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

Health and Wellbeing Board

The meeting will be held at **1.30 pm** on **14 July 2016**

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

Membership:

Councillors James Halden (Chair), Robert Gledhill, Susan Little, Leslie Gamester and Steve Liddiard

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board
Liv Corbishley, Lay Member for Public and Patient Participation NHS Thurrock CCG
Steve Cox, Corporate Director of Environment and Place
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Roger Harris, Corporate Director of Adults, Housing and Health
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Lucy Magill, Thurrock Community Safety Partnership
Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust
Clare Panniker, Chief Executive Basildon and Thurrock Hospitals Foundation Trust
Rory Patterson, Corporate Director of Children's Services
David Peplow, Independent Chair of Local Safeguarding Children's Board
Andrew Pike, Director of Commissioning Operations, NHS England - Essex and East Anglia Region
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust
Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust
Ian Wake, Director of Public Health

Agenda

Open to Public and Press

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1 Apologies for Absence

2 Minutes **5 - 10**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 21st April 2016.

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 - Health and Wellbeing Strategy Goal A 'Opportunity for All'

Goal A Objectives:
A1 – All children in Thurrock making good educational progress – Roger Edwardson
A2 – More Thurrock residents in employment, education or training – Michele Lucas and Tim Rignall
A3 – Fewer teenage pregnancies in Thurrock – Tim Elwell-Sutton
A4 – Fewer children and adults in poverty – Michele Lucas and Tim Rignall

6 Health and Wellbeing Strategy Performance Framework **11 - 46**

7 Basildon and Thurrock Hospitals Foundation Trust

Presentation on the current performance and future direction of the Hospital delivered by Tom Abell, Deputy Chief Executive.

8 Sustainability and Transformation Plan **47 - 66**

Update on the South and Mid-Essex Sustainability and Transformation Plan and Essex Success Regime, delivered by Andy Vowles, Programme Director.

9 Integrated Commissioning Executive - Meeting Minutes **67 - 70**

To receive the minutes of the May Integrated Commissioning Executive meeting

10 Health and Wellbeing Board Executive Committee Minutes **71 - 78**

To receive the minutes of the May 2016 and June 2016 Health and Wellbeing Board Executive Committee minutes

11 Work Programme **79 - 80**

Queries regarding this Agenda or notification of apologies:

Please contact Louise Smith, Project Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **6 July 2016**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

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

Minutes of the Meeting of the Health and Wellbeing Board held on 21 April 2016 at 2.00 pm

Present:	Councillors Barbara Rice (Chair), Brian Little and Joycelyn Redsell Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group Lesley Buckland, Lay Member Thurrock CCG Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board Steve Cox, Corporate Director of Environment and Place Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG Roger Harris, Corporate Director of Adults, Housing and Health Kristina Jackson, Chief Executive Thurrock CVS Malcolm McCann, Executive Director of Community Services and Partnerships David Peplow, Independent Chair of Local Safeguarding Children's Board Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust Michelle Stapleton, Director of Integrated Care Basildon and Thurrock University Hospitals Foundation Trust
Apologies:	Councillors John Kent and Bukky Okunade, David Archibald, Dr Anjan Bose, Kim James, Lucy Magill, Andrew Pike and Ian Wake
In attendance:	Tom Abell, Deputy Chief Executive Basildon and Thurrock University Hospitals Foundation Trust Ceri Armstrong, Strategy Officer Mikaela Burns, PA to the Corporate Director of Adults, Housing and Health (minutes) Mike Jones, Management Accountant Steve McManus, Managing Director Basildon and Thurrock University Hospitals Foundation Trust Christopher Smith, Programme Manager Catherine Wilson, Strategic Lead for Commissioning and Procurement

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.

1. Minutes

The minutes of the Health and Wellbeing Board, held on 10th March 2016, were approved as a correct record.

Cllr Barbara Rice updated the Board that the Health and Wellbeing Strategy has now been approved at Full Council.

2. Urgent Items

There were no urgent items.

3. Declaration of Interests

There were no declarations of interests stated.

4. Thurrock Better Care Fund Plan 2016-17

Roger Harris, Corporate Director of Adults, Housing and Health gave a presentation on Thurrock's Better Care Fund 2016-17. Roger stated that the Better Care Fund (BCF) is now in its second year and is a national initiative to drive forward local integration between health and social care.

Roger described the background of the BCF stating that it is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation - so that by 2020 health and social care are integrated across the country. What 'integration' means though is not defined.

Thurrock's BCF in 15-16 focused on people aged 65 and above who are most likely to be at risk of admission to hospital or a care home. The mandated minimum of money was £10.5m, although Thurrock's fund value was £18m. The Plan contained seven main schemes, which were as follows:

1 – Locality Service Integration;
2 – Frailty Model;
3 – Intermediate Care Review;
4 – Prevention and Early Intervention;
5 – Disabled Facilities Grant and Social Care Capital Grant;
6 – Care Act Implementation; and
7 – Payment for Performance.

Roger stated that one of the key achievements of the BCF in 15-16 was that non-elective admissions at Basildon Hospital fell by 3.2% (out of a 3.5% target). Tom Abell, Deputy Chief Executive at BTUH stated that it is encouraging, but whilst there are fewer admissions people are staying in hospital longer.

Tom stated that the challenge for the current year is how we tackle admissions and how does health and social care work together to ensure that

those people who are in hospital are discharged to the appropriate setting for their needs and also to best enable their rehabilitation.

Mandy Ansell, Thurrock CCG's Interim Accountable Officer stated that the analysis with the Success Regime shows that BTUH's length of stay for both Thurrock and Basildon CCGs is considerably longer than that in Southend and Mid Essex. This is an area that we need to drill down on and investigate further.

Cllr Brian Little queried whether people staying longer in hospital is because patients are having difficulty getting back into the community or is it a hospital issue. Tom Abell responded stated that both are contributory factors. From a hospital perspective further work needs to be done in relation to patients receiving diagnostics and scans whilst in hospital as quickly as they should be getting them. Equally one of the challenges that the Hospital is facing once patients are medically fit, is to get them to the right setting of care within the community.

Tania Sitch, Integrated Care Director NELFT provided an update on how the Better Care Fund supported social care teams. Tania stated that a lot of the focus has been around reducing admissions to the hospital but importantly the Joint Reablement Team and the Rapid Response and Assessment Team aim to prevent people going into residential care too early. The aim is to get people medically fit and to return them to their home or a community setting suitable to meet their needs.

Roger updated on the national requirements for the 2016-17 plan. They are as follows:
Plans to be jointly agreed;
Maintain provision of social care services;
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
Better data sharing between health and social care, based on the NHS number;
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
Agreement on local action plan to reduce delayed transfers of care.

The 2016-17 Plan for Thurrock continues to focus on those aged 65 and over who are most at risk of admission to hospital or a residential setting. This is a continuation from 2015-16. Additionally, the Plan expands its focus on prevention and early intervention as the key to managing demand and

resource. The Plan has been reviewed to ensure that its vision and direction of travel aligns with Thurrock's refreshed Health and Wellbeing Strategy.

There are four schemes contained within the 2016-17. These are:

1 – Prevention and Early Intervention – including both existing and developing initiatives the span the community, public health, health and social care system. The scheme is expanded from 2015-16 and brings a stronger focus on preventing ill-health and reducing and delaying the need for increased health and social care interventions.

Mark Tebbs, Director of Commissioning expanded on scheme 1 stating that it focuses on the extension and expansion of the Local Area Co-ordination service that has been successful and award winning to date. It also focuses on integrated data sets which Public Health is leading on and how we can integrate the data used across the whole system. Mark stated that an area of development is stroke prevention. Work is currently underway with public health in relation to early identification of stroke.

2 – Out of Hospital Community Integration – the scheme focuses on the development of locality-based integrated community health and care teams and aims to enable care closer to or at home whenever it is possible. This includes plans to develop four Integrated Healthy Living Centres (IHLC) across the Borough, with the first two areas being Tilbury and Purfleet.

Mandy Ansell stated that a second meeting had taken place in Tilbury where Ian Wake, the Director of Public Health presented the blueprint for Tilbury – in particular focusing on primary care and services that would be provided in the community.

3 – Intermediate Care – the scheme focuses on ensuring individuals are in the most appropriate bed when a bed is required and enabling effective reablement and rehabilitation via that intermediate care bed provision. The scheme includes investment in locality-based Integrated Community Teams.

Mark Tebbs expanded on scheme 3 stating that this was also a scheme in the 15/16 BCF plan and the main focus was to audit what was there and to identify what the issues were within the intermediate care pathways and beginning to look at the solutions going forward. The 16/17 plan focuses on the findings of the review and to develop a pathway that is easier to navigate and more close to home.

4 – Disabled Facilities Grant – This scheme contains the funding received to support major adaptations for owner occupiers, private tenants or housing association tenants. It also contains funding previously known as the Social Care Capital Fund.

Roger stated that an early draft of the current Plan was submitted to NHS England on the 21st March. The Plan was subject to a regional assurance process which contained numerous key lines of enquiry. Once feedback has

been received from both the assurance process and the Health and Wellbeing Board, the Plan will be updated and submitted by the 3rd May 2016 deadline.

Roger updated that subject to the outcome of the assurance process, Thurrock's Plan will be rated against the following levels: Approved, Approved with support; and Not Approved. It is likely that the final status of Thurrock's Plan will not be known until June 2016 as the expectation is that all Section 75 agreements should be signed and in place by the 30th June 2016.

Cllr Barbara Rice wanted to send her thanks to Thurrock Healthwatch for all the consultation work undertaken for the Health and Wellbeing Strategy and the CCG's For Thurrock In Thurrock programme.

RESOLVED:

1.1 The Board agreed the Thurrock's Better Care Fund 2016/17

1.2 The Board has agreed to delegate approval of any changes made to the Plan after the 21st April board meeting to the Chair, Corporate Director of Adults, Housing and Health, and the Interim Accountable Officer (Thurrock CCG)

The meeting finished at 3.04 pm

Approved as a true and correct record

CHAIR

DATE

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14th July 2016	ITEM: 6
Health and Wellbeing Board	
Thurrock Health and Wellbeing Strategy Performance Framework	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Councillor James Halden, Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing, Ian Wake, Director of Public Health and Health and Mandy Ansell, Interim Accountable Officer Thurrock CCG	
This report is Public	

Executive Summary

The Health and Wellbeing Strategy 2016-2021 was approved by the Health and Wellbeing Board in February 2016 and the CCG Board and Council in March 2016.

At its meeting in February, the Health and Wellbeing Board agreed that action plans and an outcomes framework should be developed to support the delivery of the Strategy and to measure its impact.

The report details the action plans that have been developed – one per objective, and the outcomes framework which contains a range of key performance indicators and targets for 2021 against each objective.

The report also notes the vital role of engagement in measuring success and further developing the supporting action plans.

It is suggested that the Health and Wellbeing Board measures the Strategy's progress and impact in a number of ways:

- Through a mid-year and end-of-year performance report;
- Through key strategies and plans being included as part of the Board's work plan as specific agenda items; and
- Through a specific focus on one of the Strategy's five goals and supporting objectives at each of the Board's meeting.

1. Recommendation(s)

1.1 That the Board agrees the Outcomes Framework supporting the delivery of the Health and Wellbeing Strategy;

1.2 That the Board agree and comment on the action plans supporting the achievement of goal A; and

1.3 That the Board endorses arrangements for monitoring the implementation of the Health and Wellbeing Strategy.

2. Introduction and Background

2.1 Thurrock's Health and Wellbeing Strategy was refreshed and agreed in early 2016. The refreshed Strategy has five goals with each of the goals supported by four objectives:

Goals	Objectives
A. Opportunity for All	A1. All children in Thurrock making good educational progress A2. More Thurrock residents in employment, education or training A3. Fewer teenage pregnancies in Thurrock A4. Fewer children and adults in poverty
B. Healthier Environments	B1. Create outdoor places that make it easy to exercise and be active B2. Develop homes that keep people well and independent B3. Building strong well-connected communities B4. Improve air quality in Thurrock
C. Better Emotional Health and Wellbeing	C1. Give parents the support they need C2. Improve children's emotional health and wellbeing C3. Reduce social isolation and loneliness C4. Improve the identification and treatment of depression particularly in high risk groups
D. Quality Care Centred Around the Person	D1. Create four integrated healthy living centres D2. When services are required, they are organised around the individual D3. Put people in control of their own care D4. Provide high quality GP and hospital care to Thurrock
E. Healthier for Longer	E1. Reduce obesity E2. Reduce the proportion of people who smoke E3. Significantly improve the identification and management of long-term conditions E4. Prevent and treat cancer better

2.2 It was agreed by the Board when the Health and Wellbeing Strategy was signed-off, that there would be an Outcomes Framework. This would contain a number of related performance indicators and would provide members of the Board with a means of measuring the impact of the Strategy.

2.3 It was also agreed that each of the objectives would be supported by an action plan containing the key actions needed to meet the objective.

2.4 Subsequently, the Health and Wellbeing Board's Executive Committee has overseen the development of both the Outcomes Framework and supporting action plans. This has included each goal having a 'goal sponsor', and each objective having an 'objective lead'. Goal sponsors are responsible for ensuring that action plans are developed and performance indicators and related information are signed-off. Objective leads are responsible for developing the action plan to support their respective objective and supplying information relevant to their objective's performance indicators. A list of goal sponsors and objective leads is attached at appendix A.

3. Issues, Options and Analysis of Options

Supporting Action Plans

3.1 Attached at appendix B are the action plans supporting goal A of the Health and Wellbeing Strategy. Action plans relating to the other four goals (B – E) will be considered as part of the 'item in focus' at each subsequent Board meeting. The Board's Executive Committee is overseeing the development of all action plans. Action plans will contain actions at a variety of levels, as activity support the delivery of some of the objectives is well underway whereas activity to support other objectives is in development.

3.2 Whilst the Health and Wellbeing Board's Executive Committee will take an active role in both monitoring and overseeing the further development of action plans, the Board will be able to assess progress in a number of different ways:

- Through key pieces of work contributing towards the delivery of objectives included as part of the Board's Forward Plan – e.g. Thurrock Obesity Strategy, Active Places Strategy, Air Quality Strategy;
- Mid-year and end-of year performance reports detailing progress on action plans and performance indicators; and
- The first part of each Board meeting being used to have greater Board discussion on a particular goal and also to ensure views gathered through engagement activity can be reported and used as a means of measuring progress and developing further actions.

3.3 Further work will take place with action plan leads to develop supporting action plans. For example a workshop is being organised to enable objective leads to come together and identify any interdependencies between action

plans. It is also expected that action plans will be updated as work progresses throughout the life of the Strategy.

3.4 The Health and Wellbeing Board is asked to agree and comment on the action plans supporting Goal A and also agree the process by which monitoring will take place.

Outcomes Framework

3.5 An outcomes framework has been developed with includes a number of performance indicators to support each objective. The intention is that the performance indicators enable the Board to identify whether the Strategy is having a positive impact, and also to identify areas that are not having the desired impact. It is important that views provided through engagement activity are also used as the litmus test as to the Strategy's success.

3.6 The Health and Wellbeing Strategy Outcomes Framework is attached at appendix 3. The Framework includes:

- Key performance indicators to support each objective;
- A baseline figure (where available); and
- A target for 2021 (where available).

Some information is unavailable where indicators are either new or being developed.

3.7 The Executive Committee will monitor progress via the Outcomes Framework, but an update by exception will be provided to the Board as part of the Board's mid-year and annual performance reports. Relevant performance updates will also be provided as part of the Board's 'item in focus' agenda item.

3.8 The Board is asked to agree the Outcomes Framework.

Engagement

3.9 Capturing the views of Thurrock people is an essential part of developing action plans and measuring success. On-going engagement managed and facilitated by Healthwatch and Thurrock Coalition will be used to further develop action plans and also help measure success.

4. Reasons for Recommendation

4.1 To ensure that the Health and Wellbeing Board is able to both ensure delivery of the Health and Wellbeing Strategy and effectively monitor its impact in terms of improving the health and wellbeing of Thurrock's population, and reduce inequalities in the health and wellbeing of Thurrock's population.

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

5.1 Engagement activity was carried out to support the development of the Health and Wellbeing Strategy. On-going engagement activity is taking place to inform the development of action plans and to be a key part of measuring the success of the Strategy.

5.2 A workshop will be organised with all objective leads to identify interdependencies and potential areas of conflict between action plans.

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

6.1 'Improve health and wellbeing' is one of the Council's five corporate priorities. The Health and Wellbeing Strategy is the means through which the priorities for improving the health and wellbeing of Thurrock's population are identified.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant – Social Care & Commissioning

There are no financial implications. The priorities of the Health and Wellbeing Strategy will be delivered through the existing resources of Health and Wellbeing Board partners.

7.2 Legal

Implications verified by: **Solomon Adeyeni**

Solicitor

There are no legal implications. The Council and Clinical Commissioning Group have a duty to develop a Health and Wellbeing Strategy as part of the Health and Social Care Act 2012.

7.3 Diversity and Equality

Implications verified by: **Becky Price**

Community Development Officer I Community Development and Equalities Team I Adults, Housing and Health Directorate

Action will need to be taken to improve the health and wellbeing of Thurrock's population and reduce inequalities in the health and wellbeing of Thurrock's

population. Being successful will include identifying sections of the population whose health and wellbeing outcomes are significantly worse, and taking action that helps to ensure the outcomes of those people can improve. This will be supported by information contained within the Joint Strategic Needs Assessment.

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

- Appendix 1 – Health and Wellbeing Strategy Goal Sponsors and Objective Leads
- Appendix 2 – Health and Wellbeing Strategy Action Plans (Goal A)
- Appendix 3 – Health and Wellbeing Strategy Outcomes Framework

Report Author:

Ceri Armstrong

Directorate Strategy Officer

Adults, Housing and Health

Appendix 1

Goal Owner	Objective Lead
A. Corporate Director of Children's Services (Rory Patterson)	A1. Strategic Leader School Improvement (Roger Edwardson) A2. Learning and Skills Manager (Michele Lucas) and Economic Development Manager (Tim Rignall) A3. Public Health Registrar (Tim Elwell-Sutton) A4. Learning and Skills Manager (Michele Lucas)
B. Corporate Director for Environment and Place (Steve Cox)	B1. Sports Development Manager (Grant Greatrex) and Head of Planning and Growth (Andy Millard) B2. Head of Regeneration (Matthew Essex) and Strategic Lead for Housing (Dermot Moloney) B3. Head of Adult Social Care (Les Billingham) and Chief Executive of Thurrock CVS (Kristina Jackson) B4. Head of Transportation and Highways (Ann Osola)
C. Corporate Director for Adults, Housing and Health (Roger Harris)	C1. Strategic Lead Early Years, Families and Communities (Sue Green) C2. Strategic Lead Learner Support (Malcolm Taylor) C3. Head of Adult Social Care (Les Billingham) C4. Public Health Registrar (Funmi Worrell)
D. Interim Accountable Officer Thurrock CCG (Mandy Ansell)	D1. Director of Primary Care (Rahul Chaudhari) D2. Director of Commissioning (Mark Tebbs) D3. Strategic Lead for Commissioning and Procurement (Catherine Wilson) D4. Director of Primary Care (Rahul Chaudhari)
E. Director of Public Health (Ian Wake)	E1. Strategic Lead Commissioner for Public Health (Helen Horrocks) E2. Director of Public Health (Ian Wake) E3. Strategic Lead for Public Health Intelligence (Emma Sanford) and Director of Commissioning (Mark Tebbs) E4. Director of Commissioning (Mark Tebbs)

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Health and Wellbeing Strategy Action Plan

Goal: Opportunity for All

OBJECTIVE: **A1: All children in Thurrock making good educational progress**		**OBJECTIVE LEAD: Roger Edwardson**		
Action	**Outcome**	**Action lead**	**Delivery Date**	**Reference to existing strategy or plan**
School place Planning Strategy for the period 2016-2020 to be published	All Thurrock CYP are offered a school place	**Janet Clark**	April 2016 (Complete)	**Plan on a Page.** **Self-Assessment Report (SAR)**
Utilising the opportunities created by the Eastern Region "Free School" programme the LA is supporting our Multi-Academy Trusts to bid for 3 or 4 new secondary schools for Thurrock. A review will take place of all Thurrock schools during the next planning window – this will contain a condition survey and a possible replacement strategy.	Successful bids are made to the DfE and EFA to secure the new schools to meet the increasing population of pupils aged 11-19 years		October 2016 May 2017	
Two all-through Special Schools are also bidding to open a new Special Free School as well as developing sixth form provision with South Essex College	Treetops secures a new Free school and Beacon Hill establishes new Post-16 provision. Currently both Special schools are judged outstanding by Ofsted.	**Roger Edwardson**	Treetops- October 2016 Beacon Hill -TBC	
LA has clearly defined its monitoring, challenge, support and intervention roles. There are regular meetings between schools and School Improvement Service to review performance and provide challenge and support.	As all Thurrock Schools move to Academy status the role of the LA is defined to support and challenge provision across the borough. The LA will provide leadership and support for the development of MAT's across the borough to support school to		Ongoing	

	school led improvement. " – The focus will be to develop a diversity of provision to ensure all pupils, including the most able are able to access an academic curriculum and therefore access to Russell Universities			
Continue to take a pro-active approach to engage all schools and academies through a number of inter-related strands (Plan on a Page) that aims to establish a local system in which the providers are working closely together and supporting and holding each other to account	Individual schools will not become isolated, and that the local system of Multi Academy Trusts (MATs) and partnerships can build a sustainable model of school-to-school support		Ongoing	
Following the Education Commission the local authority and its schools and academies are:- • Developing a detailed vision for a school-led system in Thurrock. • Ensuring all schools are part of a local cluster. These arrangements have been incentivised by the Council through the Thurrock Education Alliance (TEA) who award funds to successful bids for joint working. • Supporting schools to work together in partnerships using the recently established TRIADs support by HMI.	Partnership structures are created to enable the LA and its schools and academies to work closely together.	**Malcolm Taylor**	Autumn Term 2016 Autumn Term 2016 Autumn Term 2016	
Service Level Agreement (SLA) to be established with schools and academies for Governor Support. Regular meetings to be arranged with	Having established a highly regarded Governor support offer all Thurrock schools and academies continue to buy in to the SLA.		September 2014 Termly meetings	

Chairs of Governors				
The Education Welfare Service operates a SLA, and undertakes regular reviews of provision in schools and academies.	Effective procedures are put in place to improve attendance		Termly meetings	
The LA is working hard to ensure at transition that CYP with Special Educational Needs now have an Education Health and Childcare Plan (EHCP). The LA employs a number of Education Psychologists who are deployed by the appropriate Strategic Lead for the SEND and Inclusion Services	Ensures the statutory requirements for education are met in full and works closely with the Olive Academy – Thurrock's Pupil Referral Unit (PRU) at Primary and secondary level.		Ongoing	
The LA has an inclusion panel to find suitable alternative provision for CYP at risk of exclusion. Children Missing Education (CME) is the focus of a monthly meeting of the Directorate Management Team (DMT) who review provision form the range of services – EWO, SEND, New Arrivals etc	No child or young person is permanently exclude from a Thurrock school as a result of effective intervention to manage move the CYP to an alternative provider. The LA continues to track CME to ensure CYP are not subject to trafficking or sexual exploitation.		Meets every fortnight	
The Engagement team in Inspire - Careers works intensively with NEET young people providing targeted support to this vulnerable group. Inspire - Careers offer a drop in service from the Youth Hub in the centre of Grays offering job search, CV writing and interview skills sessions to NEET young people on an individual basis.	NEETs continue to fall and "Not Knows" remain low.	**Michele Lucas**	Ongoing	
Introduced the Duke of Edinburgh Awards programme for the Thurrock's Children Looked After cohort	A new programme is developed to ensure CLA gain the benefits from the	**Michele Lucas**	To be introduced Autumn Term 2016	

	programme			

Health and Wellbeing Strategy Action Plan

Goal: Opportunity for All

OBJECTIVE: **A2: More Thurrock residents in employment, education and training**		**OBJECTIVE LEAD: Michele Lucas**		
Action	**Outcome**	**Action lead**	**Delivery Date**	**Reference to existing strategy or plan**
Existing Economic Development and Skills Partnership Group to consider how to ensure that connections are made between health issues/initiatives and employment/skills programmes.	• Thurrock residents accessing programmes that support healthy lifestyle choices to enable them to access employment opportunities	Economic Development & Skills Partnership	Autumn 2016	Work has been undertaken and we are looking to increase the opportunities across Thurrock
Promote career opportunities in Thurrock's growth sectors to young people through local careers initiatives building on work undertaken in Tilbury to provide training and employment to people with learning disabilities	• Increased opportunities for young people with existing health needs to access training and employment opportunities	M Lucas	Ongoing	EGS Learning and Skills Plan
Develop a multi-agency approach in key geographic locations to engage hardest to reach groups in receipt of benefits to raise awareness of training and employment opportunities	• Awareness raising of different types of employment and training opportunities available for individuals in addition to services provided by DWP and local jobcentres	To be determined. HWB members invited to propose members for a task and finish group, secure additional resources	To be determined	
Monitor the impact of the Youth Employment Initiative which provides targeted support to young people and adults on how to access employment opportunities	• Will support the identification of effective practice and how the initiative can be informed to ensure that hard to reach groups can be engaged and provided with support, advice and guidance.	M Lucas		
Consider the introduction of a job brokerage service in target community hubs access to job opportunities and training.	• Pilot programme being developed in the Inspire Youth Hub to support this work.	T Rignall/M Lucas	March 2017	EGS
Continue to use planning obligations as a	• Increased local employment and	Kirsty Stokes –	Ongoing	Core Strategy and

tool for securing local jobs and training	training opportunities • Potential additional investment for infrastructure projects that seek to improve employment and education opportunities in the locality	Principal Planning Officer		Policies for the Management of Development Local Plan (Core Strategy)
Ensure that policies in the emerging Local Plan support the delivery of Objective A2 All actions plans to link to other actions plans and policies	• A more sustainable fit for purpose supply of employment land • Increased supply of jobs in existing and emerging industries	Kirsty Stokes – Principal Planning Officer	Ongoing - 2020	Emerging Thurrock Local Plan. For key consultation stages in the emerging Local Plan please refer to the Council's Local Development Scheme.

Health and Wellbeing Strategy Action Plan

Goal: Opportunity for All

OBJECTIVE: **A3: Development of a Thurrock Teenage Pregnancy Reduction Strategy**		**OBJECTIVE LEAD: Tim Elwell-Sutton**		
Action	**Outcome**	**Action lead**	**Delivery Date**	**Reference to existing strategy or plan**
Strengthen SRE in schools:	Prevention of under18 conceptions (NICE PH3)			
• Health professionals deliver relevant relationship and sex education (RSE) sessions in all senior schools	Raise awareness within school setting	**Action:** North East London NHS Foundation Trust (NELFT), Midwives/Family Nurse Partnerships	April 2016-April 2017	Teenage Pregnancy Strategy: beyond 2010 Integrated Sexual Health Service Specification
• Thurrock Careers deliver Inspirational Agenda to secondary schools to raise aspirations of girls to progress into a rewarding career with Particular focus on harder to reach areas with generation issues of teenage pregnancies.	Raise aspirations of girls to progress into a rewarding career.	**Action:** Children's Services	March 2016- May 2016	
• Develop a bespoke education programme aimed at (young boys) age 13+ to include relationships, respect, pregnancy	Raising awareness and changing attitudes of young boys around relationships, respect and pregnancy (as recommended by youth cabinet)	**Action:** NELFT	April 2016 **Complete**	
• Youth Cabinet to be involved in the development of the online C-Card and	Increase >40% of Under-25 year olds that undertake an assessment for a C-Card	**Action:** Children's Services/ NELFT	April 2016 **Complete**	

its promotion in schools				
Improve access to contraception: • Sexual Health Clinic have drop in sessions available rather than by appointment only	Prevention of under18 conceptions and Contraceptive services for under 25 (NICE PH3, PH51)	**Action:** NELFT	May 2016 – Sept 2016	Teenage Pregnancy Strategy: beyond 2010
• Sexual Health twitter post on @SHSthurrock to signpost young people to sexual health services and school nurse drop in centres	Increase the number of young people at risk accessing sexual health services.	**Action:** NELFT	May 2016 - ongoing	Integrated Sexual Health Service Specification
• Sexual health professional have a monthly session in each secondary school to be available for Long Active Reversible Contraception (LARC)	Increase accessibility to young people for the use of LARC (NICE CG30, PH51)	**Action:** NELFT	May 2016 - ongoing	
• Thurrock Careers Personal Adviser with a lead for Teenage Pregnancy/Parents works in partnership with Family Information Service (FIS), WISHES, Family Nurse Partnership (FNP), Children's Centres, youth hostels to deliver individualised and targeted career support to increase participation in employment, education and training; to increase Care To Learn take up.	Raise aspiration of young people and improved signup for Care to Learn	**Action:** Children's Services	May 2016 - ongoing	
• Supporting pastoral activities in schools for sexual health, working with the "Aspire" faith based group within Hassenbrook	Increase aspirations and accessibility to young people	**Action:** Jo Pitt	May 2016 – Sept 2016	

• Group of young people from the Youth Cabinet to work alongside NELFT to review and develop the Go Girls and Delay	Engagement of young people to create and effective prevention programme	**Action:** Children's Services	April 2016 **Complete**	
Strengthen primary care delivery of family planning: • Development of an action plan for increasing the uptake of LARC via GP's	Prevention of under18 conceptions and Contraceptive services for under 25 (NICE PH3, PH51). Increase >50% of Under-25 year olds that have had a discussion on LARC as a contraception option	**Action:** Thurrock CCG and Jo Pitt	August 2016	Teenage Pregnancy Strategy: beyond 2010 Integrated Sexual Health Service Specification
• Review and develop the community pharmacy sexual health contract	Prevention of under18 conceptions and Contraceptive services for under 25 (NICE PH3, PH51).	**Action:** Essex LPC and Jo Pitt	April 2016 **Complete**	
• Review primary care contracts and streamline process to encourage greater sign up	Prevention of under18 conceptions and Contraceptive services for under 25 (NICE PH3, PH51). Increase >50% of Under-25 year olds that have had a discussion on LARC as a contraception option	**Action:** Jo Pitt/Sarah Hurlock	April 2016 **Complete**	
Evaluation • Provision of previous Teenage Pregnancy strategy, best practice etc.	Increase ability to find areas of innovation and best practice	**Action:** Essex LPC	May 2016 - ongoing	Teenage Pregnancy Strategy: beyond 2010
• Provision of statistics on education, training, employment (EET) and not in education, training, employment (NEET) teenage parents 16-19 in Thurrock		**Action:** Children's Services	Ongoing	Integrated Sexual Health Service Specification

• Provision of validated data and current NHS tariffs		**Action**: Essex LPC	May 2016 - ongoing	
Multi Agency Working • Midwives to be included in the Forum i.e. the teenage midwives from Basildon	Prevention of under18 conceptions and Contraceptive services for under 25 (NICE PH3, PH51)	Group	May 2016 - ongoing	Teenage Pregnancy Strategy: beyond 2010 Integrated Sexual Health Service Specification

Health and Wellbeing Strategy Action Plan

Goal: Opportunity for All

OBJECTIVE: **A4: Fewer children and adults in poverty**		**OBJECTIVE LEAD: Dave Petrie**		
Action	**Outcome**	**Action lead**	**Delivery Date**	**Reference to existing strategy or plan**
Develop Neighbourhood Focussed approaches	Community consultations held in top 5 wards at suitable locations to launch, advise and gain support and guidance on the CPov Strategy and Challenge	Dave Petrie – Child Poverty Lead	3 community engagement events in 16/17	Child Poverty Strategy/Action Plan
Create Pathways into employment	Retired skilled workers acting as volunteer for development clubs and as mentors	Dave Petrie – Child Poverty Lead	8-10 Ex Thurrock Council Staff Dec 2016	Child Poverty Strategy/Action Plan
Maximise income and raise living standards	Exploration regarding food-buying coops, food wastage from local stores	Dave Petrie – Child Poverty Lead	Review of European examples and 3 local stores Dec 2016	Child Poverty Strategy/Action Plan
Support parents and carers to upgrade their skills	Twenty trained Volunteers in Literacy and Numeracy mentoring Parent-led study groups in or attached to all Thurrock children's centres	Dave Petrie – Child Poverty Lead	Training costs secured and delivered Mar 2017	Child Poverty Strategy/Action Plan

Continue to Narrow the Gap in Achievement between Children on Low Incomes and Children from more Affluent Families	Use of Pupil premium to provide family learning and other home-based support for children's learning	Dave Petrie – Child Poverty Lead	2 schools – Tilbury and South Ock to explore ways forward within this Feb 2017	Child Poverty Strategy/Action Plan
Investigate the potential for using planning obligations as a tool for securing local jobs and training	• Increased local employment and training opportunities	Kirsty Stokes – Principal Planning Officer	October 2016	Core Strategy and Policies for the Management of Development Local Plan (Core Strategy)
Review and update the Infrastructure Requirement List to ensure that the impacts of new development are appropriately mitigated	• More effective use of planning obligations • Additional investment for infrastructure projects that seek to improve employment and education opportunities in the locality	Kirsty Stokes – Principal Planning Officer	October 2016	Infrastructure Requirement List
Undertake a comprehensive assessment of economic development needs and opportunities	• A more sustainable fit for purpose supply of land for industrial and office uses • Inform policies in the emerging Local Plan	Kirsty Stokes – Principal Planning Officer	December 2016	Emerging Thurrock Local Plan. For key consultation stages in the emerging Local Plan please refer to the Council's Local Development Scheme.
Undertake a comprehensive assessment of retail development needs and opportunities	• A more sustainable fit for purpose supply of land for retail and leisure uses • Inform policies in the emerging Local Plan	Kirsty Stokes – Principal Planning Officer	December 2016	Emerging Thurrock Local Plan. For key consultation stages in the emerging Local Plan please refer to the Council's Local

				Development Scheme.
Ensure that policies in the emerging Local Plan support the delivery of Objective A4	• A more sustainable fit for purpose supply of employment land • Increased supply of jobs in existing and emerging industries • Increased supply of affordable housing in sustainable locations	Kirsty Stokes – Principal Planning Officer	Ongoing - 2020	Emerging Thurrock Local Plan. For key consultation stages in the emerging Local Plan please refer to the Council's Local Development Scheme.

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APPENDIX

Health and Wellbeing Strategy
Initial Performance Report
July 2016

Indicators highlighted in yellow relate to a proposed indicator that is not in existence as yet but will form part of a future report.

Goal	A: Opportunity for All

Objective	A1: All Children in Thurrock making good educational progress		
Indicators		**2016 Baseline**	**2021 Target**
EYFS Attainment - % of children achieving a Good Level of Development (GLD) at the end of Early Years Foundation Stage This indicator quantifies the proportion of children who achieve a Good Level of Development by the end of Reception Year / Early Years Foundation Stage. Children are defined as having reached a Good Level of Development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy. This is also an indicator on the Public Health Outcomes Framework.		**72.5%** (2015)	**Target to be confirmed**
EYFS Attainment - Percentage point gap between pupil premium children achieving GLD and others at end of Early Years Foundation Stage This indicator quantifies the gap between those eligible for pupil premium and all others in achievement of GLD by the end of Reception Year / Early Years Foundation Stage. Children from poorer backgrounds are more at risk of poorer development, and the evidence shows that differences by social background emerge early in life.		**12.2%** (2015)	**No target set as yet**
KS2 Attainment – % Achieving the National Standard in Reading, Writing & Maths Primary accountability measures have changed for 2016. Levels no longer exist and have been replaced by a scaled score outcome. The new headline measure for attainment is the percentage of pupils achieving the 'expected standard' in English reading, English writing and mathematics at the end of Key Stage 2.		**New indicator**	**85% (National target)**
% of children achieving 5 good GCSEs at A*-C including English and Maths – will be replaced by KS4 Attainment – Progress 8 score Progress 8 will replace 5+ A*-C including English and Maths (GCSE) in the 2016 Department for Education performance tables. This is a value added measure that aims to capture the progress a pupil makes from the end of primary school to the end of secondary school. As such, it is not possible to quantify a target for this indicator until it is changed.		**53.4%** (2014/15) **/ New indicator**	**National average or higher**

Objective	A2: More Thurrock residents in employment, education or training.		
Indicators		**2016 Baseline**	**2021 Target**
% of working age population who are economically active This indicator quantifies the proportion of working aged people (16-64 years currently) who are economically active – that is to say, they are either employed or unemployed.		**78.3%** (Jan-Dec 2015)	**80% [draft target]**
% of the population of working age claiming Employment Support Allowance and incapacity benefits – will be replaced by indicator regarding Universal Credit.		**5.0%**	**Unable to produce**

This indicator quantifies the proportion of working aged people (16-64 years currently) who are claiming Employment Support Allowance and incapacity benefits. The age at which women reach State Pension age is gradually increasing from 60 to 65 between April 2010 and April 2020. Throughout this period, only women below State Pension age are counted as working age benefit claimants. However, the national roll out of Universal Credit means that claimants will be required to move onto that, so this indicator will require revising in the near future.		**target as indicator will change**
% of the population of working age claiming JSA – will be replaced by indicator regarding Universal Credit. This indicator quantifies the proportion of working aged people (16-64 years currently) who are claiming Job Seekers Allowance. The age at which women reach State Pension age is gradually increasing from 60 to 65 between April 2010 and April 2020. Throughout this period, only women below State Pension age are counted as working age benefit claimants. However, the national roll out of Universal Credit means that claimants will be required to move onto that, so this indicator will require revising in the near future.	**1.6%** (August 2015)	**Unable to produce target as indicator will change**
% of 16 – 19 year olds Not in Employment, Education or Training This indicator quantifies the proportion of those aged 16-19 years who are not in employment, education or training (NEET). There is national legislation in place known as Raising the Participation Age which requires all young people to remain in education or training until their 18th birthday, so this is likely to result in a decrease in this figure. The impact this will have on 18-24 year olds who are not in employment or training is unknown.	**5.2%** (2014)	**5.0% for 2016/17**

Objective	**A3: Fewer teenage pregnancies in Thurrock.**	
Indicators	**2016 Baseline**	**2021 Target**
Under 18 conception crude rate per 1,000 This indicator quantifies the rate per 1,000 females aged 15-17 years who have had a conception. Most teenage pregnancies are unplanned and approximately half end in an abortion. Research evidence shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. This is also an indicator on the Public Health Outcomes Framework.	**25.5** (2014)	**20.0**

Objective	**A4: Fewer children and adults in poverty.**	
Indicators	**2016 Baseline**	**2021 Target**
% of children in poverty (all dependent children). This indicator quantifies the percentage of all dependent children under 20 years of age in "relative poverty" – where the household income is less than 60% of median household income before housing costs. There is a large body of evidence to suggest that poverty in childhood leads to a number of poor health outcomes in both children and adults. Reducing the numbers of children who experience poverty should improve health outcomes and increase healthy life expectancy. This is also an indicator on the Public Health Outcomes Framework.	**19.6%** (2013)	**18.0% [draft target]**

Number of homeless households supported by Thurrock Council.		
This quantifies the number of homeless households supported by Thurrock Council Housing service – i.e. those where a homeless application was processed for them because homelessness could not be prevented. There is a large amount of evidence to show that those who are homeless are at risk of experiencing poorer outcomes than those who live in stable accommodation – these include worse physical and mental health, unhealthier lifestyles and increased hospital use.	**472** (2015)	**Target to be confirmed**

Number of places given out for the 2 year old offer		
Definition and data to be agreed		

Goal	B: Healthier Environments

Objective	B1: Create outdoor places that make it easy to exercise and to be active.		
Indicators		**2016 Baseline**	**2021 Target**
% of physically active adults	This indicator quantifies the proportion of adults aged 16+ achieving at least 150 minutes a week of physical activity in accordance with the Chief Medical Officer's recommended guidelines. This is also an indicator on the Public Health Outcomes Framework.	**52.8%** (2014)	**57%**
% of physically active children	This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.		
An indicator regarding open space quality/value following publication of the future Active Place Strategy.	The Active Place Strategy is due for completion in late summer 2016, and will contain an assessment of current open space provision. It is envisaged that the Strategy will have a number of performance indicators to measure its' effectiveness – one of which will be selected for inclusion in the Health and Wellbeing Strategy Outcomes Framework.		
% of new developments that conform to the minimum Design Standards as produced by the Council's Planning Team.	The Planning Team have produced draft Design Standards guidance to be referred to by all developers submitting future planning applications. These will contain guidance on criteria for 'best-practice' developments, which include recommendations on developing spaces to encourage exercise and activity. The full suite of standards documents are currently under development.	**Standards not in place as yet**	**100%**
An indicator regarding resident satisfaction with open spaces and their ease to undertake activity.	It is proposed that a future indicator might come from the forthcoming Thurrock Residents Survey, expected to launch in the summer of 2016. This will give an understanding of residents' views.		

Objective	B2: Develop homes that keep people well and independent.		
Indicators		**2016 Baseline**	**2021 Target**
% of all major housing developments that have an approved Health Impact Assessment.	This indicator quantifies the proportion of all major (in this instance, defined as those with more than 25 dwellings) planned housing developments that have an approved Health Impact Assessment completed. A Health Impact Assessment is a means of assessing the health impacts of policies, plans and projects using a range of techniques. These should be conducted in line with the Department of Health guidance (2010). Including this as an indicator will ensure developers are mindful of the positive and negative impacts their schemes can have to population health, meaning more proposals that are received will be able to evidence positive benefits to health.		**100%**

% of all major planning applications that have been assessed by the Health and Wellbeing Housing and Planning Advisory Group		
This indicator quantifies the proportion of major (in this instance, defined as those with more than 25 dwellings) planning applications and pre applications that have been provided to the Thurrock Health and Wellbeing Housing and Planning Advisory Group for review and assessment. The Health and Wellbeing Housing and Planning Advisory Group is a multi-agency group which considers the health and well-being implications of major planning applications, and provides advice and guidance on the health, social care and community impacts of proposed new developments.	**Work in progress to establish baseline**	**100%**

Objective	**B3: Building strong, well-connected communities.**	
Indicators	**2016 Baseline**	**2021 Target**
Number of weekly hours of volunteering time.		
This indicator quantifies the total number of hours that volunteers working in Thurrock's voluntary sector workforce give per week. Volunteering can yield benefits both for the person volunteering and the people/organisations they support. These include benefits to mental health and wellbeing, improved relationships and better social opportunities, as well as reduced burdens to carers and other formal services. The source for this indicator is the State of the Sector Survey produced by CVS.	**19,069** (2014/15)	**Target to be confirmed**
Number of micro-enterprises operating in the area.		
Micro-services or enterprises provide support or care to people in their community. To be a micro -service provider they must have eight or fewer paid or unpaid workers and be totally independent of any larger organisation. This is a new initiative being rolled out in Adult Social Care and as such there is no baseline yet.	**0**	**25 by February 2017**
Estimated Dementia Diagnosis Rate for people aged 65+		
This indicator quantifies the proportion of those aged 65+ estimated to have dementia who have been formally diagnosed by their GP. This indicator is included as it provides a guide to the effective recognition and diagnosis of dementia patients in Thurrock. The national target has been set at 67%.	**66.4%** (April 2016)	**67%**
Number of "Dementia Friends" in Thurrock.		
This indicator quantifies the number of "Dementia Friends" registered in Thurrock. The Dementia Friends initiative is all about giving people in a community an understanding of dementia and the small things that they can do that could make a difference to people living with dementia. A Dementia-Friendly Community would enhance the social capital of the area they served and develop the community resilience that would make a contribution to the avoidance of unplanned or early admissions among people living with dementia.	**2564** (May 2016)	**3750**

Objective	**B4: Improve air quality in Thurrock.**

Indicators	2016 Baseline	2021 Target
Number of AQMAs declared in Thurrock.		
The Local Air Quality Management regime (Part IV of the Environment Act, 1995) requires all local authorities to review and assess the quality of their local air quality. Should this confirm that an objective will not be met within the required timescale, the local authority must designate Air Quality Management Areas (AQMAs). Thurrock currently (2016/17) has 18 declared AQMAs for exceeding threshold annual average limit values for nitrogen dioxide (NO_2). Evidence associating NO_2 with health effects has strengthened substantially in recent years; it is estimated that the effects of NO_2 on mortality are equivalent to 23,500 deaths annually in the UK.	**18** (2016)	**8**

Goal	C: Better emotional health and wellbeing.

Objective	C1: Give parents the support they need at the right time.		
Indicators		**2016 Baseline**	**2021 Target**
% of parents achieving successful outcomes from early intervention prevention parenting programmes. This indicator quantifies the proportion of parents who successfully complete 10 or more out of 12 sessions of the 'Strengthening Families' targeted parenting programme and evidence improvements in 3 or more of the 8 outcome areas. In general, there is evidence to indicate that certain parenting programs can reduce problem behaviour in children and improve parental mental health and wellbeing. It should be noted that the indicator definition may be subject to change if the commissioned offer changes between 2016 and 2021.		**72%** (2015/16)	**75%**
Number of families known to Troubled Families Service This quantifies the number of families that the Troubled Families team have provided support to. The headline criteria, underpinned by the DCLG Financial Framework 2015 for identifying families is as follows: • Parents and children involved in crime or anti-social behaviour • Children who have not been attending school regularly • Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan • Adults out of work or at risk of financial exclusion or young people at risk of worklessness • Families affected by domestic violence and abuse • Parents and children with a range of health problems		**370** (2016/17)	**1160 by May 2020 (nationally-set target)**

Objective	C2: Improve the emotional health and wellbeing of children and young people.		
Indicators		**2016 Baseline**	**2021 Target**
% of children and young people reporting that they are able to cope with the emotional difficulties they experience. This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.			
% of children and young people reporting that they know how to seek help when experiencing difficulties with emotional health and wellbeing. This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.			
% of children reporting being bullied in the last 12 months. This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.			

Objective	C3: Reduce social isolation and loneliness.

Indicators	2016 Baseline	2021 Target
Number of people who are supported by a Local Area Coordinator.	**558** (Jan - Dec 2015)	**650**
This is the number of people recorded by Thurrock Council as being in receipt of support from a Local Area Coordinator. Local Area Coordinators are based in their communities and their role is to help people, who may be isolated or excluded due to disability, mental health needs, age/frailty, to re-connect with their communities. They focus on helping to reduce isolation and offering earlier support to those who otherwise may end up requiring statutory support.		
% of people whose self-reported wellbeing happiness score is low.	**10.7%** (2014/15)	**8.0%**
This indicator quantifies the proportion of adults who rated their happiness as of the preceding day to have a score of 4 or below (maximum = 10) in the Annual Population Survey. Perceived poor wellbeing has been linked to depression and suicide risk. This is also an indicator on the Public Health Outcomes Framework.		

Objective	**C4: Improve the identification and treatment of depression, particularly in high risk groups.**	
Indicators	**2016 Baseline**	**2021 Target**
People entering IAPT as a % of those estimated to have anxiety / depression.	**15.1%** (Sep 2015)	**25%**
This indicator captures the number of people entering Improving Access to Psychological Therapy (IAPT) services as a proportion of all those estimated to have anxiety and/or depression. The ambition for increasing IAPT access for those with a common mental health disorder was set out in the Five Year Forward View for Mental Health report in February 2016, setting a national target of 25% by 2020/21.		
% of people who have completed IAPT treatment who are "moving to recovery".	**39.3%** (Mar 2016)	**50.0% (current national target)**
This indicator is a measure of IAPT patient outcome, as it shows the proportion of people that were above the clinical threshold for anxiety/depression before treatment but below following treatment.		
% of patients on community LTCs caseloads without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool.	**Baseline data not available yet**	**95%**
The indicator looks to quantify the proportion of patients known to long term conditions services who have been screened for depression using a validated tool (PHQ9) within the last 24 months. This has been included as there is evidence to indicate that those with an existing long term condition are at high risk of depression. This has only recently been added into the service contract as a requirement and as a result, baseline data is difficult to obtain at this stage.		
% of ASC clients over 65 screened for depression by frontline Thurrock Council SC staff		
This is a new indicator aiming to quantify the proportion of clients known to adult social care services who have been screened for depression. Work is in progress to start this as a pilot programme from 1st July 2016.		

Goal	D: Quality Care centred around the person.

Objective	D1: Create four integrated healthy living centres		
Indicators		**2016 Baseline**	**2021 Target**
Number of IHLCs that are operational	The future vision for Thurrock is that there will be four "integrated healthy living centres", one in each of the four locality areas. Work to detail the requirements for two of the centres (Tilbury and Purfleet) has already begun, with the other two to follow in the near future. It is the intention that these centres will incorporate a range of different health, social care and wider community services which will enable some of the root causes of ill-health to be addressed alongside treatment of more serious conditions via primary care and some secondary care services.	**0** (2016)	**4**
% of A&E attendances that are coded as no investigation with no significant treatment.	This quantifies the proportion of A&E attendances by Thurrock patients that are given the HRG code of VB11Z – defined as 'no investigation with no significant treatment'. Attendances with this HRG code are generally considered to be those that could have had their needs met elsewhere. Attending A&E for clinical conditions that are could have been treated in a more local clinical setting are both inconvenient for patients and put additional unsustainable pressure and cost on the Thurrock health economy. It is the intention that establishment of the IHLCs will result in a reduction of these patients attending A&E.	**40.93%** (2014/15)	**38.8% [draft target]**

Objective	D2: When services are required, they are coordinated around the needs of the individual.		
Indicators		**2016 Baseline**	**2021 Target**
% of the 2% highest risk frail elderly in Thurrock with a care plan and named accountable professional.	This quantifies the proportion of people registered with identified GP practices, which have been classified as living with 'moderate' or 'severe' frailty, following screening using the Electronic Frailty Index (eFI), to have a Comprehensive Care Plan (CCP) and a Named Accountable Community Professional identified. We are aiming to identify the most vulnerable frail elderly in Thurrock through a standardised tool (currently the electronic frailty index). This will enable us to ensure that each patient has a CCP, a comprehensive escalation plan to manage worsening conditions and a named accountable community professional. Our aim is that we will be able to reduce non elective attendances by better managing people in the community. This is a new indicator.	**Baseline not available as yet**	**95%**
Establish a data system linking records from primary, secondary, community, mental health and adult social care	Currently, there are a number of different information systems that hold patient-level health and social care data, but there is no easy way to link records, meaning it is difficult and often impossible to see who is accessing multiple services. This means it is difficult to identify residents who are at risk of becoming future users of expensive services, and therefore makes future service planning very complex. Approval has been given for the procurement of a solution that will	**No system in place**	**System in place**

enable Thurrock to maintain a Population Health solution, enabling population segmentation (i.e. being able to identify sub-populations who share similar characteristics to better target interventions), risk stratification across services, and predictive/scenario modelling to be carried out (enabling forecasting of future service use in line with population projection information to aid future planning).		
% of Early Offer of Help episodes completed within 6 months.		
This indicator quantifies the proportion of all Early Offer of Help episodes that were completed within 180 days. Services provided under the Early Offer of Help aim to support families and children at the edge of statutory intervention or, where statutory intervention is already in place, to prevent this escalating to care proceedings. Reducing the risk of poorer outcomes by providing support at an earlier stage prevents more costly later intervention from both a health and social care perspective.	**76.5%** (2015/16)	**Target to be confirmed**

Objective	**D3: Put people in control of their own care.**	
Indicators	**2016 Baseline**	**2021 Target**
% of people who have control over their daily life.		
This indicator shows the proportion of adult social care service users aged 18+ who feel that they have control over their daily life, and is calculated from data collected in the Adult Social Care Survey. Part of the intention of personalised services is to design and deliver services more closely matching the needs and wishes of the individual, putting them in control of their care and support. This measure is one means of determining whether the desired outcome is being achieved. This is also an indicator on the Adult Social Care Outcomes Framework.	**74.2%** (2014/15)	**85%**
% of people receiving self-directed support.		
This indicator shows the proportion of adult social care users aged 18+ who are receiving self-directed support. Self-directed support allows people to choose how their support is provided, and gives them control of their individual budget. This measure supports the drive towards personalisation of care, and is also an indicator on the Adult Social Care Outcomes Framework.	**70.3%** (2014/15)	**100%**

Objective	**D4: Provide high quality GP and hospital care to Thurrock.**	
Indicators	**2016 Baseline**	**2021 Target**
% of GP practices with a CQC rating of at least "requires improvement".		
The Care Quality Commission (CQC) inspects and regulates health and social care services under 5 domains: Are they safe? Are they effective Are they caring? Are they responsive to people's needs? Are they well-led? Providers can receive one of four ratings for each domain: outstanding, good, requires improvement and inadequate. This measure quantifies the proportion of GP practices that achieved an overall CQC rating of "requires improvement" or	**Baseline expected by the end of November 2016**	**100%**

above across all domains.		
% of GP practices with a CQC rating of at least "good". This measure quantifies the proportion of GP practices that achieved an overall CQC rating of "good" or above across all domains.	**Baseline expected by the end of November 2016**	**50%**
% of patients who would recommend their GP practice to someone new in the area. This indicator quantifies the proportion of patients who said they would recommend their GP practice to someone who had just moved to their area, when asked as part of the GP Patient Survey. A high proportion would indicate high levels of satisfaction with the care being provided by Thurrock GPs, and can be used as one indicator for quality of care.	**72.08%** (2014/15)	**80%**
% of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge. The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated and then admitted or discharged in under four hours. This is commonly known as the four-hour standard. The clock starts from the time that the patient arrives in A&E and stops when the patient leaves the department on admission, transfer from the hospital or discharge. Thurrock has an agreed recovery plan and trajectory for sustained recovery from May 2016.	**91.11%** (2015/16)	**95%**
Overall CQC Rating - BTUH This measure quantifies the overall CQC rating across all domains for Basildon and Thurrock University Hospital.	**Good (maternity department rated as "outstanding")** (May 2016)	**Retain "Good" Rating overall**
Overall CQC Rating - NELFT This measure quantifies the overall CQC rating across all domains for North East London Foundation Trust.	**Formal result expected September 2016**	**"Good" or to be working towards "Good"**
Overall CQC Rating - SEPT This measure quantifies the overall CQC rating across all domains for South Essex Partnership Trust.	**Good** (November 2015)	**Retain "Good" Rating overall**
Overall CQC Rating - East of England Ambulance Service This measure quantifies the overall CQC rating across all domains for the East of England Ambulance Service.	**Formal result expected September 2016**	**"Good" or to be working towards "Good"**

Goal	E: Healthier For Longer.

Objective	E1: Increase the number of people in Thurrock who are a healthy weight.		
Indicators		**2016 Baseline**	**2021 Target**
% of children overweight or obese in year 6		**36.7%** (2014/15)	**Below the national average**
This indicator quantifies the proportion of children aged 10-11 years classified as overweight or obese in the National Child Measurement Programme. There is concern about the rise of childhood obesity and the implications of obesity continuing into adulthood. Evidence has shown that children who are overweight or obese have higher risks of developing long term conditions such as diabetes and hypertension, exacerbation of conditions such as asthma, and poor mental health and wellbeing. This is also an indicator on the Public Health Outcomes Framework.			
% of adults overweight or obese		**70.4%** (2012-2014)	**65%**
This indicator quantifies the percentage of adults classified as overweight or obese calculated from self-reported height and weight data in the Active People Survey. Reducing the levels of obesity is a key priority for both national and local organisations, as it is known that excess weight and obesity are a major determinant of premature mortality and avoidable ill-health. This is also an indicator on the Public Health Outcomes Framework.			

Objective	E2: Reduce the number of people smoking in Thurrock.		
Indicators		**2016 Baseline**	**2021 Target**
Smoking prevalence in those aged 18+.		**20.7%** (2014)	**Below 16%**
This indicator quantifies the percentage of adults aged 18+ who smoke. Smoking is the most important cause of preventable ill-health and premature mortality in the UK, and is a risk factor for a number of other diseases. This is also an indicator on the Public Health Outcomes Framework.			
Smoking prevalence in those aged 15-17 years.			**3% reduction proposed**
This is a new indicator and no baseline data exists for this as yet. However plans are in place to obtain this.			

Objective	E3: Significantly improve the identification and management of long term conditions.		
Indicators		**2016 Baseline**	**2021 Target**
Mean score on an agreed GP practice-based LTC management scorecard.			
This is a new indicator and no baseline data exists for this as yet. However plans are in place to produce this scorecard on a monthly basis from December 2016.			
Unplanned care admission rate for conditions amenable to healthcare.		**1940.6** (2015)	**1896 [draft target]**
This quantifies the rate of emergency admissions for conditions that could have been avoided if good quality healthcare had been in place.			

These are defined using a standard list of ICD-10 codes provided by the ONS. Rates are shown by 100,000 population.		

Objective	**E4: Prevent and treat cancer better**	
Indicators	**2016 Baseline**	**2021 Target**
% of cancer admissions diagnosed for the first time via emergency presentation.		
About a quarter of people with cancer are diagnosed via emergency routes. Survival rates for people diagnosed via emergency routes are considerably lower than for people diagnosed via other routes. Identifying the proportion of people who first present as an emergency is likely to prompt investigation into how to increase earlier presentation, leading to improved outcomes.	**22.9%** (Q2, 2015)	**To be confirmed**
% of patients treated within 62 days of receipt of urgent GP referral for suspected cancer to first treatment		
This quantifies the percentage of patients whose first definitive treatment (for all cancers) took place within two months of an urgent referral by a GP for suspected cancer symptoms. This indicator is one of the national cancer waiting times standards. Achievement of these standards is considered to be an indicator of the quality of cancer diagnosis, treatment and care. The operational standard specifies that 85% of patients should be treated within this time.	**56%** (February 2016)	**Working towards national standard of 85%.**
1 year survivorship after breast cancer.		
This indicator quantifies the one year net survival rate for people diagnosed with breast cancer (after adjustment for other causes of death). Survival rates give an indication of successful service provision and can help identify differing practice requiring further investigation.	**95.7%** (2013)	**Working towards 97%**
Bowel cancer screening coverage.		
This indicator quantifies the percentage of people aged 60-69 years who were eligible for bowel screening who had a screening test result recorded in the last 2.5 years. The bowel cancer screening programme plays an important part in supporting early detection of cancer, and increasing screening coverage would mean more cancers are detected at earlier, more treatable stages. This is also included as an indicator on the Public Health Outcomes Framework.	**54.6%** (2015)	**60%** (current national target)

14 July 2016	**ITEM: 8**
Thurrock Health and Wellbeing Board	
Update on Mid and South Essex Success Regime	
Wards and communities affected: All	**Key Decision:** For information and discussion
Report of: Andy Vowles, Programme Director, Mid and South Essex Success Regime	
Accountable Head of Service: Not applicable	
Accountable Director: Chief Executive	
This report is public	

Executive Summary

This paper provides a brief update on the progress of the Mid and South Essex Success Regime (SR) and Sustainability and Transformation Plan (STP). It explains how the STP covers all aspects of health and care including prevention.

The STP includes coordination with other pre-existing strategies that are Essex-wide, such as mental health and learning disabilities. The SR concentrates on the top priorities for transformation as recommended by an intensive review that reported in December 2015.

While the STP is still at the drafting stage, some of the major workstreams within the SR are well underway and these are highlighted in the report. The SR is preparing for a period of wider engagement and a high level summary of engagement is included in the appendices.

1. Recommendation(s)

1.1 The Board is asked to note the update.

1.2 The Board is recommended to continue participating in discussions within the Mid and South Essex Success Regime and STP engagement and consultation programmes, which include stakeholder meetings and joint meetings of the Essex, Southend and Thurrock Health and Wellbeing Boards.

1.3 The Board is recommended to review progress and plans at its next meeting in September and subsequent meetings.

2. Introduction and Background

2.1 This paper summarises the current position of the Mid and South Essex Success Regime (SR) and Sustainability and Transformation Plan (STP). A progress update published in May is included in *appendix 1*. While some information given in this previous update has been superseded, it provides a helpful recap on the SR and its aims.

2.2 The STP is a five-year plan for securing a sustainable health and care system in mid and south Essex. Covering the period October 2016 to March 2021, it sets out the vision and the transformation that is required to achieve it. It includes strategic change programmes for all aspects of health and care from prevention to specialist services, including plans for mental health and learning disabilities.

2.3 The Success Regime (SR) is an intensive programme designed to tackle the most significant challenges and to achieve financial balance. The SR has a narrower focus on the areas considered as priorities for change, where both the pressures and the potential to make a positive impact are greatest. It brings in additional management expertise, financial support and provides a system-wide programme structure to plan and deliver service transformation at pace.

2.4 The SR was initially a three-year programme but to avoid unnecessary complication this is now translated to cover the same five-year planning period as the STP.

2.5 At the last meeting of the Health and Wellbeing Board, members considered a summary of the overall Success Regime plan, which had been published on 1 March. Since that time there have been a number of developments, including the following:

- National guidance has clarified the requirements of health and care systems to produce and publish their STPs.

- NHS England agreed that the “footprint” for the STP would match that previously agreed for the Mid and South Essex Success Regime, which includes Thurrock Council together with five clinical commissioning groups, Essex County Council, Southend Council, three hospital trusts, four community trusts and all GP practices and primary care services within the five CCG areas. *A map is attached at appendix 2.*

- A first draft STP is to be submitted to NHS England by 30 June. This has been completed in partnership with all the organisations involved, including Thurrock Council. This initial confidential draft is for the purposes

of discussions with NHS England colleagues during July. The draft will then be shared for further engagement and refinement, leading to completion in September/October 2016.

- The Success Regime (SR) has mobilised a number of workstreams and planning groups to develop potential options for service change. Emerging options will become clear during July and will undergo further testing and refinement with the aim of completing proposals for change within a pre-consultation business case in September 2016.

- The three hospital trusts agreed in May to form a joint committee to oversee the major change programme under the SR. The committee is chaired by Professor Sheila Salmon from Mid Essex Hospital Services NHS Trust. The lead chief executive is Clare Panniker, who is currently CEO of both Basildon and Thurrock University Hospitals NHS Foundation Trust and Mid Essex Hospital Services NHS Trust.

- The five CCGs within mid and south Essex have agreed to collaborate with a view to forming a joint arrangement by October.

- A comprehensive engagement plan is set for implementation in July to September, which will involve a wide range of service users, public, staff, clinicians and partners. This will publish the main elements of the STP and SR in July and update audiences on proposed options in September, prior to further public consultation later in the year.

3. Issues, Options and Analysis of Options

3.1 In this section, we summarise the current thinking and provide an update on some of the key Success Regime workstreams for potential service transformation.

3.2 Overall strategic direction for SR/STP

<u>For people</u>

- More emphasis on helping people to stay well and tackling problems at an earlier stage to avoid crises.
- Joined up health and care services to provide more care for people at home and in the community, avoiding the need for a visit to hospital.
- New technologies and treatments to do more for people without the need to be in hospital, even in a crisis.
- When people do need the specialist care that only a hospital can provide, collaboration between hospitals and other services will ensure the best possible clinical staff and facilities.
- By redesigning some hospital services, the improvements in staffing levels and capability will mean safer, more effective, more compassionate care for patients.

For services

- Build stronger health and care localities
    - Join up primary, community, mental health and social care linked to hospital and other services
    - Organise around GP clusters serving natural communities of 40,000-50,000 people
- Develop new models of care to ease the pressure on urgent and emergency care and avoid hospital admissions:
    - Greater emphasis on prevention – through new ways of working in localities
    - Develop new models of care for people with complex needs
    - Improve and coordinate urgent care response services e.g. 111 and ambulance

- Address clinical and financial sustainability of local hospitals by:
    - Increasing collaboration and service redesign across three sites
    - Sharing back office and clinical support services.

- Implement the recommendations of the Essex Mental Health Strategic Review:
    - Further integrate mental health and dementia services at local level with primary, community and social care
    - Merge the existing two main service providers in Essex to improve specialist care.

3.3 **Update on localities and primary care**

- Ian Stidston, Accountable Officer of Castle Point and Rochford CCG leads the workstream with working groups drawn from all five CCGs and partners.

- As well as national and local evidence, the model builds on the current developments in Tilbury where there are plans to create a new centre offering joined up care and multi-disciplinary teams.

- The aim of this workstream is to support localities in development through the following four levels, reaching level 4 across mid and south Essex over the planning period.

    - Level 1 – collaboration and consistency across the locality
    - Level 2 – cooperation and shared services with improvements in access e.g. 7-day working
    - Level 3 – further collaboration and facilities to offer new services, such as clinics that would have traditionally been in hospital
    - Level 4 – full transformation and further expansion of links e.g. with voluntary services and housing.

3.4 **Update on new models of care – priority on frailty and end of life**

- Dr Bryan Spencer, ex-local GP from mid Essex leads the workstream with working groups drawn from all five CCGs, the three local authorities, primary, community and voluntary sector partners.

- Mandy Ansell, Interim Accountable Officer for Thurrock CCG is the lead CCG accountable officer for the frailty workstream.

- The main strategic points for this workstream are:

    - Greater emphasis on prevention – strengthening resilience – support for individuals and communities
    - Early identification and care planning
    - Stratification of risks for patients to identify those in greatest need
    - Proactive care closer to home with a personalised approach and care planning
    - Integrated multidisciplinary support for each individual within the higher risk categories
    - Holistic patient-centred care
    - Better use of technology and innovation e.g. shared care records, systems to monitor health and wellbeing and intervene at the earliest possible stage
    - Developing the future workforce – changing culture towards more personalised and planned care, new roles and flexibilities to work across organisations and settings.

- The initial focus is on people aged over 75, followed by other complex care groups. The workstream is tackling four areas of development:

Identification and care planning
- Risk stratification
- Multi-disciplinary teams
- Holistic care plans
- Information sharing

Proactive care delivery
- Out of hospital services
- Single point of access
- Health and social care integration
- Care homes service development
- Falls services

Interface between community and hospital
- Blueprint for Frailty Assessment Units
- Integrated frailty assessment team
- Mental health reviews within 4 hrs
- Dementia support specialists
- Discharge to Access

End of life
- Blueprint for end of life pathways
- Identification and care planning
- System-wide education
- Outcomes aligned to 6 national ambitions
- Raising public awareness

3.5 **Update on "In Hospital" workstream**

- This workstream is coordinated by Clare Panniker as lead chief executive for the joint committee of the three hospital trusts involved; however, the work on clinical service change is clinically driven by the three medical directors under the leadership of Dr Ronan Fenton from Mid Essex Hospital Services NHS Trust. There are some 60 senior clinicians currently involved in this work.

- There are three main strands within the workstream:
    - Clinical services reconfiguration and redesign
    - Clinical support collaboration
    - Shared back office functions

- <u>Clinical services</u>
  Hospital clinicians from a range of professions and specialties are gathering evidence and service user insight to develop options for some services to work as single services across the three hospitals.

  Broad principles for this work:

    - Start from a service user perspective
    - Avoid moving or replicating high fixed cost services: maintain some "givens"
    - Ensure deliverability in 2-3 years: no major new builds, use of existing infrastructure
    - Ensure clear rationale for any service redesign: if no clear rationale, then no change
    - Design along pathways: move care between hospital and community, and increase integrated working
    - Consider opportunities to incorporate technology and innovation
    - Criteria for service change:
        - Better clinical outcomes: meet national recommendations and move towards best practice quality standards e.g. Royal Colleges
        - Sustainable clinical workforce: move towards best practice workforce standards and improve training opportunities e.g. Royal Colleges
        - Efficiency and productivity: deliver services at a lower cost, where possible
        - Access: maintain appropriate access to services
        - Interdependencies: maintain appropriate clinical adjacencies

- <u>Clinical support</u>
    - Building on current collaboration between the hospitals in terms of clinical support services
    - Currently involves 9 sub-workstreams and includes Pharmacy, Radiology, Medical Physics, Pathology, Clinical Sterile Services

- Back office functions
    - Looking at opportunities to share and standardise functions across the three hospitals
    - Currently involves 12 sub-workstreams

- Current thinking on clinical service change
  The clinical services part of the workstream is preparing to move into its next phase of wider engagement to discuss and test the principles and scenarios with service users, staff and stakeholders, while gathering further clinical evidence and considering in more detail the operational, capital and financial implications.

- The starting point for the emerging model of clinical services includes "givens" that the following centres of excellence should remain as is:

    - Cardiothoracic centre at Basildon
    - Plastics and Burns at Chelmsford
    - Cancer and Radiotherapy services at Southend

- For other services, where clinically appropriate, services could move out of hospital into community settings where there are benefits to be gained and facilities to receive them e.g. dermatology and pain services to begin with.

- All three hospitals could provide a range of services for the majority of patients, including emergency care.

- There are major benefits in establishing a designated site for life-threatening and specialist emergencies. Some majors would be taken direct by ambulance and some transferred from the other two hospitals. (In line with Willetts and other national recommendations). This is already the model for serious heart attacks and multiple injuries.

3.6 **Timescales**

July – Sep	Develop emerging options and pre-consultation business case (PCBC) Wider engagement with service users, clinicians, staff and local people
Sep/Oct	Finalise PCBC Regional checkpoint
Oct/Nov	National Investment committee assurance process
Nov-Mar	Public consultation
Mar-May	Outcome analysis, decision-making business case and assurance process Final decisions for implementation

See appendix 3 for a summary of engagement.

4. Reasons for Recommendation

4.1 The Health and Wellbeing Board is a key partner in the Success Regime and STP. The Board oversees improvement in the health and wellbeing of the people of Thurrock. It is important that the work of the SR and the aims of the STP align with Thurrock's Health and Wellbeing Strategy and that the partnership across mid and south Essex is to the greater benefit of all residents.

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

5.1 The SR/STP programme team is also in discussion with the Thurrock Health and Wellbeing Overview and Scrutiny. We have already reported to the Committee with an overview of the Success Regime and noted the views of members. We will continue to update the committee via Democratic Services and make arrangements for further consultation.

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

6.1 The Essex Success Regime will contribute to the delivery of the community priority 'Improve Health and Wellbeing'.

7. Implications

7.1 Financial

One of the objectives of the Essex Success Regime is to respond to the current NHS funding gap across the Mid and South Essex geographical 'footprint'. A number of work streams have been established as part of the Success Regime to drive forward necessary savings and to improve quality of care provided to users of services. As a system-wide issue, partners from across the health and care system are involved in the work of the Success Regime. This will help to ensure that any unintended financial consequences on any partners of what is planned as part of the Success Regime are identified at the earliest opportunity and mitigated. Further implications will be identified as the work of the Success Regime continues and these will be reported to the Health and Wellbeing Board as part of on-going updates.

Thurrock have a finance representative involved in the Success regime and any financial implications, when known, will be reflected in the MTFS.

Jo Freeman
Management Accountant Social Care and Commissioning

7.2 **Legal**

Legal implications associated with the work of the Success Regime will be identified as individual work streams progress. The Success Regime process itself will meet the requirements of NHS statutory duties, including the Duty to Involve and Public Sector Equality Duty.

Implications will be reported to the Board as part of on-going updates.

Roger Harris
Corporate Director of Adults, Housing and Health

7.3 **Diversity and Equality**

Within the SR communications and engagement programme, we will undertake actions that take full consideration of equality issues as guided by the Equality Act 2010.

During the wider engagement phase (see details attached at appendix 1) and as part of the full consultation phase, we will make use of the Essex Equality Delivery System that was first established in 2011/12. This includes details and guidelines for involving minority and protected groups, based on inputs from and agreements with local advocates.

We will incorporate discussions with such groups, as part of service user engagement within individual work streams, to test equality issues and use the feedback to inform a community equality impact assessment to be included in the pre-consultation business case and decision-making business case.

Becky Price
Community Development Officer

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

None identified

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):

For further background information please visit:
http://castlepointandrochfordccg.nhs.uk/success-regime

9. Appendices to the report

- Appendix 1 – Progress Update No.3 as at 12 May 2016
- Appendix 2 – Map showing the "footprint" of the SR/STP

- Appendix 3 – High level summary of communications and engagement

Report Author:

Wendy Smith, Interim Communications Lead, Mid and South Essex Success Regime

Appendix 1

Mid and South Essex
Success Regime

Mid and South Essex Success Regime

A programme to sustain services and improve care

Progress update

Update no.3 – 12 May 2016

What's in this briefing

- Quick recap
- Progress update
- Workstreams in progress
- Next steps and milestones
- How to have your say
- Further information

Quick recap

The Success Regime brings national support to those areas in the country where there are deep-rooted, systemic pressures. Building on transformation that is already happening, it offers management support, financial support and a programme discipline to speed up the pace of change.

The Success Regime in mid and south Essex gives us the opportunity to realise the full potential of our workforce and provide the best of modern healthcare for local people.

Area and services involved

Service providers
Basildon and Thurrock University Hospitals NHS Foundation Trust
East of England Ambulance Service NHS Trust
Mid Essex Hospital Services NHS Trust
NELFT NHS Foundation Trust
North Essex Partnership University NHS Foundation Trust
Provide
Southend University Hospital NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust

Clinical commissioning groups (CCGs)
Basildon and Brentwood
Castle Point and Rochford
Mid Essex
Southend
Thurrock

Local authorities:
Essex County Council
Southend-on-sea Borough Council
Thurrock Council

All health and social care services are involved in the programme, including some 183 GP practices, community services, mental health and social care and hospital services.

Six areas for change

1. **Address clinical and financial sustainability of local hospitals by:**
    - Increasing collaboration and service redesign across three sites
    - Sharing back office and clinical support services.
2. **Accelerate plans for changes in urgent and emergency care, in line with national recommendations e.g.:**
    - Doing more to help people avoid problems and get the right help
    - Developing same day services and urgent care in communities, to reduce unnecessary visits and admissions to hospital
    - Designating hospital sites for specialist emergency care.
3. **Join up community-based services** – GPs, primary, community, mental health and social care – around defined localities or hubs.
4. **Simplify commissioning**, reduce workload and bureaucracy e.g.:
    - Reduce the number of contracts from around 300 to around 50
    - Commission services on a wider scale e.g. with one lead provider where several may be involved
    - Agree a consistent and common offer to focus on priorities and identify limits of NHS funding.
5. **Develop a flexible workforce** that can work across organisations and geographical boundaries.
6. **Improve information, IT and shared access to care records**.

Why we are doing this

We need to keep up with the pace of change and demands on health and care so that we can do more for people now and in the future. If we took no action, the current NHS deficit in mid and south Essex could rise to over £216 million by 2018/19, and we would not be able to meet year on year growing demands.

Our aim is to get the system back into balance by 2018/19 and deliver the best joined up and personalised care for patients. The kinds of changes we are looking to make have major benefits for patients, such as:

- More emphasis on helping people to stay well and tackling problems at an earlier stage to avoid crises.

- Joined up health and care services to provide more care for people at home and in the community, avoiding the need for a visit to hospital.

- New technologies and treatments to do more for people without the need to be in hospital, even in a crisis.

- When people do need the specialist care that only a hospital can provide, collaboration between hospitals and other services will ensure the best possible clinical staff and facilities.

- By redesigning some hospital services, the improvements in staffing levels and capability will mean safer, more effective, more compassionate care for patients.

Progress update

- An overall plan to develop options for change was published on 1 March. For further information, please visit: http://castlepointandrochfordccg.nhs.uk/success-regime

- The three acute hospitals have agreed arrangements in principle for working as a group with a joint committee to oversee collaboration. The joint committee arrangements are due for approval by Trust boards in May.

  Clare Panniker is lead chief executive for the committee. Clare is chief executive of Basildon and Thurrock University Hospitals NHS Foundation Trust and interim chief executive of Mid Essex Hospital Services NHS Trust. Professor Sheila Salmon, chair of Mid Essex Hospital Services NHS Trust, is the joint committee chair. Alan Tobias, chair of Southend University Hospital NHS Foundation Trust is vice-chair of the joint committee.

- The five CCGs are working on collaborative arrangements to be agreed over the summer to improve commissioning and reduce bureaucracy e.g. reducing the number of contracts for commissioning healthcare.

- Workstreams have been set up under the two broad headings of:
  - *Local Health and Care* – developing and integrating services in the community
  - *In Hospital* – involving further collaboration and service redesign between the three main hospitals in mid and south Essex.

  Other workstreams led by the Success Regime programme office include shared care records, communications and engagement and finance.

- Workstreams under Local Health and Care currently involve a range of clinicians and frontline staff from primary, community and social care, with plans to involve service users and voluntary and independent sector representatives.

- The In Hospital workstream currently has an acute leaders group of around 30 clinicians and service leaders. They have already held a listening event with service users and more will follow.

- Early discussions with stakeholders have so far involved, for example:

    - Healthwatch Essex, Thurrock and Southend
    - Lead officers and members of the three local authorities
    - Essex, Southend and Thurrock Health and Wellbeing Boards
    - Essex and Southend local authority scrutiny committees
    - Local MPs
    - CCG governing bodies and primary care practice members
    - Staff in CCGs and acute trusts

    The three Healthwatch bodies and Essex Health Overview and Scrutiny Committee organised an all-day conference on 18 April for patient experience and service user representatives. Involving around 70 people, the delegates discussed ways in which service users could be involved.

    In Your Shoes, a listening event took place on 28 April with around 30 clinicians and 30 service users. The event invited people to talk about their experiences in emergency care, what matters to them and how they would like to see improvements. Among various themes, the overall top priority for improving urgent and emergency care was considered by those who attended to be “access to GPs and prevention”.

Workstreams in progress

The following workstreams have been set up to tackle the priorities identified by the Success Regime diagnostic review, which took place towards the end of last year. Other workstreams will be added to the programme over the next year.

Local Health and Care – current workstreams

Frailty and End of Life care

- Initial focus is on the over 75 age group, but the work will expand at a later date to include care for adults of all ages with complex long term conditions
- The work is looking at:
    - Care at the interface between community and hospital, including the development of frailty assessment units
    - Identifying people at risk and systems to manage care around individuals
    - Proactive health and care, such as health and social care planning, falls prevention and support to care homes.

Workstream leads – Bryan Spencer, Jane Hanvey
Communications and engagement leads – Rachel Harkes (Frailty) rachelharkes@nhs.net and Romina Bartholomeusz (End of Life) romina.bartholomeusz@nhs.net

For further information contact rachelharkes@nhs.net

Redesign of Pain services and Dermatology

- Looking at options for shifting outpatient services from acute hospital settings to community services
- Pain and Dermatology have been identified by clinical leaders as areas that need to shift in line with clinical good practice and opportunities for improving patient outcomes
- Other potential services for similar moves will follow

Workstream leads – Dan Doherty, Ravi Suchak (Dermatology), Simon Thomson (Pain services)
Communications and engagement leads – Claire Hankey (Pain services) claire.hankey@southend.nhs.uk , Victoria Parker (Dermatology) Victoria.parker@meht.nhs.uk
For further information contact claire.hankey@southend.nhs.uk

"Common offer"

- Reviewing current commissioning policies and thresholds to improve consistency across mid and south Essex.

Workstream lead – Dan Doherty
Communications and engagement lead – Paul Ilett paulilett@nhs.net
For further information contact danieldoherty@nhs.net

Primary and community care

- Building on developments that are already taking place within the five CCG areas to join up primary, community and social care around GP practices.
- Looking at the benefits of groups of practices working together in localities.

Workstream lead – Ian Stidston
Communications and engagement lead – Claire Routh crouth@nhs.net
For further information contact Claire Routh crouth@nhs.net

In Hospital – current workstreams

Clinical services

Hospital clinicians from a range of professions and specialties are gathering evidence and service user insight to develop options for some services to work as single services across the three hospitals.

Broad principles for this work:

- Start from a service user perspective
- Avoid moving or replicating high fixed cost services: maintain some "givens"
- Ensure deliverability in 2-3 years: no major new builds, use of existing infrastructure
- Ensure clear rationale for any service redesign: if no clear rationale, then no change

- Design along pathways: move care between hospital and community, and increase integrated working
- Consider opportunities to incorporate technology and innovation

Criteria for service change:

- Better clinical outcomes: meet national recommendations and move towards best practice quality standards e.g. Royal Colleges
- Sustainable clinical workforce: move towards best practice workforce standards and improve training opportunities e.g. Royal Colleges
- Efficiency and productivity: deliver services at a lower cost, where possible
- Access: maintain appropriate access to services
- Interdependencies: maintain appropriate clinical adjacencies

Workstream leads – Ronan Fenton, Celia Skinner, Neil Rothnie
Communications and engagement lead – Wendy Smith wendy.smith60@nhs.net
For further information contact claire.hankey@southend.nhs.uk

Clinical support

- Building on current collaboration between the hospitals in terms of clinical support services
- Current scope includes Pharmacy, Radiology, Medical Physics, Pathology, Clinical Sterile Services

Workstream lead – Jon Findlay
Communications and engagement lead – Ian Lloyd ian.lloyd@btuh.nhs.uk
For further information contact Jon Findlay jon.findlay@southend.nhs.uk

Back office functions

- Looking at opportunities to share and standardise functions across the three hospitals
- Currently involves 11 sub-workstreams

Workstream lead – James O'Sullivan
Communications and engagement lead – Ian Lloyd ian.lloyd@btuh.nhs.uk
For further information contact ian.lloyd@btuh.nhs.uk

Next steps and milestones

May-Aug	Further detailed planning within workstreams, includes service user involvement
June/July	Wider patient, clinical and staff engagement
July	Update on options development and further engagement
Sep	Notification of details for consultation
Oct – Dec	Main consultation on proposed options for change

Jan 2017	Outcome of consultation
Feb	Discussions with HOSC and others prior to decision-making
March	Formal decisions for change
April and ongoing	Implementation

How to have your say

1. Send us your views in writing

   Please write to us at england.essexsuccessregime@nhs.net

2. Hold a discussion within your team, group or organisation

   Local trusts, CCGs and other organisations are arranging staff briefings. Check your staff news, talk to your line manager or contact your local Communications team.

3. Invite us to attend your meeting

   If you would like a representative to attend your meeting, please contact us on england.essexsuccessregime@nhs.net

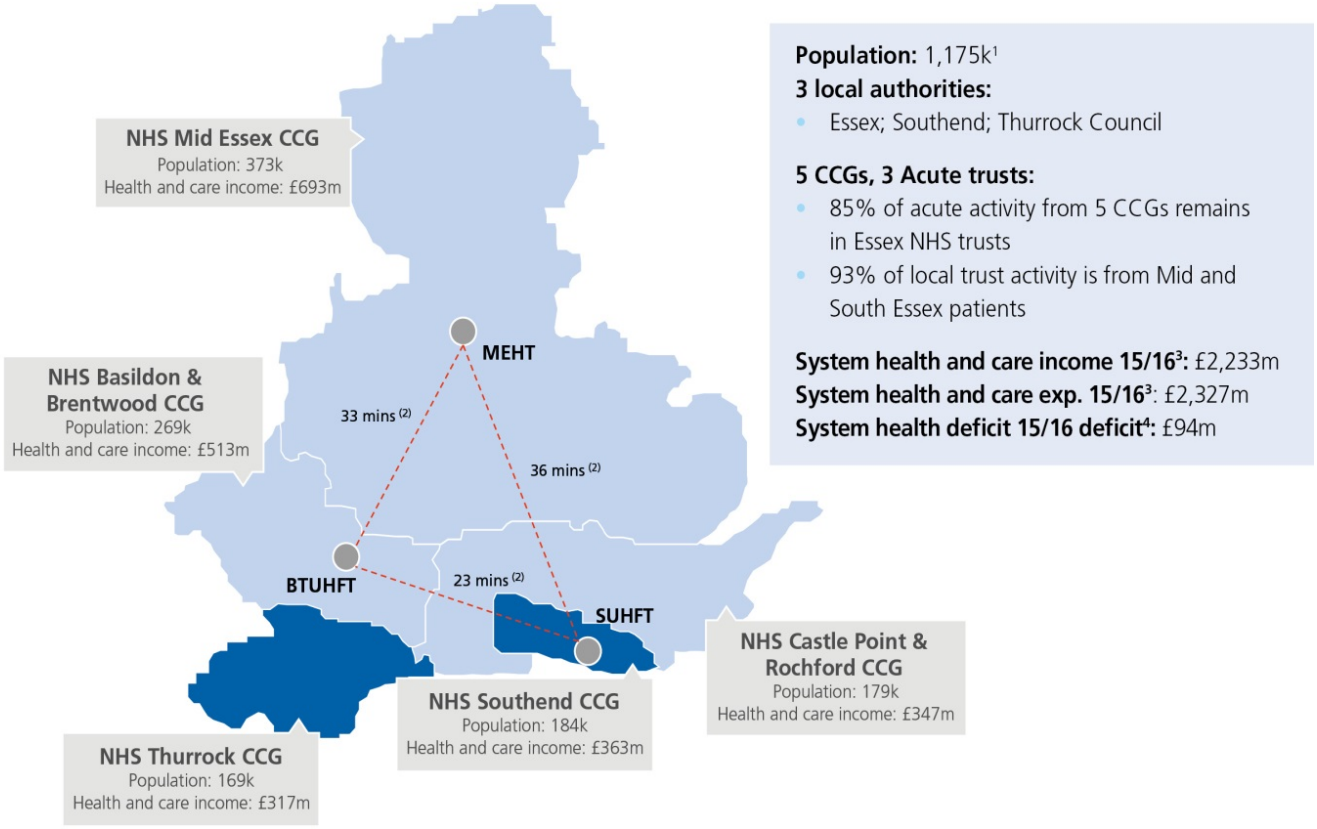
Further information

http://castlepointandrochfordccg.nhs.uk/success-regime

If you would like further information, to arrange a meeting or you would like to send us your views, please write to us at england.essexsuccessregime@nhs.net

Key contact:
Wendy Smith, Interim Communications Lead

Appendix 2 – Map showing the "footprint" of the SR/STP



Note: all financials are 2015/16 estimates: Version 13, 12th Feb modelling assumptions
1. Population based on 14/15
2. Travel times without traffic from google (Jan 16)
3. Includes estimate of social care expenditure (based on 14/15 report) related to health and CCG mental health expenditure
4. Deficit relates to health only

Appendix 3 – High level summary of communications and engagement plan

Main phases of engagement

Phases	Dates
Phase 1 – Set up and assemble partnerships and resource	January - March 2016
Phase 2 – Discussion with boards and local bodies	March – May 2016
Phase 3 – Wider engagement and workstream engagement	July – September 2016
Phase 4 – Public and staff consultation (subject to assurance)	October 2016 – Jan/Feb 2017
Phase 5 – Outcomes and decision-making process	February – May 2017

Action in July – September 2016

Main categories

1. Comprehensive communications and engagement in the overall plan (STP/SR)
2. Targeted service user engagement in workstreams - main areas for potential service change
3. Internal staff and clinical commissioner engagement

Deliverables (July-Sept)

- **Core information package,** including discussion document, support materials, films, online questionnaire, media releases, workshop guide, template for feedback
- **Open workshops for service users and public** (dates in July and Sept)
- **Independent service user research** – by deliberative democracy approach run by Healthwatch
- **Independent public engagement** – groups run by HOSC
- **Workshop framework for partner organisations** – for internal and local discussions
- **Proactive meetings and meetings on request with key stakeholder groups**
- **Wide ranging workstream specific plans** – includes both public and service user engagement, plus equality impact assessment
- **Service User Forum** - advises on engagement, promotes activities, input to PCBC
- **Feedback to inform pre-consultation business case –** Summary and analysis of activities in Phase 3, plus collation of findings from previous consultations.

Delivery channels / resource	Responsibility
Core materials and coordination of activities and feedback	SR programme office
Workstream communications plans	Workstream comms leads
Programmes run by HOSC and Healthwatch	Healthwatch Essex and Southend Healthwatch Thurrock Potentially a joint HOSC
Local discussions with stakeholders	CCG comms and execs
Internal communications for staff	Organisation comms and execs

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NHS Thurrock Clinical Commissioning Group

MINUTES

Integrated Commissioning Executive
23rd May 2016, 9-10.30am

Attendees
Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Mark Tebbs (MT) – Director of Commissioning, NHS Thurrock CCG
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement, Thurrock Council
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council
Mandy Ansell (MA) – Acting Interim Accountable Officer, NHS Thurrock CCG (Joint Chair*)
Ceri Armstrong (CA) – Directorate Strategy Officer, Thurrock Council
Allison Hall (AH) – Commissioning Officer, Thurrock Council
Kay Goodacre (KG) – Finance Manager

Apologies
Sean Clark (SC) – Director of Finance and IT, Thurrock Council
Mike Jones (MJ) – Strategic Resources Accountant, Thurrock Council
Ade Olarinde (AO) - Chief Finance Officer, NHS Thurrock CCG
Ian Wake (IW) – Director of Public Health, Thurrock Council

Item No.	Subject	Action Owner and Deadlines
1.	**Notes (April)**	
	MA asked if the meeting venue could be changed to CCG Offices. MA stated that the CCG was now in the 'danger zone' regarding finances and that this due to the new BTUH block contract. The final contract value was higher than CCG had wanted which resulted in a £800k cost pressure for 2016-17. If activity levels fell below plan savings could be made, but there was a difficulty in getting reliable activity figures for BTUH. There was an additional £500k pressure from Southend Hospital, and as a result, the CCG may need to have deficit plan - which would also mean monthly reporting to NHS England. MA stated that there was currently no news regarding the	LS to action

	rebasing of SEPT contract, and no further update on joint CCG committee (Committee in Common). RH stated that the Council's budget was very nearly in balance. Children's services still an issues with a £5.5m overspend in 15/16. A new Children's Director was starting in two weeks' time (Rory Patterson). The budget would be going to July Cabinet for final approval, and the new administration would be announced on the 25th May following Council.	
2.	**BCF Assurance Feedback**	
	CA stated that we might need to carry out some additional work regarding the points raised in the draft assurance feedback. A risk assessment process had been an additional 'ask' and it was unsure what its impact would be on Thurrock's BCF plan grading. A final score was unlikely to be known until the end of June, if not early July.	
3.	**Section 75**	
	It was agreed that we should start updating the Section 75 Agreement for 2016-17 in preparation for sign off.	CS to action.
4.	**Essex Success Regime**	
	There was some discussion about why Pain Services and Dermatology have been picked as a service in focus as it was unlikely to make difference in terms of savings. The Council had concerns about the 'Committee in Common'- which would oversee the BTUH block contract. MA stated that the CCG would have to push on with the service restriction policy so that there was parity across Essex – e.g. with IVF and sterilisation. MA also reinforced the need to carry on with the development and implementation of the local strategy: 'For Thurrock, In Thurrock'	
5.	**Multi Community Provider Arrangements**	
	MT stated that different options would be the focus of the workshop on 31st May. The majority of the available options would require a federation approach. RH was concerned about how MCP plans would fit with the BCF etc., and RH agreed to raise at the 31st May workshop. Governance arrangements would also need to be discussed.	
6.	**Intermediate Care Review**	
	Monies had now been confirmed with NELFT (Tania) There were likely to be concerns raised from BTUH regarding reduced capacity	

	Plans were being developed in to a business case which would be shared in advance of the 31st May workshop. MT further updated the Group that Mountnessing Court would close for Thurrock patients as part of the plans. There had been significant under-occupancy for some time. AFC patients would now go to Mayfield Ward would would enable AFC to close. Discussions would take place concerning how Thurrock Hospital should be used.	
7.	**Single Point of Access**	
	CS stated that one meeting had taken place with all providers and that the aim was to have the SPA in place by October. RH stated that the scope needed to be clear. MT asked if anyone from the CCG had been invited to sit on the Group (e.g. MT/JH/IL).	CS CS to invite MT/JH/IL to sit on SPA Group
8.	**BCF Scorecard**	
	Indicators and targets contained within the BCF for 2016-17 were reviewed.	
9.	**AOB**	
	None.	

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MINUTES
Health and Wellbeing Board Executive Committee
23rd May 2016, 2.00-3.30pm

Attendees Present:
Roger Harris (RH), Jane Foster-Taylor (JFT),Malcolm Taylor (MT), Kim James (KJ),Ceri Armstrong (CA), Les Billingham (LB), Maria Payne (MP), Tim Elwell-Sutton (TES)

Apologies: David Archibald (DA), Ian Wake (IW),Mandy Ansell (MA)

Item No.	Subject	Action
1.	**Apologies for absence**	
	As noted.	
2.	**Notes from the last meeting**	
	Notes of meeting on 11th April agreed.	
3 & 4	**Forward Plan & HWBB Agenda**	
	Item in focus The Committee suggested that the 'item in focus' part of the HWBB agenda should include: •An overview of the goal, •The goal sponsor should be asked to lead the session, •Any engagement feedback collated via Healthwatch; •A focus on a specific aspect of the Goal – e.g. Children's Poverty Steve McManus (Chief Executive at Basildon and Thurrock University Hospitals Foundation Trust) had been asked to attend the July Board meeting to provide an overview of his role and his priorities for the Hospital. It was agreed that Steve needed to be briefed on what would be covered at the meeting. This would include: •BTUH deficit, •priorities for the Hospital - and how they would impact on Thurrock's residents, •how the ESR could impact on the quality of care provided by the Hospital, •future DoT. 'For Thurrock in Thurrock' update – Committee members agreed that this would be added as a separate agenda item. STP- MA to come to the Board with the final STP and also any update. Annual PH report- put on September Board (move from July)	LS LS

	Ofsted action plan- there was a discussion on whether the action plan should be brought to July Board. The Committee felt the Board would benefit from seeing the action plan.	MT to confirm with Director of Children's Services
5.	**Health and Wellbeing Strategy – Performance Report**	
	MP went through progress made with the HWB Strategy performance framework. Indicators had been 'RAG' rated according to confidence in collecting the information by the 10th June deadline. The Committee made a few suggestions about amendments which were noted. Goal sponsors have been emailed, and part of their role includes signing off KPIs, a baseline for 2016, and a target for 2021. The deadline for receiving information from the relevant individuals is 10th June.	
6.	**Health and Wellbeing Strategy– Action Plans**	
	CA updated the Committee that an email had been sent to each Goal sponsor from RH setting out requirements for the development of action plans. Goal sponsors had been asked to liaise with objective leads to ensure that action plans were developed and performance indicators signed off. The deadline for the work was the 10th June – in time for the June Executive Committee meeting and then the July Health and Wellbeing Board. JFT asked if she could be copied in to any reminders.	CA
7.	**Essex Success Regime - Progress Report**	
	An update from the ESR team had been circulated to the Committee for information. KJ updated the Committee that she had been contacted by the ESR Engagement work stream lead and was inputting in to the developing engagement plan to ensure that local people were involved in ESR plans.	
8.	**AOB**	
	Launch of the HWB Strategy A series of small roadshows taking place around Borough would be planned throughout the year – this would enable engagement on the five goals at the same time.	CA/KJ/TES

	Prior to the roadshow would be a pledge from Board members to individually commit to deliver the Strategy to be photographed at the next HWBB (July). This would be followed be a press release to officially launch the Strategy. JFT- Need to return SEND Audit. The framework would be placed on the next Executive Committee agenda. JFT- Transforming Care return to be completed. JFT working with MT to confirm numbers. Still issues with ophthalmology in Southend. Issues at Queens.	LS place on agenda

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MINUTES
Health and Wellbeing Board Executive Committee
20th June 2016, 2.00-3.30pm

Attendees Present:
Roger Harris (RH), Jane Foster-Taylor (JFT),Malcolm Taylor (MT), ,Ceri Armstrong (CA), Maria Payne (MP), Mandy Ansell (MA), Rory Patterson (RP), Ian Wake (IW), Tim Elwell-Sutton (TES), Darren Kristiansen (DK)

Apologies: Les Billingham (LB), Kim James (KJ), Steve Cox (SC)

Item No.	Subject	Action
1.	**Apologies for absence**	
	As noted.	
2.	**Notes from the last meeting**	
	Notes of meeting on 23rd May were agreed. CA reminded members that the Health and Wellbeing Board had requested sight of minutes and action points arising from Executive Committee Meetings. Future Health and Wellbeing Board Executive Committee meetings will be recorded and published on Thurrock Council's website as part of Health and Wellbeing Board papers. A report on the outcome of the recent Ofsted inspection will be prepared for the Health and Wellbeing Board's meeting in September 2016. It was agreed that the report should comprise relevant sections of the Ofsted SIF report and also the SEND self-assessment.	**Action MT and RP**
3	**Health and Wellbeing Board meeting in July and Health and Wellbeing Strategy Action Plans**	
	CA summarised the process for developing action plans to support the delivery of Health and Wellbeing Strategy. Committee members considered progress made against each of the action plans that have been developed to support the delivery of the Health and Wellbeing Strategy. During discussions the following points were made and agreed: Goal A. Objective A1 (All children in Thurrock making good educational progress). It was agreed that RP would ensure that action plans are completed and provided to DK. Objective A2 (More Thurrock residents in employment, education and training). It was agreed that CA/DK will meet with Michele Lucas and Tim Rignall to consider how to both develop the	Action RP – by 27/06/16 Action DK – by 27/06/16

	supporting action plan and also to ensure that the elements of the Economic Growth Strategy that support different objectives of the HWB Strategy are identified	
	Goal C. Objective C2 (Improve children's emotional health and wellbeing). MT agreed that an action plan will be provided.	Action MT – by 27/06/16
	Goal D. Objective D2 (When services are required they are organised around the individual). It was agreed that the action plan should be sent to JFT who would add actions relating to Personal Health Budgets. CHC/PHB JFT, PHB/others MT	Action DK and JFK by 27/06/16
	Objective D3 (Put people in control of their own care). It was agreed that action plan D3 should also incorporate actions relating to children and young people – specifically Education Health and Care Plans.	Action MT by 27/06/16
	Goal E. Objective E1 (Reduce Obesity). It was agreed that the action plan should make reference to current initiatives including the mile a day programme. It was agreed that action should also focus on preventative activities.	Action Helen Horrocks by 27/06/16
	Objective E4 (Prevent and treat cancer better). It was agreed that the related performance indicators should reflect the recent deep dive recommendations on the prevention and treatment of cancer and should not be solely focused on screening. 62 day performance target to be included.	Action Funmi Worrell by 27/06/16
	To maintain version control, it was agreed that a link to action plans would be made available to Council officers sitting on the Committee, and that copies of action plans will be sent directly to partners by email.	Action DK
4.	**Health and Wellbeing Strategy Outcome Framework**	
	It was agreed that action plan owners must ensure that actions will support the achievement of indicators included within the emerging Health and Wellbeing Strategy Outcome Framework. Committee members agreed that action plan leads are owners of the relevant performance indicators and for ensuring that trajectories to 2021 are developed.	Action. Action plan leads
	Committee members acknowledged that indicators within objectives A2 may not remain relevant due to the introduction of Universal Credit and data relating to Employment Support Allowance, Incapacity Benefits and Job Seekers Allowance will not be available or relevant. It was agreed that indicators would be reviewed.	Action MP – with Tim Rignal and Michele Lucas.
	It was agreed that the suggested performance indicator for action plan B3 which focusses upon the percentage of contracts awarded to the voluntary sector should be removed as it was not the best measure of voluntary sector involvement.	Action MP
	It was acknowledged that some indicators require further work to	Action MP and

	develop. It was agreed that MP would liaise with action plan leads to finalise the indicator suite and Outcome Framework.	Action Plan leads
5.	**Any other business**	
	Essex Success Regime MA provided Committee Members with an update on the Essex Success Regime. Council Administration RH provided Committee members with an update on the new Administration for Thurrock Council. Planning the Health and Wellbeing Board meeting in July. Members were advised that action plan leads for Goal A, Opportunity for All, have been invited to present their action plans at the Health and Wellbeing Board meeting in July. It was agreed that each objective will be allocated 15 minutes each comprising: • 5 minutes presentation; • 5 minutes for challenge and questions from Board members and; • 5 minutes for related engagement feedback. It was agreed that action plan leads should ensure presentations provide contextual information and set out: •where are now; •where we want to be; •why the deliverables outlined in action plans are necessary; and •how they will support the achievement of outcomes within the Health and Wellbeing Strategy. Committee members were advised that the Managing Director of BTUH can no longer attend and will be represented by Tom Abel, Deputy CEO. Committee members were advised that Tom has been asked to provide a presentation that includes: • An overview of BTUH's deficit • Priorities for the hospital and how they will impact on Thurrock's residents • How the ESR could impact on the quality of care provided by the hospital and the • Future direction of travel. It was agreed that the presentation should also include how BTUH will contribute to the delivery of outcomes set out in Thurrock's Health and Wellbeing Strategy.	Action Secretariat Action Secretariat Action DK

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Thurrock Health and Wellbeing Board Work Plan 2016-2017

Board Meeting Date	Agenda Item	Item Owner
14th July 2016	• Item in focus – Goal A – each action plan owner to present their action plan, Kim James to feed back on results of engagement exercise concerning Goal A • Health and Wellbeing Strategy Action Performance Framework • Basildon and Thurrock University Hospitals Foundation Trust – Progress Update and Future Direction • Sustainability and Transformation Plan/Essex Success Regime	Goal A Objective Leads Ceri Armstrong/ Maria Payne Tom Abell (BTUH) Andy Vowles (NHS England)
15th September 2016	• Item in focus – Goal B • Public Health Report • CCG Transformation Programme • Ofsted Inspection Outcome and Action Plan • Air Quality Strategy? • Active Places Strategy?	Goal B Sponsor and Objective Leads Ian Wake Jeanette Hucey Rory Patterson TBC TBC
17th November 2016	• Item in focus – Goal C • HWBS Performance Report – by exception	Goal C Sponsor and Objective Leads
5th January 2017	• Item in focus – Goal D	Goal D Sponsor and Objective Leads
16th March 2017	• Item in focus – Goal E	Goal E Sponsor and Objective Leads
X May 2017	• HWBB Annual Report	HWBB Business Manager

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