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

Health and Wellbeing Board

The meeting will be held at **2.00 pm** on **12 November 2015**

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

Membership:

Councillors Barbara Rice (Chair), John Kent, Brian Little, Bukky Okunade and Joycelyn Redsell

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Lesley Buckland, Lay Member Thurrock CCG
David Bull, Interim Director of Housing
Graham Carey, Chair of Safeguarding Adults Board
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Executive Nurse, Thurrock CCG
Roger Harris, Director of Adults, Health and Commissioning, Thurrock Council
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Brid Johnson, North East London Foundation Trust
Carmel Littleton, Director of Children's Services, Thurrock Council
Sean O'Callaghan, Vice Chair of Thurrock Community Safety Partnership
Clare Panniker, Chief Executive Basildon and Thurrock University Hospitals
David Peplow, Chair of Local Safeguarding Children's Board
Andrew Pike, Director of Commissioning Operations, NHS England - Essex and East Anglia Region
Ian Wake, Director of Public Health

Agenda

Open to Public and Press

		Page
1	**Apologies for Absence**	
2	**Minutes**	**5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 1st October 2015.

3	**Urgent Items**	
	To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.	
4	**Declaration of Interests**	
5	**Item in Focus - Primary Care Transformation**	
6	**Joint Health and Wellbeing Strategy - Progress Report**	**13 - 26**
7	**Online Data Portal - Proposal**	**27 - 32**
8	**Special Educational Needs and Disabilities - update on key areas of development**	**33 - 62**
9	**Transformation Plan for the Emotional Wellbeing and Mental Health of Children and Young People in Thurrock, Essex and Southend**	**63 - 178**
10	**Safeguarding Adults Board - Annual Report 2014 - 2015**	**179 - 210**
11	**Recommendations from the Essex Mental Health Strategic Review**	**211 - 246**
12	**Work Programme**	**247 - 248**

Queries regarding this Agenda or notification of apologies:

Please contact Ceri Armstrong by sending an email to
Direct.Democracy@thurrock.gov.uk

Agenda published on: **4 November 2015**

Information for members of the public and councillors

Access to Information and Meetings

Members of the public can attend all meetings of the council and its committees and have the right to see the agenda, which will be published no later than 5 working days before the meeting, and minutes once they are published.

Recording of meetings

This meeting may be recorded for transmission and publication on the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is to be recorded.

Members of the public not wishing any speech or address to be recorded for publication to the Internet should contact Democratic Services to discuss any concerns.

If you have any queries regarding this, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

Guidelines on filming, photography, recording and use of social media at council and committee meetings

The council welcomes the filming, photography, recording and use of social media at council and committee meetings as a means of reporting on its proceedings because it helps to make the council more transparent and accountable to its local communities.

If you wish to film or photograph the proceedings of a meeting and have any special requirements or are intending to bring in large equipment please contact the Communications Team at CommunicationsTeam@thurrock.gov.uk before the meeting. The Chair of the meeting will then be consulted and their agreement sought to any specific request made.

Where members of the public use a laptop, tablet device, smart phone or similar devices to use social media, make recordings or take photographs these devices must be set to 'silent' mode to avoid interrupting proceedings of the council or committee.

The use of flash photography or additional lighting may be allowed provided it has been discussed prior to the meeting and agreement reached to ensure that it will not disrupt proceedings.

The Chair of the meeting may terminate or suspend filming, photography, recording and use of social media if any of these activities, in their opinion, are disrupting proceedings at the meeting.

Thurrock Council Wi-Fi

Wi-Fi is available throughout the Civic Offices. You can access Wi-Fi on your device by simply turning on the Wi-Fi on your laptop, Smartphone or tablet.

- You should connect to TBC-CIVIC
- Enter the password **Thurrock** to connect to/join the Wi-Fi network.
- A Terms & Conditions page should appear and you have to accept these before you can begin using Wi-Fi. Some devices require you to access your browser to bring up the Terms & Conditions page, which you must accept.

The ICT department can offer support for council owned devices only.

Evacuation Procedures

In the case of an emergency, you should evacuate the building using the nearest available exit and congregate at the assembly point at Kings Walk.

How to view this agenda on a tablet device

You can view the agenda on your iPad, Android Device or Blackberry Playbook with the free modern.gov app.

Members of the Council should ensure that their device is sufficiently charged, although a limited number of charging points will be available in Members Services.

To view any "exempt" information that may be included on the agenda for this meeting, Councillors should:

- Access the modern.gov app
- Enter your username and password

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.

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

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held 1st October 2015 at 2.00 pm

---

Present: Councillors Barbara Rice (Chair), Brian Little, Bukky Okunade and Joy Redsell

Mandy Ansell, Acting Interim Accountable Officer Thurrock CCG
Richard Parkin, Head of Housing
Graham Carey, Chair of Thurrock Adults Safeguarding Board
Roger Harris, Director of Adults, Health and Commissioning
Kim James, Chief Operating Officer, Thurrock Healthwatch
Carmel Littleton, Director of Children's Services
Michelle Stapleton, Integrated Care Director, NELFT
Chief Superintendent Sean O'Callahan, Chair of Thurrock Community Safety Partnership
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Lesley Buckland, Lay Member, Thurrock CCG
Graham Carey, Chair of Safeguarding Adults Board
Malcolm McCann, South Essex Partnership Foundation Trust
Ian Wake, Director of Public Health
Kristina Jackson, Chief Executive, Thurrock CVS

Apologies: Councillor John Kent, Leader of the Council
Clare Panniker, Chief Executive, Basildon & Thurrock University Hospital
David Peplow, Chair of Local Safeguarding Children's Board
Andrew Pike, Director of Commissioning Operations, NHS England Essex and East Anglia

In attendance:
Ceri Armstrong, Strategy Officer
Mikaela Burns, Executive Assistant
Maria Payne, Needs Assessment Manager (Item 4)
Les Billingham, Head of Adult Social Care (Item 5)

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

2. Minutes

The minutes of the Health and Wellbeing Board, held on 16th July 2015, were approved as a correct record, with an amendment to Page 7 to state that the work on the Mental Health Strategy is in line with and incorporates the Youth Suicide Prevention Strategy.

3. Items of Urgent Business

Success Regime

Roger Harris and Mandy Ansell attended a meeting on Tuesday (29th September) hosted by NHS England, Monitor and TDA. Roger Harris stated that the initiative had not progressed as quickly as first hoped considering it was announced in June 2015.

The Essex health economy was chosen with two other areas: North Devon and Cumbria. This was because of the particular financial and workforce challenges all three areas were facing. Progress is being made with Boston Consulting Group, a consultancy firm who have been appointed to conduct an initial scoping exercise to identify what the Success Regime should look at and define what it will be. This exercise will take place for four to six weeks.

There were concerns from local authorities present at the meeting that the sole focus of the Regime appeared to be solving the financial problems of the acute sector across Essex rather than looking at the system in its entirety. Roger Harris stated that the accumulated debt of all five acute trusts across Essex is £140 - £150 million, which needs to be tackled amongst other issues

Lastly, Roger updated the Board that the interviews for the Programme Director will take place on Thursday 8th October.

RESOLVED:

That the update on the NHS Success Regime in Essex be noted.

Coach House

The Chair updated that a meeting took place on the 30th September which she was in attendance along with Roger Harris, Mandy Ansell, CCG colleagues and Thurrock Healthwatch regarding the viability of the Coach House nursing home. The Chair updated that the provider, Family Mosaic has not made a decision on the future of the Coach House and discussions will take place at their Board of Governance meeting in November to determine the decision.

RESOLVED:

That the update on the Coach House be noted.

4. ITEM IN FOCUS – Demography Joint Strategic Needs Assessment (Maria Payne)

Maria Payne, Needs Assessment Manager; delivered a presentation on the Demography JSNA. The presentation covered key points and findings.

Cllr Joy Redsell stated that Thurrock is not building sufficient, fit for purpose properties for elderly residents to downsize and move into, to free up family homes. The only option available is moving to complexes, where not all residents want to live amongst other elderly residents.

Roger Harris stated that work is currently taking place by using the Housing Needs Assessment, JSNA and the Market Position Statement in developments such as Derry Avenue and Calcutta Road. The Chair further stated that in Chadwell-St-Mary there is a proposed housing development which councillors of the area have been involved in which will mainly be bungalows to suit the need of elderly residents.

Carmel Littleton, Director of Children's Services stated that by using the 2011 census the document was underestimating the massive increase in the child/ young people population and that Children's Services held live admissions data which could give a more accurate projection. Carmel provided an example that over the summer, School Admissions received one thousand in-year applications for new school places in the six weeks which was the equivalent to the whole of the previous year. The data realised from the Department of Education, Thurrock is in the top 20 (19) out of 150 authorities with the biggest increase in child population modelled between 2014- 2020.

Maria Payne stated that the JSNA is a live document and will feed in any live available data, the document will be updated on a regular basis as new information is received.

Cllr Brian Little stated that he noted in the pack that in 1948 when the NHS was formed only 52% of people survived past the age of 65 and it is now 86% which causes a considerable strain on services. Cllr Little stated that as private-sector rented housing has increased by 137.9%, how does this relate to regional and national statistics? Maria Payne will provide this information to Cllr Little outside of the meeting.

Graham Carey stated that unsurprisingly the older population is increasing as people are living longer but less of them are living in households. He queried where these people are living, either in homes or complexes or living with family members. Graham stated that the JSNA mentions households with dependent children, but does not include households with dependant adults and feels this will be an increasing population in years to come. Graham stated that he would like to see statistics on vulnerable populations included within the document – including how many people and who they were (in terms of groups).

Roger queried where the projected data comes from and reiterated Carmel's point regarding the underestimated figures within the document. Roger required clarity about what goes into this data, whether it incorporates housing developments and strategic plans or whether is it just a straight line projection.

Maria Payne stated that the projected figures are calculated by the Office of National Statistics and the factors and methods are based on previous trends, census change and changes in population. It has not been possible to factor plans and strategies into the data. Roger stated that this needed to be looked at further to ensure demographic data and related projections were more realistic.

Cllr Bukky Okunade queried the data provided in the JSNA presentation in relation to the 'other' classification. Maria Payne updated that the description of 'other' is – "*Other changes presented in this table comprise changes to the size of armed forces stationed in the UK, other special population adjustments and rounding".* In the case of armed forces this also includes UK armed forces stationed in Germany and therefore any dependants which may have returned or left the country. In essence 'other' can partially be described as a sub set of migration data

5. Housing and Planning Advisory Group Progress Report

Les Billingham, Head of Adult Services attend the Board to present a progress report of the Housing and Planning Advisory Group.

This Group is a multi-agency group which considers the health and wellbeing implications of major planning applications (25 dwellings or more), care homes and other specialist housing and provides advice and guidance on the health, social care and community impacts of proposed new developments.

The Group has been consulted on a significant number of planning applications; it has developed a role in relation to strategic policy development and has been pro-active in relation to large scale regeneration plans. The group has also raised the profile of HAPPI housing, Well Homes Programme and Care and Support Specialist Housing (CASSH) Fund, both across the Council and with developers. The group has broken down the professional barriers that can often exist between services, where there is no regular channel for communication and the sharing of information and views. This has gained interest from other people around the country and Health and Wellbeing Boards.

The Chair stated that the group is unique and congratulated Les for taking this group forward and working together to achieve the best result instead of working in silos.

Graham Carey reiterated comments made under item 4 concerning the increase in the older population but with apparently less older people living in households – e.g. were they living with family members.

Les Billingham responded stating that this is part of a larger issue which is recognised. Creating the right stimulus for older people to re-think about their housing situation is a complex question. The work taking place within the communities is vital in identifying the needs as well as building mainstream homes within communities and not segregated on their own. Although, work

still needs to be done to incentives older people in making the right decision for them so their housing needs can be sustainable.

RESOLVED:

1.1 That the Health and Wellbeing Board notes the work of the Housing and Planning Advisory Group.

1.2 That the Health and Wellbeing Board approve the Advisory Group's proposal to develop a housing strategy specifically for older adults (65+), and working age adults with support needs.

1.3 That the Health and Wellbeing Board approve the revised Terms of Reference of the Advisory Group.

6. Joint Health and Wellbeing Strategy

Ian Wake, Director of Public Health presented the Joint Health and Wellbeing Strategy 2016-2019.

Ian Wake stated that the following aspects factor into an accomplished and sufficient Health and Wellbeing Strategy: That it is co-created through effective engagement with providers and the community; driven using intelligence from the JSNA; adds value to strategic plans to reduce health inequalities; addresses wellbeing and not just health; systematically aligns partner resources with strategic priorities; has clear delivery mechanisms in place; and holds partners to account for actions and that outcomes are presented in an accessible and compelling way. Ian posed the question to Board members as to whether the currently strategy and Board met the key factors highlighted.

Ian continued stating that the current health care system is ill-equipped to meet future needs and there are a number of reasons for this. For example, 70% of the NHS budget is spent on caring for patients with long-term conditions, and the complexity of cases seen by both the NHS and Social Care has increased through the rise of conditions such as dementia, and the number of people living with multiple health conditions. The system's focus needs to shift from treating and responding to ill-health to prevention and early intervention. The proposed priorities for the strategy include: prevention and early intervention; building strong and sustainable communities; strengthening the mental and emotional wellbeing of people in Thurrock and finally Health and social care transformation.

RESOLVED:

1.1 That the Health and Wellbeing Board agrees in principle the draft outline for the refreshed Health and Wellbeing Strategy- including the direction of travel and draft priorities.

1.2 That the Health and Wellbeing Board agrees to test the vision, aims priorities and direction of travel through a period of consultation and engagement – including a stakeholder workshop with the Board to be held in autumn.

7. Health and Wellbeing Board Self-Assessment

Ceri Armstrong, Strategy Officer outlined the elements of the Local Governments Association's Improvement Offer. This is aimed at supporting Health and Wellbeing Boards to develop towards effective system leadership.

The Care and Health Improvement Programme consists of three elements; Health and Wellbeing Board Self-Assessment, Leadership Offer and Health and Wellbeing Board Peer Challenge.

The preferred method of the Board is to take part in the Self- Assessment Tool. This option was chosen as it was the less resource intensive option and provides the Board with insight of where it is and what it needs to do to establish itself as an effective systems leader. Cllr Barbara Rice will take up the Leadership offer in conjunction with the Children's Portfolio Holder if accepted by the LGA.

RESOLVED:

1.1 For the Health and Wellbeing Board to agree to participate in the LGA's facilitated self-assessment process.

8. Healthwatch Thurrock Annual Report

Kim James, Chief Operating Officer for Healthwatch Thurrock updated the Board on the key work that Healthwatch Thurrock achieved during 2014-15.

Healthwatch Thurrock is an independent organisation commissioned by Thurrock Council to gather the views of the residents of Thurrock regarding Health and Social Care services for both Adults and Children's Services.

Healthwatch Thurrock now provides PALS service for primary care services and has taken over 2,000 calls for information, advice and signposting. Including finding a GP, a NHS dentist, pharmacies, finding residential homes for a person with Dementia and providing support for residents following diagnosis of a long term medical condition.

Healthwatch Thurrock holds seats on the HWBB, HOSC, and Safeguarding board for both Adults and Children's as well as partnership boards to ensure the voices of residents are heard when decisions affecting residents are being made.

RESOLVED:

1.1 That the Health and Wellbeing Board note Healthwatch Thurrock's Annual Report

9. South Essex Emergency Doctors' Service (SEEDS) update

Rahul Chaudhari, Head of Primary Care Strategy, Thurrock CCG presented a report to update the Board on the changes to the Out of Hours (OOH) Primary Care Emergency Services.

14 Thurrock practices have OOH services provided via SEEDS who have recently announced that the service will close. The recommended and likely outcome is that those practices currently using the SEEDS OOH service will use the service provided by IC24.

RESOLVED:

1.1 The Board is asked to note the contents of the report.

10. Public Health Grant 2015/16 – Proposed Reductions

Ian Wake, Director of Public Health, updated Board members on the Government's proposed in-year reductions to the Public Health Grant.

The Department of Health ran a short consultation during August on the methodology for applying the cut and proposed four options. Thurrock supported option A which was to devise a formula that claims a larger share of the savings from Local Authorities that are significantly above their target allocation. Thurrock is currently 2.9% below its Public Health allocation which equates to being under funded by £322,478 by the Department of Health's own formula.

Ian confirmed that he did not expect there to be a final announcement until after the Comprehensive Spending Review at the end of November.

RESOLVED:

1.1 To note the proposed reductions in the Public Health Grant and to comment on the cuts put forward.

11. Work Programme

The Chair made a recommendation to the Work Programme by stating that the meeting scheduled for the 14th January 2016, will be changed to the 7th January 2015.

The meeting finished at 4.01 pm.

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at

12th November 2015	ITEM: 6
Health and Wellbeing Board	
Thurrock Joint Health and Wellbeing Strategy – Progress Report	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ceri Armstrong, Directorate Strategy Officer and Ian Wake, Director of Public Health	
Accountable Head of Service: None	
Accountable Directors: Roger Harris, Director of Adults, Health and Commissioning, Carmel Littleton, Director of Children's Services, Ian Wake, Director of Public Health and Mandy Ansell, Acting Interim Accountable Officer (Thurrock CCG)	
This report is Public	

Executive Summary

This report builds on the report presented to the Board on the 1st October. It provides an update on progress made with the development of the Health and Wellbeing Strategy and also presents a recommended approach to engagement which the Board are asked to agree.

1. Recommendation(s)

1.1 To agree the Health and Wellbeing Strategy Engagement Plan;

1.2 To note progress on the development of a refreshed Health and Wellbeing Strategy;

1.3 So as to make the necessary progress between Board meetings, to agree to delegate agreement to changes to the Strategy's development to the Health and Wellbeing Strategy Steering Group and Health and Wellbeing Board Chair; and

1.4 To agree to scheduling a special Board meeting in February for the purpose of signing off the final Strategy.

2. Introduction and Background

2.1 A report was brought to the Health and Wellbeing Board on the 1st October that presented a draft outline for a refreshed Joint Health and Wellbeing Strategy 2016 - 2019. The current Strategy agreed in 2013 is due to expire in 2016. The Board agreed the draft outline and also to testing the proposed vision, aims, priorities and direction of travel through consultation and engagement.

2.2 A presentation made by the Director of Public Health and agreed by the Board outlined the elements important to developing and achieving a refreshed and effective Health and Wellbeing Strategy. This included:

- Co-created via effective engagement with providers and the community;
- Driven using intelligence from the Joint Strategic Needs Assessment;
- Adding value to strategic plans to reduce health inequalities;
- Addresses wellbeing and not just health;
- Systematically aligns partner resources with strategic priorities;
- Clear delivery mechanisms in place;
- Holds partners to account for actions; and
- Outcomes presented in an accessible and compelling way.

2.3 It was also discussed and recommended that an outcomes framework should be developed alongside the Strategy to ensure its achievements could be monitored.

2.4 This report updates the Board on progress made on developing the refreshed Strategy since the last meet, and also provides a proposed Engagement Plan which the Board is asked to agree.

3. Issues, Options and Analysis of Options

Overview and progress update

3.1 Since the last report to the Board, activity has been focused on:

- Ensuring that the vision, aims, priorities and overall health and wellbeing direction of travel reflects both the adult agenda, and also the children and young people agenda – to ensure it reflects the whole population; and
- Developing the Strategy's engagement approach.

3.2 It is important that the Strategy develops priorities and actions that improve the wellbeing of the whole population. To ensure that the agenda for children and young people as well as the adult population is reflected within the Strategy, work is being carried out by the Strategic Lead for Children's Commissioning and Service Transformation. The results of the work undertaken will allow further development of the Strategy's priorities if and as required.

3.3 As a result of these and other possible changes, one of the recommendations to the Board is to delegate decision making on changes to the Strategy

between Board meetings to the newly formed Health and Wellbeing Strategy Steering Group. Agreeing this recommendation will help to ensure that sufficient progress can be made in between Board meetings. The Board will be made aware of any delegated decisions made when it received further progress updates.

3.4 Work has also been carried out to help contextualise each of the four draft priorities in the form of a matrix. This is appended (appendix 1). The matrix identifies what might be contained within each of the four priorities and any key documents and strategies that link to the delivery of the priorities. Once the Strategy has been approved, there will be a piece of work to ensure that the key documents identified are consistent with the Health and Wellbeing outcomes the Strategy is in place to deliver. The matrix will be further developed as the Strategy is developed and finalised. The purpose of developing the matrix at this early stage is to help people, particularly via engagement, understand what each of the priorities means and how they might be delivered.

3.5 To help with the development of the Strategy, a Strategy Steering Group has been established. The Group consists of:

- Director of Public Health (Chair)
- Head of Integrated Commissioning, Thurrock CCG
- Business Improvement Manager, Housing
- Strategic Lead for Children's Commissioning and Service Transformation
- Chief Executive Thurrock CVS
- Chief Operating Officer Thurrock Healthwatch
- Corporate Performance Officer
- Strategic Lead Commissioner for Public Health
- Directorate Strategy Officer Adults Health and Commissioning

The purpose of the Group is to steer and oversee the development of the Strategy for reporting to the Health and Wellbeing Board. The first meeting of the Group is the 5th November, and any key issues to arise from the meeting will be reported to the Board.

Engagement Approach

3.6 As reported to the Board in October, the Strategy's engagement approach has been developed in conjunction Thurrock CVS, Thurrock Healthwatch and the Health and Wellbeing Engagement Group. The suggested approach for testing the Strategy is appended – appendix 2.

3.7 The approach not only recommends how the developing Strategy should be tested, but also recommends the use of events in Thurrock as a way of feeding back to the public what has been achieved since the first Strategy was agreed in 2013.

3.8 As with the overall focus of the Strategy, work is taking place to ensure that the appropriate engagement mechanisms with children and young people are included in the approach.

3.9 Subject to the Board's agreement, activity will be developed and commence by December and complete by the end of January 2016. Feedback and analysis from the engagement events will be reported to a special Board meeting in February alongside the final draft of the Strategy.

3.10 The Board are asked to agree the engagement approach attached and/or make amendments as necessary.

3.11 Further engagement linked to the delivery of prevention and early intervention will be worked on separately to the Strategy – e.g. activity to raise awareness of health and wellbeing and an understanding of what citizens can do for themselves. This will include the promotion of existing activities, and also seeking to find gaps in provision which can then inform commissioning activity and planning.

Timescales

3.12 As further work has been carried out since the last Board, timescales to ensure the Strategy's agreement by the end of March are clearer – but stretching:

Committee	Purpose	Date
Children's Services Overview and Scrutiny	Consultation on outline strategy (vision, aims, priorities, outcomes etc.)	5th January 2016
Health and Wellbeing Board	Strategy Progress Report	7th January 2016
Children and Young People's Partnership Board	Consultation on outline strategy (vision, aims, priorities, outcomes etc.)	11th January 2016
Health and Wellbeing Overview and Scrutiny	Consultation on outline strategy (vision, aims, priorities, outcomes etc.)	12th January 2016
Children's Services Overview and Scrutiny	Final Draft including engagement feedback	9th February 2016
Health and Wellbeing Overview and Scrutiny	Final Draft including engagement feedback	16th February 2016
Health and Wellbeing Board	Approve Final Draft – including engagement feedback	TBC (Feb 2016)
CCG Board	Approve Final Draft – including engagement feedback	24th February 2016
Cabinet	Approve Final Draft – including engagement feedback	9th March 2016
Council	Approve Final Draft – including engagement feedback	23rd March 2016

Any changes to timescales will be reported to the Board.

4. Reasons for Recommendation

4.1 Recommendations are in place to ensure that the Strategy can be progressed and developed in an effective and efficient manner, including appropriate engagement and sign-off.

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

5.1 The proposed engagement approach is appended to the document. Further consultation on the Strategy as it develops will take place via Overview and Scrutiny Committees, the Board itself, the CCG Board, and Cabinet. The engagement approach will be overseen by the Health and Wellbeing Engagement Group.

5.2 Analysis of engagement will be appended to reports to the Board and to other committees per the timescale in 3.11.

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

6.1 The Health and Wellbeing Strategy is the key strategy for the community priority 'Improve Health and Wellbeing'.

7. Implications

7.1 **Financial**

Implications verified by: **Kay Goodacre**

Finance Manager

The development of the Strategy will be managed within existing budgets and costs are likely to be minimal – officer time and resources to undertake engagement activity.

There may be implications linked to the delivery of the priorities – e.g. the ability to shift resource towards prevention and early intervention as a key driver of reducing and preventing ill-health and maintaining health and wellbeing.

7.2 **Legal**

Implications verified by: **Chris Pickering**

Principal Solicitor Employment and Litigation

Preparation of the Joint Health and Wellbeing Strategy is a statutory responsibility of the Health and Wellbeing Board. This report is to update the

Board and proposes appropriate consultation before implementation. The Board is also asked to delegate to senior officers changes to the Strategy's development, but the approval of the final Strategy requires a special Board meeting to approve. There are no further legal implications.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

A key focus of the Health and Wellbeing Strategy is to reduce inequalities in health and wellbeing. This includes using local intelligence to understand the key causes of the Borough's inequalities and identify how these can be addressed. This includes a focus on the wider determinants of health.

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):

- Report to the Health and Wellbeing Board 1st October.

9. Appendices to the report

Appendix 1 – Priority Matrix
Appendix 2 – Engagement Approach

Report Author:

Ceri Armstrong

Directorate Strategy Officer

Adults, Health and Commissioning

Health and Wellbeing Strategy
Engagement Approach

Communication and Engagement	Audience/ Stakeholder	Activities	Resources	Method/ Feedback	Person Responsible	Start Date	Learning/ Influencing/ Outcome	Date to report back to HWBB
Survey	General Public	Survey – easy read and plain English	Council portal and via partner websites Youth Cabinet Children in Care Council	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong	Nov/ Dec 15	Use data gathered from event to test Vision, Aims and Priorities	February 16
		Face to face in public places – i.e. supermarkets, railway stations, schools	Ngage/ TCVS/ Healthwatch Thurrock Coalition Youth Cabinet Children in Care Council	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong – to commission group to undertake			
		Use existing groups and newsletters	Council and partners Group contacts via Healthwatch TCVS	Results back to Engagement Group and Strategy Steering	Ceri Armstrong			

			Thurrock Coalition	Group				
		Use a ‘prioritree’ to gather individuals views – via event and piggyback on existing events/meetings	Council and partner public events Healthwatch TCVS Thurrock Coalition Youth Cabinet Children in Care Council	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong			
World Cafe	General Public	Events x 2 hosted by Health and Wellbeing Board to report on what’s been achieved (or not) with the current HWBS, an to gather individual views	Board members commitment to attend two events between now and mid-January	Results back to engagement Group and Strategy Steering Group	Ceri Armstrong	Dec 15	Use data gathered from event to test Vision, Aims and Priorities	Feb 16
Information Sharing	General Public Stakeholders	Webinar/Podcast on achievements to date – circulate via existing networks	Board Chair supported by Board members to make or deliver podcast	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong to commission development of podcast/ webinar	Dec 15		
Feedback	General Public	Newsletters	Comms	Result back	Ceri	Feb	Ensure those	Feb 16

	Stakeholders	Local press E-bulletins	Support	to Engagement Group and Strategy Steering Group	Armstrong – via Comms Teams	16	involved with engagement activity understand how engagement has influenced the Strategy – will also start the process of on-going conversations about what people can do for themselves, and where they feel resources should be best utilised.	

This page is intentionally left blank

Health and Wellbeing Strategy
Engagement Approach

Communication and Engagement	Audience/ Stakeholder	Activities	Resources	Method/ Feedback	Person Responsible	Start Date	Learning/ Influencing/ Outcome	Date to report back to HWBB
Survey	General Public	Survey – easy read and plain English	Council portal and via partner websites Youth Cabinet Children in Care Council	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong	Nov/ Dec 15	Use data gathered from event to test Vision, Aims and Priorities	February 16
		Face to face in public places – i.e. supermarkets, railway stations, schools	Ngage/ TCVS/ Healthwatch Thurrock Coalition Youth Cabinet Children in Care Council	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong – to commission group to undertake			
		Use existing groups and newsletters	Council and partners Group contacts via Healthwatch TCVS	Results back to Engagement Group and Strategy Steering	Ceri Armstrong			

			Thurrock Coalition	Group				
		Use a ‘prioritree’ to gather individuals views – via event and piggyback on existing events/meetings	Council and partner public events Healthwatch TCVS Thurrock Coalition Youth Cabinet Children in Care Council	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong			
World Cafe	General Public	Events x 2 hosted by Health and Wellbeing Board to report on what’s been achieved (or not) with the current HWBS, an to gather individual views	Board members commitment to attend two events between now and mid-January	Results back to engagement Group and Strategy Steering Group	Ceri Armstrong	Dec 15	Use data gathered from event to test Vision, Aims and Priorities	Feb 16
Information Sharing	General Public Stakeholders	Webinar/Podcast on achievements to date – circulate via existing networks	Board Chair supported by Board members to make or deliver podcast	Results back to Engagement Group and Strategy Steering Group	Ceri Armstrong to commission development of podcast/ webinar	Dec 15		
Feedback	General Public	Newsletters	Comms	Result back	Ceri	Feb	Ensure those	Feb 16

	Stakeholders	Local press E-bulletins	Support	to Engagement Group and Strategy Steering Group	Armstrong – via Comms Teams	16	involved with engagement activity understand how engagement has influenced the Strategy – will also start the process of on-going conversations about what people can do for themselves, and where they feel resources should be best utilised.	

This page is intentionally left blank

12th November 2015	ITEM: 7
Health and Wellbeing Board	
Online Data Portal - Proposal	
Report of: Maria Payne, Health Needs Assessment Manager	
Accountable Head of Service: N/A	
Accountable Director: Ian Wake, Director of Public Health	

Executive Summary

This report outlines the request and rationale for creating an online data portal or repository to publish Thurrock Council and Health data. Due to the increased digital agenda both within the Council and nationally, more and more people are turning to web services for information and data sources. The creation of a shared information portal to collate and publish a range of Council and Health data indicators should result in assurance that accurate and validated data sources are used to inform decision making, support the integrated commissioning principles by encouraging closer work between local authority and health colleagues, and ensure Thurrock's alignment to the future digital agenda.

1. Recommendation(s)

1.1 An online data portal to be built – by existing IT provider or external contractor

1.2 This project to be included in the Council's Digital Transformation workplan and aligned to *Thurrock Online*.

2. Introduction and Background

2.1 There are a large number of sources of data and evidence used by agencies in Thurrock. However these can be hard to find and it can be difficult to ascertain the most current and robust source.

2.2 Historically there has been a reliance on lengthy strategies and needs assessment documents to provide the most current information. Whilst many of these are still required due to legislative policies, the process to update each document can be lengthy and data within the documents is often out of date fairly quickly.

2.3 There is increasing pressure on public sector organisations to ensure that the decisions they make are based on the most robust and current evidence

available, particularly when there are financial decisions involved. It is therefore paramount that processes are established to ensure the data and evidence required is easily accessible and understandable, to facilitate its inclusion in relevant decision-making procedures.

2.4 An increasing amount of data is being published in the public domain, and there is an appetite for this to develop further. Many other agencies have developed an increased digital presence and this facilitates the ongoing maintenance of their data and information.

2.5 Thurrock Council has been rolling out a Digital Transformation Programme, which is aiming to encourage use of online services and reduce reliance on paper-based procedures. There has been significant investment into a refresh of the Council website, but this has not focussed on improving the presentation of data or intelligence sources.

3. Issues, Options and Analysis of Options

3.1 Having an accessible data repository or portal is becoming increasingly common across local authorities in the UK. Having undertaken some preliminary research into approaches adopted elsewhere, there appears to be a mixture of separate websites, visualisation tools and downloadable content available in other local authority areas. Below are some examples of data repositories established in other areas with favoured examples highlighted:

Area	URL	Site Type	Comments
Medway	http://www.medwayjsna.info/index.html	Standalone website	This has sections for thematic JSNA sections but also a data inventory section to enable downloads of more data and a page of external useful links.
Nottingham	http://www.nottinghaminsight.org.uk/	Standalone insight website	This has sections for thematic JSNA sections, and separate mapping website.
Norfolk	http://www.norfolkinsight.org.uk/	Standalone site – "Norfolk Insight"	Opportunity to download own data but also contains thematic-based reports
Surrey	http://www.surreyi.gov.uk/mainmenu.aspx	Standalone Insight website – contains JSNA section within	Separate sections for content which could be downloaded separately. Number of other infographics which look really visual.
Peterborough	http://www.peterboroughjsna.org/	Standalone site – very technical	Provides visual mapping and shows overlays of different data indicators for the same areas. Complex and required a large investment.
Suffolk	http://www.suffolkobservatory.info/Default.aspx	Two sites – data observatory and JSNA site.	Data located on Suffolk Observatory. Good section headings, ability to manipulate by various geography types.

Devon	http://www.devonhealthandwellbeing.org.uk/jsna/	General Health and Wellbeing website	Not particularly innovative
Essex	http://www.essexinsight.org.uk/mainmenu.aspx	Standalone insight website.	Functionality to upload documents but not particularly visual and difficult to navigate despite recent refresh to site.
Cornwall	https://www.cornwall.gov.uk/council-and-democracy/data-and-research/data-by-topic/	Part of Council website	Split off sections about context to JSNA and uploads of PDF docs. No interactive or visualising content.
Southend	http://www.southend.gov.uk/info/200441/southend_insights	"Southend Insights" – part of Southend Council website	Textual stats divided by themes, no graphs or downloadable information
Milton Keynes	http://www.mkiobservatory.org.uk/	Appears to be three different sites – Mki Observatory, "My Milton Keynes" for mapping, and a JSNA part of council website	Functionality to view/visualise a lot of information, but tricky to navigate round.

Expected Benefits of an online data portal

3.2 Some of the identified benefits to creating and maintaining a portal in Thurrock include:

- A robust, continually updated data repository will ensure accurate and validated sources of data are used to inform decisions
- All Joint Strategic Needs Assessment (JSNA) products can be published on the data repository, increasing access to, and use of them across and beyond the council to support evidence based commissioning
- Increased transparency of data
- A data repository provides *one version of the truth* for all local agencies to access.
- A data repository can be used by statutory and third sector agencies in Thurrock to find data on local need to support external funding/grant applications, potentially increasing revenue.
- It could support non-analytical staff to increase their understanding and use of data sources, and subsequently increase capacity for specialist analysts to undertake more complex tasks
- It will be quicker and easier to find sources of information
- It will lead to improved joint working between Local Authority and CCG colleagues
- It will enable those who live and work in Thurrock to have a better understanding of their borough

- The ability to refresh publically-released data more regularly may result in strategy documents needing to be fully updated on a less-frequent basis.

Potential Risks

3.3 If no agreement is given to establish and maintain a data portal, risks may include:

- Ongoing dependence on specialist data analysts to perform simple data research enquiries. This reduces capacity to focus on developing innovative products which could be particularly useful pieces of commissioning intelligence.
- Council and CCG data remains separate, making integrated commissioning much more difficult
- Potential use of outdated/inaccurate data for informing decisions.

Estimated Cost

3.4 Based on knowledge of the costs for developing the full Thurrock Council website, and costs obtained from other areas that have already set up similar portals, the estimated cost to set up a data portal would be approximately £80k. The Council would need to factor this cost into the appropriate budgets.

4. Reasons for Recommendation

4.1 Support should be given to creating this data portal due to the reasons set out previously. By creating a *one-stop shop* for data and intelligence across the Council and potentially other partners, this unites multiple sources of information and facilitates the process of finding the information required, resulting in productivity gains and therefore cost savings in terms of time spent.

4.2 It is envisaged that Public Health would hold responsibility for coordinating the uploading of data to this site, and work closely with the analytical leads of other departments to ensure the portal contains the most useful and relevant information.

4.3 Provided there is full support given to ensuring the maintenance of this portal across all directorates, there can be assurance that the data available on this site is the most robust and current, and also ensures that a consistent set of data indicators are used across different work areas.

4.4 Inclusion within the work plan of the existing Digital Transformation Programme will ensure alignment with the other systems already developed, including the content management system *Objective*, and enable the

provision of a robust offer of data and intelligence to inform commissioning decisions.

4.5 The report was presented to the Council's Directors' Board on the 3rd November who gave the proposals broad support. The Board also agreed that Public Health lead the development of a business case to go to the Council's Digital Board for funding to be found from digital transformation monies.

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

5.1 The concept of an online data portal has been explored with a number of internal colleagues, including the Head of Strategy and Communications and the in-house Web Management team, Adults Directorate Management Team and the Council's Performance Board.

5.2 A paper suggesting the future establishment of an online process for maintaining Joint Strategic Needs Assessment (JSNA) products was presented to Health and Wellbeing Overview and Scrutiny on 13th January 2015 and the idea was well-received by Members. JSNA products would be hosted on this portal and become more accessible and easier to maintain.

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

6.1 Establishment of an online data portal as a mechanism for enabling a shared information resource will strengthen the work of the Council by facilitating access and use of accurate data to evidence decision-making. This in turn will result in better outcomes for residents, as the services delivered will be driven by this data.

6.2 It will also enable colleagues in other Thurrock organisations (e.g. third sector organisations) to have a better understanding of the health and social care needs of our residents, and potentially strengthen their service offer too.

7. Implications

7.1 **Financial**

Implications verified by: **Kay Goodacre**

Finance Manager

The costs associated with the creation and ongoing maintenance of an online data portal are contained within the body of the report. However, a partnership approach to establishing this portal could reduce some of the costs. If the portal is maintained and well-utilised, cost-savings could be seen in use of specialist analyst officer time to deal with routine data enquiries and also potentially reduce the time taken to answer Freedom of Information requests.

7.2 **Legal**

Implications verified by: **Dawn Pelle**
Adult Care Lawyer

There are no legal implications for the following reasons:

- The Portal is being considered to ensure accuracy of data
- To enable the authority and Health to work in an integrated way as envisaged by Care Act 2014
- Will provide data to support applications for funding etc.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**
Community Development Officer

The creation and maintenance of an online data portal would enable residents to explore variation in outcomes within their local area and develop understanding of how the Council has come to make its decisions. The authority must endeavour to ensure information is available and accessible to all sectors of the community.

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):

- None

9. Appendices to the report

- None

Report Author:
Maria Payne
Health Needs Assessment Manager
Public Health

12th November 2015	ITEM: 8
Health and Wellbeing Board	
Special Educational Needs and Disabilities, update on key areas of development.	
Report of: Malcolm W Taylor Strategic Lead Learner Support / Principal Educational Psychologist	
Accountable Head of Service: Malcolm W Taylor	
Accountable Director: Carmel Littleton Director Children's Services	
This report is Public	

Executive Summary

The report informs the Board of the progress made across key areas in relation to the introduction of the Special Educational Needs and Disability reforms introduced by the Children and Families Act 2014 whose key duties came into place from 1st September 2014.

1. Recommendation(s)

1.1 That the Board notes the progress made in the implementation of the new reforms in relation to Special Educational Needs and Disability .

2. Introduction and Background

2.1 The new Education Health and Care Plans (EHCP) were introduced from 1st September 2014 as part of the SEND reforms set out in the Children and Families Act 2014. The Local Authority has a comprehensive process of transformation of Statements of Special Educational Needs to the new Education Health and Care Plans in line with the new legislation and SEND Code of Practice 2015.

2.2 **Transformation Plans , Statements to EHC Plans.**

Thurrock Local Authority has worked through its Transformation Plan for the transfer for of Statements of SEN to EHC plans from September 2014 to August 2015. The original SEN transformation plan published in September 2014 is shown as Appendix 1 .

Out-turn 2014/15

Between 1 September 2014 and 1 October 2015 there have been 354 reviews of statements held and these are in the process of being converted to Education Health and Care Plans. This is slightly less than the number originally planned for 2014/15 however all the statutory groups that had to go through the transformation process which are the Year 11 pupils where they were changing schools or leaving school were achieved. The Local Authority has ensured that there is a Local Authority representative present at all these reviews to ensure compliance with the statutory process and so that young people achieve the appropriate opportunity to develop a meaningful plan that focusses on their aspirations and outcomes.

The Revised Plan for Transformation for Statements to EHC plan covering 2015/18 was published in August 2015 and is shown as Appendix 2. As can be seen in this table, the revised plan for the transformation of SEN Statements is based on the statutory responsibilities for transfer and additionally is identified by specific circumstances in the same format as is now recorded by the DfE. The main body of transfers will again be the Year 11 pupils but also includes Primary to Secondary School transfers and Year 9 reviews where Transition reviews take place.

The transformation reviews will continue to be supported by additional Personal Advisor staff and Local Authority SEN staff attending the reviews to ensure that there is a Local Authority representative present as required at all reviews.

2.4 **New Requests for Education Health and Care Plans**

During the academic year 2014-15 there were:

48 Educational Psychologist requests
96 School/settings requests
37 Parental requests
2 Young Person Requests

Of the above 183 requests for Education Health and Care Plans, 26 were not agreed. There was a significant increase in the numbers of requests that would normally be received under the SEN Statement system. In previous years the Local Authority would have expected to receive approximately 100 new requests per year. Two possible factors appear to be impacting on this increase. One is the change to pre-school arrangements leading to an earlier request for an EHCP than would have happened previously and the second is the increased focus on the parent / child voice in the process, empowering parents to request a move to an EHCP assessment at an earlier stage in school than previously. This is clearly a positive development in ensuring parents, children and young people are empowered to ensure their needs are being met.

2.5 Quality Assurance of Education Health and Care Plans

The Local Authority has participated in regional workshops to carry out a quality assurance exercise with neighbouring regional local authorities on the design and content of the Thurrock EHC plans. Thurrock has received positive feedback from the DfE Regional adviser for SEND on examples of completed Thurrock plans as part of the regular support provided by the DfE to all Local Authorities. The Local Authority has established a Quality Assurance Moderation Group to ensure ongoing work on quality assurance of EHC plans.

The Local Authority carried out a review of the format of the Thurrock Education Health and Care plans at the end of the Summer Term 2014 and based on feedback from Parents, School Special Needs Co-ordinators and other contributors, revised the format of the plans to develop clear links between each section of the plan and maintain a focus on outcomes.

Further development of the plan has included new targeted sections on the key 4 areas of the Preparing for Adult section of the Transition plan for young people covering ;
Further/Higher education and moving towards employment ; Preparing for independent living ; Health and wellbeing; and Friends, relationships and community.

The updated version of this plan is included in the Appendices to this report. There have been close links established with South Essex College to ensure their full engagement in the new responsibilities in relation to the EHC plans for young people post 16.

The Local Authority and the Clinical Commissioning group continues to work closely with the Thurrock Carers and Parents Forum known as Carers and Parents (CaPa) on all aspects of its work in relation to the SEND reforms through a series of regular meetings and full engagement and co-production in all strategic and process developments.

2.5 Pre-School SEND developments

The existing Early Support system which co-ordinates the support for pre-school- children has been further developed over 2015/16 to ensure closer co-ordination and planning of support across Health Education and Social Care through developments in the Early Years Panel.

Prior to the introduction of the Education Health and Care Plans, the Early Years Panel managed the requests for Early Support from a range of agencies. The panel also managed the specialist multi-agency assessments and reviews for pre-school children with complex needs. This process which includes representatives from Education, Health and Social Care results in

Team Around the Child (TAC) plans as part of the Early Support process. This system ensures a multi-agency co-ordinated approach to meet the needs of these children.

To build on this system, the requests for pre-school Education Health and Care Plans as part of the statutory process, now come to this multi-agency panel and the outcome and co-ordination of these, including the multi-agency meetings are now organised through this panel. This has led to a significant improvement in the co-ordination of pre-school statutory multi-agency work. To support this process, additional staffing capacity has been funded within the Early Support programme. This system is managed from the Early Support programme based in Treetops school and supported through the Educational Psychology Service and the Local Authority SEN service. Thus there is now a clear point of access for all pre-school support including Portage home visiting services and statutory responses by the Local Authority

2.6 **Health Provider Engagement in EHC assessments and plans**.

To support consistency in the provision of statutory advice from health providers that work across Thurrock, Essex and Southend, there has been workshop activity supported by the Clinical Commissioning Group to establish a consistent template for Health Professionals' advice as part of the Statutory Assessment leading to the development of an Education Health and Care Plan. This is now being used by Health Professionals and there is a notable difference in how this is being used to identify outcomes and provision. Feedback from School Special Educational Needs Co-ordinators is that they are working with Health providers to give as much notice as possible of planning meetings to enable their attendance as this had been an issue in schools over the past year. There has been a high level of positive engagement by Health professionals in the pre-school work facilitated by Early Support.

2.7 **Local Area Inspection Arrangements**

The DfE have recently published the consultation on the Local Area Inspection process, *The inspection of local areas' effectiveness in identifying and meeting the needs of disabled children and young people and those who have special educational needs* Ofsted / CQC which is open until 14 January 2016. This sets out the proposed process for a wide ranging inspection of the implementation of the SEND reforms introduced by the Children and Families Act 2014. The Inspection process will be over a five year cycle with the first inspections starting from May 2016. The Local Authority has attended briefings on these proposals and the ongoing development plan will be informed by the Inspection Framework. The Local Area Inspection of SEND will cover all areas of the SEND and the narrative judgement will relate to the implementation carried by the Local Authority , Clinical Commissioning Groups and Health Services and all education providers .

It will be important therefore that the Board considers how any aspects of strategic decision making, commissioning priorities and service delivery impacts on the implementation of the new SEND arrangements. To ensure the ongoing effective implementation of the SEND reforms, so as to enable the best possible opportunities and outcomes for children and young people, the Local Authority will be carrying out a thorough self-assessment of the reforms implementation in conjunction with all partners. This will also support the preparation for the new inspection arrangements.

2.7 Social Care Development

Social care staff have attended the transition reviews of young people (who access the team for disabled children) in year 11, to ensure that all aspects of their care needs are fully included as part of the new Education Health and Care plans for young people. Staff from this team have also attended regional training on the development and joining up of social care processes in line with the new SEND reforms. There is close working between social care staff and the SEN department in relation to the plans and ongoing work in bringing together the panel arrangements for resource allocation as part of the EHC plan.

2.9 Personal Budgets

The SEND reforms introduce new opportunities for parents and young people to identify areas to be supported through a Personal Budget. These budgets are identified through the development of the Education Health and Care Plan and can relate to a wide area of support identified in the plan to meet the child or young person's needs. The main areas of need identified to date as part of the development of EHC plans has been in relation to the provision of Direct Payments for Short Breaks. There are approximately 80 families accessing Direct Payments to support their child's needs. As these children and their families go through the transformation process from a Statement of SEN to an EHC plan these Direct Payments have been included as a personal Budget as part of the their new EHCP.

2.8 **Local Offer**

The Thurrock Local Offer setting out a wide range of information in relation to the support available for children, young people and their families has been in place since September 2014 in compliance with the statutory requirements placed on the Local Authority. The Local offer has been reviewed by the DfE SEND advisor over 2014/15 who has fed back her view that it meets these requirements. There has been ongoing work reviewing this offer to respond to feedback from children, parents and outside agencies to ensure its accessibility and content is appropriate and to identify and respond to areas identified for further service development. Clear actions have been taken in response to the feedback received to date. There are a series of planned targeted sessions over 2015/16 with parents, children and young people to increase the feedback on the local offer and to capture information in relation to further service development.

3. Issues, Options and Analysis of Options

3.1 This report informs the board of a number of key areas in relation to the introduction of the reforms to Special Educational Needs and Disability. It reports on the good progress across a range of areas that has been made in relation to implementing a new system of support for children, young people and their families and identifies the ongoing areas for development that impact on a range of key issues for the Board. It further identifies the need for the Board to consider the ways in which all partners may contribute to the successful implementation of these reforms.

4. Reasons for Recommendation

4.1 This is presented to the Board to ensure it is sighted on developments across the Local Authority , Health and a range of partner agencies in developing services to support children young people and their families in relation to the SEND reforms and the statutory obligations

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

5.1 There has been wide spread consultation and engagement with parents and carers facilitated by the Parent Carer Forum as part of the development of the reforms in Thurrock and previous update reports to Children’s Overview and Scrutiny.

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

6.1 The SEND reforms impact significantly on the delivery of services to meet The following Council Priorities;
Create a great place for learning and opportunity
Encourage and promote job creation and economic prosperity
Improve health and well-being.

The SEND reforms have led to increased levels of parental and child engagement in developing support arrangements with a clear focus on aspirations and outcomes for the child or young person. The increased focus on post 16 opportunities and access to employment for young people with SEND has led to a clear identification of needs and an ongoing process for young people to ensure their needs are being met. The bringing together of Health professionals alongside school and other staff with parents and children through the collaborative planning meetings as part of the EHCP development, allows for clearer health outcomes to be identified and linked to other support activities thus directly impacting on the child or young person's health and well-being.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

The additional services identified in this report to support the SEND reforms such as the Early Support staffing and the additional local Authority staff to support the planning meetings in school for Education Health and Care Plans has been funded through the additional transition grant funding from the DfE to cover these demands. The SEND reforms have been accompanied by significant changes to the national High Needs Funding regulations in schools that have been in operation since April 2013 to support clearer funding processes for placements across Local Authority Maintained Schools, Non Maintained Special Schools and Academies. These changes to the funding of High Needs have included new arrangements regarding the delegated funding available in schools to support all pupils with Special Educational Needs including those who have and do not have Education Health and Care Plans in place. The introduction of 0-25 plans with the associated increase in the level of preschool and post 16 plans , places an additional strain on the Direct School Grant funding to support these plans.

7.2 **Legal**

Implications verified by: **Lucinda Bell**
Education Lawyer

The legislation covering the SEND reforms are contained in the Children and Families Act 2014 and the associated regulations ; The Special Educational Needs and Disability Regulations 2014; and The Special Educational Needs (Personal Budgets) Regulations 2014.
The report author asks the HWBB to note the contents of this report. The Board is not asked to make any decision, and there are therefore no legal comments. Details of the legislative framework are contained within the body of the report.

7.3 **Diversity and Equality**

Implications verified by: **Becky Price**
Community Development Officer

The changes taking place within the systems of assessment and support for children and young people with special Educational Needs and Disabilities set out in this paper aims to strengthen individual's opportunities to achieve and lead independent lives. The delivery of these changes will need to be carefully monitored to ensure that the needs of all groups of children and young people particularly those with disabilities are being positively enhanced and that the Local Authority is fully compliant with its duties under the Equality Act 2010.

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):

Special educational needs and disability code of practice: 0 to 25 years
Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities
DfE / DoH January 2015

Implementing a new 0 to 25 special needs system: LAs and partners
Duties and timescales - what you must do and when
DfE / DoH March 2015

9. Appendices to the report

- **Appendix 1**
  Original SEN statement to EHCP Transformation Plan 2014/15
  (published August 2014)

- **Appendix 2**
  Revised Plan for Transformation for Statements to EHC plan 2015/18
  (Published August 2015)

- Thurrock Education Health and Care Plan template

EHCP Version 19 13
7 15.docx

Report Author:

Malcolm W Taylor

Strategic Lead / Principal Educational Psychologist

Children's Services

Appendix 1

Original SEN statement to EHCP Transformation Plan 2014/15
(published August 2014)

Year Group Sep 2014	**No. Statements**	**14/15**	**15/16**	**16/17**
N1	0			
N2	2	2		
YR	15	15		
Y1	57		57	
Y2	60	60		
Y3	63	63		
Y4	76			76
Y5	62		62	
Y6	75			75
Y7	74			74
Y8	79		79	
Y9	82	82		
Y10	103		103	
Y11	108	108		
Y12	114		114	
Y13	38	38		
Y14	26	26		
TOTAL	**1,034**	**394**	**415**	**225**
		14/15	**15/16**	**16/17**

Appendix 2

Revised Plan for Transformation for Statements to EHC plan 2015/18
(Published August 2015)

DfE No.	Groups of children/young people	Latest academic year for transfer to new SEN system		
		2015/16	**2016/17**	**2017/18)**
1	children moving from an early years setting to a school	0(tbc)	tbc	0
2	children moving from infant to junior school	0	0	0
3	children moving from primary to middle school	0	0	0
4	children moving from primary to secondary school	62	76	0
5	children moving from middle to secondary school	0	0	0
6	all other children with statements of SEN in year 6 (including those not moving institution)	0	included in 4	0
7	children in year 9	79	74	0
8	children/young people moving from school (including school sixth forms) to a post-16 institution or an apprenticeship	up to 103	None	0
9	all other children/young people in Year 11 (including those not moving institution)	0	0	0
10	those moving from mainstream to special school or vice versa	tbc	tbc	0
11	those moving between local authorities	0	0	0
12	those leaving youth custody	tbc	tbc	0
13	those with non-statutory EHC plans and who have a statement of SEN	0	0	0
14	those with non-statutory EHC plans but who do not have a statement of SEN	0	0	0
15	those with statements of SEN or LDAs who receive direct payments, under the SEN Direct Payments Pilot Scheme	0	0	0
16	young people who receive support as a result of an LDE who intent to be in education beyond 31 August 2016	tbc	0	0
17	Young people who receive support as a result of an LDA who do not intend to be in education beyond 31 August 2016	0	0	0
18	all others who do not fall into the above categories	175	75	57
	TOTAL	419	225	57

Thurrock Education, Health and Care Plan

DRAFT 1

(Id1 Id2)

Date of birth

Photograph of Child / Young Person or symbol / image of relevance to person.

Proposed/Final Education, Health and Care Plan

Date of Initial Plan:

Date of Current Plan:

Contents

General Information
Section A – **All About Me** (The views, interests and aspirations of the child and his or her parents or the young person)
Section B – My Special Education Needs
Section C – My Health Needs which are related to my SEN
Section D – My social care needs which are related to my SEN
Section E – My outcomes
Section F – My special educational provision.
Section G – My Health Provision
Section H1 – My Social Care Provision (resulting from Section 2 of the Chronically Sick and Disabled Persons Act 1970)
Section H2 – My other Social Care Provision (which can be reasonably required by my learning difficulties or disabilities)
Section I – The name and type of my school, maintained nursery school, post 16 institution or other institution
Section J – My Personal Budget
Section K – The advice and information gathered during my EHC needs assessment

DRAFT

Section A – All About Me

Child's views:

My family's views:

DRAFT 1

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

Section B – My Special Educational Needs

1. Communication and Interaction **Strengths**   **Needs**
2. Cognition and Learning **Strengths**   **Needs**
3. Social, Emotional and Mental Health **Strengths**   **Needs**
4. Sensory and/or Physical **Strengths**   **Needs**

DRAFT 1

Section C – My Health needs which relate to my SEN
Strengths   Needs

DRAFT 1

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

Section D – My Social Care Needs which relate to my SEN

(Social Care needs which are related to Id1's SEN or which require provision for Id1 under 18 Section 2 of the Chronically Sick and Disabled Persons Act 1970.
Other social care needs may also be included but inclusion must be with the consent of the child/young person and parents.)

Strengths

Needs

DRAFT 1

Section E – Outcomes (*Including forward plans for key changes in Id1's life i.e. change of school; service provider or preparing for adult hood)*
Section F – My Special Educational Provision

<u>Communication and Interaction</u>

My long term outcome

Why this is important to me

This will happen by the end of Key Stage

Objectives over the next 12 months *(written in SMART terms)*	**Provision** *(including the support to help me achieve my objectives, where this will happen, how often and who will provide this support)*

Page 51

DRAFT 1

Short term targets to achieve the above objectives will be developed by the education provider and the parents/carers and child or young person.

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

Section E – Outcomes (*Including forward plans for key changes in Id1's life i.e. change of school; service provider or preparing for adult hood)*
Section F – My Special Educational Provision

<table>
<tr><td colspan="2"><u>Cognition and Learning</u>

My long term outcome

Why this is important to me

This will happen by the end of Key Stage</td></tr>
<tr><td>Objectives over the next 12 months
(written in SMART terms)</td><td>Provision
(including the support to help me achieve my objectives, where this will happen, how often and who will provide this support)</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table>

Page 52

Short term targets to achieve the above objectives will be developed by the education provider and the parents/carers and child or young person.

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

DRAFT 1

Section E – Outcomes (*Including forward plans for key changes in Id1's life i.e. change of school; service provider or preparing for adult hood)*
Section F – My Special Educational Provision

Social, Emotional and Mental Health Difficulties

My long term outcome

Why this is important to me

This will happen by the end of Key Stage

Objectives over the next 12 months *(written in SMART terms)*	**Provision** *(including the support to help me achieve my objectives, where this will happen, how often and who will provide this support)*

Page 53

DRAFT 1

Short term targets to achieve the above outcomes will be developed by the education provider and the parents/carers and child or young person.

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

Section E – Outcomes (*Including forward plans for key changes in Id1's life i.e. change of school; service provider or preparing for adult hood)*
Section F – My Special Educational Provision

<u>Sensory and/or Physical Needs</u>

My long term outcome

Why this is important to me

This will happen by the end of Key Stage

Objectives over the next 12 months *(written in SMART terms)*	**Provision** *(including the support to help me achieve my objectives, where this will happen, how often and who will provide this support)*

DRAFT 1

Short term targets to achieve the above outcomes will be developed by the education provider and the parents/carers and child or young person.

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

To be completed each year from year 9 onwards

Section E – Preparing for Adulthood Outcomes and next steps (*Including forward plans for key changes in Id1's life i.e. education, work experience, employment, health and independence)*

<u>Preparing for Adulthood PfA</u>

My long term outcome

Why this is important to me

	Objectives over the next 12 months *(written in SMART terms)*	**Provision**
Further/Higher education and moving towards employment		
Preparing for independent living		
Health and wellbeing		
Friends, relationships and community		

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

DRAFT 1

Section G – My Health Provision		
I will have this support to help me achieve my outcomes	**It will happen at this place and this often.**	**This support will be provided by these people/services and it will be funded in this way.**

DRAFT

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

Section H1 – My Social Care Provision (which must be made for me under the Chronically Sick and Disabled Persons Act 1970)		
I will have this support to help me achieve my outcomes	**It will happen at this place and this often.**	**This support will be provided by these people/services and it will be funded in this way.**

Section H2 – Any other Social Care Provision (which can be reasonably required by my learning difficulties or disabilities)		
I will have this support to help me achieve my outcomes	**It will happen at this place and this often.**	**This support will be provided by these people/services and it will be funded in this way.**

DRAFT

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

Section I - Placement

Type of setting:	

Names and address of setting:	

Resources	

DRAFT 1

Section J – Personal Budget

	Yes	No
I and my parents/carers have decided that I want to take a personal budget for my support?		
If yes, is this a:		
Notional budget		
Notional and direct payment budget		
Direct payment budget		

Id1's Personal Budget allocation is:	£xxxxxxx

Description of support	Weekly Cost	Annual Cost
Education	£	£
Health	£	£
Social Care	£	£
Other (e.g. transport)	£	£
TOTAL AVAILABLE AS PERSONAL BUDGET	£	£

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

DRAFT

Section K – Advice

General Information

Family Name:	Id2	First Name(s):	Id1

Preferred Name:		DOB:	dob1

Ethnicity:		Religion:	

Gender:	Male/Female	Child Looked After:	Yes/No

Address:	

Telephone: Email:	

Parent(s) or Carer(s) Names:		Who has Parental Responsibility?	

Address (if different from above):	

Telephone/Email: (if different from above)	

Name of current setting (early years/school/college):	
Start Date:	
Type of School:	
UPN:	

Name of main contact in current setting:	

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

DRAFT

Local Authority Contact Information			
Case worker name		Telephone number	
Address		E-mail address	

Health workers			
General practitioner (GP)		Telephone number	
Address		E-mail address	
Paediatrician		Telephone number	
Address		E-mail address	
Allocated named therapist		Telephone number	
Address		E-mail address	
Allocated named therapist		Telephone number	
Address		E-mail address	
Allocated named therapist		Telephone number	
Address		E-mail address	
Other		Telephone number	
Address		E-mail address	
Social Care worker			
Name		Telephone number	
Address		E-mail address	

DRAFT

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

The people who have been involved in producing my plan

Name and role	Contact details	Attended the meeting	Wrote a report
		Y/N	
		Y/N	
		Y/N	
		Y/N	
		Y/N	
		Y/N	
		Y/N	

Appendix 1: Child's/Young Person Advice
Appendix 2: Parental Advice
Appendix 3: Educational Advice
Appendix 4: Psychological Advice
Appendix 5: Medical Advice
Appendix 6: Advice from Social Care
Appendix 7: Other Advice obtained by the Local Authority

This plan will be reviewed at least annually. Each service will be responsible for reviewing their part of the plan and may hold more frequent reviews of particular parts of the plan. This will be reflected in the annual review of the plan.

Child/Young Person	Signed:	Date:

Parent/Carer	Signed:	Date:

Duly Authorised Officer: Education	Signed:	Date:

Duly Authorised Officer: Health	Signed:	Date:

Duly Authorised Officer: Social Care	Signed:	Date:

This information should **not** be shared by professionals with anyone other than the people who have contributed to this assessment without **asking the child/young person or family first**. The family have the right to share it with whoever they wish.

DRAFT 1

12th November 2015	ITEM: 9
Health and Wellbeing Board	
Transformation Plan for The Emotional Well Being and Mental Health of Children and Young People in Thurrock , Essex and Southend	
Report of: Malcolm W Taylor Strategic Lead Learner Support / Principal Educational Psychologist	
Accountable Head of Service: Malcolm W Taylor	
Accountable Director: Carmel Littleton Director of Children's Services	
This report is Public	

Executive Summary

The joint Thurrock, Essex and Southend Transformation Plan for the Emotional Well Being and Mental Health of Children and Young People has been developed as part of the Collaborative Commissioning Agreement established between the seven Clinical Commissioning Groups and the three Local Authorities across Essex. This Transformation Plan forms the Local Transformation Plan required of all Local Authorities and CCGs to meet the requirements of the Government Report *Future in Mind ; Promoting, Protecting and improving our children and young people's mental health and wellbeing* DoH / NHS England, Crown 2015.

The Transformation Plan sets out the Key Principles and Priorities of the development of Emotional Health and Well Being services, it proposes key areas of activity for the five years of the plan and sets out the funding identified for these in detail over the first year of this plan 2015/16. These services develop on from the key priorities identified as part of the collaborative commissioning report to the Health and Well Being Board on the 15th July 2015.

1. Recommendation(s)

1.1 That the Board ratify the key recommendations and priorities of the transformation Plan entitled *Open Up, Reach Out* Transformation Plan for The Emotional Well Being and Mental Health of Children and Young People in Thurrock , Essex and Southend

2. Introduction and Background

2.1 The *Open Up, Reach Out* Transformation Plan for the Emotional Well Being and Mental Health of Children and Young People in Thurrock, Essex and Southend has been developed as part of the ongoing collaborative commissioning process for integrated and targeted services for children and young people across the three local authorities. The Transformation Plan builds on the work that has been carried out for the re-commissioning of these services resulting in the new service delivery that is coming onto place from the 1st November 2015.

2.2 The Local Transformation Plan has been developed in line with the recommendations of the Department of Health report *Future in Mind ; Promoting, Protecting and improving our children and young people's mental health and wellbeing* DoH / NHS England, Crown 2015 and the associated guidance *Local Transformation Plans for Children and Young People's Mental Health and Wellbeing Guidance and support for local areas* NHS England 2015.

2.3 The transformation plan for the emotional wellbeing and mental health of children and young people in Southend, Essex and Thurrock has been submitted for the first stage of assurance by NHS England. The full assurance process of this plan requires that all three Health and Wellbeing boards and the NHS England Specialised Commissioning department sign off the plan.

2.4 **Collaborative Commissioning Forum Summary**

The transformation of emotional wellbeing and mental health services for children and young people has a high national profile and the support of significant additional funding. For Southend, Essex and Thurrock, the total additional funding is anticipated to be £3.3 million. The Government's expectation is that health and care systems will use these additional funds to plan and implement radical step-change.

There is no question that that the transformation being planned for Southend, Essex and Thurrock is radical step change. It involves seven CCGs and three local authorities in formal collaborative commissioning; and begins with the transition from four main providers to a single integrated service across the whole of Southend, Essex and Thurrock.

The new arrangement will deliver care with a much stronger focus on early intervention, evidence-based treatment and measurable outcomes. The additional investment offers the opportunity not just to increase the professional help available, but also to lead a cultural transformation that will build resilience in schools, communities, families, and children and young people themselves.

2.5 Overview

The transformation plan for emotional wellbeing and mental health for children and young people is to:

- Improve access and equality
- Build capacity and capability in the system
- Build resilience in the community

2.6 Principles

The plan is built upon six agreed principles:

Early action – avoiding and preventing mental health problems

No judgement, no stigma – with care that is right for each individual, delivered in safe places and with children and young people having a say in decisions

Support for the whole family – with care as a part of daily life, backed up by professionals and specialists when needed

Inform and empower – with information there for everyone and simple to access, providing the tools for self-care and resilience, as well as recovery

Joined-up services – efficient, effective and clear for all to understand

Better outcomes – through evidence-based care and listening and responding to feedback

2.7 Where we are now

Our baseline is a complex, fragmented and poorly understood set of services with substantial variation in levels of care. While there have been notable improvements in services over the past five years, the system is essentially the product of a traditionally reactive model, designed mainly to respond to mental health needs as they arise.

However, as our transformation plan explains, services have not kept up with rising demands. For many children and young people with mental health problems, the support and care that they need is simply unavailable.

Some of the key points highlighted in the plan:

- The JSNA finds that support for children with low to moderate needs is extremely low (less than 20%) compared with national estimates of the number of children and young people in our local population who need this type of care. In Thurrock, for example, services at this level are restricted to children in care and children with highly complex mental health needs.

- The provision of services for serious mental health problems is also significantly lower than expected when compared with national estimates. Given the data

available (which is also variable), services appear to be seeing less than 50% of the children and young people who need these services.

- Eating disorder services are in need of investment to respond to the increasing prevalence of eating disorders and are only available currently in north Essex.

- Feedback from service users and stakeholders has strong common themes, which are:

    - Difficulties in accessing services
    - Referral criteria are unclear and inequitable
    - There is a need for better information, advice and signposting
    - There is a need for significant development in capacity and skills to deliver early intervention.

Our baseline information included in the transformation shows the 2014/15 combined investments to be £13.87 million.

2.8 Vision

The plan is to move from a traditional tiered service delivered by multiple providers to a single provider providing a coherent range of care across communities as described below:

A new emotional wellbeing and mental health service starts from 1 November 2015	
Support in daily life	• Information and advice for children and young people, available from our website and places in the community • Information and advice for parents and carers • Training and support for schools and others
Help from local services	• Services working with families at home • Services in schools, GP surgeries, community and children's centres • Evidence-based interventions and therapies for children, young people and families • A confident and empowered children's workforce
Expert help from specialists	• Specialist help for long-term and serious problems • Joined-up services for several problems • Referral to more specialised services
Help in a crisis	• Fast response with support at home • Links with other emergency services • Overnight and short stays in specialist services, if needs be

2.9 How the new model of care will work for children and young people

The new model builds system resilience to respond to needs, community resilience to encourage collective responsibility and individual resilience to cope with the challenges that life brings.

- To begin with, the right kind of support should be there for children and young people in daily life - people will have a better understanding of the risks to mental health and how to cope.

- Families and professionals will be able to find out where to get help quickly and easily and have the support and tools they need for self-help.

- Where extra help is needed, services will be ready to step in at an early stage, in convenient, friendly places where young people feel safe, listened to and respected.

- Workers within services will have the confidence and skills to understand needs early on and give the right support.

- Children and young people will have a say about their own care and in the design and development of services.

- Expert help for long term and serious problems will expand across Southend, Essex and Thurrock.

- Experts will be ready to act quickly in a crisis, whenever and wherever that may be.

2.10 Measurable outcomes

The specification for the new service includes measures and key performance indicators (KPIs) to monitor progress against the following outcomes:

1. Improvements in mental health for children and young people in Southend, Essex and Thurrock, using better methods to monitor and measure our progress
2. A joined-up system with no barriers
3. Reduction in inequality - no discrimination, no stigma
4. Easier access to services with shorter waiting times
5. Other services working with children and young people are enabled to promote and support good emotional wellbeing and mental health
6. Better advice, support, training and guidance for parents, teachers and others
7. Fewer visits to A&E
8. Priority for assessment of children and young people from vulnerable groups, including proactive outreach.
9. Young people aged 14-25 to get the right support and, if necessary, a smooth transition to adult services
10. Opportunities for children and young people to influence services, not just for their own care but also as part of collaboration between services and young people.

2.11 Plan of action

In year 1 (2015/16) – we mobilise and embed the new service (which starts on 1 November), using some funds non-recurrently to support transition. We will undertake a deeper dive needs assessment and a number of specific service reviews and pilots for full implementation in years 2 and 3.

In year 2 (2016/17) – we will invest in workforce expansion and development and roll out new schemes designed on the basis of our review findings.

In years 3, 4 and 5 – we will refresh the transformation plan and continue to develop new and better services in response to our detailed needs assessment and service reviews.

Building capacity and capability in our seven locality teams

With the additional investment and new ways of working we are expanding the people and skills in locality teams. The following table summarises key developments:

Identified gaps in services	Increase in staffing and skills
Specialist services to help with developmental and behavioural problems	New posts for junior doctors in training, in partnership with Health Education East of England.
Improving access to psychological therapies (IAPT)	Upgraded clinical psychology leaders. New posts in each locality.
Faster access to help for low to moderate needs – not always available currently	Recruitment and training for lower grade clinical staff. Additional resources to support locality teams and their work with partners within the community e.g. schools, children's centres, GPs, voluntary sector.
Faster access to advice, information, support and assessment where needed.	More staff for single points of access in Southend, Essex and Thurrock.

2.12 Specific service developments described in the transformation plan

Improving access and equality

- Establishment of a single point of access for each of the three local authority areas, supported by an increased workforce and workforce development
- Crisis services to extend to all localities, 9am-9pm, seven days a week
- Extended children's and young people's IAPT, with the aim of achieving 100% coverage by 2018
- Increased capacity to respond to complex needs (such those of children with learning disabilities and mental health needs) and serious disorders (such as ADHD), supported by a new intake of junior doctors
- A significant investment and development in eating disorder services
- Improvements in support for vulnerable and disadvantaged children and young people

- Improvements in transitions between services e.g. for long term needs of young people moving into adulthood

- Medicines management review

Building capacity and capability in the system

- Additional posts, including five new medical posts
- Upgrading for some posts
- Wide scale workforce development and training
- Improvements in data and IT systems
- Improvements in performance monitoring

Building resilience in the community

- Embedded and sustainable engagement with children and young people, universal services and community networks
- Structured support and training for schools
- A review and development of comprehensive support to prevent suicide and self-harm

The mobilisation of the new service and ongoing implementation of the transformation plan will be supported by a programme management office and improved performance and outcomes monitoring.

2.13 Investment

The new service will start on 1 November with an initial cost of £13.2 million per year, but, on the basis of this transformation plan, we are anticipating additional investments totalling £3.3 million to be deployed as follows:

Action	**£**
Crisis services extending from 5 to 7 days a week, 9am-9pm	190k
More staff in crisis teams to provide emergency care at home	241k
Expansion in services for eating disorders	953k
More staff in local teams to improve single points of access	144k
More medical cover with five new junior doctor posts. This will increase our ability to support children and young people with special educational needs and complex needs	208k
More senior clinicians in psychological services	76k
More practitioners in psychological services	421k
More staff in locality teams to respond to low to moderate needs	598k
Extra management capacity	104k
Training for therapy services (children and young people's IAPT)	100k
Support and Training for schools	100k
Support and resilience training in the voluntary sector	210k
Total	**3.34M**

Non-recurrent costs in 2015/16

Publication and promotion of the transformation plan	£15k
Engagement with children and young people	£115
Needs assessment “deep dive”	£150k
IM&T infrastructure etc.	£175k
Programme management office for transition	£142k
Medicines Management Review	£50k
Suicide and self-harm audit and training	£100k
Local Partnership Development Sessions	£21k
Total	£768

3. Issues, Options and Analysis of Options

3.1 The Transformation Plan has been developed through the Joint Collaborative Commissioning Process as detailed in the full report. The integrated service that has been commissioned is based on the key areas set out in the national guidance including early Intervention ; evidenced based treatment and achieving measurable outcomes and has been developed through a thorough series of consultation activities and reviews of all available data . The new service sets out a framework to move away from a purely reactive service to one that supports prevention, resilience and better mental health.

3.2 The new services and areas of investment detailed above have therefore been developed to meet the needs of the population across Essex, Southend and Thurrock to ensure full equitable access to a wide range of services including specialist needs developed through the advantages of a broader base of investment across the three Local Authorities.

4. Reasons for Recommendation

4.1 To ensure the Transformation plan for Mental Health and Well Being for children and young people is approved and implemented in line with the joint collaborative commissioning arrangements in place between Thurrock , Essex and Southend Local Authorities and the Clinical Commissioning Groups operating across the three Local Authority areas.

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

5.1 There has been detailed analysis of a range of sources of information during the development of the Transformation including responses from the Joint Strategic Needs Analysis detailed in the full report. There has also been the involvement of Health Watch Essex and information from direct consultation

with children and young people. Part of the Transformation Plan is further direct consultation with children and young people to ensure the appropriate targeting and development of services over time.

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

6.1 The development of the new Integrated Service to support the Emotional Being and Mental Health of Children and Young People in Thurrock described in the Transformation Plan impacts directly on the Council's Key Priority to improve Mental Health and Well Being.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

The extra funding for the development of the new activities is set out in the *Local Transformation Plans for Children and Young People's Mental Health and Wellbeing Guidance and support for local areas* NHS England 2015. The new activities identified in the Transformation Plan are fully funded from this additional funding. The procurement for the new integrated service was carried out in accordance with all legislative requirements. The preferred bidder was recommended as it it presented the most economically advantageous tender. The financial submission is within the financial envelope with activity levels increased by 14% . The service will deliver additional savings and social value as children and young people will receive an earlier and timelier response preventing escalation to more expensive specialist services with an improved focus on maintenance of their future well-being. The bidder presented a high quality, safe and affordable solution.

7.2 Legal

Implications verified by: **Lindsey Marks**
Principal Solicitor

Section 17 Children Act 1989 provides that local authorities have a duty to safeguard and promote the welfare of children within their area who are in need and so far as is consistent with that duty to promote the upbringing of such children by their families by providing a range of services appropriate to those children's need.
The proposals to come together to plan, design and deliver a single equal,

integrated, emotional wellbeing and mental health service for children and young people conforms with the duty placed on local authorities and their partners to work together to ensure all children and young people are able to stay safe, healthy, enjoy and achieve economic wellbeing and make a positive contribution.
The Children Act 2004 sets out the responsibilities of local authorities and their partners to co-operate and promote the wellbeing of children and this specifically includes their mental health and emotional wellbeing. The Mental Health Act 1983 as amended by the Mental Health Act 2007 provides for the treatment and care of people with mental disorder including children and young people.
Thurrock Council under the Health and Social Care Act 2012 as a local authority must take such steps as it considers appropriate for improving the health of the people in its area and this includes the mental health of people in its area.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The implementation of a high quality Emotional Well Being and Mental Health (EWMH) service is key to ensuring equality of opportunity for the children and young people of Thurrock and the Diversity Team would want to ensure that access to EWMH services is available to those who require that support. This new service offers improved “swift and Ease” for a wider group of children and young people than previously

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):

Children and Young people Emotional Wellbeing and Mental Health Service Commissioning update Health and Well Being Board Report July 2015

9. Appendices to the report

- ***Open Out Reach Out Transformation Plan for The Emotional Well Being and Mental Health of Children and Young People in Thurrock* , Essex and Southend**

- ***Future in Mind ; Promoting, Protecting and improving our children and young people’s mental health and wellbeing* DoH / NHS England, Crown 2015**
- ***Local Transformation Plans for Children and Young People’s Mental Health and Wellbeing Guidance and support for local areas* NHS England 2015**

Report Author:

Malcolm W Taylor
Strategic Lead Learner Support / Principal Educational Psychologist
Children's Services

This page is intentionally left blank

OPEN UP, REACH OUT

TRANSFORMATION PLAN FOR THE **EMOTIONAL WELLBEING** AND **MENTAL HEALTH** OF **CHILDREN** AND **YOUNG PEOPLE** IN ***SOUTHEND***, ***ESSEX*** AND ***THURROCK***.

2015-2020

Published November 2015

NHS

Essex County Council

THURROCK COUNCIL

southend on sea BOROUGH COUNCIL

Document status

Ownership	Collaborative Commissioning Forum for the Emotional Wellbeing and Mental Health of Children and Young People in Southend, Essex and Thurrock Chair: Barbara Herts, Director for Integrated Commissioning and Vulnerable People, Essex County Council
Senior Responsible Officer	Sallie Mills Lewis, Lead Commissioner, NHS West Essex Clinical Commissioning Group (CCG)
Author	Wendy Smith, Communications Adviser, NHS West Essex CCG
Date of approval	9 October 2015 Approved by the three Health and Wellbeing Boards of Southend, Essex and Thurrock and regional arm of NHS England Specialised Commissioning.
For assessment	Submitted to NHS England for assessment on 12 October 2015
Current version	Version 12 as at 13 October 2015
Publication status	Due for publication in November, subject to outcome of national assessment
Key contacts for further information	Dawn Bolingbroke, Essex CAMHS Commissioning Manager NHS West Essex CCG dawn.bolingbroke@nhs.net Christina Pace, Head of Commissioning Vulnerable People, Essex County Council christina.pace@essex.gov.uk

Open up, Reach out

Here is what we're going to do...

→ Improve access and equality

→ Build capacity and capability in the system

→ **Build resilience in the community**

Open up, Reach out – Our ambition

Our plan to improve the mental health and emotional wellbeing of children and young people sets the wheels in motion for an extensive transformation across three local authorities and seven clinical commissioning groups. It is currently the biggest transformational change in progress across the health and care systems of Southend, Essex and Thurrock.

Our goals are ambitious and reach beyond health and care services to schools, clubs, groups, families and every public service that protects and supports children and young people.

Preparations are well advanced after three years in the making. The ten commissioners behind this transformation already have a well-established partnership, secured by a legally binding contract and matured through joint working.

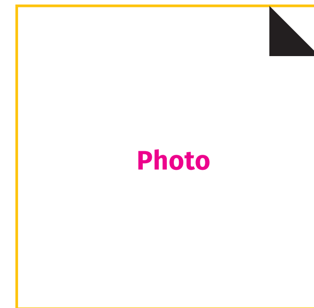
Since 2012, the partnership has charted a course away from fragmented and inconsistent services and towards a single integrated emotional wellbeing and mental health service for children and young people. We started with a joint needs assessment and several consultations. The views of children, young people, parents and professionals led us to an agreed service model. Then followed a successful major procurement exercise to select a single provider.

The new service will begin on 1 November 2015.

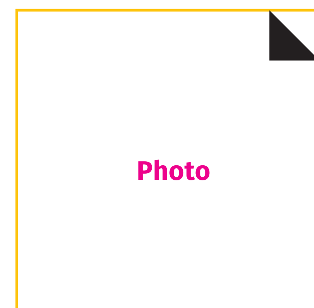
On day one, services will transfer from four previous provider organisations to North East London NHS Foundation Trust (NELFT). This transition is in itself a complex and substantial undertaking, requiring detailed mobilisation plans and management.

But this is just the start. The national guidance, *Future in Mind*, sets the challenge and provides the steer for the next five years, with a focus on early intervention, evidenced-based treatment and achieving measurable outcomes. With our newly procured service and significant additional investment, arises the opportunity not just to increase the professional help available to children and young people, but to lead the cultural transformation from a traditionally reactive service to one that invests in prevention, resilience and better mental health.

Using the best of modern care, our new service will nurture resilience and a collective responsibility for the emotional wellbeing and mental health of children and young people.



Barbara Herts
Director for Integrated Commissioning and Vulnerable People
Essex County Council



Clare Morris
Chief Officer
NHS West Essex Clinical Commissioning Group

1 Where we are now 13

- Our young population and their mental health needs 13
- Current services prior to 1 November 2015 16
- Estimated prevalence of mental health problems in Southend, Essex and Thurrock 18
- Unmet needs and gaps in services 29
- Summary of findings 34

2 Summary transformation plan 36

- How we will trasnsform over the next five years 36
- What drives our plan - six principles 37
- Transformation at scale 39
- What the new service will look like 40
- Measurable outcomes 44

3 Priorities for action 46

- Further needs assessment - a "deeper dive" 47
- Investment 47
- Improving access and equality 50
  - // Single points of access – "one way in" to better information, support and services Improving crisis services 50
  - // Improving Access to Psychological Therapies (IAPT) for children and young people 52
  - // Attention Deficit Hyperactivity Disorder - ADHD 54
  - // Creating a community service for eating disorders 55
  - // Children's learning disability services 57
  - // Support for vulnerable and disadvantaged children and young people 58
  - // Support for children and young people who move between services 59
  - // Medicines management review 61
  - // Action for equality 61
- Building capacity and capability in the system 62
  - // Training and development for staff 63
  - // Improving data and IT 64
  - // Governance and performance framework 65
- Building resilience in the community 70
  - // Engagement 71
  - // A clear role for schools 74
  - // Suicide prevention and support for children who harm themselves 76

4 Conclusion 77

5 Appendices 79

- Appendix 1 – Prevalence of mental health problems taken from ChiMat 79
- Appendix 2 – Further information on baseline activity in 2014/15 84
- Appendix 3 – Baseline assessment investment in 2014/15 92
- Appendix 4 – Staffing of current services prior to 1 Nov 93
- Appendix 5 – Terms of Reference for the Collaborative Commissioning Forum and Transformation Planning Steering Group 99

Executive Summary

Open up, Reach out

This transformation plan describes a major change in Southend, Essex and Thurrock to improve the emotional wellbeing and mental health of children and young people.

Seven clinical commissioning groups (CCGs) and three local authorities have pooled their funds to reduce inequalities across the patch, maximise the impact of services and deliver consistent high quality care for some 416,000 children and young people.

We are investing some £3.3 million to make more professional help available and easier to access.

We are moving from a traditional tiered service delivered by fragmented, multiple providers to a single integrated service across seven localities.

Over the next five years, we are promoting a cultural transformation from a traditionally reactive service to one that invests in prevention, early intervention and resilience for children, families and communities.

Our plan is to:

National context

The transformation of emotional wellbeing and mental health services for children and young people has a high national profile and the support of significant additional funding. The national guidance, *Future in Mind*, sets the challenge and provides the steer for the next five years, with a focus on early intervention, evidenced-based treatment and achieving measurable outcomes.

For Southend, Essex and Thurrock, the total additional funding to meet the requirements of Future in Mind is anticipated to be £3.3 million. The Government's expectation is that health and care systems will use these additional funds to plan and implement radical step-change.

Summary of the transformation plan

Principles

The plan is built upon six agreed principles:

1. **Early action** – avoiding and preventing mental health problems
2. **No judgement, no stigma** – with care that is right for each individual, delivered in safe places and with children and young people having a say in decisions
3. **Support for the whole family** – with care as a part of daily life, backed up by professionals and specialists when needed
4. **Inform and empower** – with information there for everyone and simple to access, providing the tools for self-care and resilience, as well as recovery
5. **Joined-up services** – efficient, effective and clear for all to understand
6. **Better outcomes** – through evidence-based care and listening and responding to feedback

Where we are now

Our baseline is a complex, fragmented and poorly understood set of services with substantial variation in levels of care. While there have been notable improvements in services over the past five years, the system is essentially the product of a traditionally reactive model, designed mainly to respond to mental health needs as they arise.

However, services have not kept up with rising demands. For many children and young people with mental health problems, the support and care that they need is simply unavailable.

Some of the key points from our assessment of current needs:

- From our Joint Service Needs Assessment (JSNA) we found that support for children with low to moderate needs is extremely low (less than 20%) compared with national estimates of the number of children and young people in our local population who need this type of care. In Thurrock, for example, services at this level are restricted to children in care and children with highly complex mental health needs.
- The provision of services for serious mental health problems is also significantly lower than expected when compared with national estimates. Given the data available (which is also variable), services appear to be seeing less than 50% of the children and young people who need these services.
- Eating disorder services are in need of investment to respond to the increasing prevalence of eating disorders and are only available currently in north Essex.
- Feedback from service users and stakeholders has strong common themes, which are:
    - // Difficulties in accessing services
    - // Referral criteria are unclear and inequitable
    - // There is a need for better information, advice and signposting
    - // There is a need for significant development in capacity and skills to deliver early intervention.

Our baseline information included in the transformation shows the 2014/15 combined investments to be £13.87 million.

Vision

The plan is to move from a traditional tiered service delivered by multiple providers to a single provider providing a coherent range of care across communities as described below:

A new emotional wellbeing and mental health service starts from 1 November 2015

Support in daily life	Information and advice for children and young people, available from our website and places in the community Information and advice for parents and carers Training and support for schools and others
Help from local services	Services working with families at home Services in schools, GP surgeries, community and children's centres Evidence-based interventions and therapies for children, young people and families A confident and empowered children's workforce
Expert help from specialists	Specialist help for long-term and serious problems Joined-up services for several problems Referral to more specialised services
Help in a crisis	Fast response with support at home Links with other emergency services Overnight and short stays in specialist services, if needs be

How the new model of care will work for children and young people

The new model builds system resilience to respond to needs, community resilience to encourage collective responsibility and individual resilience to cope with the challenges that life brings.

- To begin with, the right kind of support should be there for children and young people in daily life - people will have a better understanding of the risks to mental health and how to cope.
- Families and professionals will be able to find out where to get help quickly and easily and have the support and tools they need for self-help.
- Where extra help is needed, services will be ready to step in at an early stage, in convenient, friendly places where young people feel safe, listened to and respected.
- Workers within services will have the confidence and skills to understand needs early on and give the right support.
- Children and young people will have a say about their own care and in the design and development of services.
- Expert help for long term and serious problems will expand across Southend, Essex and Thurrock.
- Experts will be ready to act quickly in a crisis, whenever and wherever that may be.

Measurable outcomes

The specification for the new service includes measures and key performance indicators (KPIs) to monitor progress against the following outcomes:

1. Improvements in mental health for children and young people in Southend, Essex and Thurrock, using better methods to monitor and measure our progress
2. A joined-up system with no barriers
3. Reduction in inequality - no discrimination, no stigma
4. Easier access to services with shorter waiting times
5. Other services working with children and young people are enabled to promote and support good emotional wellbeing and mental health
6. Better advice, support, training and guidance for parents, teachers and others
7. Fewer visits to A&E
8. Priority for assessment of children and young people from vulnerable groups, including proactive outreach.
9. Young people aged 14-25 to get the right support and, if necessary, a smooth transition to adult services
10. Opportunities for children and young people to influence services, not just for their own care but also as part of collaboration between services and young people.

Plan of action

In year 1 (2015/16) – we mobilise and embed the new service (which starts on 1 November), using some funds non-recurrently to support transition. We will undertake a deeper dive needs assessment and a number of specific service reviews and pilots for full implementation in years 2 and 3. We will develop proposals for a new eating disorder service.

In year 2 (2016/17) – we will invest in workforce expansion and development and roll out new schemes designed on the basis of our review findings. We will continue and complete reviews.

In years 3, 4 and 5 – we will refresh the transformation plan and continue to develop new and better services in response to our detailed needs assessment and service reviews.

Building capacity and capability in our seven locality teams

With the additional investment and new ways of working we are expanding the people and skills in locality teams. The following table summarises key developments:

Identified gaps in services	Increase in staffing and skills
Services for eating disorders	Increase in clinical and support staff to cover all localities.
Specialist services to help with developmental and behavioural problems	New posts for junior doctors in training, in partnership with Health Education East of England.
Improving access to psychological therapies (IAPT)	Upgraded clinical psychology leaders. New posts in each locality.
Faster access to help for low to moderate needs – not always available currently	Recruitment and training for lower grade clinical staff.
Faster access to advice, information, support and assessment where needed.	Additional resources to support locality teams and their work with partners within the community e.g. schools, children's centres, GPs, voluntary sector. More staff for single points of access in Southend, Essex and Thurrock.

Specific service developments described in the transformation plan

Improving access and equality

- Establishment of a single point of access for each of the three local authority areas, enhanced by an increased workforce and workforce development
- Enhance crisis services and extend home treatment.
- Extended children's and young people's IAPT, with the aim of achieving 100% coverage by 2018
- Increased capacity to respond to complex needs (such those of children with learning disabilities and mental health needs) and serious disorders (such as ADHD), supported by a new intake of junior doctors
- A significant investment and development in eating disorder services
- Improvements in support for vulnerable and disadvantaged children and young people
- Improvements in transitions between services e.g. for long term needs of young people moving into adulthood
- Medicines management review

Building capacity and capability in the system

- Additional posts, including five new medical posts
- Upgrading for some posts
- Wide scale workforce development and training
- Improvements in data and IT systems
- Improvements in performance monitoring

Building resilience in the community

- Embedded and sustainable engagement with children and young people, universal services and community networks
- Structured support and training for schools
- Building relationships with other health and care professionals, including joint work on operational protocols
- Building relationships with other public services, including developing joint strategies and agreements e.g. implementation of action plans under the Crisis Care Concordat
- Building community relationships with the voluntary sector and other networks
- A review and development of comprehensive support to prevent suicide and self-harm

The mobilisation of the new service and ongoing implementation of the transformation plan will be supported by a programme management office and improved performance and outcomes monitoring.

Investment

The new service will start on 1 November with an initial cost of £13.2 million per year, but, on the basis of this transformation plan, we are anticipating additional investments totaling £3.3 million to be deployed as follows:

Action	£
Improving access and equality	
Enhanced crisis services to cover 9am-9pm, 7 days a week across Southend, Essex and Thurrock	190k
More staff in crisis teams to provide emergency care at home	241k
Expansion in services for eating disorders	953k
More staff in local teams to improve single points of access	144k
Building capacity and capability in the system	
More medical cover with five new junior doctor posts. This will increase our ability to support children and young people with special educational needs and complex needs	208k
More senior clinicians in psychological services	76k
More practitioners in psychological services	421k
More staff in locality teams to respond to low to moderate needs	598k
Extra management capacity	104k
Training for therapy services (children and young people's IAPT)	100k
Building resilience in the community	
Support and training for schools	100k
Support and resilience training in the voluntary sector	210k
Total	**3.34m**

Non-recurrent costs in 2015/16

Item	Cost
Publication of the transformation plan, with an accessible version for young people	£15k
Engagement with children and young people	£115k
Needs assessment "deep dive"	£150k
IM&T infrastructure	£175k
Programme management office for transition	£142k
Medicines management review	£50k
Suicide and self harm audit and training	£100k
Locality partnership development sessions	£21k
Total	**£768k**

WHERE WE ARE NOW

Our young population and their mental health needs

A demographic picture of Southend, Essex and Thurrock

Ref. Essex Joint Strategic Needs Assessment for Children's Emotional Wellbeing and Mental Health: http://www.essexinsight.org.uk/grouppage.aspx?groupid=19

There are three areas of local government in Essex: the two-tiered, non-metropolitan county of Essex, which covers 12 district, borough and city councils, and the unitary authority areas of Southend-on-sea and Thurrock. Health is the responsibility of seven NHS clinical commissioning groups (CCGs), which are shown on the map on the next page.

These 10 co-commissioners of services cover a total population close to 1.75 million of which around 24%, some 415,856, are under the age of 19.

Current projections expect the young population to rise to 441,632 by 2021. Thurrock Council is expected to see the largest growth of 13%, with Southend-on-sea Borough Council expecting 8% and Essex County Council expecting 6% growth by 2021.

Ref. Office for National Statistics Mid 2011 projections

1.75 million population

under **19**

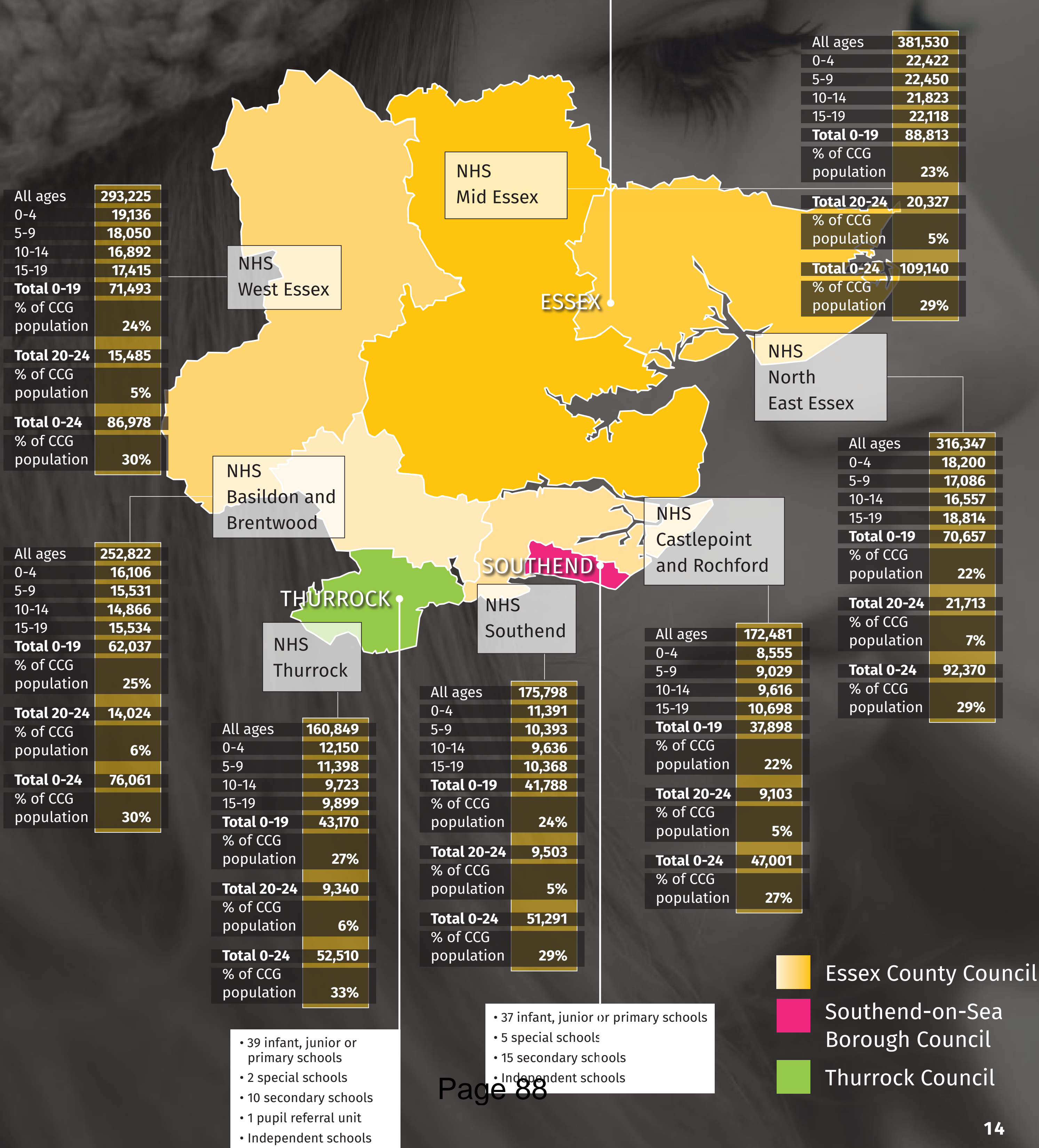
The map below shows the local authority boundaries and localities covered by the seven clinical commissioning groups (CCGs). The annotations show the number of children and age ranges.

SOUTHEND, ESSEX AND THURROCK

All ages	1,753,052
0-4	107,960
5-9	103,937
10-14	99,113
15-19	104,846
Total 0-19	415,856
Total 20-24	99,495
Total 0-24	515,351

ESSEX

- 458 infant, junior or primary schools
- 17 special schools
- 78 secondary schools
- Independent schools



NHS Mid Essex

All ages	381,530
0-4	22,422
5-9	22,450
10-14	21,823
15-19	22,118
Total 0-19	88,813
% of CCG population	23%
Total 20-24	20,327
% of CCG population	5%
Total 0-24	109,140
% of CCG population	29%

NHS West Essex

All ages	293,225
0-4	19,136
5-9	18,050
10-14	16,892
15-19	17,415
Total 0-19	71,493
% of CCG population	24%
Total 20-24	15,485
% of CCG population	5%
Total 0-24	86,978
% of CCG population	30%

NHS North East Essex

All ages	316,347
0-4	18,200
5-9	17,086
10-14	16,557
15-19	18,814
Total 0-19	70,657
% of CCG population	22%
Total 20-24	21,713
% of CCG population	7%
Total 0-24	92,370
% of CCG population	29%

NHS Basildon and Brentwood

All ages	252,822
0-4	16,106
5-9	15,531
10-14	14,866
15-19	15,534
Total 0-19	62,037
% of CCG population	25%
Total 20-24	14,024
% of CCG population	6%
Total 0-24	76,061
% of CCG population	30%

NHS Castlepoint and Rochford

All ages	172,481
0-4	8,555
5-9	9,029
10-14	9,616
15-19	10,698
Total 0-19	37,898
% of CCG population	22%
Total 20-24	9,103
% of CCG population	5%
Total 0-24	47,001
% of CCG population	27%

NHS Southend

All ages	175,798
0-4	11,391
5-9	10,393
10-14	9,636
15-19	10,368
Total 0-19	41,788
% of CCG population	24%
Total 20-24	9,503
% of CCG population	5%
Total 0-24	51,291
% of CCG population	29%

NHS Thurrock

All ages	160,849
0-4	12,150
5-9	11,398
10-14	9,723
15-19	9,899
Total 0-19	43,170
% of CCG population	27%
Total 20-24	9,340
% of CCG population	6%
Total 0-24	52,510
% of CCG population	33%

SOUTHEND

- 37 infant, junior or primary schools
- 5 special schools
- 15 secondary schools
- Independent schools

THURROCK

- 39 infant, junior or primary schools
- 2 special schools
- 10 secondary schools
- 1 pupil referral unit
- Independent schools

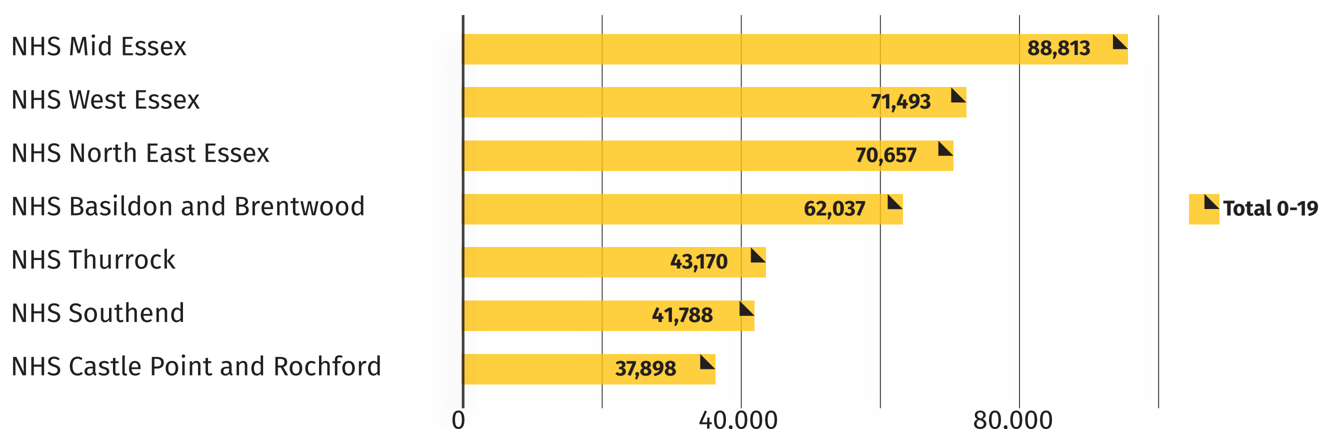
Thurrock has the least all age population; however Thurrock has the largest population of under 19 year olds, equating to 27% of the population. Basildon and Brentwood, Southend, Thurrock and West Essex have larger populations aged 0-4 years. North East Essex CCG and Castle Point and Rochford CCG have a larger population in the 15-19 year age group. Mid Essex CCG has a larger population in the 5-9 years age group.

0-19 years population

415,856

Essex

Total 0-19 population by CCG



Estimated number of children and young people (2014)

CCG Area	All 5-10 years	All 11-16	All 5-16	Boys 5-10	Boys 11-16	Boys 5-16	Girls 5-10	Girls 11-16	Girls 5-16
NHS Southend	955	1,350	2,300	640	775	1,415	315	575	885
NHS Thurrock	1,105	1,425	2,530	740	815	1,555	370	615	980
NHS Castle Point, and Rochford	780	1,255	2,030	525	710	1,235	255	545	800
NHS Basildon and Brentwood	1,410	2,045	3,455	950	1,165	2,115	465	885	1,345
NHS Mid Essex	1,815	2,695	4,510	1,220	1,545	2,765	600	1,150	1,750
NHS North East Essex	1,620	2,340	3,960	1,085	1,325	2,410	535	1,020	1,550
NHS West Essex	1,540	2,095	3,635	1,045	1,205	2,245	500	895	1,390

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Current services prior to 1 November 2015

Up to 1 November 2015, health and care in Southend, Essex and Thurrock provides child and adolescent mental health services working in tiers 2, 3 and 4 as guided by the 1995 national policy, *Together We Stand*.

Highly specialised services
Tertiary level services for children and young people with the most serious problems.

Tier 4

NHS England Specialised Commissioning commissions tier 4 services for young people between the ages of 13 and 18. Services include some local inpatient services provided by NEP and SEPT and highly specialised services in London and elsewhere.

Specialist services
Multi-disciplinary services for more severe, complex or persistent mental health problems.

Tier 3

Service providers in north Essex:
North Essex Partnership University NHS Foundation Trust (NEP)
Provide, a community interest company
Colchester MIND - informal advocacy

Service providers in south Essex:
South Essex Partnership University NHS Foundation Trust (SEPT)

Targeted services in education, social care & health
Specialist practitioners in primary and community settings. Assessment, care and interventions for children and young people with emerging emotional health needs.

Tier 2

Service providers in north Essex:
Essex County Council (ECC)
Range of voluntary sector agencies

Service providers in south Essex:
South Essex Partnership University NHS Foundation Trust (SEPT)
Range of voluntary sector agencies

Universal services
Practitioners who are not mental health specialists, people working in universal settings such as schools, voluntary sector, primary care and general hospitals.

Tier 1

Variations in service provision

In Thurrock, tier 2 services are only available for children in care.

Tier 3 services in south Essex provide community based services for children up to age 18. SEPT also provides a children's learning disability service for children aged 5-12 with learning disabilities and mental health problems, and a crisis home treatment team providing assessments in two hospital accident and emergency departments.

Tier 3 services in north Essex provide community based services for children up to age 18. NEP also provides a community eating disorder service, a children's learning disability service for children aged 5-18 and a crisis outreach team providing intensive, home-based intervention and assessments in three hospital accident and emergency departments.

Other tier 3 services (provided by NEP and SEPT) include:

- Youth offending mental health workers seconded to Youth Offending Teams in each of the three local authority areas
- Support and joint assessment services with substance misuse services in Southend, Essex and Thurrock.

Partnership with specialised commissioning

Although tier 4 services are technically outside the scope of this transformation plan, we have worked closely with NHS England Specialised Commissioning to ensure coordinated and seamless care for children and young people that, wherever possible, avoids the need for tier 4 referrals.

Current access to services (prior to 1 November)

There are single points of access for referrals to tier 2 and 3 services in the Essex County Council area. NEP provides a single point of access for the three CCGs in north Essex and SEPT provides the single point of access for two of the CCGs in south Essex, both in partnership with Essex County Council.

These integrated gateways, provided by tier 2 and 3 clinicians, manage referrals and aim to avoid delays in assessment and treatment. As well as signposting referrers to the most appropriate mental health service, they offer expert advice and guidance to ensure the best possible response to children, families and practitioners.

Although referral processes in Southend and Thurrock have similar aims, they do not operate a formal single point of access (prior to 1 November).

Managing inequality

Essex as a whole is relatively affluent and the health of the population within Essex is significantly better than the England average. Southend and Thurrock are considered relatively deprived areas compared to other areas in the eastern region. In Essex, Harlow, Basildon and Tendring are the most deprived local authority areas with Uttlesford, Chelmsford and Rochford being the least deprived.

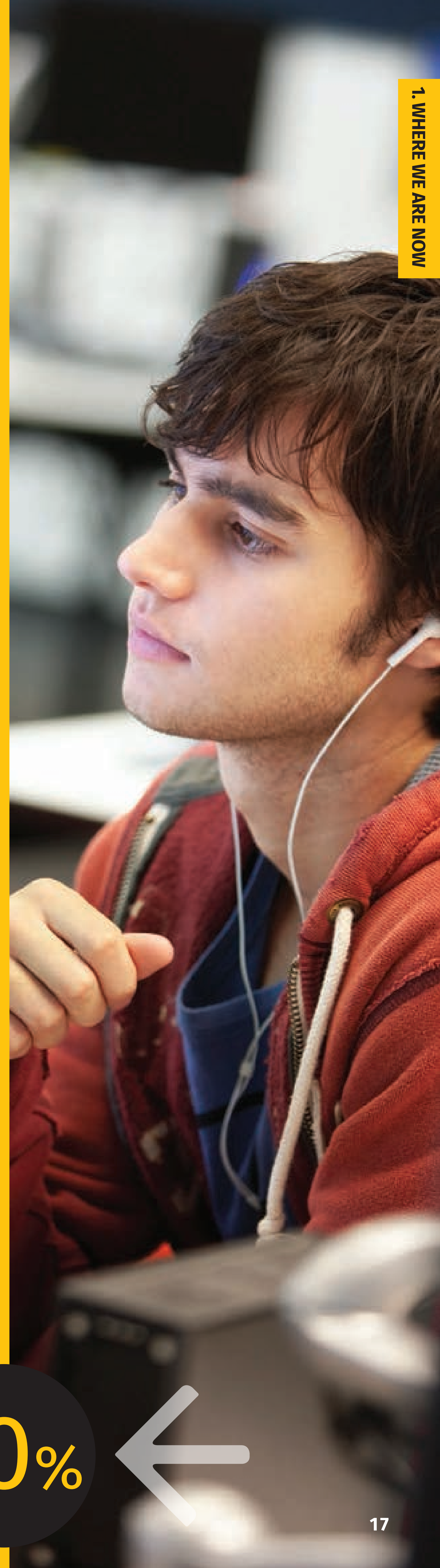
Our Joint Strategic Needs Assessment (JSNA) shows that around 15% of children were living in poverty in 2012 (Essex average) but there are higher rates in Harlow, Tendring, Basildon and Colchester. In Thurrock, around 20% of children live in low-income families and the under 16 child poverty rate in Southend is nearly 22%.

The links between deprivation and mental health problems are well documented nationally, with children in poverty around three times more likely to have mental health problems.

This inequality across our area is one of the main issues that we are addressing by moving from fragmented and variable services to a single integrated system of health and care.

Children living in **low-income** families in Thurrock

20%



Estimated prevalence of mental health problems in Southend, Essex and Thurrock

Broad indicators from national data

Ref. National Child and Maternal Health Intelligence Network

Nationally, nearly 10% of children aged 5-16 years have a diagnosable mental health condition and a further 10% have an emotional or behavioural problems requiring targeted support. These children will have a wide range of conditions including conduct disorders, self harm depression hyperactivity and less common disorders such as autistic disorders and eating disorders.

It is known that 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age 18. In addition, there are well-identified increased physical health problems associated with mental health. Mental illness in children and young people causes distress and can have wide-ranging effects, including impacts on educational attainment and social relationships, as well as affecting life chances and physical health.

The National Child and Maternal Health Intelligence Network (ChiMat) provides information on prevalence rates that enables us to estimate the number of children likely to have mental health problems in Southend, Essex and Thurrock. Some of the relevant estimates are as follows:

- 9.6% or nearly 22,420 children and young people aged between 5-16 years have a mental disorder
- 7.7% or nearly 9,225 children and young people aged between 5-10 years have a mental disorder
- 11.5% or approximately 13,205 children and young people aged between 11-16 have a mental disorder.

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children and young people who may experience mental health problems that need help from mental health services

CCG Area	Tier 1 (2014)	Tier 2 (2014)	Tier 3 (2014)	Tier 4 (2014)
NHS Southend	5,755	2,685	710	30
NHS Thurrock	6,105	2,850	755	35
NHS Castle Point, and Rochford	5,210	2,430	645	30
NHS Basildon and Brentwood	8,810	4,115	1,090	45
NHS Mid Essex	11,820	5,515	1,460	60
NHS North East Essex	9,825	4,585	1,215	50
NHS West Essex	9,760	4,555	1,205	50
Total	57,285	26,735	7,080	300

Source: Office for National Statistics mid year population estimates for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014). Kurtz, Z. (1996).

Estimated number of children between the ages of 5 and 16 in Southend, Essex and Thurrock who could have a mental health problem that needs specialist help.

22,500

ChiMat data also indicates prevalence rates for the most common disorders, which for Southend, Essex and Thurrock are as follows:

- 5.8% or approximately 13,475 children and young people per annum may have a conduct disorder
- 4.2% or approximately 8,670 children and young people per annum may have emotional disorders
- 1.5% or approximately 3,755 children and young people per annum may have hyperkinetic disorders, such as attention deficit hyperactivity disorder (ADHD).

***Appendix 1** provides information from ChiMat showing the prevalence of mental health problems by CCG area.*

The Essex Joint Strategic Needs Assessment (JSNA) for Children's Emotional Wellbeing and Mental Health includes further information on prevalence estimates for Southend, Essex and Thurrock.

Understanding more about the needs of vulnerable groups

Ref. Essex Joint Strategic Needs Assessment (JSNA) for Children's Emotional Wellbeing and Mental Health (2013/14)

All ten partners commissioned a Joint Strategic Needs Assessment in 2013 of the emotional wellbeing and mental health of children and young people in Southend, Essex and Thurrock. Examining the evidence of the needs of disadvantaged groups from previous reviews, the JSNA identified four main groups of children with a greater risk of developing mental health problems:

- Children with learning difficulties and disabilities, developmental disorders and children in residential schools
- Children in short stay schools
- Children on a child protection plan
- Looked after children in care

Ref. The Essex Child and Adolescent Mental Health Service (CAMHS) Strategy 2012-14

Examples of needs within these main groups:

Children with learning difficulties, disabilities and developmental disorders

National evidence suggests that children with learning disabilities are up to six times more likely to have mental health problems than other children; and more than 40% of families with children with learning disabilities feel they do not receive sufficient help from health and care services.

Using the ChiMat prevalence data, we have estimated the following numbers of children with both learning disabilities and mental health problems.

CCG Area	Children aged 5-9 yrs	Children aged 10-14 yrs	Children aged 15-19 yrs
NHS Southend	45	90	115
NHS Thurrock	50	95	115
NHS Castle Point and Rochford	40	90	120
NHS Basildon and Brentwood	65	145	175
NHS Mid Essex	90	195	240
NHS North East Essex	75	160	205
NHS West Essex	75	155	185
Total	440	930	1155

In 2014, only 11% of children in the Essex County Council area with special education needs (SEN) with behavior, emotional and social difficulties as their main category of need, had achieved a good level of development by age 5, compared with the Essex average of 61%.

Ref. 'Groups at risk of disadvantage: a JSNA topic report, Essex County Council, 2015

We also found that 12% of children known to Essex County Council mental health services also had a special education need.

Children on the edge of care and/or known to youth justice

Children and young people in the criminal justice system are more likely to experience mental health problems than their peers; and rates of psychosis, self-harm and suicide are higher for young people in secure facilities.

In Essex, around 33% of children and young people on the edge of care and known to the Essex Council Divisional Based Intervention Team (DBIT) were also receiving mental health services in 2014/15. This is a significant proportion, but the likelihood is that there are more young people in these groups who do not seek help from mental health services.

These young people may require assertive outreach and a coordinated response from skilled professionals.

Children in care and children with child protection plans

It has been found among children aged 5-17 looked after by local authorities in England that:

- 45% had a mental health disorder
- 37% had clinically significant conduct disorders
- 12% had emotional disorders, such as anxiety or depression
- 7% were hyperkinetic (e.g. with ADHD)

Children in care are more likely to experience mental health problems, frequently as a result of abuse, neglect, loss or attachment difficulties prior to coming into care.

Whilst the number of children in care in Essex has reduced in recent years, there continues to be a higher percentage of children in care and entering care aged 14 and over. In Essex in 2014/15, around 17% of referrals to Tier 2 mental health services were for children who were known to children's social care services.

Following the JSNA, there was deeper dive into Essex children and young people in residential care using data as at March 2015. This found that they were more likely to be young males (aged 15), and that 26% had a Statement of Special Education Need with a high proportion having behavioural and/or learning difficulties, including autism and Asperger's.

Other vulnerable groups

Our JSNA provides further information based on national evidence on a range of other factors known to put certain groups of children at higher risk of mental health problems, including:

- children who suffer bullying
- children with substance misuse problems
- teenage parents
- young offenders
- children with physical disabilities
- children with parents who have mental health issues
- children with parents who have substance misuse problems.

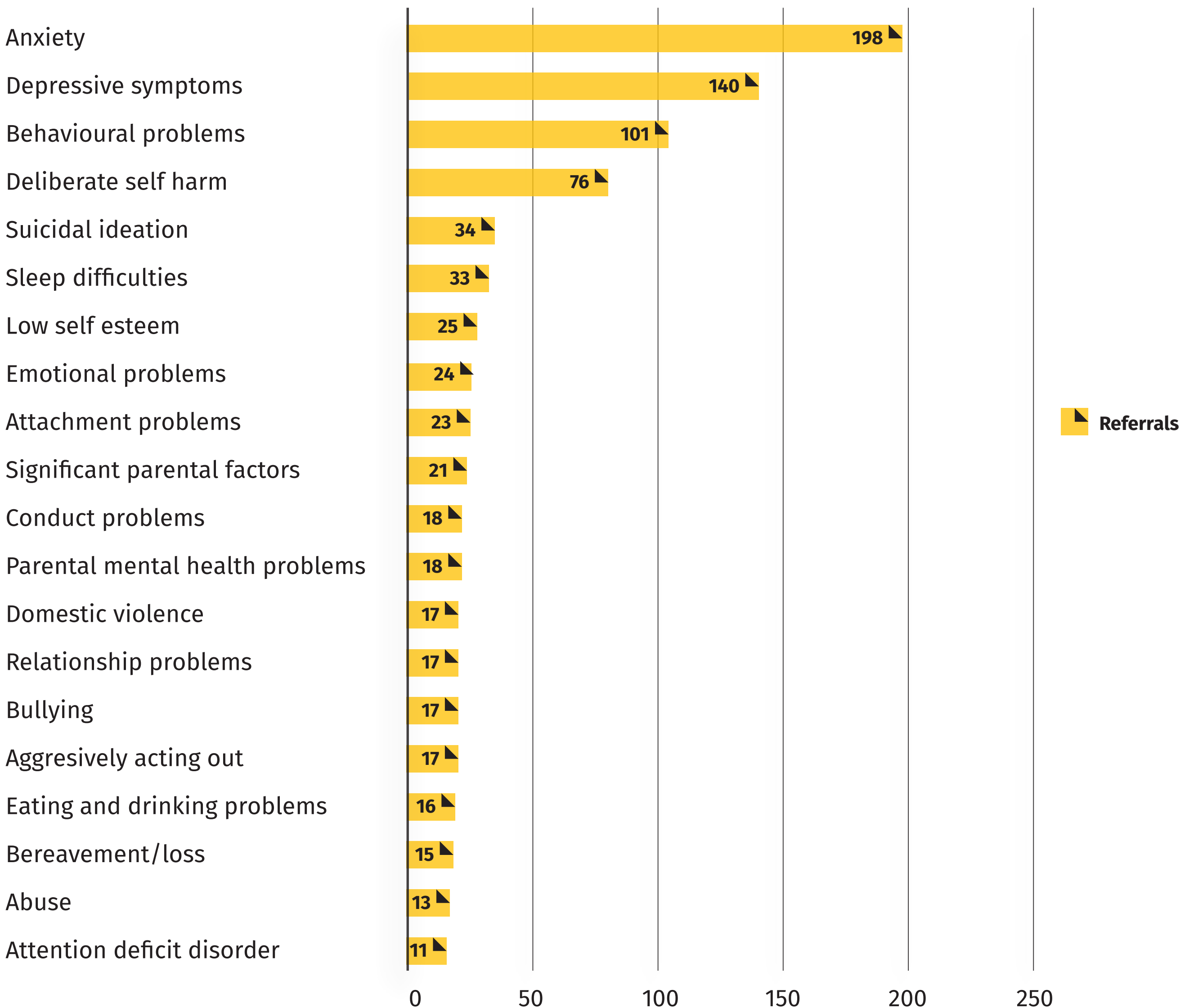
Given the potential impact of international conflicts, we are also monitoring the number of unaccompanied asylum seeking children arriving in Essex. These young people are likely to have experienced severe emotional trauma as well as physical health problems.

Needs indicated by presenting problems in Southend, Essex and Thurrock

Anecdotal reports from tier 2 services show the following strong themes:

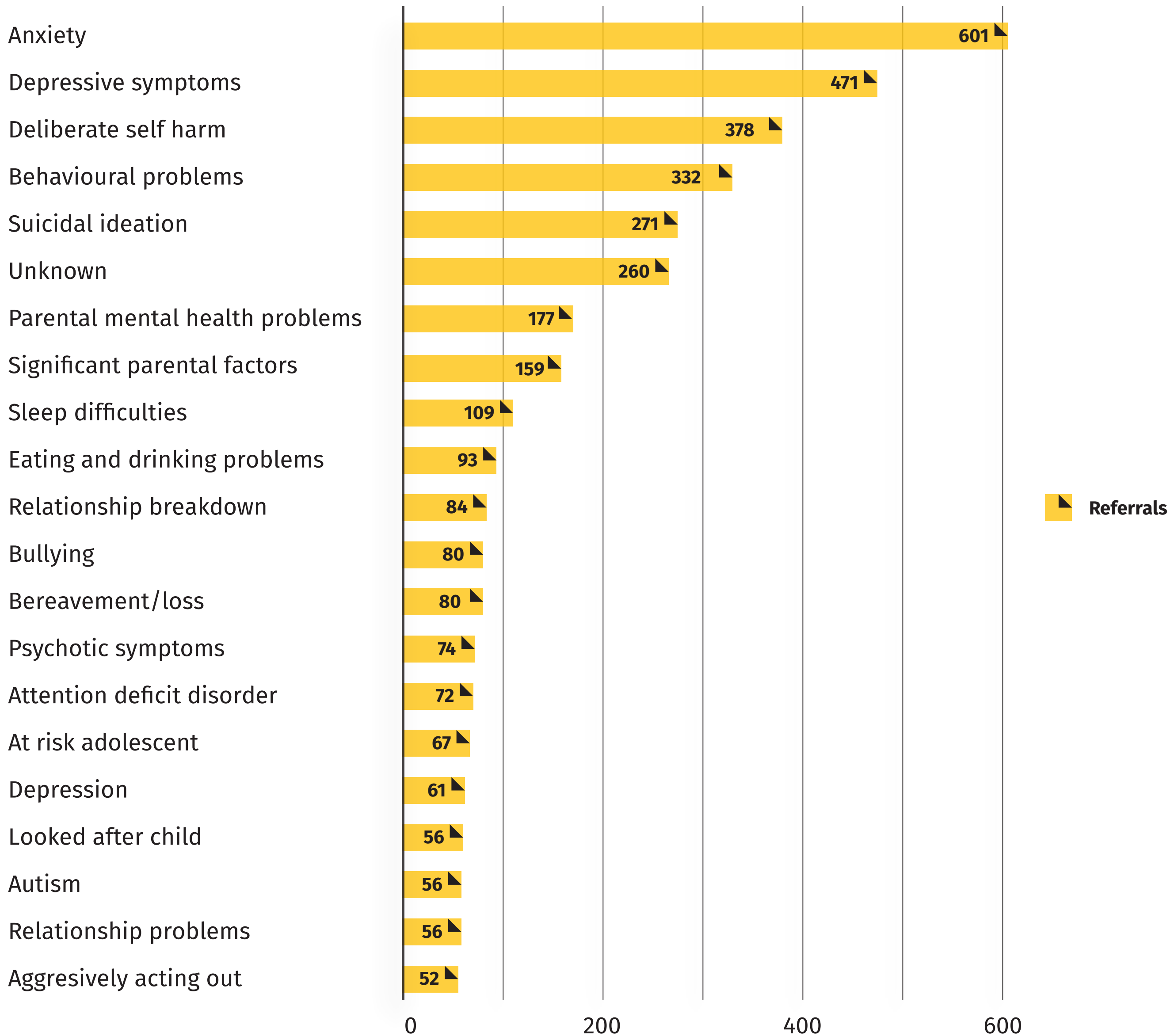
- Rising numbers of requests for advice and guidance from people who work with children and young people
- Increase in referrals for anxiety, including children avoiding or refusing to go to school.
- Concerns, particularly raised by school staff, about children and young people who harm themselves or think about suicide.

These themes are reflected in our snapshot information covering the period April to June 2014, as shown in the chart below:



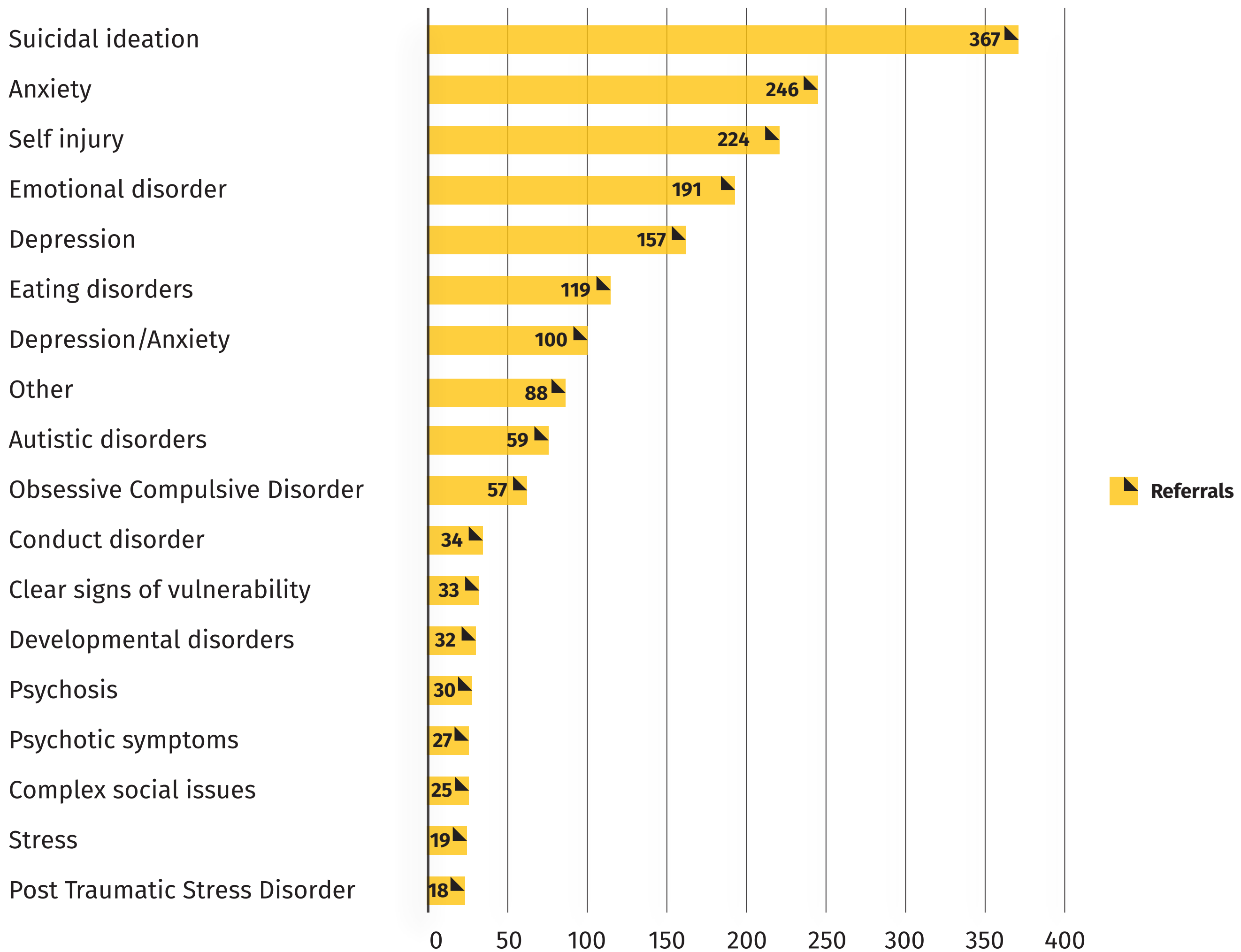
For tier 3 services, data is available from 2014/15 for SEPT providing services in south Essex and NEP in north Essex. The trusts use different methods of data capture and we have therefore kept the information separate overleaf.

Presenting problems for tier 3 services 2014/15 – data captured by SEPT



The data charted above shows that the main reason for referral to tier 3 is for anxiety, followed by depressive symptoms, deliberate self-harm, behavioural problems and suicidal ideation. This reflects national trends and, in discussion with colleagues in the voluntary sector, we are told that self-harm and anger management issues are on the increase.

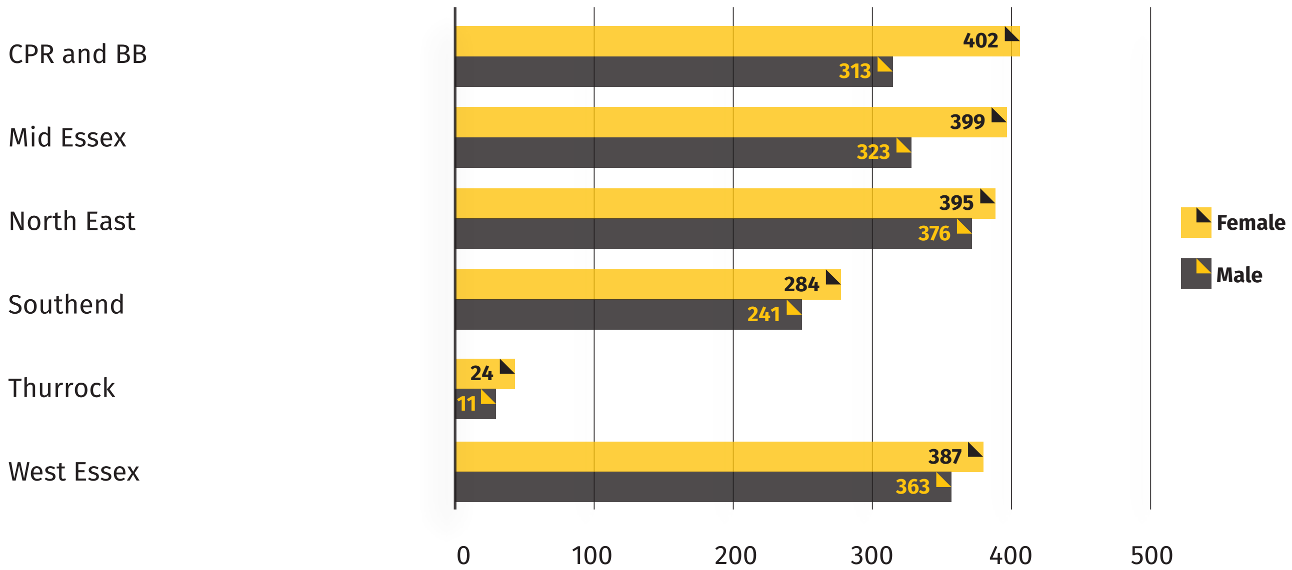
Presenting problems in tier 3 based on a snapshot relating to April to June 2014 – data captured by NEP



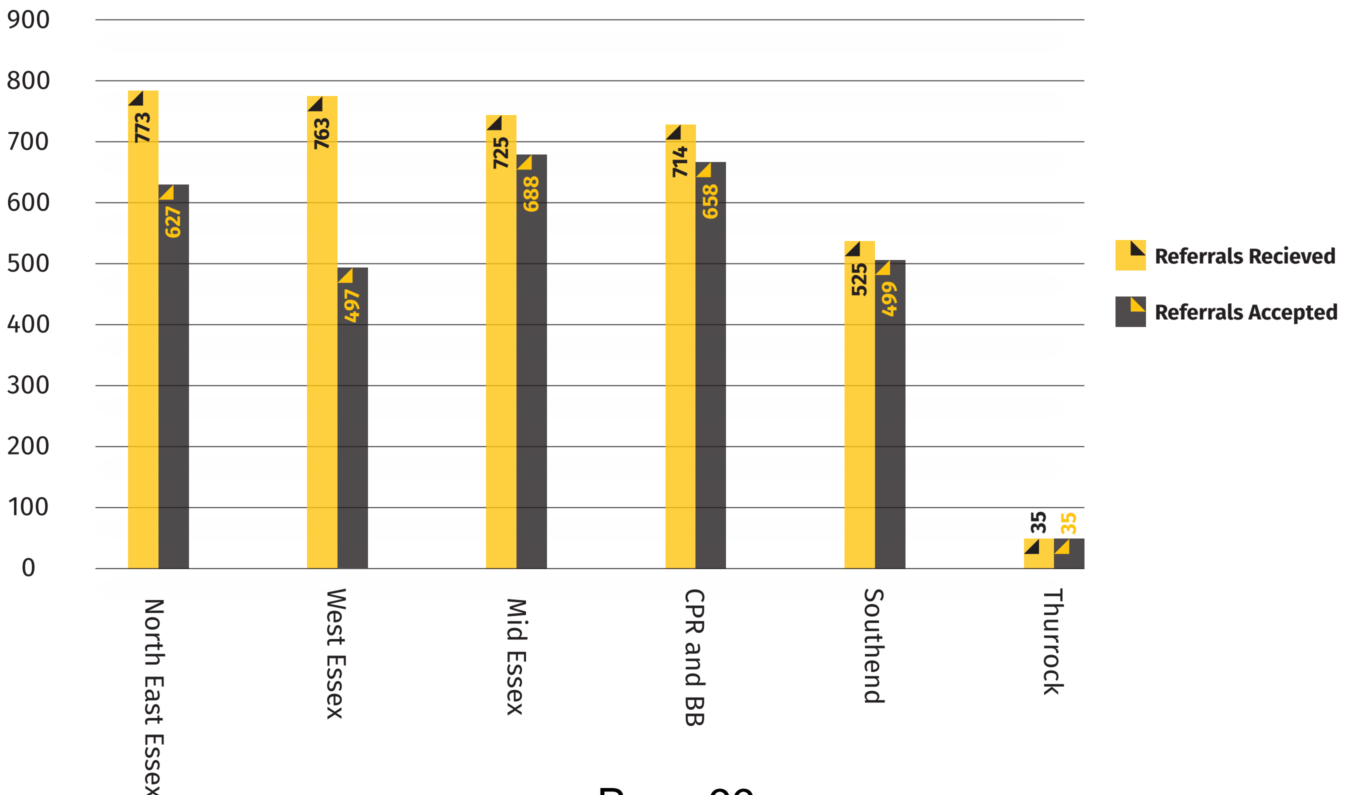
Again the data from north Essex, shows that the main reason for referral to tier 3 services is suicidal ideation followed by anxiety, self-harm, emotional disorders and depression.

Evidence from activity in 2014/15 in tier 2 services

The chart below shows a comparison of number of referrals to tier 2 services in 2014/15. Given that Thurrock has a growing population of young people, it is clear that we need to develop services in Thurrock.



The chart below shows the number of referrals received and the number accepted for tier 2 services in 2014/15, by CCG area.



The following table compares the recorded number of referrals accepted by tier 2 services against the ChiMat estimate of numbers needing a tier 2 service.

Actual referrals in 2014/15 appear to be extremely low in the light of expected demand. However, data quality is somewhat unreliable due to there being a wide range of independent sector service providers in tier 2 in Southend, Essex and Thurrock, for which we do not hold data. Even so, the information we have provides a strong indicator that we are not meeting demand for tier 2 services.

	ChiMat estimated numbers needing a Tier 2 (2014) service	Actual number of referrals accepted into the service	% of expected number
NHS Southend	2,685	499	19%
NHS Thurrock	2,850	35	1.2%
NHS Castle Pointand Rochford NHS Basildon and Brentwood	6545	658	10%
NHS Mid Essex	5,515	688	12%
NHS North East Essex	4,585	627	14%
NHS West Essex	4,555	497	11%

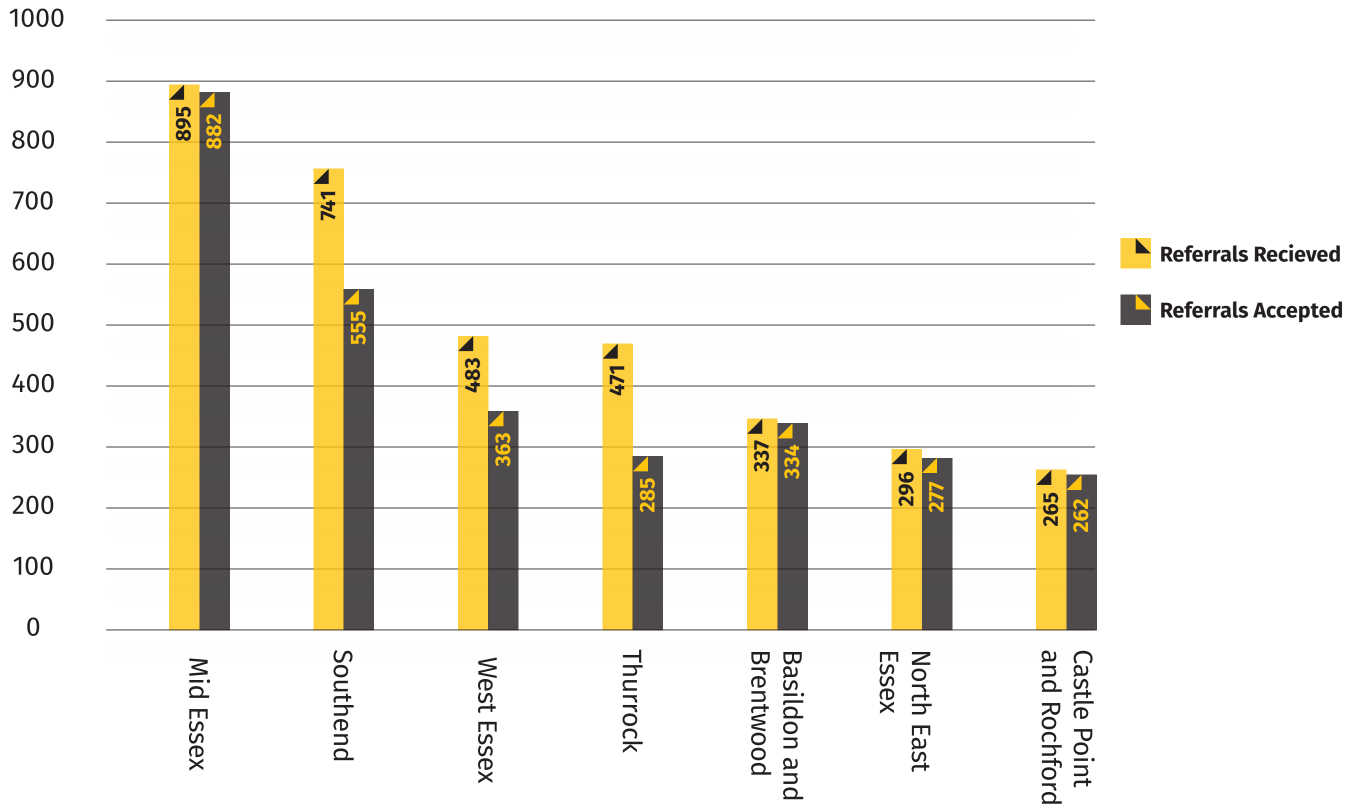
Comparing the data with our general knowledge of current services

In Thurrock, the low numbers accessing Tier 2 services are explained by the fact that services are restricted to children in care and children with highly complex mental health needs.

More generally, we know from listening to children, families and services that there are barriers to children and young people getting the help they need. There remains a stigma attached to mental health services and lingering associations with past institutions. The fragmentation of services makes it difficult to see know is available and difficult to gather reliable data on how families are using them.

Evidence from activity in 2014/15 in tier 3 services

The chart below suggests significant variation across Southend, Essex and Thurrock in terms of the number of referrals accepted compared with the number received.



The figures for Southend and Thurrock are low at 75% and 61% respectively. One reason, may be that there are currently no formal Single Points of Access in Southend and Thurrock. Evidence locally and nationally shows that Single Points of Access improve the quality of referrals.

Currently, we have no clear information to explain why only 75% of referrals received are accepted in West Essex.

The table below showing actual referrals accepted by tier 3 services compared with ChiMat estimates also suggests wide variation across Southend, Essex and Thurrock.

	ChiMat estimated numbers needing a Tier 3 (2014) service	Actual number of referrals accepted into the service	% of expected number
NHS Southend	710	555	78%
NHS Thurrock	755	285	38%
NHS Castle Point, and Rochford	645	262	41%
NHS Basildon and Brentwood	1,090	334	30%
NHS Mid Essex	1,460	882	60%
NHS North East Essex	1,215	277	23%
NHS West Essex	1,205	363	30%
Total for Essex	7080	2958	42%

The ChiMat data gives us an indication of need. The % figure suggests the level to which we are responding to need. In Southend, the data suggests that we are meeting apparent needs by 78%, in Mid the level is at 60%. The figures for the other CCG areas appear very low. This may be down to data quality and needs further investigation.

Further information on activity in eating disorder services and tier 4 services is included in ***appendix 2****.*

Inequities in current services (prior to 1 November 2015)

In levels of current services prior to 1 November 2015, there are wide variations because of historic commissioning arrangements.

Our transformation plan addresses these gaps in service, such as:

- Eating disorder services are only available in north Essex
- The tier 2 service in Thurrock is currently only available to children and young people in care
- There is no independent informal advocacy service for children and young people in the south of the county
- Specialist services for children and young people with learning disabilities in the south are limited to those who have co-morbid mental health needs, and only provide support for children up to the age of 12.

The next section summarises our analysis of service gaps and where we are aiming for transformational improvement.

Unmet needs and gaps in services

Data quality

One of the main findings from our JSNA in 2013/14 was that there was a wide variation in type and quality of information, a need in itself to be addressed as part of our transformation plan. For example, it was not possible to achieve a clear understanding of the full extent of tier 2 services and whether the proportion of children and young people who might need tier 2 interventions actually receive these services.

Unmet needs identified by local stakeholders

The JSNA process included interviews, consultation events and written submissions from a range of people working with children and young people. It also took into account previous feedback gathered from children, young people, parents and others to inform the Essex CAMHS strategy.

Consistent themes from feedback were:

- Consensus about the need for early intervention, both in terms of the stages of problems and stages of life
- The need to work with families, not just the child
- A need for more support for schools, such as:
- Training and support for school staff
- Clear information about the range of resources available for schools to use
- Better links between mental health service and schools e.g. through clear referral criteria.

What children and young people say

When asked about mental health services, most of the feedback from children and young people is about accessing services and what can be done about helping people to feel it's OK to get help. This comes out strongly from the 2013 Joint Strategic Needs Assessment and echoes again in 2014 when Healthwatch Essex went out to find out what young people feel about health and care.

The main feedback themes from children and young people:

People **don't know enough** about **mental health** or the **services** available. We need to **raise awareness** and understanding.

Support in schools was the most **popular** choice of **comfortable places** to get help.

There is still a **strong stigma** attached to mental health problems. We need to **reduce** this moving away from **institutional style services** and putting more support into **familiar** and **friendly settings**.

Some of the relevant findings from the **Healthwatch Essex YEAH! Project**

8 in 10 young people did not know how to get mental health support

9 in 10 wanted to learn about mental health

Some suggested that learning about mental health should be mandatory in schools, like sexual health and drugs

Many observed that people need help for self-harm and eating disorders

Young people who had tried to get services had waited too long

Some described the place they went to for help as unfriendly and not in tune with their situation or needs.

"My best friend has an **eating disorder**, and was **treated badly** in school. We were **never taught** about eating disorders, and therefore she **never spoke to anyone** and was eventually admitted to hospital. My school dealt with her **badly** when she returned. If we had been **taught** about it, maybe it wouldn't have become such a problem for her if she knew **who to talk to**."

"I was **scared** about getting help (the **tiny amount** of help that was available), so **no-one knows** and my issues could still continue. It would be a lot better if everyone was **aware**. Everyone should be **informed**."

"I have experienced **self-harm**, **depression** and maybe other mental illnesses. I decided to get **counselling**, but I **didn't know** where to go."

YEAH stands for Young Essex Attitudes on Health and Social Care. For further information, visit: **http://www.healthwatchessex.org.uk/wp-content/uploads/2015/03/The-YEAH-Report-Healthwatch-Essex-March-2015.pdf**

What parents say

As with children and young people, the main concern was access to help when needed and concerns about stigma.

Parents of children who had experienced mental health problems talked about the need for wider understanding, particularly at school and when dealing with other services, such as emergency services. They appreciated help by way of counselling, being listened to and developing coping strategies.

"We need **better communications** with staff. Sometimes staff need to feel more **confident** about being able to **help** families."

"People need to be **prepared** to deal with **mental health problems** in A&E and other services."

Key issues raised by non-specialists and universal services:

Feedback from people who work in education, health and care has come from several sources over the last two years, but the main themes are broadly the same throughout the range of discussions.

- Difficulties in accessing services
- Lack of clarity about referral criteria
- Better information and signposting
- Need to develop skills to enable early intervention.

Consistent views on service gaps included:

- General lack of capacity to do early intervention
- Need to empower children, young people, families and carers to help themselves where safe and appropriate, using good information and technology
- Behaviour management, notably help to manage violent behaviour at home
- Services for children with learning disabilities
- Lack of clear pathways for disorders on the autistic spectrum and ADHD
- Limited services for children with development disorders
- Children in care being unable to access services until they are in a settled placement
- Support and transition for young people who continue to need services as adults, including for some vulnerable groups of young people such as care leavers.

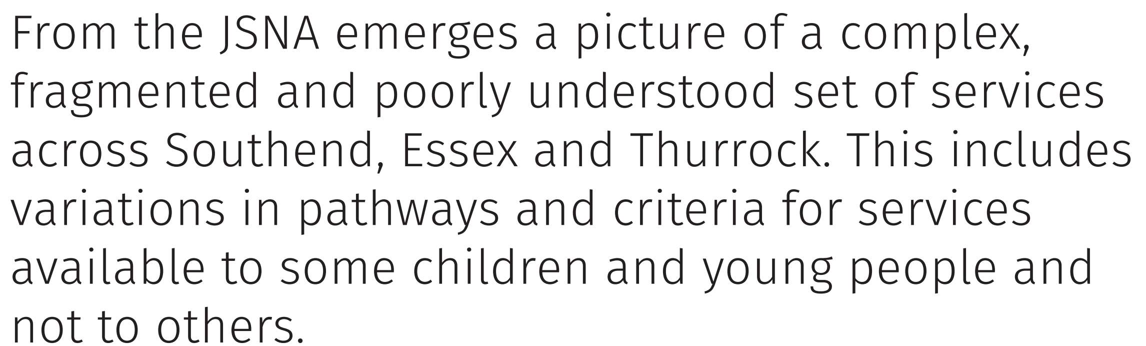
Those who work with children and young people see a need for services to be more joined up, for example between psychiatrists and paediatricians, between the NHS and local authorities and between schools and mental health services. They describe lower levels of need as an area that needs attention, where there is inconsistency, least clarity about what support is available and how it should work. There is a strong agreement that more support is needed in schools, such as training for staff, information about available resources and better links with services, so that schools can access support and advice.

Suggestions for improvements included:

- Better service mapping and awareness of available services
- Clarity on referral criteria and better feedback with referrals that are rejected
- More opportunities for information, advice and guidance before making a referral
- Training (e.g. emotional first aid training) for non-specialists and universal services including in schools and children's centres
- Development of relationships and joint working arrangements between services.

Summary of findings

It is important to note at this point that feedback from the JSNA and from our further engagement as part of the procurement process in 2014/15 does include many positive comments about current services and few concerns raised about the quality and outcomes of existing services. However, for planning purposes, we are concentrating on unmet needs and areas for improvement.



From the JSNA emerges a picture of a complex, fragmented and poorly understood set of services across Southend, Essex and Thurrock. This includes variations in pathways and criteria for services available to some children and young people and not to others.

One example of inequality, is the availability of eating disorders services in north Essex but not in the south.

The complexity of the system, lack of clarity and lack of awareness of services is undoubtedly part of the reason why our level of referrals to tiers 2 and 3 overall is much lower than the nationally estimated number of children and young people that may be in need of services.

Among the findings of the JSNA, it is notable that, from feedback across the board, the key priorities for improvement were:

- Early intervention, both in terms of problems and stages of life
- Work with families, not just the child
- More support for schools

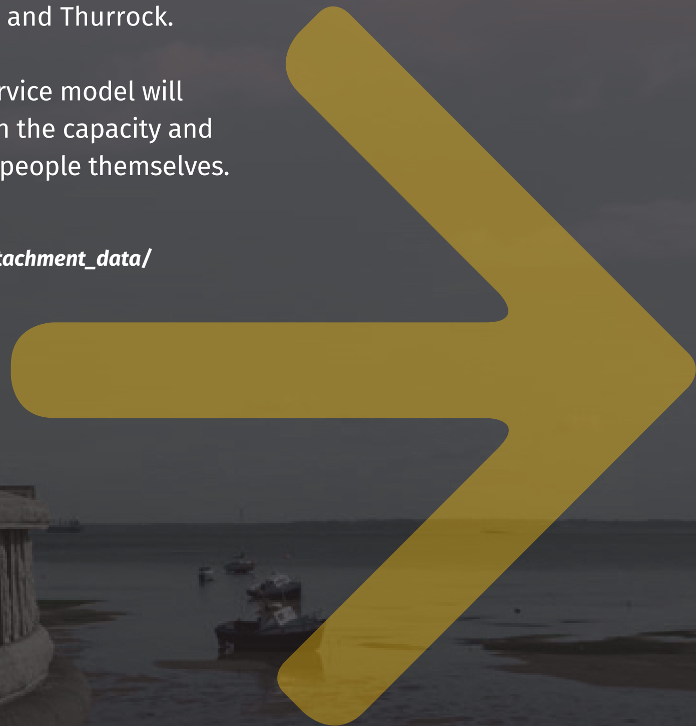
Among the main recommendations of the JSNA:

- There is a need for all ten Essex commissioners to understand the full extent of provision and support in schools
- Non-specialists need better information and clarity around access to services
- The provision of tier 2 services seems to cause the most concern amongst professionals. These are possibly the most fragmented services currently, making it difficult to achieve the full potential of early intervention.

Set against the national context, in particular the findings and recommendations of *Future in Mind*, we have already drawn our conclusions that our services should be radically transformed from a traditionally reactive service to one that invests in effective prevention and support. Our response, even before the publication of *Future in Mind*, was to design a new service model that would realise our common vision for the emotional wellbeing and mental health of the children and young people of Southend, Essex and Thurrock.

In the next section, we summarise what the new service model will look like and how we intend to expand and invest in the capacity and capability of both services and children and young people themselves.

Ref Future in Mind
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf



SUMMARY TRANSFORMATION PLAN

How we will transform over the next five years...

Improve access and equality - with a single integrated service across Southend, Essex and Thurrock

Build capacity and capability in the system – with additional resources, staff development and a unified, coherent network of services

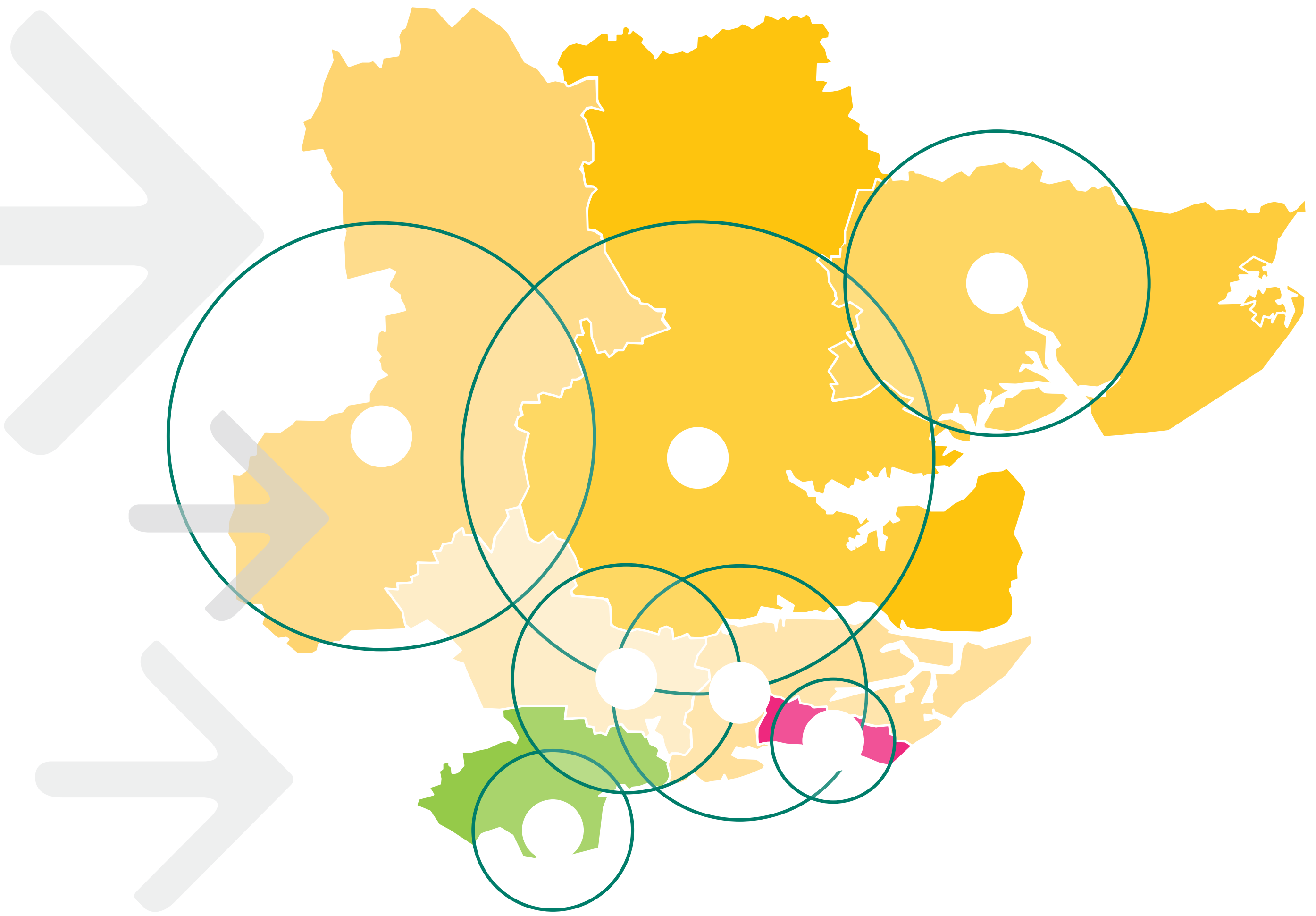
Build resilience in the community – through support for self-help, stronger partnerships, agreed protocols and a rolling training programme for those involved in protecting children and young people.

What drives our plan - six principles

1. **Early action** – avoiding and preventing mental health problems
2. **No judgement, no stigma** – with care that is right for each individual, delivered in safe places and with children and young people having a say in decisions
3. **Support for the whole family** – with care as a part of daily life, backed up by professionals and specialists when needed
4. **Inform and empower** – with information there for everyone and simple to access, providing the tools for self-care and resilience, as well as recovery
5. **Joined-up services** – efficient, effective and clear for all to understand
6. **Better outcomes** – through evidence-based care and listening and responding to feedback

Moving to a new single integrated service

On 1 November 2015, we are changing from the traditional tiered services delivered by four main providers (Essex County Council, SEPT, NEP and Provide) to a single integrated emotional wellbeing and mental health service for children and young people across Southend, Essex and Thurrock.



Support in daily life	Help from local services	Expert help from specialists	Help in a crisis
Information and advice for children and young people, available from our website and places in the community Information and advice for parents and carers Training and support for schools and others	Services working with families at home Services in schools, GP surgeries, community and children's centres Evidence-based interventions and therapies for children, young people and families A confident and empowered children's workforce	Specialist help for long-term and serious problems Joined-up services for several problems Referral to more specialised services	Fast response with support at home Links with other emergency services Overnight and short stays in specialist services, if needs be

Transformation at scale

Our transformation starts on 1 November with a transition from four previous providers to a single provider for Southend, Essex and Thurrock.

Year 1

In year 1 (2015/16) –
we will mobilise and embed the new service, using some funds non-recurrently to support transition, a further needs assessment, reviews and pilots for full implementation in years 2 and 3. We will develop proposals for a new eating disorder service.

Year 2

In year 2 (2016/17) –
we will invest in workforce expansion and development. We will continue and complete reviews.

Year 3+

In years 3, 4 and 5 –
we will continue to develop new and better services in response to our findings from a more detailed needs assessment and service reviews from year 2.

Commissioning as one across 10 agencies

The commissioners, the three local authorities and seven NHS clinical commissioning groups, have joined together to form a single "Commissioning Forum". This is a legally binding partnership that makes one body responsible for planning and funding mental health services and care for children and young people in Southend, Essex and Thurrock.

The new single service provider

Together with children and young people, schools and other partners, we have agreed a unified service model – the **Emotional Wellbeing** and **Mental Health Service for Children and Young People of Southend, Essex and Thurrock**.

In 2015, we completed a major procurement to select North East London NHS Foundation Trust (NELFT) as our single provider, on the basis of an outstanding bid.

NELFT will take over from 1 November 2015. Following the transfer of staff and services from the current four providers, NELFT will work with staff to develop new roles, new structures and protocols to become fully operational as the new model by 1 April 2016.

What the new service will look like

From 1 November, services will no longer be operating as a tiered system with several different organisations.

It will work as one organisation with local teams managing a range of services.

Open up, Reach out – what the transformation will mean for children and young people

- To begin with, the right kind of support should be there for children and young people in daily life - people will have a better understanding of the risks to mental health and how to cope.
- Families and professionals will be able to find out where to get help quickly and easily and have the support and tools they need for self-help.
- Where extra help is needed, services will be ready to step in at an early stage, in convenient, friendly places where young people feel safe, listened to and respected.
- Workers within services will have the confidence and skills to understand needs early on and give the right support.
- Children and young people will have a say about their own care and in the design and development of services.
- Expert help for long term and serious problems will expand across Southend, Essex and Thurrock.
- Experts will be ready to act quickly in a crisis, whenever and wherever that may be.

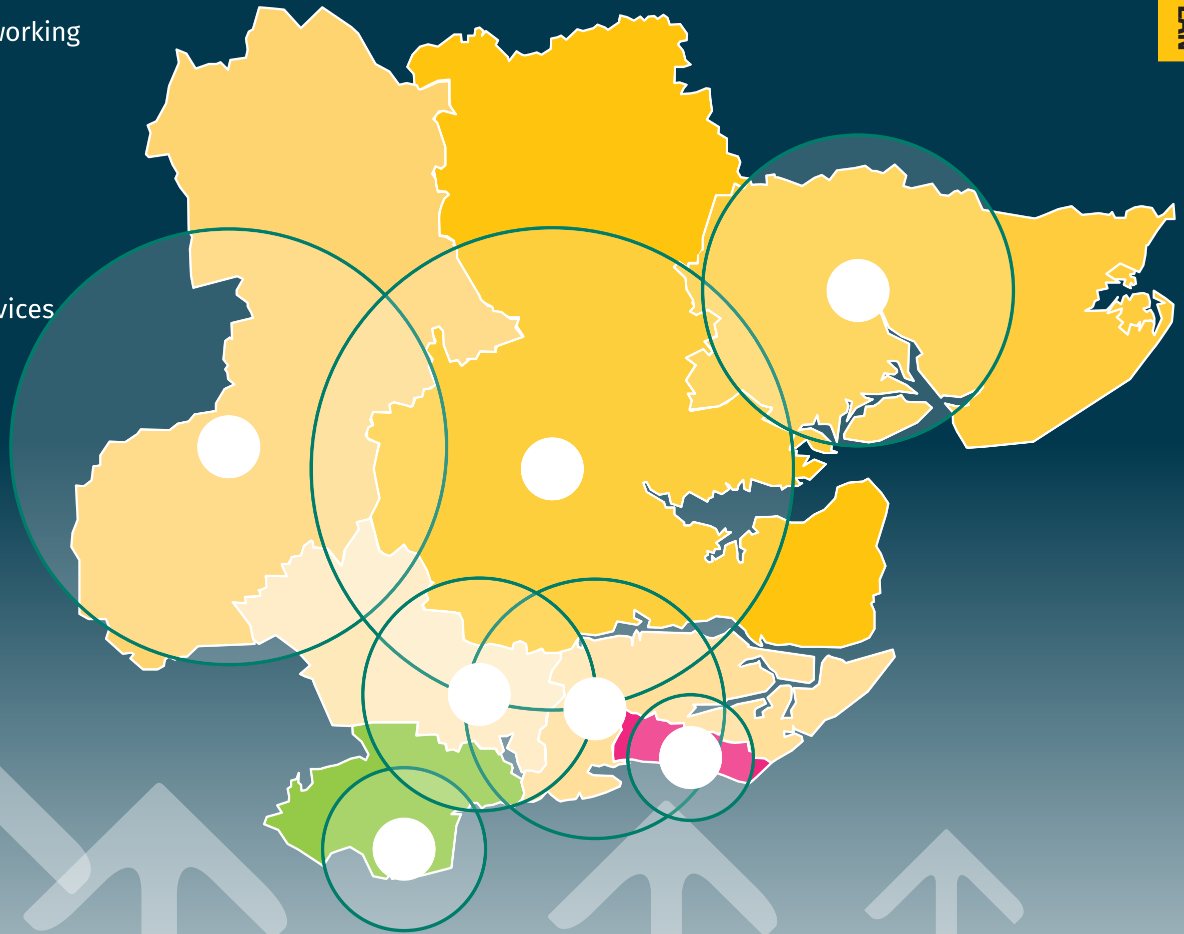
We will achieve this vision by building system resilience to respond to needs, community resilience to build collective responsibility and individual resilience to cope with the challenges that life brings.

Information, support and services from seven locality teams

The seven locality teams will have a base, but they will work out in local communities with children, young people and their families at home, in local schools and children's centres, at GP practices and in other familiar and convenient places.

They will build strong working relationships with;

- Schools
- Public health
- GPs
- Pharmacists
- Children's centres
- Children's health services
- Police
- Youth justice teams
- Services for substance misuse and a range of local voluntary organisations.



Support in daily life

Support at home, at school and in other familiar places

Back-up from information, advice and training and support for people who work with children and young people.

Help from local services

Range of evidence-based interventions for mild to moderate needs, including psychological therapies (IAPT) and brief interventions.

One to one, professional support for families

Assessment, care plans and review

Expert help from specialists

Services to meet severe and complex needs, suicide prevention, help for self-harm

Anxiety disorders, challenging behaviour

Eating disorders

ADHD

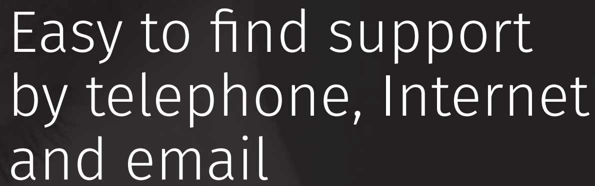
Learning disabilities

Help in a crisis

Fast response teams, available 24 hours a day to work with children and families at home to avoid a hospital admission.

On call for accident and emergency units and police.

Goals for **children** and **young people** and **families**



- Easy to find support by telephone, Internet and email
- Easy to get to services and convenient opening times
- Services in a safe place, no stigma
- Services that are responsive in the right way for you
- Guaranteed standards
- Immediately available information and advice
- Connections with other services and shared information with your permission
- Support for all the whole family

Goals for the **system**

- Whole family approach
- Whole system approach
- Skilled and confident workforce
- Early intervention
- Evidence-based interventions
- Measurable outcomes and improvement
- Better use of resources, less duplication
- Smooth transition between services and specialists
- Reduced demand on emergency and specialised services

Measurable outcomes

The specification for the new service includes measures and key performance indicators (KPIs) to monitor progress against the following outcomes:

1. Improvements in mental health for children and young people in Southend, Essex and Thurrock, using better methods to monitor and measure our progress
2. A joined-up system with no barriers
3. Reduction in inequality - no discrimination, no stigma
4. Easier access to services with shorter waiting times
5. Other services working with children and young people are enabled to promote and support good emotional wellbeing and mental health
6. Better advice, support, training and guidance for parents, teachers and others
7. Fewer visits to A&E
8. Priority for assessment of children and young people from vulnerable groups, including proactive outreach
9. Young people aged 14-25 to get the right support and, if necessary, a smooth transition to adult services
10. Opportunities for children and young people to influence services, not just for their own care but also as part of collaboration between services and young people

Page 118

Month by month improvements in mental health and services

In the past, it has been difficult to measure how we are doing. Different organisations have grown up with different ways of recording information. Until now, there has been no common data set to give a clear picture. New systems in year 1 will provide better monthly reports on outcomes in year 2 onwards.

Measures of progress are built in to every service and treatment, including feedback in real time from children and young people. The new model will use a system called ICAN to capture this information. Children and young people will have the evidence to see their own recovery and monthly monitoring will have a consistent and in-depth quality.

Improving access

In year 1, we will check monthly performance against national standards, including waiting times. Over time, we have agreed to broaden thresholds to support more children and young people. By April 2016, we will have new targets for improving against local as well as national access and waiting times.

PRIORITIES FOR ACTION

Our top priority for year 1 (November 2015 to April 2016) of our transformation plan is to manage a safe transfer to the new Emotional Wellbeing and Mental Health Service for Children and Young People

From year 2 onwards, we will roll out developments to tackle unmet needs and service gaps in order to:

- Improve access and equality - with a single integrated service across Southend, Essex and Thurrock
- Build capacity and capability in the system – with additional resources, staff development and a unified, coherent network of services
- **Build resilience in the community – through support for self-help, stronger partnerships, agreed protocols and a rolling training programme for those involved in protecting children and young people.**

Further needs assessment – a “deeper dive”

Building on the previous Joint Service Needs Assessment, we intend to commission a deeper dive needs analysis during 2015/16 to inform years 2 to 5 of the plan. There is a paucity of quality assured local data and much of the information that we have so far is an extrapolation of national data, which simply offers an indicative assessment.

Our targeted needs analysis will reflect locality specific issues and provide a richer local picture of risk factors and vulnerable groups. It will identify vulnerable groups and also develop our knowledge map of services and resources throughout our communities.

Investment

Currently, we spend just under £14 million in total per year on emotional wellbeing and mental health services for children and young people in Southend, Essex and Thurrock.

***Appendix 3** shows baseline investment for 2014/15.*

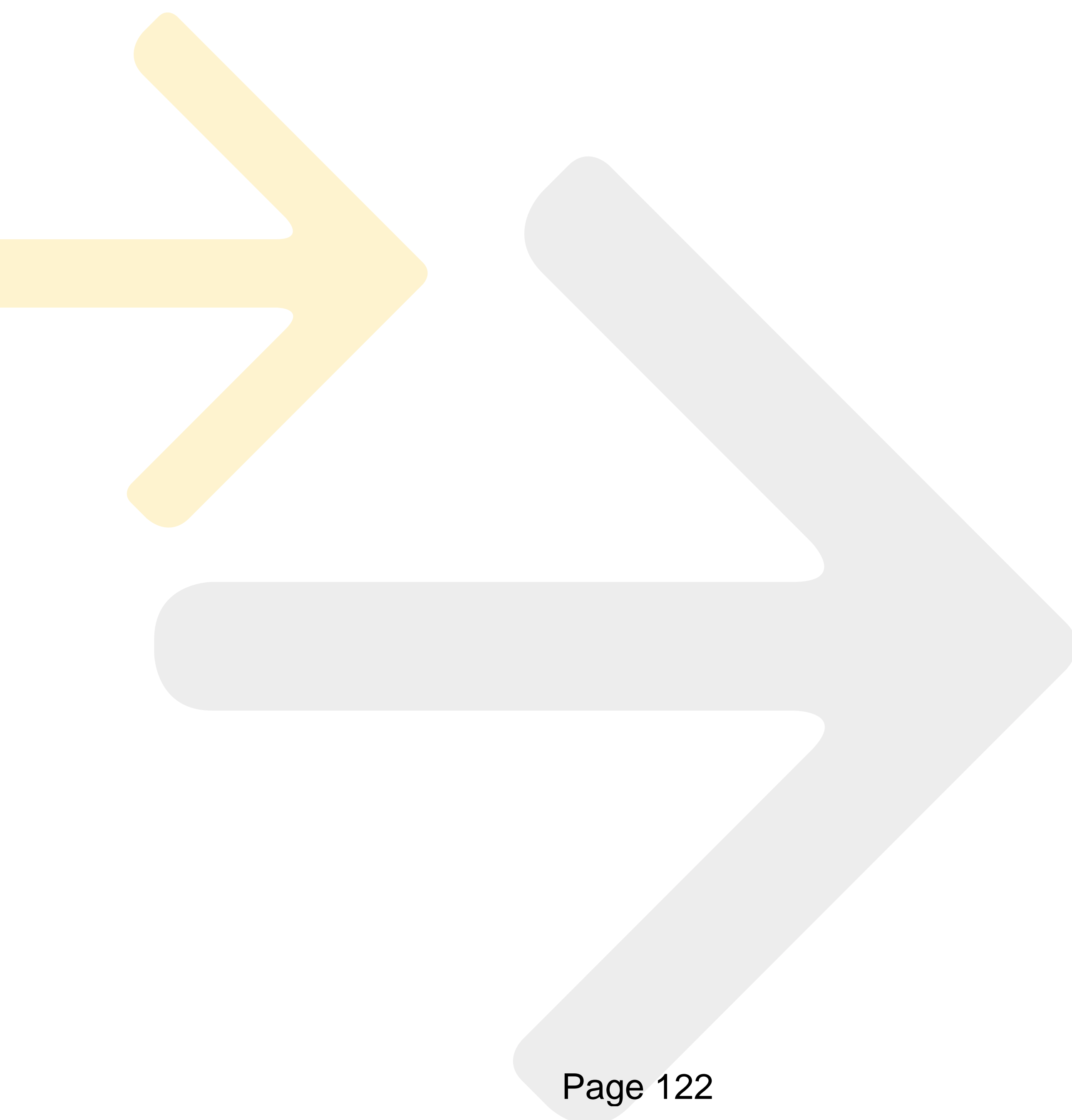
The new service will start on 1 November with an initial cost of £13.2 million per year, but, on the basis of this transformation plan, we are anticipating an additional £3.3 million to be invested in new services as follows:

Recurrent costs

Action	£
Improving access and equality	
Enhanced crisis services to cover 9am-9pm, 7 days a week across Southend, Essex and Thurrock	190k
More staff in crisis teams to provide emergency care at home	241k
Expansion in services for eating disorders	953k
More staff in local teams to improve single points of access	144k
Building capacity and capability in the system	
More medical cover with five new junior doctor posts. This will increase our ability to support children and young people with special educational needs and complex needs	208k
More senior clinicians in psychological services	76k
More practitioners in psychological services	421k
More staff in locality teams to respond to low to moderate needs	598k
Extra management capacity	104k
Training for therapy services (children and young people’s IAPT)	100k
Building resilience in the community	
Support and training for schools	100k
Support and resilience training in the voluntary sector	210k
Total	**3.34m**

Non-recurrent costs in 2015/16

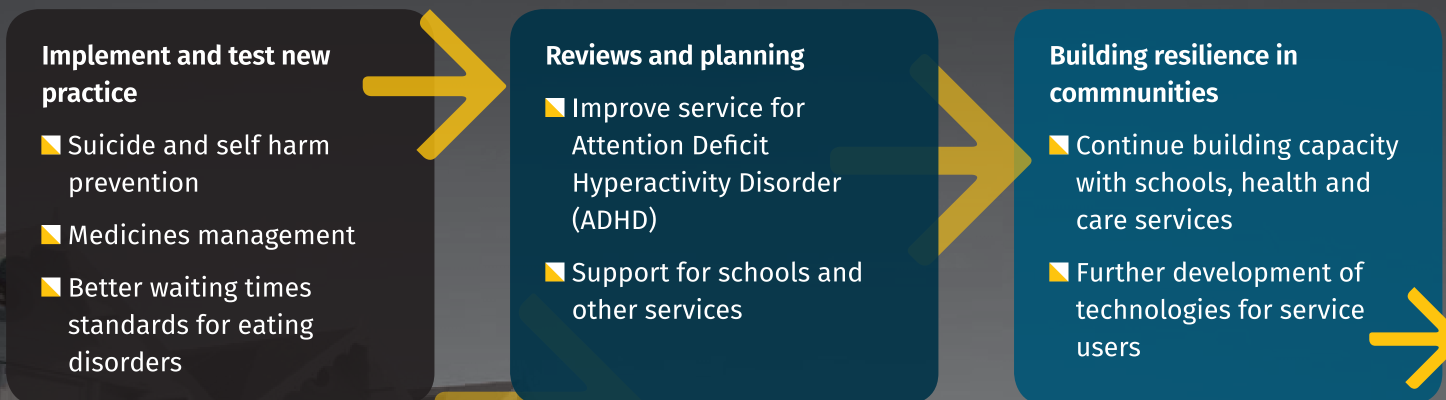
Item	Cost
Publication of the transformation plan, with an accessible version for young people	£15k
Engagement with children and young people	£115k
Needs assessment "deep dive"	£150k
IM&T infrastructure	£175k
Programme management office for transition	£142k
Medicines management review	£50k
Suicide and self harm audit and training	£100k
Locality partnership development sessions	£21k
Total	**£768k**



Years 1 and 2 - Transition to the new service

During Year 2 – Transformation in 2016/17

Year 3 and beyond



IMPROVING ACCESS AND EQUALITY

Single points of access – "one way in" to better information, support and services

There are three single points of access, one for each local authority area.

These single points of access deal with referrals from people who work with children and young people and all general enquiries.

The teams' job is to review each referral and set up an assessment or respond with information and guidance, if that's what is needed, including signposting to other services and resources in the local community.

With the introduction of the new single service from 1 November, expert advice and guidance will be available from clinicians in the Single Point of Access for any child, parent, schools worker or health and care worker. We expect to see a consistent approach to responding to need, using the full range of resources available in the community and improved access to support for those who need help from the new service.

Improving crisis services

Currently, children have access to mental health services 24 hours a day, but there are inconsistencies across Southend, Essex and Thurrock in the way that services respond to crises. For example, while teams in both the north and south of Essex are able to do emergency assessments, usually in hospital A&E departments and paediatric wards, actual crisis intervention and home treatment is only offered in north Essex.

Our new model of care will be much better placed to intervene in a crisis at the earliest possible stage. The aim is to offer intensive treatment at home or wherever a young person needs help, rather than having to go into hospital or a specialised service.

A review of crisis resolution and home treatment by the national Joint Commissioning Panel for Mental Health concluded that evidence showed:

- A reduction in repeat admissions after the initial crisis where children and young people were supported in their own home.
- A positive impact on family burden and in general a higher satisfaction with the quality of care.
- Sustained improvements in mental state after a 3 month follow-up.

We plan to enhance the current crisis services with additional, trained and experienced staff. The service will work 9am-9pm, 7 days a week across all localities in Southend, Essex and Thurrock.

See ***appendix 2*** *for further information showing current crisis referrals in Southend, Essex and Thurrock during the period April 2014 to March 2015.*

Crisis Care Concordat Mental Health

The Mental Health Crisis Care Concordat sets out how organisations work together to avoid crises in the first place and deal with them in the right way when they happen.

A commitment to improve crisis services for children and young people is already written into the action plans for the three Concordats for Southend, Essex and Thurrock and linked to this transformation plan. This will help to improve our common understanding of what children and young people with behaviour and mental health problems might need should they run into extreme difficulties, with the aim of avoiding a visit to A&E or an admission to hospital.

Commissioners for children's and young people's mental health services are represented at monthly meetings of the concordat working groups and will continue to manage developments and interdependencies.

Improving Access to Psychological Therapies (IAPT) for children and young people

Ref. Children and Young People's IAPT
http://www.cypiapt.org/children-and-young-peoples-project.php?accesscheck=%2Findex.php

A national transformation project

Improving Access to Psychological Therapies (IAPT) is a transformation project run by NHS England. It offers training and development for all staff working in mental health services for children and young people, to promote evidence-based interventions and measurable outcomes.

IAPT changes the way clinicians work with children and young people, enabling a more personalised approach that is clinically more effective. The training improves skill and knowledge in evidence-based interventions. It introduces new ways to involve children and young people in decisions about their care. It offers a way of recording outcomes session by session.

For a child or young person receiving treatment, it will be possible to see how things are improving. This becomes crucial for rapid recovery and reduces the risk of either stopping therapy too early or keeping young people in therapy longer than necessary.

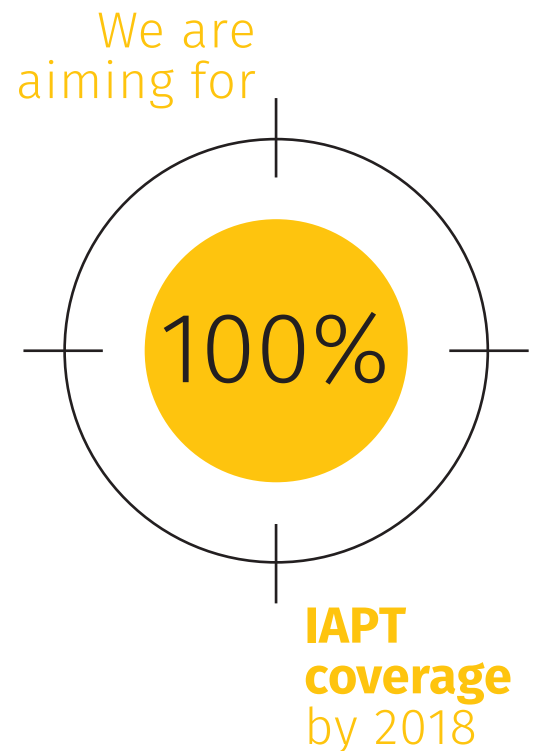
How we are changing locally

Essex County Council, previous providers of tier 2 services in Essex, and North Essex Partnership (NEP), previous providers of tier 3 services across north Essex, were part of the London and south east learning collaborative for IAPT. Several groups of our existing staff completed the IAPT training in 2015 and will continue to put learning into practice following their transfer to the new emotional wellbeing and mental health service on 1 November 2015.

NELFT, our new single service provider from 1 November 2015, was part of the first wave of the national IAPT programme for children and young people. The principles of IAPT are already in practice in NELFT and will continue to guide and strengthen the seven locality teams of our new service across Southend, Essex and Thurrock. NELFT will bring in a tried and tested, bespoke IT system (ICAN) that gives children and young people, as well as professionals, a way of recording and monitoring their outcomes.

Once we have completed transition to the new service in year 1, the commissioners will work with the London and south east IAPT collaborative to formalise our IAPT status for year 2 onwards.

We are expanding and training our workforce to make more therapy available in a range of places, such as schools and children's centres. Our aim is to demonstrate 100% IAPT coverage across our mental health service by 2018.



Attention Deficit Hyperactivity Disorder - ADHD

Parents and people in general are largely uneducated about neurodevelopmental and behavioural problems. They are unaware of the potential to tackle these problems in early life and avoid distress in the family, problems at school, and the risks of depression and self-harm in later years.

For those who do seek help, the feedback we have heard from parents, schools and health and care professionals locally is that the pathway to services is unclear or that services are unavailable at an early stage.

How we are changing locally

Our transformation plan includes investment to improve access to specialist care for disorders such as ADHD. Each locality team in our new service will have the backing of senior clinicians and medical specialists. During year 1, for example, the service will gain five new posts for junior doctors, which will increase capacity to manage early intervention for neurodevelopment and behavioural problems.

Building skills with professionals and families

At the same time, we will review and improve existing protocols to improve shared care, not just between specialists within the new mental health service, but also including GPs, paediatricians, social workers, health visitors and others, such as schools.

Parent training and education training programmes are the first line treatment for families with children with ADHD (recommended by NICE guidance). The new service will offer training that looks at ways to unlock the power of ADHD, including how to improve outcomes, how to motivate children and young adults with ADHD and offer support to build resilience.

Creating a community service for eating disorders

National evidence shows that if children and young people are treated at an early stage by eating disorder specialists, rather than in generic mental health services, the risk of a hospital admission in the future is greatly reduced.

How we are changing locally

Currently, specialist services for eating disorders are available in north Essex, but not in the south. In year 2 of our transformation plan, we will invest in a new community-based specialist service in line with NICE Guidance for eating disorders. This will provide intensive support for families at home and in the communities of Southend, Essex and Thurrock.

There will be one specialist team covering the whole area, but with a network of eating disorders clinicians working in each of the seven localities.

Families and professionals will be able to refer directly to the specialist service. In line with NICE guidance, treatment will begin within four weeks and within one week for urgent cases. The whole family will be involved in treatment and some aspects will be about developing their skills in self-help.

Building skills with professionals and families

The new service will use the principles and training of the national children's and young people's IAPT programme, which emphasises evidence-based treatment, routine outcome measures and children and young people having more say in their care. The service model includes having a group of local children and young people who will be part of the team, for example helping to shape the service and information so that it remains accessible for young people.

Workforce development for the community eating disorder service

The service will require the following skills and competencies from its workforce:

- A rapid response to referrals
- A skilled workforce competent in assessing and treating eating disorders
- Qualifications to deliver the NICE concordant modes of treatment
- Psychiatric assessment from by a specialist CAMHS consultant in eating disorders
- Medical assessment and monitoring by appropriately trained medical and nursing staff
- Access to clinical leadership and supervision in CBT, CBT-E and family based treatments
- Confidence in providing home treatment and family support
- Established strong links with acute and paediatric services
- Sufficient administrative staff to support data collation and analysis

Clinical staff will include clinical psychology, dietetics and family therapy.

Workforce capacity and costing for the new eating disorder service

Using an algorithm based on 156 new referrals per calendar year (covering north, west and mid and South Essex current and predicted rate for South) the predicted workforce capacity needed to meet the waiting time standard across Essex is shown in the table below.

This reasonably assumes that 50% of the local prevalence will seek treatment. This table does not reflect the current staffing of the north, mid and west Essex team. It shows the predicted workforce capacity needed to meet the waiting time standard in the area. Based on the population of South Essex and the national prevalence of eating disorders, it is reasonably suggested that south Essex would generate 29 new referrals per calendar year.

Staffing	**WTE**	**Cost £**
Head of service (Band 8b)	1	67,390
Specialty doctor	1	81,570
Paediatric medical consultant	0.2	24,000
Senior clinical staff (band 8a/8b)	1.7	105,310
Clinical staff (band 7)	6.7	307,330
Home treatment specialist (band 6)	2.5	96,080
Dietician (band 6)	1.5	57,650
Support staff (band 4)	1.8	47,470
Total pay		786,800
Total non-pay		48,720
Estates		25,000
Overheads		91,910
Total cost of the service		**952,430**

Children's learning disability services

It is often the case that children with learning disabilities also have mental health problems, and the complexity of this requires specialist expertise. In north Essex, there is a stand alone service for 5-18 year olds with moderate to severe problems. In south Essex, there is a limited service for children with complex mental health needs and learning disabilities up until the age of 12. Both of these teams work closely with social care services, however, the service offer is limited.

How we are changing locally

With our additional money for transformation, we intend to offer specialist services to the whole of Southend, Essex and Thurrock. We will also work with adult mental health services to support young people, if they need it, up to the age of 25.

We have identified a number of options for services for children with specialist health needs. These include:

- Combining services into an all age pathway
- Creating a joint service offer between health and the local authorities e.g. by combining with behavioural teams
- Maintaining a simpler alliance between specialist health and social services.

In year 2 of our transformation plan, we will conduct a thorough review, appraise options and refine move towards the most appropriate model of care.

Support for vulnerable and disadvantaged children and young people

There are visible differences in Essex, Southend and Thurrock as there are in other parts of the country, between affluent and deprived areas. Surveys with children and young people as part of the 2013 Joint Strategic Needs Assessment showed a 17% difference in perceptions about the quality of life between the best and worst districts of Southend, Essex and Thurrock.

From the information we have about children's care services, we know that young people who are in care, on the edge of care, or who come into contact with the police and justice system are among the most vulnerable people in terms of mental health needs. A significant number of children known to be "on the edge of care", are also known to mental health services.

We also know that there are children and families with complex and multiple needs including mental health needs who may need additional support in order to prevent escalation to social care, or to successfully 'step down' from social care. The Essex Family Solutions Service (which includes support for those families known nationally as 'Troubled Families') works with these families to help them identify their own solutions to their problems.

Our transformation plan includes specific actions for these vulnerable groups of children and young people. Some of these include:

- Mental health clinicians being linked to each youth offending team (four in Essex and one each in Southend and Thurrock)
- Joint work between mental health teams and domestic abuse services and the Sexual Assault and Referral Centre
- Joint work with substance misuse services
- Joint assessments and case reviews with a range of children's care services.
- Dedicated consultation and potentially joint assessment between the NELFT and Divisional based intervention team (DBIT) working with children on the edge of care and supporting reunification for children returning from residential care to home or long term fostering who may have significant mental health and behavioural needs.
- Developing operational links between NELFT and Family Solutions including training for Family Solutions staff. This will build capacity to support children and young people in families with multiple and complex needs.

Support for children and young people who move between services

Historically, services for vulnerable young adults with neurodevelopmental difficulties, including ADHD and ASD, have fallen outside the remit of adult mental health services and adult learning disabilities services. Some young people with mental health needs fall below the threshold for adult services, but they continue to need specialist help after the age of 18 years.

Our new service model will involve these young people in making a formal transition plan, which will offer alternatives to adult mental health services if their needs do not match the criteria for adult services.

Planning for transfer to adult services should start at least six months prior to turning 18. For those with a learning difficulty or disability this may begin from the age of 14. Children in care will also benefit from multi-agency transition planning.

Development of interagency relationships is crucial to facilitate the transition process. Key partnerships need to be developed with transitions and interfaces between services and agencies

Typical working relationships include connections with:

- Adult mental health services
- Paediatricians
- Specialised services
- Community and primary care
- Children's social care to support care leavers
- Social care services support for children and young people moving in and out of area, including children in care and residential placements.

The service will ensure continuity of care for children and young people discharged or transferred from one service to another, including, for example, primary care, adult mental health services, continuing healthcare and young people leaving care.

In year 1 of our transformation plan we will build on the existing work of a Transitions Steering Group to review the national Model Transfer of and Discharge from Care Protocol for young people with mental health problems. The aim is to establish whether the guiding principles could be applied locally to one new consistent protocol across Southend Essex and Thurrock.

Areas for development

Not all children and young people receiving mental health services need to transfer to specialist adult mental health services. However, young people may need support at this crucial point in their life.

In year 2 of our plan, we will review existing best practice transition process for young adults between the ages of 15-18 years, in particular considering what information and support will enable them to develop their capacity to self manage.

We will ensure that robust transition processes are in place for vulnerable children and young peoples groups including:

- Children in care
- Care leavers – moving to independent living
- Children and young people entering or leaving inpatient care
- Children and young people entering or leaving prison
- Young offenders
- Children and young people with neurodevelopmental disorders
- Children and young people with caring responsibilities
- Children and young people with with chronic illnesses
- Children and young people who have suffered significant harm such as sexual abuse, neglect, physical and emotional abuse and/or have posttraumatic stress syndrome.

All planning for children and young people with severe educational needs will take account of and be part of an Education, Health and Care Plan for children and young people.

In year 2 (2016/17) we will:

- Develop a single transition protocol across Southend Essex and Thurrock
- Implement training for professionals
- Ensure young people and their families contribute their expertise and experience in development of local transition processes
- Consider the needs of those young people with a wide range of developmental disorders
- Consider the needs of care leavers
- Provide resources, information and choices
- Consider arrangements for follow up and monitoring for those leaving services.

Medicines management review

Medicines is one the most frequent topics of enquiries from children and young people with mental health needs. Good practice recommends regular medicines reviews with service users. Our information about how much this happens and whether it has a positive impact is currently unclear. Given the frequency of queries about medicines, we know this is an area that needs our attention.

A full-scale medicines management review is planned for year 1 of our transformation plan. This will include looking at how we can achieve more from services working together, including children's health specialists, GPs and the role of community nurses in prescribing medicine.

Action for equality

Mental health problems in childhood can badly affect opportunities in later life. In every part of this transformation plan we include specific and proactive plans to protect young people from disadvantage and inequality. We do this by improving access, building capacity and capability in the system and by building resilience in the community, including the resilience of individuals.

Alongside service developments, our locality teams will work with others to create a wider understanding of mental health problems. By making services more responsive and easier to get to, by bringing support into places where young people feel safe and by educating families and communities we intend to eliminate discrimination and stigma.

Within our transformation plan we are taking particular action to prioritise the needs of the most vulnerable children and young people, as guided by the Equality Act and other national guidance. This includes children known to youth justice services, children in care or, "on the edge of care", children leaving care and children with complex needs such as physical or learning disabilities.

We will ensure that these young people are fully engaged in our plan as it develops, working through the routes described above and through our existing mechanisms, including our children in care councils and engagement routes within the Youth Offending Service and Divisional Based Intervention Teams.

Using the non-recurrent funding available in year 1, we will commission a detailed needs audit by locality, including targeted research on the needs of vulnerable and protected groups.

BUILDING CAPACITY AND CAPABILITY IN THE SYSTEM

Building capacity and capability in our seven locality teams

With additional investment and new ways of working we are expanding the people and skills in locality teams. The following table summarises key developments:

Identified gaps in services	Increase in staffing and skills
Services for eating disorders	Increase in clinical and support staff to cover all localities.
Specialist services to help with developmental and behavioural problems	New posts for junior doctors in training, in partnership with Health Education East of England.
Improving access to psychological therapies (IAPT)	Upgraded clinical psychology leaders. New posts in each locality.
Faster access to help for low to moderate needs – not always available currently	Recruitment and training for lower grade clinical staff. Additional resources to support locality teams and their work with partners within the community e.g. schools, children's centres, GPs, voluntary sector.
Faster access to advice, information, support and assessment where needed.	More staff for single points of access in Southend, Essex and Thurrock.

Appendix 4 *shows our baseline staffing in 2014/15*

Training and development for staff

Transition in year 1 (2015/16)

Our immediate priority in year 1 is to support staff in transition to the new service model. This includes formal induction training across the new organisation, and informal development through discussion and consultation with the new teams.

Reviews starting in year 1 (2015/16) and continuing in year 2 (2016/17)

Many of the new service developments within our transformation plan require a review process to assess the needs and the case for change. These processes, focusing on a particular service area, will also be an opportunity to listen to staff views and develop working protocols.

Opportunities within IAPT

Earlier in this section we have written about the national training programme to improve access to psychological therapies for children and young people. This will ensure that we develop the right skills and approaches to deliver our vision of preventative, responsive and listening services for the emotional wellbeing and mental health of children and young people.

Given the sheer size and scale of the transformation we are undertaking across seven CCGs and three local authorities, we are investing £100k in our own bespoke IAPT scheme, through an innovative partnership with a local university, alongside existing support from Health Education England and NHS England.

Improving outcomes

We expect to see evidence of change in working practice in year 2 and substantial improvements in treatment outcomes in year 3 onwards. In year 2, we expect to make immediate progress in real time outcomes measurement and the start of a cultural shift towards collaboration between professionals and young service users.

Improving data and IT

Development of the new service over five years needs investment in information technology, equipment and training.

Most staff will be out in the community and will work from laptops and mobile phones so that they can access systems and electronic records in any location. They will be able to log in to a clinical portal and share in an instant any clinical information. This will open up for children, young people and families over the time span of the plan.

The service provider, NELFT, has installed a new electronic patient record system with a dedicated part for our service. NELFT has also developed a measurement tool for emotional well-being services for young people, called ICAN. Children, young people and families will be able to rate the help they have received by using an iPad. This then allows NELFT to track their progress whether they feel that their therapy is making a difference to their life.

The anonymised data then goes to a performance dashboard, which enables full data interrogation for a range of performance and quality indicators.

Governance and Performance Framework

Collaborative Commissioning Forum

Each of the ten commissioners, the three local authorities and seven clinical commissioning groups are statutorily accountable for the delivery of this transformation plan. Through a legally binding agreement, the ten commissioners have established a Collaborative Commissioning Forum, which is delegated to set budgets, authorise spending and manage operational delivery of the five-year transformation plan.

The Collaborative Commissioning Forum:

- Oversees the transformation plan
- Monitors delivery against plan
- Monitors the new service contract
- Monitors performance of the forum against its objectives
- Monitors provider performance against key performance indicators (KPIs)
- Monitors mobilisation of the new service against plans

The Forum Chair is Barbara Herts, Director for Integrated Commissioning and Vulnerable People, Essex County Council

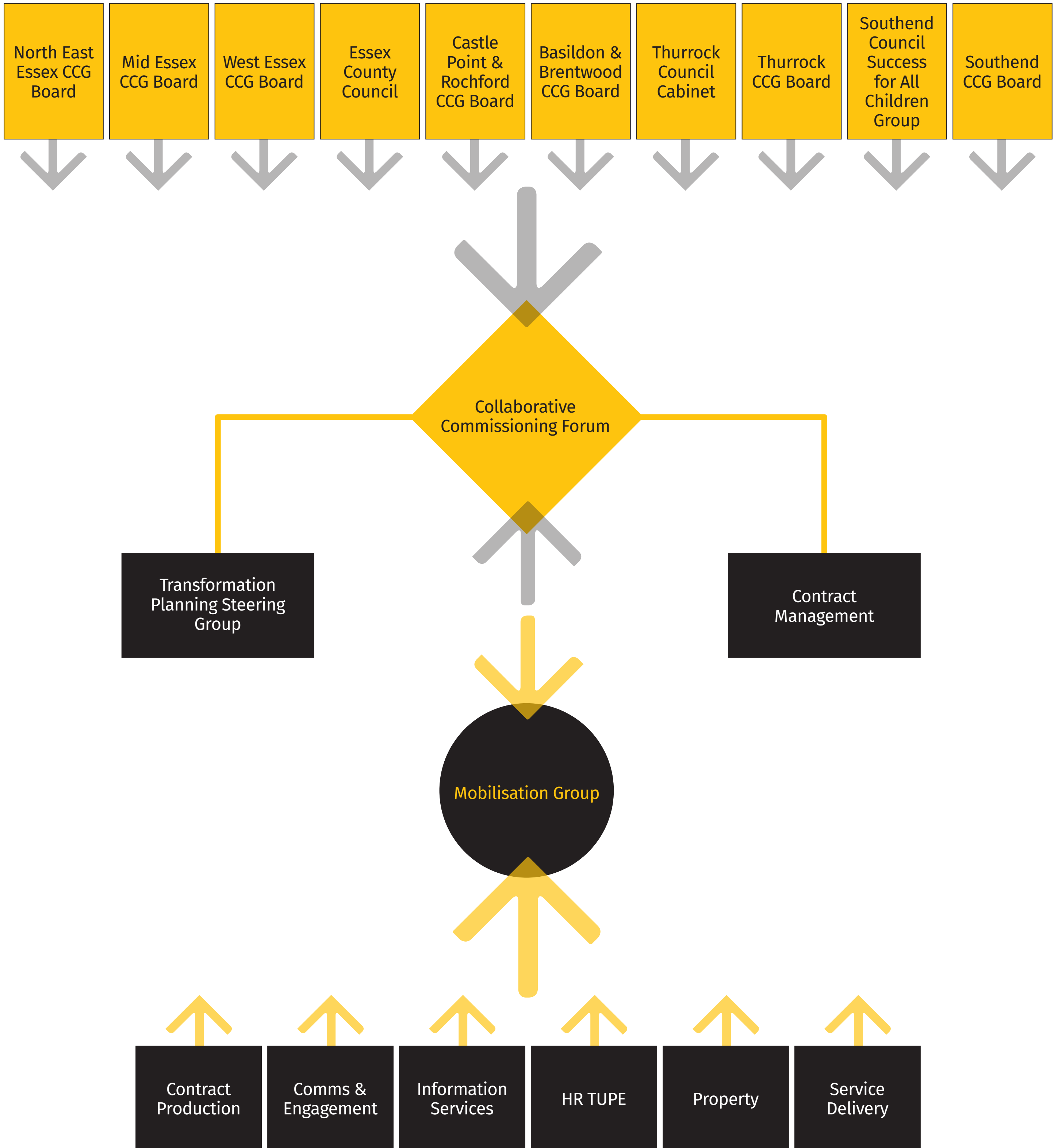
The Deputy Chair is Clare Morris, Chief Officer of NHS West Essex CCG, lead commissioner for children's mental health services.

Each of the commissioners has one appointed representative.

The Forum has appointed a Mobilisation Group to manage the transition to the new service. Sub-groups of the Mobilisation Group cover:

- Contract production
- Communications and engagement
- Information services
- HR and TUPE
- Property
- Service delivery

Children & Young People Emotional Wellbeing and Mental Health Partnership Governance



*See **appendix 5** for terms of reference of the Collaborative Commissioning Forum.*

Performance and quality framework

Within the service contract there is a comprehensive performance and quality framework, monitored monthly and reported to the Collaborative Commissioning Forum.

Our high level key performance indicators (KPIs) demonstrate our commitment to measuring improvement in outcomes year on year. The following shows our focus on a smaller number of meaningful outcomes measures, rather than a broader list of outputs-based measures.

Improved emotional wellbeing

Staff monitor individual clinical outcomes using IAPT validated outcome tools. Real time sessional outcomes monitoring will be phased in in year 1. (ICAN)
Performance monitoring will look at the number and percentage of service users with improving validated outcome scores between start of treatment and up to 6 months.
Targets for further improvements to be agreed for year 2 onwards.
Information is by locality
6 monthly reports

Satisfaction with services

Data gathering will be via an experience questionnaire and the national “friends and family test”.
Monitoring will look at the number and percentage of service users reporting satisfaction
Year 1 performance will set the baseline and targets will be set for year 2
Monthly reports

Easier access

Intervention without delays monitored against nationally recommended timescales
Monitoring will look at referral to treatment within 6 weeks, 12 weeks and 18 weeks and waiting times referral to assessment of new cases
Year 1 performance will set the baseline and targets will be set for year 2
Monthly activity reports
Single point of access
Catch and carry – no bounce
Signposting or direct intervention
Looks at referrals received, redirected, rejected

Prompt response to crisis

Monitoring will look at the number of assessments in A&E within 4 hours, aiming for 100% achievement
Monthly activity reports

Proactive outreach

Monitoring will look at DNA rates
Year 1 performance will set the baseline and targets will be set for year 2
Monthly activity reports

Delivery

We will establish a programme management office to oversee the delivery of the plan. This will be an extension of the current mobilisation team with a new remit to deliver the priorities in this transformation plan.

Partners in the transformation plan – Transformation Planning Steering Group

Because the Southend, Essex and Thurrock transformation involves a major change to create a single integrated emotional wellbeing and mental health service for children and young people, it has built-in and embedded partnerships and stakeholder engagement over three years of development.

Further details about the history and future of engagement are included in the next section.

Specifically for the transformation plan, we have established a Transformation Planning Steering Group, which has among its membership the following:

- Commissioning and strategic leads for the three local authorities and seven CCGs
- Strategic lead for NELFT, the new service provider
- Existing Tiers 2 and 3 CAMHS provider leads
- Head teacher/education commissioner representative
- Voluntary sector
- Healthwatch Essex
- Youth Offenders Services
- NHS England Specialised Commissioning
- Adult Mental Health Commissioning
- GP leads
- Public Health Commissioning

A regional forum, plus monthly meetings and teleconferences have also supported liaison with NHS England Specialised Commissioning with specialised commissioners and representatives of the Clinical Network.

*See **appendix 5** for terms of reference of the Transformation Planning Steering Group*

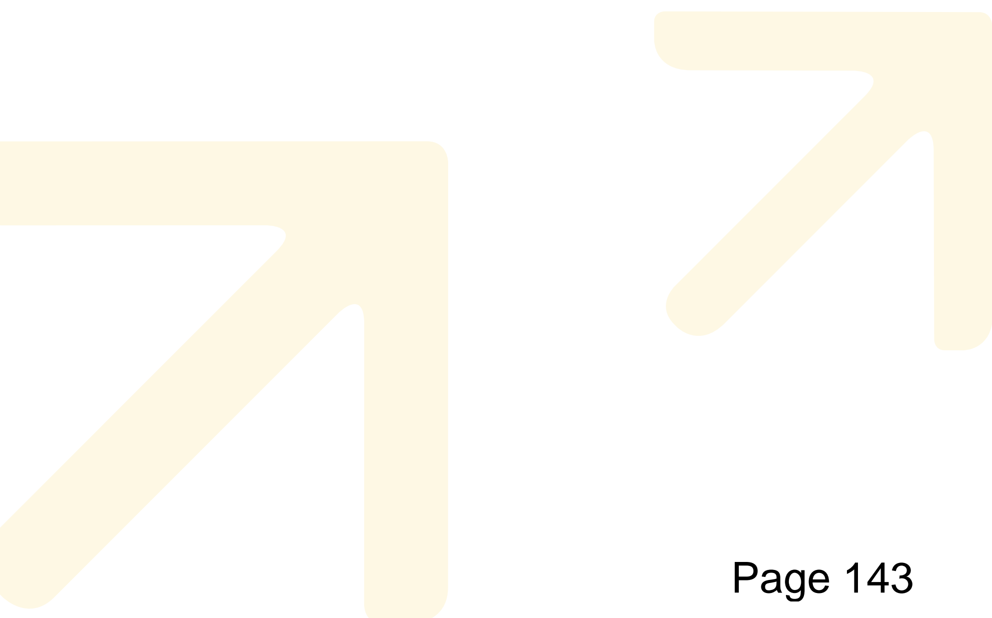
Key links with other strategies

Good mental health and wellbeing for children and young people is a priority for all three health and wellbeing boards in Southend, Essex and Thurrock. It is part of an overall commitment to children and young people having the best possible start in life and being able to maintain their resilience.

Using the findings from JSNAs, the Joint Needs Assessment for Children's Emotional Wellbeing and Mental Health and the Essex Corporate Outcomes Framework ensures coordination and consistency between this transformation plan and the wider health and wellbeing strategies for Southend, Essex and Thurrock.

Our plans are in line with the *Winterbourne View – Time for Change* and national plans to transform commissioning of services for people with learning disabilities and / or autism. The lead commissioner for CAMHS is also a partner of the learning disabilities workstream across Southend, Essex and Thurrock.

The prioritites for action in this transformation align with all those of the system resilience groups for Southend, Essex and Thurrock and the five A&E departments across the patch.

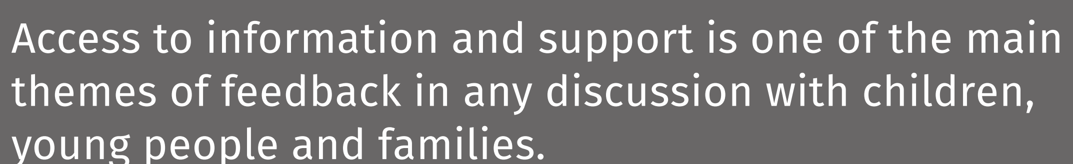


BUILDING RESILIENCE IN THE COMMUNITY

"Although we are taught how to recognise some mental health issues within our school, education about mental illnesses is very limited if not non-existent."

"I know many people who suffer from mental health issues. It is vital that teachers in charge of pastoral care receive adequate mental health training and that every teacher is taught about mental health. All teachers undergo physical first-aid training, so why do they not receive this training for mental health?"

Ellie, a participant in the **Healthwatch YEAH! Project** to hear the views of young people



Access to information and support is one of the main themes of feedback in any discussion with children, young people and families.

Over the next five years of our transformation plan, we are investing in resources that will reach further into our local communities than we have ever been done before.

Engagement

History of engagement that has helped to shape our transformation plan

We have gathered the views of children and young people in several different ways over the last three years, as part of the work to design a new service for emotional wellbeing and mental health.

Some of these listening exercises include:

- Consultation with children and young people to develop the Essex Child and Adolescent Mental Health Services Strategy (2012)
- The Essex Healthwatch YEAH! Project in partnership with Essex Boys and Girls Clubs, which held focus groups on health and social care with over 400 young people across Essex (2014)
- Discussions with Young Essex Assembly Southend and other young people as part of the development of this plan.

A group of young people was also part of the procurement team and we continue to keep in touch for their advice. We are currently conducting a survey with a range of groups of children and young people and local voluntary sector organisations to inform our detailed plans for transformation.

Publication and further engagement in our transformation plan

The publication of this transformation plan, subject to the outcome of national assessment, will launch our long-term information and engagement campaign. A version of the transformation plan that is aimed at young people will be widely available from websites across our system and communities.

During the development of the transformation plan, we have connected with children and young people mainly through the youth councils and similar arrangements in each of the three local authorities, Southend, Essex and Thurrock. We are planning a launch in partnership with these groups that will include press, radio, TV, social media and direct messages to schools and other stakeholders.

Continuing communications, information and relationship-building

Year 1 of our plan will see the start of a detailed "service mapping" exercise in each local area to build up a comprehensive database of community and voluntary organisations that can play a part in the emotional wellbeing of children and young people. This will provide the start of a growing infrastructure for the seven locality teams to make emotional wellbeing everybody's business.

The seven locality teams will be available to schools and other public services, ready to support with advice and guidance. They will build upon existing partnerships with GPs, community health services, hospitals and children's care services to set new protocols for responding to children with mental health problems.

Part of the infrastructure for reaching out to children, young people, families and professionals will be an online resource, already well-established in NELFT and known as "The Big White Wall".

The Big White Wall is a comprehensive online resource, offering online counseling, self-help apps and coping tools, as well as information.

In year 2 of the transformation plan, we will increase access to tested, evidence-based resources, working with children and young people from a range of backgrounds to test self-help techniques and tools.

Developing systematic and built-in engagement

Healthwatch Essex has done a study of existing methods of engagement across all ten commissioners involved in this transformation plan.

What works for children and young people

- Social media and online resources
- Building a campaign
- Getting young people involved as trained ambassadors
- Incentives to take part, such as opportunities to develop skills.

Reprezent

We are in partnership with a charity called Reprezent which specialises in recruiting and training young volunteers to run a peer support service, operating through a radio station and website.

Reprezent has built up a successful movement across the south east of England by bringing the voice of children and young people into public life. We are investing in a tailor-made Reprezent programme in Southend, Essex and Thurrock with training and opportunities for young people to have a powerful influence on the way we improve emotional wellbeing and mental health over the next five years.

Real-time feedback

Listening to children, young people and families will be an explicit part of frontline services. Standards for the new emotional wellbeing and mental health service require that teams will ask people for feedback, which will be recorded and used to monitor progress.

A clear role for schools

Many children and young people talk about school life when giving their views about mental health. They see a clear role for schools in understanding mental health problems and providing support. In our experience, the majority of schools already take on this responsibility and are often the first to raise concerns when someone is experiencing problems.

There is an army of skilled professionals across our 700 plus schools that form a substantial support network, including teachers, school nurses, counsellors, pastoral care staff, educational psychologists and special educational needs coordinators.

However, the potential of this resource is largely untapped. Although health, care and education for children and young people works side by side, it is not as joined up as it could be. Learning could be shared, for example, the experience of education, health and social care staff in working with young people with SEND to develop joint outcomes-focused plans, for children who require an Education Health and Care Plan or who need joined up early planning to prevent their needs escalating.

What our schools say

- We could do more with better information, advice and training
- We need easier and quicker access to expert help. It is not always clear which service to contact or how to manage an ongoing situation
- Communication around how to access on call cover for crisis and the definitions of the crisis threshold should be very clear
- We need a partnership that develops our capability, with training for staff, for example, and agreed protocols for action
- To make this work, capacity building needs to be for groups of schools and should help schools to support each other
- We need better systems to support children and young people during school holidays and when they transfer from school to school
- Some schools have their own schemes in place for emotional wellbeing and mental health problems; some have their own counseling service. We will use this opportunity to harness best practice and create a consistently effective approach for all schools, building on what works already.
- Services should support the emotional and mental health needs of parents, carers and siblings, not just the child or young person.

Partnership in action

A programme to build capacity and capability in schools is one of the most important actions in our transformation plan. In discussions with education leaders and head teachers, we have agreed to co-design a programme in year 1 that can be rolled out to schools in phases during years 2, 3 and ongoing.

This will include:

- From 1 November, fast access to advice and guidance through a single point of access in each area of Southend, Essex and Thurrock.
- From year 1, a developing website for children's and young people's emotional wellbeing and mental health, giving information to schools and online techniques, such as self-help toolkits.
- Together with young people, schools and community leaders we will develop a peer mentoring scheme that equips young people themselves to be able to help others.
- We will co-design a pilot with schools to develop training and capacity within groups of schools. This will cover training, development of a common understanding about emotional wellbeing and mental health and testing stronger links between school staff and the new service.

Suicide prevention and support for children who harm themselves

The risk of suicide and self-harm is one of the major concerns of children and young people, families, carers and school staff. Our first priority is to increase support with dedicated people in the locality teams who have particular skills in suicide prevention and managing self-harm.

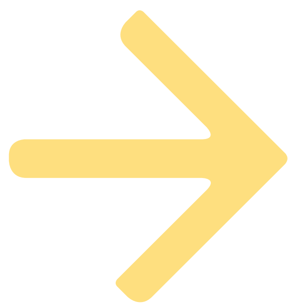
During 2015/16, we will audit the existing Essex suicide prevention guidelines to identify next steps and improvements, which will include training.

In Essex, guidelines were locally developed and issued to all schools and other partners. There is limited information relating to their use and, currently, the guidelines have not been tested in Thurrock or Southend. Our audit using non-recurrent funds in year 1, will highlight any gaps and what partners perceive is needed to include suicide prevention becomes a routine. This may include further training and development across the Essex economy.

CONCLUSION

This transformation plan is the product of a genuine collaboration between the ten commissioners responsible for Southend, Essex and Thurrock.

A formal collaborative commissioning agreement joins us together, but more importantly, the plan has bonded us with a greater determination to improve mental health for children and young people.



We agree that bigger and better things will be possible when we work together, which is why we have pooled our funds, avoiding the differences in allocations to each CCG area. We anticipate £3.3 million additional resources from the Government for 2016/17 onwards. This money will be invested in meeting the needs we have identified locally and implementing the recommendations of *Future in Mind*, the national guidance on children's mental health.

To deliver the transformation plan, we have a commissioned a completely new service from 1 November 2015. Our first priority is to shepherd the new service safely to full-scale operation in 2016, quickly followed by developments to close gaps in services, improve outcomes and reduce inequalities.

Eating disorders is one of the most serious and urgent needs that we need to tackle over the next five years. We have set aside £950,000 to expand and improve our current services. With the remaining £2.4m additional money, we will fund more posts and build our capability in dealing with self-harm, suicide prevention and disorders such as ADHD. Our crisis teams will move to a 9 to 9 service, seven days a week, and concentrate on home treatment that avoids a hospital stay wherever possible. We are also investing in evidence-based therapies making these more widely available to children, young people and their families.

All of these investments will open up our services and reach out to children and young people with mental health problems, but the "Open up, Reach out" message of our transformation plan goes very much wider than this. Our aim is to build resilience in our schools, communities and among young people themselves. From the basics of making information available, to training staff in schools and other public services, to specialists building relationships with families and communities, we will promote a collective responsibility for the emotional wellbeing and mental health of children and young people in Southend, Essex and Thurrock.

Appendix 1
Prevalence of mental health problems taken from ChiMat

Ref. National Child and Maternal Health Intelligence Network

Estimated number of children with conduct disorders by age group and sex

Estimated no. of CYP (2014)	All 5-10 years	All 11-16	Boys 5-10	Boys 11-16	Girls 5-10	Girls 11-16
NHS Southend	620	775	450	485	170	290
NHS Thurrock	715	835	515	525	205	315
NHS Castle Point and Rochford	510	700	375	435	135	265
NHS Basildon and Brentwood	910	1,160	660	725	255	440
NHS Mid Essex	1,175	1,500	855	950	325	555
NHS North East Essex	1,055	1,345	760	840	295	505
NHS West Essex	1,005	1,170	735	735	270	435
Total	**5,990**	**7,485**				

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children with emotional disorders by age group and sex

Estimated no. of CYP (2014)	All 5-10 years	All 11-16	Boys 5-10	Boys 11-16	Girls 5-10	Girls 11-16
NHS Southend	285	605	130	265	160	345
NHS Thurrock	335	630	150	270	185	360
NHS Castle Point and Rochford	230	555	100	230	130	330
NHS Basildon and Brentwood	425	920	190	395	235	530
NHS Mid Essex	545	1,210	245	515	305	695
NHS North East Essex	490	1,045	220	445	270	605
NHS West Essex	455	940	205	405	250	540
Total	**2765**	**5,905**				

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children with hyperkinetic disorders by age group and sex

Estimated no. of CYP (2014)	All 5-10 years	All 11-16	Boys 5-10	Boys 11-16	Girls 5-10	Girls 11-16
NHS Southend	210	175	185	150	30	30
NHS Thurrock	250	190	215	160	35	30
NHS Castle Point and Rochford	170	165	150	140	25	30
NHS Basildon and Brentwood	315	265	270	225	45	45
NHS Mid Essex	395	350	340	290	60	60
NHS North East Essex	355	300	310	255	45	45
NHS West Essex	340	275	290	230	50	50
Total	**2035**	**1720**				

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children with less common disorders by age group and sex

Estimated no. of CYP (2014)	All 5-10 years	All 11-16	Boys 5-10	Boys 11-16	Girls 5-10	Girls 11-16
NHS Southend	170	150	135	105	35	50
NHS Thurrock	190	155	155	110	35	50
NHS Castle Point and Rochford	140	145	110	100	35	45
NHS Basildon and Brentwood	260	230	205	160	60	75
NHS Mid Essex	340	310	260	215	80	95
NHS North East Essex	280	260	225	175	60	85
NHS West Essex	290	240	225	165	60	75
Total	**1670**	**1490**				

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of males aged 16 to 19 with neurotic disorders

	Mixed anxiety and depressive disorder (males 16-19 yrs) (2014)	**Generalised anxiety disorder** (males 16-19 yrs) (2014)	**Depressive episode** (males 16-19 yrs) (2014)	**All phobias** (males 16-19 yrs) (2014)	**Obsessive compulsive disorder** (males 16-19 yrs) (2014)	**Panic disorder** (males 16-19 yrs) (2014)	**Any neurotic disorder** (males 16-19 yrs) (2014)
NHS Southend	225	75	40	30	40	25	380
NHS Thurrock	215	70	40	30	40	25	360
NHS Castle Point and Rochford	235	75	45	30	45	25	390
NHS Basildon and Brentwood	340	110	60	40	60	35	570
NHS Mid Essex	465	150	85	55	85	50	785
NHS North East Essex	410	130	75	50	75	40	685
NHS West Essex	360	115	65	45	65	40	610

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of females aged 16 to 19 with neurotic disorders

	Mixed anxiety and depressive disorder (females 16-19 yrs) (2014)	**Generalised anxiety disorder** (females 16-19 yrs) (2014)	**Depressive episode** (females 16-19 yrs) (2014)	**All phobias** (females 16-19 yrs) (2014)	**Obsessive compulsive disorder** (females 16-19 yrs) (2014)	**Panic disorder** (females 16-19 yrs) (2014)	**Any neurotic disorder** (females 16-19 yrs) (2014)
NHS Southend	510	45	110	90	40	25	785
NHS Thurrock	505	45	110	90	40	25	780
NHS Castle Point and Rochford	510	50	115	90	40	25	790
NHS Basildon and Brentwood	775	70	170	135	60	40	1,195
NHS Mid Essex	1,060	95	235	180	80	55	1,645
NHS North East Essex	935	85	205	160	70	50	1,450
NHS West Essex	800	75	175	140	60	40	1,240

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children with autistic spectrum disorders

	Autism in children aged 9-10 years (2014)	Other ASDs in children aged 9-10 years (2014)	Total of all ASDs in children aged 9-10 years (2014)	Autism-spectrum conditions disorders in children aged 5-9 years (2014)
NHS Southend	20	35	55	180
NHS Thurrock	20	40	60	200
NHS Castle Point, and Rochford	15	30	45	150
NHS Basildon and Brentwood	30	55	80	270
NHS Mid Essex	40	70	105	355
NHS North East Essex	30	60	90	305
NHS West Essex	30	60	90	310
Total	**185**	**350**		

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Suicide and self-harm

Suicide is a complex issue and one that requires further research to understand better the specific risk factors associated with it. Looking at suicides in the UK between 1997 and 2003, one study has made the following observations (Windfuhr, K., 2008):

- Three times as many young men as young women aged between 15 and 19 committed suicide
- Only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults.
- Looking at the difference between sexes, 20% of young women were in contact with mental health services compared to only 12% of young men

According to ONS, in 2014 there were 476 deaths of 15 to 24 year olds from intentional self-harm or undetermined intent in England and Wales. This is a rate of 6.6 deaths per 100,000 population aged 15 to 24 years.

Self-harm is a related issue:

- Levels of self-harm are higher among young women than young men. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds (Hawton, K., 2012). Self-poisoning was the most common method, involving paracetamol in 58.2 % of episodes (Hawton, K., 2012)
- Presentations, especially those involving alcohol, peaked at night. Repetition of self-harm was frequent (53.3 % had a history of prior self-harm and 17.7 % repeated within a year) (Hawton, K., 2012). Common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide (Hawton, K., 2005)
- Young South Asian women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors (Hawton, K., 2005)
- As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months (Hawton, K., 2005)
- The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage boy; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital (Hawton, K., 2005)

Information about hospital admission for self-harm and for mental health conditions is included in Local Authority Child Health Profiles, available at **www.chimat.org.uk/profiles**

Appendix 2
Further information on baseline activity in 2014/15

Waiting times

NHS England is gradually developing and introducing waiting times standards for mental health services to deliver its objective of parity of esteem, which will bring waiting times for those with mental health issues in line with those in other services

The current access standard for tier 3 services requires that no one will wait for more than 18 weeks from referral to treatment. Treatment is defined as being the initial assessment.

The 2013 NHS benchmarking network report stated that the average waiting times for children and adolescent mental health services (CAMHS) had increased consistently since the first report published in January 2011. This may reflect increasing levels of demand for CAMHS and restrictions on funding. Data from 2012/13 shows that maximum waiting times for specialist CAMHS average 15 weeks across the participating providers.

SEPT – Tier 3 CAMHS waiting times

The table below provides a snapshot of the number of children and young people waiting based on the period January–March 2015

CCG	Basildon and Brentwood	Castle Point and Rochford	Southend	Thurrock
Weeks waiting	Q4 2015	Q4 2015	Q4 2015	Q4 2015
0 - <3	28	22	73	53
3 - <6	13	16	31	36
6 - <9	10	6	28	21
9 - <13	4	4	21	16
13 - <18	1	0	9	1
18+ wks	0	0	6	1
Total	**56**	**48**	**168**	**128**

SEPT waiting times compare positively with the CAMHS average of 15 weeks, with 95% of children and young people across all south Essex CCGs being seen in less than 13 weeks for this particular quarter in 2014/15.

The table below shows the numbers waiting in each of weekly waiting time cohorts as a percentage of the total children and young people waiting in the same quarter, for each of the four south Essex CCGs.

CCG	0 - <3	3 - <6	6 - <9	9 - <13	13 - <18	18+ wks
Basildon and Brentwood	50%	23%	18%	7%	2%	0%
Castle Point and Rochford	46%	33%	13%	8%	0%	0%
Southend	43%	18%	17%	13%	5%	4%
Thurrock	41%	28%	16%	13%	1%	1%

NEP – Tier 3 CAMHS waiting times

The table below provides a snapshot of the number of children and young people waiting based on the period January –March 2015

CCG	North East Essex	Mid Essex	West Essex
Weeks waiting	Q4 2015	Q4 2015	Q4 2015
< 4 weeks	34	49	28
4-12 weeks	47	63	42
13-15 weeks	4	2	9
16-17 weeks	0	1	2
18-20 weeks	1	0	0
20 + weeks	0	0	0
Total CYP	**86**	**115**	**81**

NEP waiting times compare positively to the CAMHS average of 15 weeks, with 98% of children and young people across all North Essex CCGs being seen in less than 15 weeks for this particular quarter in 2014/15.

The table below shows the numbers waiting in each of weekly waiting time cohorts as a percentage of the total children and young people waiting in the same quarter, for each of the three north Essex CCGs.

CCG	<4	4-12	13-15	16-17	18-20	20+ wks
North East Essex	40%	55%	5%	0%	1%	0%
Mid Essex	43%	55%	2%	1%	0%	0%
West Essex	35%	52%	11%	2%	0%	0%

93% of the total children and young people waiting were seen within 12 weeks for this particular quarter in 2014/15

Tier 2 – Southend, Essex and Thurrock waiting times

The table below provides a snapshot of the number of children and young people waiting based on the period January –March 2015

	Castle Point and Rochford+Basildon and Brentwood	Southend	Thurrock	North East Essex	Mid Essex	West Essex
Weeks waiting	Q4 2015	Q4 2015	Q4 2015	Q4 2015	Q4 2015	Q4 2015
0 - <3	121	76	2	128	128	66
3 - <6	13	56	2	40	39	26
6 - <9	7	54	1	1	9	28
9 - <13	3	50	4	4	1	14
13 - <18	0	31	0	0	0	0
18+ wks	0	7	0	0	3	0
Total CYP	**144**	**274**	**9**	**173**	**180**	**134**

The referral to treatment national waiting time standard of 18 weeks does not apply to tier 2 services, as this is a standard applicable to the NHS and not to local authority services.

However, in Southend there is a requirement that all children and young people are seen within 10 weeks. Currently waiting times do not meet this requirement. SEPT is delivering against an action plan to ensure that there will be no children and young people waiting in excess of 10 weeks by the time services transfer to the new model on 1 November.

There are no waiting lists in Thurrock.

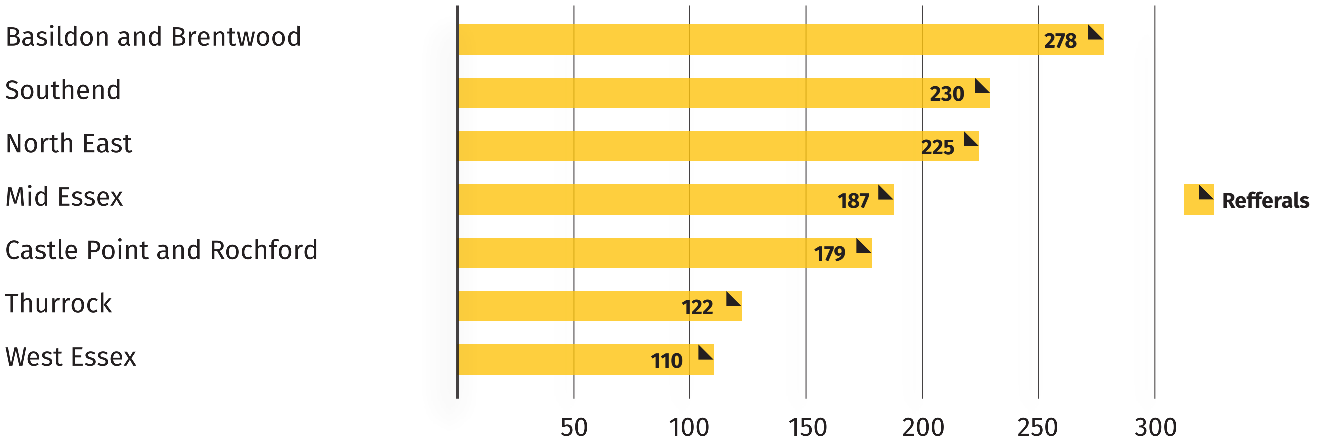
The table below shows the numbers waiting in each of weekly waiting time cohorts expressed as a percentage of the total children and young people waiting in the same quarter, for each of the CCG localities.

CCG	0 - <3	3 - <6	6 - <9	9 - <13	13 - <18	18+ wks
Castle Point and Rochford and Basildon and Brentwood	84%	9%	5%	2%	0%	0%
Southend	28%	20%	20%	18%	11%	3%
Thurrock	22%	22%	11%	44%	0%	0%
North East Essex	74%	23%	1%	2%	0%	0%
Mid Essex	71%	22%	5%	1%	0%	2%
West Essex	49%	19%	21%	10%	0%	0%

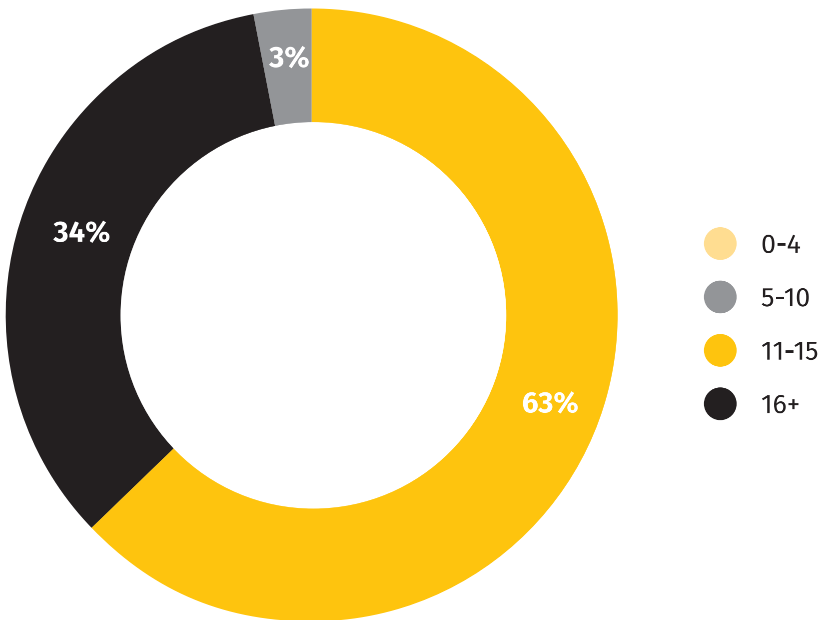
As the new service model rolls out, commissioners expect to see significant improvements in waiting time standards during 2016/17. Robust KPIs have been developed to routinely monitor referral to assessment, and referral to treatment waiting times with the aim of achieving year on year improvements over the life of the contract.

Additional information on referrals to crisis services

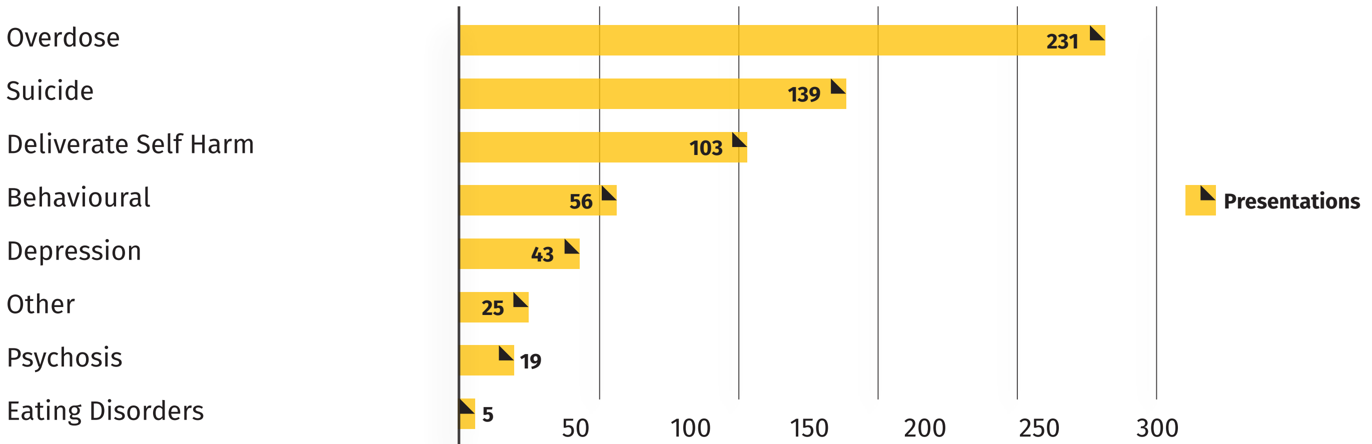
The chart below shows the number of crisis referrals received from the seven Essex CCGs during the period April 2014 to March 2015. Across Southend Essex and Thurrock there has been a year on year increase in referrals to crisis services which could be a reflection on the capacity and unmet demand in Tier 3 services.



The chart below shows the age range of crisis referrals received



The chart below shows presenting problems for the crisis teams across Southend, Essex and Thurrock. The most common presentations to the crisis teams are typically for overdose, suicide, and self-harm.



Additional information on referrals to services for eating disorders

North Essex Eating Disorder Service Baseline data 2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Referrals received	6	8	12	11	6	14	11	12	9	19	8	20
Referrals accepted for assessment												

Of the total referrals received during 2014/15, 109 were accepted in to the service.

Waiting times:
The most common initial and actual waiting time was 15 days.
The differences in initial and actual waiting time were usually due to families being unable to attend on the given date due to other commitments e.g. exams.

	Mean	Median	Mode
Initial waiting time	19	18	15
Actual waiting time	20	19	15

Tier 4 service provision – Specialised services commissioned by NHS England

Nationally, there are pressures on tier 4 inpatient services, and this is reflected at a local level.

Often our young people who are suffering severe distress, have to wait at home with intensive packages of care until a bed becomes available. In some cases, they are admitted to paediatric wards, or to adult psychiatric wards and, on occasion, to police cells.

However, Essex has the only Section 136 suite in the country dedicated to children and young people.

Specialised services (tier 4) are often out of the local area, away from family and friends and potentially causing substantial travel costs at a time when the family is already experiencing significant distress and anxiety.

Commissioners in Essex will closely monitor the development and implementation of our new crisis service model, which is based on avoiding A&E presentation wherever possible through earlier intervention, better risk management and advance care planning, plus crisis resolution/home treatment.

Local Essex commissioners will be keen to work collaboratively with commissioning colleagues in NHS England to ensure that the significant investment in improving community services has a positive impact, including reducing both risk, inpatient admissions and length of inpatient stay.

Tier 4 in north Essex

Provided by North Essex Partnership NHS Foundation Trust (NEP) at the St Aubyn Centre has the capacity to support 15 young people in an acute in patient unit and with 10 intensive care beds (PICU).

The service cares for children and young people with the most serious problems, providing hospital-based mental health care, usually on an in-patient basis. The Unit is integrated with the crisis team, which is the gatekeeper for referrals to specialised services.

Key issues following transfer to specialised services:

- To ensure effective care pathways
- To ensure that the regional governance structures oversee the integrated approach
- To ensure a local Essex 'gateway' for both planned and crisis situations

Tier 4 in south Essex

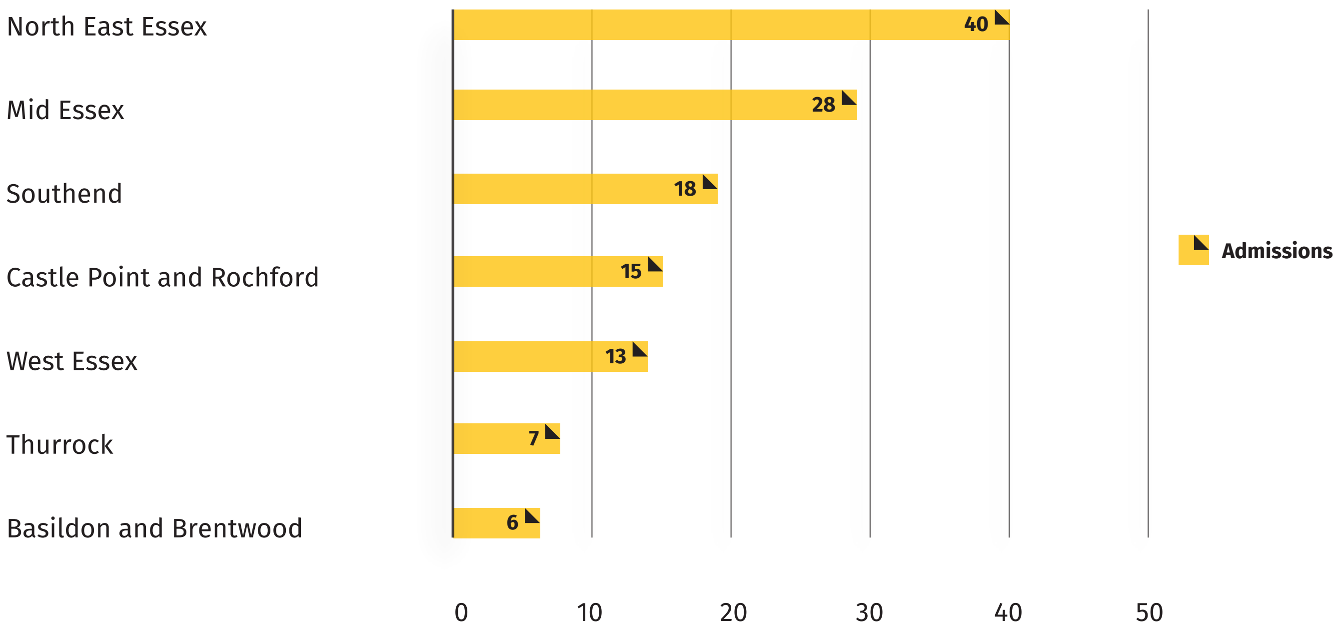
The Poplar unit is a tier 4 inpatient unit staffed by SEPT. The unit has the capacity to support up to 16 young people.

Poplar Unit's team of highly qualified mental health professionals provide high quality assessments, treatments, educational resources and short-term rehabilitation for young people aged between 11 and 17 years.

Tier 4 – Baseline data 2014/15
Our current providers SEPT and NEP have provided the following CAMHS in patient data

CCG	Admissions
Basildon and Brentwood	6
Castle Point and Rochford	15
Southend	18
Thurrock	7
North East Essex	40
Mid Essex	28
West Essex	13
Total	**127**

The Chart below shows that the highest number of admissions are in North Essex, specifically in the CCG localities of Mid Essex and North East Essex.



64% of CAMHS admissions generate from North Essex, with 36% from South Essex

NEP report the average length of stay for the baseline year 2014/15 for each North Essex CCG as 15 days.

The average length of stay reported by SEPT for discharged patients is detailed in the table below:

CCG	Average LOS
Basildon and Brentwood	142 days
Castle Point and Rochford	84 days
Southend	66 days
Thurrock	70 days

Appendix 3
Baseline assessment investment in 2014/15

Service	Thurrock LA	Southend LA	Essex County Council	Castle Point and Rochford CCG	Southend CCG	Basildon and Brentwood CCG	Thurrock CCG	North East Essex CCG	Mid Essex CCG	West Essex CCG	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
CAMHS Tier 2 - LA funding	202.00	210.00	2,071.20								2,483.20
MIND								18.11	14.51	20.39	53.00
Tier 3 CAMHS				913.72	954.16	1,723.46	1,044.66	2,349.22	1,881.87	2,644.45	11,511.55
CAMHS/LD				35.28	36.84	66.54	40.34				179.00
Children's Learning Disability Service								124.33	99.59	139.95	363.88
Specialised Commssioning				717.69	819.38	597.48	250.80	2,087.20	2,260.36	658.17	7,391.08
Grand total	**202.00**	**210.00**	**2,071.20**	**1,666.69**	**1,810.38**	**2,387.48**	**1,335.80**	**4,578.86**	**4,256.33**	**3,462.96**	**21,981.70**

Appendix 4
Staffing of current services prior to 1 Nov

North Essex Tier 3 staffing

North East Essex CAMHS Tier 3 staffing
Consultant Psychiatrist - 2.0 wte
Trainee Medical Psychiatrist - 2.0 wte
Band 5 Nurse - 1.0 wte
Band 6 Nurse - 4.0 wte
Band 7 Nurse - 2.0 wte
Psychologist - 3.0 wte
Child Psychotherapist - 1.72 wte
Admin - 7.43 wte

YOT - Col and Tendring
1 CPN - 1WTE

Crisis Team - North Essex wide
Band 5 Nurse - 1.0 wte
Band 6 Nurse - 6.0 wte
Band 7 Nurse - 1.0 wte
Occupational Therapist - 1.39 wte
Child Psychotherapist - 1.0 wte
Administrator - 1.0 wte.

Mid Essex CAMHS Tier 3
Consultant Psychiatrist - 3.0 wte
Specialty Doctor - 1.0 wte
Band 5 Nurse - 1.0 wte
Band 6 Nurse - 3.04 wte,
Band 7 Nurse - 1.80 wte
Psychologist - 3.64 wte,
Child Psychotherapist - 5.40
Admin - 8.45

YOT - Chelms. Braintree Maldon
1 OT - 0.81 WTE (30hrs)

Eating Disorders - North Essex wide
Band 7 clinical nurse specialist - 1 wte
Band 6 community charge nurse - 3 wte
Band 8a Systemic Family Psychotherapist - 1.69 wte
Band 7 Systemic family therapist - 1 wte
Band 4 Assistant Psychologist - 1 wte
Band 4 Team administrator - 1 wte
Band 8c Consultant family therapist, clinical lead and team manager - 0.5 wte

West Essex CAMHS Tier 3
Consultant Psychiatrist - 3.84 wte
Medical Trainee - 2.0 wte
Specialty Doctor - 1.5 wte
Band 6 Nurse - 2.70 wte
Band 7 Nurse - 1.0 wte
Psychologist - 4.86 wte
Child Psychotherapist - 10.0 wte
Admin - 10.0 wte

YOT - Epping, Harlow, Uttlesford
Vacancy - 1 WTE

South Essex Tier 3 staffing

CAMHS Management
Band 9 - Associate Director and Lead Nurse x 1 wte
Secretarial Support to AD x 1 0.6 wte

Basildon CAMHS Tier 3 staffing
Consultant Psychiatrist x 1 wte
Medical Secretary to CD - x 0.48
Band 8a Clinical team manager & Psychotherapist x 1 wte
Band 7 Nurse x 1 wte
Band 8a & Band 7 Psychologists x 2 wte
Band 8c Psychotherapist x 0.6 wte
Band 4 psychology assistant x 0.6
Agency Locum Speciality doctor x 0.2 wte
Band 4 psychology assistant x 0.2 wte
CT3 Trainee Psychiatrist x 2 days per week
Band 3 admin - 3 wte (1 currently senconded 0.6 secretarial support to AD)

Brentwood CAMHS Tier 3
Consultant Psychiatrist x 0.9 wte
Band 8d Family therpist x 0.9 wte
Band 8c Psychotherapist x 0.7 wte
Band 6 Nurse x 0.51wte
Band 7 Senior CAMHS practitioner x 1 wte
Band 7 Psychologists x 1 wte
Agency Locum Speciality doctor x 0.2 wte
Agency Counsellor/CAMHS Prac x 1wte
Psychotherapy Trainees x 2 wte working between both sites
Band 3 Admin - 0.8 wte x 2 and 0.49 wte x1

Castle Point and Rochford CAMHS Tier 3
Clinical Team Manager x 0.5 wte
Consultant Psychiatrist x 1 wte
Counsellor x 1 wte
Nurse practitioner x 0.6 wte
Social worker x 0.8 wte
Family therapist x 1 wte
Psychologist x 0.8 wte
Secretarial Support x 0.48
Band 3 admin 2 wte and 0.6 x 1 wte

CAMHS CRISIS TEAM - South Essex wide
Band 6 - 4 wte
Band 7 - 1wte

Thurrock CAMHS Tier 3
Consultant Psychiatrist x 1 wte
Clinical team manager x 0.5 wte
Psychologists x 2.11 wte
Family therpist x 1 wte
Senior CAMHS Practitioner x 1 wte
LA seconded social worker x 1 wte
Trainee Psychologist x 1 wte
Band 3 admin - 0.8 x 2 wte, 0.40 x 1 wte and 0.53 x 1 wte

Southend CAMHS Tier 3
Consultant Psychiatrist x 1 wte
Clinical team manager x 0.5 wte
Psychologists x 1.2 wte
Family therpist x 0.68 wte
Band 7 Nurse x 1 wte
Band 6 Nurse x 1 wte
Band 7 Art Therapist x 0.8 wte
Band 3 admin - wte x 2, 0.56 wte x 1 and 0.46 wte x1

YOT
Basildon and Brentwood and CP&R
Band 7 Social worker/CAMHS Prac x 1 wte
Thurrock
CPN x 1 wte
Southend
CPN x 1 wte

CAMHS/LD - South Essex wide
Psychologist x 0.8 wte
Assistant psychologist x 1 wte
LD nurse x 1wte
Nurse Specialist x1 wte
Pschologist (8 b or c) x 1 0.?? (15hrs)
Essex University Students x 4 (starting Oct 15)
Band 3 admin 0.6 wte x 2

PAEDIATRIC PSYCHOLOGISTS - Basildon and Southend
Counselling Psychologistin Paediatrics x 1 wte
Assistant Psychologist x 0.7 wte
Clinical Psychologist in Community Paediatrics x 0.6 wte
Voluntary Psychologist working between Southend and Thundersley

Tier 2 staffing across north and south Essex

Thurrock

Band 6 - Art therapist x 2 wte (maternity cover 1 wte)

Drama Therapist x 1 wte (maternity leave)

art therapist x 0.48 wte 18

nurse clinician x 1 wte

Band 8c - Consultant Psychotherapist x 0.025 wte

Band 8a - manager x 0.5 wte

LA seconded admin x 0.7 wte

Basildon and Brentwood and Castle Point and Rochford

Staff complement: 16 full time equivalent inc staff manager

Band 6 - Manager 1 wte

Band 5 - 7.5 wte

Band 4 - 7.5 wte

Currently in post

Band 6

Band 5 - 3.5 wte

Band 4 - 7.5 wte

Skill mix

6 x Band 4 counsellors

2 x Band 5 drama therapists

0.5 x Band 5 social worker and counsellor

Thundersley

Band 6 - Play Therapist x 1 wte

CYP IAPT x 1 wte

Band 3 Admin 0.6 wte

North East Essex

Staff complement: 16.78 full time equivalent inc staff manager.

Band 6 - manager 1 wte

Band 5 - 8.12 wte

Band 4 - 7.66 wte

Currently in post

Band 5 - 7.12 wte

Band 4 - 6.66 wte

Skill mix

2 x Mental Health nurses

1 x integrative psychotherapist

7 x councellors

1 x art therapist

2 x social workers

Tier 2 staffing across north and south Essex (cont.)

Southend

Band 7 - Team leader / Art Psychotherapist x 1 wte

Band 6 - Nurses x 2 wte and 1 counsellor 1 x wte

Band 3 x 1 wte admin

Mid Essex

Staff complement: 10.77 full time equivalent inc staff manager.

Band 6 - manager 1wte

Band 5 - 3.76 wte

Band 4 - 6.01 wte

Currently in post

Band 6 - 1wte

Band 5 - 3.76 wte

Band 4 - 5.01 wte

Skill mix

3 x social workers

1 x play therapist

1 x mental health nurse

1 x specialist health visitor

Psychodynamic counsellors

West Essex

Staff compliment: 13.18 full time equivalent inc staff Manager

Band 6 - manager 1wte

Band 5 - 6.50 wte

Band 4 - 5.68 wte

Currently in post

Band 6 - 1wte

Band 5 - 6.50 wte

Band 4 - 5.68 wte

Skill mix

5 x social workers

2 x play therapists

1 x art therapist

1 x psychotherapist

2 x humanistic counsellors

2 x CBT therapists

1 x psychotherapist (child and adolecsent)

NEP Staffing
Tier 4

Page 171

Job Role	Band 3		Band 3		Band 4		Band 5		Band 6		Band 7		Band 8a		Band 8b		Total Tier 4	
	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE
Assistant																	8	
Assistant/Associate Practitioner																	4	
Assistant/Associate Practitioner Nursing																	2	
Clinical Psychologist																	2	
Consultant																	2	
Healthcare Assistant																	15	
Modern Matron																	1	
Nurse Manager																	1	
Occupational Therapist																	2	
Officer																	4	
Psychotherapist																	2	
Sister/Charge Nurse																	4	
Specialty Registrar																	1	
Staff Nurse																	15	
Supervisor																	2	

SEPT Staffing
Tier 4

	Band 2		Band 3		Band 4		Band 5		Band 6		Band 7		Band 8a		Band 8b		Total Tier 4	
Job Role	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE
Nursing	8	8.00			5	5.00	6	6.00	2	2.00			1	1.00			22	22.00
Psychology													1	0.7	1	0.7	2	1.4
Family Therapy											1	1.00					1	1.00
Medical Staff																		
Consultant																		
SpR																	1	1.00
Staff Grade																	1	1.00
																	1	1.00
Admin																		
																	2	2.00
Advocate Service																	1	0.2

Page 172

Appendix 5
Terms of Reference for the Collaborative Commissioning Forum and Transformation Planning Steering Group

Children and Young People's Emotional Wellbeing and Mental Health Collaborative Forum

Terms of Reference

Purpose

The Collaborative Forum has been established following award of the contract on the 1st June 2015, by agreement of the Commissioners. This forum will be used as the focus for discussion of all matters relating Children and Young People's Emotional Wellbeing and Mental Health (CYP EWMH) including strategic planning the commissioning contract and the pursuit of the objectives and performance of the function of the Collaborative.

Functions

The Collaborative Forum's key functions will be to:

- Act as the strategic forum for CYP EWMH transformation
- Oversee the production of a CYP EWMH strategy and transformation plan
- Monitor subsequent delivery of CYP EWMH strategy and transformation plan
- Discuss matters relating to the CYP EWMH commissioning contract and the pursuit of the objectives and performance of the function of the Collaborative.
- Monitor performance of the provider against contract and KPIs
- Monitor mobilisation plans of the new provider

Modus operandi

Members of this group will undertake to:

- Act in an open, transparent and honest way
- Respect the processes and business imperatives of partner organisations both commissioners and providers
- Be creative in resolving the difficult issues raised through joint commissioning and partnership arrangements
- Conduct business on a consensual basis

Membership and frequency of meetings

Membership is made up of one appointed representative from each commissioner. The group will be chaired by a local authority representative and the deputy chair will be appointed by the lead commissioner (West Essex CCG). The secretary for the forum will also be appointed by the lead commissioner.

The group will be chaired by: Barbara Herts

The deputy chair is: Clare Morris

The group will be administered by: West Essex CCG

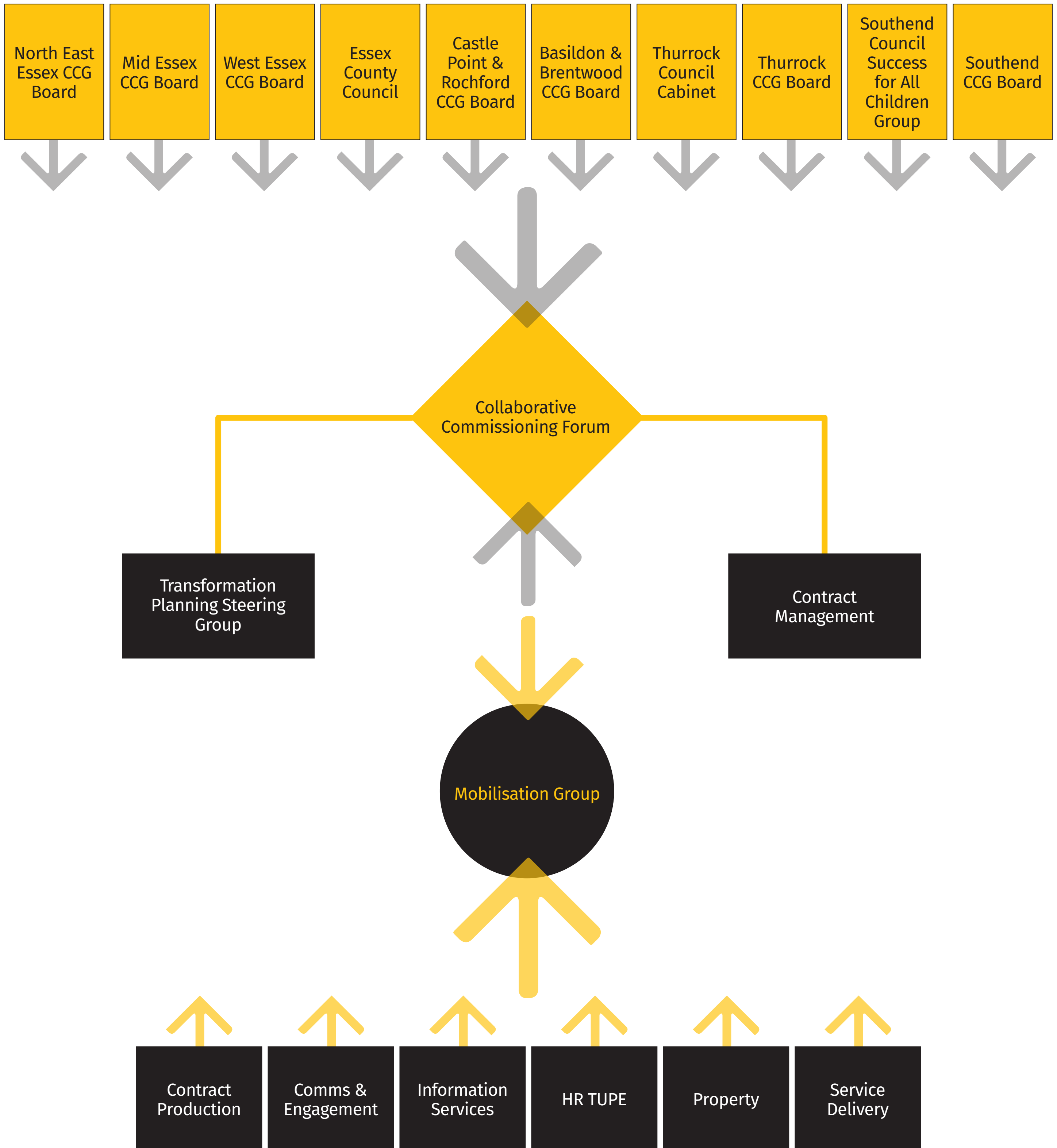
Meetings will be held monthly, with the agenda circulated 5 working days prior.

From time to time work will be carried out virtually by email or conference calls.

Governance

Below is a map detailing the governance for the collaborative forum.

Children & Young People Emotional Wellbeing and Mental Health Partnership Governance



Southend, Essex and Thurrock Transformation Planning Steering Group

Terms of Reference

Purpose

The purpose of the Southend, Essex and Thurrock Transformation Planning Steering Group is to provide a time limited working group to oversee and contribute to the development of the local Transformation Plan for improving emotional wellbeing and mental health outcomes for children and young people. This plan will set out how partners will collaborate across the system fulfil national requirements set out in 'Future in Mind' and Transformation planning guidance for improving access to and experience of services and better meeting local needs.

Objectives

To co-ordinate and contribute to detailed work on the development of the Southend Essex and Thurrock Transformation Plan to ensure that it reflects collaboration across the system and responds to local needs:

- Agreement of the joint vision and priorities for improving emotional wellbeing, resilience and mental health across the Southend, Essex and Thurrock system.
- Agreement of how joint working and collaborative commissioning arrangements will be further developed across the NHS, Local authorities, public health, youth justice, education and the voluntary sector to achieve the vision and sustain improvements.
- To ensure that children and young people are at the centre of development and delivery of the Transformation Plan.
- To deliver a joined up approach, linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable.

To ensure that the Transformation Plan includes clear actions and targets for improving the areas set out in the guidance, as set out below:

- Plans for developing/enhancing evidence based community eating disorder services.
- Set out plans for building capacity and capability across the system, so that more children and young people locally are able to access care.
- Support the further development of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme across Southend Essex and Thurrock, building on existing engagement.
- Improving perinatal care (taking into account that allocation for this will be made separately and commissioning guidance has not yet been published).
- Plans for bringing education and local mental health services together around the needs of the individual child.
- Demonstrates links with existing improvement initiatives such as the Crisis care Concordat

To ensure the Transformation Plan is agreed and submitted within agreed timescales.

Membership

The Transformation Planning Steering Group will be chaired by the Essex CAMHS Strategic Lead, West Essex CCG. The Director for Integrated Commissioning, ECC will serve as vice chair.

- The membership of the Transformation Planning Steering will comprise of;
- Commissioning and Strategic Leads for Thurrock LA, Southend LA, ECC, CCGs
- Strategic Lead for NELFT
- Tiers 2 and 3 CAMHS provider leads
- Head Teacher/Education commissioner representative
- Voluntary Sector representative
- Healthwatch Essex representative
- YOS representative
- NHSE Specialised Commissioning representative
- Adult Mental Health Commissioning representatives
- GP leads
- Public Health Commissioning representative

Frequency of meetings

The Transformation Planning Group shall meet monthly

A smaller core group will meet more regularly to ensure the plan is progressed within the set timescales.

Governance

The Transformation Planning Group will report to the CAMHS Collaborative Commissioning Forum.

The Transformation Plan will be submitted by West Essex CCG, following approval from Southend Essex and Thurrock Health and Wellbeing Boards/a nominated representative from each Board.

This page is intentionally left blank

Thurrock Safeguarding Annual Report 2014/15

Foreword by Graham Carey, Independent Co-Chair

This is the 7th Annual Report to which I have contributed and, as Les Billingham says below, the year has been one of preparing for change while maintaining the safety net of business as usual. Bringing about major change in the current economic context is not ideal, particularly as our agenda broadens to include areas such as suicide, modern day slavery, emergency planning for vulnerable adults and domestic violence. Adult safeguarding may need to be careful of both mission creep and of being used to fill gaps left by others.

That said, the headline figure for the year is that 287 alerts were raised which resulted in 199 referrals being dealt with. That is a reduction of about a third for both alerts and referrals over previous years and we, as a board, need to understand whether that is a positive decline reflecting a better understanding of what should be reported, or whether it is indicative of something that we should be concerned about.

This report also describes referrals as being "substantiated" or otherwise, which has been the established way of recording the result of a safeguarding intervention. That emphasis on culpability and on the "perpetrator" has been recognised as unhelpful and Making Safeguarding Personal seeks to move the emphasis from process to outcome. The key indicator for MSP is whether or not the outcome achieved was that wanted by the person at the centre of the intervention. This will be a challenge to professionals in the year ahead and may mean an acceptance of risk that some will be uncomfortable with, but it is a welcome challenge.

For the board and its members, our challenge ahead is to add value over and above the work already undertaken by individual agencies. As important as assurance, co-ordination, information sharing and promoting partnership working is, the board should aim to make a measurable difference to adult safeguarding in Thurrock, particularly through its preventative agenda. For the first time we have included our priorities and aims for the year ahead within this report we look forward to reporting back on our efforts to achieve those aims in next year's report.

Finally, there are as ever, many people and partners who need to be thanked for their contribution over the last year. Our partners include the CCG and NELFT, SEPT and BTUH as health providers; Essex Police, the Probation Service, Essex Fire and Rescue and East of England Ambulance. Also Thurrock's Community Safety Partnership, Trading Standards, Housing, Healthwatch and the members of the care sector who give up their time. Thank you to Fran Leddra and the Operational Group and to Jill Moorman and her team. Thank you also to Les Billingham, Sarah Attersall, Louise Brosnan and Bill Clayton from the Local Authority. Jayne Foster-Taylor and Andrea Metcalfe from the CCG; Michelle Cunningham and Jim Nicholson from the CSP; Neil Woodbridge from TLS; Kim James from Healthwatch and Ian Evans from the Thurrock Coalition.

Contents

Foreword by Graham Carey, Independent Co-Chair 2

Message from Les Billingham – Head of Adult Services and Co-Chair. 4

Executive Summary 4

Partnerships 5

Thurrock's Safeguarding Adults Board 2014/15 8

Empowerment 10

Protection 11

Prevention 14

Proportionality 18

Future Priorities 19

Appendix 1 – Asset Based Strategy 20

Message from Les Billingham – Head of Adult Services and Co-Chair

"2014/15 was a very significant year in terms of Adult Safeguarding, with the Care Act coming in to force from April 2015, placing our work within a statutory framework for the first time. The team and the extended partnership had to undertake their normal work ensuring that vulnerable adults were kept safe and free from harm wherever possible, alongside developing clear plans to ensure Thurrock's safeguarding approach was fully compliant with the new duties. Not everything is yet as good as we would want but much has been achieved and I would like to thank everyone involved personally for managing the transition successfully.

Alongside this change the implementation of Making Safeguarding Personal presented further challenges. The need to ensure that the person at the centre of each safeguarding case had their choices understood and that these choices were reflected in the outcomes achieved signalled a significant development in Safeguarding practice, one that I feel those involved locally met with success; once again I would like to offer my thanks to all involved.

Finally the increase in work load and complexity associated with Deprivation of Liberty cases has also added to the pressure on the team. This is an area of particular success for us, increasingly the work we undertake locally is being seen as representative of best practice nationally and provides further assistance means that I feel we can be very proud of the way in which safeguarding is delivered in Thurrock. As ever much remains to be done and as circumstances and expectations change we need to be ready to adapt to meet new challenges. I remain confident that we have a strong and stable partnership that is sufficient to meet these demands."

Executive Summary

Thurrock's Safeguarding Adults Partnership Board 2014/15 Annual Report provides an overview of the Board's achievements over the past 12 months.

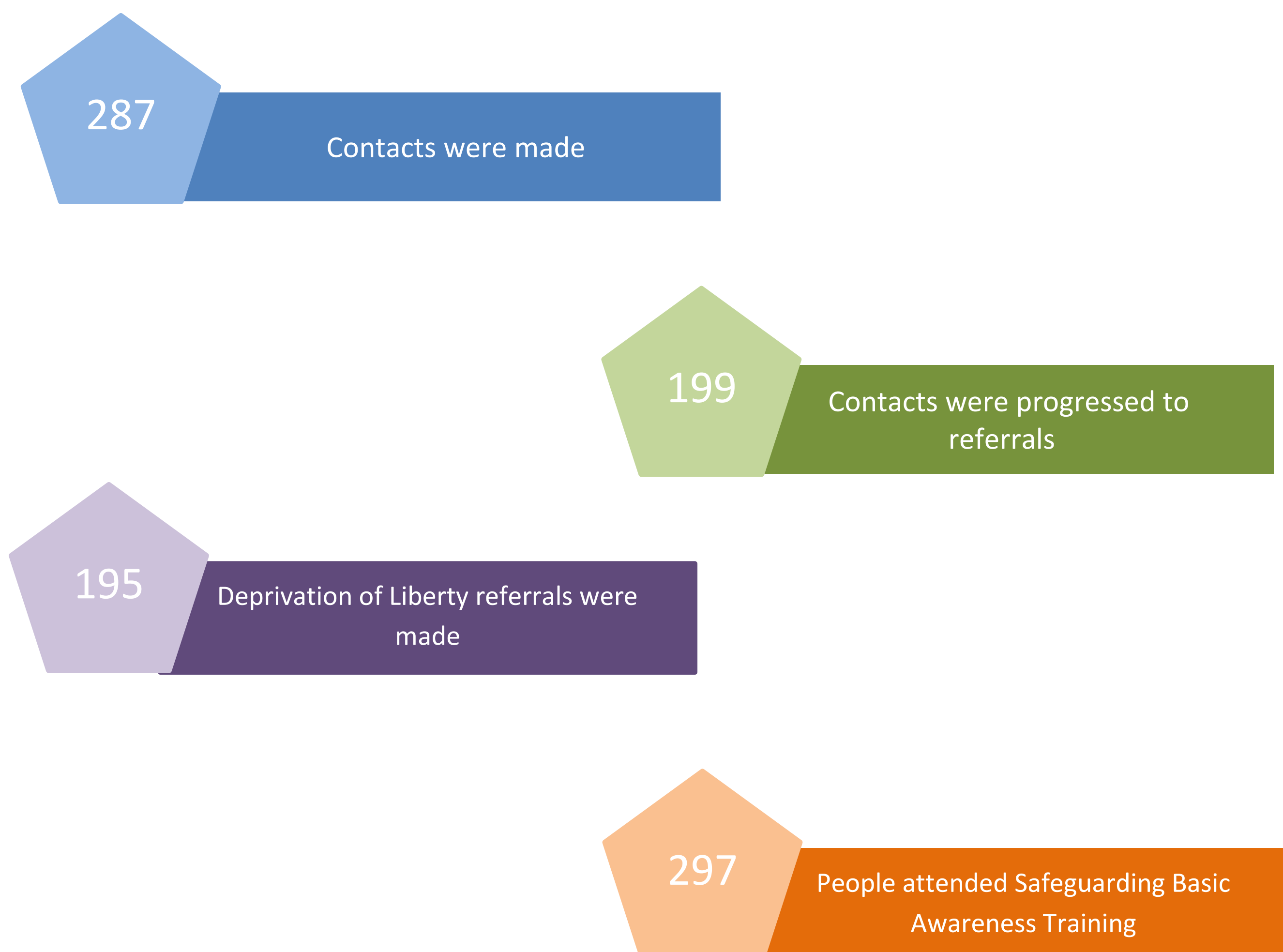
In May 2011 the Government set out its policy on Safeguarding Adults which included a statement of principles from which Local Authorities including Social services, Housing, Health and the Police could develop and measure their local safeguarding arrangements. They continue, and are strengthened with the Care Act 2014Guidelines. It is these principles which form the framework for this year's annual report.

The Board has been actively working this year to set a new Terms of Reference and Annual Work Plan which we aim to finalise within the next couple of months. The strategy and objectives have also been updated. Our future priorities are summarised on Page 17

Furthermore, the Board has asked for all providers to review their safeguarding policies as part of the new Care Act and also to consider training.

The Safeguarding Team underwent a restructure in December 2014/January 2015 with Safeguarding Senior Practitioners being moved into Adult's Social Care's front line Early Intervention and Prevention teams. This has ensured that throughout the teams safeguarding has become everyone's business and has increased the knowledge and experience of all practitioners in the teams and has been instrumental in the application of Making Safeguarding Personal.

Key Facts & Figures



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

The Adult Safeguarding Team are working with a number of different organisations to ensure Safeguarding continues to have a high profile.

Partnerships with the Safeguarding Executive Board

Thurrock Clinical Commissioning Group (CCG) – Jane Foster-Taylor

Thurrock Clinical Commissioning Group (CCG) actively supports and embraces partnership working for the Adult Safeguarding agenda across the locality. It is committed to following the SET (Southend Essex & Thurrock) Safeguarding Adults Guidelines and provides support to staff within the CCG, commissioned services and Primary Care. The CCG has Jane Foster-Taylor, Chief Nurse as the Executive lead, Dr Grewal as GP lead for safeguarding and Linda Smart as the Designated Adult Safeguarding Manager (DASM) for the CCG.

The CCG is taking forward the changes brought about by the Supreme Court Ruling with regard to the P v Cheshire West and Chester Council ruling. Plans are in place for applying to the Court of Protection for authorisation of a Deprivation of a Liberty where the person is residing outside the hospital or care home environment and is funded by the CCG.

Essex Police – Mark Wheeler

In the past year Essex Police have reviewed and increased the resources within the Safeguarding of Vulnerable Adults (SOVA) team which now includes a Detective Sergeant and Detective Inspector. This team is responsible for triage of all safeguarding referrals received by Essex Police to determine the necessary investigative and safeguarding actions required in order to protect individuals from harm. The SOVA team have close working relationships with Social Care professionals which they utilise to ensure that information is shared and plans are implemented to protect vulnerable people within our communities.

Essex Police continue to work closely with partners across Essex and will continue to do so to safeguard those who are vulnerable and at risk of harm or neglect. We have been working with the Office of Police and Crime Commissioner, our colleagues from Thurrock, Southend and Essex Safeguarding Adults Boards and Crime stoppers in the development of an Elder Abuse Helpline. The helpline, launched in February 2015 as a pilot campaign, is managed by Crime stoppers who then refer concerns regarding elder abuse to the local authority and Essex Police.

Partnerships with other agencies

Thurrock Adult Community College – Sharon Walsh

The safeguarding referral process is embedded and understood across the college. Safeguarding is a set agenda item on all team meetings held in college; this is a requirement and regularly audited by TACC's Health & Safety Committee to ensure the practice is observed. Furthermore, a safeguarding report is made to the termly H&S committee, the termly Resources Governing Body committee and an annual report to the Governors.

Community Safety Partnership (CSP) – Michelle Cunningham

Trading standards have continued to work with adult safeguarding and Essex Police to visit people who have been identified as being vulnerable to scams, providing advice and following up where they have found victims. The CSP hosted a conference for professionals to alert them to all the different types of fraud and scams that they may pick up when visiting vulnerable residents.

We have an excellent partnership with the voluntary sector, specifically Neighbourhood Watch who have continued to take referrals from all professionals to visit anyone who may be considered vulnerable and provide them with free crime prevention equipment which is fitted by Thurrock Lifestyle Solutions.

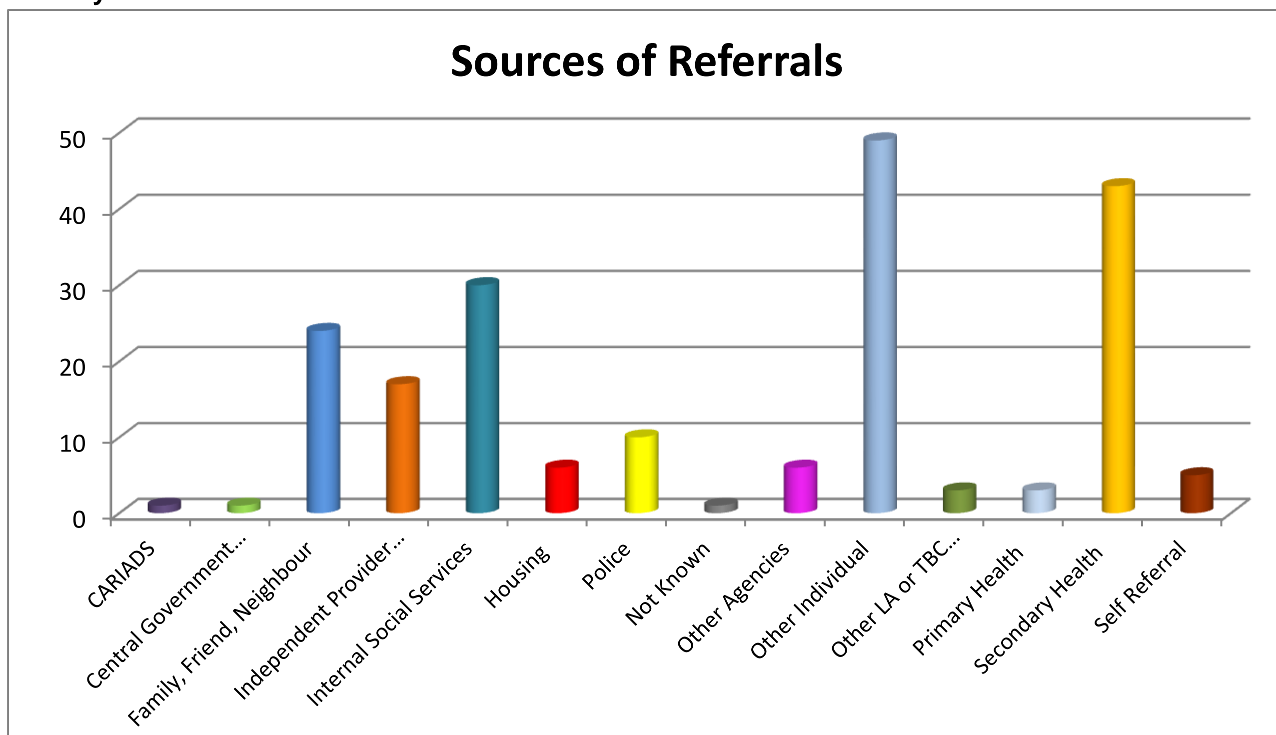
"I now feel so much safer following the visit and advice"

Following a visit by our crime reduction officer and neighbourhood watch to an elderly lady who had recently been widowed and had previously been a victim of prolonged Anti-Social Behaviour she said "thank you, I now feel so much safer following the visit and advice".

For 2013/14 the Adults Safeguarding Team received referrals from a number of different sources, showing that our partnerships with agencies is growing.

Links with our Early Intervention and Prevention teams via Multi-Disciplinary Team Meetings in Health provide valuable feedback for the concerns raised by the Ambulance Service which are all screened for Safeguarding concerns.

Graph 4: shows figures in relation to the different sources of referrals- **Please note that Primary Health Service includes GP**



Thurrock's Safeguarding Adults Board 2014/15

The Board's Vision

Thurrock is a place where every adult, in every home, in every community, matters. Our vision is:

"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"

Safeguarding is everyone's business and our vision is shared by all of our partner agencies. It cannot be delivered by agencies acting in isolation. It can only be achieved by agencies working together, through common plans and strategies.

Thurrock's Safeguarding Adults Partnership Board works with agencies to improve practice, reports and responses to adult abuse and ensures that our policies and procedures underpin and provide a solid framework for the protection of vulnerable adults in our community.

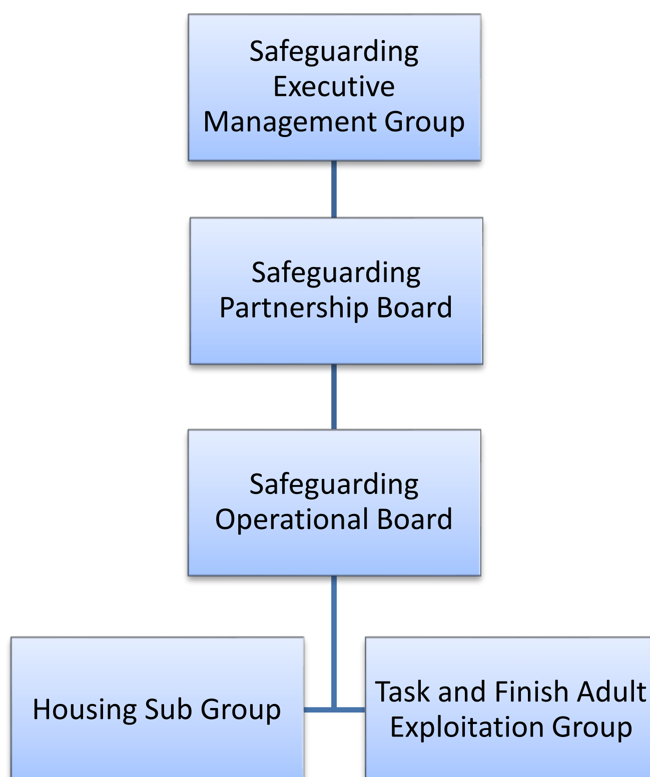
Thurrock's Safeguarding Adults Board

Graham Carey our Independent Safeguarding Champion and Co-chair and Les Billingham, Head of Adult Services have continued to challenge and support the Board in achieving continuous development for Thurrock.

The Board has representatives from a range of organisations, including:

- Basildon and Thurrock University Hospital NHS Foundation Trust
- East of England Ambulance Service
- Essex County Fire and Rescue Service
- Essex Police
- Essex Probation
- Healthwatch Thurrock
- Age Concern
- Local residential and Domiciliary Care Providers
- NHS England
- North East London Foundation NHS Trust
- South Essex Partnership University NHS Foundation Trust
- Public Health
- Thurrock Clinical Commissioning Group
- Thurrock Community Safety Partnership
- Thurrock Council – Adult Services, Children's Services & Housing
- User Led Organisation

Thurrock Safeguarding Adult's Board Structure



Thurrock Adult's Board Activities

On the 27th March an away day was organised for the Safeguarding Adults Board at the Culver Centre. An initial board meeting was held in the morning to cover any matters arising. The partnership agreed the following actions:

- Sign off of Asset Based Strategy (Appendix 1)
- Sign off of Terms of Reference
- Agreed key objectives for 2015/16 (Appendix 1)
- Agreed a work plan

The afternoon session had a presentation from Peter Hood at Essex Police looking at protecting vulnerable people during civil emergencies. This is an area of growing concern and the board have undertaken to continue to develop our approach.

Empowerment

Personalisation and the presumption of person led decisions and informed consent

In the year 2014/15, Safeguarding received 288 contacts with 199 being progressed to referrals, with 78 of those being closed as substantiated or partially substantiated.

15 of the 199 referrals were ceased at the individuals request but the Safeguarding team ensured that the individuals were advised of any information that could be of ongoing assistance.

Deprivation of Liberty (DOL)

The Deprivation of Liberty and Mental Capacity Act Lead is fully embedded in the service . The service provides knowledge and support to our practitioners and providers in and out of the borough. In 2014/15 the Council received 215 DOL referrals, this is almost a 400% increase from 2013/14 (54 referrals).

Authorisations were granted for 115 applications and by the end of the year only 13 were outstanding, although due to the added pressures associated with the Supreme Court judgement, 102 of these were not carried out within the set timescale.

Number of Days Delayed	Number of Assessments	Percentage
30 days or under	36	35%
31-60 days	34	33%
61-80 days	21	20%
81 days and over	10	10%

This is attributable to availability of Best Interest Assessors and S12 Doctors in most cases.

Making Safeguarding Personal

We have signed up to Making Safeguarding Personal to achieve a Bronze level in the next year. There has been a pilot questionnaire put in place to collate information from people who are reported to have experienced abuse and their views about their expectations of outcomes from our enquiries and actions. This is also being incorporated into our electronic systems.

While we are confident that people are already included in decision making and outcome setting it is important that it is formally recorded to enable us to monitor our performance. This will also enable us to look at our use of advocacy in safeguarding.

Not just respite but a holiday in a seaside town

Mrs B was referred to safeguarding due to financial abuse by members of her family and her inability to refuse their requests for money or purchases. As a result of our intervention the Corporate Appointee Team (now incorporated within the safeguarding team) has been working with her and her husband to manage their money alongside their instructions. Most recently, Mrs B requested to have respite from their home while adaptations were being undertaken. Discussions with them, their social worker and the corporate appointee have ensured that this was not just respite but a holiday in a seaside town which met her needs in line with their expressed outcomes.

Protection

Support and representation for those in greatest need

Out of the 287 alerts made from April 2014 to March 2015, 88 of these were not progressed to a Safeguarding referral, however, advice and information was given and referrals made to other organisations if appropriate. This has enabled us to record relevant information about these individuals which can be retrieved and matched with any other incidents or concerns that arise which puts us in a good position to help in the future.

A significant proportion of the safeguarding assessments we carried out (47%) were people who either didn't receive a current service from the Council and some were

previously not known, this is evidence that we are able to protect the wider community who meet the criteria of vulnerability.

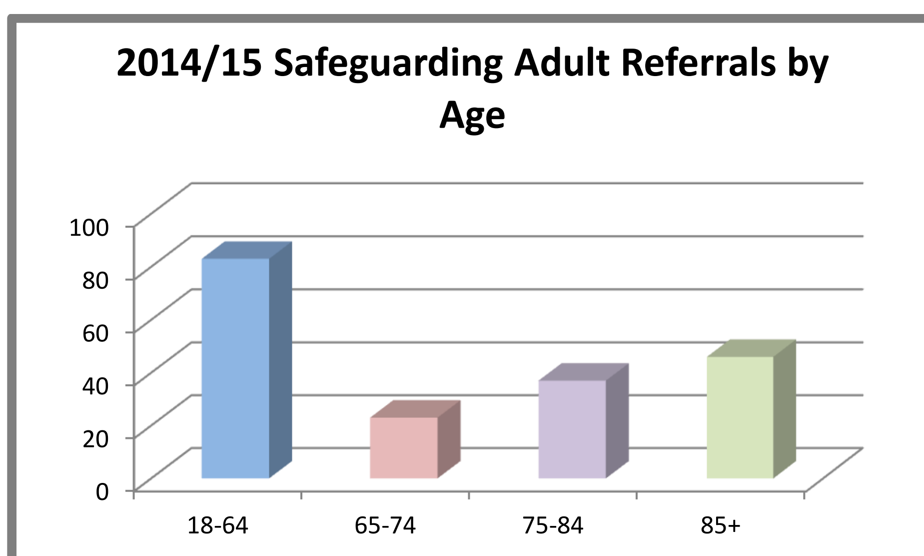
The vast majority of those who declared their ethnicity were White British, 8 (4%) people were noted to be either Black or Asian with only 1 older person being Asian.

Analysis of the types of abuse experienced reveals that 20% were victims of financial abuse and 22% were victims of Physical Abuse. This was a similar trend across all age groups.

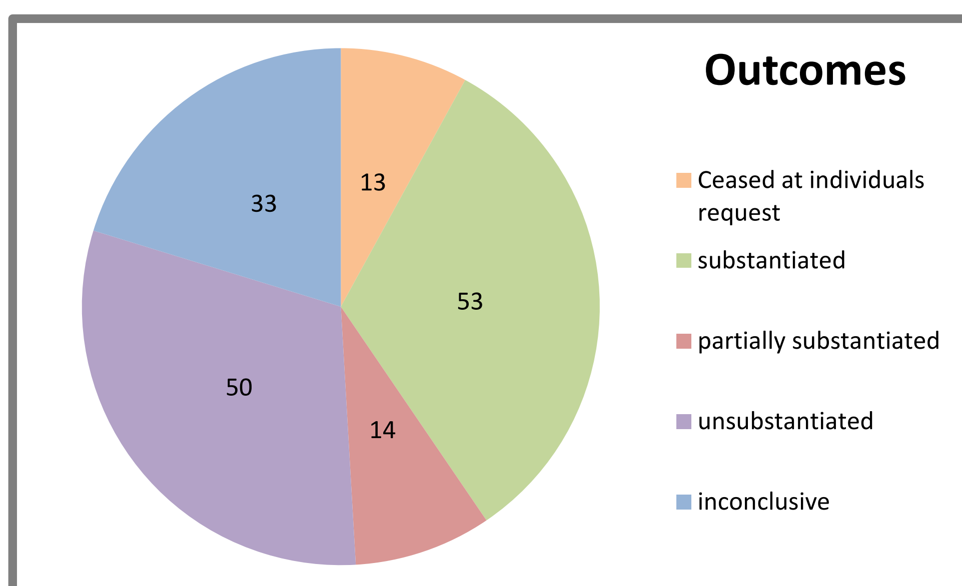
Looking at Table 1, the age range of 18-64 received the highest number of contacts of 83.

Allegations of Neglect were made in 51 of the referrals (25%). Nearly 70% of these allegations referred to people over the age of 75 and of these 37% were in their own home and 45% were in a Care Home setting.

Graph 1: shows figures in relation to the number of referrals for the different age ranges



Graph 2: shows figures in regards to the different outcomes for the 163 closures in this period

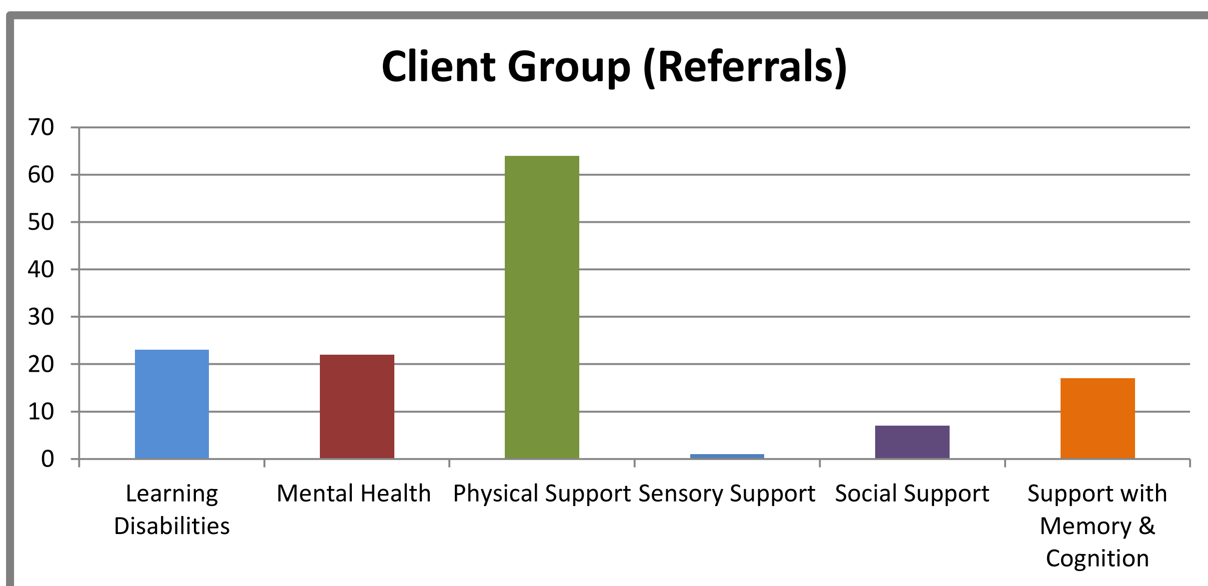


Where the allegation was substantiated, 81% had an outcome of the risk being removed or reduced. Those partially substantiated, 50%, inconclusive was 63% and even where the allegation was unsubstantiated the risk was removed or reduced in 46% of the cases.

Where the risk remains, full risk assessments are in place.

Looking at graph 3, In regards to the Physical Support client group, 32 (50%) of the alleged abuse took place in their own home, with 19 (29%) taking place in a Care Home setting, the remaining took place in other settings.

Graph 3: shows figures in regards to the client groups that referrals were made



Community Safety Partnership – Michelle Cunningham, Thurrock Community Safety Partnership Manager

The (CSP) has taken a lead on promoting Essex Police's "Stop the Hate" campaign and with great support form Thurrock Disability Network, in particular Ian Evans. Last year we trained 35 hate crime ambassadors and established 3 hate incident reporting centres – all in venues which are attended by adults with disabilities. BATIAS have also taken on the role of ambassadors and are promoting awareness amongst the community they work with.

Vulnerable people continue to be at the heart of Thurrock's community safety priorities for 2015/16 with the priority: **To reduce harm to and safeguard vulnerable victims** from:

- Domestic abuse;
- Sexual offences including rape;
- Child sexual exploitation;
- Serious Youth Violence;
- Hate crime;

- Anti-social behaviour;
- Cyber bullying;
- Honour based abuse and
- Serious Organised Crime encompassing Modern day slavery & Fraud where victims are vulnerable

Prevention

It is better to take action before harm occurs

Training

Training is an area that is high on our agenda in relation to our preventative work. Our aim is for staff to not only understand what abusive practice is but for them to be confident to report it.

Workforce Planning – Bill Clayton, Senior Training & Staff Development Officer

In 2014/15, 297 people attended Safeguarding Basic Awareness Training with 53% coming from the Private, Voluntary and Independent sector.

In addition to this, our Workforce Planning team have also worked with our Private, Voluntary and Independent sector to carry out training for managers. This training was designed to enable managers to gain a better understanding of the revised SET procedures. It also explored their responsibilities within the policy and the revised threshold.

To address concerns within our Traveller's Community in Thurrock, Safeguarding and Workforce Planning joined together to arrange training titled "One Voice for Travellers'. The sessions were run by Travellers themselves and enabled people to understand and engage with the culture better. Between October 2014 and January 2015 45 people attended including staff across the Council and partners.

At the beginning of the year the service hosted a conference day regarding Modern Day Slavery. This is of particular importance as it also included as a type of adult abuse within the Care Act. The conference covered the following: -

- Understand Modern Day Slavery in the context of Thurrock
- Understand the context of child sexual exploitation and trafficking to identify different types of Modern Day Slavery

The conference had a wide target audience and was supported by Unchosen, a leading charity in this area. 94 people attended an informative and interactive day representing adult services, children services, schools and health services.

Thurrock Adult Community College – Sharon Walsh, Principal

Thurrock Council and Thurrock Adult Community College has been working together

for a number of years for staff to have a good understanding of Safeguarding. These staff have included cleaners, caretakers, volunteers, teaching staff and Managers.

At the annual Staff Conference at the start of the academic year, Sept 2014, all staff & volunteers were encouraged to attend a Prevent session, led by Peter Martin, the PREVENT regional Further & Higher Education Coordinator.

Corporate Appointee Team – Sarah Attersall, Financial Management Officer

Demands on the Appointee & Court of Protection Team continues to grow, although the team only work cases that have been referred through Adult Safeguarding or, if no family/friends are available to take on the support role in relation to finances. They provide information and advice to Adult Services to enable them to support Thurrock's most vulnerable adults.

Funding has been agreed for a Lasting Power of Attorney project, that will hopefully raise awareness of this valuable tool which allows people to plan for any future incapacity, giving them the power to appoint who they would like to make decisions on their behalf if they are unable to.

SEPT – Elaine Taylor, Associate Director Safeguarding

A series of preventative and awareness raising initiatives have been implemented this year within the Trust and audits have evidenced that staff awareness and response to Safeguarding issues has improved in the timeframe process and quality of investigations.

Community Safety Partnership – Michelle Cunningham

The CSP have funded 2 projects which have been delivered by TLS and SERICC respectively to

i) deliver SAFER training to people with learning disabilities – how to manage bullying in the community, and
ii) self-defence awareness for victims of sexual abuse.

Working with the Adult Safeguarding Lead, the CSP have developed an action plan in response to national concerns with regards to modern day slavery and contributed to the delivery of the conference as mentioned earlier.

Thurrock Clinical Commissioning Group (CCG)- Jane Foster-Taylor, Chief Nurse

In line with mandatory CCG training requirements, all staff are required to undertake safeguarding adults training, PREVENT training and Board members training is available on MCA and DOLS. The CCG also host Time to Learn sessions which are attended by General Practitioners (GP), Practice managers and Nurses from member practices across the locality.

Furthermore, training has been provided jointly by Graham Carey and Jill Moorman from the Local Authority and Andrea Metcalfe from the CCG, which have covered the fundamentals of Safeguarding Adults and MCA and more recently legal and policy updates

The CCG is making further arrangements with Bond Solon to deliver additional MCA/DOLS training for staff in Primary Care over the next few months.

Essex Police – Mark Wheeler

Over the past year Essex Police has continued to work with our partners to share information and improve the all-round support we give to domestic abuse victims. Special operations have been set up to monitor offenders and target those considered to be a danger while improved support has been put in place to make it easier for survivors to leave abusive relationships and start afresh. We are speaking to victims and survivors of domestic abuse to help shape the way we deal with this abhorrent crime and make sure that their needs are at the heart of what we do.

In early 2014 we conducted a Domestic Abuse Crime Unit pilot in the South of Essex. The DACU introduced improvements in the investigation of domestic abuse incidents and consisted of experienced officers dedicated to protecting the most vulnerable in our community. The pilot occurred simultaneously with the introduction of body worn video equipment for officers responding to domestic abuse incidents. These cameras proved immediately beneficial in the prosecution of offenders and in supporting victims though the court process. In September the DACU pilot was extended force wide and was renamed Operation JUNO.

Domestic Violence Protection Notices (DVPN) and Orders (DVPO) were introduced on 1st June 2014. These are civil orders introduced by the Crime and Security Act 2010, which have been introduced to help provide immediate safeguarding to victims of domestic abuse, and can be used when a perpetrator has been violent or threatened violence against a victim during an incident. Orders can last for 28 days and provide victims with space to consider what to do next. Perpetrators who breach orders are liable for arrest.

Essex Police together with NEP and SEPT piloted a Street Triage project across Essex from 01/12/2014 – 31/03/2015. During this period, triage cars operated on Friday, Saturday and Sunday nights (supported by a telephone advice line outside of operating hours). Different models of Street Triage have been implemented across the UK, with some police forces having a street triage car available 7 days a week, and others using a mix of street triage and telephone helplines. In Essex we adopted a mixed model – this has provided the opportunity to compare different models of intervention, however initial results strongly indicate that the helpline was not utilised by Police Officers and has limited impact on diverting individuals to appropriate mental health resources.

During the Street Triage pilot project, the street triage cars saw 269 individuals, appropriately assessing and diverting 110 individuals to appropriate mental health services, with 20 individuals (7.4%) accepting an offer of informal admission. As a result of direct feedback from those police officers involved in the Street Triage pilot, 46 individuals assessed by the Street Triage car would have been detained by Police Officer using their powers under s136 MHA (1983) (but for the availability of the Street Triage service) and a further 17 would have required intervention using s135

Mental Health Act. Street Triage has already produced a number of significant benefits – these include:

- Significantly improved relationships between police and mental health professionals
- A small decrease in waiting times for Mental Health assessments
- An emerging shift in police culture from being risk adverse to positive risk management
- Improved police confidence in talking about mental illness from those officers directly involved in the project who have provided very positive feedback on their experience.
- Greater understanding within both Police and Mental Health professionals of each agencies respective powers and authority Experiential learning due to multi-agency teamwork, leading to greater understanding of the roles of other professionals within the Mental health Service and a greater understanding of mental illness and pathways to support such clients.
- Significant multi agency financial savings. During the pilot project, Street Triage directly prevented 63 individuals from requiring detention under s136/s135 resulting in efficiency savings of £18,900 during the pilot project (Police & Mental Health Professionals) – or potential annual efficiency savings of £56,700.

North East London Foundation Trust (NELFT) – Rita Thakaria

In February 2015 NELFT had the pleasure of co-ordinating a multi-agency one day workshop centring on the Self-Neglect agenda, especially in the light of this being included as a category of harm under the *Care Act 2014*.

Speakers were invited from a range of statutory partners (both Essex and London) and delegates were drawn from across the wider Essex and Eastern London areas from a variety of agencies including Voluntary, Housing, Local Authorities, Commissioners and staff from NHS services for people with Learning Disabilities, Mental Health needs, Community Health needs and Acute Hospitals.
Jill Moorman, Strategic Safeguarding and Intervention Manager, led a session on the ground-breaking approach to multi-agency working being implemented in Thurrock which has gone on to be embraced within the Southend, Essex and Thurrock (SET) SGA Guidelines regarding Self-Neglect.

NELFT has a number of bespoke training relating to Domestic Abuse, Honour based Violence, Trafficking, Forced Marriage and Sexual Exploitation. Training is available for partner agencies as part of the existing safeguarding arrangement to improve services and protect families from the impact of harmful practices

Proportionate and least intrusive response appropriate to the risk presented

Mrs A "would like help but doesn't have the money and doesn't know where to start"

Mrs A is a hoarder and the neighbours had concerns for their well- being. Safeguarding had tried to engage with Mr A numerous times but each time Mrs A cancelled at the last minute. Susan Griggs, Local Area Coordinator was asked to try and engage with Mrs A.

Susan Griggs started to meet with Mrs A and for her to gain trust and confidence. Susan slowly started to mention to Mrs A her living conditions and the hoarding issue. Mrs A agreed she would like help but doesn't have the money and doesn't know where to start.

Firstly it was agreed that the front garden could be cleared as winter was fast approaching and Mrs A was finding the stairs to the property hard as the garden was overgrown. A local gardening company was contacted and they were happy to help free of charge, the garden was then cleared. Mrs A stated that she felt like a new woman with a lovely garden and being able to access the hand rail to the steps that she had forgotten existed.

Susan and Mrs A discussed the potential for a Fire Safety Officer to come round. When the Officer came round, there was some initial reluctance from Mrs A but eventually let the Officer into the back area where they discussed fire safety and explained the risks of hoarding and said that he would offer Mrs A any help if needed.

Following the conversation with the Fire Safety Officer, Susan and Mrs A discussed the clearing of the back door as this was Mrs A main access into her property and for her to get in, she has to climb to the top of a pile of possessions before she can enter the property. Mrs A said there was no rush to get items and possessions cleared, however, due to the nature and capacity of the hoarding, Environmental Health are now also on board.

Mrs A will be having her property cleared by a professional company and doesn't need to worry about the finances as Environmental Health will put a charge onto the property. Whilst the property is being cleared Mrs A may be offered temporary accommodation as the property may not be safe.

Mrs A is looking forward to having her property cleared but apprehensive at the same time.

Small but significant improvements

Self-neglect due to alcohol abuse has been an increasing issue for the safeguarding team, Mr C was referred following a call to the fire service, further concerns were raised by neighbours and housing staff which resulted in a meeting to discuss the risks involved and the actions that could be taken, all of which were relayed back to Mr C via the Local Area Coordinator (LAC) who had managed to engage with him over the previous weeks. A coordinated approach resulted in fire prevention equipment being explored, how housing staff can approach concerned neighbours to diffuse what could become a volatile situation, and continued support from the LAC resulting in small but significant improvements.

Future Priorities

In 2015/16 we want the profile of Safeguarding to continue growing, therefore, we have a number of future priorities, they are:

- Taking forward the role of Designation Adult Safeguarding Manager (DASM)
- Review training in line with the Care Act
- Formalise budget monitoring for the team and Boards
- The 4 Key Objectives to be met
- Using the SET guidelines for Serious Adult Reviews
- 2 projects to be agreed and taken forward
- Organising a safe house for vulnerable adults
- The Lasting Power of Attorney project

THURROCK SAFEGUARDING PARTNERSHIP BOARD

SAFEGUARDING ADULTS STRATEGY – 2014-2016

An Asset Based approach

Introduction

The Thurrock Adult Safeguarding Partnership Board has been clear from the beginning that Adult Safeguarding is everybody's concern with communities playing their part in support, prevention, detection and in sharing concerns about potential abuse and neglect. Many people are able to self protect. Some adults with care and support needs, however, may be more at risk of abuse or neglect than others. Some are less able to protect themselves from harm. No one agency can cover all these situations on their own: we need to work together.

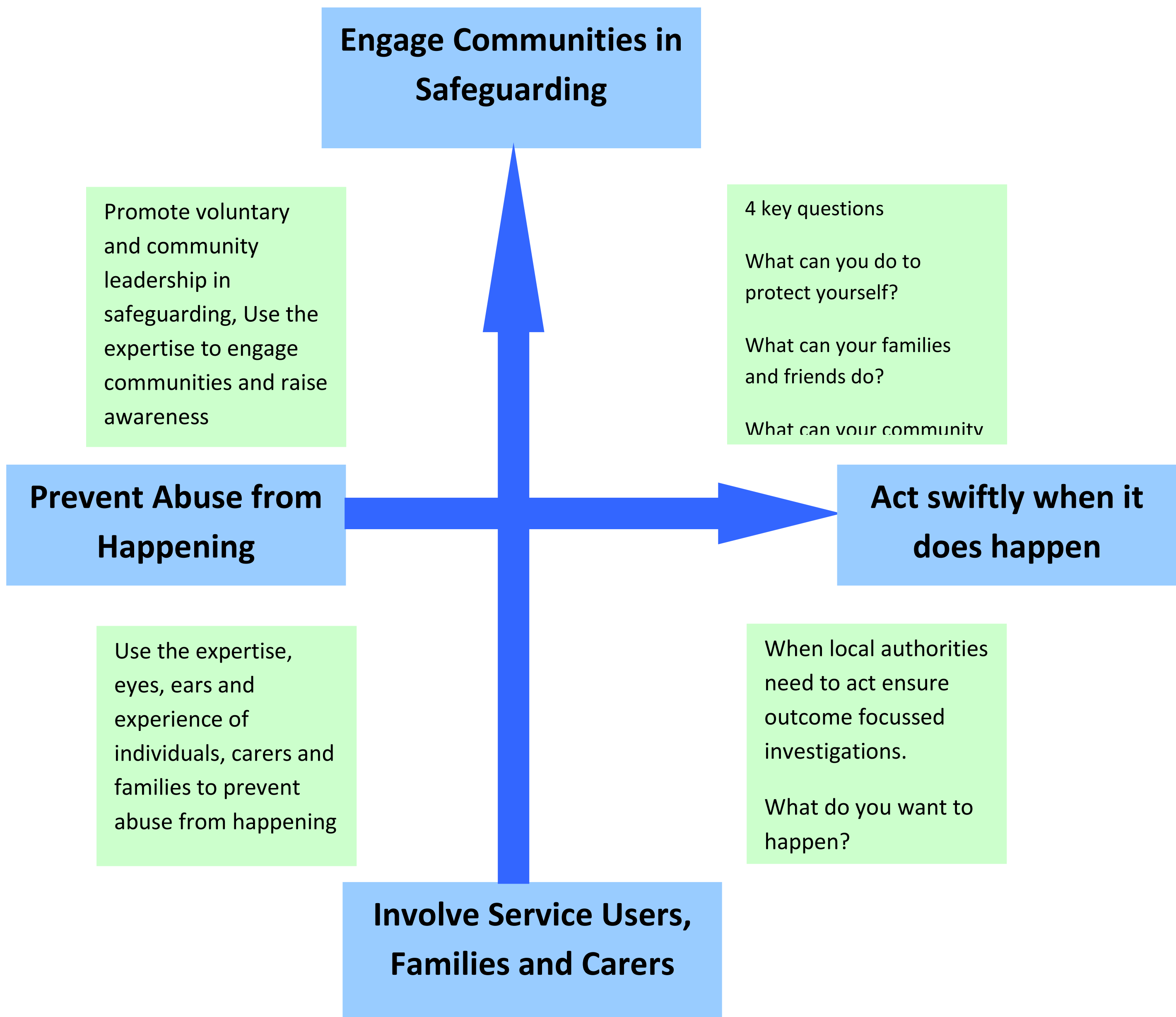
The Coalition Government has included provision in the ***Draft Care and Support Bill*** for partnerships, such as ours, to be placed on a statutory basis. We welcome this. It may mean changes to the way we work or what we do. To ensure that Safeguarding is everyone's business each Board will need to develop a shared strategy with key partners and to report their progress to local communities. A successful partnership depends on sustaining a shared vision and agreed priorities. Thurrock has been developing an Asset Based approach to all aspects of social care; using people's strengths instead of looking at their problems, and promoting independence rather than creating dependence. We believe the same principles can apply to Adult Safeguarding.

Engaging Communities in Adult Safeguarding

A number of values underpin user involvement in health and social care, and these include respect, equality, social inclusion, partnerships and choice. No Secrets (2000) included references to the importance of involving and working with communities, and this was strengthened in its review of 2009, focussing on personalisation, choice and control and people empowered to do more for themselves and self- direct their support.

This legislative context continues to grow in the new Care Bill. There is more emphasis on prevention and community strengths rather than vulnerability and protection, with the role of safeguarding boards to be more representative, more engaging and supporting communities and individuals to protect themselves.

Asset Based Safeguarding Model



Using an Asset Based Model

Asset based models of working are being introduced in a number of different areas across the UK. The model considers local assets as the primary building blocks of sustainable community development. By building on the skills of residents, the power of groups and networking, communities solve their own issues, manage their own development and create something a lot more meaningful and real than any service being imposed upon them.

The discussion regarding adopting the same model when it comes to the adult safeguarding agenda is again one which is growing. The sector led project 'Making Safeguarding Personal' has provided valuable information on what Councils are already doing to focus on the outcomes for individuals who use safeguarding services. It raises questions about whether a person centred, outcome focused approach could be more cost effective, than a professionally led and process driven one.

We should start from the premise that an Adult Safeguarding Board does not keep people safe. It is individuals, families, neighbours, friends and the community that can keep people safe. Community engagement therefore is far more about providing the tools to help people help themselves, than it is to tell them what to do. The tension however is the balance between promoting choice and control whilst managing the risks. We know that as well as neighbourhoods supporting one another, individuals can be destructive, prejudice and harmful. It is the balance of those risks and responsibilities that often lead to barriers to community engagement and involvement. Community engagement is also about engaging with professionals/ providers in the community

- Strong links with the voluntary and independent sector will assist good community engagement
- SAB's should use the strengths of these providers who are locally based, have good community links and directly work with vulnerable adults, their families and carers
- Some people will prefer to engage via one of their service providers rather than directly with Local Authority. Examples such as Healthwatch, home care agencies, local residential providers, Advocacy groups etc.

National Developments and Drivers influencing strategy

Thurrock's Safeguarding Adults Strategy is influenced by National policy and legislation. These include

- **Safeguarding Adults (ADASS) 2005** a national framework of standards for good practice in adult protection work.
- **Mental Capacity Act 2005**
- **Making Safeguarding Personal – (LGA/ ADASS) 2013**
- **Safeguarding Vulnerable Groups Act 2006**
- **Deprivation of Liberty Safeguards (DoLs)**
- **Draft Care and Support Bill**

Key elements of the draft Care and Support Act are:

- To place Safeguarding Adults Partnership Boards on a statutory basis.
- Boards will have to report to local communities.
- Core membership needs to consist of the local authority, NHS and Police.
- There is a duty on partners to cooperate.
- Strategic Plan to be agreed by the local community.
- The Strategic Plan and Annual report to be published

Safeguarding Principles

The Coalition Government's six principles for adult safeguarding are important to us:

Empowerment – people feeling safe and in control, being more able to share concerns and manage risk of harm either to themselves or others

Protection – support and help for those adults who are vulnerable and most at risk of harm

Prevention – working on the basis that it is better to take action before harm happens

Proportionality – responding in line with the risks and the minimum necessary to protect from harm or manage risks

Partnership – working for local solutions in response to local needs and expectations

Accountability – focusing on outcomes for people and communities and being open about their delivery

Priority areas for 2013 – 16 (agreed by partners)

PERSONALISATION

The Board will ensure that safeguarding activity makes a difference to peoples' lives, with them being at the centre of, and influencing any approach to achieve a personalised outcome.

- ✓ Build in outcomes that people want right through the process and develop a system of measuring how effective that process has been.
- ✓ Ensure community engagement is meaningful and asset based. The Board wants to work in a different way utilising community strengths to help safeguard vulnerable people.
- ✓ Ensure all partners understand the principles of personalisation and the implications for them.
- ✓ Encourage and enforce provider's standards of dignity and rights.
- ✓ Develop and deliver a communication strategy.

BOARD AND LEADERSHIP

In preparation for the Care Act , The board will provide leadership and effective management of safeguarding across all council departments and partners to ensure high level engagement and readiness for statutory governance.

- ✓ Ensure the chair has independence, knowledge and skill to challenge, lead and hold Board members to account.
- ✓ Regular review of the Board's terms of reference to keep it up to date with NHS and other organisational changes.
- ✓ Use the self-assessment tool to audit Board performance and to identify and fill gaps to measure its effectiveness and to hold members to account.
- ✓ Hold development sessions for Board members to keep up to date, encourage joint working and hear from and respond to people who have been through safeguarding.
- ✓ Ensure safeguarding is embedded in corporate and service strategies across the Council and partners, including new PCC, CCG and Healthwatch.
- ✓ Provide awareness training to Councillors and give them a role in preventing abuse.
- ✓ Present the Annual Report to the Overview and Scrutiny Committee and Health and Wellbeing Board.

WORKFORCE DEVELOPMENT

The Board will ensure that staff of all levels and needs have access to appropriate levels of training and have the skills and competence to work with and safeguard vulnerable people of Thurrock.

- ✓ Monitor, audit and deliver the Training and Development strategy as developed by Workforce Planning.
- ✓ Involve communities in developing a user friendly guide to safeguarding
- ✓ Ensure the voluntary and Independent sector provide good quality training by introducing endorsements through the Safeguarding Operational group.

POLICY DEVELOPMENT

Participate in cross cutting policy development with Children's Service, Community Safety Partnership to further develop Violence against women's and girls, Human Trafficking, and forced marriage

- ✓ Ensuring Adult safeguarding is a key agency delivering the Thurrock Violence Against Women and Girls Strategy
- ✓ Develop further information and knowledge in respect of Forced Marriages, ensuring each practitioner has an awareness and carries an information card
- ✓ Work with the Essex Police Lead in Human Trafficking and develop a local policy and guidance.

PARTNERSHIPS

For the Board to be truly representative of partners, with shared vision and commitment. There is a duty to have core membership from Police, Health and the Local Authority.

- ✓ Ensuring data sharing protocols are in place and are fit for purpose
- ✓ Develop strong links with partners across health, housing, emergency services, probation, police, third sector partners and citizens
- ✓ Ensure that ownership of safeguarding adults is shared with mutual learning through Serious Case Reviews

Agreed Key Objectives for 2015/2016:

1. Develop a relevant local audit tool to include both a qualitative person centred focus and a set of performance data with relevant analysis and reporting functionality to drive improvement.

2. Implement a process check to ensure appropriate processes for delivering a Serious Case Review locally in accordance with national guidance.

3. Implement and evaluate processes that demonstrate the key principles associated with “Making Safeguarding Personal” are in place across all partner agencies.

4. Provide clear evidence of community involvement in, and understanding of, local safeguarding policy development and operational delivery.

Statutory Board Outcomes

Annual Plan

Success of the Board Strategy will be measured by the following outcomes:

By March 2016 the Board will have:

1. Encouraged partners to move to a more outcomes based recording process. In particular the person at the centre of the enquiry or intervention should have the opportunity to have recorded their initial desired outcome from the process.

2. The Board will have championed an Asset Based approach to safeguarding Adults in Thurrock

3. Produced a quality audit report focussing on personalisation and community engagement.

4. Produced its first strategic assessment of adult safeguarding in Thurrock

5. Undertaken at least two different preventative initiatives within the Community.

6. Run a one day adult safeguarding event in either February or March 2015 to both launch the Board and provide information to a broad audience.

7. Run at least one part day session on board development and one part day session on learning from relevant serious case reviews. (*easy*)

8. Reviewed the practices around the appropriate sharing of serious incident reports between health and social care professionals and make recommendations for changes if needed.

9. Completed all matters related to the statutory Board's membership, governance, finance, structure and role/function

This page is intentionally left blank

12th November 2015	ITEM: 10
Health and Well Being Board	
Safeguarding Adults Board – Annual Report 2014 - 2015	
Wards and communities affected: All	**Key Decision:** Not required
Report of: Jill Moorman	
Accountable Head of Service: Les Billingham, Head of Adult Services	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

Thurrock Safeguarding Adults Board produces a yearly report on Safeguarding Adults activity. This report is for the year April 2014 to March 2015.
It was approved by the Safeguarding Adults Board on 24th September 2015.

1. Recommendation(s)

1.1 That the Health and Well Being Board notes the content of the Safeguarding Adults Annual Report 2014-15

2. Introduction and Background

2.1 Thurrock Safeguarding Adults Board produces a yearly report on the Safeguarding Adults activity during the previous year this one referring to 2014 - 15

2.2 The report contains information about safeguarding referrals and outcomes giving statistics.

2.3 The report also contains information about how the partners in the Safeguarding Adults Board work together to safeguarding vulnerable people in Thurrock.

3. Issues, Options and Analysis of Options

3.1 Not applicable – for information only

4. Reasons for Recommendation

4.1 For members of the Health and Wellbeing Board to be aware of the Safeguarding Adults activities undertaken over the previous year.

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

5.1 Not applicable, for information only.

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

6.1 The statistics that are reported within this are a summary of those reported to HSCIC on a yearly basis and used as comparators with other local authorities.

6.2 Performance of the team is monitored and can influence priorities if patterns are identified.

7. Implications

7.1 Financial

Implications verified by: **Michael Jones**
Management Account, Corporate Finance

There are no financial implications in the production of this report.

7.2 Legal

Implications verified by: **Dawn Pelle**

Adult Care Lawyer,
Legal and Democratic Services

7.3 Diversity and Equality

Implications verified by: **Rebecca Price**
Community Development Lawyer
Community Development & Equalities Team

This report highlights the impact that the Safeguarding Adults Board, Partners and team have had on the safety of individuals and groups in Thurrock. This is across all types of vulnerability. The statistics gathered are used to identify

areas of need, particularly with specific vulnerable groups and how safeguarding practice can be modified or targeted in future years as a result. Ethnicity of individuals is recorded – but not reported in this document – future plans are for the identification of issues pertinent to specific ethnic groups in the area.

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

The work identified in this report highlights the contribution Safeguarding Adults has made to the Community Safety Agenda.

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):

- Not applicable

9. Appendices to the report

- Safeguarding Adults Board Annual Report 2014 -15

Report Author:

Jill Moorman

Safeguarding and Legal Intervention Manager

Thurrock Council, Adults Health and Commissioning

This page is intentionally left blank

November 12th 2015	ITEM: 11
Thurrock Health and Wellbeing Board	
Recommendations from the Essex Mental Health Strategic Review	
Report of: Roger Harris, Director of Adults, Health & Commissioning / Mandy Ansell Acting, Interim Accountable Officer Thurrock CCG	
Accountable Director: As above	
This report is Public	

Executive Summary

To provide the HWBB with an overview of the recommendations made following the recent Essex Mental Health Strategic Review.

1. Recommendation(s)

1.1 That the HWBB note the recommendations of the Essex Mental Health Review outlined in this report and further detailed within the appendix.

1.2 That the HWBB also note that decisions on implementing recommendations from the Review will be made formally at the CCG Boards and to the Thurrock Cabinet if there are any significant changes to the way MH services are commissioned or provided.

1.3 That the HWB Board reiterates its previous view that commissioning decisions should be taken at a local level i.e. Thurrock, and that any decisions on a wider geographical area will only be taken where there is a clear, strong case that will benefit Thurrock residents.

2. Introduction and Background

2.1 Partners in the Greater Essex Health and Social Care Economy have undertaken a strategic review of the provision of mental health (MH) services across the county.

2.2 Basildon and Brentwood CCG; Castlepoint and Rochford CCG; Essex County Council; Mid Essex CCG; North Essex Partnership NHS Foundation Trust (NEP); North East Essex CCG; South Essex Partnership University NHS Foundation Trust (SEPT); Southend CCG; Southend Unitary Authority;

Thurrock CCG; Thurrock Unitary Authority; West Essex CCG jointly commissioned the Boston Consulting Group (BCG) to support them in conducting the Review.

2.3 The review was focused on mental health services commissioned locally and provided by the two main local NHS providers: North Essex Partnership NHS FT (NEP) and South Essex Partnership NHS FT (SEPT). The impact and implications of recommendations on adjacent services (for example, mental health services commissioned by NHS England) were also considered.

2.4 The Review has made a number of recommendations:

1. **Simplify the commissioning landscape**.
   This includes clarifying the integration agenda (what's in and what's out) and agreement to a more uniform timeline; alignment around a commissioning pathway (i.e. what will be commissioned, by whom and when) – this will allow providers to refine strategies and assess whether collaboration or merger would result in a stronger financial (and clinical) position from which to deliver care; plan to re-align funding between CCGs in preparation for implementing the integration agenda; define where dementia should sit within an all-age pathway.

2. **Encouraging closer working relationship between the two main providers.**
   In the appendix it is clear that our current mental health providers face a difficult financial environment. They have been un-successful with a number of service contracts recently – drug and alcohol, child and adolescent mental health services being two examples. This has prompted a discussion over whether the two organisations should collaborate more closely and how far this collaboration might go – including a possible merger. They have increasingly worked on joint tenders and held a joint Board meeting in September which agreed to continue to work together.

3. **Generate and share more data across the system**
   It is recommended that commissioners work with clinicians and professionals to assess service user health and personal care needs, including how these differ by geography, locality (e.g. urban vs. rural), and cluster segment; Development and tracking of better outcomes; sharing of output from ongoing needs assessment work in dementia by Local Authorities.

4. **Work more jointly**
   Recommendations include; creation of a smaller and more senior pan-Essex Mental Health commissioning team - this could provide real leverage and help make necessary trade-offs between services and cost; Optimise AMHP arrangement by Local Authorities working

together; Work together to ensure all-age, cross-system car, ultimately developing a shared vision for Mental Health in Essex.

2.5 The Review has been overseen via an Accountable Officer/ Director level Steering Board. This steering group will continue to meet monthly during early Implementation phases of the work (which are subject to CCG and Local Authority Governance processes). Funding has been sought from NHS England for some ongoing project resource to support the delivery of the recommendations from the review.

3. Issues, Options and Analysis of Options

3.1 The summary report from the Review is contained in the appendix. They articulate issues such as; the complexity of the Essex commissioning landscape for Mental Health (multiple commissioners and commissioning bodies); an inconsistent approach to integration which makes planning difficult for providers; funding 'misalignment' with block contracts dating back many years; and a shrinking provider market with challenging financial constraints.

3.2 The Review concludes that "the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail (financially) posing risk to the continuity of services and the safety of service users".

3.3 The conclusions make it clear that that a continuation of the status quo - current structures and ways-of-working - is not an option.

3.4 There is a clear desire to see the two Trusts work together more closely, whether this leads to a full merger depends on a number of strategic and regulatory discussions that will need to be undertaken.

3.5 As regards the proposals for the commissioning of mental health services Thurrock had a number of concerns. We see our relationship as being primary between Thurrock local authority and Thurrock CCG. There may be some areas where we need to work on a larger footprint – South West Essex, South Essex or even Pan Essex – but these need to be justified by what is in the best interest of Thurrock residents - administrative neatness is not a criteria for those decisions. As such we have reservations about the establishment of a single commissioning team for mental health across Essex and have not committed ourselves to support that. We have limited commissioning resources and could not commit any money nor staff to such a team at this point in time.

4. Reasons for Recommendation

This review has come out of discussions across the County between the three local authorities, the seven CCGs and the two MH Trusts. The report largely is looking at what is commissioned from where and how services might better work together. It does not change the main strategic direction of travel which was agreed two years ago within the South Essex Mental Health Strategy. We remain committed to a more local service, developing a more personalised mental health services, strengthening prevention and early intervention and supporting GPs and primary care to take a more active role.

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

This will be undertaken when a more formal proposal has been developed

6. Impact on corporate policies and performance

This will be picked up as part of the refresh of the Health and Well-Being Strategy which will be coming back to the HWB Board in February.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

Any financial implications will need to come back and be approved either by the Cabinet or the CCG Board.

7.2 Legal

Implications verified by: **Chris Pickering**
Principal Solicitor Employment and Litigation

As this report is for noting only, there are no legal implications.

7.3 Diversity and Equality

Implications verified by: **Becky Price**
Community Development Officer

Section 149 of the Equality Act 2010 creates the public sector equality duty which requires that when public bodies make decisions they must have regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act

- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding

The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation.

The objective of the Essex Mental Health Review is to consider the best way forward for providing mental health care to Essex residents in the context of challenging financial, demographic and operational pressures. Any potential equality and social inclusion implications will be fully considered as part of the governance processes for implementing any of the recommendations from the Review.

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

N/A

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

- Essex Mental Health Review Report

9. Appendices to the report

- Essex Mental Health Review (Summary Report by the Boston Consultancy Group)

Report Author:

Roger Harris

Director of Adults, Health & Commissioning

Adults, Health and Commissioning

This page is intentionally left blank

Basildon & Brentwood
Clinical Commissioning Group

Southend
Clinical Commissioning Group

Castle Point and Rochford
Clinical Commissioning Group

Thurrock
Clinical Commissioning Group

Mid Essex
Clinical Commissioning Group

West Essex
Clinical Commissioning Group

Essex Mental Health Review

Final Report

28th September 2015

Contents

1. The Essex Mental Health Review: purpose and scope 3
2. Key messages 4
3. Context 7
4. Findings: Commissioners 13
5. Findings specific to the Local Authorities 14
6. Findings: Providers 17
7. The momentum case 18
8. Recommendations: Commissioners 20
9. Recommendations: Providers 25
10. Next steps 26
Appendix 1 (attached PDF): Contents 27
Appendix 2: Engagement as part of this review 28
Appendix 3: Option appraisal 29

1. The Essex Mental Health Review: purpose and scope

Commissioners and providers across Essex have engaged in discussion over the last year around how best to provide mental health care to service users in the context of challenging financial, demographic and operational pressures.

In May 2015 they jointly commissioned a formal review in order to assess the current state and make recommendations around the best way forward[1].

The scope of the review is focused on mental health services commissioned locally and provided by the two main local NHS providers: North Essex Partnership NHS FT (NEP) and South Essex Partnership NHS FT (SEPT). The impact and implications of any recommendations on adjacent services (for example, mental health services commissioned by NHS England) are also considered.

This document is the final output of the review, and provides an overview of the context, findings and recommendations. There are additional detailed facts and data in the accompanying document: **Appendix 1.**

The work has been shaped by over 200 individual points of engagement – including with service users, clinicians and other healthcare professionals, and commissioners. For full details of the stakeholders and overall process see **Appendix 2** below**.**

[1] Review commissioned jointly by Basildon and Brentwood CCG; Castlepoint and Rochford CCG; Essex County Council; Mid Essex CCG; North Essex Partnership NHS FT; North East Essex CCG; South Essex Partnership NHS FT; Southend CCG; Southend Unitary Authority; Thurrock CCG; Thurrock Unitary Authority; West Essex CCG.

2. Key messages

Findings

The ***commissioning*** landscape for mental health is complex driven by three main factors:

Multiple commissioners: feedback suggests that the current configuration of 30-50 roles are not commissioning mental health services effectively. This is driven by (i) fragmented resources in a specialist and increasingly complex environment; (ii) insufficient seniority and capabilities; and (iii) the lack of a robust fact base on needs, service activities and outcomes.

The integration agenda: each CCG is considering different local models of integrated care with different views on which mental health services should be included and are all moving different speeds This 'ragged edge' makes planning from a provider perspective challenging – particularly as some of their mental health teams work across more than one commissioning area. Moreover, we expect these emerging models to be further refined as they receive greater clinical and professional input.

Funding misalignment: the current block contracts originate from PCT days with costs allocated using different approaches in the north and the south. This has resulted in a number of misalignments between CCGs: as finances become tighter and CCGs look to fund some services in local models, these subsidies need to be unwound.

The ***providers*** NEP and SEPT are facing three significant and inter-related challenges:

Shrinking market: The overall market for specialist mental health trusts is shrinking as commissioners pursue their integration agenda. In addition, NEP and SEPT have recently lost market share to competitors, for example Essex CAMHS services to North East London NHS FT (NELFT).

Challenging finances: mental health funding has been historically challenging, and providers face a 4% year-on-year efficiency requirement as well as significant CIP targets. NEP in particular is facing significant short term difficulties.

Potential brand issues: feedback indicates that both providers face challenges around the strength of their brand – perception amongst commissioners is mixed around responsiveness to changes in policy, communication regarding service changes, and data transparency.

Implications

The status quo is not an option: the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail (financially) posing risk to the continuity of services and the safety of service users.

Summary of recommendations

1. Simplify the commissioning landscape

1a Clarify the integration agenda: commissioners should refine the scope of mental health services planned to be within their local integration models with greater clinical and professional leadership. In addition, rather than each moving at their own pace, we recommend commissioners agree a more uniform integration timeline. This will involve a change of pace for some but result in faster and less complicated implementation.

1b Align around a clear commissioning path: building off *1a* above, commissioners should agree a shared commissioning path to clarify what mental health and personal care services will be commissioned, by whom, and when. A draft view has been described as part of this work for commissioners to consider.

For providers, clarity of the path and timing will enable them to refine their strategy - including which services to focus on, and whether collaboration or merger would result in a stronger financial (and clinical) position from which to deliver care.

1c Work through how best to deploy social workers as the integration agenda plays out: as services are integrated and existing pathways change, local authorities and CCGs will need to jointly assess how best to deploy social workers – for example whether these should follow services or whether they should be organised in a more centralised way.

1d Agree a plan to re-align funding between CCGs: commissioners should agree the approach and timeline to reapportion expenditure and Resource Limit to ensure an affordability neutral solution ahead of implementing the local integration agenda.

1e Define where dementia services should sit: local authorities should agree with their local CCGs whether to move dementia under Public Health and Wellbeing as an all-age pathway, whether it should remain split within Adult Social Care

2. Create a common language and use to clarify needs and expectations

2a Agree a common language: commissioners and providers should agree to use a single terminology / language going forward. Clinical input suggests clusters may be the most reasonable lexicon given the national direction – although there is no single perfect solution.

2b Clarify the desired provider capabilities: commissioners should, working with providers, undertake to create a common and shared set of required provider capabilities, for example around IT; culture; flexibility; data transparency.

2c Optimise section 75 partnership arrangements: in the south, the three local authorities should commit to working together to create a common template, shared performance targets, and single joint oversight meeting in order to reduce effort and avoid duplication.

2c Work with providers around The Care Act compliance: local authorities should develop clear and consistent expectations for providers' compliance with the Care Act, including what should be

incorporated into their contracts in terms of access to pathways for people in distress. This will involve discussions around appropriate funding to ensure these are realistic expectations.

3. Generate and share more data across the system

3a Conduct robust needs assessments: commissioners should work with clinicians and professionals to assess service user health and personal care needs, including how these differ by geography, locality (e.g. urban vs. rural), and cluster segment.

3b Develop and track better outcomes: building off *3a* above, commissioners should work with clinicians and professionals develop desired outcomes – these will inform which services should be commissioned, and how they will be monitored. They will also support funding prioritisation decisions.

3c Share the output of ongoing needs assessment work in dementia: local authorities should ensure learnings and outputs are widely disseminated to avoid duplication.

4. Work more jointly

4a Create a pan-Essex MH commissioning team: commissioners should consider a smaller, more senior mental health team – for example around 10 FTEs – that includes senior analytics, business intelligence, and financial expertise. This would provide real leverage and help make necessary trade-offs between services and cost – the need for which was highlighted at the Clinical Conference held in August.

The exact organisational form and governance processes should be jointly agreed by commissioners in the coming weeks. Importantly, a single team does not mean a 'one size fits all' solution. Needs, services, activities and outcomes need to be tailored to local geographies.

The principles behind having a smaller, shared team are to attract and fund the appropriate seniority of resource; support simplification; enable the use of a common language; create a single fact base of needs, activities, and outcomes; and build off the CAMHS experience of joint working across health and social care.

Between now and April 2016 the team would work through recommendations *3a* and *3b* above: conduct robust needs assessments; determine gaps; agree outcomes; describe what services should be commissioned to deliver these; prioritise funding; draft commissioning intentions; and refine the draft commissioning path described in *1a* above. From April onwards, there are choices around what role it should continue to play – for example whether it should take on a more supportive role or commission pan-Essex services.

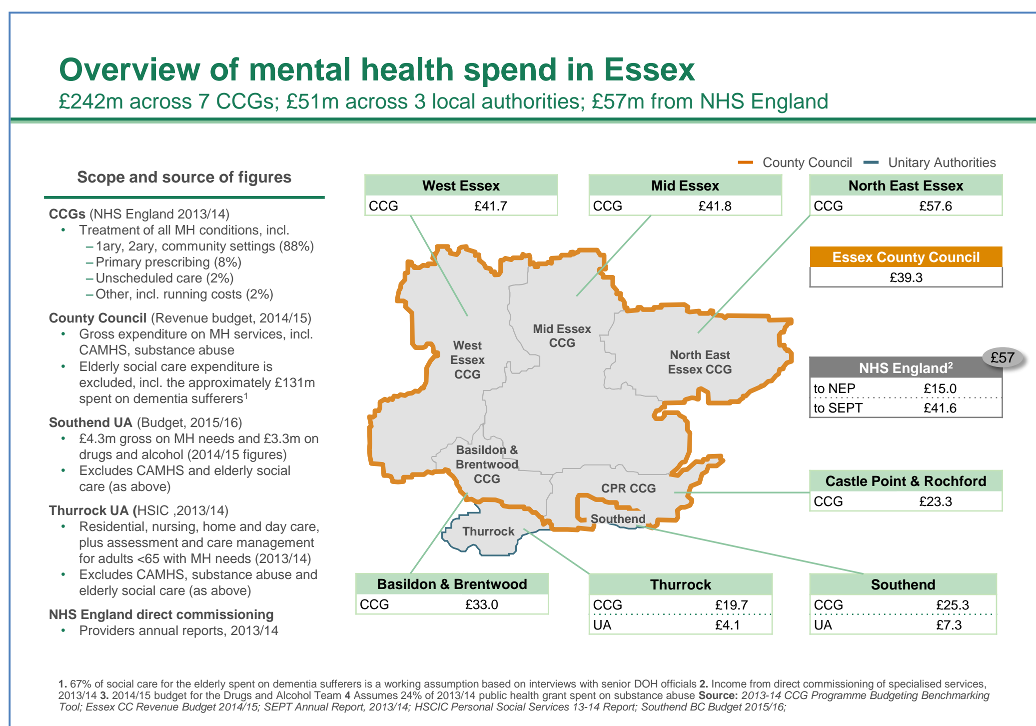
4b Optimise AMPHs arrangements: local authorities should work jointly to increase the overall number of AMPHs, and consider sharing a single rota to maximise efficiency.

4c Work together to ensure all-age, cross-system care: all commissioners should build on the CAMHS experience and commit to working together to improve outcomes for the most vulnerable individuals, and ultimately develop a shared vision for mental health in Essex.

3. Context

(i) Spend on Mental Health (MH) services in Essex

The Essex health economy spends a total of £c.350mm on MH services. Of this, £242m is commissioned by the 7 local NHS CCGs; £51m by Essex County Council (ECC) and the two Unitary Authorities (UAs) in the south; and £57m by NHS England. In addition, ECC spends an additional £195m social care of older adults, of which approximately £130m is spent on dementia[2].



Per capita, the CCGs spend between approximately £98 and £151 per capita when adjusted for differences in population - this is broadly in line with the national average. ECC spend £45 per capita which is slightly above the national average, and the two UAs spend £56 (Southend) and £50 (Thurrock) which is slightly below.

Historically, mental health funding has been constrained. National investment in mental health services fell in real terms between 2011 and 2014[3]. In Essex, CCG spend on mental health has decreased by around 6% p.a. between 2010/11 and 2014/15. The funding challenge has been driven by a number of factors, including a tariff deflator of -1.8% (vs. -1.2% in the acute sector). In addition, services have been impacted by budget cuts on the Local Authority (LA) side: ECC spend on adult mental has declined by 2% and older adult mental health by 3% over the same period.

Going forward, the working assumption is that the mental budget has been ring-fenced and so unlike other areas of the system, will not decline further – but is not expected to increase. See **Appendix 1, Section 1** for additional detail regarding mental health spend.

---

[2] £131m of the £195m spent on social care for older people in 2014/15 is estimated to have been spent on dementia sufferers based on national estimates from DoH; includes residential and nursing care (£80m), homecare and respite (£26m), reablement (£5m) and cash payments (£6m)

[3] Mental Health Network: The Future of Mental Health, March 2014

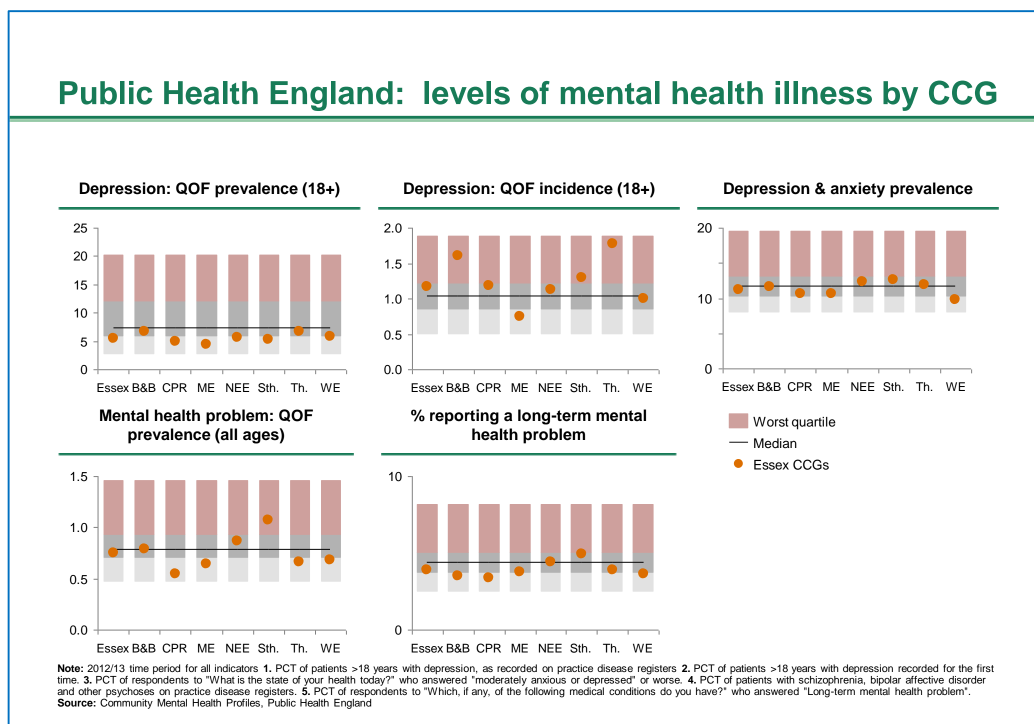
(ii) Demand

The working assumption of this review is that total spend on mental health services in Essex is fixed. However there are no recent, robust needs assessments to properly guide what services should be commissioned, and for which service users[4].

Nationally, demand for mental health services is growing. By 2030, there are likely to be approximately 2 million more adults in the UK with mental health problems due to population growth alone[5]. In addition, prevalence is thought to be increasing, particularly for common mental health disorders such as depression and anxiety[6]. Unmet need is already high. The London School of Economics and Political Science estimates that only around a quarter of people with mental health problems receive treatment[7].

For older adults, demand for dementia services will rise in line with an increasingly elderly population. For example in North Essex, 51% of the population growth by 2016 will be in over-65s[8]. Some estimates suggest that the prevalence of dementia will increase by 40% over the next 12 years[9].

Data from Public Health England for Essex are shown below.



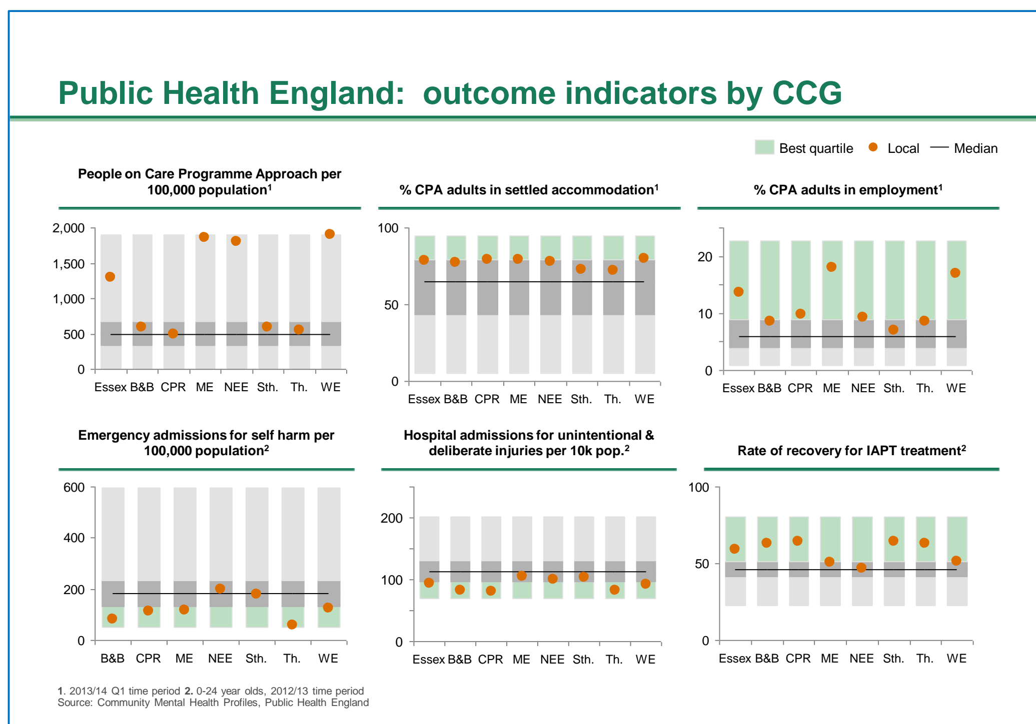
---

[4] See also Section 7: Recommendations for Commissioners
[5] Mental Health Network factsheet, 2014
[6] Mental Health Foundation: Starting Today: Future of Mental Health Services, 2013
[7] Centre for Economic Performance: How mental illness loses out in the NHS. London School of Economics and Political Science, June 2012
[8] NEP operational plan 2014-16
[9] Alzheimer's Society: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=412

(iii) Outcomes

There is an overall paucity of robust, consistent outcome data in mental health. This is highlighted in the recent interim report from the Royal College of Psychiatrists[10] which suggests a significant data and information shortfall is making it difficult to understand what is happening throughout the system, to measure variation, and to bring about improvements. The Royal Society of Psychiatry has recently highlighted a significant shortfall in mental health data and wide variations in service models and definitions, which compares poorly to the acute sector.[11] Poor data and inconsistent definitions, compounded by a lack of consensus around outcome measures, is recognised to be undermining management and commissioning of mental health services. Improvements have been made – IAPT is more consistent and data rich for instance – but overall feedback from clinical and professional engagement in Essex reinforces the national viewpoint.

Limited data are available around outcomes for mental health in Essex. Nationally gathered Public Health England indicators are shown below. Over time, there is a need to agree outcome metrics locally to help define the goals for services and against which to monitor provision.[12].



(iv) National policy / trends in mental health

Early intervention

In line with the national policy embodied in *No health without mental health*[13], there has been a push towards increasing investment in early intervention schemes in order to manage demand and avoid costly inpatient admissions. Most notably, the Improving Access to Psychological

---

[10] Royal College of Psychiatrists: Interim report, Improving acute inpatient psychiatric care for adults, July 2015
[11] Improving acute inpatient psychiatric care for adults in England: Interim report, RCPsych Commission on Acute Adult Psychiatric Care, July 2015
[12] See also Section 7: Recommendations for Commissioners
[13] HMG/DG, No health without mental health, February 2011

Therapies (IAPT) programme aims to improve access to talking therapies for depression and anxiety. The Department of Health estimated that talking therapies can save the public sector £1.75 for every £1 invested.[14] The service model is based on a ratio of ~40 therapists for every quarter of a million of population, and allows both GP and self-referral to maximise access. As at April 2015, there are over one million referrals each year (over 40% are self-referrals) of which around three-quarters enter treatment after an average waiting time of just under 30 days. Of the 40% that complete treatment, over 60% improve and 40-45% recover – although this remains short of the national target of 50%.[15]

The integration agenda

People with severe and prolonged mental illness are now known to die on average 15 to 20 years earlier than the general population, and there are clear benefits to a holistic approach to their care which is unrestricted by provider boundaries. The *Five Year Forward View* set out the ambition and dimensions for integration: physical and mental care, health and social care, primary and specialist care.[16] Commissioners have a critical role in this agenda, particularly in shifting payments and incentive systems to accommodate integrated physical and mental health outcomes.[17] The Kings Fund recently highlighted three main ambitions for commissioners: holding providers to account for outcomes; holding providers to account for streamlining the delivery of patient care across the gaps between service providers; and shifting the flow of money between providers.[18] There are good parallels between the 'diabetes journey' to integrated care and what mental health needs – commissioner and provider engagement; strengthened capability and capacity in primary care; brought about with time and effort from multiple stakeholders; over many years.

Move to commissioning by results / PbR

The mental health sector lags behind the acute sector by more than a decade in moving away from block contracts and towards commissioning and payment by results (PbR). This is related to its relatively poor progress in generating good quality data from a consistent set of outcomes and services. But progress has been made, most notably with the development of the mental health care clusters as a common currency for the sector. Clustering works by assessing patients based on their needs and the severity of their conditions. Each cluster is linked to a set of interventions which have a total cost and for which a tariff could be paid. Widespread adoption of cluster-based PbR could reverse the real terms drop in funding for mental health, as well as facilitate integration.[19] Data quality (and clinical) concerns have delayed creation of a national tariff, but commissioners and providers have been moving ahead on the basis of local data.[20]

However whilst clustering is acknowledged as a potentially helpful commissioning tool, its use clinically is subject to considerable debate: service users within clusters are heterogeneous in terms of diagnoses, needs, risk and severity - which creates challenges around treatment and care packages. Service users themselves are not familiar with the segments and terminology, and clustering has potentially added to the complexity around language and lexicon in mental health[21].

---

[14] DH, Impact Assessment of the expansion of talking therapies services as set out in the Mental Health Strategy, 2011
[15] DH, Talking therapies: A four-year plan of action, February 2011
[16] NHS England et al., Five Year Forward View, October 2014
[17] Dr Geraldine Strathdee (National Clinical Director for Mental Health), Treating mind and body together, June 2015
[18] Kings Fund, Commissioning and contracting for integrated care, November 2014
[19] HSJ Intelligence, The future for mental health payment systems, 20 August 2014
[20] RCPsych, Position Statement PS01/2014, January 2014
[21] See also Section 7: Recommendations for Commissioners

The Care Act

The Care Act was introduced in 2014, with many of its provisions coming into effect on 1 April 2015. The Sutton Trust calls it the most comprehensive overhaul of the social care system since 1948.[22] The Act requires a shift from a narrow and clinically-lead focus on the treatment of disease towards a broader conception of promoting individuals' wellbeing – including both physical and mental health – as well as preventing or delaying the need for that support. It also places local authorities under a duty to collaborate and coordinate with other authorities on the integration of social services and health care[23].

The Better Care Fund

The Better Care Fund (BCF) was announced in the June 2013 spending round to promote integration of health and social care. It creates local single pooled budgets to incentivise the NHS and local authorities to work more closely together.

See **Appendix 1, Section 2** for additional detail around key trends and recent publications.

(vi) NHS specialist mental health trusts in Essex

The provision of the majority of specialist mental health services in Essex has been by North Essex Partnership University NHS FT (NEP) South Essex Partnership University NHS FT (SEPT).

NEP

NEP is a £110m turnover organisation headquartered in Chelmsford employing around 2000 staff. It provides a range of mental health services to a population of over 1 million predominantly in Essex. These include adult and older adult mental health services, CAMHS, forensic and substance abuse services. The majority of the adult and older adult work is commissioned by the three CCGs in the north of the county through a block contract worth £69m (lead CCG North East Essex).

NEP – historical data

Financials

	2011/12	2012/13	2013/14
Income (£ m)	105.5	108.8	112.7
Special services			*9.4*
Op surplus (£m)	2.9	1.3	-12.2
Ret surplus (£m)	0.8	-1	-14.7

Performance

2014/15	Q1	Q2	Q3
# Beds	357	356	336
% Bed occupancy	93.1%	95.6%	97.1%
% Patients assigned clusters	55.8%	59.9%	41.6%
% CPA in settled accom	54%	35%	37%
% CPA review within year	68%	51%	63%
Early intv'n psychosis cases	500	450	415

Workforce

2014/15	Q1	Q2	Q3	Q4
Total workforce	1,798	1,766	1,724	1,699
Medical	*119*	*117*	*109*	*107*
Nursing	*620*	*607*	*597*	*588*
Other	*1,058*	*1,042*	*1,018*	*1,004*

	2012/13	2013/14	2014/15
% Staff recommending care here	60%	59%	55%

Source: HSJ.

[22] Sutton Trust, The Care Act 2014: A briefing, March 2014
[23] See also Section 9: Findings and Recommendations Specific to the Local Authorities

SEPT

SEPT is currently a £324m turnover organisation headquartered in Wickford employing around 5000 staff. It provides a range of services to a population of around 2.5 million in Essex, Luton, Bedfordshire and Suffolk. These include mental health (adults, older adults, IAPT, CAMHS, forensic and substance abuse); general community, and learning disability services. In Essex, mental health services are commissioned via a block contract worth £81m (lead CCG Castlepoint and Rochford).

SEPT – historical data

Financials

	2011/12	2012/13	2013/14
Income (£ m)	314.1	323.9	324.5
Special services			*23.1*
Op surplus (£m)	8,7	10.9	5.3
Ret surplus (£m)	2.4	4.3	-0.5

Performance

2014/15	Q1	Q2	Q3
# Beds	706	707	706
% Bed occupancy	91.2%	90.6%	92.4%
% Patients assigned clusters	83.8%	84.0%	79.3%
% CPA in settled accom	73%	54%	75%
% CPA review within year	88%	41%	42%
Early intv'n psychosis cases	465	425	985

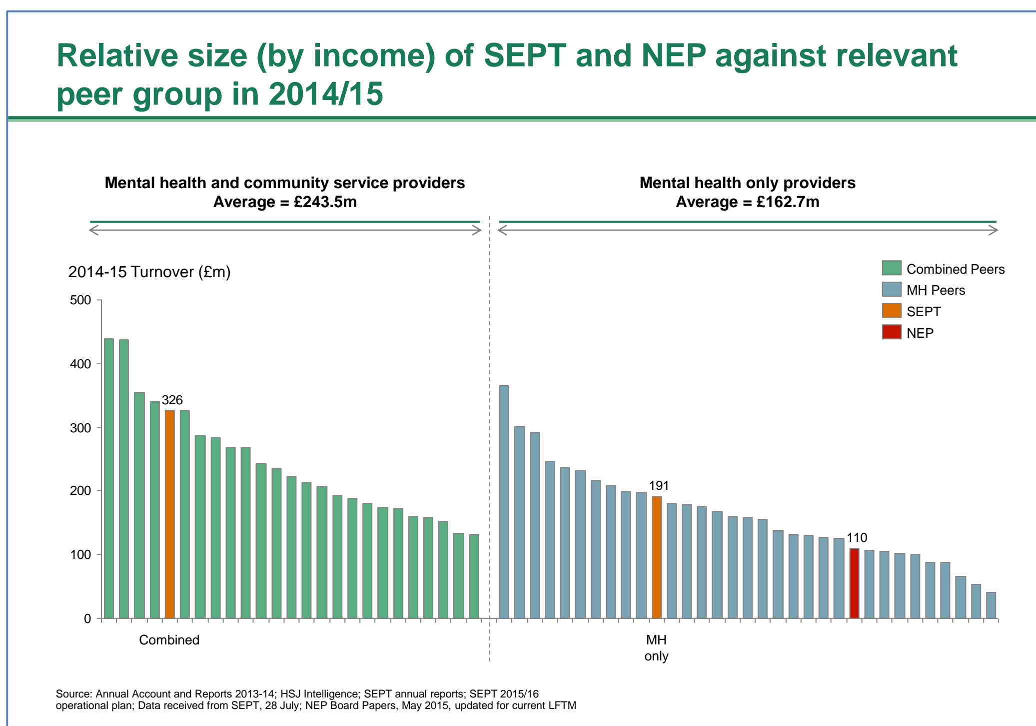
Workforce

2014/15	Q1	Q2	Q3	Q4
Total workforce	5,114	5,081	5,007	5,007
Medical	*204*	*204*	*193*	*192*
Nursing	*1,590*	*1,568*	*1,529*	*1,524*
Other	*3,319*	*3,309*	*3,285*	*3,291*

	2012/13	2013/14	2014/15
% Staff recommending care here	63%	64%	65%

Source: HSJ.

In terms of scale, the NEP is in the lower quartile; SEPT, in 2014/15, is currently above average.



See **Appendix 1, Section 3** for additional data on NEP and SEPT finances, operations and quality.

4. Findings: Commissioners

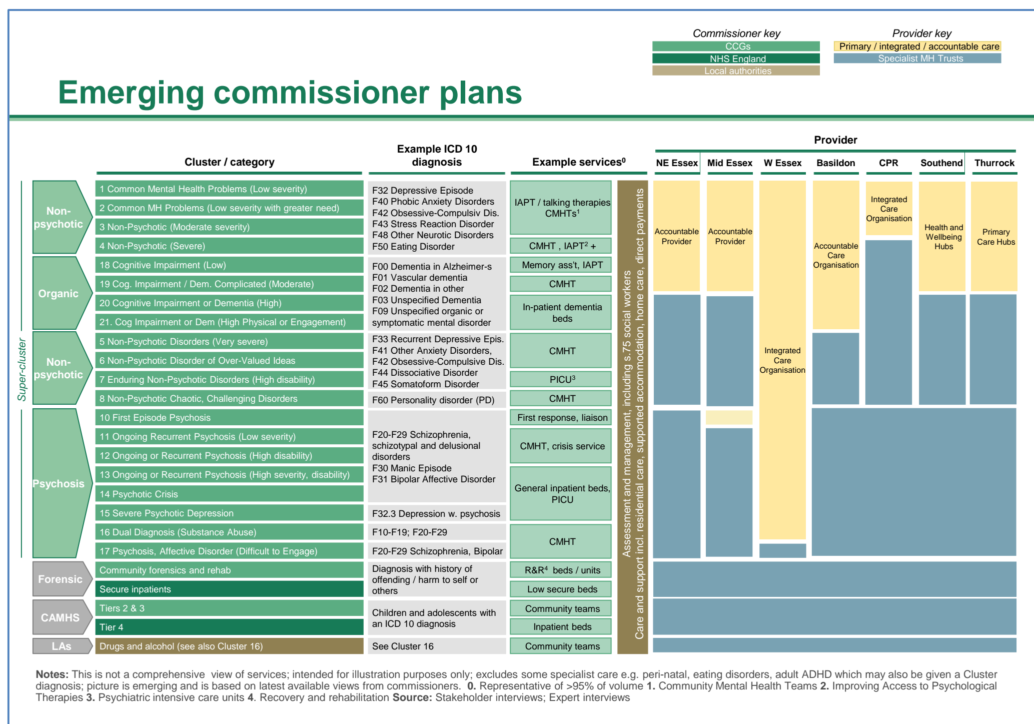
The commissioning landscape for mental health services in Essex is a complex picture which would benefit from simplification. There are three main factors contributing to the complexity:

Multiple commissioners:

Each of the 10 commissioning bodies has resources commissioning mental health services, involving a total of around 40-50 roles, fragmented across the patch. Stakeholder feedback suggest this lacks sufficient contextual oversight and does not have robust data around the services commissioned (outcomes and costs), and service user needs. For example, clinicians have identified potential service gaps – including adult ADHD and community forensic – but there is insufficient data to ascertain whether these should be prioritised. Additionally, there is no shared language – clusters, services, diagnoses, care setting are used interchangeably.

The integration agenda

Each CCG is moving at different speeds and considering different local models of integrated care, and has different views on which mental health services should be included.



This 'ragged edge' makes planning from both commissioner and provider perspective quite challenging – for providers more so given that their teams work across different CCGs. Cfeedback suggests further work is needed to fully understand which service users can appropriately be managed in primary care, new models of care, and shared care teams.

Funding misalignment

The current block contracts originate from PCT days with costs were allocated using different approaches in the north and the south. The impact of this is a number of misalignments between resources and utilisation between CCGs through the block contracts, which creates a complicated picture and hinders pan-Essex commissioning. **See Appendix 1, Section 4** for additional detail around historic CCG allocations.

5. Findings specific to the Local Authorities

In addition to those described above, there are additional findings which are specifically related to Essex County Council, Southend UA and Thurrock UA (the local authorities).

Section 75 partnership agreements

Section 75 of the National Health Service Act (2006) provides – amongst other things – for local authorities to enter into arrangements with NHS trusts for the exercise of authorities' health-related functions, and the provision of staff for those purposes. Essex County Council has section 75 agreements with both NEP and SEPT, and provides social workers to the trusts' multi-disciplinary assessment and care management teams under those agreements. County Council social workers are TUPE'd to NEP and seconded to SEPT.[24] Southend UA and Thurrock UA also have their own section 75 partnership agreements with SEPT. These arrangements ensure mental health and social workers are integrated in operational teams at the front door.

The Essex Local Authorities are not alone in using section 75 to integrate their mental health social workers into healthcare teams – or in facing challenges with this approach. Results of a Freedom of Information request from late 2013 suggest that about half of local authorities use section 75 in this way. But it also highlighted authorities' concerns – including loss of social work focus, slower progress on personalisation, slower progress on recovery models and financial pressures – that had prompted some authorities to withdraw from these arrangements.[25]

In Essex, feedback suggests that integration of social workers into the trusts is variable. There are challenges around communication back into the local authorities so as to ensure the desired ways of working are in place. In the north, recent changes to service models and pathways at NEP (Journeys) have exacerbated concerns around integration within teams. In the south, there are challenges around NHS management and leadership of local authority staff. In addition, there is significant duplication of effort around the section 75 arrangements. SEPT has different partnership agreements with all three local authorities – Essex County Council, Southend UA and Thurrock UA – which involves three sets of monitoring arrangements, performance targets, and oversight meetings. For example, Essex County Council hold monthly performance and budget meetings with both trusts – and a three monthly partnership meeting.

AMHPS

Approved mental health professionals (AMHPS) are responsible for organising and coordinating assessments under the Mental Health Act (1983), including detentions (sectioning) and community treatment orders (CTOs). Traditionally performed by specially trained social workers, the role is increasingly held by occupational therapists, community mental health nurses and psychologists due to shortages of staff and the cost and length of training. The CQC has highlighted falling numbers and rising workload for AMHPs across the county.[26] Most recently, it has highlighted the pressure that AMHPS are under to section users under the Act purely to increase their chances of securing a bed amidst the general shortage.[27] The revised Mental Health

---

[24] TUPE refers to the Transfer of Undertakings (Protection of Employment) Regulations 2006 regulating terms of employment for staff transferred to new employers.

[25] Andy McNicoll, Councils split on integration of mental health social workers in NHS, Community Care, 24 September 2013

[26] CQC, Monitoring the Mental Health Act 2011/12, January 2013

[27] CQC, Monitoring the Mental Health Act 2013/14, January 2015

Act code of practice – which came into force on 1 April – requires local authorities and providers to support AMHPs in addressing delays to bed access.

Essex is facing a severe shortage of qualified AMHPs (and the trusts bed occupancy are generally above target levels). Essex County Council currently employs 84 AMHPs and estimates that it will need to train and deploy another ~50% by 2017, and then continue to train 20 AMHPs a year to manage the churn. Feedback suggests that the role has become less financially and professionally attractive, partly as a result of these pressures, and failure to maintain numbers has made it more difficult to maintain a reasonable rota, putting more pressure on the remaining personnel. Part of the problem is reported to be a lack of consensus between the trusts and the council around ultimate responsibility for closing the gap and covering the costs. Section 75 of the NHS Act is not clear on this point.

In terms of provision of the service, the providers run the in-hours rota on behalf of the local authorities. In the north, Essex County Council runs the out-of-hours rota. In the south, Southend UA contracts Essex County Council for out-of-hours services, whilst Thurrock UA runs its own out-of-hours rota. In practice, due to the shortage of staff, the same AMHPs work on all of the rotas.

Care Act compliance

As described earlier, the Care Act, key elements of which entered into force on 1 April 2015, shifts the focus in mental health from a narrow conception of disease management to a broader duty to promote wellbeing and early help and prevention for service users and their carers. Local authorities are the responsible bodies under the Act. Feedback included concerns that the two providers were not yet fully compliant with the Care Act, and specifically that the trusts' thresholds for specialist treatment varies across the county. Too high a threshold may not be compatible with the legislative shift to 'wellness'. More generally, feedback has suggested that local authorities would like greater transparency and input earlier in the patient journey to manage the implications of thresholds for admission being set low in some instances.

Dementia

Currently, the vast bulk of local authority spend on older adults suffering from dementia is accounted for under adult social care spend not mental health spend. For example, Essex County Council spent ~£131 million on social care for older adults suffering from dementia in 2014/15. This includes residential and nursing care (£80m), homecare and respite (£26m), re-ablement (£5m) and cash payments (£6m). Note that many of the older adults receiving these services have not been officially diagnosed with dementia, even though their carers will be confident of the fact.

On the one hand, accounting for this spend under social care rather than mental health spend obfuscates the size and shape of the combined spend on mental health in Essex. It can inhibit coordination between the local authority teams responsible for different aspects of care for the same set of service users. On the other hand, shifting the budget and related structures may inhibit coordination between adult social and older adult social care, which also share commonalities.

In addition, this is an area where there is significant unmet demand. The local authorities are currently participating in a needs review around dementia to assess this in further detail.

All age and cross-system working

Evidence suggests that 50% of mental health problems start by the age of 15 and 75% by the age of 18[28]. More work is needed to ensure a joined up, all-age approach to mental health. For Essex County Council for example, mental health services relate to adult mental health for adults up to the age of 65 and sit separately to CAMHS. Within the providers, there have been challenges in securing sufficient Adult Mental Health input into the Children's Social Care Family Solutions teams. There also needs to be good integration into schools and other young peoples' services. More widely, local authorities are a key interface with other parts of the system: police, housing, voluntary and community sectors, district councils and employment as well as public health.

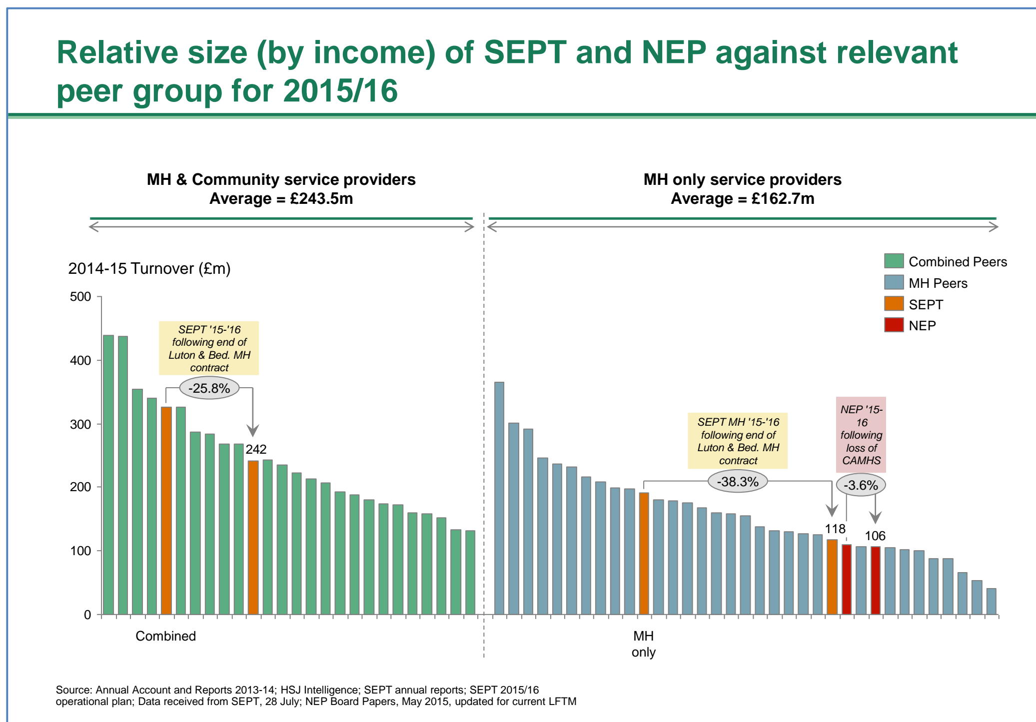
[28] Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays, Chapter 10

6. Findings: Providers

NEP and SEPT are facing three significant and inter-related challenges:

A shrinking market

The overall market for specialist mental health trusts is shrinking as commissioners integrate the lower acuity services into primary care and new models as described above. In addition, NEP and SEPT are losing market share. They increasingly face competition from out-of-area trusts for local services: the recent pan-Essex CAMHS contract was lost to North East London NHS FT (NELFT); IAPT services in the north are already provided by Hertfordshire Partnership University NHS FT (Herts Parts); SEPT's community mental health contract with Luton and Bedfordshire is not being renewed. These developments will see SEPT lose around 30% of total turnover, and NEP 3.6%.



Challenging finances

As described above, mental health funding has been historically challenging. Funding for the providers is constrained, with a 4% year-on-year efficiency requirement and significant CIP targets. NEP in particular is facing short term difficulties. It posted a deficit in 2013/14 and the plan for 2015/16 as submitted to Monitor is dependent on realising significant CIPs; on CCGs not realising all their planned savings around Clusters 1-4; and on being able to offset activity loss with a reduction in associated costs.

Potential brand issues

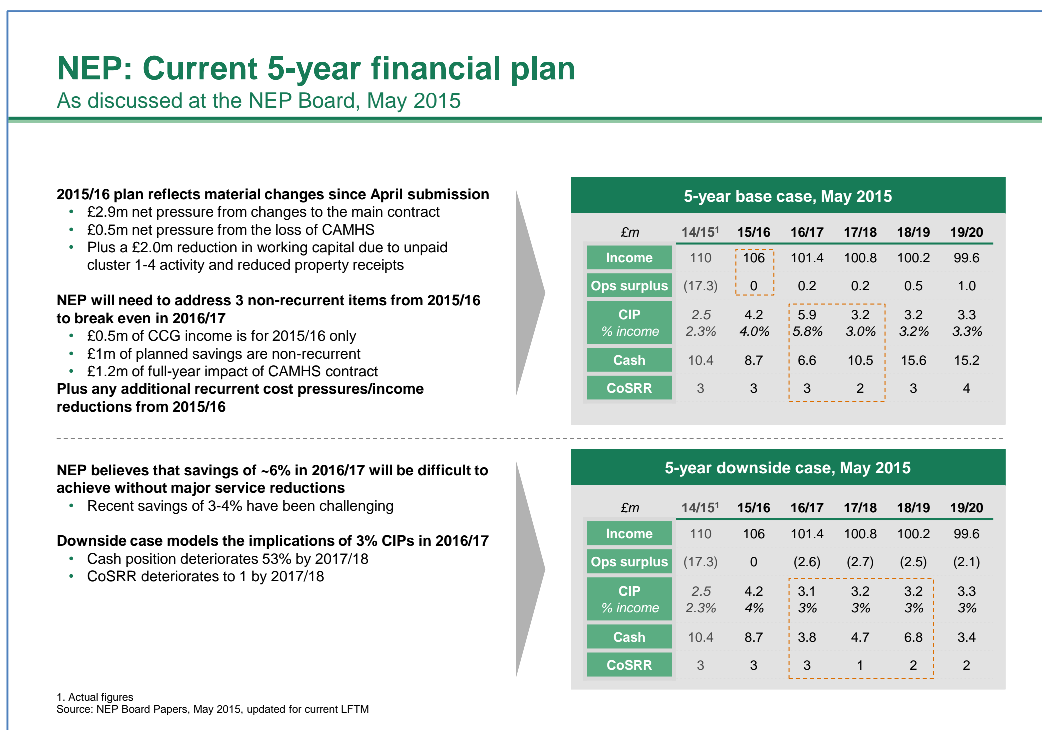
Stakeholder feedback indicates that both providers face brand issues. Perception exists amongst some commissioners that there has not been an adequate response to changes in policy, such as The Care Act, and that the threshold for admission into secondary care is too high. Communication around changes to services – for example, Journeys at NEP – has not been deemed sufficient, and there is a perception that providers are not sufficiently data transparent.

7. The momentum case

The status quo is not an option: the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail posing risk to the continuity of services and the safety of service users.

For providers, as the integration agenda progresses, they may ultimately lose access to between 30-50% of the current available mental health market in Essex[29]. Both trusts risk becoming subscale in mental health care, with difficulties attracting, training and retaining staff, supporting consultant rotas, and having the capacity and capability to effectively bid for new contracts – thus effectively creating a downward spiral.

In the north, NEP has already submitted a challenging financial forecast to its Board which indicates that it is unlikely to be financially viable in the short term.



5-year base case, May 2015

£m	14/15[1]	15/16	16/17	17/18	18/19	19/20
Income	110	106	101.4	100.8	100.2	99.6
Ops surplus	(17.3)	0	0.2	0.2	0.5	1.0
CIP	2.5	4.2	5.9	3.2	3.2	3.3
% income	2.3%	4.0%	5.8%	3.0%	3.2%	3.3%
Cash	10.4	8.7	6.6	10.5	15.6	15.2
CoSRR	3	3	3	2	3	4

5-year downside case, May 2015

£m	14/15[1]	15/16	16/17	17/18	18/19	19/20
Income	110	106	101.4	100.8	100.2	99.6
Ops surplus	(17.3)	0	(2.6)	(2.7)	(2.5)	(2.1)
CIP	2.5	4.2	3.1	3.2	3.2	3.3
% income	2.3%	4%	3%	3%	3%	3%
Cash	10.4	8.7	3.8	4.7	6.8	3.4
CoSRR	3	3	3	1	2	2

SEPT has other business units in addition to mental health – community healthcare and learning disabilities – which mean that there is more strategic ambiguity over its future. However its 2014-19 strategic plan suggests that without further income growth, "SEPT would need to merge by 2018/19" to ensure sustainability.

[29] Based on approximate costs per cluster grouping and range of ambition around CCG integration plans. See Appendix 3, Section 5 for further details.

SEPT: 2014-19 Strategic Plan, 2014

From Annual Report and Operational Plans

Extracts

"Assuming no other income is secured, SEPT is sustainable over the 5-year planning period ... as long as it is able to deliver the required year on year efficiency requirements [through] 10 programmes of work" *(p.12)*

"Although Trust has an excellent track record of delivering CIPs ... it has been increasingly difficult to deliver planned efficiencies as the 'low hanging fruit' schemes have been delivered" *(p.16)*

" Opportunities for growth will have to be pursued to minimise longer term risk to sustainability...without growth in income SEPT would need to merge by 2018/19" *(p.13)*

5-year base case

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	234.4	194.9	193	191.1
Ops spend	326.0	315.4	234.9	193.1	192.4	189.3
Ops surplus	(0.5)	1.2	-0.5	1.8	0.6	1.8
CIP *% income*		16.5 *5%*	13.7 *6%*	10.8 *6%*	10.8 *6%*	10.8 *6%*
Cash	38.6	40.4	36.5	33.9	29.6	26.5
CoSRR	3	4	3	4	3	4

5-year upside

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	342.7	361.2	358.2	355.1
Ops spend	326.0	315.4	339.4	349.4	347.6	343.3
Ops surplus	(0.5)	1.2	3.3	11.8	10.6	11.8
CIP *% income*		16.5 *5%*	9.0 *3%*	13.7 *4%*	6.9 *2%*	9.4 *3%*
Cash	38.6	40.4	36.5	40.3	45.9	44.6
CoSRR	3	4	3	4	4	4

5-year downside

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	228.4	159.2	157.6	156.0
Ops spend	326.0	315.4	231.8	160.2	159.6	157
Ops surplus	(0.5)	1.2	(3.4)	(1.0)	(2.0)	(1.0)
CIP *% income*		16.5 *5%*	13.7 *6%*	10.8 *7%*	10.8 *7%*	10.8 *7%*
Cash	38.6	40.4	36.5	41.8	40.8	41.8
CoSRR	3	4	3	3	3	3

Notes: 13/14 actuals based on annual report; 14/15 actuals and 2015-19 forecasts based revised data received from SEPT; Text extracts from 2014-19 Monitor Strategy
Source: Annual Report 2013/14; Revised 5-year forecast received 28 July

Clinical and professional feedback supports the need for change: there is broad agreement that the current state is not sustainable. Clinical and operational performance is already under pressure, with bed occupancy over 100% in some areas for example.

Importantly, service users consulted as part of this review also reflected back the increasing complexity of the current landscape. They describe the need to become experts in order to 'navigate' to the right services, and describe having to 'game' the system so as to access the care they need.

See **Appendix 1, Section 5** for additional data around provider findings and the momentum case, and **Section 6** for selected competitor vignettes.

8. Recommendations: Commissioners

In order to change path and avert the momentum case, this review makes a number of recommendations. These are described below, grouped according to four key themes.

1. Simplify the commissioning landscape

1a Clarify the integration agenda: commissioners should refine the scope of mental health services planned to be within their local integration models. This should be done with greater clinical and professional leadership, and tailored to local primary care capacity and capabilities. Clinical risk currently lies with the clinicians in secondary care: how this works in shared and integrated care teams will need to be clarified a part of this process. In addition, rather than each moving at their own pace, we recommend commissioners agree a more uniform timeline. This will involve a change of pace for some but potentially result in faster and less complicated implementation.

1b Align around a clear commissioning path: this review considered a number of paths for commissioners. Each represents different trade-offs and has a range of impacts on providers. A preferred path – 'Option 2b' – has been described below. See **Appendix 3** for the longer list of options and additional detail around the option appraisal process.

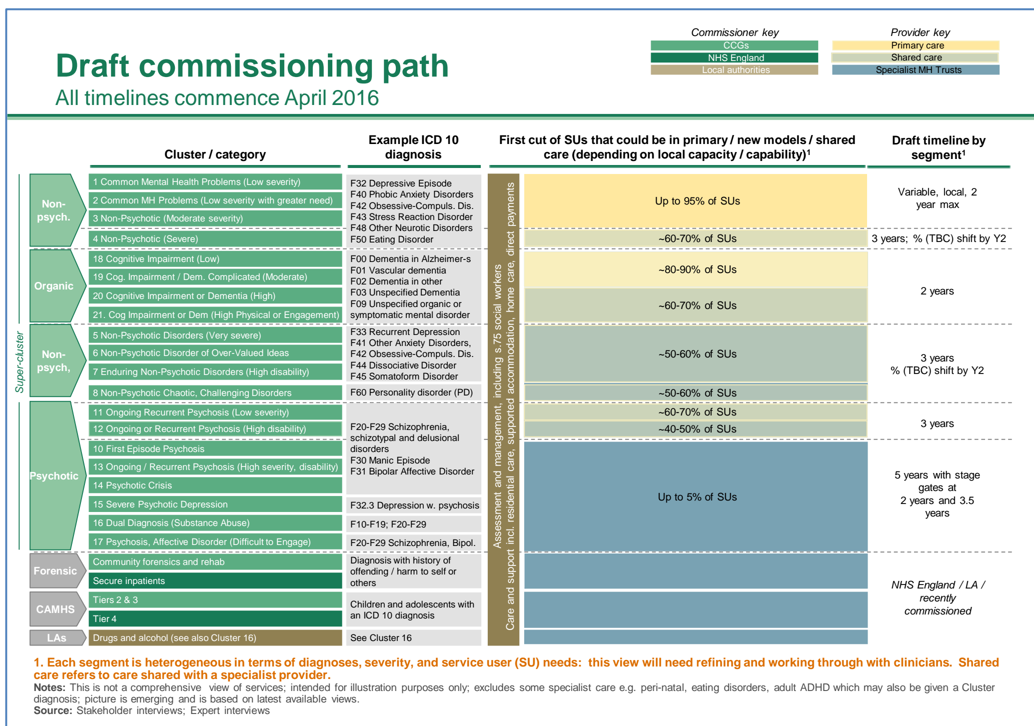
As part of this path, and to allow commissioners to de-average their approach to commissioning, mental health has been considered in segments. These segments are based on clusters and have been tested with clinicians[30]. They are intended as a way of approaching service user health and personal care needs in a more customised, de-averaged way in order to ultimately describe which future services should be commissioned. The timelines for each segment are based on how long is needed before any competitive benchmarking, market testing and potential procurement processes can be considered.

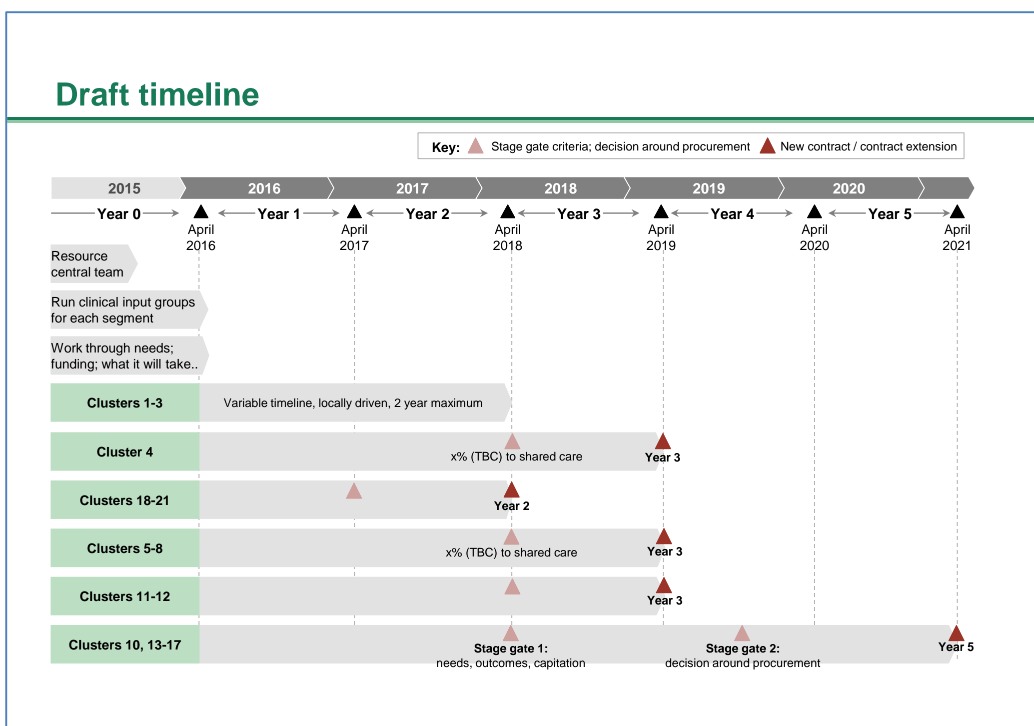
For example, for clusters 1-3, all commissioners are aligned that these form part of the integrated care agenda and will provided locally – either in primary care, new models of care, shared care, or by locally commissioned providers. The services that are needed are relatively clear. There is no requirement for a fixed or shared timeline: contracts can be commissioned locally and timelines are variable.

At the other end of the acuity spectrum, for clusters 10 and 13-17, most commissioners are agreed that the majority of care will continue to be provided by specialist mental health trusts. However there is work to be done by both commissioners and providers, as described in the recommendations above, to conduct robust needs assessments; agree outcomes; determine which services to commission; and allocate funding. Moreover, if a competitive process was to be considered around inpatient services, a strategy would need to be found to address the current estate ownership. For this segment, contracts would therefore be continued for a further 5 years. However importantly, there would be clear stage-gates in place. For example, for providers, these would be around meeting pre-agreed conditions around and ways of working; for commissioners, these would be around providing clarity in terms of service specifications.

---

[30] These segments are not intended to replace clusters as the unit for PbR





The belief is that this path potentially represents the best balance between ensuring commissioners have sufficient time to implement the recommendations, whilst ensuring the needs of service users are met in a timely manner. It also provides NEP and SEPT the opportunity – in terms of space and clarity – to rethink their strategies around service and form.

See **Appendix 1, Section 7** for additional detail around the emerging integration agenda and Option 2B.

1c Work through how best to deploy social workers as the integration agenda plays out: as services are integrated and existing pathways change, local authorities and CCGs will need to jointly assess how best to deploy social workers – for example whether these should follow services or whether they should be organised in a more centralised way.

1d Agree a plan to re-align funding between CCGs: commissioners should agree the approach and timeline to reapportion expenditure and Resource Limit to ensure an affordability neutral solution ahead of implementing the local integration agenda. This has already been agreed in principal in the north of the county.

1e Define where dementia services should sit: local authorities should agree with their local CCGs whether to move dementia under Public Health and Wellbeing as an all-age pathway, whether it should remain split within Adult Social Care.

2. Create a common language and use to clarify needs and expectations

2a Agree a common language: commissioners and providers should agree to use a single terminology / language going forward. Clinical input suggests clusters may be the most reasonable lexicon given the national direction. However it remains imperfect: in clinical practice, services users within clusters are heterogeneous and clustering does not align perfectly with diagnoses, nor are services users familiar with the terminology.

2b Clarify the desired provider capabilities: commissioners should, working with providers, undertake to create a common and shared set of required provider capabilities, for example around IT; culture; flexibility; data transparency.

For example, regarding IT systems, commissioners should agree the key requirement – for example that all IT systems be compatible and able to interface effectively – and then work collaboratively with providers and key experts to understand the different options and the trade-offs around these. For example, moving towards System 1, as has been done in Hertfordshire, will have funding implications which would need to be worked through jointly.

2c Optimise section 75 partnership arrangements: in the south, the three local authorities should commit to working together to create a common template, shared performance targets, and single joint oversight meeting in order to reduce effort and avoid duplication.

2c Work with providers around The Care Act compliance: local authorities should develop clear and consistent expectations for providers' compliance with the Care Act, including what should be incorporated into their contracts in terms of access to pathways for people in distress. This will involve discussions around appropriate funding to ensure realistic expectations.

3. Generate and share more data across the system

3a Conduct robust needs assessments: commissioners should work with clinicians and professionals to assess service user health and personal care needs, including how these differ by geography, locality (e.g. urban vs. rural), and cluster segment.

3b Develop and track better outcomes: building off *3a* above*,* commissioners should work with clinicians and professionals develop desired outcomes – these will inform which services should be commissioned, and how they will be monitored. They will also support funding prioritisation decisions - which clinical feedback suggests are inevitable given the tight funding environment.

3c Share the output of ongoing needs assessment work in dementia: local authorities should ensure learnings and outputs are widely disseminated to avoid duplication and ensure a shared understanding of what is needed.

4. Work more jointly

4a Create a pan-Essex MH commissioning team: commissioners should consider a smaller, more senior mental health team – for example around 10 FTEs – that includes senior analytics, business intelligence, and financial expertise. This would provide real leverage and help make necessary trade-offs between services and cost – the need for which was highlighted at the Clinical Conference held in August.

The recent CAMHS commissioning points to a more effective model. Despite some initial challenges around the process, the outcome to date is deemed positive. The team was co-led by senior health and local authority resources who had sight of the overall context, the right skills and capabilities, and led joint working across the patch on behalf of all commissioners.

The exact organisational form and governance processes should be jointly agreed by commissioners in the coming weeks. Importantly, a single team does not mean a 'one size fits all' solution. Needs, services, activities and outcomes need to be tailored to local geographies.

The principles behind having a smaller, shared team are to attract and fund the appropriate seniority of resource; support simplification and enable the use of a common language; create a single fact base of needs, activities, and outcomes; and build off the CAMHS experience of joint working across health and social care.

Between now and April 2016 the team would work through recommendations *3a* and *3b* above: conduct robust needs assessments; determine gaps; agree outcomes; describe what services should be commissioned to deliver these; prioritise funding; draft commissioning intentions; and refine the draft commissioning path described in *1a* above. From April onwards, there are choices around what role it should continue to play. It should take on a more supportive role around common templates and sharing best practices; or it could commission pan-Essex services provided by specialist mental health trusts – this would exclude for example clusters 1-3 and the dementia clusters, which will be integrated.

4b Optimise AMPHs arrangements: the three local authorities should confirm the numbers required over the next 3-5 years across Essex and work with the trusts to agree costs and approach. At the same time, local authorities should work with the trusts to ensure AMHPs receive appropriate support in addressing delay, as this may improve retention. Finally they should review the service arrangements to ensure that it is as efficient and cost-effective as possible. For example, they may consider contracting a single provider to run the entire rota.

4c Work together to ensure all-age, cross-system care: all commissioners should build on the CAMHS experience and commit to working together to improve outcomes for the most vulnerable individuals, and ultimately develop a shared vision for mental health in Essex. For example, with the new CAMHS contract in place, there is an opportunity to take a life course approach, setting out the vision and standards of care needed from early life, childhood, teenage years into healthy older age and end of life. In addition, local authorities should ensure that the wider impact of mental illness – on employment, housing, and families for example – are accounted for in future commissioning and service specifications. Finally, local authorities should continue to work with public health and primary care to ensure that the stigma that surrounds mental health is continuously addressed through public awareness campaigns.

9. Recommendations: Providers

Providers need to react strategically to the challenges described above, in the context of greater clarity around the integration agenda and timelines from commissioners.

Focus on the core portfolio of services

Providers should review the current portfolio in order to focus on what is core. This will involve defining what their key competencies are and identifying the key adjacencies, skillsets and capabilities required to support these core services. It may also involve a de-prioritisation of non-core services – providers may choose not to bid for these as they are tendered over time.

Build greater depth of capability

In collaboration with commissioners and service users, they should seek to build greater depth around the capabilities which are seen as 'requirements' by commissioners (see Recommendation 4 above).

Consider the form and scale required to deliver within the confirmed timeframe

For providers, the recommended path creates clarity around timelines – and provides them with space to pursue an appropriate strategy around form and scale for their core services. Doing this economically may involve collaboration or merger.

10. Next steps

The proposed next steps are for stakeholders to:

- Consider the recommendations outlined in this report
- Agree which to take forward
- Work together to agree a robust implementation plan
- Set up appropriate governance processes

Appendix 1 (attached PDF): Contents

Section 1: mental health funding in Essex

Section 2: additional detail around key trends and recent publications

Section 3: NEP and SEPT financial, operational, and quality data

Section 4: historic CCG allocations

Section 5: provider findings and momentum case

Section 6: selected competitor vignettes

Section 7: additional materials around Options 1 and 2

Section 8: commissioning cycle and best practices

Appendix 2: Engagement as part of this review

The project team conducted nearly 50 1:1 interviews with the following stakeholders:

Interviews: providers and CCGs

Providers (10)

Group	Name	Date
NEP (5)	Andrew Geldard, CEO	23 June
	Ian Carr, Area Director (West Essex)	23 June
	Vince McCabe, Director of Operations	23 June
	David Griffiths, Director of Resources	14 July
	Mike Chapman, Director of Strategy	25 June
SEPT (5)	Sally Morris, CEO	22 July
	Dr Llewellyn Lewis, Dep. Medical Director	6 July
	Andy Brogan, Exec. Director of Clinical Gov. & Quality	22June
	Dr Milind Karale – Medical Director	23 June
	Malcolm McCann – Executive Director of Operations	6 Aug

CCGs (22)

Group	Name	Date
North East Essex (4)	Sam Hepplewhite, Chief Officer	16 June
	Lisa Llewelyn, Director Nursing & Quality	16 June
	Christine Dickenson, Head, MH Commissioning	16 June
	Joanne Reay, Commissioning Lead	23 June
West Essex (4)	Clare Morris, Chief Officer	17 June
	Miranda Roberts, Clinical Lead, Mental Health	28 July
	Dean Westcott, CFO	17 June
	Kirsty O'Callaghan , Finance Lead	20 July
Mid-Essex (4)	Caroline Rassell, Chief Officer	22 June
	Dr. Caroline Dollery, Chair	19 Aug
	Daniel Doherty, Clinical Commissioning	30 June
	Dee Davey, CFO	14 July
Basildon & Brentford (1)	Tom Abell, Chief Officer	16 June
Castle Point & Rochford (4)	Ian Stidston, Chief Officer	29 June
	Kevin McKenny, Chief Operating Officer	23 June
	Margaret Hathaway	9 July
Thurrock (2)	Mark Tebbs, Head of integrated commissioning	23 June
	Jane Itangata, Head of MH Commissioning	23 June
Southend (3)	Melanie Craig, Chief Officer	29 June
	Dr José Garcia, Chair & mental health lead	23 July
	Hugh Johnston , MH commissioning mgr	23 June

Interviews: local authorities and external experts

Local authorities (12)

Group	Name	Date
Essex (5)	Mike Boyle, Director of Local Delivery (South)	16 June
	Barbara Herts, Director, Integrated Commissioning & VPs	16 June
	Ben Hughes, Head of Commissioning PH & Wellbeing	16 June
	Emily Oliver, Commisioner, Vulnerable People	16 June
	Matthew Barnett, Senior Analyst	24 June
Thurrock (3)	Catherine Wilson , Lead Commissioner	23 June
	Fran Leddra, Lead Council Ops	15 July
	Roger Harris	18 Aug
Southend (4)	Sharon Houlden, Head of Adult Services & Housing	6 July
	Jacqui Ainsley, Director Integrated Care Commissioning	4 Aug
	Jo Dickenson	4 Aug
	Simon Leftley, Director for Adult Services	16 July

External (3)

Name	Role	Date
Martin Brown	Professor, University of York	9 June
John Richards	Director, J Richards Solutions	16 June
Dr. Geraldine Strathdee	National Clinical Director for MH	28 July

The project team met with service users to understand their perspectives and gain their input on July 14th.

Robust clinical input into the review was ensured through a Clinical and Professional Leadership Group, set up as part of the review, and attended by individuals nominated by each stakeholder organisation. Two meetings were held on July 6th and July 28th.

A wider Clinical Conference, attended by over 50 clinicians and professionals from primary and secondary care, was held at the Marconi Club in Essex on August 3rd.

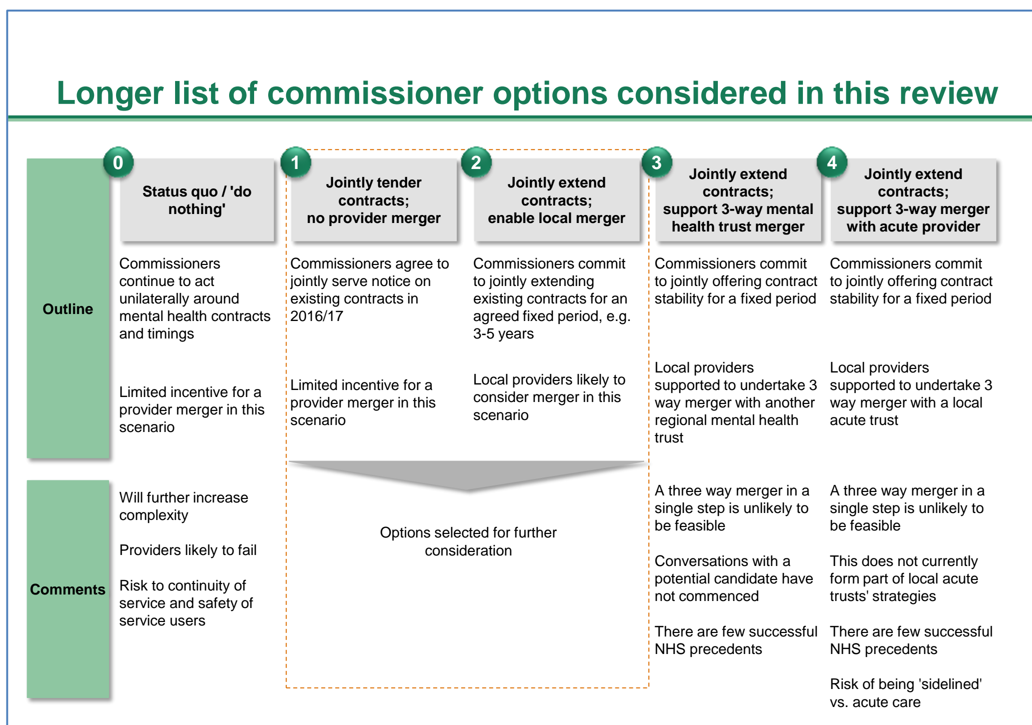
Clinical and professional input: Clinical conference and leadership group attendees

Name	Organisation
Sunil Gupta	CP&R CCG
Michael Bailey	Mid Essex CCG
Elizabeth Towers	Mid Essex CCG
Lisa Llewelyn	N Essex CCG
Miranda Roberts	N Essex CCG
Alexina Weston	N Essex CCG
Liz Carlisle	NEP
Ian Carr	NEP
Benita Christie	NEP
John Cleaver	NEP
Sarah Croot	NEP
Ian Daldry	NEP
Tom Dannhauser	NEP
Lloyd Davies	NEP
Sarah Dowse	NEP
Malte Flechtner	NEP
John Gardner	NEP
Ratna Ghosh	NEP
Harsha Gopisetty	NEP
Natalie Hammond	NEP
Mary Kennedy	NEP
Linda Law	NEP
Ian Lea	NEP
Anna Marley	NEP
Gbolahan Otun	NEP
Hemraj Pal	NEP
Jo Paul	NEP
Lynn Prendegast	NEP
Abdul Raoof	NEP

Name	Organisation
Stephanie Rea	NEP
James Sawtell	NEP
Toni Scales	NEP
Kallur Suresh	NEP
Lizzy Wells	NEP
Russell White	NEP
Gaynor Abbott-Simpson	SEPT
Maria Gutierrez	SEPT
Ron Gutu	SEPT
Annie Heining	SEPT
Milind Karale	SEPT
Gary Kupshik	SEPT
Llewellyn Lewis	SEPT
Julia Renton	SEPT
Karin Thies-Flechtner	SEPT
Andrea Ather	Southend CCG
Sharon Connell	Southend CCG
Linda Dowse	Southend CCG
Hugh Johnston	Southend CCG
Andrea Metcalfe	Southend CCG
Syed Taz	Southend CCG
Anand Deshpa	Thurrock CCG
Jane Itangata	Thurrock CCG
Catherine Wilson	Thurrock UA
Sanjeev Rana	West Essex CCG
Miranda Roberts	West Essex CCG

Appendix 3: Option appraisal

A number of options were considered as part of this review.



These were discussed and assessed against agreed criteria, which included risk to continuity of care and the safety of service users; sustainability; access to services; compatibility with overall national policy; feasibility; and preservation of mental health expertise and parity of esteem.

Based on the discussions, Options 1 and 2 were selected for further more detailed consideration. Both involve trade-offs, and these are different for different commissioners.

Option 1:

In this scenario, commissioners would align around jointly serving notice on the existing NEP and SEPT contracts in 2016 in order to commence new provision in Q1 2017, in line with existing contract timelines. There is little incentive for a provider merger in this scenario; local providers may still choose to bid for services. If the local providers are not successful, a transition plan would need to be agreed to ensure short term continuity of service in the north – in the south, SEPT would still have other business units to consider and may not be immediately financially unsustainable.

The key beliefs around this option are that:

- Service users are best served by moving quickly to a final configuration around provision of mental health services
- Any short term instability and risks to continuity of service can be mitigated
- Commissioner recommendations described as part of this review can be conducted in sufficient time and / or in parallel to the re-procurement process: this includes setting up new models of integrated care and ensuring enablers for the integration agenda are in place, for example new clinics and the necessary support in primary care practices

- A strategy around estates can be worked through in time so as to enable competition around inpatient services (given the incumbent local providers are the legal owners of their infrastructure)
- There is sufficient high quality competition in the system to enable a robust procurement process for all services…
- …and that should the local providers be unsuccessful, having local providers present in Essex longer term is not a key requirement

Option 2:

In this option, commissioners would align around jointly extending the existing NEP and SEPT contracts for a fixed time period, for example 3-5 years. This would be subject to clear conditions, such as agreed outcome metrics and a commitment to joint dialogue around service optimisation – and involve clear stage-gates to review progress. Under these circumstances providers may consider proceeding with a merger, building on discussions that have already commenced.

The key beliefs around this option are that:

- This timeline would ultimately lead to a better final answer for service users with less risk of service disruption in the interim
- Commissioner recommendations described as part of this review will require time to implement, and should be done prior to commencing procurement for new contracts – for example, conducting robust needs assessments, describing what services are required, prioritising funding, and writing robust service specifications
- There is not yet sufficient high quality competition in the system, and competition for inpatient services is not yet possible given the current estates ownership
- Giving local providers the space to consider merger, refocus strategically, and remodel their services will enable them to remain competitive in the longer term – and that having sustainable local providers is in the longer term interest of services users

See **Appendix 1, Section 6** for additional materials around Options 1 and 2.

Following discussion amongst commissioners at the Steering Committees and at three Accountable Officer meetings in July, August and September, a middle ground - Option 2b - was considered the preferred path and is described in detail above.

ITEM 12 **Health and Wellbeing Board Forward Plan**

Date	Agenda	Lead
07/01/15	• Item in Focus - TBC • Health and Wellbeing Strategy Progress Report • Well Homes Project • Suicide Prevention – Children and Young People • Results of 10th December Self-Assessment and next steps	 Ceri/Ian Louisa Moss Malcolm Taylor
Feb - TBC	• Final HWBS Sign Off • Better Care Fund Section 75 Agreement Sign Off	Ceri/Ian Ceri
10/03/16	• Item in Focus - TBC • Care Act 2014 – Part 2 Implications	 Ceri Armstrong

- **Primary Care Estates Strategy**
- **Primary Care Strategy**
- **Early Offer of Help**

This page is intentionally left blank