement Jenny Shade, Senior Democratic Services Officer

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Before the start of the Meeting, all present were advised that the meeting was being filmed and was being recorded onto the Council's YouTube.

58. Minutes

Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 18 June 2020 were approved as a correct record.

Councillor Holloway raised her concerns on the appointment of a Vice Chair to this committee and not having a Vice Chair in place for this meeting had shown a lack of respect to the committee. The Chair explained that the appointments of Vice Chairs had to be made at Council and that September's meeting would be the next time for this to be agreed.

Councillor Holloway referred to the Chair's comments made at the June committee on how difficult it was for male victims of domestic violence to get help in Thurrock and he had asked whether there had been any funding appraisals or sources of information support for male victims to which Councillor Holloway had explained that services were offered to both men and woman as it was important that everyone received support. Councillor Holloway then went on to say that domestic violence and sexual violence prominently impacted and affected women and quoted that it was in the high 90%. The Chair had stated that figure was incorrect and had been aware of

only one male shelter and added that a 2012 figure of 44% victims were male and saw a large percentage of males coming through with the work that he undertook. Councillor Holloway then continued to state she had contacted SERICC who provided support to adults and children, male or female, who confirmed that in April 2019 to March 2020 1216 Thurrock victims of which 1179 were female and 37 male had been helped, that was 97%. Councillor Holloway had also contacted Changing Pathways and from 2019 to 2020 all the people they had supported were female, that was 100% and so far had supported two males. Councillor Holloway then questioned where Councillor Ralph had got that 40% figure from eight years ago as she was unable to find it and stated it was important that Members were aware of facts before being presented with domestic violence and sexual violence disproportionately impacting women. The Chair stated that from the history of domestic violence and sexual violence men had trouble coming forward and speaking out about their abuse and how they had suffered, that figure was a lot lower than the 95% towards woman than it was to men. The Chair offered this item to be added to the work programme for the next meeting where a full debate could be undertaken regarding the figures on sexual violence and domestic violence involving all parties. Councillor Holloway stated that this was a complex issue as to why men do not come forward and it would be the chair's prerogative if this was an item to be brought to committee. Councillor Holloway summed by saying that when studies of the different kinds of violence that were perpetrated on men and women, it would show that the violence perpetrated on woman was always more severe.

Councillor Muldowney raised her point made at this meeting for an update on the mismanagement of funds taken from Thurrock's Clinical Commissioning Group to bail out Peterborough and Cambridge Clinical Commissioning Groups to which Anthony McKeever had agreed to provide a specific update in writing to Members. Councillor Muldowney questioned why a written response had not been received to which Anthony McKeever apologised that he had failed to respond as although he had immediately pursued this matter and persisted with his enquiries within the region there had been no substantial information to share with Members. Anthony McKeever agreed to pursue this matter and Mark Tebbs stated this matter was on their agenda and would continue to be pursued through financial routes and would endeavour to get sorted. Councillor Halden was invited to speak by the Chair who stated that Anthony McKeever was not the decision maker in this issue and had been working hard to get some concessions and making a case for Thurrock.

Councillor Muldowney referred to the point that Mark Tebbs stated in these minutes that a national bid was in process for domestic violence and sexual abuse and worked had been undertaken with SERICC to get that bid and asked for an update. Mark Tebbs stated that this bid had been successful.

Councillor Muldowney referred to the point that Councillor Mayes stated in these minutes that mental health and the fewer number of referrals had been a concern, he reported that a Deep Dive Report on focusing on the status of mental health would be undertaken with a recommendation to set up a

working partner taskforce to focus on mental health in its own right and questioned whether this had been carried out. Roger Harris stated an Adult Mental Health Service Transformation Update had been presented at the July's Health and Wellbeing Board and an item was on the Health and Wellbeing Overview and Scrutiny Committee work programme for Mental Health Providers to present in November 2020.

59. Urgent Items

No urgent items were raised.

60. Declarations of Interests

Councillor Ralph declared that he was a private tutor in mental health who had worked for other providers throughout Essex and the wider area including Thurrock Mind.

61. HealthWatch

Healthwatch had no matters to raise.

62. 2019/20 Annual Complaints and Representations Report - Adult Social Care

Lee Henley, Strategic Lead, Information Management presented the Annual Adult Social Care Complaints report covering the period 1 April 2019 to the 31 March 2020. Members were referred to the Appendix which summarised the representations received for this period.

Councillor Muldowney questioned whether the number of complaint and compliment responses received were down due to COVID and whether the concerns raised at the last meeting that residents still felt that services would be taken away from them if they made complaints had been addressed. Lee Henley stated that the drop in the number was not COVID related as this report was for the period that ended March 2020. Lee Henley stated that the drop in compliments may be due to these not being sent to the complaints team for logging onto the system. In relation to the drop in complaints, this was despite the complaints team linking in with internal teams and writing to commissioned providers to ensure complaints were being captured and sent to the complaints team. Lee Henley stated leaflets were being provided to commissioned providers to put up in care homes, in order to provide information to individuals on how to complain.

The Chair asked how easy it was for someone to make a complaint. Lee Henley stated the process was easy with different channels that people could use to make complaints such as telephone, email or letter and stated that anything that met the definition of a complaint would be dealt with as a complaint. Roger Harris reassured members from a service point of view that complaints were taken very seriously and was included as part of the induction of all staff, leaflets were provided for care homes and the

complainants confidentiality was protected at all stages. There may be incidents where service users may feel vulnerable and worried if they were to make a complaint they may lose their services and although there was no evidence to support this, Lee Henley's team would be used as the team was independent from adult social care who would give an element of confidentiality and independence. Service users were also encouraged to use advocates, HealthWatch and other numerous channels that service users could raise complaints. Roger Harris stated that receiving more complaints would be a good thing as this would help with complacency, learning and an opportunity to change the way services work.

Councillor Redsell stated this was a good report and questioned whether the "not available" or "not applicable" comments on the report were due to COVID. Roger Harris reminded members that this report covered the period up to the 31 March 2020 with a very limited period that would overlap with COVID.

Councillor Holloway stated that vulnerable people may still have concerns on the repercussions of making a complaint and questioned how the different means of reporting a complaint would reassure that person. As that person may think that complaints submitted, in whatever format, would have repercussions. Roger Harris stated that there were numerous channels outside the direct service provision where complaints could be made. Complaints could be made directly to Lee Henley's team, through the Council or HealthWatch and encouraged service users to use those opportunities outside their direct care setting. Councillor Holloway hoped that the low numbers reflected the good work that the Council was doing.

Kim James stated that HealthWatch received calls through service users who were concerned about making formal complaints. For those service users who did not wish to make a formal complaint were directed to the monitoring teams and their situation explained. There was still a need for HealthWatch to link in with Lee Henley's team to ensure any complaints received via HealthWatch were captured by that team. Lee Henley and Kim James agreed to talk further outside of this meeting.

Councillor Massey thanked Officers for the report and stated it was good that the number of complaints was down apart from one area and questioned whether there were any common factors with these complaints. Councillor Massey also asked whether in future reports the service areas would be shown for compliments from previous years. Lee Henley stated that this was still a low number of complaints received throughout the year and noted Councillor Massey request for compliments data to capture previous years data.

RESOLVED

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

63. COVID Update

Ian Wake, Director of Public Health, provided Members with an update on COVID within in Thurrock.

- A snap shot of the COVID-19 Surveillance Dashboard for the 3 September 2020 was provided which provided details of the Exceedance RAG Report, Daily Tests and Confirmed Cases, Case Data, Contact Tracing, NHS Test and Trace and Google Mobility Report.
- That Thurrock remained at threat level zero.
- The rate of cases per 100,000 population (for last 7 days) was 5.16.
- Thurrock was ranked 135 nationally.
- The number of tests and positively rate had increased over the last seven days.
- The increase in community cases would be closely monitored.
- There had been a decrease in average age of those testing positive.
- There had been no evidence of increased health or care service use.

The Chair thanked Ian Wake for the very detailed presentation at very short notice and questioned whether the increase of those aged 30 was an indication that they had travelled on holiday. Ian Wake stated that was an interesting point as there had been some evidence that there had been some seeding especially from abroad but with the numbers so low it would be hard to confirm this.

Councillor Muldowney questioned what impact this would have on children going back to school. Ian Wake stated that more the epidemic had gone on a lot more had been learnt about risk and it was now known that not everyone was at equal risk with the risk increasing to those over the age of 50. Therefore if children were to get infected they would more than likely not have any serious health problems. That there was evidence that children would not contract COVID in the first place and less likely to transmit it if they were to contract it.

Councillor Rigby questioned at what threat level would have to be raised to before any thought of any local interventions and low local would these local interventions be. Ian Wake stated that being at zero threat level there had not been any interventions as there were detailed protocols for various risk settings with a full range of preventative work that would need to be continued within those settings. For example in care homes, video for school children and parents and the team were monitoring risks all the time. That a large scale lockdown intervention would be determined from advice from Public Health England to Central Government who would focus on the top 20 nationally, with Thurrock at 135 we were a long way from any national intervention at Thurrock level. Thurrock threat level would be raised to level 1 if there were any indication of sustained community transmission or a major outbreak in a setting or a substantial increase in hospital transmissions.

Councillor Holloway thanked Ian Wake for the update and thanked him and his team for the work undertaking in keeping the cases low in Thurrock and suggested that this report be a standing item on the work programme to which the Chair agreed.

Councillor Redsell requested that a copy of the PowerPoint be sent to Members, Democratic Services would pick up this action point.

64. Temporary reconfiguration of NHS Community Beds across Mid and South Essex including Mayfield Ward from Thurrock Hospital to Brentwood Hospital

Tania Sitch, Partnership Director, Adults Health and Social Care Thurrock (NELFT and Thurrock Council) and Stephanie Dawe (Chief Nurse and Executive Director of Integrated Care (Essex & Kent) NELFT) presented the report and stated that in response to the need to create additional Community Hospital Beds quickly to respond to the Covid Pandemic, Brentwood Community Hospital was reconfigured and Mayfield Community Hospital Beds were moved temporarily to Brentwood Community Hospital in April 2020. The Mid and South Essex partners had to agree a medium-term solution to manage the demand for community inpatient beds during the surge over the winter period. Stephanie Dawe thanked the Thurrock residents for their understanding through this challenging time and the impact this may have had on local people and that following a review by all partners looking at all of the 19 possible options the decision had been made to:

- Hold 20 beds in Halstead
- 16 beds in CICC, Rochford
- 50 beds in Brentwood Community Hospital
- 24 beds to be returned to Mayfield Ward, Thurrock Hospital
- 16 stroke beds to St Peters, Maldon
- 6 stroke beds to CICC, Rochford
- Totalling 110 beds for immediate care and 22 beds for stroke.

The Chair thanked Officers for the report and stated that it was pleasing news that the beds were returning to the Mayfield.

Councillor Holloway asked for confirmation on the 24 beds that had been removed from Thurrock Hospital all 24 beds would now be returned and asked when this would take place. Stephanie Dawe confirmed this was the case and these beds should be returned by the end of September, early October, to which Councillor Holloway stated this was fantastic news.

Councillor Holloway raised her concern that in six months' time a further review may take place that would remove those beds again and asked for reassurances that these services would remain permanently in Thurrock. Councillor Holloway also referred to the Business Case and noted there had been no mention of patients or businesses being included in this. Stephanie Dawe stated that resources would always be required in Thurrock to provide the best health care for all residents in the community. That senior clinicians

would be involved in this process and longer term work would continue to look at what was right for individuals. Councillor Holloway agreed with the principles but questioned whether health professionals would look to work in Thurrock but see that services were being moved out and would question whether this was the right place for them to live and work. Stephanie Dawe stated that patients would be continually offered home as their first destination and be able to provide specialist services locally therefore Thurrock would still be seen as a great place to live and work and would certainly encourage that.

Councillor Halden welcomed the decision to return those beds back to Mayfield and that the decision at the time to move those beds was wise and sensible it was now wise and sensible to return those beds. With winter pressures being routine for adult social care no further changes to services should be made. Where other pressures arise such as COVID, additional systems would need to be catered for and not move services out of the borough. That a permanent move of services leaving the borough would be a significant variance to the recently signed Memorandum of Understanding. Stephanie Dawe stated that work had been carried out with Thurrock Officers to ensure that what services were offered was the cohesive package and had recognised the need to have those beds there for Thurrock residents.

Councillor Muldowney welcomed the decision to move Mayfield Ward back but stated her concern that the terms did not exclude a permanent move and had continually been promised that Thurrock services would remain in Thurrock. That also patients were not involved in the report and provided Members with some example of comments received. Stephanie Dawe apologised that Members had to hear those stories and assurances were given that they wanted to get this right.

The Chair thanked Officers for the report and agreed that Members were very keen to keep services in Thurrock.

Councillor Redsell questioned the change of use of the Day Room at Mayfield to accommodate beds and was informed this would now be changed back to what it was previously.

Mark Tebbs agreed this was a good decision to bring the beds back to Thurrock during the winter period and stated how complex the process had been with 19 different options being considered to balance those services. That the COVID reset work was also looking at how more services could be moved into the community, in primary care and what opportunity there would be for outpatient services to be delivered within Thurrock. Anthony McKeever reiterated that these changes were made based on what was best for patients and it was now the right decision to bring those services back to Mayfield. Anthony McKeever thanked the Mayfield staff on the ward at Brentwood Hospital. That Stephanie Dawe had undertaken a considerable amount of work looking at all those changes and was grateful to the Health and Wellbeing Members for their support on this difficult move in such a crisis and that the Memorandum of Understanding with health care partnerships would enable develop services in place and broaden the services within the

integrated medical centres and offered reassurances and commitment to build services locally.

Councillor Holloway recognised the hard work undertaken and praised staff and thanked Councillor Halden for being in agreement with this decision. Councillor Holloway asked when Mayfield staff would be informed of those decisions. Stephanie Dawe stated as this meeting was to be broadcast live this evening, the decision had been made to ensure that staff heard it first, therefore staff were told today by letter.

Members had a brief discussion on the Integrated Medical Centres to which Roger Harris stated that a full update would be provided at the November meeting.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee to note and comment on the updated position of the Temporary reconfiguration of NHS Community Beds across Mid and South Essex including Mayfield Ward from Thurrock Hospital to Brentwood Hospital.

65. Proposed Consultation on Adult Social Care (Non-Residential) Fees and Charges 2021/22

Catherine Wilson, Strategic Lead Commissioning and Procurement, presented the report that outlined the issue of the gap between what the Council charged for domiciliary care and the actual cost the Council paid providers. Members were provided with a brief background to the report and were directed to the different charging options that were being proposed for the public consultation for internally provided and externally commissioned domiciliary care.

The Chair thanked Officers for the report and asked Councillor Halden to speak.

Councillor Halden stated he respected the scrutiny of this committee and as he had stated in his Annual Report presented at Council, care fees would need to be increased and this had now been undertaken in the most transparent way possible. With the gap increase between the cost of services and what was charged for services would create a great instability in the service and the gap had to be closed. Councillor Halden continued to state that he preferred Option 3 of the three options being presented to Members this evening, as this option would be tapped over a number of years, be able to close the gap and allow the Council to programme in above an inflation increase for the providers of domiciliary care. Councillor Halden finally stated that for a stable system that Thurrock residents could always rely on, the Council needed a flexible system to pay the workers more but needed to make sure the revenue was there. Councillor Halden thanked the Chair for giving him the opportunity to speak and left the meeting.

The Chair stated that the increase of fees was feasible and was reassured that it would only be 10% that would need to pay an increase fee.

Councillor Holloway stated that Options 1 and 2 provided figures but the recommended Option 3 there was not a breakdown of how much each year would bring in. Roger Harris stated the increase was approximately a third each year but it was very difficult to provide an exact figure as the Council had to undertake individual financial assessments on everyone and everyone's situations may be different. Councillor Holloway stated she was not happy with the increases and that it was still an incredible increase even for those 10% even when this was spread over three years. Councillor Holloway welcomed that some services had been ruled out she still had concerns that the increase had not been considered as part of a range of proposals and questioned were there any other options. Councillor Holloway requested her comments be noted for the Cabinet Paper and had not felt comfortable looking at this financial discussion on its own and asked the Chair to add to the work programme the detailed financial proposals that would be proposed for the department for fees and charges and for any other future cuts for the committee to scrutiny. Roger Harris replied by saying that at this stage the committee were only be asked to support the statutory consultation and when the recommendations come back for final decision these would be presented as other options and choices that Members would have to make. Councillor Holloway noted that the process but stated it was vital to get objections and intentions noted early on consultations. The Chair replied that he would check and if feasible would add to the work programme.

Councillor Rigby stated there was not an option not to increase the fees and agreed that Option 3, staged over three years, was sensible and would allow people to plan and would be supporting that option.

Councillor Muldowney referred to the Points of Consultation and questioned that where the responses to the consultation received back stated they did not want any increases there would be no increases. Roger Harris stated that he could not guarantee that as this would need to be looked at as part of the Council budget decisions. The purpose of the consultation was not to get a yes or no answer but would also provide the opportunity to carry out equality impact assessments, look at fair charging policies and a further range of responsibilities would be looked at. Once the results of that consultation came back to committee Members would have to make that decision on a range of budget decisions. Councillor Muldowney asked for her strong objections to be noted and stated that it was wrong that these increases in charges were being made on the most vulnerable in Thurrock. The Chair asked for clarification on the number that would pay the full charge to which Roger Harris stated that at this time this stood at 160 service users who had been assessed to pay the full cost of their care but stated that this figure could change.

Councillor Massey noted that this would be going out to consultation and echoed Councillor Holloway comments on making objections early and that the consultation would be coming back to committee. Councillor Massey questioned when the consultation would start and finish and stated he would

like to see more details of financial breakdowns. Roger Harris stated the consultation would start immediately following the report going to Cabinet on the 16 September and following their agreement. Members were informed that this was a 30 day consultation.

Councillor Redsell stated she was in favour of Option 3 but had concerns that not all people would be able to provide their responses back within this timescale. Catherine Wilson stated that the Council would endeavour to reach as many user services as possible with a questionnaire being sent to all those that received care services, the questionnaire would also be put on the portal, arrangements would also be made available for telephone enquiries and face to face meetings would take place.

Kim James requested that HealthWatch be involved in the consultation to capture some independent views and raised her concern on the 30 day consultation period and previously NHS providers that had presented to this committee had been challenged on proposed short periods of consultation and stated that this 30 days consultation period was not long enough to give service users the time to fully respond. Catherine Wilson thanked Kim James for her comments and would take away and review in consultation with HealthWatch. The Chair agreed this was a good point that should be reviewed.

Councillor Holloway stated that a better understanding was required for each individual that were being charged and agreed this should be picked up from the requested financial scrutiny report to be added to the work programme. Roger Harris reassured Councillor Holloway that her concerns were taken into account as part of the financial assessment and would be happy to forward the fair charging policy to Members. That a detailed assessment carried out looked at income and outgoings before any charges were imposed. Councillor Holloway requested that the information should be included in reports that were presented in the future.

Councillor Muldowney clarified that these charges were being made on the most vulnerable in the borough and supported Councillor Holloway that these cuts and charges should be looked at and scrutinised on block and be a substantial item on the agenda.

The Chair noted the comments made and registered Councillors Holloway and Muldowney objections and requested when the consultation report came back to committee it contained more financial data and the options alongside it.

Councillor Muldowney suggested that recommendation 2 be changed to include that the consultation period be extended to which the Chair agreed.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee reviewed the three options for charging regarding the services in scope detailed in section 3.1**

2. **That the Health and Wellbeing Overview and Scrutiny Committee supported the three options going out to public consultation. That the consultation would be extended past the 30 days originally set for this consultation.**

3. **That the Health and Wellbeing Overview and Scrutiny Committee supported consultation with providers, as soon as possible, over the rates the Council pays with the presumption of an above inflation increase to stabilise the market and reflect the increased costs arising from COVID.**

66. Procurement to provide Autism Specialist Support - Medina Road

Roger Harris, Corporate Director of Adults, Housing and Health, presented this very positive report to Members that outlined the proposal for the service model of care at the Medina Road development and the next steps for the delivery of this new service. Members were also asked to support the proposal to commence the procurement of a service provider to implement this new service into Thurrock.

The Chair thanked Officers for the positive report and stated this was an opportunity to offer long life support in Thurrock and hopefully this service would remain in Thurrock.

Councillor Redsell asked for some clarity on Page 92, Paragraph 2.5 “have a local connection or live within the borough”. Roger Harris stated that this may be someone who had originated from Thurrock but had moved into residential care outside of the borough who may now wish to move back to Thurrock.

Councillor Massey gave praise to the report and stated that the Council should build on this and do more.

Councillor Muldowney welcomed the specialist development that provided a great provision for children and families in Thurrock.

Councillor Redsell questioned why had there been an increase in the number of those being diagnosed with autism. Roger Harris stated that the number had definitely increased as more people were being recognised, that means of recognition had improved and become clearer.

The Chair agreed with the recommendations of the report and recommended that the report go to Cabinet.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee reviewed the future design of the service model to support people living at Medina Road.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee supported the proposal to commence the procurement of the support for Medina Road.**

67. Memorandum of Understanding across Mid and South Essex STP and update on CCG Merger and Single CCG Accountable Officer

Roger Harris, Corporate Director of Adults Housing and Health, presented the report that the Memorandum of Understanding currently being considered was to formalise and build on the existing partnership arrangements and relationships across the Mid and South Essex footprint. Roger Harris stated that the Memorandum of Understanding was the product of a lot of work undertaken and thanked all those involved from an STP to local level. Mark Tebbs echoed Roger Harris's comments that this was a very important report that laid the foundations for the way forward and settled the debate around system place and neighbourhood. That the report reflected the development of alliance working, the involvement in primary care networks in an alliance infrastructure and identified some challenges on the next steps around how the alliance would evolved and be developed.

Ian Wake, Director of Public Health, welcomed the report and referred Members to the Principles for Integrated Working set out on pages 113 and 114 of the document, especially Principle 5 – Subsidiarity – made the point that we should plan at the lowest footprint level possible unless there was a really good case to do something at a wider footprint level. That Principle 7 – Pragmatic Pluralism – needed to aim for a quality of outcome amongst the population. That the Council needed to continue to hold itself to account on what they had signed up to.

Councillor Holloway welcomed the report and thanked Officers for the hard work undertaken in getting the report to this committee. That the report was very substantial but stated what was important was "Place", that Thurrock was the core of our service delivery even though we were part of Mid and South Essex and would be thought of first.

The Chair thanked and noted Councillor Holloway's level of input into this.

Councillor Muldowney stated although it was a substantial document it had been good to see elements such as the focus on Place, addressing inequalities in health care deliveries and health across the area. That it was good that the Health and Wellbeing Overview and Scrutiny Committee would keep their scrutiny role alongside Essex and Southend scrutiny committees.

The Chair thanked Officers for the report and stated it was now for the committee to continue with their scrutiny.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted and commented on the Memorandum of Understanding.

68. Work Programme

Members discussed the work programme.

The Chair referred to the Care Quality Commission (CQC) rating of the Maternity Unit at Basildon University Hospital as inadequate with failings found in six serious cases and requested that a report be presented at the next meeting.

Members agreed to have a COVID Update as a standard item on the work programme.

Councillors Holloway, Muldowney and Massey requested a detailed Fees and Charges Report for November committee. The Chair agreed in principle only based on the time available for Officers to prepare the report.

The meeting finished at 9.38 pm

Approved as a true and correct record

CHAIR

DATE

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

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5 November 2020	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
Basildon University Hospital Maternity Services	
Wards and communities affected: All	**Key Decision:** Not applicable.
Report of: Diane Sarkar, Chief Nursing Officer, Mid and South Essex NHS Foundation Trust.	
Accountable Assistant Director: Not applicable – report produced by Council Partner	
Accountable Director: n/a	
This report is Public	

Executive Summary

The Care Quality Commission (CQC) carried out an inspection of maternity services at Basildon University Hospital on Friday 12 June 2020. Following this inspection, and a review of Trust incident reports, the CQC published its report on Wednesday 19 August 2020. This rated the service as Inadequate.

The Trust is extremely disappointed, but fully accepts the findings of the report and has taken urgent and significant action to improve the service. Mothers should feel safe when giving birth, and it is vital that staff are able to provide the best care to women and babies. The Basildon Maternity Unit remains safe, but did not keep pace with the increasingly complex demands being placed upon the service.

A number of changes have already been implemented and the CQC highlights this in its report. These include investing £1.8million in recruiting 29 more midwives and two additional consultants, improved security and a restructuring of ward facilities, plus we have increased bed capacity on the Delivery Suite and Cedar Ward.
We have learned from these incidents, with immediate leadership changes. The changes already made will be embedded, putting in place enhanced robust processes so that our Maternity Unit can deliver at the very highest standards.

1. Recommendation

1.1 For the Health and Wellbeing Overview and Scrutiny Committee to note and comment on this report.

2. Introduction and Background

2.1 The CQC inspected maternity services at Basildon University Hospital on Friday 12 June 2020. The inspection was unannounced and focused on maternity services. It was carried out in response to concerns raised by a whistleblower about safety in the department. Alongside this, a review of incident reports provided by the Trust showed that in March and April 2020, there were six serious incidents where babies were born in a poor condition and transferred for cooling therapy.

2.2 There is a safe maternity service at Basildon University Hospital, with lower-than-average neo-natal deaths and stillbirths. However, the service did not keep pace with the increasingly complex demands being placed upon it, with more higher-risk women using the service and a greater prevalence of obesity and diabetes, leading to increased risks of complications for these women.

3. Issues, Options and Analysis of Options

3.1 The report was published on 19 August 2020. It found the following issues:

- Poor multi-disciplinary working
- Training was not always up to date
- Staff shortages
- Safety concerns were not always identified and escalated
- Junior medical staff were not supported sufficiently
- High-risk women were giving birth in a low-risk area
- Incidents were not always graded correctly
- Lessons learnt were not always implemented
- Care records were not always securely stored.

3.2 The report found the following areas of good practice:

- Recognised issues are being addressed, but not yet embedded
- Good control of infection risk
- Staff managed medicines well
- Women protected from abuse
- Staffing levels and skill mix reviewed and adjusted
- Bank and agency staff given full inductions.

3.3 The Trust has already made the following improvements:

- New leadership team in place
- Mandatory training back on track following COVID-19
- Consultants given bleeps to respond to emergencies
- New processes and procedures in place
- £1.8million invested to recruit 29 additional midwives and two consultants
- Foetal Surveillance Lead Midwife and Better Births Lead Midwife recruited

- Three more delivery beds opened for high-risk women and four more post-natal beds
- Creation of a 24-hour triage service
- Two Continuity of Care Teams launched
- Bereavement room restructured and refurbished to provide a self-contained suite
- Birthing pool to be provided in delivery suite
- Dedicated drugs rooms built on all three ward areas
- Improved security for women and their babies: controlled entrance and exit to all ward areas
- Safe staffing and escalation policy updated and implemented
- Central monitoring for CTG
- All staff have had CTG refresher training
- Educational update for instrumental deliveries
- Strengthened delivery suite handover and huddles.

Learning will be shared across all of our hospitals.

3.4 This has already led to positive results:

- Number of perinatal deaths is below expected levels
- Number of still-births is below expected levels
- Number of complaints down on previous years and in line with national average

4. Reasons for Recommendation

4.1 This report provides an overview of the changes made and planned to the maternity services at Basildon University Hospital.

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

5.1 Consultation has taken place with Health and Care system partners. There have been extensive opportunity for local stakeholders to engage with management at the Trust to discuss these issues.

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

6.1 The recommendations of the report as set out in 1.1 have implications for users of the maternity services Basildon University Hospital. There are also implications for stakeholders including the NHS.

7. Implications

7.1 Financial

Implications verified by:

Not applicable – externally produced report

7.2 Legal

Implications verified by:

Not applicable – externally produced report

7.3 Diversity and Equality

Implications verified by:

Not applicable – externally produced report

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

None

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

Inspection Report of the CQC: Basildon University Hospital, Wednesday 19 August 2020.

9. Appendices to the report

Appendix 1 - Inspection Report of the CQC: Basildon University Hospital

Report Author:

Diane Sarkar

Chief Nursing Officer

Mid and South Essex NHS Foundation Trust

Care Quality Commission

Basildon University Hospital

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Date of inspection visit: 12/06/2020
Date of publication: 19/08/2020

Ratings

Overall rating for this hospital

Are services safe?	
Are services effective?	
Are services well-led?	

Summary of findings

Overall summary of services at Basildon University Hospital

Basildon University Hospital is operated by Mid and South Essex NHS Foundation trust. The maternity unit at Basildon University Hospital provides a comprehensive range of services including; ambulatory care assessment, prenatal diagnostic screening, antenatal care services, perinatal mental health and counselling service, midwife led birthing unit, delivery suite and home birth service.

The maternity unit offers women the following birth options:

- Home birth: around 3% of all trust births are home births.
- Midwife-led birthing unit: Located on the Willow suite, consists of five delivery rooms (including two pool rooms) and four postnatal beds.
- Delivery suite: eight birthing beds and four enhanced care beds. There are two dedicated maternity theatres.

The maternity unit also includes Cedar Ward, a 33-bedded postnatal ward that also provides antenatal care and the Mulberry Suite, which is a seven-bedded ambulatory care assessment unit for all women from 14 weeks gestation.

From April 2019 to March 2020 there were 4,304 deliveries at Basildon University Hospital.

We last inspected the maternity service at Basildon Hospital in February 2019. The service was rated requires improvement overall; safe and well led were rated requires improvement, effective, caring and responsive were rated good.

During the 2019 inspection, we identified a number of concerns in the maternity service. As a result, requirement notices for breaches of regulation 12 and 17 of the health and social care act (2014), were issued against the trust. The requirement notices informed the action the trust must take to comply with its legal obligation, and we requested an action plan from the trust, outlining steps that had been taken to address the concerns we raised. The trust submitted an action plan following publication of the inspection report in July 2019. The trust submitted regular updates on the progress of the action plan and in February 2020, the actions relating to the maternity service were all signed off as completed by the trust.

In May 2020 we received information from an anonymous whistle-blower, raising safety concerns at Basildon Hospital maternity services. The information received and a review of the trust's incident reporting data highlighted a cluster of six serious incidents where babies were born in poor condition and subsequently transferred out for cooling therapy from March and April 2020. Cooling therapy is a procedure which can be offered as a treatment option for newborn babies with brain injury caused by oxygen shortage during birth. It involves bringing baby's temperature from the normal body temperature of 37°C to a temperature between 33°C and 35°C soon after birth and for a few days afterwards.

In response to the information we carried out a focused inspection on 12 June 2020 to follow up on the concerns raised.

During this inspection we:

- Spoke with 16 staff members; including service leads, matrons, midwives, doctors, midwifery care assistants and administrative staff.
- Checked 12 pieces of equipment.
- Reviewed 12 medical records.
- Reviewed five prescription charts.

Summary of findings

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused inspection related to the concerns raised, this does not include all of our key lines of enquiry (KLOEs). As a result of this inspection we rated safe, effective and well-led as inadequate, and overall the service was rated inadequate.

We found some improvements from our last inspection. There were continued concerns in relation to requirement notices we served to the trust at our inspection February 2019. Following the focused inspection, we undertook enforcement action in relation to the maternity service, and told the trust it must improve. We issued a warning notice, on the 23 June 2020, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 14 August 2020. The trust initiated an immediate action improvement plan.

The link below is our report published following our last inspection:

https://www.cqc.org.uk/location/RDDH0/reports

Maternity

Inadequate

Summary of this service

We rated it as inadequate because:

- Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately. The service did not always have enough staff keep women safe and to provide the right care and treatment. Multidisciplinary team working was dysfunctional which had impacted on the increased number of safety incidents reported. Incidents were not always graded correctly according to the level of harm and lessons learnt were not being implemented. High risk women were inappropriately giving birth in the low risk area (Midwifery Led Birthing Unit - MLBU). Staff collected safety information, but it was not routinely shared with staff, women and visitors. Care records were not always stored securely. Most of these concerns were raised at our previous inspection February 2019, the service had not improved.
- The service did not make sure staff were competent for their roles. Senior medical staff did not support, supervise and mentor junior medical staff effectively. Staff did not always work well together. Some staff did not feel able to approach some colleagues which was not to the benefit of women and babies. There was poor multidisciplinary presence and structure to the safety handover on the delivery suite and postnatal ward.
- Leaders did not have the skills and abilities to effectively lead the service and did not operate effective governance processes throughout the service. The service did not have an open culture where staff could raise concerns without fear. There had been a lack of learning from previous incidents and actions put in place were not embedded. We were not assured the vision and strategy of the service was achievable with the current standard of multidisciplinary working within the service.

However:

- The service controlled infection risk well. Staff understood how to protect women from abuse. Staff managed medicines well.

Is the service safe?

We rated it as inadequate because:

- Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately.
- Multidisciplinary team working was dysfunctional which had impacted on the increased number of safety incidents reported.
- The service had a comprehensive training programme to provide staff with the training they required, however the trust target for attendance at training was not met by the service.
- The service had enough consultant cover although presence on the delivery suite was poor and responses to emergencies had been inconsistent.
- The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- High risk women were inappropriately giving birth in the low risk area (Midwifery Led Birthing Unit - MLBU).

Maternity

- Staff did not always record and monitor women's carbon monoxide levels in line with the trust policy and saving babies lives (2016).
- The design, maintenance and use of facilities, premises and equipment were not always suitable. The delivery suite birthing rooms were not in line with national guidance.
- Care records were not always stored securely.
- The service did not always manage safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately according to grading and level of harm. Lessons learnt from past incidents were not being implemented by the whole team and the wider service.
- The service did not use monitoring results well to improve safety. Safety information was not shared with staff, women and visitors.

However, we also found:

- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff managed clinical waste well.
- The service used systems and processes to safely prescribe, administer, record and store medicines an improvement from our last inspection February 2019.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Is the service effective?

We rated it as inadequate because:

- We were not assured that the service made sure staff were competent for their roles. There were no effective systems in place to ensure competencies of medical staff.
- Processes to manage staff competency of interpreting cardiotocography (monitoring the fetal heart) had been completed was poor
- Middle grade doctors' competencies were not reviewed, and consultant obstetricians did not support and mentor middle grade doctors appropriately.
- Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. They did not support each other to provide good care.
- The longstanding poor staff culture had created an ineffective multidisciplinary team.
- Annual appraisals had not identified that medical staff had not been competency assessed.

Is the service well-led?

We rated it as inadequate because:

Maternity

- The service leaders did not have the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation. However, staff were positive about the arrival of the interim clinical lead.
- We were not assured the vision and strategy of the service was achievable with the current standard of multidisciplinary working within the service.
- Leaders did not operate effective governance processes to continually improve the quality of its service and safeguarding standards of care. Whilst governance processes were in place these were not fully effective, there remained a lack of oversight and acknowledgment of risk and cultural concerns from the maternity senior leadership team.
- The service did not have an open culture where staff could raise concerns without fear. Staff were very aware of the long standing poor culture and safety concerns.
- There had been a lack of learning from previous incidents and actions put in place were not embedded

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service had a comprehensive training programme to provide staff with the training they required, however the trust target for attendance at training was not met by the service.

The trust set a target of 85% for completion of mandatory training, with the exception of information governance, safeguarding and mental capacity training for which the target was 95%.

A breakdown of compliance for mandatory training courses as of March 2020 for qualified midwifery staff in maternity is shown below:

Training Module name	Eligible Staff	Staff trained	Completion rate
Conflict Resolution	193	175	91%
Mental capacity Act	47	41	87%
Dementia Awareness	193	167	87%
Equality & Diversity	193	126	65%
Fire Safety Yearly (eLearning)	193	153	79%
Fire Safety (Face to Face)	193	123	64%
Information Governance	193	74	90%
Learning Disabilities	159	140	88%
Manual Handling	193	76	39%
Recognition and management of Sepsis - eLearning	192	137	71%
Record keeping - eLearning	190	170	89%

Risk management & incident reporting	193	187	97%
Venous Thromboembolism	174	148	85%
Infection prevention and control	193	178	92%
Adult Basic Life Support	191	127	66%
Neonatal Basic Life Support	190	187	98%

For the reporting period April 2019 to March 2020, the training target was met for eight of the 16 mandatory training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for mandatory training courses as of March 2020 for medical staff in maternity is shown below:

Training Module name	Eligible Staff	Staff trained	Completion rate
Conflict Resolution	19	16	84%
Mental capacity Act	26	21	81%
Dementia Awareness	30	18	60%
Equality & Diversity	30	21	70%
Fire Safety Yearly	30	17	57%
Fire Safety (Face to Face)	30	11	37%
Information Governance	30	27	80%
Learning Disabilities	8	6	75%
Manual Handling	30	24	80%
Recognition and management of Sepsis - eLearning	13	8	62%
Record keeping - eLearning	8	3	38%
Risk management & incident reporting	30	27	90%
Venous Thromboembolism	17	7	41%
Infection prevention and control	30	26	87%
Adult Basic Life Support	19	5	26%
Neonatal Basic Life Support	29	29	100%

For the reporting period April 2019 to March 2020, the training target was met for three of the 16 mandatory training modules for which medical staff in maternity were eligible.

Non-compliance with completion of mandatory training in line with the trust target was a breach identified at the February 2019 inspection and a trust wide requirement notice was issued.

During this focused inspection, mandatory training for staff in the maternity unit did not always meet the trust targets. Following the inspection, the trust executive team acknowledged that there were a number of concerns regarding training compliance within the maternity services and actions were already in place to improve compliance. Due to the

COVID-19 pandemic, all statutory and mandatory training was cancelled for three months in order to release staff to front line clinical duties. The senior leadership (SLT) team told us this had compounded the situation and the improvements the service had planned did not take effect. Following our focused inspection, the SLT informed us that statutory and mandatory training programmes had recommenced to address the poor training compliance.

We raised our concerns and were told that senior leaders were meeting with medical and midwifery staff to ensure that any outstanding training was completed by 17 July 2020. Additional dedicated adult basic life support (BLS) training sessions were specifically arranged for the service to ensure all staff receive an update by the end of August 2020.

Data provided by the service on 20 July 2020 showed 72% of midwifery and 41% of medical obstetric staff had completed their BLS training. The remaining 51 midwifes and 17 medical staff were set to complete their training by the 14 August 2020.

The mandatory training programme was comprehensive and met the needs of the maternity service. Training was provided online learning and at face to face sessions.

The service used nationally recommended 'Practical Obstetric Multi-Professional Training' (PROMPT) to deliver some of the maternity mandatory training. The delivery of PROMPT training was introduced following our inspection February 2019. The topics covered by the PROMPT training included: fetal monitoring, inverted uterus, human factors, sepsis, Modified Early Obstetrics Warning Score (MEOWS) use to identify deterioration in a woman's condition, obstetric haemorrhage (excessive bleeding), shoulder dystocia (an emergency where the baby's shoulders are difficult to birth), breech (baby is birthed bottom presenting), eclampsia (seizures during pregnancy), twin birth and cord prolapse (the baby's cord slips down in front of the baby after the waters have broken). The training was delivered by a multidisciplinary team and involved a mixture of skills and live drills sessions and presentations.

From April 2019 to March 2020, 98% of midwives and 100% of medical staff including obstetric and anaesthetic medical staff completed the PROMPT training.

Data from 18 June 2020 showed that 44% of midwifery and 24% of medical obstetric staff had completed the 'Gestation Related Optimal Weight' (GROW) e-learning, a recommendation from Saving Babies' Lives 2019. Following the inspection, we were told by senior leaders that staff were required to complete the GROW e-Learning by the 31 March 2020. However due to the Covid-19 pandemic a decision was made to suspend the learning. On the 9 June 2020 GROW e-learning training was reinstated and all staff have been given until the 19 July 2020 to complete the training. As of 20 July 2020, 94% of midwifery and 45% of medical obstetric staff had completed the GROW e-learning. The remaining 28 midwifery and medical obstetric staff were set to complete by 30 July 2020.

The trust employed three practice development midwives (PDMs) who were responsible for developing and delivering the mandatory training programme and recording midwifery attendance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training attendance was monitored electronically, and staff received reminders to complete training. Training compliance remained poor, therefore we were not assured that oversight was robust.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Medical staff had not all completed training on how to recognise and report abuse, however they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

Maternity

A breakdown of compliance for safeguarding training courses as of June 2020 for qualified nursing and midwifery staff in maternity is shown below:

Name of course	Number of staff eligible	Number of staff trained	Completion rate
Preventing Radicalisation Basic	193	174	90%
Preventing Radicalisation Awareness	189	165	87%
Safeguarding Adults Level 1	192	181	94%
Safeguarding Adults Level 2	188	119	63%
Safeguarding Children Level 1	241	235	98%
Safeguarding Children Level 2	224	214	96%
Safeguarding Children Level 3	206	196	95%

The trust compliance target was met for five of the seven safeguarding training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as of June 2020 for medical staff in maternity is shown below:

Name of course	Number of staff eligible	Number of staff trained	Completion rate
Preventing Radicalisation Basic	19	19	63%
Preventing Radicalisation Awareness	19	11	58%
Safeguarding Adults Level 1	15	12	80%
Safeguarding Adults Level 2	30	16	53%
Safeguarding Children Level 1	30	27	90%
Safeguarding Children Level 2	30	27	90%
Safeguarding Children Level 3	23	20	87%

The trust compliance target was not met for any of the safeguarding modules for which medical staff were eligible. The maternity senior leadership team told us that due to the COVID-19 pandemic, all statutory and mandatory training was cancelled for three months in order to release staff to front line clinical duties. Medical staff had been allocated to the next available training sessions.

Midwifery and medical staff received safeguarding training specific for their role on how to recognise and report abuse. The safeguarding training staff received included child sexual exploitation (CSE) and female genital mutilation (FGM).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The staff we spoke with could confidently inform us of what a safeguarding concern would be and their process for reporting this. For example, domestic violence cases were some of the issues that had been identified and reported by maternity staff. Staff used the trust intranet safeguarding page to access contact details for further advice or support with safeguarding referrals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were familiar with the process of escalation and referral to the safeguarding specialist midwife for extra support and understood the reporting system for women presenting with FGM. Staff told us they were always able to get support from the lead safeguarding midwife if they needed advice.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well maintained.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The service had housekeeping staff who were responsible for cleaning wards and public areas, in accordance with daily and weekly checklists.

Staff cleaned equipment after each contact and labelled equipment to show when it was last cleaned. We saw that there was a system in use throughout the service to identify clean equipment by using 'I am clean' stickers.

Infection prevention and control (IPC) audits were undertaken and the results were used to improve IPC practice where needed. From December 2019 to May 2020, the service scored 100% for all elements of the cleaning and decontamination monthly audit.

The service audited hand hygiene and displayed the results in the entrance to the ward area. Data from December 2019 to May 2020 showed that all areas of the service scored 100% in the monthly hand hygiene audit, with the exception of Cedar Ward scoring 90% for December 2019.

The service followed current guidance for infection prevention and control when assessing and caring for women with possible or confirmed cases of COVID-19.

Women with possible or confirmed COVID-19 were cared for in a side room away from other women. We saw good practice when staff attended to these women, they were cared for in single side rooms with appropriate IPC signage and staff wore the correct personal protective equipment (PPE) before making contact.

Staff followed infection control principles including the use of appropriate PPE. We observed staff using PPE which was readily available, such as disposable gloves, masks and aprons.

We observed staff adhered to the trust's 'bare below the elbows' policy to enable effective hand washing and reduce the risk of spreading infections. We observed staff performed hand washing before and after episodes of direct care. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public.

Women were screened for Methicillin resistant Staphylococcus aureus (MRSA) at booking. Where inpatient women had a known or suspected infection, they were cared for in single side rooms. There had been no cases of Clostridium difficile (C Diff) or MRSA bloodstream infections in the maternity service from September 2019 to November 2019.

Environment and equipment

The service mostly had suitable premises to care for women. Staff managed clinical waste well.

During our focused inspection the Midwife Lead Birthing unit (MLBU) was closed following an assessment due to escalation of staffing issues, this was in line with the trust policy, therefore we did not visit this area.

The birthing rooms on the delivery suite did not have en suite facilities, which meant women in the delivery suite had to walk past other women, visitors and staff to use any toilet or shower facilities. This was not in line with national guidance (Department of Health (DH), Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities (2013)). The service had plans for the future to improve services however this work was in its infancy.

The service had two dedicated obstetric theatres and recovery area. The neonatal unit was close by if a baby's condition deteriorated and they required an urgent transfer.

Maternity

In February 2020 the service started a capital build project to increase bed capacity and support care of women in the appropriate setting. This included work to the delivery suite, postnatal ward, the development of the bereavement facilities and a birthing pool on the delivery suite.

Due to COVID-19 pandemic, the suspension of building works had led to some delay with completing the work. However, at the time of our focused inspection six extra beds had been opened, four on the postnatal ward and two on delivery suite.

We were told that work on the bereavement suite improvements would recommence on the 8 June 2020 and would be completed by the end of June 2020 and that work on the birthing pool would commence by the end of June 2020.

During our focused inspection a number of staff told us that they were not involved or consulted in the redesign and layout of the ward area. This was particularly highlighted about the redesign of Cedar Ward. Staff felt the new layout was not workable, for example the desk and administrative space was much smaller and located further away from where the bedded bays were. This meant staff had to either write their notes just outside the bay which did not offer any privacy or take the notes to the desk area some distance away from the women and babies they were caring for.

All areas of the maternity units had card swipe in access for staff and visitors had to ring the buzzer to gain entry or exit. This was an improvement from the last inspection in February 2019 where we were not assured that staff were monitoring who was accessing the ward to mitigate the risk of a baby abduction.

The entrance to each ward was manned by a ward clerk between 9am and 5pm each day and after hours ward staff were responsible for ensuring the correct entry and exit procedure was adhered too. A camera monitor was positioned at the midwifery station which showed who was at the door awaiting entry or exit.

The service had enough suitable equipment to help them to safely care for women and babies. We checked 12 items of equipment and saw that they had up to date safety testing including resuscitaires, weighting scales and sonicaids, which are used to monitor the fetal heartbeat.

Staff carried out daily safety checks of specialist equipment. Staff checked adult and neonatal emergency equipment daily. We reviewed daily checklists for the emergency equipment from 15 April to 12 May 2020 which were all completed.

Staff disposed clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed in sharps containers which were dated and labelled with the hospital's details for traceability purposes. This was in line with national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013)).

Arrangements for the control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials. Staff disposed of clinical waste safely.

Assessing and responding to risk

Staff did not always fully complete risk assessments for each woman. Risk was not always acted upon appropriately.

The Mulberry assessment unit had a designated four-bedded bed and three triage rooms. This provided 24-hour assessment, review and care planning for pregnant women from 16 weeks gestation. Women who visited the assessment unit were triaged by midwives using a traffic light RAG (red, amber, green) rating to see a midwife and/or doctor based on the symptoms they had. We reviewed the notes of seven women who visited the assessment unit, and all were seen within the appropriate time for their RAG rating. This was in line with national guidance (National Institute for Health and Care Excellence (NICE), Safe midwifery staffing for maternity settings overview (September 2019)).

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff took all observations required and scored correctly on the 'Modified Early Obstetric Warning Score' (MEOWS) charts. We reviewed 19 MEOWS charts in women's records on the day assessment unit, delivery suite and postnatal ward, we found all observations were completed and scored correctly.

Staff used a nationally recognised tool the 'Newborn Early Warning Score' (NEWS) to identify new born babies at risk of deterioration. At the time of our inspection we reviewed the two available NEWS charts, which were both completed and scored correctly.

Managers told us audits had recently started to assess compliance with the MEOWS guideline. We requested the last three audits and received the audit results and action plans for only one audit in June 2020 the month we inspected. The results showed out of 50 sets of healthcare records which were randomly selected from women who delivered in April 2020; 100% had a MEOWS assessment undertaken on maternity triage and 79% on antenatal admission. The audit also showed that MEOWS assessment was undertaken 12 hourly in only 52% of antenatal admissions and in 66% following birth. However, in postnatal ward, 12 hourly MEOWS assessments were undertaken in 93% of cases. The audit also showed that, nearly 50% of cases were not actioned in accordance with guidance when a MEOWS triggered a score of one or two, the majority of observations were repeated between two or three hours when they should be reassessed every hour. The action plan that was submitted consisted eight actions for the service to complete. The action plan had just been developed in June 2020 the month of our inspection and was yet to be implemented.

Staff used a buddy system to review cardiotocography (CTG) interpretation. This was in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). The service used the 'fresh eyes' approach. This meant a second midwife was required to review the CTG recording hourly during the woman's labour, to ensure it had been interpreted and classified correctly and escalated when needed. We reviewed 12 maternity records which showed CTG peer reviews were performed hourly and were escalated appropriately.

During the focused inspection the maternity senior leadership team told us, in response to the findings from the review of six serious incidents, themes had been identified with misinterpretation of CTGs and where abnormalities had been identified this had not been appropriately escalated. The SLT told us they had taken immediate action, which included; only senior midwives signed off CTG fresh eyes, classifications, and discontinuation. However, staff told us that some senior midwives were not up to date with their CTG training and competencies but signed off CTGs. We escalated our concerns to the maternity senior leadership team and following the inspection we received confirmation that all senior midwives had completed training and been assessed and were competent for CTG interpretation.

Staff did not always complete screening for specific risk issues. For example, we found that carbon monoxide screening which is part of the 'saving babies lives 2016' initiative was not always performed in line with trust guidance. We reviewed 12 records for carbon monoxide monitoring and found that all 12 women's records showed that they were not monitored in line with the trust's policy. Information provided post inspection stated that an electronic system for all antenatal bookings had been introduced in September 2019 and that this had replaced the antenatal booking handheld maternity records. Data provided demonstrated that compliance with testing of carbon monoxide ranged between 90% in November 2019 and 86% in February 2020. This meant the target within the trust guideline that "all women be offered a carbon monoxide screen" was not being met. In addition, having two systems duplicating the same information meant a potential risk of inconsistent and incomplete documentation.

Staff completed booking risk assessments for each woman at their initial booking appointment which included social, medical, obstetric and mental health assessments. This enabled staff to decide if the woman was a high or low risk pregnancy, staff updated them throughout pregnancy, labour and the postnatal period as needed. We reviewed 12 maternity care records which confirmed these details.

Maternity

Women who were assessed as high-risk and unsuitable for the midwife led birthing unit (MLBU) were referred to an obstetrician for review and management. However, following our inspection we reviewed the midwifery led birthing unit births report for April and May 2020 and found high risk women were inappropriately giving birth in the MLBU low risk area. There were three cases in April 2020 and four cases in May 2020 which showed high risk women had given birth in the MLBU. This was an area of concern highlighted in the February 2019 inspection and a requirement notice was issued. We escalated our concerns to the trust executive leadership team and received information that a review of all of the cases in April and May 2020 had taken place. Of the seven cases, three were confirmed as high-risk women and the service had developed an action plan to address the immediate concerns. However, this was yet to be embedded.

Staff completed venous thromboembolism (VTE) assessments of in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein.

We attended a delivery suite safety handover. This was not multi-disciplinary (MDT) attended, there was no representation from the neonatal unit (NICU) or theatres. The format of the handover was not effective, the anaesthetist arrived late, there were several interruptions and on some occasions two conversations were happening at the same time. The handover from the postnatal ward did not follow situation, background, assessment, recommendation (SBAR) format. SBAR is a tool used to facilitate prompt and appropriate communication between wards/services. Senior staff had to prompt staff to give more information regarding the women's history and care plan. Women were referred to by their room number and not their name, which posed a risk if the woman moved rooms or wards.

We reviewed the delivery suite safety handover daily register for week commencing 8 June 2020; on the 8 and 11 June there was no junior doctor present and, on the 10 June 2020, there was no anaesthetist present at the handover. The afternoon medical staff board round from the 8 June 2020 to 10 June 2020 was blank therefore we were not assured that the medical board round was actually held on these dates.

During the morning safety handover, there was no mention of staffing levels, acuity or escalation. On the day of the focused inspection, the Midwifery led birthing unit (MLBU) was closed but this information was not shared. We raised our concerns and following the focused inspection, we were told that the MLBU lead midwife would attend the delivery suite safety huddle at every shift change to update the delivery suite coordinator with regards to all women present on the MLBU.

Midwives did not receive a full handover of all the activities within the delivery suite at the beginning of their shift. Staff told us when they were allocated a woman to care for or if they had to cover for a colleague's break time, they would receive a one to one handover from their colleague. If there was an emergency and urgent cover was needed, the midwife would not have full knowledge of all of the risks and plans of care for all women or the activity on the delivery suite. They would also not be present for the daily safety briefings. This was yet to be embedded and audited as compliant.

There was a pathway for the management of sepsis. Staff we spoke with described what actions they would take if a woman was admitted with suspected or known sepsis including the prompt use of the sepsis six tool, administration of fluids and antibiotics.

Swabs used for vaginal birth and perineal suturing were counted for completeness by two members of staff. This was in line with national recommendations (NSPA, Reducing the risk of retained swabs after vaginal birth and perineal suturing: 1229 (May 2010). We reviewed 12 records and saw two members of staff had verified the swab count.

The World Health Organisation (WHO) surgical safety checklist 'Five Steps to Safer Surgery' was used in maternity theatres. The service carried out observational audit to demonstrate compliance in all sections of the checklist utilised in maternity theatre. The audit measures whether all sections of the checklist are verbalised, exceptions noted and that all relevant staff are fully involved in the process. The WHO surgical checklist maternity observational audit report

showed compliance for the anaesthetist sign out from October 2019 to December 2019 was 36.2% and compliance from January 2020 to March 2020 was worse at 18.3%. Anaesthetist sign out compliance was identified at the February 2019 inspection as poor and a requirement notice was issued. Processes of monitoring improvement have not been effective to mitigate or reduce the omissions.

The service shared an action plan that had been developed to improve compliance. The service planned to re-audit completion of surgical safety checklists in June 2020. During the focused inspection we reviewed seven WHO checklists and found they were fully completed.

Midwifery and nurse staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, to mitigate the risk of harm managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough midwifery staff to keep women and babies safe. Staff told us the delivery suite coordinator was not always supernumerary which meant that in the event that a high number of women attended the delivery suite then they would be providing one to one care for a woman and not facilitating the communication between professionals and overseeing the risk and appropriate use of resources. This was not in line with the 'Safer Childbirth recommendations, October 2007, which states that each delivery suite must have a rota of experienced senior midwives as delivery suite shift coordinators, supernumerary to the staffing numbers required for one-to-one care.'

The service used an acuity tool to identify if the it had the correct number of midwives employed to match the acuity of women accessing the service. Acuity is the measurement used to decide the level of care needed by a woman when in labour and giving birth. The service had conducted a staffing review in 2019 which indicated there was a shortfall of 15.39 whole time equivalent (WTE) registered midwives and 10.98 WTE for maternity support staff. The maternity senior leadership team told us the service was in the process of recruiting midwives.

The managers told us they adjusted staffing levels daily according to the needs of women. The service had an escalation policy which all staff we spoke with were aware of. The policy included calling in community midwives or closing the MLBU in the event of high levels of activity or staff shortages. Staffing was reviewed by managers within the service four times a day.

We saw staffing levels were displayed publicly in all clinical areas for midwives and maternity care assistants. On the day of our focused inspection we found planned staffing levels were mostly met. Although there were staffing shortages managers filled vacancy with bank or agency midwives. The service tried to use midwives familiar to the service all bank or agency midwives had received an induction.

Planned vs actual

The trust reported the following numbers for qualified midwifery staff for June 2020 below for maternity services:

	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing and midwifery staff	193.78	169.18	87.3%

Vacancy rates

As of June 2020, the trust reported an overall vacancy of 20.32 WTE which equated to 10.49% of qualified midwifery staff in maternity. The trust told us that they had recruited 20 WTE midwives who were due to commence their role in September 2020.

Turnover rates

Maternity

From June 2019 to May 2020 the trust reported an overall turnover rate of 6.41% for qualified midwifery staff in maternity. This was lower than the trust target for turnover of 12%.

Sickness rates

From June 2019 to May 2020 the trust reported an average sickness rate of 5.6% for qualified midwifery staff in maternity. This was higher than the trust target of 4%.

Bank staff usage

The service used bank staff to fill gaps in midwifery staff. Bank staff completed an induction programme before working in the service. Ward managers told us they tried to use the same staff to promote continuity of care for women.

From January to March 2020 the service reported 6427 hours were covered by bank midwives.

Medical staffing

The trust informed us that medical staff worked across maternity and gynaecology. For this reason, the data below includes medical staff that work in both core services.

Planned vs actual

The trust reported the following numbers for medical staff for June 2020 below for maternity and gynaecology services:

	Planned WTE Staff	Actual WTE Staff	Fill rate
Gynae Clinical Services	1.00	0.00	
Obstetrics Clinical Services	34.75	30.80	88.6%
Total	35.75	30.80	88.6%

The service had sufficient consultants to cover presence on the delivery suite in line with national guidance 'Labour Ward Solutions (Good Practice No. 10) 2010'. Monday to Friday, consultants were rostered from 8am to 8pm and from 8pm to next day 8am on call off site. At weekends the consultants were rostered for five hours each day and when required to provide offsite on call cover.

During the focused inspection the maternity senior leadership team (SLT) and staff told us there was lack of consultant body support to junior doctors and midwives. Staff told us consultant presence was very poor. The junior members of staff were not comfortable asking consultants for support. In addition, the maternity SLT stated that the consultant body did not feel that it was part of their role to support and teach the junior members of staff. Following the identification of themes from the cluster of six serious incidents the executive team had appointed a new interim maternity clinical director and general manager to ensure clinical presence on the delivery suite improved. Staff spoke highly of this change; however, this had just been actioned in May 2020, we were not assured that this was an embedded practice.

Staff told us that there was a lack of response by consultants to emergencies which meant delays in treating women. An action had been put in place for all consultants to carry bleeps in May 2020. The SLT were monitoring this action, however, this was yet to be embedded and response times were not yet audited.

We escalated our concern to the executive leaders and following our inspection, we received confirmation that a number of changes had been implemented to increase consultant presence on the delivery suite. This included the SLT meeting with the consultant body, reviewing competencies of junior medical staff and supporting them with training. Utilising senior locum medical staff to support the service. All elective caesarean sections would be performed by a

consultant dedicated to an all-day list and not on call for emergencies. This meant that there would be a dedicated consultant that covered delivery suite. In addition, gynaecology and antenatal triage emergencies were going to be managed by a separate consultant from 9 am to 6 pm Monday to Friday. All of these actions had been implemented May 2020, therefore we were not assured that these were embedded, and practices had changed.

Vacancy rates

As of June 2020, the trust reported an overall vacancy of 5.55 WTE, which equated to 15.27% of medical staff working across maternity and gynaecology. The trust reported that the vacancies were in middle grade medical staff posts. Senior leaders for the service told us that they were conducting interviews in July 2020 to recruit into the vacant posts. There were no vacancies in consultant roles.

Turnover rates

From June 2019 to May 2020 the trust reported an overall turnover rate of 2.40% for medical staff working across maternity and gynaecology. This was lower than the trust target for turnover of 12%

Sickness rates

From June 2019 to May 2020 the trust reported an average sickness rate of 2.74% for medical staff working across maternity and gynaecology. This was lower than the trust target of 4%.

Bank and locum staff usage

Locum staff were employed to complete any rota gaps and staff confirmed locum doctors were regularly employed within the service. The service had an induction process to ensure locum doctors understood the process and protocols and to familiarise them with the environment.

From January to March 2020 the service reported 767 hours were covered by bank and 1807 hours covered by locum doctors.

Records

Staff kept detailed records of women's care and treatment, but records were not always completed in line with good practice. Information that was recorded in records was clear, up-to-date and easily available to all staff providing care. Records were not always stored securely.

Staff could access women's records easily. The service mainly used paper-based records, with some information held on the trust's electronic patient record system.

We viewed 12 care records of women who had used the maternity service in the previous 48 hours or whom were still on the ward at time of inspection. The records related to all of the episodes of care during their pregnancy. The records were mostly completed in line with records management code of practice for health and social care. However, records did not always include time of the woman's antenatal appointment this was not in line with the national Nursing and Midwifery (NMC) record keeping guidance (January 2019). This was an issue identified at our February 2019 inspection and a requirement notice was issued to the trust. In addition, staff did not always complete carbon monoxide screening in line with trust guidance. We have provided further detail in the assessing and responding to risk to women and babies section.

During our inspection in February 2019, the completion of women's records in line with trust policy and national guidance was an area identified as a concern and a requirement notice was issued. During this focused inspection some improvements had been made. For example, fetal movements, date of the observation and signature of the member staff undertaking the review were all completed in line with trust policy.

Records were not always stored securely. On the postnatal ward the records were kept in lockable mobile storage trolleys, at the end of each bedded bay. On two occasions during our focused inspection these were left unlocked and accessible to women and unauthorised personnel. Staff we spoke to also stated that this was an issue especially since the changes to the layout of the postnatal ward. Therefore, we were not assured that the service kept women's records secure at all times.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Medicines were stored securely in all clinical areas we visited. Since the February 2019 inspection Cedar and Willow Wards medicine rooms were moved into purpose built rooms which were compliant with medicine management standards. This was an improvement from our last inspection February 2020.

Controlled drugs (medicines subject to additional security measures) were stored correctly in locked cupboards and stock was checked by two qualified members of staff twice a day.

We found medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines we checked were within their use by date, including intravenous fluids (fluid given through a vein).

We saw that staff kept records of medicines fridge temperatures and ambient room temperature of their medicine rooms on the delivery suite and postnatal ward.

Secure bedside storage was provided for women's own medicines, which meant women's own medications were stored securely on the wards. This was an improvement from the February 2019 inspection

Staff reviewed women's medicines regularly and provided specific advice to in relation to options of pain relief during and following the birth of their baby. The service had access to pharmacy staff to support the maternity areas.

We reviewed the medicine records for five women and found prescriptions were readable and signed, allergies were clearly documented, and administration and route of administration were also clearly recorded. However, women's weight was not documented in three prescription charts. This is important because the correct dose of some medicines are determined by a woman's weight, such as anti-clotting medicine.

Women at risk of developing a blood clot were prescribed anti-clotting medicine to reduce this risk; the correct dose of which was determined by the woman's weight. However, staff told us they used the woman's booking weight to determine the correct dose which was in line with national guidance (RCOG, Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium: Green-top Guideline No. 37a (April 2015).

Incidents

The service reported safety incidents, staff recognised incidents and reported them. However, we were not assured that incidents were always graded correctly according to the level of harm and if lessons learnt from past incidents were being shared with the whole team and the wider service.

Staff we spoke with knew what incidents to report and how to report them. The trust used an electronic reporting system which all grades of staff had access to. Staff we spoke with said they were encouraged to report incidents.

From January 2019 to December 2019, staff reported 1,697 maternity incidents through the National Reporting and Learning System (NRLS). The incidents were graded as having caused no harm (88%), low harm (11%), moderate harm (0.5%), severe harm or death (0.1%). The most common themes for incidents reported were related to treatment and/or procedure (41%), access, admission, transfer, discharge (including missing patient) (13%) and other (22%).

Never events

Maternity

From April 2019 to March 2020 the service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. All potential serious incidents were reviewed by the trust's serious incident panel which met three times a week. If an incident was declared as a serious incident the panel appointed an appropriate senior member of staff to lead the investigation and conduct a root cause analysis (RCA). Incidents which met the reporting criteria were referred to the Healthcare Safety Investigation Branch (HSIB) for independent investigation. The HSIB's maternity investigation programme is part of a national action plan to make maternity care safer. They investigate incidents that meet the 'Each Baby Counts' criteria and maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from April 2019 to December 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	11	85%
Maternity/obstetric incident meeting SI criteria: mother only	2	15%
Total	13	100%

We reviewed the root cause analysis for nine of the 13 serious incidents reported between April 2019 to December 2019. The themes identified included; incorrect interpretation of CTGs and failure to escalate risk from midwife to middle grade doctors and from middle grade doctors to consultants.

The service had a maternal death in February 2019, which was investigated and an action plan produced. The issues identified from the investigation related to: incorrect interpretation of CTGs; failure to escalate risk from the midwives to medical staff; and failure to escalate risk from middle grade doctors to consultants. There were a further six serious incidents reported between January 2020 and April 2020. These serious incidents identified the same failings of care. This demonstrated a lack of learning from previous incidents and actions put in place were not embedded. Therefore, we were not assured that lessons were being learnt to prevent similar incidents from occurring.

We observed that incidents were not always graded correctly. For example, incidents reported on NRLS by the trust from January 2020 to April 2020, a post-partum haemorrhage (PPH) with blood loss of 3000ml, a maternal transfer to intensive therapy unit (ITU) and term babies admitted to the neonatal unit were graded as no or low harm. This meant that there was a risk that women were not informed of the significance of harm caused to them or their baby, or that appropriate action was taken to prevent further occurrences. This was an area that was identified at the February 2019 inspection and a requirement notice was issued.

The trust had an up to date duty of candour policy which staff could access through the trust's intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of

the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with women and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. However, where incidents were not graded correctly there was a risk woman may not receive the correct response, duty of candour and support from staff.

Safety thermometer

Staff collected safety information, but it was not routinely shared with staff, women and visitors.

Safety thermometer data was not displayed on wards for staff and women to see. While managers collected data for the maternity safety thermometer, the results were not displayed.

Managers submitted data monthly to the national maternity safety thermometer. The safety thermometer was designed to support improvements in women's care and experience. Harms associated with maternity were recorded such as perineal trauma, infection and babies with an apgar score less than seven at five minutes. An apgar score is a tool to assess the condition and wellbeing of a baby following birth.

The maternity safety thermometer data from August 2019 to October 2019 showed the service achieved an average of 81.3% harm free care. This was higher than the England average of 76.3%.

Is the service effective?

Competent staff

We were not assured that the service made sure staff were competent for their roles.

At the time of the focused inspection there were no effective systems in place to ensure competencies of staff to interpret cardiotocography (CTG) had been completed. There was poor audit and recognition of staff CTG training compliance and competency assessments following repeated themes identified from serious incidents of misinterpretation of CTG traces.

As a result of the six serious incidents reported between January to April 2020, the service review highlighted concerns about incorrect CTG classifications and lack of escalation which resulted in harm to some mothers and babies. The service decided that only senior midwives were allowed to sign off classifications, discontinuation and hourly reviews of CTG traces.

We raised our concerns with the trust executive team that the senior oversight and staffing on delivery suite could be compromised due to the senior midwives leaving the delivery suite to review CTGs in other areas of the unit.

During our inspection staff told us there were midwives and junior midwives that had completed CTG training and competency assessments, who were no longer allowed to utilise their skills to classify, discontinue or perform a fresh eyes hourly reviews of CTG traces. This decision was based on seniority and not competence of staff and posed potential delays for senior midwives to be able to leave the delivery suite to review CTGs in other areas.

Following the inspection, the trust notified us that actions had been taken to manage and mitigate immediate risk of harm. A masterclass had been booked for all staff to attend and a new competency work book would be completed by all staff. Not all staff had been allocated to attend, we raised our concerns and the executive team responded that more sessions had been arranged and staff in high risk areas would be prioritised to attend first. Training was due to be fully completed September 2020.

The maternity senior leadership team (SLT) told us during our focused inspection that there had been a lack of consultant body support for junior medical staff. Consultant response to an emergency was inconsistent and consultant

presence on the delivery suite was very poor. The junior medical staff were not comfortable asking the consultants for support as they were made to feel incompetent. The maternity SLT said that following a meeting with the consultants in May 2020, the consultants felt it was not their role to support and teach the junior staff. An action plan to address the lack of junior staff supervision and support had been developed by the SLT and was implemented in June 2020. However, the action plan was dependent on the interim clinical director checking consultant presence on the delivery suite daily. In addition, the interim clinical director telephoned the delivery suite every evening to ensure consultant presence at the evening board round and handover; they also checked if the midwives and middle- grade medical staff were happy with the plan of care for women overnight whilst the consultant was on call from home. These actions have only just been put in place, therefore were not yet embedded and audited as compliant.

The SLT told us middle grade doctors' competencies were not reviewed and that the consultant obstetricians did not support and mentor middle-grade doctors appropriately. Following the focused inspection, the executive team informed us that processes were in place to review all middle grade doctors' competencies. As a result, six middle grade doctors had been placed under supervision by senior locum middle grade doctors to ensure they met all of their competencies.

In addition, senior leaders told us that the training director and trainee medical staff had devised an action plan to improve supervision of the junior medical staff, and encouraged the junior medical staff to speak out and raise concerns. This was only implemented in June 2020 and therefore is yet to be embedded.

Staff told us the clinical educators supported the learning and development needs of staff. The service had three practice development midwifes (PDM). The PDM's role included organising mandatory training, inductions for new staff and band five midwives' (junior midwives) preceptorship training. A preceptorship is a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.

Professional midwifery advocates (PMAs) supported midwifery staff to develop through regular, constructive clinical supervision of their work. The PMAs provided group clinical supervision sessions. Staff could also contact a PMA for advice and support when needed, such as if they had been involved in an incident.

The service had staff members who were trained to deliver the Practical Obstetric Multi-Professional Training (PROMPT) approach to obstetric emergency training. The PROMPT team consisted of consultant obstetricians, anaesthetists and midwives.

Appraisal rates

The service met the trust's target of 90% for appraisals between June 2019 and May 2020. Appraisal compliance data for midwifery and medical staff in maternity is below:

Staffing group	Appraisals required	Appraisals Complete	Completion rate	Target met
Qualified Midwifery Staff	192	177	92%	Yes
Medical Staff	30	29	97%	Yes

However due to the concerns raised regarding middle grade doctors' competencies, we were not assured how comprehensive appraisals had been.

Multidisciplinary working

Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. Staff were not always supportive of each other to provide good care.

Staff did not hold regular multidisciplinary handover meetings to discuss women and babies and improve their care. Not all staff necessary in assessing, planning and delivering women's care and treatment were present.

We observed the delivery suite morning safety huddle. This was not attended by all members of the multidisciplinary team. There was no representation from the neonatal unit or theatres. There was some confusion at the beginning of the handover who was leading the discussions. The 'sharing concerns' bulletin was not discussed, a folder was referred to if staff wanted to read them. We raised our concerns to the trust executive leadership team and following our inspection we were informed that neonatal staff and theatre staff would attend, and the sharing concerns bulletin would be read out loud for the multidisciplinary team to discuss.

Staff told us that consultant presence had been inconsistent and that senior medical oversight and supervision and support for the delivery suite team was poor. This history had affected team work and led to difficulty with multidisciplinary decisions being made with high risk cases and emergencies. Following the review of the cluster of incidents from January 2020 to April 2020, a theme identified was there had been a team lack of awareness and appreciation of the roles and responsibilities of others.

Some staff told us that not all consultants and midwives were approachable and accepting of new initiatives and guidance, they were resistant and wanted to continue old practices. Since the appointment of the clinical director May 2020 there had been actions agreed and some improvement, staff welcomed this change. However, this had been recently implemented and was yet to be embedded in practice,

The service held multidisciplinary clinics for women to attend, such as, diabetes clinic which included the diabetic team support.

The anaesthetists held an antenatal clinic for women determined as needing an anaesthetic review. However, staff told us that the clinics were double booked and felt they couldn't give women enough time. Staff told us, since the interim clinical lead started a dedicated anaesthetist was assigned to the elective caesarean section lists on Tuesdays and Thursdays.

There was an enhanced care area within the delivery suite for women requiring extra observations and care. Staff could call for the outreach critical care team for support if they were required. Women who needed level two care (support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care) were transferred to the intensive care unit.

Staff we spoke with said that mental health referrals were dealt with efficiently, in an emergency they would call the obstetric team and mental health team to attend. The service had a vulnerable women midwife to support midwives, women and their families.

Is the service well-led?

Leadership

We were not assured that the service leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation.

Maternity services were within the women's and children's division in the trust's structure. There was a head of midwifery, clinical director and general manager.

At the time of our focused inspection, following the cluster of serious incidents from January 2020 to April 2020 the trust's group clinical director for the three hospitals maternity services had stepped in as an interim clinical director for Basildon hospital. In addition, the service had an interim general manager. Following the inspection, we were informed the trust was reviewing the operating model to bring together management and leadership of services across the three sites. This would then determine any subsequent recruitment.

The head of midwifery (HOM) and the clinical director met with the chief nurse but did not present regularly to the board in line with Spotlight for Maternity 2016. The 'Spotlight on Maternity' March 2016 states 'to ensure that there is a board-level focus on improving safety and outcomes in maternity services, organisations should provide the opportunity for the Medical Director for maternity and the Head of Midwifery to present regularly to the board.' This was an area of concern that was raised at the February 2019 inspection for which a requirement notice was issued.

During our focused inspection, the HOM told us that in the last 12 months she had only presented once to the board. We were told that the chief nurse met monthly with the HOM and clinical director to discuss performance, operational capacity and any concerns. We asked for copies of the last three meeting minutes and found these meetings were held every two months and not monthly. We also noted that the clinical director did not attend two out of the three meetings. The chief nurse also met monthly with all three of the HOM across the trust. We requested minutes of these meetings; however, none were received.

Information provided post inspection outlined that as part of the integration of the corporate governance structures across the group principle assurance committees would meet in common only and retain oversight of performance at individual site level.

We were provided with information that demonstrated papers relating to the maternity service were regularly submitted to the monthly 'quality committees in common', 'site governance forum' and quarterly 'boards in common' meetings. However, direct presentation by either the director and / or head of midwifery was less frequent, occurring quarterly. In the absence of the maternity leadership team presenting to the board the chief nurse would present. However, due to the infrequency of meetings between the chief nurse, head of midwifery and clinical director, where all were in attendance, and lack of minutes from the meetings between the chief nurse and all three HOM we were not assured that concerns were being escalated to the board in a timely manner.

The executive team, maternity senior leadership team, managers and staff reported a longstanding poor culture over a number of years, which had resulted in a deterioration of the safety of the service, and as a result governance and oversight for improved progress and change was not robust. We raised our concerns to the executive team regarding the length of time maternity senior leadership team (SLT) had allowed the culture to continue and were provided with a change in the maternity SLT structure with the appointment of an interim clinical director and general manager from another hospital within the trust and an action plan to address the SLT issues.

Following our focused inspection, the executive leaders acknowledged that culture in the maternity unit needed to be improved and that they had been addressing this since the last inspection in February 2019. In May 2020, concerns for the safety of women and babies were raised by a whistle-blower to the CQC. During our focused inspection, the SLT told us the poor culture had been present for numerous years. Therefore, we were not assured sufficient steps had been taken to address the culture issues prior to the interim clinical director and general manager's appointment. Whilst actions and change of processes to improve culture were implemented in May 2020, this was still in its infancy and yet to be embedded.

The new SLT also told us that there had been a lack of leadership oversight of the consultant body's support for junior medical staff. The junior medical staff found it difficult to approach and escalate risk to some of the consultants for support as they were made to feel incompetent. An action plan to address the lack of junior staff supervision and support was developed by the maternity senior leadership team and was implemented in June 2020. However, the action plan was dependent on the interim clinical director checking consultant presence on the delivery suite daily. In addition, the interim clinical director telephones the delivery suite every evening to ensure consultant presence at the evening board round and handover; they also checked if the midwives and middle grade medical staff were happy with the plan of care for women overnight whilst the consultant is on call from home. At the time of our focused inspection, these actions had only been put in place, therefore were not yet embedded.

Staff spoke positively about the arrival of the interim clinical director. The head of midwifery and interim clinical director told us that they worked well together and were supportive of each other. However, we were not assured around the long-term sustainability and impact of the action plan as it appeared heavily dependent on one person checking behaviours. Following the inspection, the executive team told us that substantive changes were being made including the appointment of a director of midwifery, and the implementation of a revised group model for maternity risk and governance management for long term sustainability.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust developed a five year strategic plan following the recent merger of Basildon University Hospital with Mid Essex and Southend University Hospitals to form Mid and South Essex NHS foundation Trust. The maternity service strategy was included with the trust's five year strategy.

The maternity service's strategy detailed the service's ambitions for the next five and was aligned to the local maternity board (LMB) strategy. The strategy spoke of close collaborative working with the LMB throughout. We did not see an action plan in place with actions assigned to individual staff members, to achieve the strategy.

The maternity service has its own vision of "working in partnership with women, empowering them to make informed decisions about their care, ensuring that it is personalised to meet their individual needs." Staff did communicate and plan care with the women individually, however, due to the concerns raised throughout our inspection we not assured that this was always achievable with the current standard of multidisciplinary working within the service.

Culture

The service did not have an open culture where staff could raise concerns without fear.

All staff we met during our inspection were welcoming, friendly and helpful. It was evident that staff were concerned about the recent cluster of serious incidents and wanted to improve the care they provided to women and babies. However, staff were very aware of the longstanding poor culture and safety concerns. They expressed to us the impact the longstanding poor culture had impacted on women and babies care and staff morale. Staff told us that some of the consultants and longer serving midwives were difficult to approach and support from medical staff was a struggle.

In May 2020, concerns for the safety of women and babies were raised by a whistle-blower to the CQC. During the focused inspection both staff and maternity senior leadership team (SLT) told us the poor culture had been present for a number of years. Although a new maternity SLT were in place from May 2020 actions to improve the long-term history of poor culture and ineffective multidisciplinary team working which had impacted on safety in the maternity unit, were in their infancy and not yet embedded. Therefore, we were not assured sufficient steps had been taken to address the culture issues prior to interim clinical director's appointment and our focused inspection.

All NHS trusts are required to nominate a freedom to speak up guardian (FTSUG). The role of the FTSUG supported staff who wished to speak up about a concern or issue and ensured that any issue raised was listened to and the feedback was provided to them on any actions or inactions because of them raising an issue. Most staff we spoke with were aware the trust had a FTSUG service and how to report their concerns if required.

In the last 12 months, FTSUG service had received three enquiries in relation to the maternity service. We were told that none of the concerns raised were in relation to safety. The SLT told us that following our inspection they will be raising staff awareness of the FTSUG service.

The trust executives told us that in May 2020, it was decided to bring in a new leadership to the maternity unit to support and develop an action plan to address the safety culture. The interim clinical director initiated daily safety calls on delivery suite and weekly meetings with the consultants.

Following our concerns raised to the executive team we received an action plan to improve the culture which contained the following for example: establishing regular staff forums, the development of a communication strategy to encourage staff to escalate concerns and involving external stakeholders for cultural support. However, these are all in their infancy and are not yet embedded.

Governance

Leaders did not operate effective governance processes to continually improve the quality of its services and safeguarding standards of care.

Whilst governance processes were in place these were not fully effective, there remained a lack of oversight from the senior leadership and executive team. A number of the issues identified during our focused inspection, were pre-existing issues that had already been highlighted at the February 2019 inspection. Requirement notices were issued in relation to these breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust developed an action plan in response to these breaches, submitted regular updates and closed the actions, however, we found at our focused inspections the concerns were still present. The actions put in place did not address or remedy the issues and the maternity governance did not identify issues with the quality of care being provided. The systems and processes that were in place to address the concerns from February 2019 had still not been embedded within the service.

The maternity service had a maternal death February 2019, which was investigated by HSIB and an action plan produced. The issues identified related to: incorrect interpretation of CTGs; failure to escalate risk from the midwives to medical staff; and failure to escalate risk from middle grade doctors to consultants. There were a further six serious incidents reported between January 2020 and April 2020. Five of these serious incidents identified the same failings of care. This demonstrated there had been a lack of learning from previous incidents and actions put in place were not embedded. Therefore, we were not assured that the governance and oversight of lessons learnt was robust enough to prevent similar incidents from occurring.

The head of midwifery (HOM) did not have direct access to the board and did not present to them regularly in line with 'Spotlight on Maternity' 2016. This was an area of concern that was raised at the February 2019 inspection for which a requirement notice was issued. The governance systems were not effective to ensure appropriate escalation, scrutiny and overall responsibility at board level.

We found concerns relating to the governance processes of incident grading and appropriate review. This was an area that was identified at the February 2019 inspection, for which a requirement notice was issued. Incident data reported by the trust from January to April 2020, demonstrated that incidents were not always graded correctly in accordance to moderate harm as stated in Regulation 20 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

The service had a formal governance structure in place. The maternity service was within the

women's and children's division. The clinical maternity governance and risk manager held responsibility for managing risk within the maternity services, including monitoring incident reports, compliance with learning outcomes, and actions resulting from serious incident reviews.

At our focused inspection we found a number of areas of concern within the structure of the maternity governance and risk management team. The clinical governance lead role was vacant. As an interim measure the clinical governance lead from paediatrics and gynaecology had been providing support to maternity and at the time of our focused inspection they had returned to their substantive role.

At the time of the focused inspection there were a number of overdue investigation reports, action plans and open incidents. Information received from the trust following the focused inspection showed three serious incident investigations that were overdue (over 60 days), nine internal root cause analysis overdue, 11 external report recommendations overdue to be developed into action plans and/implemented, and 27 serious incident action plans overdue for closure. This meant the governance systems and processes in place were not robust to ensure timely review of incidents and sharing of lessons learnt.

Following the focused inspection, we were told that a group wide maternity governance and risk management structure had been developed. This was subject to a staff consultation, before it could be implemented.

The service held monthly clinical governance meetings. We requested the last three meeting minutes and we were provided with the minutes from November 2019, January 2020 and May 2020. We were not assured on the frequency and regularity of these meeting to monitor risk and governance within the service. In addition, the minutes showed that the head of midwifery was not present at any of the meetings and the risk lead for maternity was only present at the November 2019 meeting. We reviewed the meeting minutes which confirmed governance matters such as incidents, risks, performance, guidance, audits and complaints were discussed, however not all actions were clearly assigned to a member of staff with a deadline for completion.

The service held perinatal mortality and morbidity meetings. Following our focused inspection, the executive team told us that the interim clinical director had reviewed some of the cases discussed by the perinatal review group and had raised concerns about the decisions made by the group and sometimes the group was not quorate and hence the discussions and decisions would not be valid. Senior leaders confirmed that they had taken urgent actions and put new measures in place to address the concerns raised; by reviewing all the cases discussed since January 2020, and a review of the terms of reference of the perinatal mortality and morbidity review group.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively.

There were some processes in place to identify risk. The maternity service had a risk register and we saw that risks within the service were on the risk register. Risks were recorded and managed using the trust's electronic risk reporting system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. We observed the risk register and risks were in date and had been reviewed.

The service had reported compliance to the board and NHS resolution for safety action six compliance with the saving babies lives initiative 2016. However, from our review of the 12 maternity handheld records the service were not always monitoring carbon monoxide in line with the trust guidance in all of the records. Therefore, they were not compliant with the saving babies lives initiative 2016. Information provided post inspection stated that an electronic system for all antenatal bookings had been introduced in September 2019 from which reports were generated to monitor compliance. Data provided demonstrated that between November 2019 and February 2020 compliance was 90%, 86%, 88% and 86% respectively. Carbon monoxide testing should be offered to all pregnant women at the antenatal booking appointment with the outcome recorded (Saving babies Lives Care Bundle Version 2 2019). We were not provided with any additional evidence to provide assurance that this was regularly audited and reviewed or that actions had been taken to improve compliance.

Daily handovers included a briefing of any issues highlighted by managers. However, we observed that the handovers were not detailed, and qualified midwives did not attend the whole handover. Therefore, not all would not be aware of the risks discussed.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The dashboard was not displayed in clinical areas, this meant that staff and the public were not informed of the outcomes and risks of the maternity service.

Maternity

We saw that the services dashboard was reviewed as part of the women's health clinical governance & risk group meeting. We requested the meeting minutes for these and reviewed three sets from November 2019, January and May 2020. We saw that the meetings also discussed incidents, complaints, guidelines, the risk register, and audits, however not all actions were clearly assigned to a member of staff with a deadline for completion.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

- The service must complete carbon monoxide screening in line with trust policy. Regulation 12 (2) (a)
- The service must ensure staff completed mandatory and safeguarding training with the trust target. Regulation 12 (2) (a)
- The service must ensure that the delivery suite daily handover is fully attended, situation, background, assessment, recommendation (SBAR) format is used for all women, they are referred to by name and the afternoon board round is attended and documented. Regulation 12 (2) (b)
- The service must ensure the delivery suite coordinator is always supernumerary. Regulation 12 (2) (b)
- The service must ensure multidisciplinary team working is improved. Regulation 12 (2) (b)
- The service must ensure that the medical staff competencies are reviewed and up to date. Regulation 12 (2) (c)
- The service must ensure that appraisals are comprehensive and assess staff competencies. Regulation 12 (2) (c)
- The service must ensure that all records are kept securely. Regulation 17 (2) (c)

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

- The service should ensure weights are documented on prescription charts.
- The service should display safety information.

Our inspection team

The team that inspected the service comprised an of inspection manager, a lead inspector and specialist advisor. The inspection team was overseen off site by Mark Heath, interim Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Section 29A HSCA Warning notice: quality of health care

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ManKind Initiative

Male Victims of Domestic Abuse

Thurrock Council

1 October 2020

Mark Brooks OBE

ManKind Initiative

Overall Picture

British Crime Survey (2018/19)

- 1 in 6 men and 1 in 4 women will be a victim in their lifetime
- 800,000 men and 1.6 million women are victims of domestic abuse (500,000 and 1 million – partner abuse)

Essex

- 5,988 men (17,018 women) reported to Essex Police in 2018
- DA organisations in Essex are supportive of male victims including Changing Pathways
- No refuge or safe house in Essex – nearest is Northamptonshire (90 miles away)

ManKind Initiative

Who Do Men Tell?

Who do men tell

- Male victims (49%) are nearly three times as likely than women (18%) not to tell anyone they are a victim.
- 15% of male victims will tell the police (18% women), 6.6% (4.7% women) will tell a local council and specialist support service 1.2% (7.3% woman)
- Only 5% of people using DA services are male and same with MARAC referrals
- 53% of the men who call the ManKind Initiative helpline have never spoken to anyone
- 70% would not have called if the helpline was not anonymous

ManKind Initiative

Who Can It Happen To?

STONEMASON
POLICEMAN
ACCOUNTANT
SOLICITOR
POLITICIAN
CARER
TEACHER
BRICKLAYER
LIBRARIAN
DOCTOR
NURSE
PLUMBER
GARDENER
AUTHOR
LAWYER
GAMEKEEPER
ELECTRICIAN
CARPENTER
ARTIST
ACTOR
STUDENT
MECHANIC
SOLDIER
PILOT
ANALYST
PRISONER
RETIRED
DRIVER
BUILDER

ManKind Initiative

Barriers

Masculinity

Societal
Belief
Systems

Lack of
Visible
Services

Public Policy
& Story

ManKind
Initiative

(1) Masculinity

It is not masculine to be a victim:

- Do not understand or recognise they are a victim
- They are not strong, resilient and providing security
- Shame, embarrassment and pride
- Fear of ridicule

ManKind Initiative

(2) Societal Impact

Male Victims

- They won’t be believed
- Will face ridicule
- They will be the ones accused
- Stigmatised for getting help
- Losing contact with children

Societal Response

- Not believed
- Ridiculed
- Not encouraged to get help
- Not enough personal or professional curiosity
- Men cannot be victims / Women cannot be perpetrators
- Men generally need less help
- A man has done something to deserve it

ManKind Initiative

(3) Lack of Visible Services

How do you get men to understand and connect to support?

- Are services available to men (and are they well funded)
- Are services proactive and clearly visible to men (communications)
- Are all local agencies and organisations looking out for male victims
- Do all local agencies and organisation know who to signpost to
- Are local agencies and organisations trained to support male victims

ManKind Initiative

(4) Public Policy and Story

Being gender inclusive and gender informed

- Local policies not clear for male and LGBT+ victims (VAWG) too (are they more than a footnote)
- Assumptions that all men have the ability to leave (no accounting for children)
- Are services proactive and clearly visible to men (communications)
- Website and PR clear for men
- Are case studies included of men
- Male specific campaigns

ManKind Initiative

Being Male-Victim Friendly

A male-victim friendly and inclusive approach

- Do not try and change men – because you will fail to support them adequately.
- Bring services closer to men, do not expect men to bring themselves closer to you (access hours, location, anonymous/telephone, decent website)
- Ensure male victims are equally recognised and validated as female victims throughout policies, training and situations
- Make clear you support men (same service or parallel)
- Ask the question "and what about men (and their children)"

Ask yourself and test – "does a man with the same level of risk as a woman receive the same level of support and recognition?"

ManKind Initiative

ManKind Initiative

mankind.org.uk

Admin: 01823 334229
Helpline: 01823 334244

Training Courses

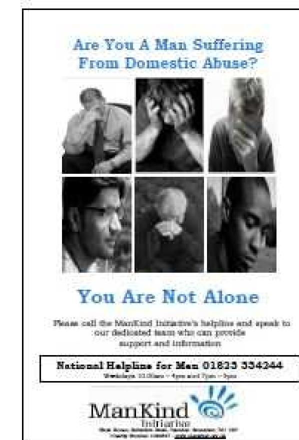
Male Domestic Abuse Network

Presentations, Conferences and Speakers

DHRs

training@mankind.org.uk

@mankindinit



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5 November 2020	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
• **Report : Mental Health Update: Essex Partnership University NHS Foundation Trust** • **Presentation : Thurrock Inclusion** • **Presentation : Thurrock MIND**	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Nigel Leonard, Executive Director of Strategy and Transformation, Essex Partnership University NHS Foundation Trust	
Accountable Assistant Director: Lynnbritt Gale, Associate Director, Essex Partnership University NHS Foundation Trust	
Accountable Director: Sue Waterhouse, Director of Mental Health, Essex Partnership University NHS Foundation Trust	
This report is a progress update by Essex Partnership University NHS Foundation Trust Essex on the development of Mental Health Services in Thurrock.	

Executive Summary

Essex Partnership University NHS Foundation Trust (EPUT) is undertaking a programme of work to improve and transform mental health services across Mid & South Essex. This includes working closely with Health Commissioners and Thurrock Borough Council to improve mental health care for the residents of Thurrock.

This report outlines EPUT's response to Covid-19, providing the Thurrock Health and Wellbeing Overview and Scrutiny Committee (HOSC) with assurance that the Trust's emergency planning arrangements have ensured that no mental health services have been reduced or cancelled due to the pandemic.

The report also provides progress updates on the development of mental health services across Thurrock, including:

- 24/7 Mental Health and Emergency Response and Crisis Care Service
- Personality Disorder Pilots

- Integrated Primary and Community Care
- Individual Placement and Support
- Early Intervention Psychosis
- Older People Transformation
- Other Specialist Services

1. Recommendation

1.1 The Health and Wellbeing Overview and Scrutiny Committee are asked to note the response made by EPUT during the first wave of the Covid-19 Pandemic and the progress with the development of mental health services across Thurrock.

2. Introduction and Background

2.1 Essex Partnership University NHS Foundation Trust (EPUT) has been working closely with colleagues from Thurrock CCG, Thurrock Council, other statutory and voluntary sector providers in our response to Covid-19 and the forthcoming winter pressures, as well as the development of mental health services for adults and older people across the Borough.

2.2 The HOSC will be aware that over the last 18 months health and care organisations have been working on the delivery of the NHS Plan and a series of reports identifying specific areas for development and investment have previously been presented to the committee by officers from Thurrock Borough Council and colleagues from Thurrock CCG.

2.3 This report outlines EPUT's progress with the delivery of services associated with the Mental Health Investment Standard and other initiatives for the residents of Thurrock.

2.4 Mental health services across Mid & South Essex will receive significant investment over the coming years as part of the Mental Health Investment Standard. This work is being overseen by the Mental Health Partnership Board and the health system provides regular updates on progress to NHS England / Improvement.

3. Issues, Options and Analysis

3.1 This section highlights the wide range of work that EPUT is undertaking to improve and transform mental health services across Mid & South Essex, with particular reference to activities within the borough. EPUT has worked closely with local commissioners and other providers, and to date this has been extremely beneficial and enabled Thurrock to maximise the advantages of additional funding.

3.2 A summary of each of these initiatives, together with issues arising from Covid-19 and areas for further work, is detailed below.

3.3 **EPUT'S Covid-19 Response**

It is pleasing to note that no mental health services provided by EPUT were stood down during Wave 1 of Covid-19. The Trust's emergency planning arrangements included a significant investment in technology to ensure that all front line clinicians had the appropriate technology to be able to move towards providing a digital service to patients.

3.4 Over 1,000 laptops were made available to staff to deliver front line services and to enable home working wherever possible. We have provided IT equipment and access to our email and systems to the voluntary sector as part of our crisis service.

3.5 In addition, EPUT prioritised caseloads to ensure that vulnerable people received more regular contact either by telephone or digital consultations during this period. Each community mental health team held a risk register identifying who was more vulnerable both from a physical health perspective as well as a mental health perspective.

3.6 In line with other public sector organisations, EPUT redeployed a number of clinical staff in support functions to support front line services, and were fortunate that a number of retired staff volunteered to support our clinical work.

3.7 EPUT activated its emergency preparedness processes and this has enabled us to provide a wide range of support to the system. Our focus, from a mental health perspective, is on the provision of adequate support to front line staff especially equipment and PPE. Other contingency measures, including oxygen management on the wards, were also a key focus during this period.

3.8 A good example of the Covid-19 work undertaken by the Trust resulted in the establishment of an A&E Diversion service for mental health patients within 48 hours. This service alleviates pressure on A&E departments and has been running since April 2020.

3.9 During the spring and summer 2020, our clinical service significantly reduced occupation rates on the wards to below 60%, and our out of area placements were virtually zero during this period.

3.10 A support service was established staff working in the NHS and social care across Essex, where our psychological therapy staff provided an assessment of level of service required and one-off sessions or a series of therapeutic interventions dependent on need.

3.11 As with other public sector organisations, EPUT has increased our communications with staff by introducing daily briefings to advise staff of any decisions made by Gold Command and to provide advice on Covid-19 issues. In addition, a live weekly video briefing was, and continues to be, held by the CEO alongside Executive Directors and other key managers. This also

enables staff to post questions which are answered 'live' or published on the Trust intranet.

3.12 **24/7 Mental Health and Emergency Response and Crisis Care Service**

In September 2019, a detailed report outlining the proposals for people facing a mental health crisis across Mid & South Essex was presented to Thurrock HOSC by colleagues from Thurrock CCG. I am pleased to confirm that EPUT has been active in the implementation of this service and the associated 111 telephone service.

3.13 The report presented to Thurrock HOSC in September 2019 identified the ambition that the new service will be fully operational by April 2020. This new service went live in early April 2020 and has been operational throughout the Covid-19 period.

3.14 With strong support from Thurrock CCG, the Trust has worked very closely with Mind. This has included EPUT enabling staff from the Sanctuaries provided by Mind to have access as appropriate to NHS email accounts and our operational systems. This has facilitated a close working relationship between organisations operating within Thurrock.

3.15 **Personality Disorder Pilots**

Thurrock is in a key position across the system for the provision of personality disorder services in Essex. The Trust has worked with Inclusion in piloting joint working to screen and assess appropriate referrals. This new service makes joint decisions on how to provide more holistic care for this client group.

3.16 This service is developing and piloting joint group treatments to meet the complex needs of this patient group. These pilots will inform how secondary and primary care services can utilise their resources, skills and knowledge to share learning across Essex.

3.17 Personality Disorder Service user networks have been established to aid co-production and improve service development. It is the intention of the service to develop peer support workers to support service delivery over the next year.

3.18 EPUT is working closely with inclusion to deliver a new Tier 4 pathway to treat people with a history of Trauma, Personality Disorders and/or complex needs which, together with IAPT and secondary care provision, will provide an appropriate pathway for the people of Thurrock.

3.19 **Integrated Primary and Community Care (IPCC)**

EPUT is delighted to be part of the new proposals for IPCC. This new service provision will deliver an enhanced integrated MH team with PCNs in Thurrock. The service model was created with 35 representatives from primary care,

secondary care, social care, the third sector and public health. This service aims to provide faster and safer access to advice, support and treatment as required within a primary care setting.

3.20 EPUT's mental health clinicians, including consultant psychiatrists, will be working as colleagues in an integrated way in primary care. The work has included the development of shared care protocol and will enable:

- Consultant psychiatrist clinical sessions in PCNs.
- Easier access to consultant psychiatrist advice.
- Improved support for the 'missing middle' – those people who have not traditionally met thresholds for either IAPT or secondary mental health services but have a need for support.
- Improved consultation between consultant psychiatrists, GPs and clinical staff.
- Nurse managers overseeing mental health primary care working with PCN colleagues.
- Mental health nurses working with PCN colleagues to screen, assess and treat people with MH problems, and identify complex cases. This will help primary care to navigate patients seamlessly into secondary care where appropriate.
- Seamless step down support pathways from secondary care to primary care.
- Weekly multidisciplinary team meetings with professionals from secondary and primary care working together to discuss complex cases.
- Ongoing daily advice and support to GPs in primary care.
- Joined up care pathways between primary, secondary care and the voluntary sector. This will include clear links with new and existing roles including:
    - Social prescribers
    - Care navigators
    - Local area coordinators
    - The recovery college
- The potential for self-help resources to ensure need can be met by the right person at the right time in the right place.

3.21 **Individual Placement and Support (IPS)**

This service delivered by Inclusion partners is now a fully integrated service. EPUT works closely with Inclusion in the provision of improved access to education and work advice for people with mental health problems in secondary care.

3.22 This support is provided by improving access to education and employment. This is achieved by wrapping education and support to enable people to remain in employment or obtain employment.

3.23 The Trust is working with NHSE/I regarding the opportunity to develop this initiative.

3.24 **Early Intervention Psychosis (EIP)**

EIP is delivered alongside Inclusion as an integrated multi provider team with shared care pathways.

3.25 EPUT has recently received the results from the national assessment relating to 2019/20 and has received a rating of Performing Well. The Trust is working with Commissioners to look at the development of the At Risk Mental Health State (ARMS) Service as part of our future development programme.

3.26 **Older People Transformation**

Although Covid-19 has impacted on the ability for people to receive the appropriate dementia diagnostic testing at the acute trust, our older people's service has continued to provide support through the use of an indicative diagnostic protocol. Within south west Essex, EPUT provides the memory assessment service and works in conjunction with NELFT who provide the Dementia Intensive Support Team (DIST) service.

3.27 A number of system wide workshops have taken place to develop new models to make admission to hospital an unusual event for older people with dementia. Pilots in other parts of Mid & South Essex have proven an enhanced community team and the Trust is working very closely with Commissioners to reduce the dependency of hospital admissions for this client group.

3.28 **Other Specialist Services**

The Trust is working very closely with Commissioners within Mid & South Essex as well as Essex-wide to deliver specialist perinatal and eating disorder services and these are priority areas nationally for expansion.

3.29 Our perinatal service is an Essex-wide service that provides mental health support for women and will be progressively expanded over the next couple of years. This expansion is based on national best practice guidance and includes access to new therapeutic interventions including psychology. Service performance and the outcomes for women are linked to clear activity and quality targets and coverage based on new births across Essex. There is also a focus on women's experience of perinatal mental health services, building on existing work with Health Watch.

3.30 Recently the perinatal service has submitted a bid to co-produce and develop a peer support model which includes screening and sign-posting for partners of those known to the specialist Perinatal Mental Health (PNMH) service.

4. Recommendation

4.1 The Thurrock Health and Wellbeing Overview and Scrutiny Committee is asked to note the progress update by Essex Partnership University NHS Foundation Trust Essex on the development of Mental Health Services in Thurrock.

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 -** N/A

7.2 **Legal -** N/A

7.3 **Diversity and Equality -** N/A

7.4 **Other implications** - N/A

8. Background papers used in preparing the report

N/A

9. Appendices to the report

None

Report Authors:

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Lynnbritt Gale, Associate Director, Essex Partnership University NHS Foundation Trust

inclusionthurrock

Fulfilling Potential. Forging Success.

Overview of Service Provision
October 2020

inclusion thurrock
Talking Therapies

Services Delivered in Thurrock

- Increasing Access to Psychological Therapies (IAPT) – Steps 2 & 3
- Recovery College – informal education to assist wellbeing and recovery
- Individual Placement & Support (IPS) employment aid for SCMH patients
- Early Intervention Psychosis (EiP) caring for individuals and their families experiencing their first episodes of psychosis
- At Risk Mental States (ARMS) treating those deemed to be **at-risk** of developing psychosis – will launch in the near future
- IAPT Step 4 for patients with complex needs – about to launch
- Visions Substance Misuse Service

Effective partnership working is central to everything we do

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IAPT Service COVID-19 Response

- Rapid transition from F2F delivery to telephone and video consultation resulted in minimal service delivery interruption
- Referrals dropped significantly country-wide but are building slowly
- Surge planning – Following guidance to expect 20% increase
- Significant therapist support given to optimise remote delivery outputs
- Recovery & Attendance Rates have increased - 59.5% and 80.4% YTD
- Waiting lists reduced – now 0.67 patients waiting for every one in treatment - 629 in treatment 424 waiting
- Delivering on-line groups and digitally cCBT via SilverCloud

IAPT COVID-19 Response cont.

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- Keyworkers are being fast-tracked to treatment
- All treatments including those for Trauma are being delivered
- The plan is to continue remote working, with regular reviews to determine how and when F2F work might be feasible
- Only a small number of patients have not been able to engage with remote working - 60 so far
- Access to treatment normally occurs within 14 days of receipt of referral
- Waits for second appointments currently average 37 days
- Snr Clinicians attend SC MDT meetings to facilitate collaborative working

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IAPT Service - Performance Overview

Thurrock IAPT Performance		Year 1	Year 2	Year 3	Year 4
Access	Referrals	3,527	4224	4548	5352
	Entering Therapy	2,927	3450	3534	4234
	Entering Therapy Target	3,096	3225	3618	4347
	Performance	-169	225	-84	-113
Waiting Performance	Waiting <6 weeks	1,600	1818	2043	2249
	% Waiting <6 Weeks (75% Tgt)	99%	99%	100%	100%
	Waiting <18 weeks	1,614	1828	2048	2250
	% Waiting <18 Weeks (95% Tgt)	100%	100%	100%	100%
Outcomes	Completing Therapy	1,622	1,833	2049	2,250
	Moving to Recovery	691	885	1059	1,086
	Recovery Rate (50% Tgt)	45%	52%	55%	53%
	Reliable Improvement	1,073	1,255	1420	1,534
	Reliable Improvement Rate	66%	68%	69%	68%

On target to meet Year 4 Access Target until COVID impacted in weeks 51 and 52.

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IAPT Disorders & Interventions

Staff	Disorder	Intervention
Step 3: High intensity service	Depression –moderate and severe	CBT, IPT
	Depression – mild to moderate	CBT, IPT, Counselling, Couples Therapy
	Panic disorder[1]	CBT
	GAD[1]	CBT
	Social Phobia[1]	CBT
	PTSD[1]	CBT, EMDR
	OCD[1]	CBT
Step 2: Low intensity service	Depression - mild to moderate	CCBT, Guided Self-Help, Behavioural Activation, Problem Solving, Structured Exercise
	Panic disorder - mild to moderate	CCBT, Guided Self-Help, Pure Self-Help[2], Psychoeducational Groups
	GAD - mild to moderate	CCBT, Guided Self-Help, Pure Self-Help[2], Psychoeducational Groups
	PTSD	n/a
	Social Phobia	n/a
	OCD - mild to moderate	Guided Self-Help
Step 1: Primary Care/IAPT service	Recognition of problem	Assessment/Watchful Waiting

[1] For these disorders high intensity interventions are effective across the full range of severity.
[2] Pure self-help is likely to be of benefit only in milder cases and in most instances guided self-help is to be preferred.

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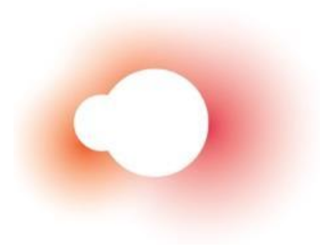
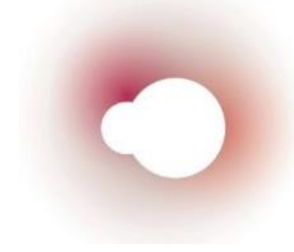
IAPT Step 2 Interventions Delivered

- Behavioural activation
- Cognitive restructuring
- Medication support
- Exposure therapy
- Problem solving
- Managing panic
- Sleep hygiene
- cCBT Silvercloud

IAPT Step 2 SilverCloud cCBT Packages





Mental Health

Space from Anxiety

Space from GAD

Space from OCD

Space from Panic

Space from Social Anxiety

Space from Health Anxiety

Space from Phobia

Space from Depression

Space from Stress

Additional focused modules:

My Self Esteem and I
Sleep Difficulties
Relaxation
Employment Support
Anger Management
Behavioural Experiments
Communications and Relationships
Grief and Loss

Eating Issues

Space for Positive Body Image

LTCs

Space from Chronic Pain

Space from Diabetes

Space from CHD

Space from COPD

Well-Being

Space for Sleep

Space for Resilience

Space for Mindfulness

Space from Money Worries

SilverCloud MAKING SPACE FOR HEALTHY MINDS

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Fulfilling Potential. Forging Success.

IAPT Step 2 SilverCloud cCBT Packages cont.

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IAPT Step 3 Interventions Delivered

- CBT
- EMDR
- Counselling for Depression
- Brief Dynamic Interpersonal Therapy
- Interpersonal Psychotherapy
- Couple Therapy for Depression
- Psychosexual Therapy

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Recovery College

- Informal educational support to assist wellbeing and recovery
- Service delivery moved to telephone and on line
- Newsletter to maintain contact with students not on courses
- Courses currently being delivered include:-

  * Creating Mindfulness Course
  * Anxiety & Me: My Plan to Thrive Course
  * Food and Mood
  * Visualisation for Relaxation
  * Ways to Well-being: Be Active

- Co-production a key element of all service delivery
- Peer Trainers share their lived experience to encourage others
- Significant demand – 270 students on waiting list for courses

Individual Placement Support (IPS)

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- Assistance to obtain and retain employment for secondary care patients
- Currently supporting 44 Patients
- We work collaboratively with Care Co-ordinators to identify patients
- Have capacity to support additional 46 Patients
- In Quarter Two, 9 service users were supported into employment. Two obtained employment this week
- More were supported to retain jobs
- During lockdown some staff delivered food parcels to vulnerable service users too scared to leave their homes

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Early intervention Psychosis (EiP)

- High Intensity Therapists delivering CBT for Psychosis
- Family Wellbeing Practitioner providing Brief Family Therapy interventions
- Therapists embedded within the Early Intervention Psychosis Team
- Co-facilitate the STEPs course for patients with Emotionally Unstable Personality Disorder
- Attends SCMH MDT meetings

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Current Challenges & Responses

- **Supporting a high number of trainee therapists**

  Close Clinical & Case Management Supervision, Liaison with HEIs and Buddy System

- **Maintaining Moral & Fighting Fatigue**

  Close Clinical, Management & Peer Supervision, Weekly Team and Modality Specific Meetings, Talking openly about issues, introducing some humour into activities to try and re-establish the connectedness staff had when working in the hub together

- **Coping with the surge, when it materialises**

  Securing additional therapists/trainee posts to ensure waiting lists do not rise

- **Increase in severity/complexity of patients accessing the service**

  Close Clinical, Management & Peer Supervision to support therapists. Developing strategies to reach out to encourage earlier access i.e. PCNs to SMS text message patients encouraging any who are stressed re COVID-19 to contact us and a similar message being sent to parents via school newsletters

Contact Details

inclusion thurrock
Talking Therapies

Robert Waugh (Operations Lead)

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Inclusion Thurrock:

Inclusion.thurrock@nhs.net

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1. **Introduction and Background**

Thurrock & Brentwood Mind's services have remained open (with the same opening hours) throughout the Coronavirus pandemic, except retail which operated in accordance with Government guidelines. Our services, most of which are worked in partnership with NHS providers and other local organisations include:

- Advocacy- Care Act & Independent Mental Health Advocate (IMHA)
- Carers Service
- Counselling & Groupwork; Bereavement Counselling; Multi Ethnic Counselling Service (MECS)
- Crisis Sanctuary
- Digital Mentoring & Befriending
- IAPT
- Individual Placement & Support-Employment (IPS)
- Inclusion Thurrock Recovery College
- Peer Mentoring & Peer Support
- Positive Pathways-Adults & Youth (For service users to transfer from secondary care to the community as part of the Shared Care Protocol)
- Retail-Work experience
- Supported Housing (15 units)
- Wellbeing Centre

2. **Issues and Options**

The immediate issue for the organisation was the ICT and not being designed for remote working; very few staff had telephones or laptops, with most staff having not used digital platforms. The goodwill of staff to find solutions to the ICT challenges ensured services could continue. With the support from Commissioners at Thurrock CCG and Thurrock Council, together with successful grant funding applications we were able to provide staff with the equipment required and updated our systems to enable staff to work remotely.

Where required, staff and volunteers received in-house training to use digital platforms and/or how to deliver telephone counselling, if needed. Staff were then able to support service users to set up and use digital platforms. The greatest take up for digital has been with carers.

All service users were offered additional support through wellbeing calls; frequency and duration were individually assessed and ranged from daily to fortnightly. Staff worked flexibly to cover wellbeing calls from projects with higher demands.

People that were on our counselling waiting lists were also informed that we remained opened and changes to how services were provided; they were offered additional support through Peer Support, Wellbeing Activities or Wellbeing calls.

3. **Services funded by Thurrock Council**

Day Opportunities - The number of service users accessing the Wellbeing Groups zoom sessions have doubled since lockdown. Service users who would not have attended a face to face group, whether this be due to anxiety about leaving their house and/or meeting new people, have attended regularly. Examples of activities include:

- Armchair yoga: As part of Mind's Mindful Monday, Service Users got involved doing gentle breathing exercises and body movements.
- Art sessions: Two art sessions with Kara at Smiles4all, a council funded art initiative group.
- Two Service Users have taken the opportunity to stay on the Zoom after the sessions have finished, to learn guitar together.
- A socially distanced meet up in September where four service users met with staff in the local park.

Those unable to use digital platforms have continued to receive wellbeing calls, with some transferring to telephone befriending at the end of the 2nd quarter.

Advocacy - The Advocates have undertaken face to face work in specific circumstances e.g. safeguarding concerns, or where telephone or digital is not appropriate/unavailable. Advocacy has been undertaken in rear gardens, through windows in care homes and in client's homes in exceptional circumstances. Our volunteer advocates are supporting the service through volunteering on other days and increasing their hours.

Counselling and Group-work - Referrals almost ceased at the start of lockdown. A considerable number of people on the waiting list were either not able/or did not want counselling via telephone or Zoom. Students on placement were not authorised to undertake telephone counselling and it was not until July that the British Association for Counselling & Psychotherapy (BACP) approved students to undertake telephone counselling provided that the University, Clinical Supervisor and Agency were satisfied of the counsellor's ability. By the end of the 2nd quarter referrals were back to 70 % compared with the same period the previous year, with 35% of referrals experiencing depression, compared with 18% of referrals for the same period last year. By the end of the second quarter, a second review of the waiting list took place where more people opted for telephone counselling. The waiting time is currently 6 weeks.

Through our experience of virtual recruitment and going live on 1st April 2020 with the Crisis Sanctuary, the experience gave us the confidence to seek further funding to meet increasing demands and enquiries. Successful grant applications have enabled us to increase the number of counsellors for the Multi - Ethnic Counselling Service and provide a telephone and Digital Befriending Scheme.

Thurrock Carers Service referrals have come in steadily; the main need for people at the beginning of lockdown was shopping, advice, adaptions to the home and carers assessments.

Carers were provided with 1-1 telephone support to join zoom, providing practise sessions before joining a zoom group. It was a challenge initially; it was described as quite scary for a lot of people, but as more carers joined, we were able to share that experience with others. Now, new carers are supported by existing carers when they join zoom groups. They are enjoying regular activities such as quizzes, new activities that they have suggested and support groups, giving them time for themselves. The carers choose activities for the months ahead. Carers have found the new carers booklet beneficial.

A virtual Carers week programme included a singer, a mindfulness session, quizzes etc. which were successful events.

Teleconference and WhatsApp groups have been set up for all carers, with additional calls to people who cannot access zoom. With consent, counselling clients are assessed by Inclusion Thurrock. Carers that are allocated to our counselling service are then prioritised to prevent carer breakdown.

4. **Future Demand**

As an organisation we are planning for an increase in referrals of 20-25% and are currently preparing to meet that demand by considering staff working hours, groups and recruitment of volunteers.

Our greatest challenge is likely to be the recruitment of volunteers, with numbers considerably less than pre-COVID-19.

Lynne Morgan CEO
Thurrock & Brentwood Mind
lynne.morgan@tbmind.org.uk

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5 November 2020	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Thurrock Adult Safeguarding Board Annual Report	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Jim Nicolson - Independent Chair of Adult Safeguarding Board Fran Leddra - Principal Social Worker and Strategic Lead Adult Social Care	
Accountable Assistant Director: Les Billingham - Assistant Director Adult Social Care & Community Development I Adults, Housing and Health	
Accountable Director: Roger Harris - Corporate Director, Adult's Housing and Health	
This report is Public	

Executive Summary

The Thurrock Safeguarding Adults Board (TSAB) is a multi-agency partnership, comprising statutory and non-statutory stakeholders. The role of the Board is to ensure that robust safeguarding procedures are in place across the Borough, to protect those adults more vulnerable to abuse and/or neglect. The Board provides a strategic and operational scrutiny of the three statutory core partners; these being the Local Authority, Police, and the Clinical Commissioning Group. Where abuse and neglect does occur the Board and its partners are committed to tackling this and promoting person-centred care for all adults experiencing such abuse or neglect.

The Care Act 2014 sets out a clear statutory framework for how local authorities and other key partners, such as care providers, health services, housing providers and criminal justice agencies, should work together to protect an adult's right to live in safety, free from abuse and neglect. It also specifies three core responsibilities for Boards, namely;

1. To produce and publish an Annual Report - This has been completed and is the subject of this Report.
2. Produce and publish a Strategic Plan - This has also been completed In collaboration with stakeholders and Healthwatch.
3. Conduct Safeguarding Adult Reviews if the need arises - No Safeguarding Adult Reviews were commissioned in 2019/20.

1. Recommendation(s)

1.1 That Members of the Health and Wellbeing Overview and Scrutiny Committee note the report.

1.2 For members of the Health and Wellbeing Overview and Scrutiny Committee to be presented with some of the key data and strategic priorities of the TSAB.

2. Introduction and Background

2.1 The Care Act 2014 requires that each Safeguarding Adults Board (SAB), having published an Annual Report, will disseminate it widely and specifically to key partners including the Chief Executive and Leader of the Local Authority; Essex Police; Healthwatch; and the Chair of the Health and Wellbeing Board.

2.2 The Annual Report is a public document that informs both our partners and our communities of the breadth of safeguarding work undertaken in the preceding year, with some key data and information about the Board's strategic priorities. The report of the TSAB for 2019/20 is attached.

2.3 The TSAB Annual Report highlights the achievements against the following three strategic priorities for 2019/20;

1. Implement a Communications Strategy;
2. Implement a Prevention Strategy, and;
3. Understand the scale of adult sexual exploitation and the gaps in transition from children's to adult's services for those at risk.

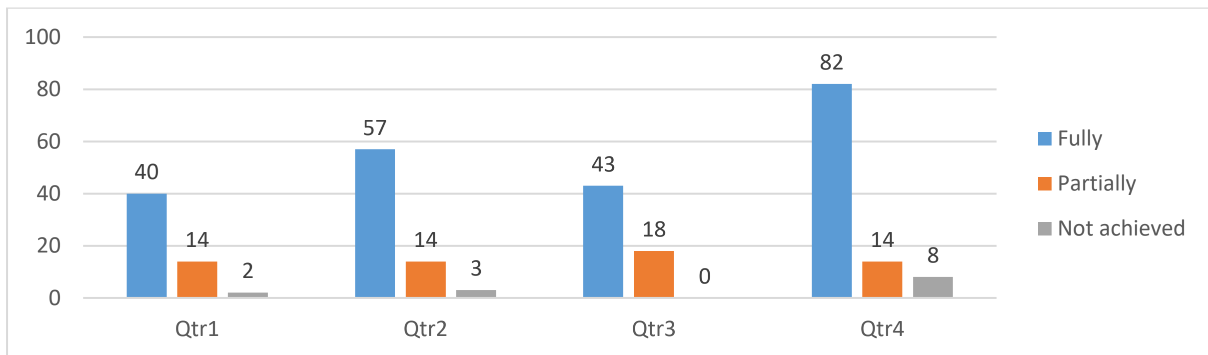
2.4 In regard to performance the Annual Report has comprehensive data, of which the key is the total number of Concerns reported and Enquiries subsequently undertaken and with what outcomes.

2.5 Despite a reduction in Quarter 4, probably attributable to the Covid pandemic, as well as in the previous Quarter, the total number of Concerns reported in 2019/20, was 1000, which represents an increase of 167 (20%) compared with the total of 833 in 2018/9.

2.6 The total number of Enquiries in 2019/20, also increased, resulting in a yearly total of 444. This represents an increase of 175 (68.9%) compared with 269 in 2018/19.

2.7 Dividing the number of Concerns by the number of Enquiries that arise from them provides a Conversion Rate for 2019/20, of 44%, which compares favourably with current national averages, as it does with the local conversion rate of 32% in 2018/19. Managers attribute this to the fall off in the number of Concerns at the end of the year, freeing up time to complete more Enquiries.

2.8 It was also very encouraging to see that peoples' desired outcomes are being met in a significantly higher number of cases, as can be seen from the table below. Other improvements in recording were also noted.



2.9 During the coming year, April 2020 to March 2021, our main focus will be to begin implementation of the Strategic Objectives which are in the new Strategic Plan 2020/23, by developing a detailed, measurable action plan for each explaining what we want to achieve and how we will do it..

2.10 We will also:

- Analyse the impact of the pandemic on vulnerable people and plan to address any additional safeguarding needs that emerge;
- Work with agencies to test how well the safeguarding system works;
- Continue to work with the Community Safety Partnership, and improve our connections with the Local Safeguarding Children's Partnership;
- Improve resilience within communities and individuals;
- Take a broader approach to safeguarding by discussing a more diverse range of topics that will engage all board member agencies;
- Target community engagement to increase accessibility, content, and reach, and introduce TSAB content on social media platforms.

3. Reasons for Recommendation

3.1 It is a statutory requirement for the TSAB to publish an Annual Report. The HOSC will wish to be made aware of that Report and the strategic priorities of the Board

3.2 Safeguarding is a corporate and partnership priority.

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

4.1 The TSAB produces this report following consultation with all the statutory and non-statutory partners that make up the Board. Many of whom have contributed and helped write specific sections of the report, reflecting the views of the service users and communities they engage with.

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

5.1 The work of the SAB contributes the Council's Priorities and Vison in the following areas:

- **People** – a Borough where people of all ages are proud to work and play, live and stay.
- This means high quality, consistent and accessible public services which are right first time
- 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

5.2 The TSAB achieves this by empowering communities and developing their ability to identify and report abuse or neglect. It promotes effective multi-agency collaboration to create safer communities, which in turn helps prevent abuse/neglect.

5.3 The TSAB works closely with all partners to improve the physical and mental wellbeing of all residents and visitors by responding swiftly to allegations of abuse and neglect; supporting preventative initiatives and providing information to raise awareness of available services.

6. Implications

6.1 Financial

Implications verified by: **Rosie Hurst**

Interim Senior Management Accountant, Finance, Governance and Property

The TSAB received ring-fenced funding from the Council; the Police, Fire and Crime Commissioner for Essex; and the Clinical Commissioning Group, which meets all its planned expenditure.

6.2 Legal

Implications verified by: **Lindsey Marks**

Deputy Head of Law, Legal Department

In producing this Annual Report, the TSAB has discharged its responsibilities in respect of one of the core roles as defined by the Care Act, 2014. Confirmation of discharging its responsibilities in relation to the remaining two is contained within this Report.

6.3 **Diversity and Equality**

Implications verified by: **Becky Lee**

Team Manager – Community Development and Equalities, Adults, Housing and Health Directorate

In addressing adult safeguarding the focus of the TSAB is to help and support those suffering inequality, neglect, and abuse within all sections of our communities. This Annual Report details the work both completed and planned to improve further the resilience of individuals, their carers and friends as well as the wider community to combat abuse and neglect.

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

There is close cooperation with the Community Safety Partnership (CSP) on matters of shared interest. Many areas of operation covered by the Annual Report are also subject to complementary activity by the CSP.

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

Thurrock Community Safety Partnership Delivery Plan 2020/21, available via; https://www.thurrock.gov.uk/sites/default/files/assets/documents/tcsp-plan-2020-v01.pdf

8. Appendices

Appendix 1 – Thurrock Safeguarding Adults Board – Annual Report 2019/20.

Report Author:

Jim Nicolson

Independent Chair Thurrock Safeguarding Adults Board

Adult Social Care and Community Development

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Thurrock Safeguarding Adults Board

Annual Report 2019/20

THURROCK SAFEGUARDING ADULTS

NHS Thurrock Clinical Commissioning Group

ESSEX POLICE Protecting and serving Essex

thurrock.gov.uk

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PLANS FOR THE FUTURE – 2020/21 21

To make this annual report user friendly we have kept the information brief, giving enough information to let everyone know what the TSAB has been working on, but not too much to make this document ineffective.

To raise a concern email **safeguardingadults@thurrock.gov.uk** or call **Thurrock First 01375 511000**

www.thurrocksab.org.uk

FOREWORD

I am pleased to present the Thurrock Safeguarding Adult Board's Annual Report for 2019/20. In many ways this has been a very successful year, although two very serious events have left an indelible terrible impact on local communities and the agencies of the Safeguarding Adult Board.

The first was the tragic death of 39 Vietnamese people in a container lorry in the Waterglade industrial park, Grays, on 29th October 2019. The response by Essex Police, the Council and many other local services to this dreadful crime has rightly been widely acclaimed. The second is the still on-going impact of the Covid-19 pandemic, which began during the first Quarter of 2020. This pandemic has raised wholly exceptional challenges that have continued into 2020/21. The local response to this pandemic; unprecedented in recent times, has been extraordinary. Officers from all relevant agencies; community groups; and large numbers of the public have worked together to show unremitting and compassionate determination to help those affected by the disease.

Looking at other matters during the year as a whole, in line with the Vision of the Board, members have worked hard to raise awareness amongst statutory partners, stakeholders and the communities we serve to recognise what safeguarding is and how to report concerns. As a result, the number of concerns reported in 2019/20 increased by 25% compared with the previous year.

We have focused on presenting the performance figures of the Board's activities in a much more user-friendly way, as I hope you will see later in this Report. It can be seen that demand has continued to grow significantly in several areas, and it reflects extremely well on the staff of our core agencies that they have managed to still provide a very professional response.

All the members of the Board and the supporting Operational Group took part in the programme of unannounced night visits to our residential care homes in Thurrock. This event is intended to help ensure that residents receive proper care in a safe environment. The results of these visits were fed back to care home managers.

I am very grateful for the continued level of funding provided by the core agencies of Thurrock Council, NHS Thurrock CCG and the Police, Fire and Crime Commissioner, despite the budgetary pressure they face. This is essential for the Board to function effectively and this financial support is greatly valued and appreciated.

As we move forward into 2020/21, we look to build on the progress made in 2019/20, notwithstanding the impact of dealing with the Covid pandemic and its aftermath, to improve further the work of the Board in safeguarding adults in Thurrock.

Jim Nicolson

Independent Chair

INTRODUCTION

The Thurrock Safeguarding Adult Board (TSAB) has produced this Annual Report to explain the role of the Safeguarding Adult Board (SAB); what we have achieved during 2019/20; and what we plan to do in the coming years. The Annual Report is one of the important ways that TSAB communicates with all those people involved in adult safeguarding in Thurrock.

We have publicly demonstrated our commitment to protecting adults from abuse and neglect for more than a decade. The Care Act 2014 requires all local authorities to have a SAB; at this point the TSAB became a statutory Board, which gave it more powers to look at the quality of services that protect and support adults with care and support needs. It also gave SABs specific responsibilities, to:

- Prevent abuse and neglect happening
- Ensure that the safeguarding adult system works well to prevent abuse and responds swiftly and effectively when abuse and/or neglect does happen.
- Ensure that the adult's wishes and wellbeing are at the centre of everything that we do.

The TSAB's vision is *that people are able to live a life free from harm, where the community has a culture that does not tolerate abuse, works together to prevent abuse, and knows what to do when abuse happens.*

Adult safeguarding applies to **adults with care and support needs**, who cannot protect themselves from abuse and, or neglect as a result of those needs.

When someone is worried about an adult in this way, they can raise a **concern.** Staff in the adult social care department will assess the information and decide what action to take next. They talk to the adult who is the subject of the concern to find out what they want to have happen. They may also talk to other agencies who know the adult, or have had dealings with them, weighing up the risk to the adult, and others.

The adult social care department might then decide to start a **Section 42 enquiry.**

For more information about the adult safeguarding process or to read the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines visit https://www.thurrocksab.org.uk/information-and-resources/policies-procedures/

ROLE OF THE SAFEGUARDING ADULTS BOARD (SAB)

TSAB has a strong and consistent multi-agency membership. The aim of the TSAB is to ensure that different agencies work well together to prevent, and tackle abuse and neglect of adults with care and support needs. The Care Act 2014 and the accompanying Statutory Guidance set out the responsibilities of the SABs, which form a national network.

We all live our lives in different ways, coming into contact with education, work, health, social care, private companies etc. at different times, as a result no one agency can protect people from abuse on their own. Usually, it is a team effort, with different people having important information that when brought together, can help to protect an adult from an abusive situation, or neglect. The TSAB's role in this is to make sure that this happens well.

Some of the actions we take are to:

- Develop policies, procedures and guidance to make sure that all agencies are aware of their roles and responsibilities.
- Make sure our workforce is aware of abuse types, know how to spot it and work towards prevention.
- Make sure everyone knows what to do if they are worried about an adult with care and support needs.
- Provide a supportive working environment with opportunities to learn and develop innovative solutions using a strengths based approach.
- Discuss information that tells us what is happening in Thurrock so that we can target our efforts towards specific locations, abuse types and vulnerabilities.
- Work with the Community Safety Partnership on crime prevention that particularly affects adults with care and support needs.
- Work with the Local Safeguarding Children's Partnership to ensure that as children become young adults, they remain protected from abusive situations until they are able to safeguard themselves.

SABs have three core responsibilities:

1. To produce and publish an Annual Report
2. In collaboration with stakeholders and Healthwatch, produce a Strategic Plan, and
3. Conduct Safeguarding Adult Reviews if the need arises.

The SABs ethos is based upon the six safeguarding principles:

Empowerment
People being supported and encouraged to make their own decisions and informed consent.

Prevention
It is better to take action before harm occurs.

Proportionality
The least intrusive response appropriate to the risk presented.

Protection
Support and representation for those in greatest need.

Partnership
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability
Accountability and transparency in safeguarding practice.

THURROCK AS A PLACE

Thurrock is located on the north side of the River Thames, immediately to the east of London.

As of June 2018, the population of Thurrock is estimated to be 172,525, of which 51% are female and 49% are male and is home to 9% of Essex residents. In terms of population density, there are 1,055 people per square km, which is considerably higher than the England average of 430.

Thurrock has a relatively young population, with a larger proportion of its residents aged 0-19 and a smaller proportion aged 60+ when compared to the national population profile. This is reflected in the median age of the Thurrock population being much younger than the UK average (36.9 years compared to 40.1 years). However, it is important to note that the Thurrock population aged 60+ is projected to increase by 22.6% in the next ten years, which is a higher growth rate than the all-age population will reach 200,000 by 2035.

Care profile

The Thurrock Joint Strategic Needs Assessment (JSNA)[1] and the Market Position Statement are tools that help health and care organisations to plan services for their population. In Thurrock there are a suite of documents based on particular themes which summarise some of the key issues facing Thurrock. The majority or residents in residential care are older people with physical support needs and access/mobility issues, however Thurrock also has above average need for residential placements for young adults with a learning disability, which is to be expected given that there are two special schools in Thurrock.

[1] https://www.thurrock.gov.uk/healthy-living/joint-strategic-needs-assessment

CASE STUDY: Financial abuse by family member

A safeguarding concern was raised by the customer finance department due to unpaid care bills. The team had contacted the Care Home and found that AA had not been receiving her personal allowance since moving in to the home 18 months previously. AA was having to use toiletries that were left by other residents who had moved out of the home or had sadly passed away.

I carried out the Initial safeguarding enquiry by way of speaking to the customer finance team who advised that AA's outstanding care fees were in excess of £7000, payments had not been received since moving in to the home. Attempts had been made to contact the son (BA) without success. It was established that BA registered with the DWP as his mother's Appointee 6 months previously. Due to further enquiry being required the concern was progressed to S42 enquiry.

In view of the concerns raised the DWP was informed and the benefits stopped immediately. I then visited AA in the Care Home to discuss the concerns with her. AA was not aware of and did not acknowledge the concerns. Her view was that her son was visiting daily and that he was paying her bills and bringing her money. From the information available this was not the truth and on further assessment it was established that AA lacked capacity around the concerns raised.

I obtained AA's bank statements from the Care Home and found numerous outgoing transactions to restaurants and for services. On speaking to the staff and from speaking to AA it was evident that she had not been responsible for the transactions. Having made attempts to speak to BA (telephone calls, home visit and hand delivered letter) without success I spoke to AA's bank and requested that the account was frozen to protect her private pension. The case was also reported to the police.

According to our records there were no other family or friends so a referral was made for an advocate. AA was assessed as lacking capacity to manage her finances.

Outcomes achieved:

- The Corporate Appointee Team manage AA's finances.
- Application to the Court of Protection for finances to be completed.
- Police investigation underway due to the allegations of theft.
- Thurrock Council's legal department to consider action to recoup outstanding fees from BA.

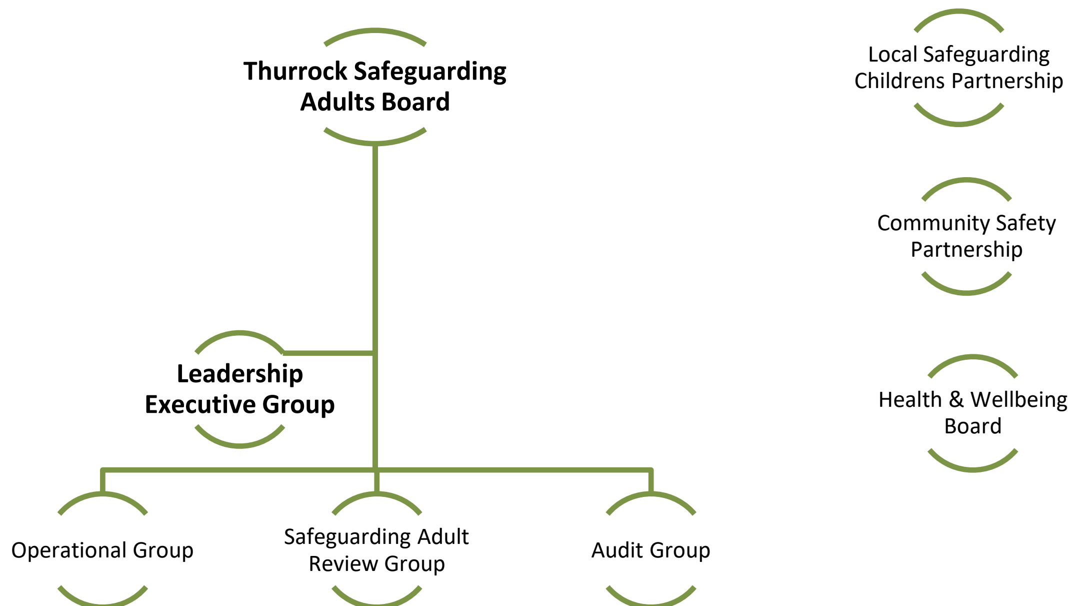
The outcome for AA is positive, she now has access to her personal allowance which enable the home to purchase the items she needs, including chiropody and hairdressing services. Her care bills will be paid and the risk to her placement (through non-payment of funds) will be removed.

HOW THE SAFEGUARDING ADULTS BOARD WORKS

As a relatively small area, Thurrock benefits from a professional safeguarding network whose members know each other well and are able to respond to incidents quickly. The SAB joins up with Essex and Southend Safeguarding Adult Boards to develop joint guidance and policy to support its workforce, as many colleagues work across the boundaries of each local authority area.

The Thurrock SAB operates on three levels, unlike other areas that have many role-specific sub-groups the majority of the SABs work is undertaken through the Operational Group. The Safeguarding Adult Review (SAR) sub-group only meets if a case is referred to be considered for a SAR. All terms of reference can be found at [www.thurrocksab.org.uk.](http://www.thurrocksab.org.uk)

The Audit Group was reinstated during 2019/20 however activity was postponed during the initial response to the Covid-19 pandemic to reduce demand on the groups' members, as all provide a frontline service. It is expected that the Audit Group will be reinstated as services begin to resume a steady state in service delivery.



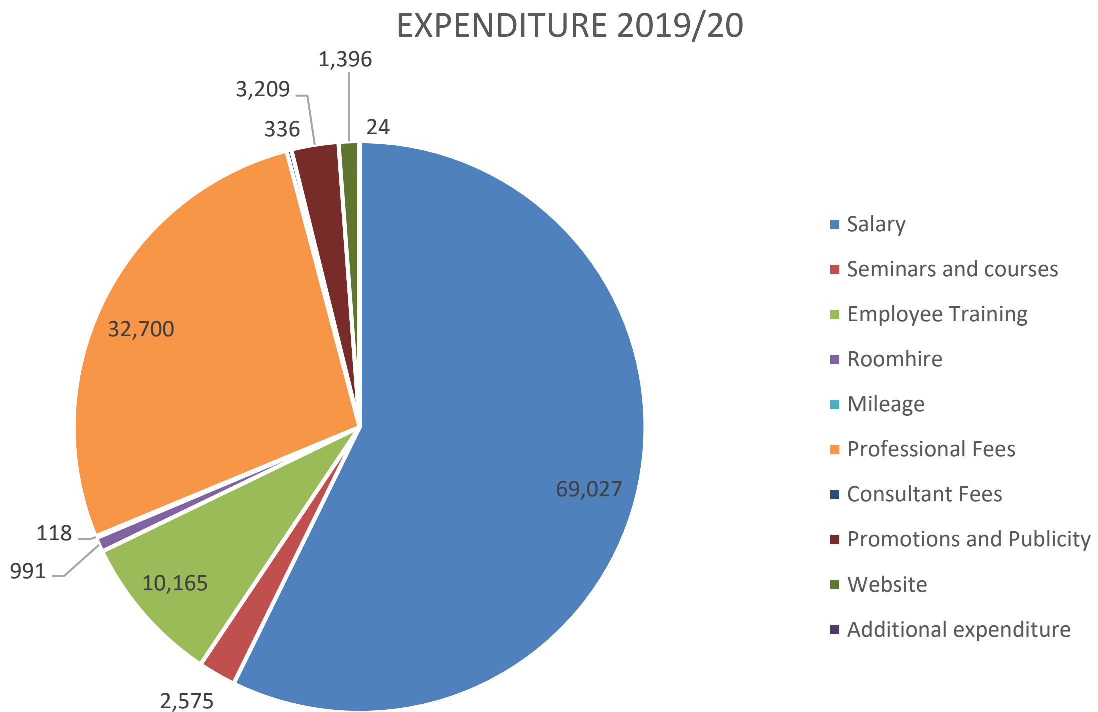
THE SAB BUDGET

The TSAB receives funding from Thurrock Council (£54,025); NHS Thurrock Clinical Commissioning Group (£18,750); and the Police, Fire and Crime Commissioner for Essex (£18,750).

The budget for 2019/20 was £133,998, this included a carry forward from 2018/19 (money not spent from the previous year) of £79,973.

£15,000 is held separately in the event a SAR is commissioned.

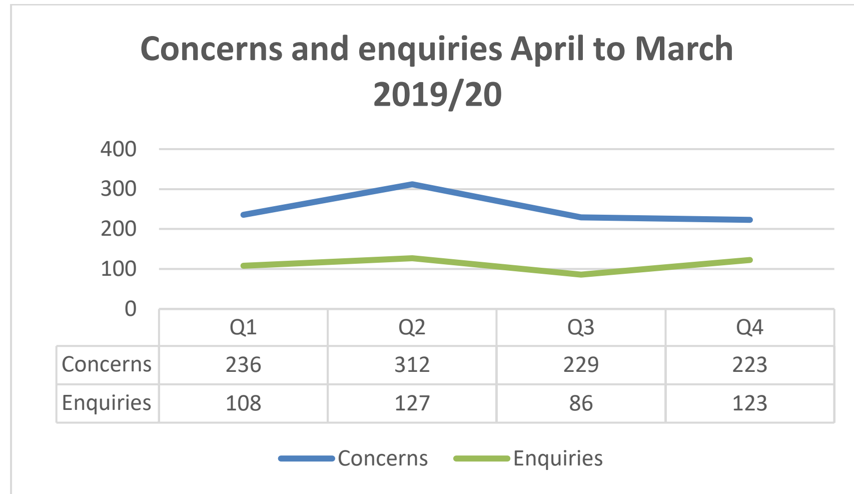
The agreed funding from NHS Thurrock and the OPFCC for 2019/20 is currently being processed and will therefore show in next year's annual report.



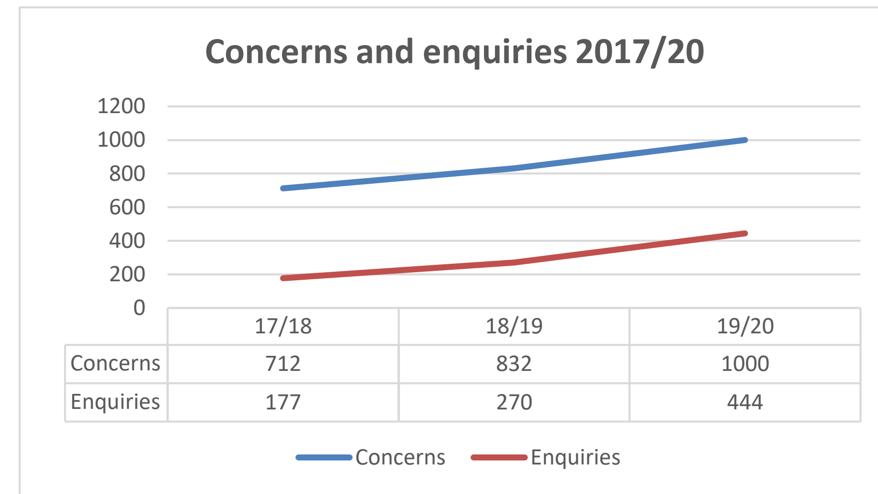
The majority of the budget is spent on staff costs, training and communications/ engagement activity. All of which raise awareness of adult safeguarding, support professionals, and people with care and support needs.

Total spent during 2019/20 is £110,541

THE PICTURE OF ABUSE AND NEGLECT DURING 2019/20



	Q1	Q2	Q3	Q4
Concerns	236	312	229	223
Enquiries	108	127	86	123



	17/18	18/19	19/20
Concerns	712	832	1000
Enquiries	177	270	444

Concerns

- Concerns increased by 17% from 2017/18 to 2018/19 and by 20% from 2018/19 to 2019/20.
- The number of safeguarding concerns is fairly stable over the year.

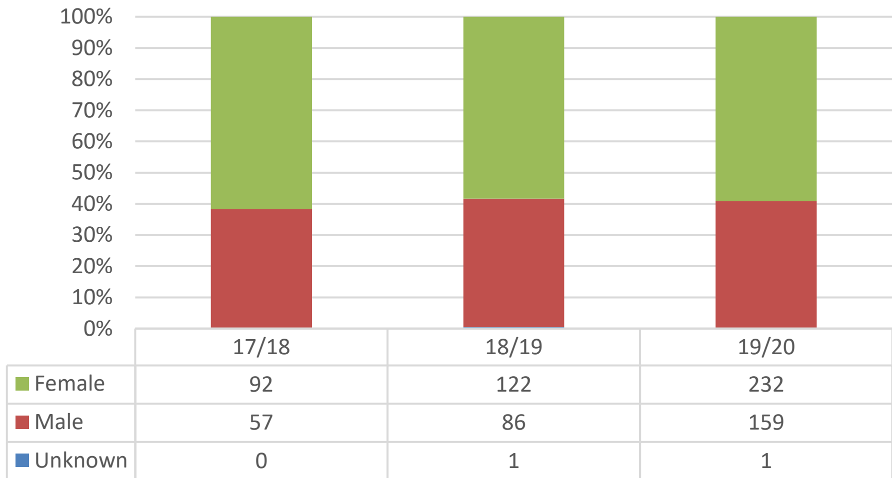
Enquiries

- Up 52% from 2017/18 to 2018/19.
- Up 65% from 2018/19 to 2019/20.

Conversion rate (rate of concerns that become enquiries)

- 2018/19 = 32%.
- 2019/20 = 44%.

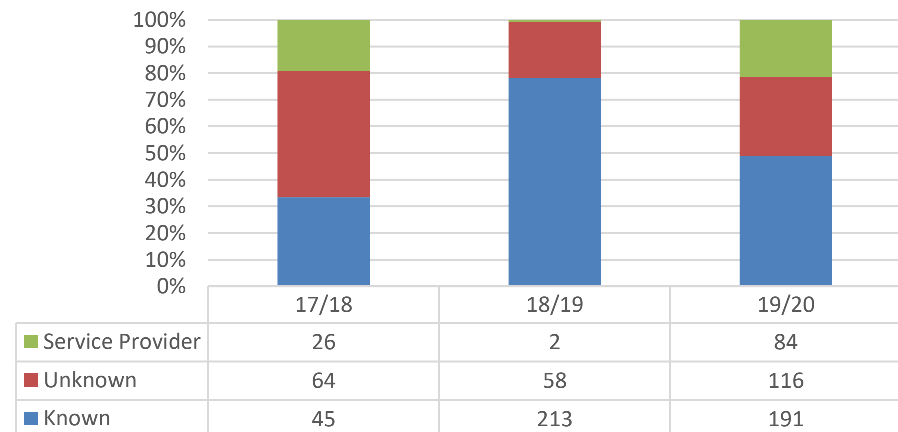
The conversion rate has increased for this year meaning that more concerns were progressing to safeguarding enquiries.



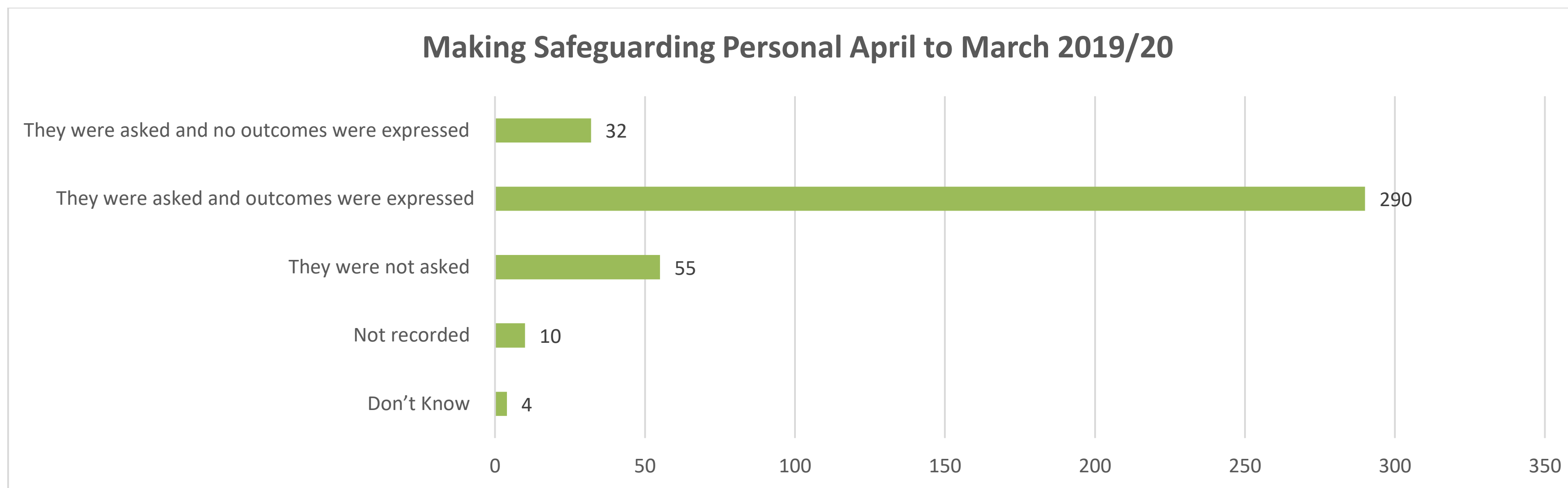
	17/18	18/19	19/20
Female	92	122	232
Male	57	86	159
Unknown	0	1	1

During the year, 444 safeguarding concerns progressed to enquires and 391 of these were concluded. This does not mean that social care are no longer involved with the individual, but that the safeguarding enquiry has concluded.

Enquiries by gender and person alleged to have caused harm remain consistent despite the increase in enquiries and concerns. Most commonly, the person alleged to have caused harm is known to the victim, with approximately 50% of all safeguarding enquiries in 2019/20.



	17/18	18/19	19/20
Service Provider	26	2	84
Unknown	64	58	116
Known	45	213	191



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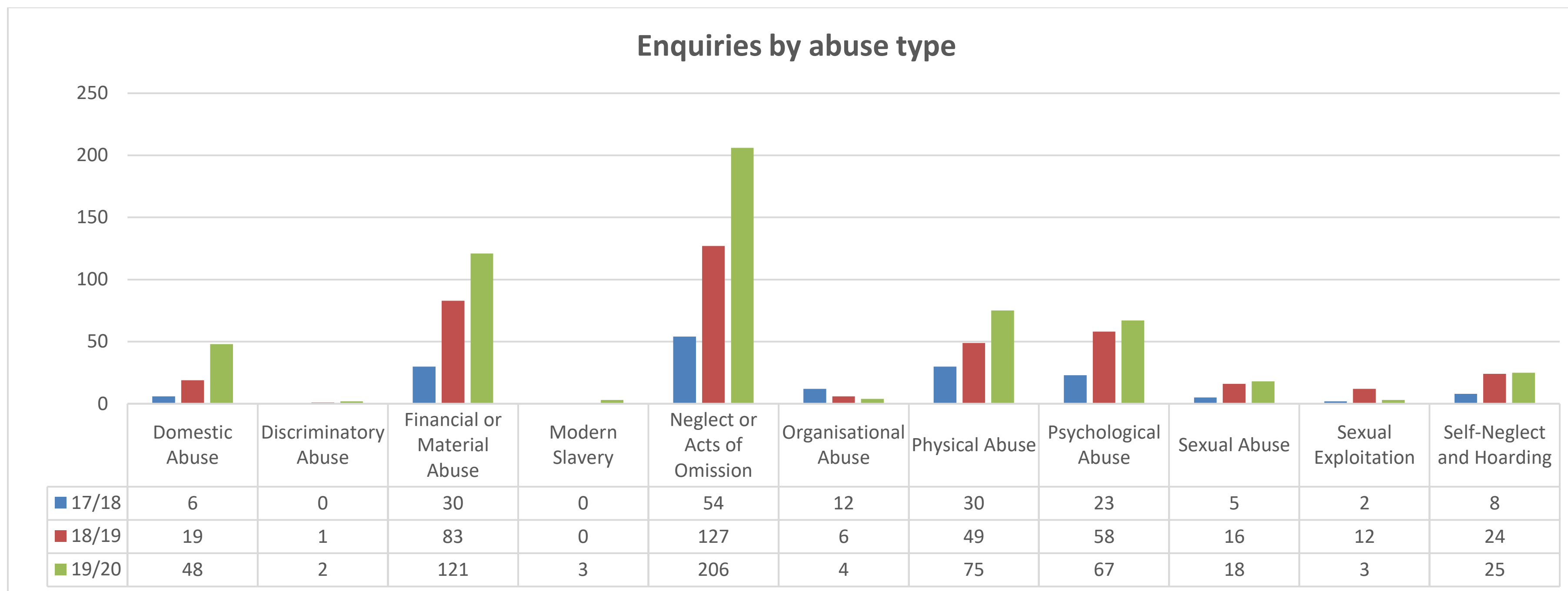
Of the concluded enquiries, the adult was asked what they would like to happen in 82% of cases.

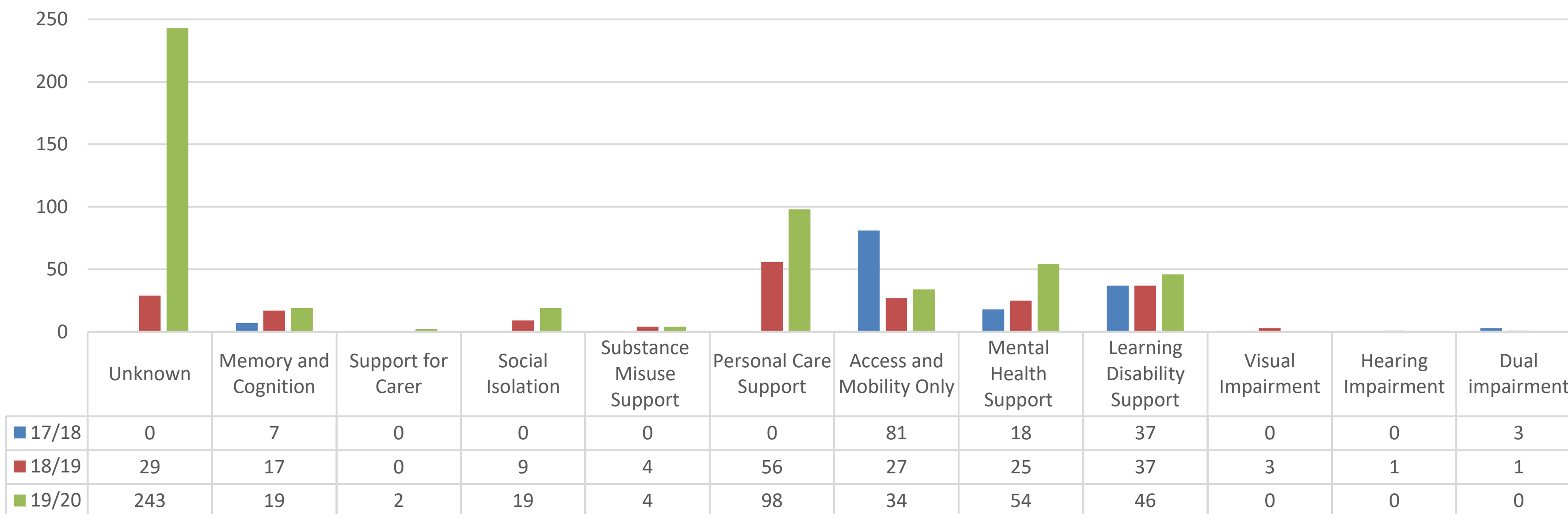


	Domestic Abuse	Discriminatory Abuse	Financial or Material Abuse	Modern Slavery	Neglect or Acts of Omission	Organisational Abuse	Physical Abuse	Psychological Abuse	Sexual Abuse	Sexual Exploitation	Self-Neglect and Hoarding
17/18	6	0	30	0	54	12	30	23	5	2	8
18/19	19	1	83	0	127	6	49	58	16	12	24
19/20	48	2	121	3	206	4	75	67	18	3	25

The graph and table above shows the abuse types from concluded enquires. The most common abuse types are;

- Financial or material abuse
- Neglect or acts of omission
- Physical
- Psychological/emotional.

Some enquiries will feature more than one abuse type for example domestic abuse may be recorded as domestic and emotional.



	Unknown	Memory and Cognition	Support for Carer	Social Isolation	Substance Misuse Support	Personal Care Support	Access and Mobility Only	Mental Health Support	Learning Disability Support	Visual Impairment	Hearing Impairment	Dual impairment
17/18	0	7	0	0	0	0	81	18	37	0	0	3
18/19	29	17	0	9	4	56	27	25	37	3	1	1
19/20	243	19	2	19	4	98	34	54	46	0	0	0

The graph and table above shows the abuse types from concluded enquires. The most commonly recorded support need of people subject to safeguarding enquiries is:

- Learning Disability
- Mental Health condition
- Access and Mobility
- Personal Care

During 2018/19 a category of 'not recorded' was included, this has increased significantly from 2018/19 to 2019/20. This will be monitored during 2020/21.

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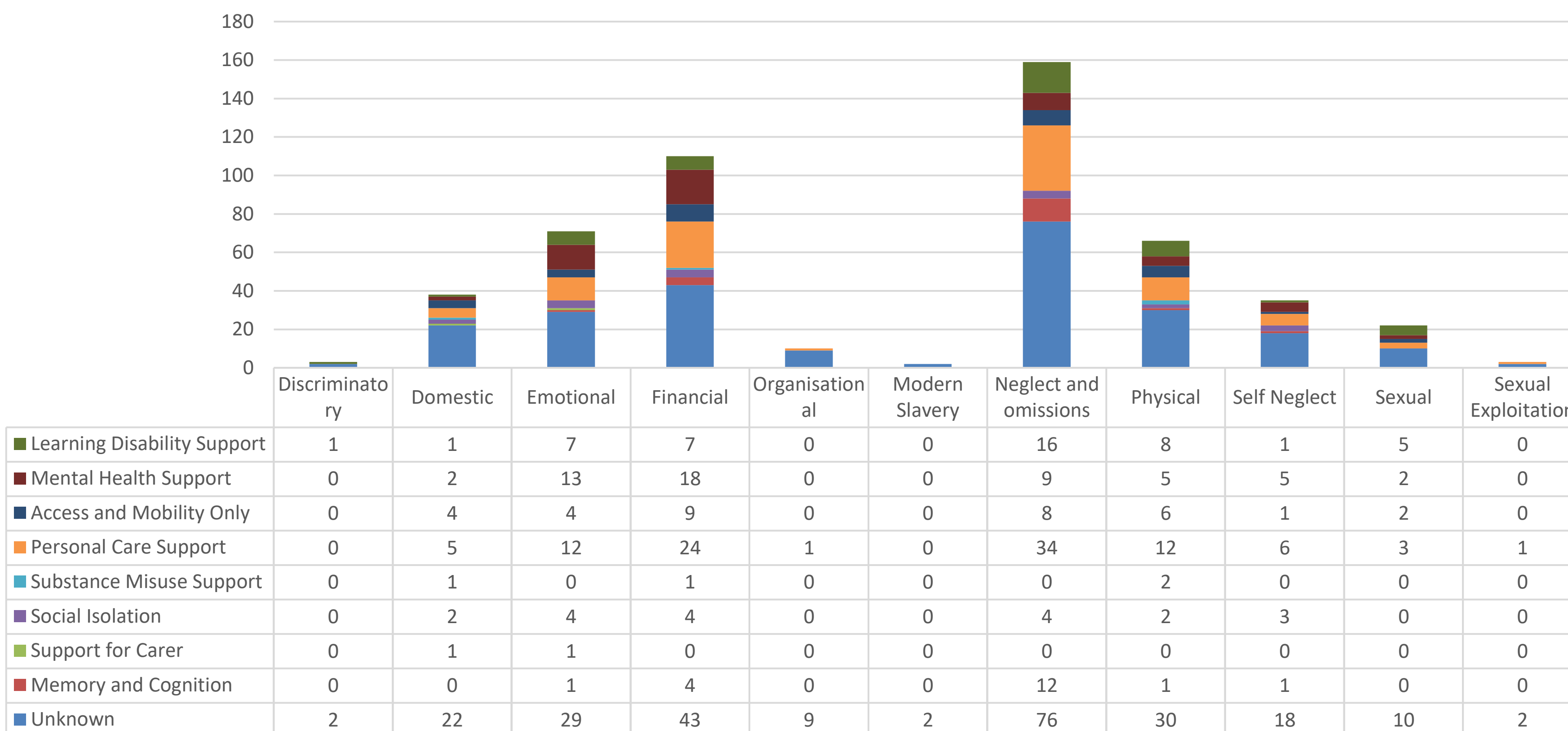

	Discriminatory	Domestic	Emotional	Financial	Organisational	Modern Slavery	Neglect and omissions	Physical	Self Neglect	Sexual	Sexual Exploitation
Learning Disability Support	1	1	7	7	0	0	16	8	1	5	0
Mental Health Support	0	2	13	18	0	0	9	5	5	2	0
Access and Mobility Only	0	4	4	9	0	0	8	6	1	2	0
Personal Care Support	0	5	12	24	1	0	34	12	6	3	1
Substance Misuse Support	0	1	0	1	0	0	0	2	0	0	0
Social Isolation	0	2	4	4	0	0	4	2	3	0	0
Support for Carer	0	1	1	0	0	0	0	0	0	0	0
Memory and Cognition	0	0	1	4	0	0	12	1	1	0	0
Unknown	2	22	29	43	9	2	76	30	18	10	2

Data from the Thurrock Council Social Care department 2019/20. These figures will not match the SAC return for Thurrock as the SAC reports on individuals whereas this reports on activity, for example one individual may have multiple concerns raised which are captured in this data. This data is a more accurate representation of safeguarding activity in Thurrock.

WHAT THE TSAB ACHIEVED DURING 2019/20

Strategic Plan 2017/20

The table below provides an update on year three of the current Strategic Plan, what we have achieved and actions for the rest of the 2019/20.

Strategic Objective **Communications Strategy**	
Planned activity during 2019/20	**What we achieved**
• Implement social media. • SET coordination of Safeguarding Adults Week. • Increased information on www.thurrocksab.org.uk. • Improved stakeholder engagement in Strategic Plan development.	• Developed a social media plan, implemented in February 2020. • Distributed public information to health and care settings as well as public locations such as libraries. • Attended 11 public events, including the Orsett Show and supported Safeguarding Adults Week. • Commissioned Thurrock Centre for Independent Living to lead community engagement in the Strategic Plan 2020/23. • Continue to add to the content on the website and improve accessibility. This work will continue, business as usual.

Strategic Objective **Prevention Strategy**	
Planned activity during 2019/20	**What we achieved**
• The Prevention Strategy will be approved by the TSAB mid-2019. • The action plan will be regularly monitored via the Operational Group.	The Prevention Strategy was led by the Principal Social Worker, Thurrock Council and signed off in July 2019. The Strategy pulled together initiatives from a range of agencies all with the aim of preventing abuse, neglect, empowering the community to maintain and improve their own wellbeing and safety. Prevention is a consistent thread throughout the Strategic Plan 2020/23 as opposed to being an isolated objective, to ensure it is embedded in all work.

Strategic Objective **Understand the scale of adult sexual exploitation, and the gaps in the transition from children's to adults services for those at risk**	
Planned activity during 2019/20	**What we achieved**
• Deliver the multi-agency sexual exploitation training to adult social care staff. • Deliver the Exploratory Study and make recommendations to the SAB. • Raise awareness of sexual exploitation (and exploitation	• Developed training package with the NWG, pilot delivered to multi-agency groups. • Project experiences shared with the NWG Network. • Explored opportunities to strengthen perpetrator disruption. • Sexual exploitation profile raised during the TSAB Annual Conference which focussed on Trauma Informed Care.

generally) of adults with professionals and the community.	• The publication of the study has been delayed as some agencies were unable to provide data due to prioritising responses to Covid-19. The Report will be published during 2020/21. • To ensure the outcomes are embedded within business as usual the work-stream will continue under the Violence against Women and Girls Governance Group and report back to the TSAB.

As well as implementing the Strategic Objectives, the TSAB also worked on the following projects.

TSAB Conference

Hosted the Annual TSAB Conference with the theme Trauma: safeguarding adults who have complex and challenging needs, delivered by Zoe Lodrick (Sexualised Trauma Specialist). The conference received outstanding feedback and provided insights that could be further developed and taken forward in every organisation that supports adults with care and support needs. To demonstrate our commitment and determination to improve practice and organisational responses to this area of abuse, and to support delivery of the 2020/23 Strategic Plan, Zoe Lodrick has been commissioned to deliver the content for the next TSAB Conference.

Board effectiveness

Following the TSAB Development Session during 2019, we improved the efficacy of the TSAB by making the following improvements:

- Improved stakeholder engagement in development of the Board agenda and Strategic Plan.
- Review frequency and format of Board meetings, opting for a community location and allowing time for in-depth discussions at board meetings.
- Improved the use of data and reporting that information to the TSAB. Analysis and interrogation are to be refined during 2020/21.
- Established and implemented an audit programme.

Outstanding is the development of an induction pack for new Board members to improve their understanding of the role and increase their participation in the agenda, this will be progressed during 2020/21.

Hoarding and self-neglect panel

During 2020/21 there will be a review of learning and development needs to ensure the workforce are aware of all options and best practice, to support people who hoard or self-neglect to achieve a safe and healthy living environment, along with a review of the Hoarding and Self-Neglect Panel.

Out of hours care home visits

The Thurrock SAB has been committed to ensuring good quality care in its residential homes in Borough. Since 2015 it has been committed to a bi-annual programme of visits to those homes, both for residents with learning disability and older people. The latest programme of visits was conducted during October and November 2019. These are not inspection or monitoring visits, but citizen lay people visits to gauge the atmosphere, physical surroundings and happiness of residents in those homes. This has been welcomed by providers who have been wholeheartedly behind the visits and allowed us access to the Home. This reassures Board members of resident's wellbeing, safety and general standard of care received.

Any safeguarding incident on visiting is reported immediately through normal channels; overwhelmingly care has been found to be good. The measure is 'would I like myself or loved ones to be cared for in this home'?

Training

The safeguarding training offer is aimed at a multi-agency audience and is reviewed every year to address the priorities in our Strategic Plan, emerging risks and to respond to the needs of the workforce.

Training delivered during 2019/20	Training planned or in development, to run during 2020/21
Safeguarding Adults Basic Awareness	Safeguarding Adults Basic Awareness
Safeguarding Adults Level 2	Safeguarding Adults Level 2
J9 (raising awareness of domestic abuse/violence)	Safeguarding Adults Level 3
Mental Capacity Act	J9 (raising awareness of domestic abuse/violence)
Challenging Myths, Changing Attitudes (raising awareness of sexual abuse/violence)	Challenging Myths, Changing Attitudes (raising awareness of sexual abuse/violence)
Domestic violence/abuse including DASH	LGBTQ+ awareness raising for commissioners and providers
Sexual Exploitation pilot – transition age young people and adults	Adult Sexual Exploitation Training for Taxi Drivers (added to the existing CSE programme)
Cuckooing	
Safeguarding Adults Level 2 and S42 enquiries for Providers	

Community and stakeholder engagement

The TSAB team attended the events listed below to raise awareness of adult abuse and neglect, and of the TSAB. During 2020/21 we will refine this approach to make better use of our limited resources, attempting to meet larger groups of people or specific communities with each event.

Community/Stakeholder Engagement Events during 2019/20	Community Engagements Events planned during 2020/21
The Orsett Show	The Orsett Show
Thurrock Garden Centre – Stand to coincide with National Dementia Day	Tilbury Carnival
TSAB Professionals Conference	TSAB Professionals Conference 2020
National Safeguarding Adults Week o Stand in the Civic Offices Reception Area (4 days) Stand at the South Essex College, Grays	National Safeguarding Adults Week
Winter Warmers Project	Winter Warmers Project
Faith Leaders Event	Faith Leaders Event
Sexual Violence & Abuse JSNA Summit	Purfleet Fun Day
	Thurrock Housing Conference
	Essex Partnership University Trust Conference 2020

CASE STUDY: Risk of self-neglect / no access to funds due to poor communication

This was referred as a safeguarding concern by a bank. TA is 54 years of age and he lives alone in a council flat. He lives with a stroke which has affected his speech and the right side of his body. The bank informed that TA had a block placed on his account as he attended the bank with somebody else but he was not able to speak for himself or verify his identity. The staff were concerned that he may be at risk of financial abuse.

A home visit was carried out by a safeguarding practitioner and with support to communicate, TA expressed his views, his desired outcome was to have this resolved and to be able to access his money. TA informed the practitioner that he had a bank card and knew the pin number, which he would normally use to access money; nobody else had access to his pin number. TA said he liked to be independent and that he had a mobility car, which he drove to do his own shopping and get other essentials.

TA also had a personal assistant who provided him with some support, such as making phone calls, sorting out and responding to correspondence and managing his bills, including setting up direct debits. TA's personal assistant also made contact with the safeguarding team to request help for TA because the bank had placed a block on his account; therefore, TA was not able to access his money for food and daily living, including petrol.

Outcomes achieved:

- Contact was made with the bank to explain TA's communication needs, and TA was given alternatives to ensure he could communicate with the bank such a writing things down.
- An appointment was arranged for TA to attend the bank in person with identification for staff to verify his identity to enable him to have access to his money.
- TA's immediate needs were taken care i.e. food supply and daily essentials arranged and delivered to TA.
- With TA's consent, a referral was made for advocacy support to ensure that future support was in place so that he would always able to access his money and banking facilities safely. A communication system was also put in place. This enabled TA to continue managing his finances independently.

SAFEGUARDING ADULT REVIEWS

There were no cases raised with the SAB to be considered for a Safeguarding Adult Review during 2019/20. Therefore, there were no SARs during this period, or reviews of any other kind.

Learning from past experiences is vital to ensure all agencies stay abreast of best practice and emerging risks; the Operational Group discusses the findings of SARs that have taken place in other local authority areas so that we can still learn. If the Group feels that the SAR presents the opportunity for significant learning and improvement in Thurrock, a Learning Event is planned and a report given to the SAB including recommendations.

PLANS FOR THE FUTURE – 2020/21

During the coming year, April 2020 to March 2021, our main focus will be to refine the Strategic Objectives 2020/23 which are in the new Strategic Plan by creating an action plan explaining what we want to achieve and how we will make that happen. We will also:

- Analyse the impact of the pandemic on vulnerable people and plan to address any additional safeguarding needs that emerge as a consequence.
- Work with agencies to test how well the safeguarding system works by reviewing different parts of the process, looking for evidence of good practice and areas for development.
- Continue to work with the Community Safety Partnership, and improve our connections with the Local Safeguarding Children's Partnership. The TSAB and CSP has cross referenced their Strategic Plans, ensuring alignment between joint priorities. Also to be completed with the LSCP.
- Improve resilience within communities and individuals, empowering them to feel more capable and confident in protecting their right to feel and be safe, and seek support and action when abuse or neglect has taken place.
- Take a broader approach to safeguarding by discussing a more diverse range of topics that will engage all board member agencies, make better use of their knowledge and expertise, and considering groups of people who do not usually come to our attention such as offenders.
- Target community engagement to increase impact for each event monitor how the website is used so that we can improve accessibility, content, and reach, and introduce TSAB content on social media platforms.

FURTHER INFORMATION

If you want to know more about any project or topic within this report please send an email to TSAB@thurrock.gov.uk or visit www.thurrocksab.org.uk. **To raise a concern** email **safeguardingadults@thurrock.gov.uk** or call **Thurrock First 01375 511000.**

“To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities”

5 November 2020		ITEM: 11
Health and Wellbeing Overview and Scrutiny Committee		
Orsett Hospital and the Integrated Medical Centres – Update Report		
Wards and communities affected: All	**Key Decision:** Non-Key	
Report of: Roger Harris, Corporate Director of Adults, Housing and Health; Mark Tebbs, Deputy Accountable Officer, NHS Thurrock Clinical Commissioning Group – Joint Chairs of the Integrated Medical Centres Strategic Programme Board.		
Accountable Director: Roger Harris, Corporate Director of Adults, Housing and Health		
This report is Public		

Executive Summary

The Council and NHS partners have been working together to develop a new model of care that will provide integrated health and social care services, delivered from modern, high quality premises, and able to attract the best staff. Four new Integrated Medical Centres (IMCs) will locate the new model of care in the heart of the communities they serve, bringing a greater range of health and care services under one roof, and improving and simplifying care pathways for patients.

Good progress continues to be made with planning, financing and service transformation for all four IMCs, and dedicated programme management is in place. This report updates the Committee on progress of the IMC programme, the proposed closure of Orsett Hospital, and the work which may result in a new integrated health centre in South Ockendon.

1. Recommendation(s)

1.1 The Health and Wellbeing Overview and Scrutiny Committee is asked to consider and note this report.

2. Introduction and Background

2.1 The Committee will be aware that the quality of health provision in several areas of the Borough falls below the standards that the Council and NHS partners would like to see achieved. The Council, with its NHS partners, now have an exciting opportunity to address this underachievement. New Integrated Medical Centres will improve the health and well-being of the population of Thurrock by moving from outdated facilities and fragmented

services, improving the capacity and capability of primary, community and mental health care, and delivering an integrated health, social care and community/third sector care model with Thurrock's residents at its heart.

2.2 To this end the Council entered into a Memorandum of Understanding – Replacing Orsett Hospital with four new Integrated Medical Centres (IMCs). The MoU, agreed in May 2017 with Basildon and Thurrock Hospitals NHS Foundation Trust (BTUH) – now part of Mid and South Essex NHS Foundation Trust (MSE), Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT), and Thurrock Clinical Commissioning Group (the CCG), ensured that our strategy evolved from the broad concept of Integrated Healthy Living Centres into a firm commitment to deliver the four IMCs in Thurrock. A dedicated programme management resource, reporting to an alliance of the Council and health partners, was established to oversee delivery of the IMCs.

2.3 The IMCs will serve local populations and will be located in:

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

2.4 The Council has been working with the CCG and health providers to develop the detailed concept of the IMCs which will provide an integrated model of care, in high quality premises located in the communities that they serve. The IMCs, will be crucial to the introduction of the New Model of Care as presented by the Director of Public Health, including the new Primary Care offer, Well-Being Teams and Technology Enabled Care.

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

3. Issues, Options and Analysis of Options

The Operating Model for the IMC Programme

3.1 The new model of service provision which will be delivered from the IMCs is focussed on integration of services across provider boundaries. With the exception of the primary care areas (which have a distinct funding mechanism), providers will not have dedicated rooms that may stand empty outside of set clinic hours, instead the rooms will be multifunctional and therefore interchangeable across services.

3.2 Providers have agreed a set of finance principles which seek to share the risk and rewards created as a result of actual occupancy levels when the IMCs are operational, and reflecting the principle of integrated services in shared spaces. The shared approach to risk incentivises all partners to maximise utilisation of the Centres. These broad principles are agreed by all partners in the Thurrock Integrated Care Partnership (TICP). TICP is the overall umbrella group established by all NHS partners and the Council locally to take forward our integrated health and care agenda.

3.3 To ensure this shared approach results in effective, efficient and economic use of space, Public Health worked with the Adult Social Care staff, NHS providers and the CCG to identify all anticipated health and social care service activity data for the IMCs. The following has been confirmed:

- Service activity across Thurrock has been apportioned to each IMC;
- Health planners have been engaged to finalise the design requirements;
- Future proofing will address Thurrock's planned population growth.

Consideration is being given to services operating at different times to improve space utilisation, along with new ways of working, and maximising agile working. Confirmation of the design requirements from all parties has been obtained for each IMC, and detailed funding and other commitments agreed. NHS Thurrock CCG has agreed in principle to commit growth monies to support the funding of the IMCs.

3.4 The decision taken by the July 2018 meeting of the Joint Clinical Commissioning Group (CCG) Committee to close Orsett Hospital and re-locate services into the community potentially further supports the need to develop IMCs in a timely manner. This decision was referred to the Secretary of State. On 17 July 2019 the Independent Referral Panel wrote to the Secretary of State noting that "The Memorandum of Understanding co-signed by the CCG, Council, and Basildon Hospital explicitly stated that services at Orsett Hospital would not cease prior to the construction and opening of the IMCs. The CCG Joint Committee decision on 6 July 2018 quoted the agreement and reiterated that services at Orsett Hospital would not be closed until new services were in place in agreed new locations. The Panel expects this undertaking to be honoured." The letter also observed that "They will need to be developed, and the outstanding details agreed, with the collaboration of relevant partners including the proposed People's Panel and local Healthwatch and subject to ongoing consideration by the relevant scrutiny bodies."

Stanford and Corringham IMC

3.5 The delivery of the Stanford and Corringham IMC, on the site of 105 The Sorrells, Stanford Le Hope, is being led and funded by NELFT. Planning consent for the IMC was secured in 2016 and amended in 2018 to extend the proposed opening hours.

3.6 The building will accommodate the following clinical services:

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

3.7 The Business Case for the development was approved by the NELFT Board on 24 March 2020. The contract for the development has recently been awarded and start on site is expected in November. With an estimated build period of 15 months, it is anticipated that the IMC could be operational from early 2022.

Tilbury and Chadwell IMC

3.8 Since the Council took the decision to lead on the delivery of the Tilbury and Chadwell IMC on the site of the Community Resource Centre in Tilbury, work has progressed significantly. The financing of this scheme has been modelled by the Council using prudential borrowing.

3.9 The Council, CCG and service providers have worked collaboratively to develop a schedule of accommodation that can be provided at Tilbury and Chadwell IMC. This accommodation schedule fully subscribes to the integrated vision and includes provision for:

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

3.10 The suite of flexible clinical rooms enables multiple services to make use of the space meaning patients can access the range of services they need on a single site. The community elements in the IMC, including the library and community hub, have a key role to play in addressing the wider determinants of health. The linkage to the Towns Fund bid will mean the IMC will also form a significant part of the new town centre for Tilbury. Pick Everard have been engaged to design the IMC and detailed floor plans are currently being developed. The development is expected to be operational in early 2023.

Purfleet IMC

3.11 The Purfleet IMC will be delivered as part of the wider Purfleet town centre regeneration scheme. An outline planning application which included medical facilities was approved in March 2019, together with a Section 106 Agreement which commits Purfleet Centre Regeneration Ltd (PCRL) to develop the facility. The Purfleet IMC is part of the Phase 1 development proposal from PCRL, and, together with the remodelled station, is a key element of the scheme.

3.12 The schedule of accommodation for Purfleet IMC has been agreed with partners and initial floor plans (commissioned by PCRL) are expected in the next month. Delivery of this IMC is anticipated to be in late 2023.

Grays IMC

3.13 Thurrock Community Hospital has been designated as the new IMC for Grays, and is the only IMC which will be predominantly a refurbishment of an existing healthcare facility rather than an entirely new-build development. The site is owned by EPUT which leases part of the site to NELFT, and third sector providers. The site currently has 19 separate buildings, with over half of the buildings vacant or underutilised which means the estate is inefficient in use and offers an opportunity to reconfigure and redesign to improve delivery. The layout of the site lends itself to the zoning of two main areas: a "Health Village", incorporating quieter and more long-term activities, and a "Day Hub", the space where service users and patients would come for appointments and more short term activities.

3.14 As the only site already built, Thurrock Community Hospital offers the opportunity to renovate and redesign facilities to accommodate services, with the potential to bring services on line in a shorter time frame. The CCG is also in consultation with relevant primary care providers to ensure that there is a significant primary care service on site.

The proposed closure of Orsett Hospital

3.15 MSE Trust remains committed to the long term closure of the Orsett site and the relocation of services accessed by the Thurrock population into the four IMCs, with the dominant presence in Grays IMC. A project group has been established to progress the detailed planning but this has been put on hold

due to other priorities in the Trust following the COVID-19 pandemic. It was planned to restart this work in October, but due to increased risk of the second COVID spike this has been further deferred this until January 2021. However, part of the COVID restart programme is the relocation of outpatients and diagnostic services into community locations to free up space on the main hospital sites. This programme of work will provide a good foundation for the Orsett project once it restarts and will increase the range of services available closer to home for the Thurrock population.

The Programme Business Case for the IMCs

3.16 The development of the four IMCs requires the development of a Programme Business Case. The purpose of this Programme Business Case is to obtain approval from the Mid and South Essex Health and Care Partnership, the Boards of the NHS providers and from NHS England / Improvement for investment in four local Integrated Medical Centres in Thurrock. The Programme Business Case has been produced using HM Treasury's Five Case Model for business cases, and this sets out the economic assessment of the social costs and benefits of the new policies, projects and programmes associated with the IMCs.

Integrated Medical Centres (Phase 2)

3.17 The Committee will be aware the Council is currently progressing the design for a 21st Century Residential Facility on the White Acre/Dilkes Wood site on Daiglen Drive in South Ockendon.

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

3.19 A programme of work is currently being planned to progress this proposal. This is not an IMC but may emerge as a related project which will improve health provision in an area of Thurrock which has seen, and in the future is likely to see, significant housing growth.

4. Reasons for Recommendation

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

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

5.1 Reports were presented to Planning, Transport and Regeneration Overview and Scrutiny Committee and Health Overview and Scrutiny in September 2018, and Health and Well-Being Board in June 2019. Public consultation on Corringham IMC was undertaken during the course of the planning application process, and again more recently as the development gets under way. Further consultation with local communities on the specifics of each of the other three IMCs will be undertaken as part of the planning process.

5.2 Health Watch have organised a People's Panel to gain public input into the development of all four IMCs.

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

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

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

7. Implications

7.1 Financial

Implications verified by: **Rosie Hurst**

Interim Senior Management Accountant

This report presents details of the current proposals for the development of 4 integrated medical centres. Any financial implications related to the proposals in this report will be considered at the time decisions related to the proposals are to be taken.

7.2 Legal

Implications verified by: **Tim Hallam**

Deputy Head of Law and Deputy Monitoring Officer

This report presents details of the current proposals for the development of 4 integrated medical centres. Any legal implications related to the proposals in this report will be considered at the time decisions related to the proposals are to be taken.

7.3 **Diversity and Equality**

Implications verified by: **Becky Lee**

Team Manager - Community Development and Equalities

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

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

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

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

- None

9. Appendices to the report

- None

Report Author:

Christopher Smith

Programme Manager

Adults, Housing and Health

Health Overview & Scrutiny Committee
Work Programme
2020/2021

Dates of Meetings: 18 June 2020, 3 September 2020, 5 November 2020, 14 January 2021 and 4 March 2021

Topic	Lead Officer	Requested by Officer/Member
18 June 2020		
HealthWatch	Kim James	Members
Health and Adult Social Care System COVID-19 Response	All	Members
Progress Update on Major Health and Adult Social Care Projects	Roger Harris, Mark Tebbs, Les Billingham	Officers
3 September 2020		
HealthWatch	Kim James	Members
2019/20 Annual Complaints and Representations Report – Adult Social Care	Lee Henley	Officers
Proposed Consultation on Adult Social Care (Non-Residential) Fees and Charges 2021/22	Catherine Wilson	Officers
Temporary reconfiguration of NHS Community Beds across Mid and South Essex including Mayfield Ward move from Thurrock Hospital to Brentwood Hospital	Tania Sitch (NELFT)	Members
Memorandum of Understanding across Mid and South Essex STP and update on CCG Merger and Single CCG Accountable Officer	Roger Harris / Mark Tebbs	Members
Procurement of Autism specialist Support Services - Medina Road	Les Billingham / Catherine Wilson	Officers

5 November 2020		
HealthWatch	Kim James	Members
Orsett Hospital and the Integrated Medical Centres - Update Report	BTUH	Members
Verbal Update Targeted Lung Health Checks	Mark Tebbs	Members
Mental Health Update: Essex Partnership University NHS Foundation Trust	Providers	Members
COVID Update Presentation	Ian Wake	Members
Basildon University Hospital Maternity Services	BTUH	Members
Verbal Update on Detailed Fees and Charges Report	Catherine Wilson	Members
Mankind – Male Domestic Abuse - Presentation	Mark Brooks (Chairman)	Members
Thurrock Adult Safeguarding Board Annual Report	Jim Nicholson	Officers
14 January 2021		
HealthWatch	Kim James	Members
Adult Social Care – Fees & Charges Pricing Strategy 2021/22	Roger Harris	Officers
Update on the Whole Systems Obesity Strategy Delivery and Outcomes Framework	Helen Forster / Faith Stow	Members
Personality Disorders and Complex Needs Report	Mark Tebbs / Andy Brogan	Members
Worklessness and Health Joint Strategic Needs Assessment	Helen Horrocks / Sue Bradish	Officers
COVID Update	Ian Wake	Members
Detailed Fees and Charges Report	Catherine Wilson	Members
Safeguarding Strategic Plan 2020/23	Les Billingham / Fran Leddra	Officers

4 March 2021		
HealthWatch	Kim James	Members
Update on Orsett Hospital / IMCs	Roger Harris	Members
COVID Update	Ian Wake	Members

Clerk: Jenny Shade
Last Updated: May 2020

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