APPENDIX 1

Local Government Association

Thurrock Council Adults Social Care – Mental Health **Peer Review Report**

June 2018

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Executive Summary

1. Thurrock Council requested that the Local Government Association undertake an Adults Social Care Peer Review at the Council and with partners that specifically focussed on the work to support adults with mental health issues. The work was commissioned by Roger Harris, Director of Adults, Housing and Health and he was the client for this work. He was seeking an external view on how the Council and its partners primarily in the NHS identify and make changes to both the adults mental health offer and the way the service is delivered and managed.

2. One of the areas Thurrock wished to test through the peer review was whether the current mental health 'offer' was fit for purpose and the extent to which it prevents as well as reacts and deals with the whole person, taking account of key areas such as housing, employment, social isolation and physical health, all of which contribute significantly to identifying a sustainable, long term solution for the individual.

3. The Public Health team published a Joint Strategic Needs Assessment on Mental Health in February 2018. The key findings of the JSNA are:

    - The mental health offer is fragmented;
    - There is under-diagnosis and variation in diagnosing mental health – there is a wide range of diagnoses between GP practices;
    - Quality of care is not always in line with the highest standards; and
    - A better understanding of the link between long-term conditions and mental health in particular is required.

4. The peer team was impressed with the commitment of the elected members that they met and the passion of the Chief Executive and Director of Resources for addressing the mental health needs of the people of Thurrock. There was a clear vision expressed by all the leadership team with the challenging aim to ensure that, "no one is left behind".

5. There was a cross-party commitment to health and social care and this was evident in the support for initiatives to address mental health needs. It was reported by some of the people whom the team met that the scrutiny function could be somewhat adversarial in nature. There may be opportunities for elected members to adopt a more outward looking and enquiring style in its work which could enhance their approach to scrutinising the Mental Health offer.

6. The team saw significant evidence of the council's Transformation work, building on a "strengths based approach" through initiatives such as the introduction of the Local Area Coordinators and through close working relationships with local community organisations. However, this has yet to be transferred into Mental Health services and more needs to be done to support those in the community who are at risk of escalating into crisis. The maintenance of high NHS thresholds is seen by service users as an obstacle in accessing more general, prevention services. There is a need for a clear action plan to drive forward the required improvements in the MH offer, so that it achieves the articulated vision. The big challenge here is to modernise and

personalise the seconded and commissioned services in the partnership (Section75) between the Council and the current NHS provider.

7. The team was impressed with the council's ability and skill to agree a four year balanced budget and recognised this achievement, particularly given the wider context of the challenges to public sector finance. Nonetheless, savings are being applied to Adult Social Care (ASC) and these will have implications for the wider service offer.

8. It was evident from all the people that the team met there was a strong pride in their community. Although people identified with their own 'urban village' within the overall area of Thurrock there was a commitment to the people around them. The workforce is relatively stable with many people who had come to work for the council remaining for a number of years; building knowledge of their local communities and developing strong inter-agency relationships.

9. The team considered that the council had the right people participating in the Health and Wellbeing Board (HWB). Though it was also recognised that it was not functioning to its maximum capacity. The HWB could benefit by refocussing on Thurrock's response to immediate and longer term mental health issues and supporting strong and consistent leadership based on transforming the care right across all adult services, including in seconded and commissioned Mental Health services.

10. Healthwatch involvement in the Mental Health agenda was strong and they have a standing item on the scrutiny committee's agenda. This could be further built on so that the scrutiny process and the work of the HWB could become more proactive.

11. The team recognised the commitment of the council's leadership on the Mental Health agenda, bringing in the components of Adult Social Care (ASC), Health, Housing and the influences of the economic environment. This is supported by skilled analysis and information from Public Health. This provides a basis for developing challenging and more robust relationships with partners in the development of services.

12. The team recognised the tension of a stretched leadership team wishing to focus on the transformation of Thurrock and the call to participate in a complex set of Sustainability and Transformation Partnership (STP) and other arrangements of a wider geography. Thurrock may not be able to sustain its local innovations unless they are perceived as part of a set of solutions within a wider geography with the NHS and are urged to play a full leadership role within the wider NHS/Social care environment.

13. An important start to achieve more rapid change would be to strengthen the commissioning/programme management support to Mental Health services. This is best done in partnership with the CCG. While there is a need to re-establish some of the "harder" elements of a transactional contract relationship with the NHS Trust provider, there is also a need to rapidly challenge and then develop a firm commissioning framework based on outcomes for people.

14. Thurrock's current arrangements for statutory adults' mental health services are not unusual. The concerns and frustrations expressed and experiences of individuals would be common to many local authority areas across England. Mental health provision is combined as part of a large provider (EPUT) within an NHS governance provision. Social care is provided by the local authority in-house, with a number of commissioning contracts in the independent sector. There is no straightforward structural solution to ensure that the resources and processes at Thurrock's disposal achieve the right outcomes for the people of Thurrock and their mental health. The report outlines a number of areas to be strengthened and partner collaborations which can be re-thought to achieve better outcomes for communities of Thurrock.

Report
Background

15. Thurrock's Mental Health offer for adults of working age is delivered through a section 75 agreement between the Council and Essex Partnership University Foundation Trust (EPUT). The Council's mental health social work staff (ASW) are seconded to EPUT and based at Grays Hall, EPUT's Thurrock base. Older People's Mental Health services are delivered from and by the Council with EPUT employees as part of the team.

16. An initial Mental Health strategy was developed in 2012 across South Essex. This was a partnership strategy and included South Essex PCTs, Essex County Council, Southend Borough Council, and Thurrock Council. The Strategy was overseen by a mental health steering group with the lead partner being Southend Council. The Strategy recognised that a significant amount of work was required to improve service provision and it was agreed to work in partnership with the South Essex Partnership NHS Foundation Trust (SEPT) to re-model provision. This had limited success which then led to a wider review of services.

17. Following the NHS restructure and establishment of Clinical Commissioning Groups (CCGs), the seven CCGs across greater Essex, three local authorities and two mental health providers (South Essex Partnership NHS Foundation Trust – SEPT, and North Essex NHS Foundation Trust – NEPT) commissioned a formal review of mental health services in 2015 in order to assess the current state of those services and make recommendations for a way forward. The review found that commissioning and service provision was fragmented across Essex, with no clear focus regarding integration together with significant financial challenges.

18. A number of recommendations were identified as a result of the 2015 review. These included simplifying commissioning arrangements and working better across commissioning organisations. Following the review, a decision was made to develop a joint Strategy to deliver mental health services across all ten partner organisations. This resulted in a Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021, which reflected the direction of travel contained within the Five Year Forward View for Mental Health. It was agreed that whilst the Strategy itself spanned greater Essex (e.g. the totality of Southend Council, Thurrock Council and Essex County Council boundaries), each area would have its own implementation plan.

19. Following a decision not to retender for a provider to deliver the mental health offer, the two Mental Health Trusts announced their intention to pursue a merger – which would offer the opportunity for service redesign. The merger was completed in 2017. Whilst there has been change over the years through strategy redevelopment and organisational restructure, the 'offer' and model used to deliver it is seen by Thurrock in their position statement as very traditional and lacking in flexibility and creativity. In reality the newly formed Trust has been mainly consumed by its internal issues of merger and financial stability. There is an emerging acceptance that a new focus on service development in Mental Health is needed.

Scope:

20. The Council's delegated Statutory Duties relating to Adult Social Care under the Care Act 2014 are delivered by Essex Partnership University Foundation Trust through a Section 75 Partnership Agreement.

21. The Council asked the peer review team to comment on the following areas within the current model of metal health service delivery:

    - The extent to which the current service 'gate keeps' with thresholds set so high as to prevent a significant group of people from accessing required support;
    - The extent that current arrangements and organisational culture delivers a person-centred, strength-based approach – including a focus on delivering outcomes and a move away from 'one size fits all';
    - To what extent the current 'offer' needs to expand – both to respond to the recent Mental Health Joint Strategic Needs Assessment and the extent to which the market is robust enough to deliver against this;
    - The extent to which the current offer is holistic – e.g. deals with both the MH condition and with the underlying conditions which we know exacerbate or contribute towards the needs.
    - The extent to which the service is preventative, not just reactive, in its approach;
    - The interface between other key partners – e.g. housing and primary care;
    - The extent that the Section 75 (including robustness of governance, decision making arrangements and the delivery of delegated statutory duties) is fit for purpose and possible areas of change; and
    - To what extent current partnership arrangements are working effectively – both in terms of provider (Essex Partnership University Foundation Trust – EPUT, and commissioning (Thurrock CCG/Thurrock Council).

22. A peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.

23. The members of the peer review team were:

- **Ian Winter CBE** – Independent Consultant (formerly Director of Social Services and Senior Civil Servant)
- **Cllr Philip Corthorne** – Cabinet Member for Social Services, Housing, Health and Wellbeing London Borough of Hillingdon
- **Caroline Taylor** – Director of Adult Services and Housing, Torbay Council
- **Helen Maneuf** – Assistant Director – Planning and Resources (Adult Care Services) Hertfordshire County Council

- **Bryan Michell** – Charity Coordinator, My Life My Choice, Oxfordshire
- **Katherine Foreman** – Independent Nurse, Medway CCG
- **Jonathan Trubshaw** – Peer Review Manager, Local Government Association

24. The team were on-site for three days from Tuesday 12th June to Thursday 14th June 2018. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

- interviews and discussions with councillors, officers and partners
- focus groups and interviews with managers, practitioners, frontline staff and people using services and their carers
- reading documents provided by the Council, including position statements developed by the council and by the Thurrock Coalition.

25. The peer review team would like to thank staff, people using services, carers, partners, commissioned providers and councillors for their open and constructive responses during the review process. The team was made very welcome and would in particular like to thank Ceri Armstrong, Senior Health and Social Care Development Manager and Deirdre Whyte for their invaluable assistance in planning and undertaking this review.

26. Our feedback to the Council on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the review in response to the eight points set out in the Scope that Thurrock asked the peer team to consider.

Thresholds

27. The team recognised that thresholds for accessing various levels of support for Mental Health (MH) issues had been set and applied. However, there was some disagreement as to how the thresholds were met and this has resulted in a lack of consistency in how they were applied.

28. The team heard differences in perception of what was considered to be a "crisis", how this was determined by the individuals working with the service user and also in the understanding of how the threshold criteria were then applied. This was the case at both individual and service level understanding. Further clarity about the threshold definitions would be a priority activity, but needs to be done with the direct involvement of service users/3rd Sector colleagues.

29. There appeared to be an open referral system from Local Area Coordinators (LAC), which is an Adult Social Care (ASC)-led approach now embedded within Thurrock for people with lower level care and support needs. The LACs aim to connect people into their local communities and to access opportunities aimed at supporting them to sustain their independence. However, it was unclear to the team what the threshold levels were for this service, although it was understood to have been designed to support 'vulnerable people', typically those with: feelings of isolation, depression, physical disability, sensory impairment, learning difficulties and more complex mental health problems. The impression was that the service was for anyone who felt they needed some help and that the support on offer did not appear to be time limited. A clearer and more widely communicated understanding of the LAC offer may benefit those delivering, referring into and receiving the service.

30. The team heard evidence from service users that when high level need was identified; they perceived that the service they received from Grays Hall (the acute MH provision) was good. This was evidenced from a number of sources.

31. However, the team heard from service users, carers and some frontline staff that the Crisis Team was seen as the 'gatekeepers' of access to MH services and that they maintained high thresholds, which denied those in lower levels of need access to services that might prevent their condition escalating. Some service users described Grays Hall as being "impenetrable", which caused them and those caring for them increased distress and increased effort in putting their case forward. Service users stated that if they did not meet the threshold for being allocated a bed then getting access to other services was very difficult.

32. The Essex Partnership University Trust (EPUT) made the team aware that Grays Hall does not operate a crisis line. This was not the perception of the service users whom the team met and it was heard that people in crisis may be directed to attend Grays Hall by other partners in the system, for example Housing staff. More needs to be done urgently to ensure that those wishing to access services or may potentially wish to do so in the future have clear

information about what is available to them and who enables them to access it.

33. The GP referral system was described by both front line staff and service users as building in delays and uncertainty into the process. The view expressed to the team was that the model adopted was medically driven and did not fully align to ASC or the aspirations of individuals. Whilst it was recognised that managing demand and shaping demand to meet the resource available was necessary, the team heard a number of times that the GP gateway was not easy to get through. There is now a need to open up other referral routes; although this would need to be done as part of an holistic review and change of the system supporting MH provision.

34. The performance information that the team saw was not clearly based on outcomes for people. This needs to be addressed so that individual workers can demonstrate how service users are benefiting from specific interventions and managers can clearly see how the service is delivering for the people of Thurrock in line with the stated aims and aspirations. There needs to be a clear, robust and defendable performance management system that will drive and determine future action.

Person-centred, Outcome Focussed

36. The introduction of the LACs was widely considered a strength and that they contribute significantly to a person-centred service. The team heard examples of where the LACs work with individuals was perceived to have prevented a deterioration of the person's circumstances into crisis and other examples of outcome focussed support. Examples included; a homeless individual with a complex MH illness who was helped to access benefit payments and housing. Another example was of a man who was released from prison with a supply of medication without being linked to either a GP surgery of community mental health team and the LACs were able to arranged this However, some service users reported LACs were not always easy to get hold of or able to respond to requests quickly enough. There may need to be further communication on how the LAC resource is used, so as to manage expectations both internally with other frontline staff and with service users. There were also reports of some inconsistency in approach and skill level between different LACs. The team also acknowledge that the LAC programme is designed to respond to individual and locality need and that therefore some variation is inevitable. More could be done to ensure the overall programme is managed so there is a more consistent standard of offer.

37. The team heard evidence of individual social workers putting in significant effort to ensure the people they work with were cared for in a personalised and appropriate way. However, needs to be more challenging discussions with managers to ensure that social workers focus on the complex issues and cases. Those with less complex needs should be signposted to other MH support arrangements and interventions.

38. In the team's view there needs to be greater clarity about what is required of social workers in the MH service to both ensure statutory requirements are met and the priorities and transformation programme is fulfilled. Social work practice and values as a profession need to be more robustly asserted and owned within the EPUT arrangements, including support to staff working within the Grays Hall team. The team was told that "the nursing and social work roles at Grays Hall are indistinguishable, other than that the nurses give injections" and that social workers at Grays Hall seem to have "lost their compassion" because of process driven top-down mechanisms of the NHS Trust. The team received evidence that staff seconded to EPUT were seen as separate from the council. Seconded staff were working to a medical model of care rather than the ASC transformation model that has been undertaken elsewhere in the council and which promotes a strengths-based approach. The work already undertaken in Thurrock, including the Chief Social Worker initiative, is strong and should be used as a catalyst to change the dynamic that currently exists within the present arrangements. The team acknowledged that significant change has occurred in EPUT but more pace is needed.

39. The fact that the Thurrock based services for Mental Health is but a small part of EPUT should not detract from the urgent need for person centred outcome

focused changes in practice and process. This should not wait for any complex/revised S75 arrangements.

40. The team received evidence from both frontline staff and service users that Mind, Inclusion Thurrock (IAPT) and the Recovery College services are well regarded. The work with and by partners was generally regarded as good and that once an individual had been given a diagnosis they were positive about the service that they received. However, getting a diagnosis was seen as not being a straightforward process. Without a diagnosis the services received were reported as being very variable in terms of quality, level of provision and geographic availability, depending on what was available within the community.

41. Cross-party elected member support for the MH agenda and for service improvement was evident. Future potential changes in the requirement for MH services are considered sensitively at the top levels of the organisation and work to develop political relationships is on-going.

42. Housing services reported that they worked well with Grays Hall on individual cases. By the nature of the Grays Hall cases, these were individuals with high levels of need. However, more needs to be done to develop a more preventative approach, particularly for those individuals who do not quite meet the threshold criteria. The team was not aware of a specialist housing plan for individuals with MH issues that builds on the existing positive work in Housing.

43. The team noted that Thurrock has low numbers of rough sleepers. Whilst this is commendable there could be more done to understand the reasons for this and how people access services once coming to the council's attention.

44. The team considered that there was some effective preventative provision for vulnerable people who may have a heightened risk of homeless. There is an outreach worker who is responsible for identifying rough sleepers and working with them to find housing solutions. This is a shared resource with Basildon, which is building intelligence on hidden homelessness in the borough. However, this was stretched and given the rising demand from the movement of people from inner-London to Thurrock and some evidence of deliberate movement of people by inner London authorities may be of concern for the future.

Market Capacity and Development

45. In the team's view the Joint Strategic Needs Analysis (JSNA) for MH was a strong and robust document that was clearly evidenced based and provides the basis for some clear decision making. There was also a Market Position Statement (MPS) and this too could form the basis of sound decisions; although this may require some updating. However, more could be done to ensure that frontline staff are aware of the JSNA and how this can be used to inform their practice and to take forward the recommendations contained therein. In short, this very useful document needs some straightforward practice based applications and priority suggestions for next steps. There should also be a more detailed analysis of the MH market needs to inform an updated MPS and the specialist accommodation required to support this. There is an appetite and now is the right time to pursue this though a more robust joint commissioning approach.

46. The team noted that the Housing Investment and Regeneration Group recognised vulnerable people and the impact that their living circumstances can have on their MH. There is a proactive in-house housing team dealing with difficult supply issues for those with MH concerns. The team heard that Housing was interested in how the asset based community development work that ACS has taken forward could be applied to MH.

47. The team heard from frontline housing staff that they would appreciate if the personalisation approach and values in that are practiced in ASC could be built on and taken into Housing. More could be gained by considering the individual's needs at the outset and arranging accommodation to meet these.

48. Thurrock has shown innovation in terms of supporting the fragile social care market particularly in Domiciliary Care. Lessons learnt from this could be applied to approaches in addressing capacity within the MH market.

49. The team was impressed with the examples of good practice that were seen during the review, including Community Hubs and strength based conversations that were witnessed in ASC and voluntary sector settings. These need to be aligned and more coherently planned into the overall service model, which includes the nascent, four integrated medical centres. Transformed services must be the driver at the heart of these developments whatever their final configuration.

50. Building on the council's experience in other areas of work there is an opportunity to Invest to Save to deliver accommodation to meet the needs of those with MH issues in Thurrock. The peers considered that a business case could be developed for investment in housing in-borough to avoid potentially more expensive out-of-area placements. This should be an opportunity to explore jointly with colleagues in the Clinical Commissioning Group (CCG), focus could be given to addressing out of area placements. The positive and pragmatic support of the CCG was very evident in this Review and should be capitalised on.

Holistic Offer

52. The team heard that the new combined access point 'Thurrock First' is experienced as responsive and innovative in streamlining pathways into care and support. Thurrock First is a telephone service which acts as a single point of contact for social care, mental health and community services. Feedback regarding the service has been positive and demonstrates a commitment to integrated working. There has been difficulty recruiting to the mental health positions and an opportunity exists to strengthen the offer to local people by incorporating housing.

53. The joint commitment to the development of (four) Integrated Medical Centres was seen as creating a clear vision for how a whole service/system approach, to meet the needs of service users, could be delivered. Although the difficulties in realising this vision were understood the programme provided real opportunities for working more closely together and supporting transformation.

54. The joint funding of the Integrated Care Director was seen as positive and as a commitment to working together.

55. Housing officers reported that there are good opportunities for resolve operational housing issues through the existing forum of the Mental Health Operational Group.

56. There is 70% coverage of social prescribing across GP surgeries and the voluntary sector reported this is having a positive impact and links in with other community resources including practical support in dealing with debt, housing difficulties, weight management, and sexual abuse. An example of strong community leadership is the re-generation of Hardie Park that offers a 'Men in Sheds' initiative, gardening groups and a café with a children's play area.

57. The team was impressed with the work being undertaken with the North East London NHS Foundation Trust (NELFT) and piloted in Tilbury and Chadwell. Opportunities now exist to develop these further with EPUT and this may also help enhance the relationship between Thurrock and EPUT.

58. Secondary Mental Health care needs to benefit from a wider multi-disciplinary approach, where currently the focus is too narrow on specific disciplines. The team also heard from some services users that they perceived there to be a high level of staff turn-over at Grays Hall. The council may wish to consider how changes affecting service users are communicated and what additional support may be required in any hand-over processes.

59. It was clearly recognised that there were incompatibilities between the EPUT and ASC IT and information systems. Staff reported having to put information in twice and of losing information off the system even when it was correctly entered. Duplication of effort causes frustration and there is concern that some records are incomplete. Over the past 6 months EPUT has experienced internal IT issues and has been unable to generate management

reports. In the team's view this has contributed to a disconnect between ASC and EPUT. Steps are now being taken to address communication issues between the two organisations; however the data cleanse is still in process. The team appreciate that the issue is not unique to Thurrock nor is reconciling the two systems necessarily achievable in the short-term. However, ways of working around some of the priority requirements need to be devised quickly.

Prevention

60. The work of the Recovery College and Inclusion Thurrock in supporting people to develop the capacity to cope with their MH issues was seen as positive. The work of Mind was recognised as a significant asset, both within the council and in the wider community. There were requests from service users for Mind to reinstate their offer of a 'safe place' for those with MH issues to meet and discuss their concerns without necessarily needing further interventions. Service users recognised the importance of the services provided by a range of organisations and asked for wider promotion and accessibility for all those in the community.

61. The team heard from frontline staff and providers that there is a cohort of people, who although not presently in crisis may well escalate and require high-level support. These people were not currently receiving services, either through their GP or elsewhere but were struggling and not accessing any preventative support. The team was also told that the Older People's Mental Health service workload does not allow for a focus on prevention. The council, together with the CCG may wish to consider the funding of prevention activities in MH as an invest to save approach. This could include the wider promotion and signposting of existing community support as well as directly facilitating initiatives.

62. The team was made aware that Thurrock First currently had a gap in expertise around MH housing. It may be worthwhile putting in place interim measures to ensure this is filled as soon as possible, whilst a permanent solution is arranged.

63. In the team's view there are opportunities with partners to agree a housing strategy and policy for people with MH issues. It was widely recognised that a person's immediate environment could contribute, both positively and negatively, towards their mental wellbeing. It was reported that; "*The same people float around the system*", whose circumstances are known and if systemic interventions could be made their recovery could be improved.

64. The team recognised that Thurrock has put considerable effort into developing good links with providers and service user groups. These provide useful mechanisms for communicating and gaining views, not least in shaping the preparations and scope for the peer review. However, more could be done to ensure there is greater understanding of the Care Act 2014 and the requirements this places on partners and the impacts this has on those wishing to access services.

65. A number of participants reported to the team that there was improving out-reach in Purfleet and South Ockendon and that Healthwatch was providing useful feedback to prevent direct interventions.

Working with Other Community Partners

66. There was recent evidence of EPUT and local authority actively acknowledging that they urgently need to improve their relationship. The team heard that some forthright communications from ASC had been a key prompt in promoting a more positive attitude towards working together. It was recognised that EPUT had undergone significant change and that as this process evolved there was an increasing ability to focus on external relationships. However, the joint relationship is not yet sufficiently robust to ensure the challenges of meeting the MH needs of the community are adequately addressed and the opportunities that combined effort brings are realised. The relationship between EPUT and the local authority needs recalibrating so that both organisations move on from legacy issues and past working differences. This work is now urgent and must be driven by practical, real and measurable outcomes. Process measures will not suffice. Evidence of this was abundant in this Review. The local authority and the CCG should work hand in hand to set out specific practice based requirements and development plan with EPUT. While emphasising this is a commissioning relationship (i.e. mainly transactional), it is in the interest of all partners to work co-operatively on a practice basis to achieve change, while recognising that where necessary the rigour of contracting may need to be invoked

67. The team received robust evidence of good practice taking place in the community. Some of the examples included: Community Hubs, Social Prescribing, Micro-enterprises, Housing First and Shared Lives. Service users recognised that Community Hubs were places to get information, to connect with others and to use resources, including access to computers.

68. From the meetings with partners the team concluded that there were positive relationships across partners and those involved came with a ‘can-do’ attitude. There was an ability and openness to talk about problems and difficulties that partners were experiencing and that others were willing to support or help where appropriate. However, some of the work appeared to be disjointed and isolated, which is understandable in an environment of innovation. More work could be done to share ideas and link with existing interventions and projects in a consolidating framework. This could build on existing networks and focus what is required, as identified in the JSNA.

69. The Thurrock Coalition was considered to be strong by a range of contributors. The council appreciated that the Coalition provided robust and valuable challenge that effectively contributed to service and care improvements. It was recognised that some of the feedback may be difficult to act upon, including the view expressed from the independent sector about uncertainty regarding future funding and the risk this places on further integration. By engaging earlier so that solutions can be fully co-produced difficult decisions can be jointly owned.

Section 75

70. In the team's view the Section 75 arrangements are the means by which agreed outcomes are achieved. In this respect while there may be merit in re-writing the agreement, the time and effort taken to do this should not outweigh the benefits that may result from the reworking. In short, it may be better to continue with the current agreement but underpin and extrapolate these with more specific outcome based and transformational measures that help to change the actual practice in services.

71. There are already some more beneficial relationships with EPUT, as noted earlier. The Operations Group has been given new impetus and is ready to take on a more engaged role; including provider and service user representation. This gives more opportunity for co-production and jointly developing innovative ideas, building on the work already undertaken to make use of the Better Care Fund.

72. The team could find no evidence of a single reporting and outcomes framework. This is a significant shortfall. There did not appear a clear way of linking performance and outcomes for individuals and for the wider impact of interventions. There are opportunities to work with Southend-on-Sea Borough Council and Essex County Council to create a mechanism that can be used to compare data. There are also opportunities to build on the similarities between Thurrock and Southend-on-Sea (both unitary authorities on the southern edge of Essex and both working with EPUT) to create a single point of contact to help focus and consistently target commissioning issues.

73. In the team's view the current operating model for social work practice appeared to be under some strain in the current working arrangements. There needs to be greater levels of assurance that social care values and approaches are part of EPUT ways of working, including executive board level representation of social work issues. A higher level awareness of social work practice may help address practical issues, including the ensuring that the crisis team is available to support Approved Mental Health Professionals (AMHPs) when they are working with someone in crisis and to minimise the need for AMHPs to be responsible for bed-finding. The Principle Social Worker may also have a role in championing social care values within the wider Health and Social Care partnership.

74. The Team heard that social care staff seconded into EPUT seemed to adopt the health led culture of their host organisation. This health-based influence shapes practice, which can lead to professional tensions. More needs to be done to ensure that social care values and personalised practices are recognised and given equal priority.

Commissioning Arrangements

75. Public Health was considered to be a very significant asset in Thurrock's commissioning work. There is a clear understanding of what needs to be done and has driven the "Case for Change" which has been identified through the JSNA. This was evidenced through the setting of Stretched Quality and Outcomes Frameworks (QOF) for GPs.

76. There are now open opportunities to work together with other commissioners, particularly with those in similar authorities, such as Southend-on-Sea. There are also opportunities to work more closely with EPUT to realise the benefits of a more developed commissioning culture. A clear plan of priority action is required that consolidates the new approach (see para 46) with the management of EPUT, that sets out and monitors what is required from the relationship.

77. There are opportunities to build on the joint commissioning approach with the CCG and to capitalise on the strong relationship. The team heard that due to staffing issues there has been a gap in the Council's commissioning capacity and this needs to be addressed quickly and in partnership with the CCG. The team also saw some evidence that at present the CCG appears to be specifically focussed on commissioning primary and secondary care. Although this may be understandable a more collaborative approach would also more effectively take social care considerations into account.

78. Thurrock has developed a reputation for innovation and the ability to deliver transformation. The council is well regarded by partners and there are opportunities to build on existing relationships developing a co-production approach within the commissioned environment. Now is the time to take the learning and experience of ASC transformation and apply it directly to Mental Health activity. This will get the service in the right shape for innovation and support the fulfilment of the Council's vision.

79. In the team's view there is a need for a clear plan on how the partners will address those people who were described as the "*Missing Middle*"; those with MH issues that are not severe enough for in-patient treatment nor who can function well without support. Subjects that the plan could cover include; access to 24/7 crisis support (for frontline professionals supporting those escalating to crisis in the community), clearly signposted and resourced step-down support, specific support for those with a dual diagnosis. The absence of support for this latter point was seen as a significant gap by stake-holders that the team met.

80. The development of four Integrated Medical Centres was seen as a great aspiration for providing a focus for support to people in their communities. The council may wish to consider, within context of NHS/STP, how realistic is the delivery timetable and how flexible is the service model. There may be options for a different number of centres, whilst still achieving the necessary outcomes for those wishing to access services. Expectations will then need to be managed at the political, organisational and community levels if there is variance to the original concept. There does need to be a realistic and

pragmatic approach that acknowledges further major changes in NHS formulations/organisational shape which may impact on local arrangements and priorities.

Recommendations

- Commissioners to develop an agreed improvement plan with and for EPUT as a provider in Thurrock that clearly sets out expectations and direction through the contractual arrangements using the existing operational group to drive this.

- Develop joint commissioning arrangements between council and CCG specifically to 'beef up' the broad requirements of the existing S75 and set out outcome based performance driven measures.

- Commission for 'the Middle' of Mental Health needs, i.e. emphasise prevention.

- Create a Mental Health programme group, including Children and Transition, to ensure the elements of an improvement plan are coordinated to overcome current fragmentation of initiatives, including the JSNA recommendations.

- Develop service user involvement further e.g. in training, remunerated participation in project groups, reviews and inspections.

- Thurrock Council and CCG to agree new operating model which develops referral routes and new pathways whilst managing demand in the system.

- Drive innovation for Thurrock Mental Health, which matches Adult Social Care transformation. Capitalise on the 'place at the table' to push models of integration in STP. Recognise the risk of NHS changing footprints and requirements in the next ten years.

- The current model of social work needs urgent revision; social workers need support to practice with assistance provided in crisis incidents and bed finding.

Contact details

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