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

Health and Wellbeing Board

The meeting will be held at **1.00 pm** on **15 September 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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	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.	
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Exclusion of the Public and Press

Members are asked to consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **7 September 2016**

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

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

Pecuniary

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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

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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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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 14 July 2016 at 1.30 pm

Present:	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 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 Rory Patterson, Corporate Director of Children's Services David Peplow, Independent Chair of Local Safeguarding Children's Board Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust Ian Wake, Director of Public Health
Apologies:	Steve Cox, Lucy Magill, McCann and Andrew Pike
In attendance:	Roger Edwardson, Interim Strategic Leader School Improvement, Learning and Skills Tim Elwell-Sutton, Consultant in Public Health Michelle Lucas, Learning and Skills Manager Maria Payne, Needs Assessment Manager Dave Petrie, Targeted Access Manager Andy Vowles, Programme Director Essex Success Regime Tom Abell, Deputy Chief Executive Basildon and Thurrock University Hospitals Foundation Trust Ceri Armstrong, Directorate Strategy Officer Darren Kristiansen, HWB Business Manager Mikaela Burns, Executive PA

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.

5. Minutes

The minutes of the Health and Wellbeing Board held on 21st April 2016 were approved as a correct record. Cllr James Halden passed on his thanks to

officers and councillors for the cross party agreement which had secured approval of the Health and Wellbeing Strategy.

6. Urgent Items

There were no urgent items stated.

7. Declaration of Interests

Roger Harris explained that the Council's constitution requires Health and Wellbeing Board members to complete declaration of interest forms. This is because the Health and Wellbeing Board is a Committee of the Council. It was noted that some declaration of interest forms remain outstanding for some members and it was agreed that forms will be circulated to members for completion.

8. Item in Focus - Health and Wellbeing Strategy Goal A 'Opportunity for All'

The Health and Wellbeing Strategy contains five Strategic Goals. The item in focus for this meeting was Goal A, which comprises four objectives:

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.

Action plans, created to support the delivery of Health and Wellbeing Strategy's objectives and goals were presented to Board members. It was agreed that Microsoft PowerPoint presentations would be circulated with these minutes and made available on Thurrock Council's website.

In summary:

Action Plan A1 was presented by Roger Edwardson, Interim Strategic Lead, School Improvement, Learning and Skills. During the presentation the following points were made:

- Thurrock's ambition is that all schools and academies will be assessed as good or better by September 2017. As of June 2016:
  - 88% of primary schools were assessed as good or better.
  - 80% of secondary schools were assessed as good or better.
  - All special schools were assessed as outstanding.
  - Only one school in the Borough was subject to Special Measures.

Action Plan A2 was presented by Michele Lucas, Learning and Skills Manager. During the presentation the following points were made:

- Action will be taken to promote career opportunities in Thurrock's growth sectors to young people through local careers initiatives. This will involve providing training and employment opportunities to people with learning disabilities.
- Action will be taken to develop a multi-agency approach in key geographic locations across Thurrock to engage the hardest to reach groups in receipt of benefits, raising awareness of training and employment opportunities.
- The Economic Development and Skills Partnership Group will continue to consider how to ensure that connections are made between health issues/initiatives and employment/skills programmes.

Action Plan A3 was presented by Tim Elwell-Sutton, Consultant in Public Health. During the presentation the following points were made:

- There has been a 40% reduction of teenage pregnancies in Thurrock over the last 14 years. Thurrock is performing above the national average. The under 18 conception rate is currently 30.7 per 1,000. The target for 2021 is 20 per 1,000.
- The strategy to improve teenage pregnancy rates is focused on education and increasing the use of contraception by:
    - Improving access to contraception.
    - Strengthening primary care delivery of family planning.
    - Strengthening sexual and reproductive education in schools.

Action Plan A4 was presented by Dave Petrie, Targeted Access Manager. During the presentation the following points were made:

- Reducing child poverty is a key priority. Support will be provided to vulnerable families by:
    - Develop Neighbourhood-Focused approaches.
    - Create Pathways into employment.
    - Maximise income and raise living standards.
    - Support parents and carers to upgrade their skills.
    - Continue to Narrow the Gap in achievement between Children on low incomes and children from more affluent families.

Community Engagement activities which ensure that Health and Wellbeing Strategy Action Plans are informed by the public were presented by Kim James, Chief Operating Officer of Thurrock Healthwatch. During the presentation the following points were made:

- It is important that people are involved in the design, delivery and commissioning of Health and Social Care Services.
- Engagement activity for Goal A comprised a survey targeted at adults, a survey for younger people (aged 15-21 years) and Group work with youth club children (8-13 years).
- Between the end of April and June 2016, Healthwatch had engaged with :
    - 52 adults
    - 35 young people (16-21 years)
    - 70 children (8-13 years)

Following presentations Board members were invited to provide comments, questions or challenge on the action plans. During discussions the following points were made:

- Cllr Sue Little suggested that encouraging females at school to have high aspirations may reduce the likelihood of them becoming pregnant at an early age. It is important to ensure that boys are also supported to develop ambitions and aspirations. Tim Elwell- Sutton advised the Board that a programme is currently being developed that is targeted towards boys in school. An anonymous online survey has also been developed and will be rolled out to year 8 students. The survey will gather qualitative information about aspirations, views on sexual health and a wide range of other issues.
- Kristina Jackson advised the HWB that an individual survey has been completed within the 6 community hubs across Thurrock. The results from the surveys show that young people wanted sex education in a setting that was not their school due to embarrassment. It was agreed that that a need is there to ensure that sexual advice is available and accessible for young people within the local community.
- Ian Wake acknowledged the high quality employment programme for 18-26 year olds but questioned the level of support available for older adults seeking employment. Michele Lucas advised Board members that work is underway to develop a trainee shift programme, linking in with the job centre.

Cllr Steve Liddiard stated that many organisations in Thurrock have a zero tolerance to substance misuse as part of their employment practice. It was suggested that up to many young people interviewed at Tilbury docks fail to secure employment following a drugs test.

9. Health and Wellbeing Strategy Performance Framework

Maria Payne, Needs Assessment Manager provided the Board with a summary of the Health and Wellbeing Strategy Outcome Framework. The Framework includes a number of performance indicators to support the Board with identifying whether the Health and Wellbeing Strategy is having a positive impact and supporting the delivery of improved outcomes for the residents of Thurrock.

The Health and Wellbeing Strategy Outcomes Framework includes key performance indicators to support each objective, a baseline figure and a target for 2021. Further work is underway to identify trajectories, enabling the Board to consider progress that is being made.

It was agreed that the Board's Executive Committee will monitor progress in delivering the action plans and impact using the Outcomes Framework. An update by exception will be provided to the Board as part of the mid-year and annual performance report.

RESOLVED:

1.1 Board members agreed the Outcomes Framework supporting the delivery of the Health and Wellbeing Strategy.

1.2 Board members agreed action plans supporting the achievement of goal A

1.3 The Board endorsed arrangements for monitoring the implementation of the Health and Wellbeing Strategy

10. Basildon and Thurrock Hospitals Foundation Trust

Tom Abell, Deputy Chief Executive, Basildon and Thurrock Hospital attended the Board to provide a presentation that comprised:

- An overview of BTUH's deficit;
- Priorities for the Hospital and how they will impact on Thurrock residents;
- How the Essex Success Regime might impact on the quality of care provided by the Hospital;
- Future direction of travel; and
- How the Hospital will contribute to the delivery of outcomes set out within Thurrock's Health and Wellbeing Strategy.

A copy of the Microsoft PowerPoint presentation will be circulated with the minutes of the meeting.

Key points of the presentation include:

- The Trust secured a 'good' rating across all CQC domains and has delivered a significant improvement in mortality rates.
- Challenges remain. There has been an increase in Accident and Emergency waiting times and people being admitted who have remained in hospital longer than usual.

Members of the Board were invited to provide comments, questions or challenge. During discussions the following points were made:

- Roger Harris queried how the hospital can continue to operate while experiencing a financial deficit each year. Tom Abell explained that the Department of Health manages an Independent Trust Finance Facility. This provides loans directly from HM Treasury to NHS providers who are running a deficit. Central Government provides this facility as part of ensuring that hospitals can continue to operate.
- Cllr Sue Little challenged operating times for Orsett Hospital services. Cllr Little explained that evidence suggests that the most probable time for an elderly person to experience a fall occurs in the afternoon. While the clinic can treat these types of incidents because it remains open until 7.00pm, it is restricted from doing so due to the necessary X-ray service closing at 5.00pm. The minor injuries service is currently being reviewed as part of responding to concerns previously raised.

11. Sustainability and Transformation Plan

Andy Vowles, Programme Director, Essex Success Regime provided the Board with an update on the Essex Success Regime (ESR) and the Sustainability and Transformation Plan (STP). In summary:

- The STP is a five year plan for securing a sustainable health and care system spanning the Middle and South Essex areas from October 2016 to March 2021. 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.

Members of the Board were invited to question, comment or challenge on the STP and ESR. During discussions the following points were made:

- Board members learned that an early draft of the STP had been submitted to NHS England on the 30th June. The draft document will be shared with key partners to inform its further development. The final document will be available by October 2016.
- Mandy Ansell advised Board members that an engagement event is taking place on 28th July, facilitated by Healthwatch.
- Cllr James Halden welcomed the Success Regime and the Sustainability Transformation Plan using the same geographical footprints. However, Cllr Halden remains committed to ensuring that the programme's Committee in Common should not be provided with executive powers to take decisions that affect Thurrock that could be managed locally within Thurrock Health and Wellbeing Board and Thurrock Clinical Commissioning Group.
- Andy Vowles agreed to provide Thurrock Council with a copy of the paper that has been provided to NHS England.

12. Integrated Commissioning Executive - Meeting Minutes

The minutes of the Integrated Commissioning Executive were noted.

13. Health and Wellbeing Board Executive Committee Minutes

The minutes of the Health and Wellbeing Executive Committee were noted.

14. Work Programme

Cllr James Halden invited members of the Board to provide any amendments or suggestions on the Board's future work plan to Roger Harris.

The meeting finished at 3.32 pm

Approved as a true and correct record

CHAIR

DATE

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

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15 September 2016	**ITEM: 5**
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 an update on the progress of the Mid and South Essex Success Regime (SR) and Sustainability and Transformation Plan (STP). It follows previous reports to the Health and Wellbeing Board. The last report was considered at the 14 July Health and Wellbeing Board meeting.

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 a diagnostic review that reported in December 2015.

While the STP is still in development, some of the major workstreams within the SR are underway and these are highlighted in this report. The SR is now in a period of wider engagement and a list of public workshops in September and October is included in appendix 1.

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 meetings of the Essex, Southend and Thurrock Health and Wellbeing Boards.

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).

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 Since the last update for the Health and Wellbeing Board, there have been a number of developments, including the following:

- **National assurance of the early draft STP**
  NHS England and all national arm's length bodies have reviewed the initial high level draft STP submitted for mid and south Essex on 30 June. Representatives for the Mid and South Essex SR/STP attended a national panel on 22 July. The STP was commended by the arm's length bodies and progress continues.

- **Engagement**
  There have been 14 discussion workshops; 6 with service user representatives and 8 staff workshops. This has provided early insight to inform the development of the SR/STP and potential options for hospital reconfiguration*. See further details later in this report*.

- Stakeholder discussions took place on 13 July and on 11 August for representatives of all partners involved in the Success Regime, including from the local authorities and Healthwatch. These events included an update from senior acute care clinicians on the latest thinking. Attendees discussed and gave views on criteria and the weighting of criteria to be used to appraise potential options for hospital reconfiguration.

- **Work in progress**
  The Success Regime (SR) has mobilised a number of working groups to develop potential options for hospital reconfiguration and redesign. In addition to groups looking at corporate and clinical support functions, there are four main clinical groups looking at acute and emergency medical care, acute and elective surgery, paediatrics and women's services.

- Working groups on community and primary care services have continued with two main plans; one covers primary care and localities and the other a framework for frailty care. Thurrock CCG (Acting) Interim Accountable Officer, Mandy Ansell, is the lead for the frailty workstream, while Castle Point and Rochford CCG Accountable Officer, Ian Stidston, leads on primary care and localities.

- **Finance**
  A system-wide Financial Oversight Group has been set up to support the SR/STP and meets monthly.

- **Timescales**
  The timescales for the development of options leading to consultation have changed since the last report. Given the depth of detail required for the pre-consultation business case, NHS England has agreed, following a strategic sense check on 4 July, that the business case should be reviewed in November (rather than in September as in previous plans). Public consultation will be subject to approval of the pre-consultation business case.

3. Issues, Options and Analysis of Options

3.1 In this section, we provide a summary update on current thinking in terms of potential hospital reconfiguration and redesign.

3.2 Reiteration of key points in case for change

- An aging population is placing pressure on the health and care system. Health outcomes are notably worse for those on lower incomes and those living with higher deprivation. The SR/STP must review capacity and capability to meet the needs of a future population. An initial diagnostic review identified the following:

- Services in the community are fragmented. Some parts of primary care have numerous independent practices with limited integration. Primary care and end of life care are two examples of where access in mid and south Essex is below national levels.

- In acute hospitals, key services are falling short of some clinical quality and safety standards. For example, only 81% of A&E patients are seen within 4 hours, where the national standard is 95%.

- Emergency attendances in A&E are growing at double the national growth rate (8% versus 4% in 2014/15, for example). Emergency admissions are also higher than the national average. With development in community and primary care, there is great potential to reduce these pressures and improve the quality of care for people.

- Neither acute care nor primary care services are currently configured to meet rising demand.

- There are clinical workforce gaps in primary, community and acute care due to recruitment challenges, which also leads to a higher than average spend on locum care and agency staff. Hiring more staff is not a sustainable option given national and local workforce shortages. There are similar recruitment challenges for social care. The potential for improvement lies with new ways of working across the spectrum of professional roles.

- The annual financial challenge for the NHS in mid and south Essex reached £101 million in 2015/16. A "do nothing" scenario would increase the deficit to some £430 million by 2020.

3.3 **Overall strategic direction for SR/STP**

The SR/STP has refined its priorities for action, with the aim of improving health, quality and financial balance, achieving long term sustainability and reducing health inequalities. The current thinking is to:

- Build stronger health and care localities, including a focus on prevention, self-care and mental health
- Develop urgent and emergency care pathways to provide care closer to home, earlier interventions and avoid the need for a hospital admission
- Reconfigure services in the three acute hospitals to improve patient outcomes and develop a sustainable clinical workforce
- Redesign clinical pathways

3.4 **Update on "In Hospital" workstream**

- The main changes for consultation in 2016/17 lie within the "In hospital" workstream of the Success Regime/STP. Developments in primary and community services will continue to build on health and wellbeing strategies that were already in progress and reported on regularly within the Health and Wellbeing Board programme.

- For this update, we focus on current thinking around hospital reconfiguration.

- Work to date has been driven by local clinicians, mainly within the three hospitals. Some 60 senior clinicians have formed an Acute Leaders Group

which is considering local and national evidence and developing preliminary options for change. During September and October there will be wider engagement involving community and primary care clinicians, community stakeholders and local people.

- The current goals for reconfiguration are summarised as:

    - Designation of the hospitals to function within an urgent and emergency care network, in line with national guidance – to improve and sustain clinical staffing levels
    - Separation of planned and emergency surgery – to improve efficiency and reliability for patients
    - Consolidate specialised services (centres of excellence) - to improve patient care and outcomes

- The starting point for the emerging models 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

- Some key points from national guidance on developing an urgent and emergency care network:

    - Urgent and emergency care needs should be met as far as possible within the community. With the right services and strong coordination between them, hospital admissions are not always necessary.
    - An urgent and emergency care network should serve a population of between1 and 5 million (mid and south Essex has a population of around 1.2 million).
    - The network should maximise the chances of survival and good recovery from serious and life-threatening emergencies by designating a hospital to provide emergency care with specialised services. This ensures a 24/7 consultant presence for every patient and reduces mortality, harm and length of hospital stay.

- Some key points from national guidance on separating planned from emergency surgery:

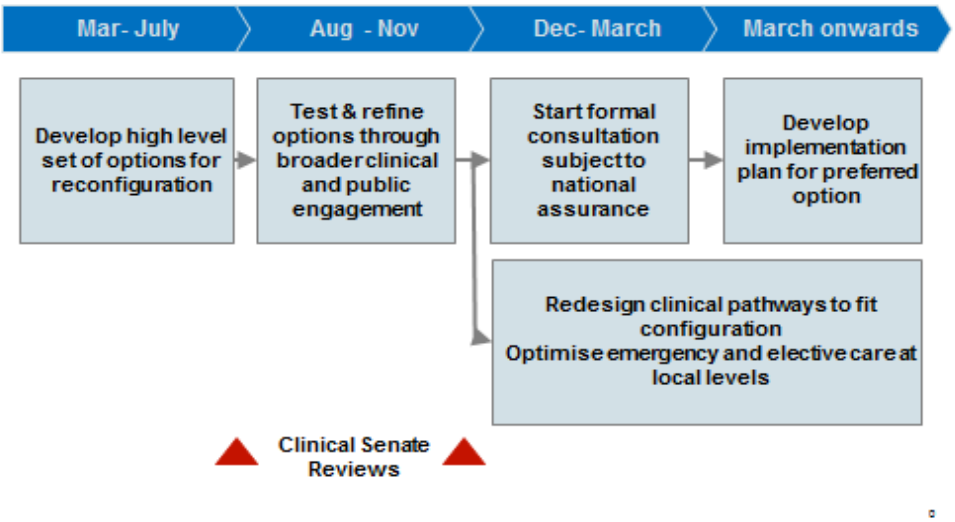
    - Separating low-risk, planned operations from emergency care can improve efficiency and avoid cancelled operations. It can also increase the number of day cases and short stays (and hence increase capacity)
    - A greater consultant presence at elective centres enhances patient safety and quality of care for complex cases.

- While considering the possibilities for designation of emergency care and the separation of planned and emergency care, there are a number of inter-dependencies across hospital services. The priorities for current development are:

    - acute and emergency medical care
    - acute and elective surgery
    - paediatrics
    - women's services, including maternity care

- The acute clinicians will continue working on possible options for the potential reconfiguration during August and September with the aim that a shortlist of preliminary options will become clear in September. A programme of open public workshops and other methods of engagement is planned for September and October leading to the completion of the pre-consultation business case in November.

3.5 Timescales



3.6 Service user engagement in this work

- During July, we held a programme of workshops to gain staff and service user insights on the strategic overview of the SR/STP and potential hospital reconfiguration. This has highlighted important issues at an early stage.

- Workshops were held in Chelmsford, South Woodham Ferrers, Grays, Southend, Rayleigh and Canvey Island, involving over 94 people. Further workshops were held with some 300 staff.

- The following table shows common themes raised:

Common themes raised by Service users	Common themes raised by staff
Transport – consider public transport, patient transport and accommodation	Travel/transport for both patients and staff
People will need more help to cope with complexity of using different centres	Need to work on standardisation to ensure consistency. Complex pathways could be more complicated not less
Families will need more support	Need critical development in information and IT
GP access needs to improve	Community and locality capacity – need system-wide working
Ambulance – development of operations, clinical practice and training	Resources to deliver change - support for staff
Patient and public education	Patient and public engagement
Concerns about recruitment – some comments on benefits of centres of excellence	Impact of change process on recruitment / retention

- The following table shows examples of important issues raised during the workshops for consideration in developing proposals:

E.g.s issues raised by service users	E.g.s issues raised by staff
Training for staff (dementia highlighted)	Community capability and support
Link with voluntary sector to improve efficiency and productivity	Invest in training
Whole patient pathway – after care and choice after emergency event	Keep staff well-informed and listen to views in terms of developing operational model
Invest in new ways of communicating	Clear roles, responsibilities, protocols, **accountability**
Understand behaviour and develop better urgent and out of hours care e.g. minors units close to A&E	Build-in needs of vulnerable people and those on low income
Value staff	Ensure change is attractive to clinicians and other specialists

See appendix 1 for list of dates of open public workshops in September and October.

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

Verified by: Jo Freeman
Position: Management Accountant Social Care & Commissioning

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

7.2 Legal

Verified by: Roger Harris
Position: Corporate Director of Adults, Housing and Health

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.

7.3 **Diversity and Equality**

Verified by: Rebecca Price
Position: Community Development Officer

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

During the wider engagement phase 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 workstreams, to test equality issues and use the feedback to inform an equality impact assessment to be included in the pre-consultation business case and decision-making business case.

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 – List of open public workshops in September and October 2016

Appendix 2 – Summary of meeting with Anita Donley : Chair of ESR

Report Author:

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

Appendix 1- List of open public workshops in September and October 2016

Date	Time	Venue
26 September	6-8pm	Braintree District Council
20 September	6-8pm	Saxon Hall, Southend
22 September	5.00 – 8.30pm	Orsett Hall
27 September	6-8pm	Maldon Town Hall
3 October	6-8pm	The Crystal Hall, Rayleigh
4 October	6-8pm	Brentwood Baptist Church Hall
6 October	6-8pm	South Essex College, Basildon Campus
7 October	6-8pm	The Paddocks, Canvey Island
10 October	6-8pm	Essex Cricket Ground
12 October tbc	6-8pm tbc	South Woodham Ferrers TBC

Appendix 2 – Summary of discussion with Anita Donley: Chair of ESR

- Cllr James Halden, Roger Harris and Ian Wake met with Dr Anita Donley on Monday 5th September.
- Dr Donley was appointed as the Independent Chair of the Essex Success Regime from 1st April this year.
- Dr Donley is vice-president of the Royal College of Physicians.
- The meeting was an opportunity for Dr Donley to discuss the work of the ESR and in particular the role of the proposed Programme Board which will act as the key governance group for both the ESR and the STP process.
- It was also an opportunity for the HWB Board reps to emphasise that Thurrock was very willing to work collaboratively where it made clinical and economic sense, but the starting point for that discussion had to be the HWB Board footprint – i.e. Thurrock.
- Dr Donley agreed to send through the draft terms of reference for the Programme Board and we agreed that we would comment on these and also be more explicit over the principles that we would use to define when something needs to be commissioned or provided at a local level and when we think there is strong evidence for a larger footprint.

15 September 2016	ITEM: 6
Thurrock Health and Wellbeing Board	
Thurrock Health and Wellbeing Strategy Goal B, A Healthier Environment Summary Report	
Wards and communities affected: All	**Key Decision:** To note action plans
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: Steve Cox, Corporate Director of Environment and Place	
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.

This paper provides action plans that have been developed to support the achievement of Thurrock's Health and Wellbeing Strategy Goal B, Healthier Environments. It follows the previous action plans considered by Health and Wellbeing Board members at their meeting in July for Goal A, Opportunity For All.

1. Recommendation(s)

1.1 The Board is asked to agree action plans developed to support the achievement Thurrock's Health and Wellbeing Strategy Goal B, Healthier Environments.

2. Introduction and Background

2.1 Thurrock's Health and Wellbeing Strategy comprises five strategic goals which make the most difference to the health and wellbeing of the people of Thurrock.

2.2 Goal B, A Healthier Environment, focusses on creating places that keep people well and independent.

2.3 Creating a healthier environment will help to keep people well for as long as possible. This will involve ensuring that communities are strong and inclusive and making sure that Thurrock is designed and built to make it easy for people to live active and healthy lives.

2.4 Four key objectives have been established as part of clearly defining and determining what needs to be done to create a healthier environment for Thurrock:

i. Outdoor spaces that make it easier to exercise and to be active
ii. More homes that will be built to keep people well and independent
iii. Communities will be stronger and better connected
iv. Air quality will be improved

2.5 Each of the objectives would be supported by an action plan containing the key actions needed to meet the objective. Health and Wellbeing Board members approved an outcome framework containing a number of related performance indicators at your meeting in July. Performance indicators have been incorporated into individual action plans, ensuring that the impact of specific actions and the Health and Wellbeing Strategy can be measured.

3. Issues, Options and Analysis of Options

3.1 Action plans are being presented to the Health and Wellbeing Board that have been subject to consultation. Health and Wellbeing Board members are asked to note the action plans for Goal B, Healthier Environments and invited to provide feedback on the actions and delivery timescales

4. Reasons for Recommendation

4.1 Health and Wellbeing Board members are responsible for driving forward Thurrock's Health and Wellbeing Strategy. Action plans have been developed for each of the Strategy's five Goals. Health and Wellbeing Board members have agreed to consider action plans for one of the Strategy's Goals at each meeting.

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

5.1 Action plans are developed in partnership between Thurrock Council, CCG, VCS and key stakeholders. Community engagement is a key part of the development of action focussed plans to support the achievement of Thurrock's Health and Wellbeing Strategy.

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.

6.3 As part of creating outdoor spaces to make it easier to exercise and be active the action plan includes a commitment to undertake comprehensive audits and needs assessments for open spaces, play areas, footpaths and cycle ways across the borough. It also contains a commitment to ensure that all new developments appropriately contribute towards the creation and/or enhancement of open spaces and play areas across the borough.

6.4 Actions identified to develop homes that keep people well and independent include encouraging the development of high quality private sector housing across the borough that appropriately reflects the needs of all communities including older people households. There is also a commitment to explore the demand and potential to develop specialist housing for vulnerable people across the borough.

6.5 Actions identified to build strong, well connected communities within Thurrock includes promoting and encouraging volunteering activities, increasing awareness of the Small Sparks Grant Funding which involves providing up to £250 to members of the public for projects created to improve their neighbourhoods

6.4 Thurrock's Air Quality Strategy is currently under review. Councillors Little and Halden will be bringing a further paper back to the Health and Wellbeing Board which looks at the borough wide implications for air quality and how this fits with the overall agenda for the regeneration of Thurrock.

7. Implications

7.1 Financial

Implications verified by: **Roger Harris, Corporate Director Adults Housing and Health**

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: **Roger Harris, Corporate Director Adults Housing and Health**

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: **Roger Harris, Corporate Director Adults Housing and Health**

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 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):

- None

9. Appendices to the report

- Action plans for Goal B, Healthier Environments.
    - Action Plan B1, Create outdoor spaces that make it easier to exercise and to be active
    - Action Plan B2, Develop homes that keep people well and independent
    - Action Plan B3, Building Strong, well connected communities

Report Author:

Darren Kristiansen

Business Manager, Health and Wellbeing Board and Adult Social Care Commissioning

Housing and Health, Thurrock Council

Goal: HEALTHIER ENVIRONMENTS

OBJECTIVE: **B1: Create outdoor places that make it easy to exercise and to be active**		**OBJECTIVE LEAD: Grant Greatrex and Andy Millard (Contributions from Kirsty Paul)**		
Action	**Outcome**	**Action lead**	**Delivery Date**	**Reference to existing strategy or plan**
A. 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 outdoor spaces and leisure facilities	Kirsty Paul– Principal Planning Officer	October 2016	Infrastructure Requirement List
B. Undertake a comprehensive audit and needs assessment for open spaces and play areas in the borough (Active Place Strategy)	• Identify key sport, leisure open space improvement projects that need to be delivered • Inform policies in the emerging Local Plan • Reduce the proportion of people who are inactive in Thurrock	Kirsty Paul – 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.
C. Undertake a comprehensive audit and needs assessment for footpaths and cycleways in the borough (Active Place Strategy)	• Inform policies in the emerging Local Plan • Identify key footpath and cycleway improvement projects that need to be delivered Reduce the proportion of people who are inactive in Thurrock	Kirsty Paul – 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.
D. Undertake a public consultation on Local Green Spaces as part of ongoing work on the emerging Local Plan	• Encourage discussion in local communities about green spaces in their area • Protect locally important green spaces from development • Inform policies and site allocations in the emerging Local	Kirsty Paul – Principal Planning Officer	August 2016 (Completed as part of the Active Places Strategy)	National Planning Policy Framework Emerging Thurrock Local Plan. For key consultation stages in the emerging Local Plan please refer to the Council's Local Development Scheme.

	Plan			
E. Ensure that policies in the emerging Local Plan support the delivery of Objective B1	• Protect locally important green spaces from development • Ensure that all new residential dwellings have appropriate access to open space	Kirsty Paul – 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.
F. Ensure that all new developments appropriately contribute towards the creation and/or enhancement of open space and play areas in the borough	• More effective use of planning obligations • Additional investment for infrastructure projects that seek to improve outdoor spaces and leisure facilities • Reduce the proportion of people who are inactive in Thurrock	Kirsty Paul – Principal Planning Officer	October 2016	Infrastructure Requirement List
G. Explore the opportunity to create a riverfront walk/cycleway along the Thames	• Encourage discussion between key partners as to how the riverfront walk/cycle project could be delivered • Increase recreational tourism along the riverfront • Reduce the proportion of people who are inactive in Thurrock	Steve Cox	To be confirmed	Infrastructure Requirement List Cycle Infrastructure Delivery Plan Active Place Strategy (emerging)

Outcome Framework

Objective	B1: Create outdoor places that make it easy to exercise and to be active.					
Indicators	**2016 Baseline**	**2017**	**2018**	**2019**	**2020**	**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)	53.64%	54.48%	55.32%	56.16%	**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.			**Note – this will not be measured every year**			
% 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.			**Note – this will not take place every year**			

This will give an understanding of residents' views.				

Health and Wellbeing Strategy Action Plan

Goal: B – Healthier Environments

OBJECTIVE: B2 – Develop homes that keep people well and independent	**OBJECTIVE LEAD: Les Billingham and Andy Millard**			
Action	**Outcome**	**Action lead**	**Delivery Date**	**Reference to existing strategy or plan**
A. Encourage the development of high quality private sector housing across the Borough that appropriately reflects the needs of all communities including older person households	Greater choice of private accommodation for people aged 65 and over	Andy Millard		National Planning Policy Framework Draft Design Strategy SPD South Essex Strategic Housing Market Assessment 2016
B. Bring forward the development of a HAPPI scheme in Tilbury (Calcutta Road) and explore the demand and potential for further schemes across the Borough as opportunities arise.	Greater choice of Council owned accommodation for people aged 65 and over	Matthew Essex	Calcutta Road scheme completed by 2020. Further milestones to be determined as opportunities arise. Delivery date to be determined	
C. Explore the demand and potential to develop specialist housing for vulnerable adults across the Borough.	Determine the requirements for specialist housing/	Les Billingham	2021 – need to identify interim milestones	
D. 65% of the council stock to have benefitted from the Transforming Homes Programme (6553 properties in total)	Improved kitchens and bathrooms, including electrical rewriting and installation of new boilers, resulting in warmer homes, allowing residents to stay	Susan Cardoza	April 2017	Housing Strategy 2015-2020

	in their homes for longer.			
E. Visit vulnerable private residents 65 and over and those with long term health condition to meet the Well Homes Criteria	300 residents seeing an improvement to their wellbeing after a Well Homes assessment in the community	Dulal Ahmed	2016/17	Housing Strategy 2015-20 Joint Strategic Needs Assessment
F. Well Homes to sign post vulnerable private residents over 65 onto Thurrock Council Services (social services, homelessness and DV) within the Well Homes index areas of high risk	200 residents seeing an improvement to access a variety of services	Dulal Ahmed	2016/17	Housing Strategy 2015-20 Joint Strategic Needs Assessment
G. Well Homes to sign post vulnerable private residents 65 and over and those with long term health condition to the Private Housing Service (Private Rented Property Inspection Requests)	A 180 reduction in the number of Category 1 Hazards (HHSRS) removed from private homes.	Dulal Ahmed	2016/17	Housing Strategy 2015-20 Joint Strategic Needs Assessment
H. Action currently under consideration to translate the 'Well Homes' principles to Council tenants. The principles of Well Homes should be adopted for social housing properties provided by Thurrock Council.		Dulal Ahmed	Action under development timescales to be determined	
I. Develop the "Right Size" scheme: A scheme enabling older owner occupiers to downsize into sheltered accommodation whilst leasing their property to the Council to use for homeless households	Older residents living in accommodation which better suits their needs.	Dawn Shepherd	2016/17	Homelessness Prevention Strategy Action Plan
J. Develop a "Housing First" approach for homeless individuals with	Individuals with complex needs are able to maintain housing and improve their	Dawn Shepherd	2016/17	Homelessness Prevention Strategy

	enduring complex needs including mental & physical health, drug and alcohol abuse	health and life expectancy			Action Plan
K.	Adopt the Thurrock Design Strategy SPD as part of the Borough's Development Plan	• New developments with better layouts and improved functionality • Improved connectivity between existing and new developments • Increased public pride • Creation of more cohesive communities • Improve the overall character and attractiveness of the borough	Kirsty Paul – Principal Planning Officer	October 2016	Core Strategy and Policies for the Management of Development Local Plan (Core Strategy) Design Strategy SPD
L.	Review existing design standards in the Thurrock Borough Local Plan - Annex	• Improvements to layout and functionality of new developments	Kirsty Paul – Principal Planning Officer	March 2017	Core Strategy and Policies for the Management of Development Local Plan (Core Strategy) Design Strategy SPD
M.	Ensure that all 'major' planning applications for new homes are reviewed by the Housing and Planning Advisory Group	• New developments with better layouts and improved functionality • Improved connectivity between existing and new developments • Creation of more cohesive communities • A more appropriate mix of house typologies	Kirsty Paul – Principal Planning Officer	Ongoing	Core Strategy and Policies for the Management of Development Local Plan (Core Strategy) Design Strategy SPD South Essex Strategic Housing Market Assessment (2016)
N.	Ensure that policies and site allocations in the emerging Local Plan support the delivery of Objective B2	• New developments with better layouts and improved functionality • Improved connectivity between existing and new developments	Kirsty Paul – Principal Planning Officer	Ongoing - 2020	Emerging Thurrock Local Plan. For key consultation stages in the emerging Local

	• Creation of more cohesive communities • A more appropriate mix of house typologies			Plan please refer to the Council's Local Development Scheme.
O. Ensure that the NHS, CCG, Public Health and other health partners are actively involved in updating the Council's Infrastructure Requirements List (which forms the basis for all future Section 106 negotiations including new applications).	• Strengthened partnership working between the Council and key Partners • Funds spent on facilities that are needed due to development taking place • Health and wellbeing maintained or enhanced as a result of the use of planning obligation monies • How monies are spent reduce or mitigate the impact of developments – e.g. via provision of community facilities or green space projects	Kirsty Paul – Principal Planning Officer	Ongoing	Infrastructure Requirements List
P. Thurrock will consider how to develop a local keyworker scheme to attract a wider range of key worker including GPs, Social Workers and Nurses.	• Action under development.	John Knight – Head of Housing management	ASAP	

Outcome Framework

Objective	B2: Develop homes that keep people well and independent.					
Indicators	**2016 Baseline**	**2017**	**2018**	**2019**	**2020**	**2021 Target**
1. % of all major housing developments that have an approved Health Impact Assessment.						**100%**
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.						
2. % of all major planning applications that have been assessed by the Health and Wellbeing Housing and Planning Advisory Group	**Work in progress to establish baseline**					**100%**
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.						

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Health and Wellbeing Strategy Action Plan

Goal: B – Healthier Environments

OBJECTIVE: B3 – Build Strong, well-connected communities		**OBJECTIVE LEAD: Kristina Jackson and Les Billingham**		
Action	**Outcome**	**Action lead**	**Delivery Date**	**Reference to existing strategy or plan**
A. To increase time bank facility by 10%	Increasing the number of timebank exchanges will help to stimulate volunteering and reduce isolation experienced by citizens who join	Jacqui Payne, nGage	April 2016	
B. Further develop existing Community Hubs as they become focal points for supporting the delivery of priorities in their area. C. To integrate a range of services for children, young people and families through the development of the 0-19 Wellbeing Offer D. As a part of creating a twenty-first century wellbeing offer for children and young people, explore opportunities to deliver a range of 0 – 19 services through Community Hubs and the Integrated Healthy Living Centres, including services currently housed in Children's Centres.	Community Hubs will become the focal points for resilient communities in Thurrock. Creating community hubs that are that are self-managing will ensure their positive impact upon health and well-being is sustained.	Natalie Warren Roger Edwardson / Tim Elwell Sutton / Sue Green Roger Edwardson / Tim Elwell Sutton / Sue Green	Ongoing August 2017 Review completed by March 2017 Changes to buildings to be implemented on a	

			phased approach from April 2017 – March 2018	
E. Promote and encourage volunteering e.g. Raise awareness of volunteering week, providing publicity to existing volunteers by acknowledging their ongoing community commitment	Potential increase in volunteering	Natalie Warren		
F. Undertake feasibility study focussing on developing Thurrock's 'Giving' Initiative	Establish a fund across business and communities which helps meet local priorities, bringing communities together to build stronger neighbourhoods	Kristina Jackson / Natalie Warren		
G. Increase awareness of Small Sparks Grant Funding	Increase in people undertaking small projects of no more than £250 monetary value to improve their neighbourhood	Kristina Jackson		
H. Develop and deliver a pilot on Social Prescribing in the areas of Aveley, Purfleet, Tilbury and East Tilbury	Members of the public who do not require medical support will be signposted to other activities to support them and reduce the likelihood of isolation and loneliness	Kristina Jackson	Pilot to commence in October 2016 and will conclude in October 2017	
I. We will work to facilitate the creation, development and sustainability of a Dementia Action Alliance in Thurrock. We will invite organisations across all sectors to join the DAA to ensure that there is a broad commitment across statutory and voluntary sector organisations as well as community groups.	This work will reinvigorate the Dementia work across Thurrock and ensure we can meet the national target set for Dementia Friendly Communities. By ensuring the development and sustainability of the DAA it will enable Thurrock to reach the 2021 target of 3750 dementia friends. The current number is 2564 (May 2016), this is an increase of 1180 dementia	Kelly Redston, Adult Social Care Commissioner. Gemma Tomsett, Alzheimer's Society Thurrock	Alliance formulated and initial plan agreed June- Dec 2016 Implementation January 2017 onwards.	Code of practice for the recognition of dementia friendly communities in England.

	friends over this 5 year period.			
J. To review and revise the current Strategy to include the creation of the DAA and to ensure that it fits with the development of the Thurrock market in line with the Market Development Strategy and the recent development of service provision around older peoples care including the BCF.	The review and revision of the Strategy will ensure that a clear plan is set in line with the current market development for services in Thurrock. The plan will ensure that the asset based community development and the community offer is at the heart of Thurrocks commitment to its population that have dementia and the carers of these residents. The revision of the strategy will also enable Thurrock to support the set-up and the sustainability of the Thurrock DAA.	Kelly Redston, Adult Social Care Commissioner		Essex Thurrock and Southend Dementia Strategy 2012. Improving Support for people with Dementia and carers in Thurrock, LB 2014. Dementia Specialist Topic Needs Assessment, Essex CC May 2015. Thurrock Better Care Fund Plan. Living Well in Thurrock Pilot, MT 2016 ????
K. Adopt the Thurrock Design Strategy SPD as part of the Borough's Development Plan	• New developments with better layouts and improved functionality • Improved connectivity between existing and new developments • Increased public pride • Creation of more cohesive communities	Kirsty Paul – Principal Planning Officer	October 2016	Core Strategy and Policies for the Management of Development Local Plan (Core Strategy) Design Strategy SPD
L. Ensure that all 'major' planning applications for new homes are reviewed by the Housing and Planning Advisory Group	• Delivering an appropriate mix of new house types across the borough • New developments with better layouts and improved functionality • Improved connectivity between existing and new developments	Kirsty Paul – Principal Planning Officer	Ongoing	Core Strategy and Policies for the Management of Development Local Plan (Core Strategy) Design Strategy SPD South Essex Strategic Housing Market Assessment (2016)
M. Create a Local Plan Residents	• Increased public pride	Kirsty Paul – Principal	September 2016	Thurrock Local Plan:

Forum	• Increased sense of ownership and responsibility in relation to the built environment • Creation of more cohesive communities	Planning Officer	(NB: Meetings are intended to be held on a quarterly basis)	Statement of Community Involvement
N. Ensure that Local Plan Youth Forum continue to be engaged in local planning, housing and regeneration matters	• Increased public pride • Increased sense of ownership and responsibility in relation to the built environment • Creation of more cohesive communities	Kirsty Paul – Principal Planning Officer	Ongoing (NB: Meetings are intended to be held on a quarterly basis)	Thurrock Local Plan: Statement of Community Involvement
O. Ensure that policies and site allocations in the emerging Local Plan support the delivery of Objective B3	• Delivering an appropriate mix of new house types across the borough • New developments with better layouts and improved functionality • Improved connectivity between existing and new developments • Increased public pride • Creation of more cohesive communities	Kirsty Paul – 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.
P. Undertake work to identify options and the feasibility of expanding the Local Area Coordination Service	• Reduce the number of people requiring a service • Reduce the number of people reaching crisis point before receiving an intervention • Giving more people an opportunity to live a 'good life' • Enabling more people to connect within their communities • Reduce isolation and loneliness	Tania Sitch – Integrated Care Director Thurrock Council/NELFT Les Billingham – Head of Adults and Communities	March 2017	Living Well in Thurrock Programme Stronger Together

Outcome Framework

Objective	B3: Building strong, well-connected communities.					
Indicators	**2016 Baseline**	**2017**	**2018**	**2019**	**2020**	**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**				**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)	66.52%	66.64%	66.76%	66.88%	**67%**
% of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12	**70.7%**	71.96%	73.22%	74.48%	75.74%	**[77.0%**

months. This indicator quantifies the proportion of those diagnosed with dementia who have a care plan that has been reviewed in the last 12 months. This review should address four key issues: an appropriate physical and mental health review for the patient if applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs if applicable, the impact of caring on the care-giver communication and co-ordination arrangements with secondary care (if applicable). This indicator is measured as part of the Quality Outcomes Framework for Mental Health (DEM002) and is also a measure on the CCG Outcomes Framework.	(2014/15)					**was national average in 2014/15]**

Thursday 15 September 2016	**ITEM: 7**
Health and Wellbeing Board	
"For Thurrock in Thurrock" **Transformation Programme Update**	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Jeanette Hucey, Director of Transformation, Thurrock CCG	
Accountable Head of Service: Director of Transformation, Thurrock CCG	
Accountable Director: Mandy Ansell, Acting Interim Accountable Officer, Thurrock CCG	
This report is Public	

Executive Summary

The Thurrock Transformation Plan: Delivering our Vision (January 2016), shared at the February Health and Wellbeing Board is now coming to life as we work through the finer detail of the programme.

Agreement to the proposed changes in how and where intermediate care will be delivered gained strong support from the public and stakeholders alike, and confidence amongst system partners on the programme's ability to deliver has been growing at pace.

We know that the key to successful delivery of our vision is the coordination of a range of out of hospital services which are based around local patient need as opposed to pre-determined service models, and prioritise domiciliary care packages over bed based care but offer bed based care where required.

This presentation serves to provide an update on progress to date, the timeline for delivery, and the linkage with the Success Regime and Mid and South Essex Sustainability and Transformation Plan.

1. Recommendation(s)

1.1 Comment on the progress update provided for information, as requested following the initial report to the Health and Wellbeing Board in February.

2. Introduction and Background

2.1 Towards the end of 2015 the Thurrock health and care system embarked on an ambitious piece of work to align its vision for older people (the Better Care Fund (BCF)) with the primary care transformation programme already underway.

2.2 The scope of this programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services **"For Thurrock in Thurrock"**.

2.3 The focus has been on improving the quality and accessibility of service for the local population based on need (identified through health need, social need and deprivation analysis provided by Public Health), with a view to providing a more holistic model of locality based care closer to home for the local population.

3. Issues, Options and Analysis of Options

3.1 We know that the system is not currently set up to cope with the rapid growth in demand for health and care service. In developing our vision and the enhanced locality (neighbourhood) based teams, we will be in a better position to meet that demand.

4. Reasons for Recommendation

4.1 To share progress and keep committee members informed.

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

5.1 Healthwatch Thurrock led the initial phase of public engagement, which ran from 22 February to 31 March 2016 and included over 4300 contacts.

5.2 The next phase of engagement is due to comments on 22 August and will run for 6 weeks. Healthwatch Thurrock will again lead this phase of engagement.

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

6.1 The programme supports delivery of the Thurrock Joint Health and Wellbeing Strategy 2016 - 2021.

7. Implications

7.1 **Financial**

Implications verified by: **Ade Olarinde, Chief Finance Officer, Thurrock CCG**

The programme includes an enhanced community offer funded through the BCF to support people in their own homes or in the community whenever possible. The funding was approved through the respective Local Authority

and CCG governance routes earlier in the year. This update outlines how the programme is now being mobilised.

7.2 **Legal**
Implications verified by: **None Identified**

7.3 **Diversity and Equality**
Implications verified by: **Rebecca Price Community Development and Equalities Team**

Full commitment is made to public, user and partner engagement to ensure that the service under development meets the current and future needs of those that require access. Members of Thurrock Coalition, the CCG, Healthwatch and Thurrock CVS have been involved with the development phase of the vision in addition to a Patient Champion and the Commissioning Reference Group.

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

Thurrock's transformation programme is considered to be driving best practice by the Success Regime and as such forms the basis of the out of hospital care model within the Mid and South Essex Sustainability and Transformation Plan (STP). As a result Thurrock CCG have been asked to lead development and delivery of the out of hospital model with CCG colleagues across the STP footprint.

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):

- Thurrock Transformation Plan: Delivering our Vision - January 2016
- Thurrock Transformation Programme: Bringing our Vision to Life – March 2016
  (Attached for ease of reference at Appendix 2 and Appendix 3).

9. Appendices to the report

- **Appendix 1**
  Presentation: "For Thurrock in Thurrock"
  Transformation Programme Update
- **Appendix 2**
  Thurrock Transformation Plan: Delivering our Vision (January 2016)
- **Appendix 3**
  Thurrock Transformation Programme:
  Bringing our Vision to Life (March 2016)

Report Author: Jeanette Hucey
Director of Transformation

Thurrock Clinical Commissioning Group

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NHS
Thurrock
Clinical Commissioning Group

Thurrock Transformation Plan: Delivering our Vision

January 2016

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1. Foreword

This transformation plan outlines our vision for providing health and care closer to or at home for the population of Thurrock - **For Thurrock in Thurrock**, in line with our strategic direction set out in our 5 year Strategic Plan 2014-19, and acts as a refresh to that plan in terms of building on that vision.

This plan also aligns with the local Health and Wellbeing Strategy and builds on the aims of the Better Care Fund (BCF) as a new model of care emerges from the vision and local ambitions through the course of the transformation programme in line with the NHS England document the “Five Year Forward View”.

Patients often tell us that they find the health and care system overwhelmingly complex and disjointed. While there have been major improvements in health and care services recently, these improvements have not kept pace with changes in society over the years, and if these are not addressed we know the system will struggle to meet future needs.

In recent public engagement events, a recurring theme is the desire for health and care services to be more accessible for Thurrock people.

We also know that the system is not currently set up to cope with the rapid growth in demand for health and care service. By developing our vision and the enhanced neighbourhood based teams, we will be in a better position to meet that demand.

While we are in a more stable financial position than some of our system partners, maintaining that position gets more challenging every year. We recognise that there are still efficiencies that we can make across the system and we are committed to working together to get the most for the Thurrock pound.

We already work closely with our local authority partners and neighbouring CCG in Basildon and Brentwood as well as our provider organisation Basildon and Thurrock University Hospital Foundation Trust (BTUH) our acute provider, North East London Foundation Trust (NELFT) our community provider, and South Essex Partnership Trust (SEPT) our mental health provider. We will continue to work in partnership with each of them to develop a more integrated workforce with the skills, experience, capability and capacity to provide care closer to home in a more holistic way as we develop our new care models for the future.

We are fortunate in that NHS England launched 50 vanguard sites in 2015 to test new models of integrated care and we will learn from their experience as we more forward on our journey towards delivering new models of care.

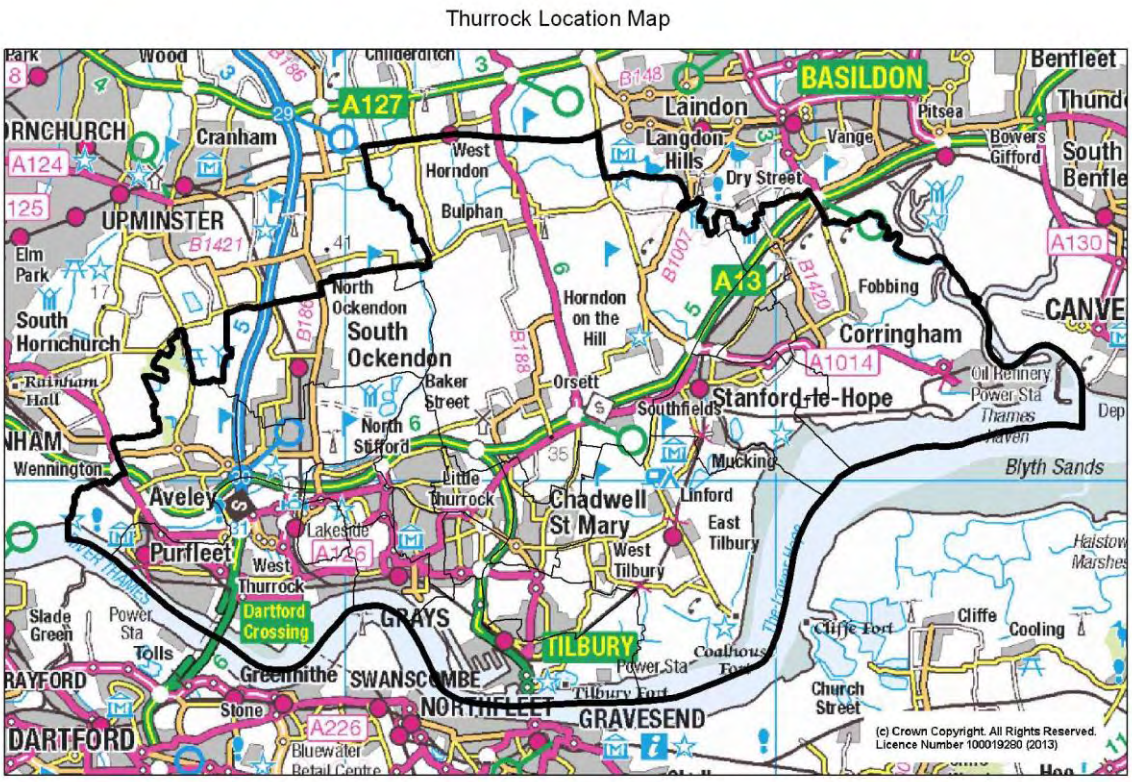
Anand Deshpande, Chairman

Mandy Ansell, Acting Accountable Officer

2. About us

Thurrock Clinical Commissioning Group (CCG) is situated in the south of Essex and lies to the east of London on the north bank of the River Thames. It has a diverse and growing population with a population density of 976 persons per square kilometre.

Figure 1 Map of Thurrock



The CCG is made up of 32 GP practices, clinicians, nurses and NHS managers and staff and is responsible for buying and delivering local health care services for its population.

The services include healthcare from hospitals, community and mental health services and some specialist services however service contracts with GPs, dentists, pharmacists and opticians are managed by NHS England, and Thurrock Council is responsible for all social care services in Thurrock.

2.1 Locality Overview

The CCG is broadly made up of four localities (neighbourhoods), situated in Tilbury, Purfleet, Grays and Corringham and surrounding areas. We serve a population of just over 163,000, which is increasingly ethnically diverse, and there has been substantial movement of people from London to Thurrock, particularly from geographically close boroughs.

2.2 Our Ambitions

Our local Health and Wellbeing Strategy is built on 5 key principles:

Figure 2 Health and Wellbeing Strategy – 5 key principles

Prevention and early intervention: A system wide Primary, Secondary and Tertiary prevention strategy with clear outcomes and key actions for each partner agency, a locality based population health system.

Building strong and sustainable communities: Integrated housing, health, planning and transport policy, building on the "Thurrock revolution", embedding wellbeing into the regeneration agenda

Strengthening the mental and emotional: Wider determinants of mental health, preventing mental ill health, finding and treating the missing thousands, bring services closer to Primary Care.

Health and social care transformation: Improving Primary Care, integrating care around the person (closer to home).

Ensure that all agencies work together to deliver services that collectively improve the lives of all children and young people, ensuring that every child in Thurrock regardless of their circumstances has access to the best services and outcomes.

To achieve these ambitions we need to radically change how our health and care system current works. This plan sets out our journey toward the last of the 4 ambitions (health and social care transformation), which if we are successful will provide the environment for the other 4 ambitions to flourish.

2.3 Our Vision

The Thurrock health and care system is embarking on an ambitious piece of work to align its vision for older people (BCF) with the primary care transformation programme already underway.

The current scope of this programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services **"For Thurrock**

in Thurrock". This will be refined as the programme gains pace in order to align with the context of the Essex Success Regime (ESR) to ensure a comprehensive plan for Essex sustainability going forward.

The focus is on improving the quality and accessibility of service for the local population based on need (identified through health need, social need and deprivation analysis provided by Public Health), with a view to providing a more holistic model of locality based care closer to home for the local population.

Primary care underpinned by primary care needs assessment linked with social needs, in order to cross reference social needs and deprivation with health outcomes to allow us to forecast future health needs in line with demographic changes, and local regeneration and development programmes.

We already know that there are areas where we could improve, and by developing our services and estate for the people of Thurrock within Thurrock, and using a joint health and care community team within a care coordination model of delivery, more formally supported by our local voluntary services we will truly be able to do so.

The more radical element of our transformation programme centres on the current configuration of beds across southwest Essex, which spans 2 CCG catchments (figure 3).

With an open mind and some radical thinking about how current estate and services could be reconfigured to deliver a place based system of care specific to each CCG's local population, an alternative model has emerged (figure 4).

Figure 3

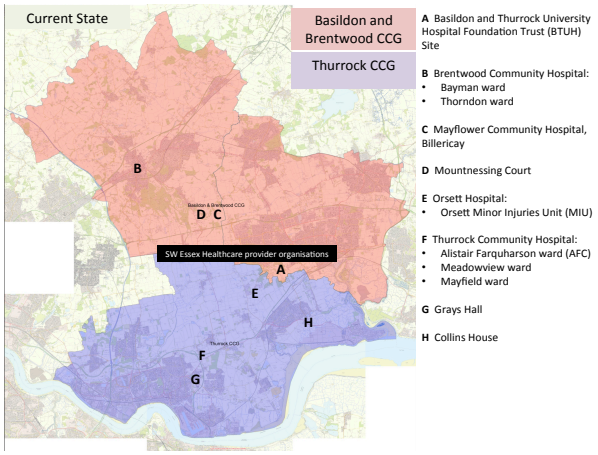
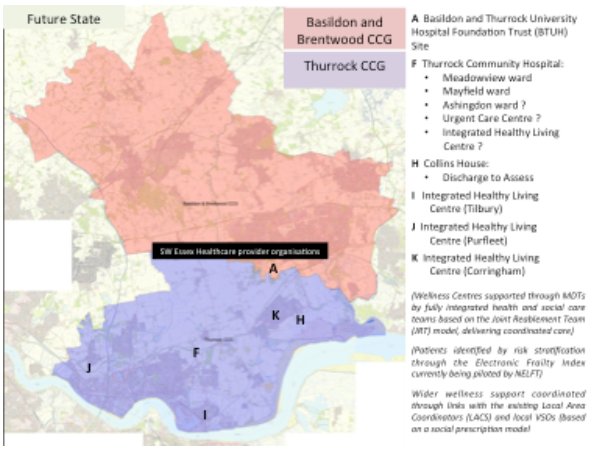


Figure 4



The focus of the alternative model is based on shifting patient flows into appropriate beds (clinically) where a bed is needed, and into an appropriate environment to meet each individual patient's needs (a key factor of good quality care for people with dementia or challenging behaviour). Where a bed is not the best solution in helping to maintain independence and wellness, patients will be supported by the integrated health and care community teams, in other words: right care, right place, right time.

2.4 Our Corporate Commitment

As commissioners, we are responsible for buying and delivering local health care services for our population and in doing that we have a statutory obligation to balance our financial accounts.

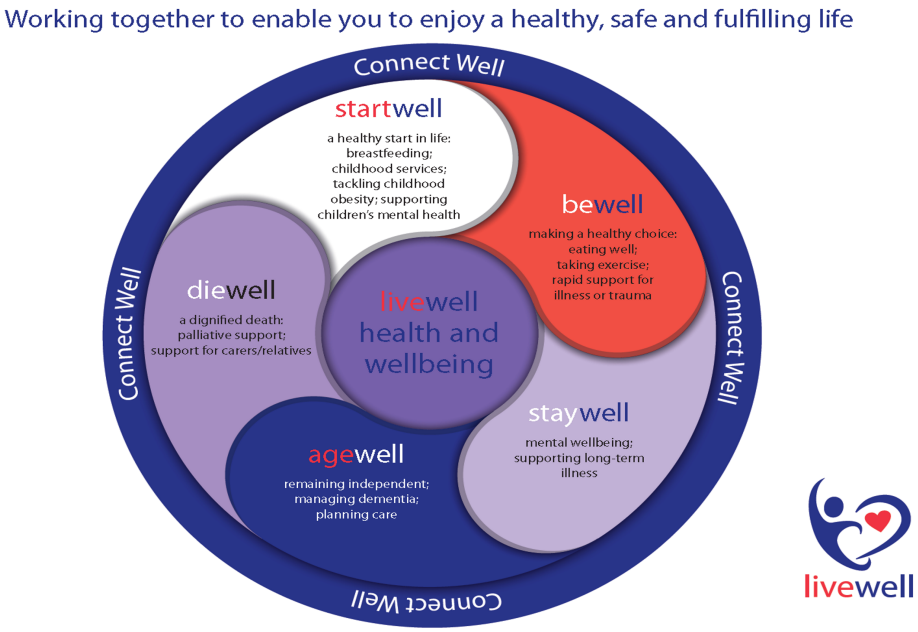
Whilst we are in a more stable financial position than some of our system partners, maintaining that position gets more challenging every year. We recognise that there are still efficiencies that we can make across the system and we are committed to working together to get the most for the Thurrock pound.

2.5 Quality, Safety and Patient Experience

We are committed to improving the health and wellbeing of our population and to working together with our system partners to enable them to enjoy a healthy safe and fulfilling life at every stage of their life journey, ensuring that the services we commission support that life journey (figure 5), are safe, and offer a good patient experience.

We know our patients find the current system overwhelming complex and disjointed and we aim to address this by bringing care closer to home by developing locality (neighbourhood) based integrated community health and care teams which will be extended and enhanced to increase current staff numbers and to provide a wider skill mix to enable care closer to or at home whenever it is clinically relevant. Helping our people to be well, live well and stay well at every stage of their lives as outlined in the "Live well health and wellbeing life cycle" at figure 5 below.

Figure 5 Live well health and wellbeing life cycle



To further support this end we will be working with CCG colleagues and partners to agree a set of whole-system outcomes which apply across organisational boundaries in the form of a multi-agency incentive scheme through the co-alignment of CQUINs / Enhanced Payments. The details of the proposed scheme are outlined in Section 5 below (figures 12, 13 and 14).

3. Why do we need to change?

We know that the system is not currently set up to cope with the rapid growth in demand for health and care service. By developing our vision and the enhanced locality (neighbourhood) based teams, we will be in a better position to meet that demand.

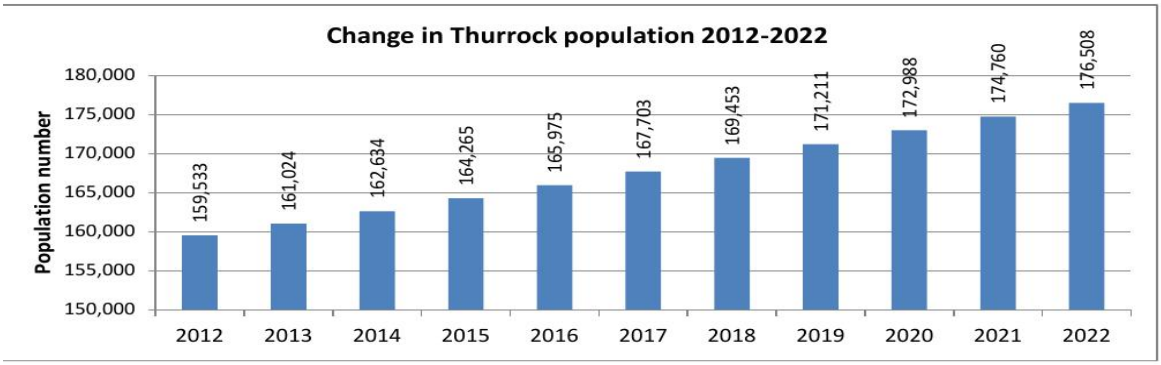
3.1 Expected Population Growth

The CCG has a larger young population aged 0-19 years – particularly 0-4 year olds, and a larger population in their 30s and early to mid-40s than both East of England and England.

There has been a 47.5% increase in the over 85 population between 2001 and 2011, equating to 846 more residents in this age group, and it is estimated that the total population will increase to 176,500 by 2022 and 192,535 by 2032.

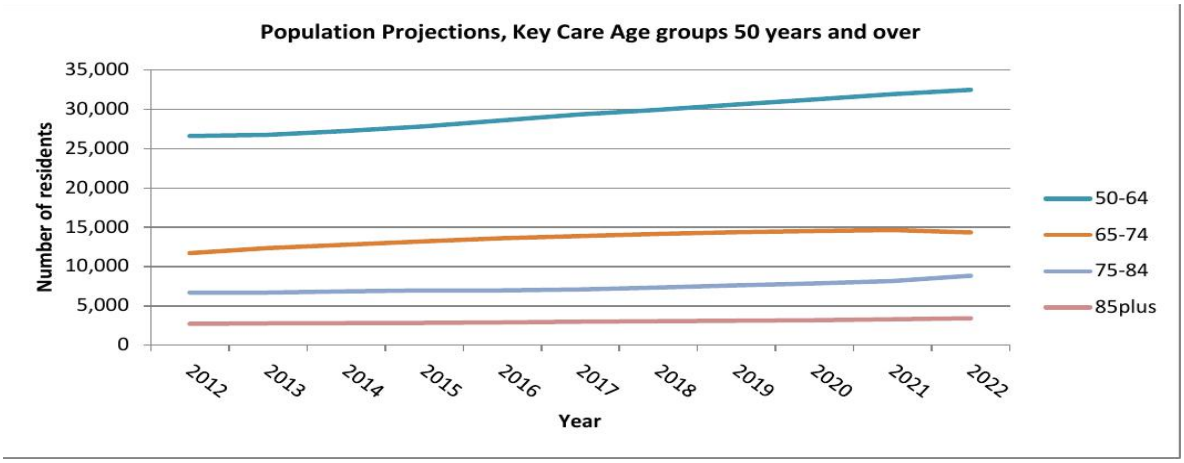
Figure 6 shows the projected change from 2012 to 2022, by five year age group. There is predicted to be a rise in number for almost every age group however the most significant rises occur in age groups clustered in the 0-14, 25-29, 50-59 and 70 plus age groups.

Figure 6 Population Projection Age Structures 2012-2022



The age and sex distribution within our population has an impact on the level of need for health services. Older people and the very young tend to have a greater utilisation of health services. An increase in a younger population indicates opportunities to maximise an early offer of help and prevent future ill health, in line with local authority public health responsibilities. Whilst an increase in the older population has implications for service provision and the levels and ways that care and social services are provided to meet needs.

Figure 7 Population Projections, Key Care Age groups 50 years and over



This plan sets out the journey through which we aim to address those needs and should be read in conjunction with our Primary Estates Strategy which set out our plans for developing local primary care services which dovetail into delivering our vision for transformation change.

3.2 Current Financial Position

The true financial implications and risks will not become be clear until the rebasing has been completed and we have received sign-off by each of the providers to the proposed plan. This is not likely to be achieved until into February when the contracts are being finalised.

3.3 Future Financial Position

The programme of work will be a key part of delivering financial sustainability and we will work through the detail of each strand of the programme so that they contribute to this overall aim.

We are working on transformational change which will lead to a rationalisation of estate, less duplication, better coordination and ultimately better care for the patient in the right place at the right time.

3.4 Achievement of Constitutional Targets

We have a statutory obligation to meet a range of constitutional targets including: A&E transit times, Referral to Treatment Times, Cancer waiting times, mental health access targets and others, in addition to meeting our financial obligations.

- Our system is currently under pressure with a range of targets such as:
- IAPT standard for entering treatment, dementia diagnosis rates
- Cancer 31 and 62 day targets
- A&E four hour waiting times
- Ambulance response rates
- 18 week referral to treatment time target

We are working with system partners to address these immediate pressures and in longer term planning linked to delivery of our vision so that sustainable systems and processes are in place to better manage these pressure in the future.

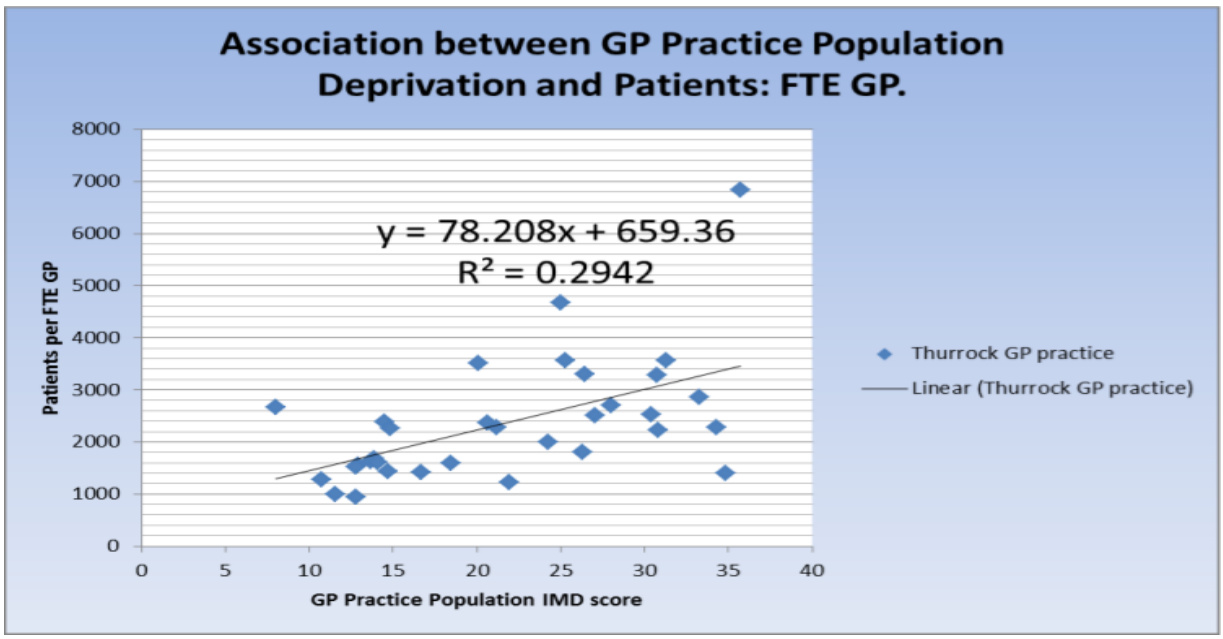
3.5 Workforce Constraints

Thurrock is significantly ‘under doctored’ with an average of 2,032 patients per FTE in 2014/15. All but four GP practices have list sizes per FTE GP that are greater than England’s.

The average number of patients cared for by a FTE GP in England is 1391.

Figure 8 (below), shows the association between GP practice population deprivation and ratio of patients: FTE GP in Thurrock.

Figure 8



We know that under-doctoring and nursing is a huge issue and people are waiting for an unacceptable length of time in order to obtain a GP appointment. We also know that if people cannot get a GP appointment they are more likely to use more expensive parts of the system such as A&E, and that under- doctoring leads to a reduced ability of GP practices to care proactively for patients with long term conditions, increasing the risk of patients experiencing an emergency event such as diabetic coma, stroke or other such event.

In Thurrock our vision is to provide more integrated health and social care services, and provide a more holistic population health approach to the way in which we commission services.

We are working with Health Education England (HEE) on a range of workforce transformation initiatives, in partnership with other Essex CCGs and healthcare providers to support recruitment, training, workforce development and specific projects to alleviate workforce-related pressures in the short, medium and longer term. Workforce planning will be a key part of our strategy in order to implement our vision, and create a sustainable care system for the future.

3.6 National Drivers for Change

3.6.1 Five Year Forward View

The Five Year Forward View (2014) sets out a clear direction for the NHS and how future services could be configured, including outcomes based commissioning. There is an expectation that when people do need health services, patients will gain far greater control of their own care. In addition the Care Act (2014) has a clear focus on wellbeing, preventing, reducing and delaying people's needs from developing. The Care Act sets out the integration agenda between local authorities and the NHS by making it a default position for the design and delivery of services.

3.6.2 Success Regime (Essex)

On 3 June 2015, the NHS Chief Executive announced that Essex (including Southend and Thurrock) is part of the first ever NHS Success Regime. The aim of the Success Regime is to provide increased support and direction to the most challenged systems in order to secure improvement in three main areas:

I. Short-term improvement against agreed quality, performance or financial metrics;
II. Medium and longer-term transformation, including the application of new care models where applicable;
III. Developing leadership capacity and capability across the health system.

Unlike under previous interventions, this success regime will look at the whole health and care economy: providers, such as hospital trusts, service commissioners, clinical commissioning groups and local authorities will be central to the discussions.

4 Our Vision for Care in the Future

The current system is built on a “reablement” ethos across all health and care services where the emphasis of all providers is to support the service user to gain or maintain their optimal potential level of independence however this is often not achieved.

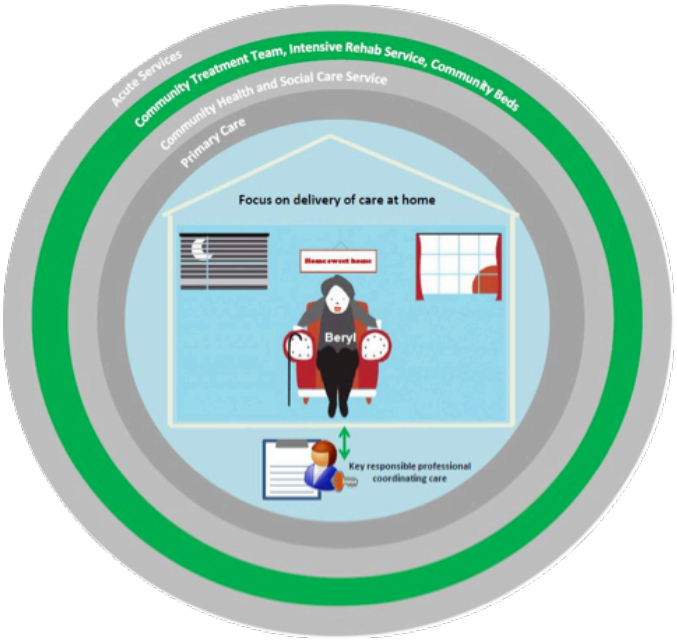
Successful delivery of our vision will require a range of out of hospital services which flex during changes in demand e.g. winter/summer, are based around local patient need as opposed to pre determined service models, and prioritise domiciliary care packages over bed based care but offer bed based care where required.

Our new models of care will be locality (neighbourhood) based and will be delivered through MDTs by fully integrated health and social care teams (based on the Thurrock local authority Joint Reablement Team (JRT) model, delivering coordinated care closer to or at home (see figure 9 below).

The locality (neighbourhood) based teams will align with the existing health hubs taking a virtual ward approach to providing care closer to or at home within each locality (neighbourhood), and with new developments in primary care estate as they emerge, and as outlined in the Primary Care Estate Strategy.

Patients will be identified by risk stratification through the Electronic Frailty Index currently being piloted by NELFT our community provider, and will received wider support to maintain wellness through links coordinated with the existing Local Area Coordinators (LACS) and local voluntary services, based on a social prescription model.

Figure 9 Our vision for Care Closer to home through integration and care coordination



This new model means that district nursing, pharmacy, dentistry, domiciliary care teams will work in partnership to develop care plans that are personalised, holistic, and are delivered by specialists from across the health and care system. Care will be co-ordinated around the patient as opposed to traditional organisational and service structures.

The voluntary sector will also play a key part in helping communities to support and maintain the independence.

4.1 What this will mean for patients

Our patients often tell us that they find the health and care system overwhelmingly complex and disjointed. While there have been major improvements in health and care services recently, these improvements have not kept pace with changes in society over the years, and if these are not addressed we know the system will struggle to meet future needs.

We also know that the system is not currently set up to cope with the rapid growth in demand for health and care service. By developing our vision and enhanced locality (neighbourhood) based teams, we will be in a better position to meet that demand and to offer care closer to or at home for our local population.

4.2 Patient and Service User Involvement

We are committed to providing the best services we can for our population to meet their current and future needs, and recognise that we will only know if we are doing this if we ask.

We are fortunate in that our local Health and Social Care Engagement Group which meets monthly includes members of Thurrock Council, Thurrock Coalition, the CCG, HealthWatch and Thurrock CVS and we have been using this forum as a sounding board during the developing phase of the vision to ensure we continue to get the message right, and communicate it in the best way possible.

With their advice and feedback we produced a Public Facing Document, which will give people the opportunity to tell us whether they think that our vision is right for the Thurrock population.

We will also work with them to engage our local population (tapping into and learning from engagement currently underway to gauge views on the refreshed Health and Wellbeing Strategy), and will be commissioning support from HealthWatch and Thurrock Coalition to help us gain feedback from a widely representative group of at least 1% of our local population over the first quarter of this year.

The results of our engagement will be published on our website.

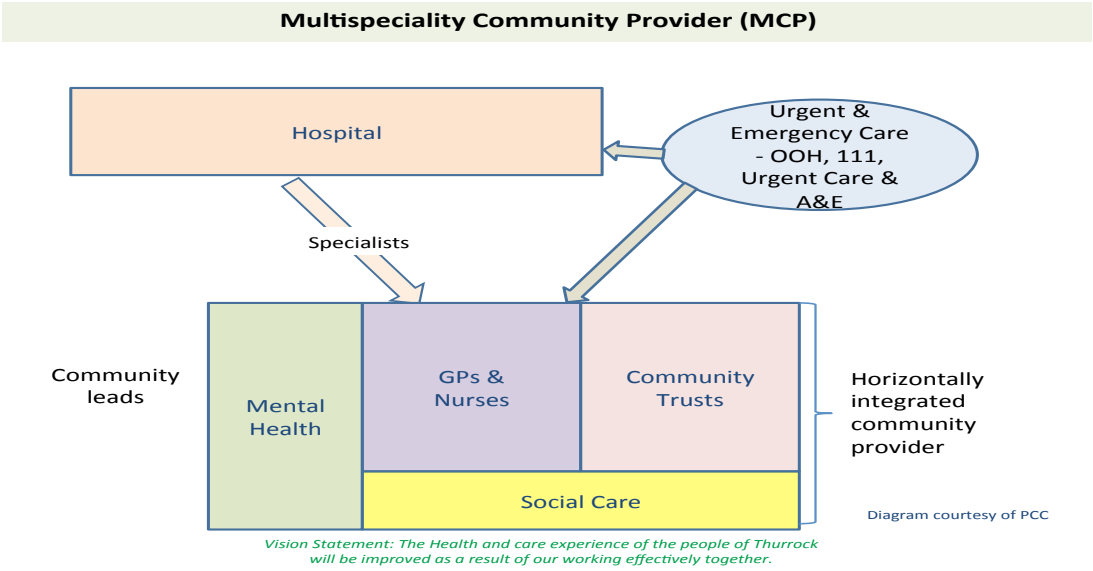
5 New Models of Care

NHS England's Five Year Forward View invites local systems to propose co-creating new models of care and organisation locally.

The document identifies (but does not limit us to) four possible models:

- Multispecialty community providers (MCPs), including a number of variants
- Integrated primary and acute care systems (PACS)
- Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms such as specialist franchises and management chains
- Models of enhanced health in care homes.

Figure 10 Multispecialty Community Provider (MCP) Model



5.1 Our New Service Model

Our model of care whilst not designed specifically as such does seemingly predominantly match the makeup of a Multi-speciality Community Provider (MCP) and as such organically take us into the realms of the types of models currently being tested through the national vanguard sites (see figure 10 above and what that might look like for Thurrock at figure 11 below).

Under this new care model outlined in the Five-Year Forward View, groups of practices would expand bringing in nurses and community health services, hospital specialists and others to provide integrated out of hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out of hospital settings.

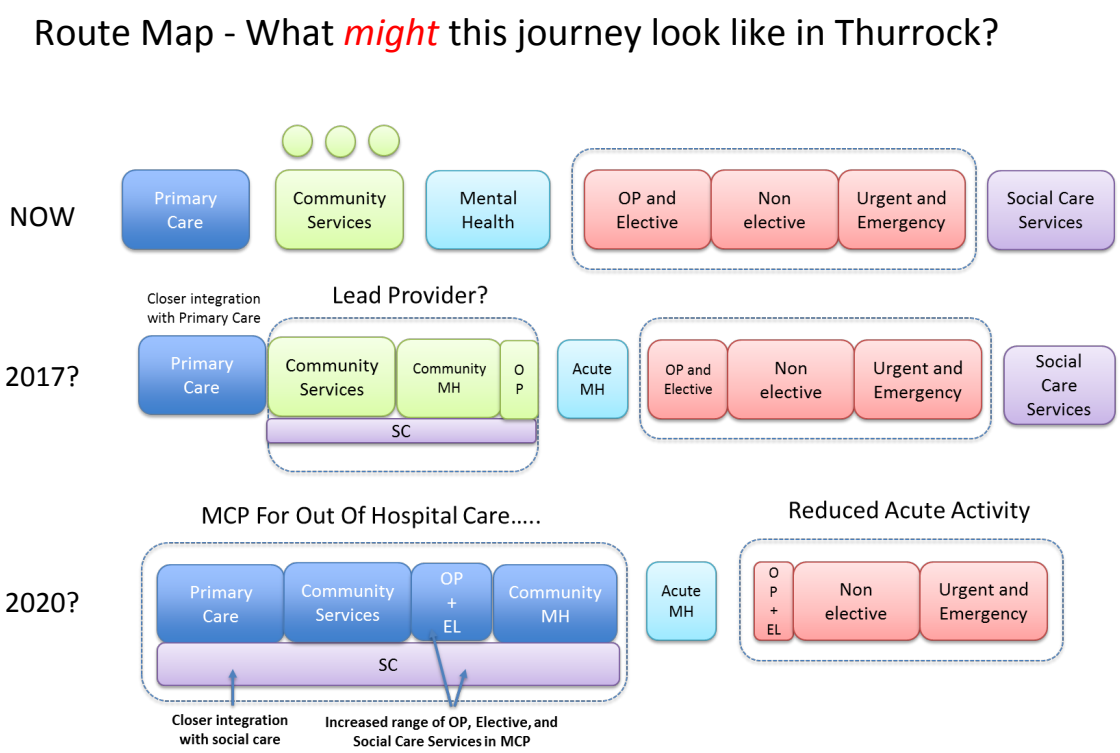
Over time, these providers might take on delegated responsibility for managing capitated NHS budgets (or combined health and social care budgets) using a place based commissioning model to commission outcomes based services for their registered patients.

This model also offers the opportunity to reduce the number of contracts and thereby, the associated administration, monitoring and management costs incurred in keeping them on track.

We have the opportunity to shape and deliver a future model of care, which works for the population of Thurrock (and southwest Essex), rather than subsequently receiving direction in later years on a model of care which we should adopt and there was wholehearted support at the recent Board Seminar for the Thurrock transformation approach.

We also have the opportunity to review and reshape how and where our urgent care is provided and this will form another strand of work within the transformation programme.

Figure 11 What the journey to an MCP Model might look like for Thurrock
(developed by Attain for a Board Seminar Session November 2015)



Vision Statement: The Health and care experience of the people of Thurrock will be improved as a result of our working effectively together.

5.2 Objectives for our New Service Model and greater focus on Outcomes

We have been working with CCG colleagues and partners to agree a set of whole-system outcomes which apply across organisational boundaries in the form of a multi-agency incentive scheme through the co-alignment of CQUINs / Enhanced Payments.

The proposed scheme (outlined in figures 12, 13 and 14 below) is currently being shared with partners and provider colleagues.

Figures 12, 13 and 14: Development of whole-system outcomes in the form of a multi-agency incentive scheme through the co-alignment of CQUINs / Enhanced Payments.
Figure 12 Background and Current Position

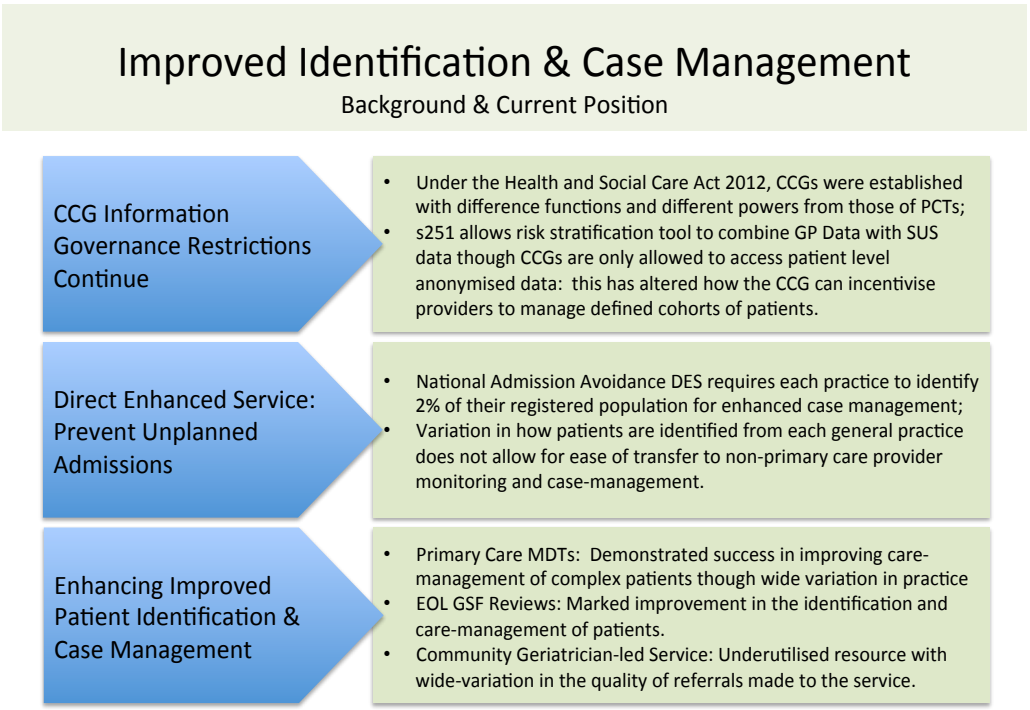


Figure 13 Whole-system Service Improvement

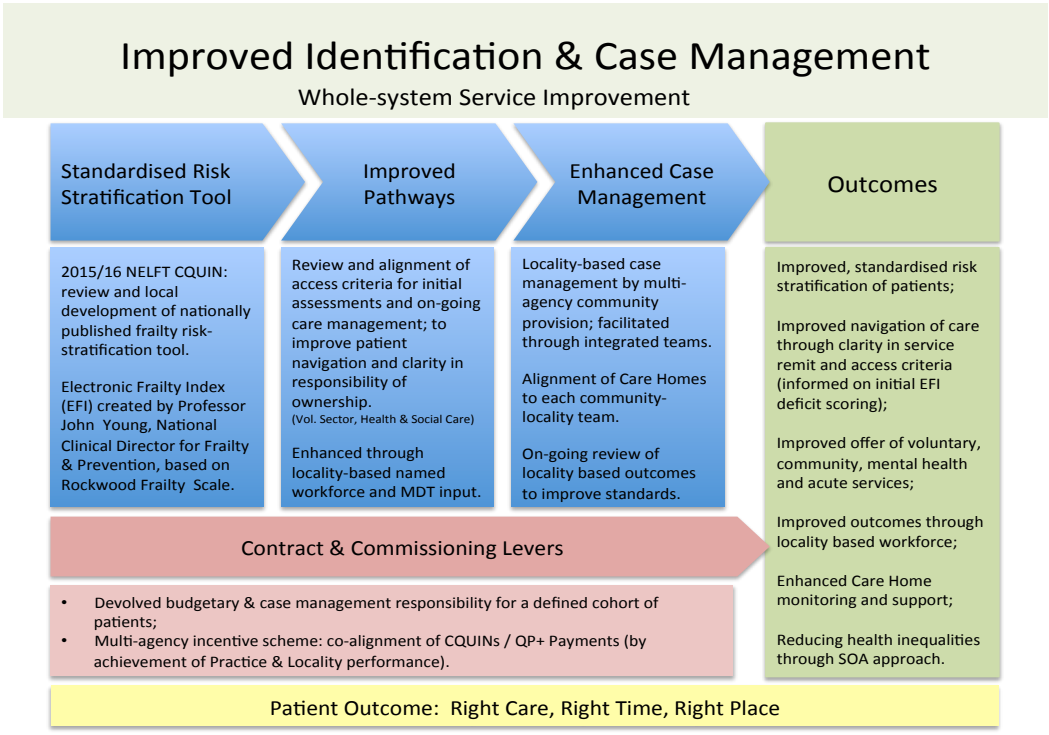
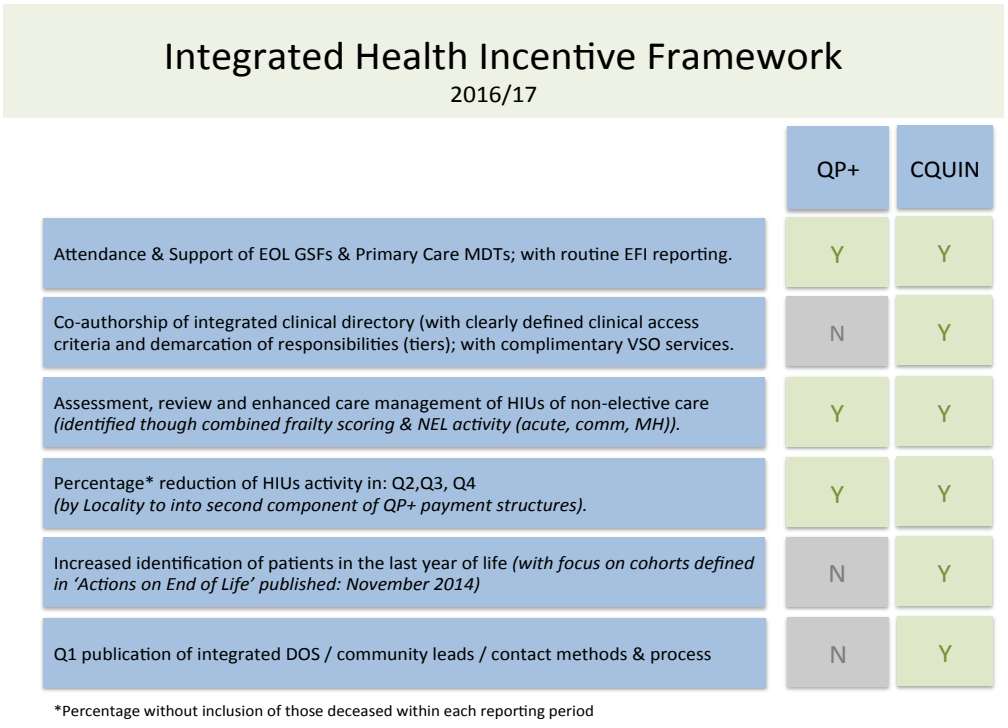


Figure 14 The Framework



Integrated Health Incentive Framework

2016/17

	QP+	CQUIN
Attendance & Support of EOL GSFs & Primary Care MDTs; with routine EFI reporting.	Y	Y
Co-authorship of integrated clinical directory (with clearly defined clinical access criteria and demarcation of responsibilities (tiers); with complimentary VSO services.	N	Y
Assessment, review and enhanced care management of HIUs of non-elective care *(identified though combined frailty scoring & NEL activity (acute, comm, MH)).*	Y	Y
Percentage* reduction of HIUs activity in: Q2,Q3, Q4 *(by Locality to into second component of QP+ payment structures).*	Y	Y
Increased identification of patients in the last year of life *(with focus on cohorts defined in 'Actions on End of Life' published: November 2014)*	N	Y
Q1 publication of integrated DOS / community leads / contact methods & process	N	Y

*Percentage without inclusion of those deceased within each reporting period

6 Our Service Development Process

We have already defined what we thing our new care model should look like, and have been working through the impact of this on our current health and care system with our system partners.

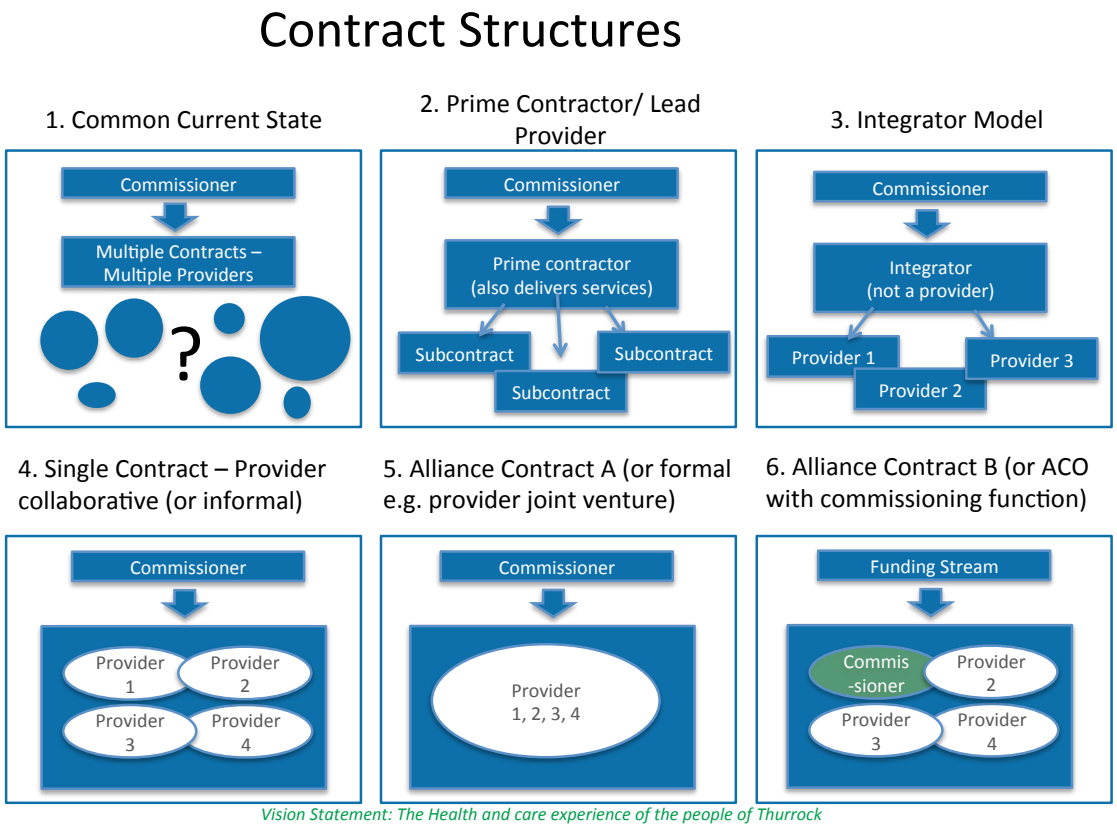
Our future care delivery system will include detailed pathway redesign, activity and financial modelling, workforce planning, and working through the full range of enabling infrastructure such as estates and IT connectivity. We have started the process of developing a plan that sets out the high level timeline required to develop the new care model through 3 phases over the next 3 years, and for phase 1 over the first 9 months.

A more detailed programme plan has also been developed to set out the tasks and actions required to further develop the new care model. This informs our governance for the programme.

6.1 New Financial Flows

We recognise that integrated care delivery models will require radical changes to the way we fund care and we are already exploring how as part or our integrated community teams we deliver co-ordinated care for our frail and elderly population. Our neighbouring CCGs are working on developing capitated models for frail and older people, and in addition pilot "Vanguard" sites are testing a range of different models. All of these will contribute to our work on developing appropriate funding and contracting methods for the integrated co-ordinated care model that might resemble one of the structures outlined in 15 below.

Figure 15 Contractual structures supporting the delivery of new models of care
(developed by Attain for a Board Seminar Session November 2015)



6.2 User Engagement / Involvement

We are committed to providing the best services we can for our population to meet their current and future needs, and recognise that we will only know if we are doing this if we ask.

We are fortunate in that our local Health and Social Care Engagement Group which meets monthly includes members of Thurrock Council, Thurrock Coalition, the CCG, HealthWatch and Thurrock CVS and we have been using this forum as a sounding board during the developing phase of the vision to ensure we continue to get the message right, and communicate it in the best way possible.

We are also fortunate in having the support of a Patient Champion for the programme.

In addition, our Commissioning Reference Group (CRG) is providing supportive challenge as a critical friend to help guide us on our journey. The CRG is an advisory body to the CCG and helps us to fulfil our statutory duty to engage with and involve the public and patients in healthcare decisions. The chair of Thurrock CRG also serves on Thurrock CCG's Governing Body as a Lay Member (Patient and Public Involvement) and sits on the Thurrock Health and Wellbeing Board.

6.3 Engagement with our Partner & Provider Organisations

We have already been working closely with our system partners on a range of service developments and are committed to continue to work with them as we embark on our transformational journey.

The first phase of the transformation programme includes out of hospital adult care, and localising community and mental health (initially organic) in hospital adult care services **"For Thurrock in Thurrock"**. To this end are already taking steps to further scope the development of the out of hospital adult care model by working with our local authority and provider colleagues to identify workforce needs with a view to jointly commissioning fully integrated locality based health and care teams.

The locality based health and care teams will need to be mobilised before implementation of the vision can formally commence and we are working closely with our acute, community and mental health providers to map and gap what we currently have and what workforce capacity, skills and capability we will need for the future.

The locality based health and care teams will work through multi disciplinary teams (MDTs) to delivery coordinated care as part of community offer to support the proposed locality (neighbourhood) Integrated Health Living Centres (outlined in 6.5 below), and provide care closer to or at home.

6.4 IT and Infrastructure

Timely, accurate and relevant Information supported by a robust and responsive infrastructure, which is confidential and ensures data security is critical to the commissioning and delivery of good health and social care.

We are currently working with other CCGs and the Local Authorities in Essex on a shared vision that will provide a patient focussed approach to information and technology that:

- Ensures that clinicians can access health records regardless of provider
- Uses technology to help patients manage their own health and wellbeing

- Allows patients to access various services using digital options
- Enables patients to navigate to the right service and book online appointments
- Allows patients to own and see their health records online.

We are also exploring alternative options to support better primary care access through the use of technology.

6.5 Estates

Thurrock is currently developing its Primary Care Estate Strategy with local health and social care partners across south west Essex. The strategy includes work already underway to look at new and innovative ways of ensuring the long term sustainability of Thurrock's more deprived localities highlighted in the local Joint Strategic Needs Assessment (JSNA), the localities being Tilbury and Purfleet.

Work to date has included a Tilbury Integrated Healthy Living Centre Needs Assessment from which, based on the needs identified in the report, a 'blue print' of recommended services has been provided for commissioners to consider providing/co-locating within any new facility.

Learning from the development of the Tilbury Integrated Healthy Living Centre will be used to inform future development options in Purfleet, Grays and Corringham over the next 3 years outlined in figure 17 in section 7 below.

We have also been in discussion with our local acute, community and mental health providers to explore the "art of the possible" to see whether we can come up with innovative ideas of how we might be able to use existing estate to support the proposed new care model going forward.

7 Timescale for Change

The High Level Plan below at figure 16 sets out the steps Thurrock CCG and its neighbour in Basildon and Brentwood will be taking in partnership with provider colleagues through the first 3 phases of the transformation programme, over the next 3 years. This includes work currently underway:

- Primary care estate development to support the provision of new models of care.
- Development of the new commissioning model to enable the new models of care.
- A joint outcomes based CQUIN signed up to by all providers to improve quality and standards, and to drive integration.
- A focus on education and workforce development to build capacity and capability to support the new models of care.
- Regeneration of Thurrock Community Hospital, developing the case for change whilst considering our population's urgent care requirements for future.

Figure 16 High Level Timeline for the next 3 years

Timeline	Now	2016-17	2017-18	2018-19
Commissioning Model	- Business Case - Support plan - Engage plan	Dialogue for Thurrock MCP	Appoint MCP for Thurrock - Locality 1	- Locality 2 - Locality 3 - Locality 4
Primary Care Estate	- Develop specification based on JSNA	Planning process based on Blueprint	Finalise plan and build Tilbury	Finalise plan and build Purfleet (tbc)
Locality Teams	- Draft and negotiate CQUIN	Locality CQUIN – Complex care team	Locality based integrated teams – Tilbury	- Locality 2 - Locality 3 - Locality 4
Thurrock Community Hospital Regeneration	- Business case and engagement	Phase 1 and 2 - Intermediate Care Review	Phase 3 – Functional mental health	
Urgent Care Requirements	- NELFT and SEPT negotiations	Joint working protocol (RRAS, DCST, CRHT)	Review and consult on MIU	Develop Urgent care centre (tbc)
Essex Success Regime	- Detail Feb 16	(tbc)	(tbc)	(tbc)
Workforce and Education	- Identify current capacity/gaps			
Governance and Engagement	- Southend and CPR re SW/SE Dementia - Provider Exec Sign-off - Future use of Buildings - MPs/HOSC etc - Public Facing Document			

We have also developed a high level timeline highlighting our priorities over the next 9 months (figure 17 below).

Figure 17 High Level Timeline for the next 9 months

	Governance (Board and H&WB)	Engagement	Commissioning Model	Primary Care Estate	ICR	Locality teams	Workforce	Thurrock Community Hospital	Success Regime
Dec	Project Mandate and plan	Stakeholder		Tilbury JSNA		Draft CQUIN	Review Baseline Staffing	Shape MIU Review	Shape ESR
Jan	Monthly update/ sign-off engagement Plan	Shape H&WB engagement and public facing document	Exec to Execs		Staff engagement, Community Spec (IC)	CQUIN Workshop		Review TCH estate	
Feb	Transformation strategy	First newsletter	Provider engagement	Thurrock JSNA	Recruit to IC posts	CEG CQUIN follow up	Shape ESR workforce plan		ESR Plan sign off
Mar	H&WB Strategy	Public engagement	Provider engagement	Building Blue Print	Staff engagement	Contract sign off		Orsett Estate Review	
April	Monthly update and sign-off	Public engagement	Outline Business Case		Divert IC patients				
May	Monthly update and sign-off	Public engagement						Consider opportunities	
June	Monthly update and sign-off	Outcome			Possible closure of ward	Risk Strat, DoS, Care co-ord.			STP sign-off
July	HWBB Update								
Aug	Monthly update and sign-off		Dialogue						

A more detailed programme plan has also been developed to set out the tasks and actions required to further develop the new care model. This informs our governance for the programme.

8 What does this mean for our Providers?

We have already been working closely with our system partners on a range of service developments and are committed to continue to work with them as we embark on our transformational journey. We know that to deliver our vision we will need to change the way we commission and deliver care and we are keen to work with our local providers to find new and innovative way of doing this. We need to be able to reduce current pressures on acute services and an enabler for this will our integrated locality (neighbourhood) based teams providing care closer to or at home for our local population.

We also know that delivering an integrated care delivery model will require radical changes to the way we fund that care and we are already exploring how we can do this by learning from the vanguards and their experiences, whilst at the same time ensuring we follow public sector procurement rules.

We recognise that like the CCG, our providers are also exploring the new models landscape and are considering its implications for their futures, and are committed to continue working with them to find the best solution (new model of care) for our population.

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Thurrock Transformation Programme: Bringing our Vision to Life

1 Purpose and background

The purpose of this paper is to:

- Provide an update on progress as we move through the first phase of our transformation programme
- Seek the Board's approval for the proposed investment in the enhanced integrated care teams to support care closer to or at home.
- Propose a revised approach towards achieving our new model of care.

In summary, our vision and the aspiration of developing an MCP remain as set out in our Transformation Plan however an alternative to structured dialogue has emerged from recent system partner engagement which could be the perfect vehicle to help us achieve that end in a more collaborative and timely way.

2 Overview

The Thurrock Transformation Plan: Delivering our Vision, shared at the January Board is now coming to life as we work through the finer detail of the programme.

Agreement to the proposed changes in how and where intermediate care will be delivered is gaining strong support from the public and stakeholders alike, and confidence amongst system partners on the programme's ability to deliver is growing at a pace.

We know that successful delivery of our vision will require a range of out of hospital services which are based around local patient need as opposed to pre determined service models, and prioritise domiciliary care packages over bed based care but offer bed based care where required.

A notable achievement on that journey was the receipt in early March of a joint proposal from our community and mental health providers setting out their views on the required workforce capacity and level of investment required to fund fully integrated coordinated care closer to or at home.

We are currently reviewing the proposal for affordability but are confident that we will (by the end of March) have reaching agreement on the required level of investment in order for recruitment to then commence.

3 Engaging System Partners

Our journey since January has also seen us engaging with system partners, not just through meetings and discussions to firm up plans but also through Exec-to-Exec Meetings to share our Vision and gauge support.

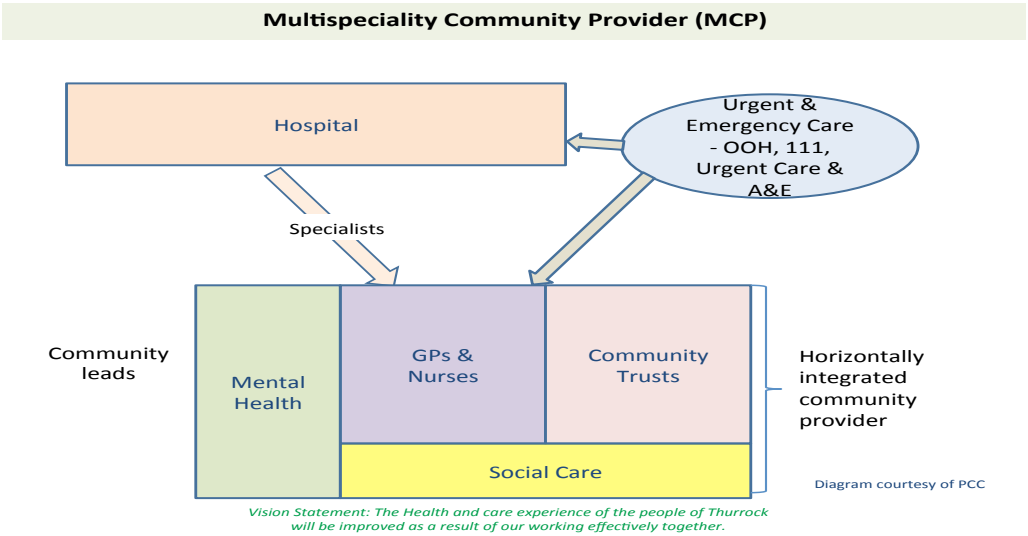
Another notable achievement has been their sign-up in principle to what we are aiming for and a willingness to work in partnership with us to make it happen.

This willingness has prompted further discussion with our system partners on whether there is an opportunity to take our first step as a system towards developing our proposed new model of care in line with the NHS England's Five Year Forward View by forming an Accountable Care Partnership (ACP).

4 New Models of Care

Of the new models of care outlined in NHS England's Five Year Forward View, whilst not designed specifically as such, our new care model does seemingly predominantly match the makeup of a Multi-speciality Community Provider (MCP) examples of which are currently being tested through the national vanguard sites (see figure 1 below and what we though that might look like for Thurrock at figure 2 below).

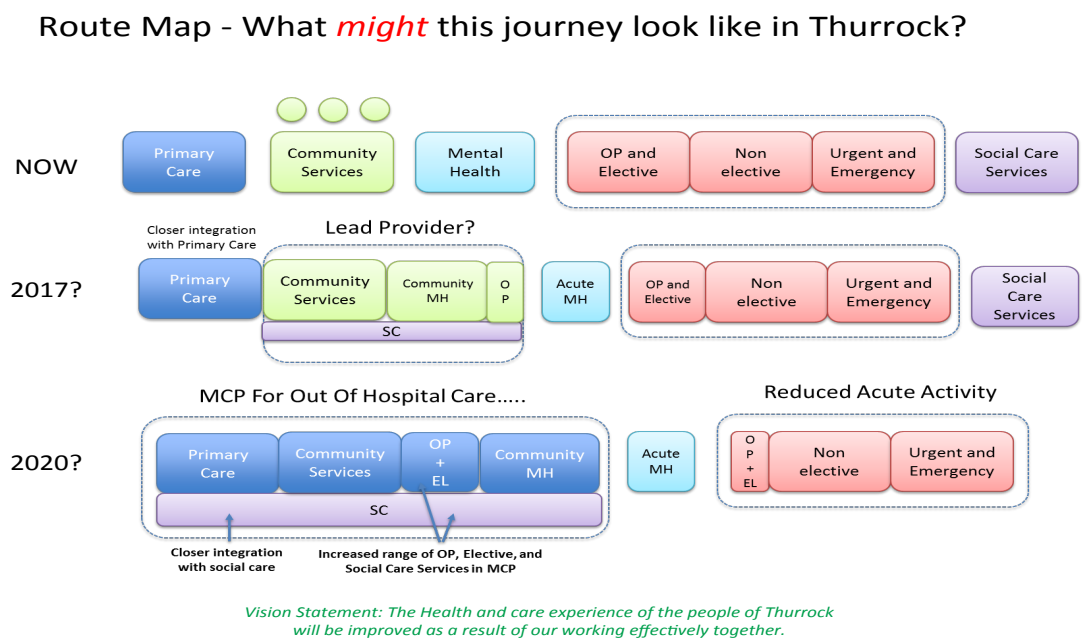
Figure 1 Multispecialty Community Provider (MCP) Model



Under this new care model outlined in the Five-Year Forward View, groups of practices would expand bringing in nurses and community health services, hospital specialists and others to provide integrated out of hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out of hospital settings.

Over time, these providers might take on delegated responsibility for managing capitated NHS budgets (or combined health and social care budgets) using a place based commissioning model to commission outcomes based services for their registered patients.

Figure 2 What the journey to an MCP Model might look like for Thurrock
(Developed by Attain for a Board Seminar Session November 2015)



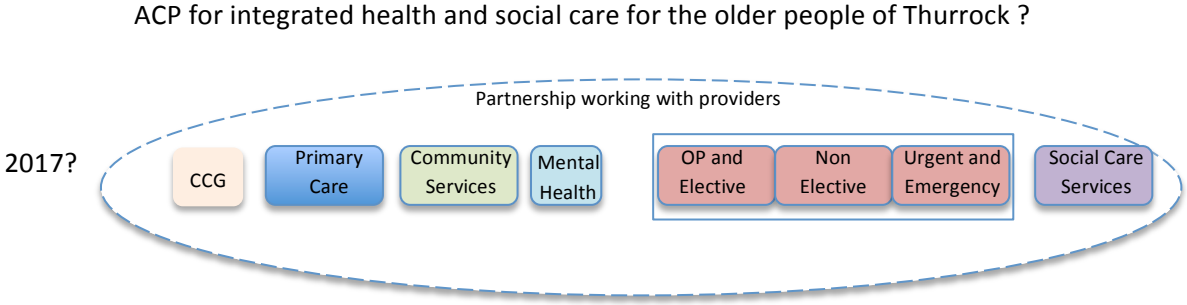
Whilst we are still in the early stages of our journey to becoming an MCP and were originally considering using a structured dialogue process to help us achieve that end, we now recognise that an Accountable Care Partnership may offer the perfect vehicle to help us get there in a more collaborative way.

5 Accountable Care Partnership (ACP)

Accountable Care Partnerships are new organisational forms, which integrate care around patients - and are accountable for the delivery and quality of that care. The partners include a range of providers working together to develop new ways of integrated working, governed by a form of partnership agreement.

Within this model, each partner organisation retains their own identify, autonomy and governance, but agrees to work in partnership to achieve a desired outcome.

Figure 3 Route Map – How an ACP might fit within Thurrock's journey if we take the model outlined in Figure 2.



6 Proposed Approach and Next Steps

For us, the first step to progressing this approach would be to establish the basic legal framework for an ACP and to decide the detail of what sits within that framework. This would give time to build trust and to work through any problems, before developing into a full MCP.

Therefore our next step would be to gain more formal agreement from system partners to the formation of an Accountable Care Partnership (ACP). This could initially focus on the provision of integrated health and social care for the older people as outlined in our Transformation Plan.

The partnership could have 2 distinct strands due to our differing local authority boundaries and state of readiness to progress:

- One with a focus on the older people of Thurrock.
- A parallel agreement for the older population of Basildon and Brentwood.

The following organisations would form the backbone of the Thurrock partnership: Thurrock Council, Thurrock CCG, BTUH, SEPT, NELFT, Thurrock GP Federations.

The next step would be to invite Hempsons to our next Board Seminar to take us through the pros and cons of the proposed approach and how it could be taken forward.

7 Recommendations

The Board are asked to note progress to date and to endorse the direction of travel as set out in this paper, and more specifically to:

- Approve the proposed investment in the enhanced integrated care teams
- Agree the revised approach towards achieving our new model of care.

15 September 2016	ITEM: 8
Report to Health and Well-Being Board	
Ofsted Inspection Report and Action Plan	
Wards and communities affected: All	**Key Decision:** To note Action Plan
Report of: Andrew Carter, Head of Children's Social Care	
Accountable Head of Service: Andrew Carter, Children's Social Care (CATO)	
Accountable Director: Rory Patterson, Corporate Director of Children's Services	
This report is Public	

Executive Summary

This covering report provides information on the outcomes of the recent Ofsted Inspection, the recommendations from the inspection and draft Action Plan to address the recommendations.

1. Recommendations

1.1 That the Health and Wellbeing Board note the outcomes of the recent Ofsted Inspection, recommendations and draft action plan to address the recommendations; and

1.2 That the Board receive assurance that action plan will deliver the required improvement.

2. Introduction and Background

2.1 All local authorities in England are inspected under the Single Inspection Framework (SIF) within a three-year period. The Children's Safeguarding Board is inspected at the same time. The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers took place between 22.2.16 – 17.3.16. The full report of the inspection is attached to this report as Appendix 1.

2.3 In response to the recommendations of the Ofsted Report the department has drafted a detailed action plan. The action plan is attached to this report as Appendix 2.

3. Issues, Options and Analysis of Options

3.1 Services to children, young people and families in Thurrock were judged to 'Require Improvement' by Ofsted. The inspectors stated in their report that 'children and young people were found to be safe in Thurrock during this inspection, with none identified who were at immediate risk of significant harm without plans and services being in place to reduce these risks and to meet their needs'.

3.3 Ofsted has made 16 recommendations in relation to practice improvements that are required in Thurrock. The 16 recommendations can be found at page 7 & 8 of the Ofsted Report. Key areas of concern included:

- The instability of the social care workforce. The service was dependent on a high proportion of agency social workers, although it was acknowledged that a range of creative ideas had been implemented to improve recruitment;
- The service for children looked after was not consistent and too many children became looked after on an emergency basis:
- More needed to be done to increase the number of in-house foster carers as too many children and young people were placed out of the borough;
- Management oversight needed to be improved and frontline staff had to be supervised regularly to improve the quality of practice;
- The organisation's use of management information and quality assurance was poor and this impedes improvement; and
- Training for all social workers to ensure permanence work with children starts earlier and that delay is avoided.

3.4 A one page summary of the report for children and young people can be found at page 9 of the Ofsted Report.

3.5 The local authority is required to prepare and publish a written statement of the action it intends to take in response to the report. It should send a copy of this to Ofsted within 70 working days of receiving the final report. A detailed action plan has been completed by the department and submitted to Ofsted by the deadline on 31 August. The plan was quality assured by the regional Ofsted Inspector and the Inspector who lead the inspection before submission.

3.6 An improvement Board has been established to ensure that all of the recommendations and other areas for improvement have been implemented. The Board is chaired by the Corporate Director of Children's Services. The Portfolio Holders for Children and Adults and Education and Health will provide an additional layer of oversight and challenge through by monitoring progress against the action plan on a monthly basis.

3.8 Ofsted is currently consulting on a new inspection framework where it is proposed that those authorities who were judged Requires Improvement will receive another inspection within three years. In addition, it is anticipated that

new modular inspections will be undertaken in the next year. These inspections are carried out over 2-3 days to test whether authorities are making the requisite progress with their improvement plans. Furthermore, social care departments will be expected to submit an annual self- evaluation to Ofsted which must evidence improvement. While this is discretionary, failure to do so could trigger a full inspection of the service.

4. Consultation

N/A

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

The completed action plan will allow the council to meet and improve upon its core statutory functions in the delivery of services for children in need of help and protection, children looked after and care leavers.

6. Implications

6.1 Financial

Implications verified by: **Kay Goodacre**

Finance Manager

There are no immediate financial implications for the authority arising out of the action plan.

6.2 Legal

Implications verified by: **Lindsay Marks**

Principal Solicitor, Children's Safeguarding

The Local Authority has a statutory duty to provide services to children in need of help and protection, failure to effectively do so could lead to legal challenges and reputational damage. The Local Authority is required to provide clear evidence of how it is implementing the inspection recommendations.

6.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The local authority and its partners must ensure that a range of services and provision is in place to protect children from all backgrounds. In implementing the action plan the authority must ensure that improvements are made for children and young people from all backgrounds and that none are directly or in-directly discriminated against.

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

N/A

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

Ofsted Single Framework Inspection Report dated 24.5.16

8. Appendices to the report

Ofsted Single Inspection Report & Local Authority Draft Action Plan

Report Author:

Andrew Carter

Head of Service

Children's Social Care

Thurrock Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 22 February 2016 to 17 March 2016

Report published: 24 May 2016

Children's services in Thurrock Council require improvement to be good		
1. Children who need help and protection		Require improvement
2. Children looked after and achieving permanence		Require improvement
	2.1 Adoption performance	Require improvement
	2.2 Experiences and progress of care leavers	Require improvement
3. Leadership, management and governance		Require improvement

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Services to children, young people and families in Thurrock require improvement. Children and young people were found to be safe in Thurrock during this inspection, with none identified who were at immediate risk of significant harm without plans and services being in place to reduce these risks and to meet their needs.

While there are pockets of good practice across all areas of children's social care, the majority of practice is less than good, specifically much of the core business regarding assessment and planning for children, securing a stable workforce, supervision and management oversight. In the last inspection of safeguarding and looked after children services in 2012, the local authority was judged to be good. Following this inspection, senior officers and leaders did not continue to ensure that children and families received consistently good services.

The local authority has addressed effectively almost all areas for improvement that were identified at its last inspection, including its response to referrers, access to a range of leisure activities for children looked after and implementation of early help assessments. However, the quality of assessments and plans for children in need, including children with a disability, those in need of protection, children looked after and care leavers, requires improvement.

The local authority appointed a new permanent head of children's social care in October 2014, a new chief executive in September 2015 and an interim director of children's services (DCS) in late January 2016, pending the swift appointment of their new DCS who is due to start in May this year. These appointments have been of highly skilled professionals who have demonstrated their positive impact on services in a relatively short time.

Most children benefit from early help provided by a range of strong commissioned services. Children who have more complex needs and require a coordinated response do not always receive such effective early help and support. The local authority does not ensure that all children who have been missing from home or care benefit from a return home interview after they have been missing. Children in need of protection receive a swift and appropriate service, but children in need often experience delay in seeing their social worker for an assessment of their needs. Children are not effectively supported to attend and participate in their formal review meetings. When these meetings take place, reports and minutes from previous meetings are often shared too late to be fully considered.

Children looked after do not receive a consistently good service, and too many become looked after in an emergency. The recruitment of foster carers is not resulting in an appropriate range of local placement options, and too many children live outside the borough, away from their communities, families and friends. Children looked after achieve well relative to their peers in the early years. Outcomes for children looked after at the end of key stage 2 have improved significantly, but are still below outcomes for all children. However, educational outcomes for children looked after who are taking GCSE examinations are poor. Personal education plans are not sufficiently detailed. The virtual school does not effectively monitor the educational progress and outcomes for the majority of children looked after who live outside the borough.

Waiting times for children with a plan for adoption are reducing. However, workers within mainstream social work teams do not consistently consider adoption for all children who cannot return home. Post-adoption support is insufficient for children and families who are entitled to this service. Care leavers receive good day-to-day support, but not enough young people are benefiting from staying put arrangements after they turn 18 years, and they do not all receive effective support to transition into adulthood. Pathway reviews are not being undertaken within timescales.

The local authority's use of performance management and quality assurance information across all areas of the service is poor, and impedes any improvement needed. Use of feedback from children and families to inform service development is underutilised. Accurate data regarding performance is collated, but managers do not analyse this data in order to inform service developments. There are weaknesses in the analysis of social workers' activity in relation to timeliness (for example, of multi-agency safeguarding hub (MASH) processes and assessments), the consideration of trends from return home interviews and 'children missing education' information, the overview and analysis of findings from audit, and the full analysis of key factors affecting services for children in need of protection and children looked after.

The instability of the workforce leaves services vulnerable. The local authority is fully aware of the workforce challenges and has a range of creative initiatives in place to address this in the longer term. Management oversight of frontline practice is inconsistent, with too many areas of weakness, and results in a lack of effective challenge to progress children's plans and effect change for children. Currently, the local authority does not systematically ensure that the workforce receives supervision of sufficient quality and frequency.

Some elements of services to children and their families have improved. The local

authority's Multi-Agency Safeguarding Hub (MASH), for example, is securing strong information sharing between professionals and robust decision making regarding appropriate services for children and their families. Management oversight within the MASH is very strong. Other improvements include the response for children who are at risk of child sexual exploitation, which reduces their risks. The authority has also substantially improved its offer to teenagers, the vast majority of whom receive a good service from the adolescents team.

Despite changes of key personnel, the local authority has greatly improved its corporate and cross-party political support for children's services. The local authority had a recent peer review of its corporate arrangements by the Local Government Association, which endorsed the strong working relationships seen during this inspection. Effective support from the political leadership is evident through the challenging overview and scrutiny function, and in the proactive Health and Wellbeing Board.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection of the local authority's safeguarding arrangements was in June 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in June 2012. The local authority was judged to be good.

Local leadership

- The interim director of children's services has been in post since January 2016.
- The chair of the Local Safeguarding Children Board has been in post since August 2012.

Children living in this area

- Approximately 40,093 children and young people under the age of 18 years live in Thurrock. This is 25% of the total population in the area.
- Approximately 21% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 14% (the national average is 16%)
  - in secondary schools is 14% (the national average is 14%).
- Children and young people from minority ethnic groups account for 22% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic group of children and young people in the area is Black or Black British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 17% (the national average is 19%)
  - in secondary schools is 10% (the national average is 15%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data, where this was available.

- Thurrock has the highest rate of unaccompanied asylum-seeking children (UASC) in the eastern region: 20.7 children per 10,000 population. The number of UASC has doubled in the last 12 months. In December 2015, one in four children looked after was a UASC.

Child protection in this area

- At 22 February 2016, 1,609 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,563 at 31 March 2015.
- At 22 February 2016, 263 children and young people were the subject of a child protection plan. This is an increase from 201 at 31 March 2015.
- At 22 February 2016, two children live in a privately arranged fostering placement. This is a reduction from seven at 31 March 2015.
- Since the last inspection, four serious incident notifications have been submitted to Ofsted and five serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 22 February 2016, 336 children are being looked after by the local authority (a rate of 87.2 per 10,000 children). This is an increase from 280 (70 per 10,000 children) at 31 March 2015.
  - of this number, 245 (or 72.9%) live outside the local authority area
  - 31 live in residential children's homes, all of whom live outside the authority area
  - one lives in a residential special school[3] outside the authority area
  - 238 live with foster families, of whom 65.1% live outside the authority area
  - five live with parents, of whom two live outside the authority area
  - 77 children are UASC.
- In the last 12 months:
  - there have been 18 adoptions
  - 25 children became subjects of special guardianship orders

[3] These are residential special schools that look after children for 295 days or less per year.

- 114 children ceased to be looked after, of whom 5.3% subsequently returned to be looked after
- 21 children and young people ceased to be looked after and moved on to independent living
- no children or young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that accurate performance data is analysed and that this leads to specific actions for improvement.

2. Strengthen oversight, coordination and quality assurance of early help services to ensure that children and families are receiving the right support at the right time.

3. Ensure that assessments and plans for children are of a consistently high quality.

4. Improve the offer of return home interviews to children and young people who have been missing from home or care to increase take-up of these interviews.

5. Ensure that more children are supported to participate in, and contribute to, their meetings, conferences and reviews, that they and their parents have access to reports beforehand, and that meeting minutes are circulated promptly.

6. Ensure that robust arrangements are in place to reduce the need for children and young people to become looked after in an emergency.

7. Ensure that the recruitment of foster carers is appropriately targeted, better to meet the current and future demand for foster placements, and to reduce the number of children looked after who have to be placed out of the borough.

8. Ensure that personal education plans are of a consistently high standard and that the virtual school monitors and analyses effectively the progress of all children looked after, including those who attend schools outside of Thurrock.

9. Ensure that managers oversee and drive forward permanence plans for children effectively.

10. Develop post-adoption support arrangements to ensure that all children and families who are eligible have access to an appropriate service.

11. Ensure that an effective 'staying put' policy makes it possible for more young people to live with their former foster carers beyond the age of 18 years.

12. Ensure that pathway assessments and plans are developed to engage care leavers effectively, and that care leavers benefit from regular reviews.

13. Ensure that care leavers are supported to gain independence skills effectively, including through the setting of aspirational targets to help them to achieve educational and employment goals.

14. Secure a more stable workforce to ensure that children are able to build enduring relationships with social workers and to enable the local authority to drive through improvement to services, such as increasing early planning for permanence for children that starts at the front door.

15. Ensure and demonstrate that children's and families' views and feedback are used well to shape service developments.

16. Regularly audit supervision files to ensure that frequency and quality of supervision are resulting in improved practice.

Summary for children and young people

- Services to children and families in Thurrock require improvement. This means that the local authority has not maintained the quality of services since its last inspection in 2012, when services were judged to be good.
- Managers do not effectively use the information that they have about the performance of children's social care to understand what is going well or less well, or to help them to plan relevant improvements to services.
- Early help to children and their families is often helpful when only one service is involved. However, when children's needs are more complex and several services need to be involved to help them, these services do not always work well together to provide effective help to children.
- Most children who need a social worker are properly referred for this service. However, there are a small number of children who experience increasing levels of need and risk, and are not referred for a social work service quickly enough.
- The council set up a new team in 2014 to manage referrals for children: the multi-agency safeguarding hub (MASH). This team is doing some very good work. There is a range of professionals from different agencies within this team and they work closely together to share information and make good decisions about who should be working with children and families to meet their needs.
- Children who need immediate protection are seen quickly, and professionals work well together to make sure that any immediate risk is reduced. For those children who are in need, there is often a delay in seeing their social worker.
- The quality of assessments and plans for children, including those in need of protection, those who are looked after and care leavers, are not good enough. Managers do not monitor social workers and the progress of plans well enough, which means that there is sometimes a delay in things changing for the better for children and their families.
- The vast majority of teenagers receive a good service from the adolescents team. They have detailed assessments of need and effective plans.
- Younger children looked after are doing better at school, but most teenagers looked after are not supported to achieve good grades in their GCSEs.
- Although improving, there is still some delay for children who are being adopted.
- Managers have worked well to make sure that children who are at risk of child sexual exploitation receive a good service that reduces their risk.
- When children have been missing, return home interviews help them to talk through any issues. However, not all children receive an interview.
- There is a Children in Care Council, but managers and politicians need to do more to make sure they listen to the children and care leavers of this council.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Early help commissioned services are effective and underpinned by a comprehensive early help commissioning strategy. However, oversight and monitoring of early help is not fully developed, so not all children and families receive early intervention and coordinated services at the time that they need it. Thresholds across early help and children's social care are not always applied appropriately, leading to delays in a small number of children and families receiving timely support.

Strong multi-agency partnership working ensures that urgent responses to protect children are established through the multi-agency safeguarding hub (MASH). Contacts are progressed quickly and receive effective management oversight, and appropriate consent is obtained from families.

The majority of social work intervention for children in need requires improvement. There are some examples of more positive practice, but this is inconsistent across the service. Weaker practice is particularly evident in assessments, planning and driving change for children. High caseloads and frequent changes in staff in some teams have had an impact upon relationships with children and families. For a minority of children, this means that change to meet their needs or reduce risk is not always timely or sustained.

A few children experience delays in being seen for an assessment of their needs. Feedback and advocacy for children and young people are not routinely used, and not enough children are supported to attend meetings. Plans are neither proactively driven forward to improve outcomes nor specific enough for families to know how to improve their circumstances.

Risks relating to child sexual exploitation are responded to well, and risk assessments tools are used effectively to reduce risks to children. Responses to children missing are inconsistent. Not all children receive a return home interview, and records from these are not always uploaded into children's records. When completed, return home interviews are of good quality.

While there is detailed oversight of individual children missing education and children electively home educated, the local authority does not routinely analyse and evaluate the data on them to respond to trends or to inform service development.

Inspection findings

17. A comprehensive early help commissioning strategy is in place, and appropriate early support is available for most children and families. This includes an effective range of commissioned services which are leading to improved outcomes for children and their families. Although all universal services are signed up to the offer of early help across the local authority area, children's centres and health visitors currently underuse early help assessments to inform their work with children and families. This means that they are not effectively coordinating early support for children and their families with other agencies.

18. When children and families with more complex needs require a coordinated early help response by more than one agency, there is some variability in practice. For most children, the local authority's early help team oversees these cases effectively, providing support to lead professionals, and makes good use of the multi-agency group (MAG) panels in the locality to clarify additional support needs for children and their families, and to signpost relevant services. For a small minority of children, there is insufficient monitoring and quality assurance of the early help offer, which results in a lack of assessment and a lack of a successful offer of help. The local authority recognises that coordination and oversight of early help are an area for improvement. It is currently exploring relevant options to achieve this (Recommendation).

19. Thresholds are understood, and are being appropriately applied in the large majority of cases, which means that children's and young people's needs are effectively risk assessed and their cases stepped up to children's social care when required. However, a small number of children do not receive the right help at the right time, or help that is proportionate to their needs and risks. During this inspection, a small number of cases were raised where children would have benefited from receiving a social work service rather than early help. The local authority responded swiftly and robustly to ensure that these children's needs and risks were being appropriately recognised and addressed. Parents spoken to by inspectors shared their frustration at not receiving support in a timely way. Conversely, some children who could have received appropriate support though provision of early help have received a statutory service.

20. Effective step-down arrangements between children's social care and early help are not consistently in place. A lack of continuing oversight of children's cases that have been stepped down means that the local authority cannot be assured that all children continue to receive services that promote their welfare via early help after closure to children's social care. During this inspection, no children

were identified to be at immediate risk of significant harm without services in place to reduce risk and meet their needs.

21. The MASH provides a strong response to referrals for early help, troubled families and children's social care. Contacts made using early help assessments are variable in quality, with a minority lacking basic information that is needed to inform decisions fully regarding the most appropriate response. For children in need of protection, strategy meetings are identified swiftly and prioritised for urgent action.

22. The troubled families programme in Thurrock is successful. All 360 families in phase one were helped to turn around much earlier than the target deadline. Managers have set a target to build upon existing success, with a further 1,160 families being helped by 2020. Recently, a frontline troubled families worker has been based in the MASH to identify eligible families actively and to make sure that they receive a timely response. The proactive way in which the local programme is prioritising children with child protection and child in need plans is providing additional practical support to these most complex families.

23. Strong multi-agency performance and information sharing has enabled the MASH to respond to 96% of contacts within 24 hours over the past six months. Good use is made of risk assessment tools and children's family history, alongside clear management oversight and direction in all cases. Professionals obtain appropriate consent from families and, where the need for consent is overruled for the protection of children, the reasons for this are clearly recorded. Appropriate feedback following contact is provided to referrers in order to share the actions taken to promote children's welfare. An experienced and stable emergency duty team ensures that immediate responses to safeguard children out of office hours are effective. The MASH has a good reputation with professionals, who praise the holistic approach taken in responding to children's needs, the advice available to professionals and the range of information collated to help inform decisions to safeguard children.

24. When children need protecting, strategy meetings are timely and include professionals from an appropriate range of agencies. Development of the MASH has helped to secure routine engagement from health and police professionals in strategy meetings. This means that intelligence about risks to children is shared effectively, and demonstrates a real shared ownership of decisions to keep children safe. In a small number of cases, not all key professionals participated in strategy discussion to inform decision making, although minimal impact on decision making for individual children was seen during this inspection. However, the large majority of children in need experience a delay

in being seen after allocation by children's social care, including after a step up from early help. Additionally, some teams have high caseloads and have had many changes of staff, which means that not all children and families were able to develop trusting relationships with workers.

25. The large majority of child protection investigations are thorough, timely and informed by information gathered from relevant professionals and children's histories. Children are seen, and parental involvement and views are appropriately obtained. Responses to safeguard children are proportionate to risks identified, and effective actions are taken to ensure their safety and welfare.

26. Developments to safeguard children at risk of female genital mutilation, as part of a Department for Education-funded innovation project, are beginning to improve awareness of this safeguarding issue across agencies. Referrals to the MASH have increased since December 2015, but further awareness raising is needed to ensure that all children who may be at risk of female genital mutilation in the local authority area are identified and appropriately supported.

27. Assessments of children's needs, risks, strengths and wishes vary in content and quality. Most assessments do not identify the impact of risks or family history for children well, and only a minority fully explore the child's experience. Consideration of identity, diversity and cultural needs, or how these can increase children's vulnerability, is inconsistent, and these needs are identified only in a small minority of assessments. These include assessments completed for children with disabilities, where evidence that social workers know the children well is not always clear and the impact of disability on children's identity is not fully addressed. Too few assessments contain the views of children. Their experiences do not routinely inform decisions made for them. Although there are systems in place to review the progress of assessments, these are not robust. A lack of management oversight contributes to drift in achieving change for a minority of children (Recommendation).

28. Child protection conferences are well attended by relevant agencies and include positive multi-agency engagement. Families do not always receive child protection reports in time to be able to prepare adequately for meetings, and advocacy is not routinely accessed for those families that would benefit from additional support. Children's assessments are used for initial and review conference reports, but do not always clearly record what changes and actions have been taken or progressed to safeguard children. The local authority is reviewing this, but a new process is not yet in place (Recommendation).

29. Child in need and child protection plans do not consistently address children's needs and are variable in detail. Half the plans seen require improvement to ensure that clear outcomes are identified and specific outcome targets set for individual children. In a small minority of cases, poor management oversight has led to drift in plans being progressed, and they are not updated following reviews. Few plans seen by inspectors showed evidence of strong management oversight and direction. However, core groups are held regularly, and are appropriately attended by parents and the relevant professionals in order to review and progress plans. When cases transfer between teams, risk assessment tools are appropriately used to identify actions, and appropriate challenge by managers is evident (Recommendation).

30. Positive and focused work with most teenagers and their families is completed by the adolescents team. This includes effective use of the child sexual exploitation risk assessment and adolescent neglect tool, when relevant, to support young people in need, including those in need of protection. Clear, directive and creative plans help professionals to prevent family breakdown and provide effective direct work with young people.

31. At the time of inspection, 263 children were subject to child protection plans, which is a substantial increase from the 201 who were subject to a plan at 31 March 2015. Managers have explored the reasons for this increase and appropriately identify that it is in response to stepping-up cases where no meaningful change or reduction of risk for children was being achieved at the child in need level. During this inspection, no children were found to be subject to child protection plans who did not require this level of statutory intervention.

32. At the time of this inspection, there were 125 children subject to child protection plans due to risk of emotional abuse, 120 due to neglect, six due to risk of physical abuse and 12 due to risk of sexual abuse. The local authority removed the category of multiple abuse by the end of January 2016 after a review revealed that the category was masking information regarding the risk of sexual abuse. This led to an increase in children who were subject to child protection plans for risk of sexual abuse, from 1% to 5%, since March 2015. There has also been an increase in the use of the category of emotional abuse, from 26% to 48% in the same period. The local authority is appropriately reviewing this in order to gain a fuller understanding of the issues leading to this increase. Effective child protection surgeries with senior managers are held in order to review progress and to reduce risk for children who have been subject to child protection plans for a nine-month period or longer. The additional oversight provided by these surgeries has helped the local authority

safely to manage down the number of children remaining on child protection plans for over two years.

33. Social workers recognise and respond well when children are at risk of sexual exploitation. Good use is made of the pan-Essex risk assessment tool to identify those who are most at risk. This leads to strategy meetings for those with complex needs to share information and to develop a strong, coordinated, multi-agency response for individual children. The child sexual exploitation coordinator provides social workers and managers with effective challenge, advice and guidance. Although the local authority currently keeps separate data in respect of children missing from home, school or care, and those at risk of child sexual exploitation, the operational risk assessment group rigorously cross-checks data against the most recent list of children reported as missing to the police to ensure that individual children are safeguarded and protected. However, the group is not using data collected from return home interviews to inform planning for these vulnerable children.

34. Appropriate referrals are made to a commissioned service to deliver return home interviews, but the large majority of children decline the offer of a return home interview after they have been missing. When they are completed, the return home interviews are rich in information about the child's life, home circumstances, who their friends are and places where they like to go. However, these records are not reliably uploaded to children's local authority records. This limits the potential use of this information to plan actively to reduce risk for children and young people (Recommendation).

35. The local authority has developed a range of good initiatives to help children and young people, including children looked after, to keep themselves and others safe from issues such as from bullying and online grooming. Successful projects such as 'Show racism the red card' are used in schools to deliver key messages about hate crime and 'Prevent'. An e-safety project has reached a number of troubled families, helping to make parents aware of potential dangers online.

36. A consultant practitioner provides expert advice to social workers in supporting children and families where parental substance misuse or mental health issues are a feature. This includes advice on hair strand tests and reports for court processes, to ensure that all risks to children are appropriately identified.

37. Children and young people aged five to 16 years who are experiencing domestic abuse within their families have access to domestic abuse support groups that are innovative, fun and creative. These groups support children to understand their rights, protect themselves and learn new skills. Appropriate

referrals are made to the multi-agency risk assessment conference (MARAC), where positive attendance, engagement from a range of agencies and clearly recorded safety plans ensure that effective actions are in place to protect children and adults.

38. Homeless 16 and 17 year olds who are identified as vulnerable or living in unsuitable accommodation are effectively assessed, and provided with accommodation if they are found to be in need. Those young people who do not wish to become looked after are appropriately supported through a joint protocol between housing and children's social care for homeless young people. They are provided with expert mediation from the homeless intervention project to assist them to return home, or they are provided with hostel accommodation with additional support from a commissioned provider. Bed and breakfast accommodation has not been used for the past two years.

39. There are 79 children missing education, including those who are in alternative education but not receiving their full 25 hours per week offer, with the number being reduced each month. A rigorous system is in place to monitor children missing education, and effective monthly strategic meetings on children missing education involve key professionals and their managers to focus on all children missing education. The local authority assures itself that children have a suitable school place and are confirmed as attending before it ceases its monitoring. Vulnerable children, including unaccompanied asylum-seeking children and those in Years 10 and 11, are discussed at detailed monthly inclusion panels. Here, the headteachers of secondary schools explore who can provide the best place for each individual child.

40. There are currently 173 Thurrock children who are electively home educated. The local authority actively reviews all children who are electively home educated at the monthly strategic meetings on children missing education. This includes checking the information that they hold to ensure that children are not at risk and that they have been seen, and to identify when a conflict with school can be resolved. A 'traffic light' system is used to flag families on this list that may need additional support. The local authority does not sufficiently analyse and evaluate the data about children missing from education and those who are electively home educated to find out if there are particular trends, for example if numbers are increasing or decreasing, or to consider fully why this may be (Recommendation).

41. Notifications about private fostering arrangements are responded to within statutory timescales and, in the large majority of cases, are subject to robust scrutiny to ensure that children are safe. Children are seen and visited

frequently, with their views and wishes recorded in private fostering assessments. Neither proactive engagement with community faith groups nor awareness raising with professionals and the public have increased notifications. These are very low, and only two children are currently being supported as privately fostered children.

42. The local authority's response to allegations against professionals working with children are effective and timely. Referrals and management planning meeting minutes clearly record risks to children and the actions to be taken. All planning meetings are well attended by appropriate agencies in order to share relevant intelligence and information, and to ensure that children are protected. Officers efficiently track the progress of investigations and plans.

43. The 'Prevent' duty has a high profile in Thurrock as a result of cooperative working relationships through the community safety partnership. Multi-agency working is supported by a clear 'Prevent' strategy and a thorough action plan that has recently been refreshed. A helpful practitioner guide for direct work with young people was used well with 14 young people in the past year. An excellent equality impact assessment underpins the 'Prevent' agenda. There is strong collaboration between agencies, including the Local Safeguarding Children Board (LSCB).

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Greater persistence is required to translate senior managers' goals into improved outcomes for all children looked after. Most become looked after in an emergency, including unaccompanied asylum-seeking children (UASC). The recruitment of foster carers needs to be better targeted. The fact that most children looked after live outside of the borough is having a significant impact on social work time, energy and resources. This is contributing to the generally poor quality of assessments and plans. Children's electronic case files are often incomplete. Family group conferences are not used fully, and the use of the public law outline is not consistently well recorded. The quality of pre-proceedings letters is variable. Assessments completed in support of care or adoption proceedings are generally of a good standard. The length of care proceedings has been reduced, and most are completed within 26 weeks. Good use of special guardianship is providing long-term stability for children and young people.

Most children live in settled and stable placements, but the staying put policy is not yet successful in achieving stability for young people post-18. Good attention is paid to children's health and emotional well-being. Reviews are regular, but children and families do not routinely see social workers' reports beforehand, and there are significant delays in distributing review meeting minutes. Not enough is done to support children to contribute to and participate in their reviews. Children looked after who are at risk of sexual exploitation receive effective help. The response for children who have been missing is inconsistent, and one in five are not offered an interview to explore their issues. The virtual school is not effectively evaluating the educational progress of children looked after. While the gap in attainment between younger children looked after and their peers is narrowing, very few young people looked after achieve five good GCSEs.

Adoption is not routinely considered at the earliest opportunity for all children who cannot safely return home. Once children have a plan for adoption, timely progress is made in recruiting and matching them with adoptive families. Further work is required to improve the volume and range of post-adoption support.
Assessments of care leavers' needs and subsequent plans are not sufficiently detailed and their style does not engage young people. Not all care leavers are supported to gain relevant independence skills. Care leavers do benefit from good day-to-day support, live in safe and suitable accommodation and the number of care leavers engaged in education, employment or training has increased.

Inspection findings

44. Children become looked after when risks increase and they need to be safeguarded and protected. The local authority responds positively to the needs of unaccompanied asylum-seeking children (UASC), who currently account for 23% of the children looked after population. However, too many children come into care in an emergency. These include UASC, for whom it is often not possible to forward plan. However, emergency placements are potentially traumatic for children and undermine the local authority's ability to match them with suitable placements (Recommendation).

45. The number of children looked after has increased from 280 at 31 March 2015 to 336 at the time of this inspection. In a small number of cases, inspectors saw evidence of the local authority having missed the opportunity to prevent family breakdown because it had been slow to intervene. However, when the vast majority of children return home, robust arrangements are put in place to ensure that they are appropriately safeguarded and protected.

46. The local authority is making extensive use of the public law outline, but this is not always well recorded, and the quality of pre-proceedings letters is variable. Some letters identify issues and concerns clearly and concisely, and explain in plain and simple language what needs to change. Others are over-complicated and include jargon and acronyms, which makes them less easy for parents to understand.

47. The creative potential of family group conferences (FGCs) to explore and develop family-based solutions is not being fully realised. FGCs are only used in cases where the public law outline has commenced, and there is a waiting list for this service. As a result, when cases come to court the local authority frequently finds itself under pressure to complete multiple viability assessments.

48. In the last nine months, the weekly threshold panel has become increasingly influential in overseeing potential placement decisions for children looked after. However, it does not retrospectively review all emergency placements, and this limits the local authority's ability to learn from these cases in order to reduce the number of children who become looked after in an unplanned way (Recommendation).

49. The majority of assessments require improvement. Inspectors observed delays in starting assessments, particularly in the case of UASC and older assessments that had not been updated. Assessments completed in support of care or adoption proceedings are generally of a much better standard. Almost all are

timely, take good account of historical issues and concerns, and are strong on analysis (Recommendation).

50. In the majority of cases, children are seen alone by their social worker, the views and experiences of the child are well recorded, and there is good observation and analysis of children's behaviour and interactions, and purposeful direct work. In a minority of cases, there is evidence of poor recording, lack of focus, historic gaps in the pattern of regular statutory visits and, in the case of UASC, delays between children becoming looked after and being seen by a social worker. In 2015, high staff turnover made it difficult for children and young people to build and maintain meaningful relationships with their social workers, and this contributed to drift and delay. According to foster carers, since then the appointment of a number of newly qualified social workers with protected caseloads has made a significant difference. Improved stability of social workers within the children looked after social care teams now means that frequent changes of social workers are now the exception rather than the norm.

51. Until very recently, social workers have not been sufficiently proactive in identifying children, particularly those who are estranged from their families, including UASC, who would benefit from having an independent visitor to befriend, advise and support them during their time in care. Between April and December last year there were 106 requests for advocacy support, all of which were met. Currently, however, nearly half of children looked after who are old enough to do so do not participate in or contribute to their reviews. The local authority has also recognised that further work is required to ensure that children and young people know how, and feel confident to, provide feedback on the services that they receive (Recommendation).

52. While good understanding and awareness of child sexual exploitation, and the need to safeguard and protect children who go missing from care, ensure that risks are identified and assessed, one in five children looked after who go missing are not offered a return interview. The local authority recognises that this is not good enough and is appropriately planning to address the problem (Recommendation).

53. Progress has been made in promoting the health and well-being of children looked after, as evidenced by improved performance figures. For example, dental checks are up from 84% in 2013–14 to 93% in 2014–15, and in 2014–15 86% of children looked after were to up to date with their immunisations compared to only 57.8% the year before. However, confusion about referral pathways and delays in completing the necessary paperwork mean that the

timeliness of initial health assessments (IHA) is still a cause for concern. While the issue is being actively addressed, as of 1 March 2016 approximately 20% of children looked after who were eligible for an IHA assessment were waiting for an appointment and a further 20% were waiting for the necessary paperwork to be completed. This is not acceptable, particularly given the high number of UASC who may not have had their health needs assessed for some time.

54. The local authority and its health partners are developing a more responsive approach to the emotional well-being and mental health of children and young people, including children looked after. Since 1 November 2015, children and families are able to self-refer to a single point of contact. Here, they are offered an effective weekday triage service resulting, for the most vulnerable, in an immediate response from the crisis team, or, in the case of those whose needs are less urgent, in timely clinic-based appointments. Six-weekly looked after children surgeries, chaired by the head of service, make sure that, after initial health assessments have been completed, the education and health needs of children looked after are met.

55. Although 87% of children looked after attend a good school, the virtual school does not consistently analyse and evaluate the information that it collects on the educational progress of children looked after, particularly the 73% of children looked after who attend schools outside of Thurrock (Recommendation).

56. In 2014/15, 80% of children looked after reached a good level of development at the end of the early years foundation stage (EYFS) and performed better than their peers overall. During the same period, the number of children looked after who attained a level 2B+ at key stage 1 in reading dropped to 70% and in writing to 50%. However, the most recent, unvalidated data suggests an improving picture at the end of key stage 2 with 89% of children looked after making the expected two levels of progress between key stage 1 and key stage 2. Although slightly below the average for all Thurrock children, the gap in attainment in reading, writing and mathematics at the end of key stage 2 is closing. The corporate parenting committee has identified the attainment of young people looked after at the end of key stage 4 as a cause for concern. Very few young people achieve five A* to C grades, including maths and English, at GCSE. The prediction that 15% of Thurrock young people looked after would achieve five A* to C grades in 2015/16 has been reduced to a prediction of 10%.

57. The quality of personal education plans (PEPs) is not good enough. The better ones include clear targets with measurable success criteria, and capture the

child's voice and foster carers' views well. The minority that are less good lack key information, include targets that are general rather than specific, and are not always sufficiently individualised for brothers and sisters. While 90% of compulsory school-aged children have a PEP, only 76% of those in Year 12, and 69% in Year 13, have one (Recommendation).

58. When children looked after are missing education, prompt action is taken to find a suitable school place for them. Currently, four school-aged children looked after are missing education. Two of these are not in receipt of full-time education and are accessing suitable alternative part-time provision or tutoring, as part of agreed plans to support them back into full-time education as soon as possible. For the remaining two children, the local authority is working proactively to identify an appropriate education place.

59. Most children looked after live with families. Only 31 (9%) live in residential care. A service level agreement with Essex County Council increases access to foster placements within a reasonable distance of Thurrock. The local authority is aware that it needs to improve long-term stability for children looked after, but inspectors found that most children are living in settled placements.

60. The large majority of placements are of a good standard and are meeting children's needs. Good communication and liaison between carers, placements, schools and social workers ensure that packages of support, sometimes involving a range of different agencies, are well coordinated. Children looked after are encouraged and supported to maintain contact with their birth families, where applicable. In most cases, contact arrangements are clear, appropriate and well recorded. Children looked after are encouraged and supported to participate in social and leisure activities. However, while the local authority has a formal scheme of delegation, it is not being used. In practice, foster carers contact social workers for permission for children to participate in everyday activities. This is wasteful of social workers' time, unhelpful for carers and potentially intrusive for children.

61. The quality of care plans varies considerably. Although most focus on outcomes, the majority are over-lengthy and are neither sufficiently specific nor measurable. This makes it difficult for children looked after to understand or own their plans and, in some cases, contributes to drift (Recommendation).

62. The majority of reviews are timely, purposeful, well attended and well recorded. Independent reviewing officers (IROs) are knowledgeable and experienced, and know the children well. They are concerned by and continue to challenge the fact that children and families do not routinely have the opportunity to read social workers' reports or view proposed changes to their

care plans before their looked after reviews. This is disempowering as well as disrespectful for children. Delays in circulating review meeting minutes are contributing to drift and delay. They also mean that children looked after, and those who are caring for them, do not have ready access to the decisions taken and actions agreed at their reviews. The backlog, which is substantial, is due to a combination of relatively high IRO caseloads and a lack of administrative support, exacerbated by the number of children who are living out of borough (Recommendation).

63. With refreshed marketing and publicity materials, the fostering team has recently renewed its efforts to attract potential foster carers. In the absence of any specific recruitment targets, the general focus is on increasing the number of in-house foster carers who are able to foster older children, and brothers and sisters together. It is too early to evaluate the full impact of the recruitment campaign, but there is evidence of some success in recruiting new carers. The number of expressions of interest in fostering have increased and, in October 2015, Thurrock had 96 fostering households, up from 85 in March 2015 (Recommendation).

64. Prospective foster carers are assessed thoroughly. In-house foster carers are well supported, have good access to training and are subject to rigorous annual household reviews. With training accredited by the University of Essex and support from a clinical psychologist, a skilled group of therapeutic foster carers provide high-quality placements for children who might otherwise need residential care.

65. The quality of evidence and legal applications is generally good. Positive working relationships with the Child and Family Court Advisory and Support Service (Cafcass) and the judiciary are helping to drive down the average length of care proceedings, which has fallen significantly. The large majority are now completed within 26 weeks. This means that children do not have to wait longer than necessary for key decisions to be made about their futures.

66. Achieving permanency is not always clear or straightforward for children, with evidence of delays in some cases and plans being changed significantly in others. In the absence of full engagement from the frontline teams to achieve earlier permanence, the drive and ambition evidenced by middle and senior managers is not yet consistently evident. Inspectors observed a lack of urgency in some cases. The local authority continues to make good and effective use of special guardianship orders (SGOs) to make it possible for children to live with extended family members when it is not safe for them to return to live with

their birth parents. In the last 12 months, 25 children became the subject of an SGO.

67. Staying put arrangements, which enable care leavers aged 18 and over to continue to live with their former foster carers, are not yet fully developed. Only seven young people are living with their former foster carers as part of a staying put arrangement. Lack of certainty about their future is a potential source of anxiety for young people and their carers (Recommendation).

68. The generally poor quality of chronologies makes it difficult for children and young people to understand their life stories. The quality of case records is variable. Key documents including, for example, threshold panel minutes, return home interviews and pre-proceedings letters are not consistently being uploaded to the electronic case record system. This has significant implications for children, if and when they choose to access their records.

69. A small but active Children in Care Council is having an impact. For example, members of the council have been involved in the recruitment of social workers, and in reviewing and refreshing the pledge. They are particularly proud of having managed to secure a commitment from senior managers to include passports, savings accounts and life story work within the new pledge. However, disillusion has led to some young people leaving the Children in Care Council. Currently, the council has very little contact with the many children looked after who are living more than 20 miles outside the borough.

70. In the majority of cases, the service that children and young people receive is sensitive to their individual needs and unique identities. However, social workers are not always sufficiently creative or imaginative in overcoming barriers to communicating with children with disabilities.

The graded judgement for adoption performance is that it requires improvement

71. Adoption is not always considered for all children looked after who are unable to return home. There are initial delays in progressing plans, and early opportunities to secure the child's permanency arrangements have been missed. Consequently, some children have lived with uncertainty for too long. However, it is evident that permanency arrangements for children, either through adoption or SGO, are progressed with a greater degree of urgency once the case is transferred to the permanency team (Recommendation).

72. There has been an increase in the number of children being adopted in Thurrock, from 13 in 2014–15 to 18 in the year to date. Managers are actively working to raise the profile and consideration of adoption and permanence in frontline teams through training, inter-team seminars and case tracking. However, it is too early to see the impact. An adoption and permanency case-tracking tool is also used to improve timely progression through children's social care to adoption. Its effectiveness is limited, as dates and details are not included or updated for all children on the tracker to enable them to benefit from this extra scrutiny.

73. The local authority is committed to pursuing adoption as an option for children with complex needs, and has successfully secured adoptive placements for children with disabilities or who have special needs, brother and sister placements, and a young person in their teens. In the last year, the local authority appropriately rescinded the decision of placement for adoption for one child.

74. There has been an improvement in the length of time that children wait from the date at which they enter care to when they are placed for adoption. For the 2012–15 three-year average this was 625 days, which is 85 days shorter than the 2011–14 period (710 days). However, this figure, while showing a speedier process, is greater than both the national average of 593 days and the government target of 487 days. Similarly, after the court makes an order for a child to be placed for adoption, the local authority now takes less time to place the child in an adoptive family. For 2012–15, this was 186 days, which was 58 days shorter than the 2011–14 period. This is shorter than the national average of 223 days, but longer than the government target of 121 days.

75. The positioning of the adoption family-finding social worker in the permanency team has strengthened parallel planning. A greater sense of urgency is now

being applied to reduce the time that children have to wait before being matched with a suitable family. The local authority has been proactive, and currently 10 children are subject to placement orders and waiting for adoption. One is still in the family-finding stage, six have already moved in with families and three children are linked to prospective adopters, awaiting panel decisions regarding the match.

76. Children are prepared well for adoption. A complete picture of the child, their views and needs are captured well in child placement reports in order to facilitate a positive match with prospective adopters. Detailed introduction plans, although intense for carers, maintain a clear focus on the child. Well-managed arrangements achieve a seamless transition for children into their adoptive families. However, the lack of timeliness in completion of children's life story work in 2015 limited the effectiveness of this work.

77. The recruitment and assessment of potential adopters is thorough and rigorous, and adheres to national regulations. All assessments, including prospective adopter reports, are of a good standard, sufficiently detailed and informative. Adopters spoken to described their experiences as 'stressful', 'rewarding' and 'challenging'. However, prospective adopters waited between seven and 10 months for approval. There has been a lack of clear feedback to adopters across all stages of the recruitment and assessment process, and adopters said that this caused them unnecessary anxiety and stress.

78. The adoption panel is made up of representatives with relevant personal and professional experience of adoption. The panel has appropriately identified areas for improvement in relation to the quality of the medical contribution, quality assurance and support. Improvements in these areas would help to ensure that cases were better prepared for panel and avoid unnecessary delay. The head of service, in his role as agency decision maker, provides oversight and examination of panel information, and his decision-making is clear, concise and timely.

79. The local authority completed a comprehensive appraisal of its adoption services for children and has established a detailed action plan to address the challenges for the service. For example, weaknesses include a lack of 'foster to adopt' and concurrent placements, and the requirement of placements for brothers and sisters and older children who do not match many of the prospective adopters' profiles. As a result, the recruitment, assessment and approval of prospective adopters moved to a commissioned service in October 2015. Thurrock's new and prospective adopters (eight approved, four at stage two, three at stage one and 27 enquiries) have moved to the commissioned

provider, and this transition has been well managed. There is emerging evidence of these new arrangements making a difference, with two children and their prospective carers soon to be presented to panel for matching.

80. Potential adoptive families are provided with effective support when children are first placed. However, once an adoption order has been secured, support is less developed and the range of services are limited. Adoptive parents are not clear about their future entitlements or what support could be available. Over the past year, only 11 families have received post-adoption support, with eight to 10 adults (total 20) attending bi-monthly group support sessions. Support offered includes bereavement support, direct work with children, life story and therapeutic play/work. The quality of this work is valued by the children and adults, but the number receiving support is too low. Thurrock is not meeting its responsibility to ensure that adoption support is available to all adoptive children and their parents living in their area. Inspectors were informed of seven adoption breakdowns for children who were previously adopted through other local authorities but who now live in the borough and are the responsibility of Thurrock. Workers with these young people failed to recognise the need to refer them to the adoption support service or to offer specialist adoption support, which they are entitled to (Recommendation).

81. The local authority provides an impressive support group for adoptive children. This gives them the opportunity to meet regularly, share experiences, gain confidence and learn from each other. Letterbox arrangements for 152 children are in place and effective; birth parents and adoptive parents are supported to maintain agreed levels of contact. Specialist support is also beginning to be secured through good use of the adoption support fund. Since November 2015, 17 applications have been made, nine of which have been successful, primarily for therapeutic counselling support. Five further requests are awaiting an outcome. Adoption support for new carers will be provided by the new commissioned provider. It is too early to evidence the impact of this new offer.

82. The local authority supports families with SGOs well and provides financial support to 133 children's special guardians at the same level as its foster carers. Following the commissioned provider taking over the support of adoptive carers, the adoption support service now has some capacity and has extended its support offer to special guardianship carers and their families. While it is still an emerging offer, the local authority successfully engaged 28 special guardians in a three-day workshop in March 2015, and it has a plan in place to provide regular support groups for adult carers, children and young people.

The graded judgement about the experience and progress of care leavers is that it requires improvement

83. At the time of the inspection, the local authority was responsible for supporting 157 care leavers. Of these, 61 were aged 16 to 18, 92 were aged 19 to 21 and four were over 21. Of these, 68 (43%) are unaccompanied young asylum-seekers (UASC), which is a greater proportion than in previous years.

84. There has been a creative decision to place two after-care workers within the targeted youth service, where their line manager and colleagues have great experience of engaging young people in purposeful activities. This has led to a significant improvement in the number of care leavers staying in education, or entering employment or training. Currently, 62% of care leavers aged 19 to 21 are in employment, education or training, compared to 41% in March 2015 (which was lower than statistical neighbours at 51% and the England average of 48%). Effective links have also been established with the local careers centre. Care leavers state that the drop-in sessions at the local careers office give them an insight into writing CVs and getting a job, which is very helpful. However, the take-up and impact of this service is not monitored to evaluate benefit and outcomes.

85. The local authority has appropriate plans in place to increase further the number of care leavers engaged in education, employment and training, through work with the Duke of Edinburgh's Award scheme and Prince's Trust. To date, 10 care leavers have participated in a Duke of Edinburgh's Award scheme programme and just one in the Prince's Trust, so this is still at an early stage of development.

86. After-care workers have a tangible and clear commitment to the care leavers whom they support. They frequently go beyond what they need to do in order to support them. As a result, the local authority is regularly in touch with 89 (97%) of its current care leavers aged 19 to 21, a significant improvement from 2014–15 when the reported figure was 79%. Five care leavers were in custody at the time of inspection. The local authority maintains regular contact with these young people to ensure that appropriate plans can be made for their release.

87. Regular contact with workers who know them well means that young people know where and how to get help if they need it. They feel safe, and any concerns or issues about their safety or well-being are taken seriously. All care leavers who were spoken with as part of this inspection were aware of the risks

associated with sexual exploitation. Their workers know about their situations and act promptly when required, such as in helping their care leaver when faced with a situation of domestic violence or abuse.

88. Assessment records are too formulaic and are not presented in a user-friendly format. The majority of pathway plans do not use the views of care leavers in planning targeted next steps or to suggest how improvements can be made. Young people told inspectors that they lose interest when developing and reviewing their plans, saying that they stay involved in meetings because they like, and do not want to offend, their workers (Recommendation).

89. Plans are not reviewed with sufficient regularity, due to capacity issues within the after-care team. Crucially, plans and reviews neither record longer-term aspirations nor adequately capture educational achievements and next steps that might encourage or motivate young people to attain qualifications or to broaden their horizons. For example, reviews are not suggesting possibilities for apprenticeships at different levels and where these can lead. Information about staying-on rates in school sixth forms and the numbers of those who enter further education or training are not systematically collected. This limits further planning and improvement to help young people make effective transitions through adulthood (Recommendation).

90. Care leavers receive prompt and helpful support for their health and well-being needs, and they know how to access medical help. They receive effective help from a range of services such as counselling, and mental health and sexual health services. They receive good personal support at times of need, and their workers encourage and coax them to persevere. The local authority has invested in a health app to give care leavers access to their health histories. Although this is a promising development, it is not known how many care leavers are using this new technology.

91. Support is limited for care leavers to develop skills for their transition to greater levels of independence. There are currently no groups for care leavers to support them in developing their independent living skills, although work is undertaken on an individual basis. Care leavers are provided with appropriate information, for example when applying for driving licences or passports. The progress in implementing the 'staying put' policy to maintain stability of accommodation and care has been too slow (Recommendation).

92. The large majority of care leavers (92%), including all those who have special educational needs or a disability, live in suitable accommodation. Full checks are made to ensure that accommodation is safe and that young people feel secure. Additionally, managers carry out spot checks effectively to be assured

that agreed measures are being followed by accommodation providers. Close attention is paid to making sure that UASC are housed where they are safe and can access services to help them, such as proximity to colleges to learn English.

93. The local authority gives priority and appropriate help to care leavers when they seek their own accommodation. However, further work is required to ensure that the process for securing local authority tenancies becomes more young person friendly. If issues arise over tenancies, such as rent arrears or unsocial behaviour, workers promptly intervene to minimise disruption, and to make sure that the care leaver learns from the error or misbehaviour and can be rehoused promptly.

94. Care and support for the 18 care leavers with disabilities are effective. They have clear pathway assessments and plans, and benefit from much stability. All are in suitable accommodation, with nine in residential accommodation and nine in foster care. The majority have high needs and attend two local special schools graded as outstanding by Ofsted.

95. Care leavers understand their rights and entitlements, and know what support they can expect from their workers. They told inspectors that this is achieved more successfully through personal contact with their workers than through the written information available about their entitlements, which they described as uninteresting and not engaging. Care leavers, including those with special educational needs or who have a disability, receive a care-leaving grant which helps them to settle into living more independently. The local authority celebrates the achievements of care leavers positively at an annual awards ceremony.

Leadership, management and governance	Requires improvement

Summary

Leadership, management and governance require improvement in Thurrock, because many elements of core business do not deliver consistently good services to children, young people and families. Performance management is unsophisticated. Key data is not sufficiently analysed to provide leaders and managers with a narrative to understand the underlying issues or trends over time, and thereby develop relevant action plans. Of note is the absence of regular case audit analysis. This gap means that an accurate understanding of the quality of practice and any differences between teams or particular aspects of work is missed, and improvements over time cannot be monitored.

The effectiveness of management oversight varies between teams, and this is an area for improvement recognised by the local authority. Steps are being taken to address this, with a number of panels and surgeries set up to ensure that cases are kept on track, alongside the development of management training and initiatives. However, the quality of supervision is not routinely scrutinised.

Strong partnership working is evident, alongside effective corporate and cross-party support for the maintenance and development of services. Swift action has taken place when improvements were identified. This is evident in the response to issues raised during this inspection and the recent appointment of a new DCS.

Commissioning arrangements are robust, and based on a comprehensive analysis and understanding of local needs. This has led to joint commissioning of new services, and detailed scrutiny and evaluation of the effectiveness of services already commissioned. Further work is needed by the local authority to ensure that there is a sufficient range and choice of placements for children and young people, and that specific targets are in place for the recruitment and retention of foster carers.

The local authority uses learning from a range of sources to develop practice, but it does not gather feedback from children and families sufficiently or demonstrate how it has been used to improve services.

The high number of agency staff and vacancy rates within the workforce have prompted the local authority to set up a retention and recruitment board to give this issue continued attention. The local authority is appropriately working with neighbouring authorities to develop joint strategies to reduce instability in the workforce, and has achieved some success in the longer-term teams.

Inspection findings

96. Performance management and quality assurance in Thurrock are underdeveloped. As a result, the local authority lacks a full understanding of the effectiveness of its services to children and families. A range of performance data is available, including a daily snapshot providing basic information such as numbers of children subject to plans and a corporate scorecard, which provides more detailed recording of monthly activity. However, while some documents offer a narrative and analysis, there are too many key areas, such as return home interviews for children who have been missing, in which data is not analysed to consider the key themes behind the figures. The newly appointed interim DCS quickly identified performance reporting and analysis as an area of weakness, and is working with colleagues to develop a strategic model to strengthen this critical area. Despite a regular programme of case auditing within the local authority, the information from these audits has not been evaluated and does not form the backdrop for an action plan. This means that there is an overall lack of clarity about the quality of practice, or improvement and trends over time (Recommendation).

97. Management oversight is not effective across all teams, contributing to inconsistent service delivery. The local authority found that management oversight was less than good in 85% of its own case audits for this inspection. The majority of case supervision records are poor, where actions agreed are not specific enough and workers are not challenged. This contributes to poor quality assessments and delays in progressing plans for children. In the minority of cases that were better, clear decision making is seen, which leads to decisive actions to protect and promote the welfare of children and young people, and to progress plans. When cases were referred by inspectors to the local authority for a review of decision making and actions, these were dealt with thoroughly and swiftly, and detailed action plans were immediately put in place to meet children's needs.

98. The local authority is aware of the variability of management oversight and is taking steps to address this. Senior managers are chairing a number of panels and surgeries to regain management grip, and to ensure that casework is progressed. The local authority also provides specific management training courses for new managers, and during 2015 three new managers received mentoring. A managers' forum is in place, and a new aspiring managers' scheme is being developed to provide training and support for those moving into management roles. This scheme is under development and its impact cannot yet be seen. Staff spoken with during the inspection stated that their

managers are supportive, know about the work they do, and are available to offer advice and guidance when needed.

99. Senior local authority managers, leaders and elected members work effectively together to promote services for children and families in Thurrock. Very clear governance arrangements are established between the key committees and groups, and there is active communication between board chairs, leaders and officers of the council. There is full corporate support for the work of children's services, and this critical function is receiving appropriate focus and prioritisation across the council. For example, through budget setting, leaders have maintained funding for children's services, and the local authority's planning department plays an active part in the Health and Wellbeing Board, helping to promote healthy lifestyles for children.

100. Children's social care receives strong cross-party support from elected members. This engagement is enhanced through monthly meetings between the chief executive and the lead for each political group to ensure that they are informed of current issues. Senior leaders and officers engage in regular discussions and meetings to ensure that key issues are communicated in a timely manner. For example, the head of care and targeted outcomes meets fortnightly with the lead member for children's services to provide an overview of key issues and progress of work undertaken. These meetings are supplemented by more informal discussions when critical incidents occur regarding the welfare of children or staff.

101. The chief executive and lead member have not held formal meetings over the past six months to hold the chair of the Local Safeguarding Children Board (LSCB) directly to account. However, this gap in meetings has had limited impact during what has been a busy time for the LSCB, as there have been numerous discussions between the LSCB chair, council leaders and officers regarding the publication of the recent serious case review, and the DCS and lead member regularly attends the LSCB. These activities have ensured effective scrutiny and oversight of the work of the LSCB and the chair.

102. The successful Health and Wellbeing Board is at the centre of the local authority's work with children, with its strategy providing the overarching framework for the children and young people plan (CYPP). This plan sets out four clear aims, priorities and actions, and gives direction to the Children Partnership Board in promoting and securing children's welfare. Although the Children Partnership Board could evidence its activity in a number of areas, it was not able to show readily the impact of its work or how this linked to the CYPP.

103. The vast majority of commissioning arrangements are robust and based on a joint strategic needs assessment (JSNA), which provides a detailed analysis of local needs. This has led to a clear commissioning strategy with seven priorities linked to the CYPP. Joint commissioning between Thurrock, Southend and Essex, alongside the seven Essex Clinical Commissioning Groups (CCGs), has been effective, for example with the recent commissioning of a children's and young people's emotional well-being and mental health service. In addition, examples of commissioned services within the early offer of help show these services to be making a real difference to the lives of children and families. Services such as those for alcohol and substance misuse, a domestic violence perpetrator programme and a sexual violence service are well evaluated, and contracts are regularly and robustly monitored. Monitoring arrangements consider how far services are meeting performance indicators and improving outcomes, whether they are achieving value for money and whether their work is preventing statutory involvement for children. Service user feedback about these services gives clear indications that individuals feel safer as a result of the help that they have received, and that they better understand the impact that their behaviours have on their children and young people.

104. While there is a good understanding of local needs, there is mismatch between the needs of the children looked after population and the availability of suitable placements to meet these needs. The sufficiency statement does not adequately address this gap and does not contain an updated action plan. This means that there are no set targets for the recruitment and retention of a specific number and type of foster carers to meet the needs of children looked after in Thurrock. Too many children are looked after in placements outside the borough (Recommendation).

105. With strong leadership, the corporate parenting committee is successfully driving improvements on a number of fronts, as evidenced by improved performance figures on immunisations, health assessments, dental checks and return home interviews, and better marketing and recruitment of foster carers. Not afraid to challenge senior managers and leaders, the committee has also listened to the Children in Care Council and is taking action on passports and savings accounts for children looked after. The committee has further work to do to ensure that members of the Children in Care Council feel valued for their contributions, and also to continue to improve timeliness of initial health assessments.

106. Councillors have a good understanding of children's social care and their corporate parenting role. However, this is limited due to the poor quality of strategic analysis of performance information. All 49 councillors in Thurrock

have successfully completed induction training to aid their understanding of children's social care, and 17 have attended corporate training courses. In addition, the lead member meets with the Children in Care Council, and elected members sit on the fostering and adoption panels. However, councillors do not ensure that they regularly engage with children and families to seek their views to inform service development. A recent report to the corporate parenting committee noted that opportunities for senior officers and councillors to attend meetings have not been used, which means that chances to hear children's views have been missed (Recommendation).

107. The overview and scrutiny committee is an effective group, which has increased its workload in order to consider a wide range of issues affecting children and families. The chair ensures that meetings consider a broad spectrum of reports and activities, while maintaining an open slot for the LSCB, Youth Cabinet or health services to bring any matters requiring immediate attention. The group is mindful of local authority spending and has sought evaluations of services and reasons for the development of particular packages of care. It has demonstrated its tenacity by repeatedly raising issues of concern arising from a serious case review.

108. Leaders, managers and elected members have a broad understanding of the service's strengths and weaknesses. Their self-assessment demonstrates a good understanding of the quality of their services to children and families. The local authority shows a willingness to assess its own performance and to bring in external agencies to advise or take on improvement work to augment its work. It has used independent scrutiny, such as a review of the MASH in 2015, and has recently commissioned an external provider to help it to strengthen its edge of care and early help services to seek to reduce the number of children becoming looked after. The local authority demonstrates that it can be swift in responding when change is identified. This was seen during the inspection in the effective response to cases requiring review and the response to a question from an inspector which led to the development of a leaflet for young people to explain the troubled families programme.

109. The local authority actively disseminates learning from serious case reviews, information about practice developments and national research through easy-to-read monthly blogs by the principal social worker. The local authority evidences learning from complaints, with clearly recorded learning logs which set out lessons learned and recommended actions. These have been effective and led to changes in practice, such as better arrangements for transporting children with disabilities, and identification of managers' actions to ensure that work is completed when staff are off sick. Children's and families' views and

feedback are not routinely sought, limiting opportunities for them to inform service development (Recommendation).

110. Despite a workforce development strategy, and a regular retention and recruitment board, the high number of agency staff in Thurrock leaves the local authority vulnerable to staff churn. Currently, half of the social workers employed in Thurrock are agency staff (49 of 98 registered social workers). Some children have experienced delay in progressing their assessments and plans as a result of changes in their social worker. The vacancy rate at the time of the inspection was 21%, which is a slight improvement from 25% at December 2015. Some teams such as the MASH and Children Family and Assessment Teams are predominantly staffed by agency workers, and the past nine appointments have been agency staff. Staff changes mean that teams lack cohesion, identity and resilience when challenges occur. Although this leaves the local authority potentially vulnerable, 22% of agency staff have been in post for over two years, and 51% between six months and one year, which does provide some stability. Conversely, staffing stability has improved within the longer-term teams, with the successful recruitment of a number of newly qualified social workers. Thurrock is taking action and working collaboratively with the 10 other local authorities in the eastern region in an attempt to limit the number of agency staff by managing pay rates, and terms and conditions. The impact of this measure is yet to be seen.

111. Caseloads for workers are increasing and are currently above comparators. They have risen from an average of 16 cases for a full-time worker in 2014 to 18 in 2015, and some social workers currently have caseloads of up to 28, which is too high. This will need further monitoring by the local authority, as it will not assist the recruitment of permanent staff.

112. The continued professional development of staff is actively encouraged, with clear pathways established from the assessed and supported year in employment (ASYE) social workers through to management level. This focus on staff development is a strength of the local authority. The ASYE academy is reported by staff as attractive to newly qualified social workers and, to date, is showing signs of success. An increasing number of newly qualified social workers are joining the local authority (19 this year and 12 last year). They receive relevant training through an increasingly effective academy, and they receive valued individual and group support. Successful use is being made of additional agency social work staff to ensure that caseloads for ASYEs remain low during their first year. Succession planning is being well considered, with the development of mentoring, senior practitioners as practice educators and the current development of an aspiring managers' scheme.

113. A comprehensive training programme is available to staff, and over the past 12 months 390 days' training have been presented across a range of relevant subjects. Figures are collated for the number of staff attending, but the impact of the training is not fully evaluated over time. Specific management training courses are available, such as a management essentials course with a focus on leadership style and priority setting. However, this area of training provision requires additional focus, as management oversight and supervision of staff remains too variable. Of 14 supervision files audited by inspectors, none were judged good, only four demonstrated reflective supervision and only one demonstrated follow up on previous actions. Despite the local authority's awareness of the variability of management oversight and the poor quality of supervision, it is not completing a regular audit of the frequency and quality of supervision. This leaves the local authority unclear about the performance of individual managers and the impact of management training (Recommendation).

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

The Local Safeguarding Children Board (LSCB) in Thurrock is effective and innovative, and has a clear understanding of the key safeguarding priorities across partner agencies. A renewal of governance and terms of reference in 2015 has brought helpful clarity and demonstrates continued progress, following a review of the board in 2013. There is a clear collective ownership of safeguarding across all partners, who are positively engaged in action and reflection to support children, young people and their families. The board is chaired well by an influential chair who both supports and challenges partners, and accountability is high. Strong and efficient support is offered by a committed business team. Partners report clear and collective responsibility, and a high degree of challenge, scrutiny and accountability. This was described by one board member as 'good transparency and honesty'.

Child sexual exploitation, female genital mutilation and 'Prevent' duty have a high profile, with key leads from relevant agencies working effectively with the LSCB. Elements of the work of the LSCB, such as the 'Walk on line' roadshows, are outstanding, ensuring that over 10,000 schoolchildren will have received interactive safeguarding workshops of a high quality. The children most at risk of going missing, sexual exploitation, gang involvement and online exploitation are given comprehensive multi-agency consideration. The effective risk assessment group (RAG) demonstrates added safeguarding value. Capitalising on the high degree of multi-agency commitment, it leads case discussion using live access to a range of databases and expertise.

The board considers the range of experiences for children, young people and their families. It has influenced the development of the MASH, the use of appropriate categories for child protection plans and deep-dive audits. These have evaluated the experiences of the most vulnerable, including those who have been on a child protection plan for more than 12 months and children looked after. The chair has challenged MARAC about the lack of a MARAC report to the LSCB for the past two years. This limits the board's ability to monitor the work of this critical multi-agency safeguarding group effectively. The quality of the audits undertaken individually is high, but they lack overarching analysis. The take-up of multi-agency training offered is good, and participants and partners speak positively about the benefits. More analysis is required to enable full understanding of the impact of the training offer.

Recommendations

114. To improve further the strategic learning available from the multi-agency audits through overarching evaluation and analysis of outcomes and impact.

115. To undertake a comprehensive evaluation of the training provided in order to demonstrate the impact on frontline practice.

Inspection findings – the Local Safeguarding Children Board

116. The LSCB in Thurrock meets its statutory requirements well. Governance arrangements were refreshed in 2015, leading to new terms of reference which provide a strong framework for the work of the board. This is also supported by a helpful protocol between the Health and Wellbeing Board, and both the children and adult safeguarding boards.

117. The LSCB works closely with other relevant boards and panels, and has ensured that it has access, either as a member or through an open offer of attendance, at the appropriate groups in order to influence planning. This includes either the LSCB chair or business manager sitting on the Health and Wellbeing Board and the separate health and well-being strategic group, and the community safety partnership group where the 'Prevent' duty is considered, the Children Partnership Board and the early offer of help, MASH and troubled families groups. The LSCB business team apprentice sits on the Youth Cabinet. This enables fully integrated planning and detailed links back to the LSCB executive group and the LSCB full board. A positive action that came from the Children Partnership Board ensured that each school was provided with a height and weight profile to address childhood obesity.

118. The board is able to prioritise and challenge effectively, according to local need, and in the last 12 months has shown impact through increasing the police attendance at child protection conferences. Between April and November 2015, police attended 18 out of 87 initial case conferences. At the time of this inspection, this had increased to attendance at 96% from April 2015 for all conferences. Other recent challenging conversations have focused on the need for equity of funding and an overall increase in funding to manage the increase in serious case reviews (SCRs), oversight of the development of the child sexual exploitation local strategy and action plan, and ensuring the board's proactive involvement in the development and analysis of the MASH. There is a clear business plan for the work of the board, and an action plan appropriately

reflects key local priorities, including missing children, protection from abuse and exploitation, and the early offer of help.

119. Challenge within the board is strong, with agencies held to account through the main board, and the chair demonstrating a strong and assertive style. Partners are challenged collectively through themed discussions at the full board, for example each agency's performance relating to listening to the voice of the child, and the impact of funding constraints and restructuring in individual organisations. This was particularly helpful in enabling probation to explain the transformation of their agency. The police identified a gap in following up with comprehensive victim support in the discussion about the voice of the child.

120. There is a clear challenge to make improvements, if needed, in individual agencies, and the chair demonstrates a strong challenge to the performance of partners. One partner agency described this as 'open, honest. We can fight, disagree and still be okay with each other'. There have been recent challenges to the police, for example, on the speed of their response to actions required by agency-specific inspections. The chair has also challenged when there has been poor attendance at subgroups and the lack of a report from MARAC for the past two years. This has still not been produced. The board challenged children's social care on the low use of sexual abuse as a category in child protection plans and on whether this fitted the anecdotal knowledge of risks to adolescents. This has resulted in an increase in the age profile of child protection plans to safeguard those at risk of child sexual exploitation. The number of 10 to 15 year olds on a child protection plan has risen from 24% to 31%. At the time of the inspection, 12 children (5%) had an open plan for sexual abuse. Numbers were previously suppressed, due to the low figure.

121. The work of the board is supported by the work of the management executive group, where the detail of operational issues and concerns is appropriately considered. As an example, the November 2015 meeting considered the decrease in private fostering figures, the multi-agency review of child sexual exploitation, a report from the youth offending service, risks of legal highs and the planning for feedback from the new child protection level 3 pilot training programme.

122. The performance board subgroup started in March 2015, enabling each partner agency to attend and present data on the safeguarding work of their agency. This is scrutinised by other board members, including the LSCB chair. This has provided in-depth information on the broad range of functions of each agency. This has led to peer challenge and an opportunity for detailed questioning, including, for example the caseloads of midwives, and training on child sexual

exploitation and female genital mutilation for fire, rescue and ambulance services. Board members spoke highly of the learning afforded by the performance board, the impact on understanding partner functions and the rigour of challenge.

123. Section 11 assessments are undertaken annually, and the board flexibly accepts the different formats used by agencies in acknowledgement that many agencies report to three LSCBs within the pan-Essex arrangements. Compliance is high, with very good progress made at the time of this inspection for the end-of-year submission. The board maximises the potential from the returns, and recently (spring term 2016) added a 'Prevent' audit to the school returns. This has enabled specific data to be extracted and used to inform the 'Prevent' duty action plan. A gap in training for school governors was identified and is now being met, with some training having already taken place and more planned.

124. The board has developed a helpful learning and improvement framework with statutory partners. The LSCB carefully considers whether a SCR is required, and demonstrates a strong commitment to learn and improve practice. Over the past three years, this has resulted in the board completing two SCRs, and it is currently in the process of completing a further three. Correct decisions have been made to explore learning through the rigorous SCR journey, resulting in added value to the understanding of safeguarding practice.

125. The SCR subgroup is an effective group and has appropriately checked with the national panel to reach decisions to proceed when there has been a split decision among the subgroup members. The SCRs are undertaken thoroughly and published on the website, and learning is disseminated widely. All of the SCRs and the one individual management review showed appropriate learning and led to a reconsideration of risk. For example, the adolescent neglect tool came from this learning, as did the reconsideration of child sexual exploitation as an increased area for a child protection plan for adolescents. It is clear from this inspection that support to adolescents from the local authority has improved. The majority of social workers are aware of the key issues from the most recent published SCRs. The board also produces excellent summary booklets to maximise learning, with a well-presented high-quality product.

126. If a decision is made that a SCR is not required, but that there are lessons for a single agency, then the board undertakes a management review. One such review has appropriately been undertaken and published in relation to fabricated illness, showing openness in the learning for health partners. All action plans are thoroughly followed up through an action matrix, and the chair presented one SCR to the local authority's overview and scrutiny committee.

127. The financial position of the board has been stretched, with challenges to ensure an equitable contribution from one pan-Essex partner and, additionally, to meet the need for SCRs. The number of SCRs has put added pressure on time and resources. The majority of partner agencies make a proportionate financial contribution overall, and the chair requested a review with one agency when this was not the case, and a constructive solution was found. All agencies have agreed to add finance to the board to meet the demands of the SCRs.

128. All partner agencies are committed to the board, and contribute time and resources to ensure that it functions effectively. The chair is very clear with partners that board business is part of everyone's work. Suitably senior and influential partner representatives attend the board, and are able to take back lessons and challenges to their individual agencies. This has been challenged by the chair previously to ensure that appropriate membership is now in place. Subgroups are chaired across a range of partner agencies, reflecting the collective ownership of the work of the board.

129. The LSCB in Thurrock benefits from being part of the Southend, Essex and Thurrock (SET) shared arrangements, including shared policies and procedures updated and available on the Thurrock LSCB website. Policies and procedures are clear, accessible and easy to understand. Shared resources offer an economy of scale between the three LSCBs as shown through the recent 'I didn't know' child sexual exploitation awareness campaign and sharing of local expertise, including the strategic SET child sexual exploitation group and a strategic SET child death review overview panel (CDOP) group. Child death overview arrangements are effective, and there are strong rapid response protocols in place. The number of notifications in Thurrock have remained consistent over the last three years (10 in 2013–2014, nine in 2014–2015 and nine in the year to date).

130. The Southend, Essex and Thurrock group enables collective pan-Essex learning to be analysed for appropriately focused awareness-raising campaigns. These have included safer sleeping, furniture safety and water safety. The current pan-Essex focus is on suicide prevention, with relevant planning underway using specialist mental health practitioners. There is a very strong commitment and attention to detail in the work undertaken by CDOP. For example, the safer sleeping campaign is launched every holiday with helpful information sent to holiday parks, where usual sleeping arrangements will be different. This is a highly efficient pan-Essex service with a strong commitment to prevention, understanding and to support for families.

131. Local understanding of child sexual exploitation in Thurrock is considered through the developing multi-agency sexual exploitation group (MASE). This subgroup has equipped itself for its task through exploration of the Ofsted child sexual exploitation thematic study and is ambitious to understand the local landscape more fully. This has included, for example, challenging each agency to identify its 10 most vulnerable children or young people, an exercise which revealed a gap in health data. It has also identified the five boys most at risk of child sexual exploitation.

132. The comprehensive child sexual exploitation strategy and action plan have been developed, and these are rigorously overseen through the work of the LSCB. The strategy has been tested during 2015 through both internal and peer review, which showed good steady progress, and the board has further developed the child sexual exploitation action plan in response. Further work will be undertaken, including the prosecution of perpetrators and increased awareness raising. The 'I didn't know' child sexual exploitation awareness-raising campaign was launched during this inspection, and the board works closely with the police. The MASE group has a good understanding of what more needs to be done and this is informed by the detail of the experiences of children through the risk assessment group (RAG). The plan for data analysis will address the need for a more sophisticated 'heat map' of local risks.

133. The RAG established in March 2015 has brought together a number of separate panels that looked at risk (child sexual exploitation, online exploitation and missing children). This effective group has offered a real-time live multi-agency discussion for the most vulnerable children, with immediate access to the range of different agency databases. This approach has enabled a more sophisticated understanding to emerge of the complex overlap between different types of risk. This has resulted, for example, in coordinated intervention when children are referred as being at risk, and also then found to be a risk to others. It has started to reveal more detail on the prevalence of underlying risk, such as children going missing and then found to be affected by gang involvement. A clear action matrix ensures that all actions for each child are followed up effectively. The RAG is chaired by the local authority and is an operational service, sitting under the auspices of the LSCB. This unusual positioning allows the broadest opportunity for referrals from all partners, and harnesses all knowledge and investment from partner agencies in Thurrock to consider and safeguard children. It is working well, with evidence of reduced risk for children who are particularly vulnerable. However, it does not currently consider information from return home interviews.

134. The quality of the multi-agency audit work undertaken is highly detailed, resulting in clear action plans that are effectively followed up. These audits consider a broad range of relevant safeguarding issues across the partnership. These include audits regarding children and young people who have been on a child protection plan for more than 12 months and attendance at child protection conferences. Issues considered demonstrate that the board is aware of key issues across the local authority, and the findings from the audits regarding areas for development are reflective of some of the findings from this inspection, for example management oversight and life story work. Despite good-quality detailed work, the audit subgroup is without a consistent chair and attendance has not been strong. In its role of overseeing the multi-agency audit programme in Thurrock, it has analysed and disseminated learning from the audit programme through a recent learning and improvement booklet, but requires regular multi-agency attendance to ensure a sustained higher degree of overarching analysis and evaluation (Recommendation).

135. The LSCB values the views and contributions of children, and ensures that their views and experiences influence the work of the board. The board is creative and innovative in how it does this, including holding a 'voice of the child' conference in 2013–14 and ensuring that children actively participated in the board's conference in 2014–15. The board, working jointly with the Community Safety Partnership, has recruited 12 safeguarding ambassadors aged 13 to 16, including a hate crime and a youth crime ambassador through the Youth Cabinet.

136. To gauge understanding and risk to children online, the LSCB started a series of roadshows called 'Walk on line' in 2014. These covered the broadest range of risks to children and young people, including child sexual exploitation, grooming, sexting, going missing, cyber-bullying, female genital mutilation and 'Prevent' from a child's perspective. Initially offered to Years 5 and 6 pupils, they were extended to Years 10 and 11 pupils at the request of the Youth Cabinet. 10,000 children and young people have attended, and impact has been shown through changed behaviours such as amending privacy settings, as measured through anonymous child-friendly questionnaires. 'Walk on line' demonstrates a creative and comprehensive understanding of risks to children and young people. This outstanding piece of practice demonstrates a strong partnership approach between the LSCB, education, parents and the specialist police knowledge by the child exploitation online service.

137. A good range of training is offered, and this is valued by partner agencies, with 117 agencies currently participating in the training programme. The LSCB has engaged well with non-statutory partners, including faith groups, and meets

regularly as a member of Thurrock Faith Forum. It has good relationships with local voluntary organisations that access training through the board and are represented on subgroups of the board. Each course is evaluated by the individual participant, and the learning and development subgroup evaluates the effectiveness of specific training through feedback forms. Training is also observed to evaluate its effectiveness directly. Partners are held to account for both their attendance at multi-agency training and the training that each agency offers on safeguarding, but there is no overall evaluation of the impact of the full training offer. This means that the board cannot assure itself that the training offer is having sufficient impact on frontline practice (Recommendation).

138. The LSCB produces a clear annual report that demonstrates a comprehensive understanding of the strengths and achievements of the board, together with work still to be done. Strengths include improved engagement of all types of educational establishments, close partnership work with the Youth Cabinet and the overall steady progress made since the review of the board in 2013. Evidence of impact includes the monitoring of child protection plans and the challenge to increase consideration of sexual abuse, which had been an area for improvement. All agencies contribute their own end-of-year evaluation, including data, to the annual report so that their voices are heard, and they are held to account for the difference that they have made.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

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Deputy lead inspector: Karen Wareing

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Thurrock Council Children's Services Single Inspection Framework Improvement Action Plan v3 - 25.8.16

Rory Patterson	**Name of Reviewer**
31-Aug-16	**Date of Review**

Introduction

The Ofsted inspection of services for children in need of help and protection and for looked after children in February 2016 agave and overall judgement that children's services require improvement to be good. Although services to children, young people and families in Thurrock require improvement, children and young people were found to be safe during this inspection, with none identified who were at immediate risk of significant harm without plans and services being in place to reduce these risks and to meet their needs.
We welcome the recommendations and areas of improvement highlighted by Ofsted. As a result we have incorporated these into our regular performance monitoring but also want to be explicit about how we are responding to these recommendations. This plan sets out how we will do this.
The improvement plan will be overseen by the corporate parenting committee. In addition a further level of scrutiny has been created by the children's portfolio holders who will be meeting regularly with officers to review progress against plans.

No.	Recommendation	Assigned Lead - Job Title/Name	Score - please select	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
1	Ensure that accurate performance data is analysed and that this leads to specific actions for improvement	Iqbal Vaza, Strategic Lead I Performance, Quality & Business Support I HR,OD & Transformation	3	Maintained	A) Increase capacity to develop and implement new performance digest, with clear metrics & analytics. B) Implement new 'Improvements Board' to be chaired by the DCS and underpinned by metrics & analytics within new digest . C)Review structure of Data and Performance Team to maximise effectiveness.	Director of Children's Services	Aug-16
2	Strengthen oversight, coordination and quality assurance of early help services to ensure that children and families are receiving the right support at the right time	Clare Moore, Acting Strategic Lead- Disabled Children, Family Group Conferencing, Emergency Duty Team and Early Offer of Help.	2	Improving	A) Complete demand management service review B) Implement improvement plan and service restructure to maximise effectiveness of the Early Offer of Help. C) Re-engage partners in the provision of help to the right families at the right time. D) Ensure quality assurance framework is reviewed and extended to include EOH services. E) To increase the amount of Early Help assessments for 0-5 by targeting Childrens Centres, Health Visitors and Early Years settings to promote the need for early intervention.	Head of Children's Social Care	June - Dec 16
3	Ensure that assessments and plans for children are of a consistently high quality	Teresa Gallager, Service Manager, FST & Joe Tynan, Service Manager, MASH & CFAT	3	Maintained	A) Complete implementation of Signs of Safety and monitor through audit programme. B) Introduce regular quality workshops with social workers to review quality of practice. C)Scope the introduction of volunteers within the assessment service to strengthen direct intervention with families during assessments. D) Implement demand managment plan to reduce the number of assessments undertaken (specifically those that lead to NFA), to reduce quantity and increase quality.	Head of Children's Social Care	June - Dec 16
4	Improve the offer of return home interviews to children and young people who have been missing from home or care to increase take-up of these interviews	Paul Coke, Service Manager, Children Looked After & Neale Laurie, Service Manager, Safeguarding and Child Protection	2	Improving	A) Weekly monitoring of children who go missing from home and care, and the referral and take up rate of return home interviews. B) Monthly monitoring of referral rates for looked after children to ensure that this increases from 80% - 100%. C) Improved contract monitoring to require pro-active engagement of young people by provider.	Head of Children's Social Care	Jun-16
5	Ensure that more children are supported to participate in, and contribute to, their meetings, conferences and reviews, that they and their parents have access to reports beforehand, and that meeting minutes are circulated promptly	Neale Laurie, Service Manager, Safeguarding and Child Protection	3	Maintained	A) Monitoring systems in place for all Child Protection Conference and Review minutes. B) Scoping exercise to be undertaken re: how best to increase participation drawing on good practice models. C) Advocacy and support services to be reviewed to ensure that these are promoting activity engagement and participation / challenging poor practice.	Head of Children's Social Care	Nov' 2016
6	Ensure that robust arrangements are in place to reduce the need for children and young people to become looked after in an emergency	Joe Tynan, Service Manager, MASH & CFAT and Teresa Gallagher, Service Manager, Family Support.	3	Maintained	A) Review the patterns and numbers of children coming into care B) Strengthen preventative and support services to avoid accommodation or delay accommodation, so that this is planned. C) Strengthen role of Threshold Panel in managing accommodations	Head of Children's Social Care	Sept 16 / ongoing
7	Ensure targeted recruitment of foster carers to better meet the current and future demand for foster placements and reduce the number of children looked after who have to be placed out of the borough	Andrews Osei, Service Manager, Fostering, Adoption and Placements	3	Improving	A) Targets are now in place for the recruitment of foster carers in line with current and predicted demand. Performance against these targets will be monitored at monthly performance surgeries. B) Monitor impact of refreshed recruitment campaign.	Head of Children's Social Care	June' 16

No.	Recommendation	Assigned Lead - Job Title/Name	Score - please select	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
8	Ensure that personal education plans are of a consistently high standard & that the virtual school effectively monitors and analyses the progress of all children looked after, including those who attend schools outside of Thurrock	Keeley Pullen, Head of the Virtual School	3	Maintained	A) Establish a governing body to monitor, drive and improve all aspects of the work of the virtual school. B) Corporate Parenting Committee and Children's Overview and Scrutiny to continue to monitor and challenge the academic progress and outcomes for looked after children. C) Regularly undertake quality audits to monitor improvements in plans	Roger Edwardson, Interim Strategic Lead,School Improvement,Learning and Skills	Sep-16
9	Ensure that managers oversee and effectively drive forward permanence plans for children	Paul Coke, Service Manager, Children Looked After & Andrews Osei, Service Manager, Fostering, Adoption and Placements	2	Improving	A) Embed partnership working with Coram and strengthen early permanency with a pro-active offer of concurrency and foster to adopt. B) Maintain and increase reduction in number of days between court authorisation to place for adoption and placement for adoption. C) Continue to target with Coram, through effective permanency planning, a significant reduction in the number of days between a child becoming looked after and placement for adoption - to bring this below the England average.	Head of Children's Social Care	May 16 - March 17
10	Develop post-adoption support arrangements to ensure that all children and families who are eligible have access to an appropriate service	Andrews Osei, Service Manager, Fostering, Adoption and Placements	3	Maintained	Develop a new delivery model for post adoption support with Coram. Seek feedback from adopters on the quality of provision.	Head of Children's Social Care	Oct-16
11	Ensure that an effective Staying Put policy makes it possible for more young people to live with their former foster carers beyond the age of 18 years	Paul Coke, Service Manager, Children Looked After & Andrews Osei, Service Manager, Fostering, Adoption and Placements	3	Maintained	A) Update and improve current Staying Put policy in consultation with Thurrock Foster Carers and IFA providers. B) Promote Staying Put as an option for all fostered young people. C) Monitor and review the number of young people who are Staying Put to identify blocks and address these. D) Work in partnership with Eastern Region partners to better improve the local and regional offer.	Head of Children's Social Care	June - Sept 16
12	Ensure that pathway assessments and plans are developed to engage care leavers effectively and that care leavers benefit from regular reviews	Paul Coke, Service Manager, Children Looked After	3	Maintained	A) Redesign the current Pathway Plan with care leavers and the CICC (update on previous re-design), to make it as simple and user friendly as possible. B) Establish Senior Practitioner post currently within the Aftercare Team to continue to lead on the review of pathway plans and track timeliness within revised performance digest. C)Undertake regular quality audits of plans.	Head of Children's Social Care	Sept 16 & June 16
13	Ensure that care leavers are effectively supported to gain independence skills, including through the setting of aspirational targets to help them to achieve educational and employment goals.	Paul Coke, Service Manager, Children Looked After	2	Improving	A) Develop a group work model of independence training / support for carer leavers and complement current 1:1 work. B) Continue to increase the number of care leavers who are EET (62%) and exceed aspirational target of 70% EET. Strengthen integrated working with Employability and Skills service to drive improvements.	Head of Children's Social Care	August 16 & March 2017
14	Ensure a more stable workforce to ensure that children are able to build enduring relationships with social workers and to enable the local authority to drive through improvement to services, such as increasing early planning for permanence for children that starts at the front door	Andrew Carter, Head of Children's Social Care	3	Maintained	A) Continue to drive effective retention and recruitment through the Retention and Recruitment Board, chaired by the DCS. B) Expand on programme to 'grow our own' staff through the ASYE Academy and the Aspiring Managers programme. C) Reduce the use of agency staff within the Eastern Region, MoC & work with iMPOWER on demand management.	Director of Children's Services	Ongoing
15	Ensure and demonstrate that children's and families' views and feedback are used to demonstrably shape service developments	Cherrylyn Senior, Principal Social Worker	3	Maintained	A) Strengthen participation work stream to ensure that this is producing clear outcomes that are monitored and evaluated at the 'Improvements Board'. B) Corporate Parenting Board and Children's Overview and Scrutiny to be encouraged to set clear targets for evidence of improvements / service developments that have been based on user feedback, consultation and or co-production.	Head of Children's Social Care	Nov' 2016
16	Regularly audit supervision files to ensure that frequency and quality are resulting in improved practice	Neale Laurie, Service Manager, Safeguarding and Child Protection	3	Maintained	Establish a new quality assurance framework and put in place a regular cycle of auditing. Review and disseminate supervision policy and monitor compliance. Progress to be monitored at Improvements Board and proposed annual report to Children's Overview and Scrutiny on the quality of practice.	Head of Children's Social Care	Ongoing & TBC

Once you have completed this sheet, please review scoresheet - next 'Tab'

Sheet Complete

NHS Thurrock Clinical Commissioning Group

MINUTES

Integrated Commissioning Executive
29th July 2016, 9-10.30am

Attendees
Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Mandy Ansell (MA) – Acting Interim Accountable Officer, NHS Thurrock CCG (Joint Chair*)
Ade Olarinde (AO) – Chief Finance Officer, NHS Thurrock CCG
Rahul Chaudhari (RC) – Director of Primary Care, NHS Thurrock CCG
Jo Freeman (JF) – Management Accountant, Thurrock Council
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council
Ceri Armstrong (CA) – Directorate Strategy Officer, Thurrock Council
Allison Hall (AH) – Commissioning Officer, Thurrock Council
Iqbal Vaza (IV) – Strategic Lead for Performance, Quality and Information
Ian Wake (IW) – Director of Public Health
Les Sweetman (LS) – Strategy Manager, NELCSU

Apologies
Sean Clark (SC) – Director of Finance and IT, Thurrock Council
Mike Jones (MJ) – Strategic Resources Accountant, Thurrock Council
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement
Mark Tebbs (MT) – Director of Commissioning, NHS Thurrock CCG

Item No.	Subject	Action Owner and Deadlines
1.	**Notes (23rd May)**	
	The June meeting had been cancelled. AO updated the Group about the CCG's finances and said that CCGs were now unable to access the 1% non-recurrent transformation funding for 2016-17 (this equated to £2.2m for Thurrock CCG). The CCG had anticipated being able to access some of the 1% and had included that assumption in their budget calculations for the year. All CCGs had been asked to set aside 1% of their budget for transformation. AO was waiting for confirmation from NHS England as to how the 1% was to be used. 2016/17 A&E Improvement Plan	

	MA made the Group aware of a letter CCG Accountable Officers had received concerning the plan to improve A&E waiting time performance. MA also stated that a number of CCGs had been named as needing a recovery plan. Thurrock CCG had been judged by NHS England as 'requiring improvement'. AO updated the group on Sustainability and Transformation Plans. STPs are due to be resubmitted by September with related plans being finalised by December – e.g. the 2 year Operational Plans. This would mean all contracts would need to be agreed by December. IW raised a concern about whether the LA could influence the STP as there were a number of prevention priorities that needed to be reflected within the STP and data sets. MA said it was important to focus on local plans – e.g. For Thurrock In Thurrock	
2.	**Local Digital Roadmap**	
	Les Sweetman, Strategy Manager for North East London Commissioning Support Unit (NELCSU), attended to update ICE members. LS stated that the LDR had been submitted to NHS England and was in the process of being reviewed. It had passed 19 of 23 criteria. Work would now be carried out and a resubmission would be made in October. One of the areas that the LDR had not passed was lack of sign-off by the Health and Wellbeing Board. LS stated that the document was strategic, and that it currently set out aspirations. It was not a delivery plan. Concerns were raised about ensuring plans contained within the LDR supported joint working across health and social care. LS replied that one of the aspirations within the document concerned data sharing between systems and the necessary infrastructure. The deadline for the delivery of the LDR was 2020. No funding would be available this year, but it was likely that some would be available for 2017-18. MA said that there was a need to pilot some of the work streams in the Tilbury and Purfleet Integrated Healthy Living Centres when developed. Integrated data would be essential to the IHLCs' success. LS said that the next step would be to establish the right delivery structure.	

	It was agreed that the STP and LDR would be placed on the next HWBB agenda subject to Cllr Halden's approval.	**Action: CA**
3.	**Better Care Fund Plan**	
	CA updated the Group that Thurrock's BCF had now been approved and a letter of confirmation had been received on the 13th July. CS had updated the S75 agreement accordingly. A report would now need to go to Cabinet in September in order to get agreement to a waiver to allow the Council to enter in to NHS contracts. RH wanted to be sure that this was what was required and would have a separate meeting with the Council's legal team. AO said that all areas were required to resubmit the technical part of the BCF Plan by the 19th August. The final Plan would be brought to the next ICE for noting alongside the Q1 assurance return. It was agreed that final sign-off of the technical Plan would be delegated to AO and IV. Monitoring arrangements for the implementation of the BCF were discussed and agreed. This included: • Highlight report to be brought to each meeting; • Finance report; and • Performance report. Additionally, ICE agreed that a 'deep dive' on projects within each scheme would be carried out at each meeting – starting with scheme 1. **Finance** – AO confirmed that the CCG would pay NELFT directly until the Council had the authority to pay. This was likely to be after Cabinet had met in September. Budgetary statements would be provided to ICE as of the next meeting. In relation to last year's payment for performance monies (£664,303), it was confirmed that the Care Home pilot would run for 21 months (£192,500). The hypertension scheme (£100,000) was for three years – but it was unclear as to whether the amount provided was to be spread over the 3 years. IW would confirm. The amount awarded to the Falls project needed to be clarified and signed off at the next ICE. AO would confirm. AO said that there were two contracts for Alzheimer's UK, but that only 1 had been accounted for. It was agreed that the outstanding contract would be brought within the BCF for 2016/17 – this would cover the amount for both 2015/16 and 2016/17 = £38k. This would be financed from the balance of the brought forward funds.	**Action: RH** **Action: AO/IV** **Action: AO/JF** **Action: IW** **Action: AO**
4.	**Living Well in Thurrock**	
	CA proposed that the ICE act as the Living Well in Thurrock Programme's Programme Board. This would mean the	

	timing of the ICE meetings being extended slightly (by 30 minutes). Membership of the ICE would not change, but there might be different attendees invited to the ICE meeting to report back on elements of the LWIT programme. ICE ToR would be altered to take account of the change. MA commented that there were important links with FTIT which would also be included on the ICE agenda.	**Action: CA**
5.	Five Year Forward View for Mental Health	
	Not discussed – previously discussed at the HWBB Executive Committee	
6.	**Any Other Business**	
	RH informed the Group that a report from the CQC on the Council's Joint Reablement Team was expected imminently. Improvements were likely to be required, caused by the additional pressure placed on the service by the Council having to bring homecare contracts back in house. An action plan would be put in place alongside an independent review of the service.	

MINUTES

Integrated Commissioning Executive

25th August 2016, 0900 - 1100

Attendees
Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Mandy Ansell (MA) – Acting Interim Accountable Officer, NHS Thurrock CCG (Joint Chair*)
Ade Olarinde (AO) – Chief Finance Officer, NHS Thurrock CCG
Mike Jones (MJ) – Strategic Resources Accountant, Thurrock Council
Mark Tebbs (MT) – Director of Commissioning, NHS Thurrock CCG
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council
Ceri Armstrong (CA) – Directorate Strategy Officer, Thurrock Council
Allison Hall (AH) – Commissioning Officer, Thurrock Council
Iqbal Vaza (IV) – Strategic Lead for Performance, Quality and Information
Ian Wake (IW) – Director of Public Health, Thurrock Council
Les Billingham (LB) – Head of Adult Social Care and Community Development, Thurrock Council

Apologies
Sean Clark (SC) – Director of Finance and IT, Thurrock Council
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement, Thurrock Council

Item No.	Subject	Action Owner and Deadlines
1.	**Notes of the last meeting 29th July 2016**	
	The notes of the 29th July were agreed. **Matters arising** CS confirmed that the Section 75 agreement has been finalised and was to go to Cabinet for agreement in September. The CCG would continue to pay NHS provider invoices until the end of September. AO stated that he was going to clarify how the 2015-16 payment-for-performance monies had been allocated to remove any ambiguity. MA that an ICE action log accompany meeting minutes.	AO to clarify how P4P monies have been allocated. CA to provide action log
2.	**Terms of Reference**	

	CA clarified that the Terms of Reference had been updated to incorporate the expanded role of the ICE as agreed at the July meeting. This included the ICE acting as the programme board for Thurrock Council's Living Well in Thurrock programme, and ensuring that Thurrock CCG's For Thurrock in Thurrock transformation programme had reporting lines in to the ICE. Membership of the ICE had been expanded to include the Head of Adult Social Care and Community Services who had a key role in driving forward all three elements of the Living Well in Thurrock programme. RH noted that the Director of Public Health was not included in the ToR. CA confirmed that this was an oversight and that the ToR would be updated accordingly. The Group agreed the ToR (and subsequently agreed that the ToR would be appended to the ICE minutes at the September Health and Wellbeing Board).	CA to amend ToR to include Director of PH
3.	**Better Care Fund**	
	Progress Reports – Scheme 1 (Prevention and Early Intervention) CA provided an overview of scheme 1 which contained progress reports provided by initiative/project owners. IW commented on the falls service and stated that a falls risk register was required to prevent falls as well as ensure that falls were dealt with once they had occurred. Whilst work had not greatly progressed on this due to capacity constraints, IW said that two additional members of staff were due to start in the CCG's primary care team and the work would be taken forward from there. The Group commented that the initiative linked well with the Well Homes approach. MT added that the falls service was part of the broader intermediate care review and that the aim of this was to ensure that silos were reduced. MT commented on the Voluntary Grants work stream and said that capacity restrictions had meant that work had not progressed. The idea was to join up the offer across the CCG and Council for grants related to older people. IW said that he was speaking to Kristina Jackson concerning the pooling of funding for voluntary sector grants and the need to align with Health and Wellbeing Strategy outcomes. RH clarified that the first task was to bring together grants for older people. **Finance Report**	

	MJ agreed to circulate a finance report after the meeting. He confirmed that whilst the pooled fund was yet to be established (subsequent to agreement by Cabinet), the expenditure for Council services was in line with the Plan. AO said that it was important to have the finance report available for each meeting and it was agreed that MJ and AO would meet in advance of the ICE and then report any issues to the ICE by exception. ICE members commented on the payment-for-performance monies from 2015-16. IW said that he was concerned that the £100k allocated for the hypertension project would not be sufficient. Emma Sanford was currently remodelling resource requirements. RH wanted clarification about the Enhanced Care Home pilot and where this was being funded from. CA stated that the pilot was being funded directly from the BCF but would clarify after the meeting. RH asked for a proposal to be brought to the next ICE meeting. AO said that £101k remained uncommitted from the payment for performance monies but that an update would be brought to the next ICE meeting. **Performance Report** IV made the group aware that there were some issues regarding the population data used by NHS England and that the figures were different to those used by Adult Social Care. This was because the population figures contained within the BCF template came from the ONS subnational population projections whereas the Adult Social Care returns used ONS mid-year estimates. The issue had been flagged to the BCF team, but it did mean that the performance data differed slightly. 5.2 – long-term support needs of older people met by admission to residential and nursing care homes per 100,000: this indicator was currently not meeting target, but last year's trajectory had been similar and the end of year target was still achieved. LB said the only way of knowing more accurately whether the end of year target was likely was to know how the target had been achieved last year. IV agreed to do further analysis of last year's performance relating to this indicator. 5.3 – Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation: there were some issues with how this indicator was reported on as currently all people leaving hospital were provided with a reablement service yet not all	MJ and AO to arrange to meet prior to each ICE and to identify issues by exception IW to clarify funding once remodelling complete CW to provide Enhance Care Home pilot project brief to next ICE AO to bring finance report on P4P monies to the next meeting

	of those had reablement potential. 5.4 – Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+): there had been an increased number of dtoc. There was some concern about how meaningful the indicator was – e.g. IW suggested that it would be more meaningful to know the proportion of DTOC that related to those aged 75 year and over. IV was asked to clarify the definition between 'acute' DTOC and 'non acute' DTOC. MA commented that the System Resilience Group were focusing on DTOC levels but that Thurrock was doing well compared to other areas despite an increase. Further work would be carried out to analyse the DTOC increase. 5.1 – Total non-elective admissions in to hospital (general and acute), all age: AO stated that performance to date was a 2% increase on last year. AO was going to do some further analysis on admissions for the 65 years and above age group. 5.5 – Number of A&E attendances for people aged 65+: levels were slightly higher than last year. 5.6 - % of Adult Social Care service users who are satisfied with their services and support – IV reported that this was likely to hit the target and as it was from a survey, then there would be no change for the rest of the year. **Revised Planning Template** AO reported that he had submitted the revised BCF planning template and that the only change related to the patient survey. **Annual Governance Statement** CA reported that it was a requirement of the section 75 agreement to produce an Annual Governance Statement. An AGS for 2015-16 had been developed for agreement. The ICE agreed the AGS and it was also agreed that the AGS would be appended to the ICE minutes for the next Health and Wellbeing Board.	IV/MT/IW to review and analyse DTOC figures for the next ICE
4.	**For Thurrock in Thurrock – progress report**	
	MA made ICE members aware that the Mid and South Essex Sustainability and Transformation Plan (STP) had been assessed and a letter had been received. MA stated that Thurrock CCG was the lead for the frailty work stream. MT confirmed that further work regarding the possible development of an Accountable Care Organisation (ACO) in Thurrock was taking place and that a follow-up to the Executive to Executive meeting held a few months ago would be taking place in September. This needed to be	

	consistent with Essex Success Regime plans and related provider arrangements. CS stated that the Council would need to seek legal advice concerning any change of provider arrangements facing NHS service lines currently contained within the BCF. IW raised concerns about a potential conflict between block contracts and that ability to encourage increased performance relating to keeping people healthy. MT clarified that the ACO was likely to include functions relating to Mental Health and Community Health, and not Acute or Primary Care. The second engagement phased for FTIT had just commenced with the focus being the intermediate care review. Only 5 people remained in Mayfield.	
5.	**Integrated Data Set**	
	MT said that a paper on the Integrated Data Set (IDS) had been taken to the CCG Board this week. There had been a mixed reaction and further work was being done through the Clinical Engagement Group to enhance understanding of what the IDS would achieve. A second workshop was taking place with data providers and procurement documents were being finalised for a provider of the IDS. ICE agreed that the Procurement Process would start immediately after the second workshop being held with NHS providers on the 2nd September – subject to RH signing off the final service specification. As the procurement process was being carried out by the Council, RH required sign-off and needed to see all papers prior to the procurement process commencing.	MT/IW to provide RH with papers for sign-off
6.	**Living Well in Thurrock**	
	CA provided ICE members with a progress update on the Council's Living Well in Thurrock programme. There was discussion about the merits of formally joining up with the CCG's For Thurrock in Thurrock transformation programme and this was agreed. It was important to identify interdependencies between the two programmes and opportunities for join-up.	
7.	**Any Other Business**	
	AO stated that the deadline for negotiating NHS contracts was 23rd December. RH made the Executive aware that the Council had developed a number of Corporate Delivery Boards to oversee the identification and delivery of required savings. The Council needed to deliver an approximate 10% saving	

	against the current budget. RH commented that the Living Well in Thurrock Programme was the Adult Social Care response to the service reviews required as part of the Corporate Service Review Board. It was agreed that early thoughts requiring how savings might be delivered would be discussed at the ICE.	

FINAL MINUTES
Health and Wellbeing Board Executive Committee
1st Sept 2016, 2.00-3.30pm

Attendees Present
Roger Harris (Chair), Ian Wake, Kim James, Mandy Ansell, Maria Payne, Helen Horrocks and Darren Kristiansen.

Apologies
Les Billingham, Jane Foster-Taylor, Steve Cox, Ceri Armstrong, Rory Patterson, Malcolm Taylor.

Item No.	Subject	Action
1.	**Welcome and apologies**	
	The Chair noted apologies, as recorded. The Chair advised members that Cllr Halden wishes to meet with Dr Mallick.	**Action Mandy Ansell**
2.	**Notes from the last meeting**	
	Notes of meeting on 25 July were agreed. The Chair noted that actions arising that had been completed. Actions that are in progress have been carried forward are: • Delivery of an annual development session. Induction session to be organised for new members of the Board. • Paper will be presented to the next HWB on CCG plans to reflect NHS England and NHS Improvement document Strengthening Financial Performance & Accountability in 2016/17 for the which are to be published in December and will include total expenditure for 2016/17. • It was agreed that Executive Committee members will consider mental health at the next meeting. This will include an update on the five year forward plan for mental health and the emerging mental health strategy being developed by Essex County Council. • Action plan owners will be responsible for considering engagement feedback that has been received, incorporate feedback into action plans and provide a response to the feedback that has been received to members of the public through Healthwatch and other forums. Feedback provided to members of the public should include what has changed as a result of the engagement, demonstrating impact.	**Action Secretariat** **Action Ade Olarinde** **Action: Jane Itangata / Catherine Wilson** **Action – Secretariat, Healthwatch and owners of action plans** (Ongoing action)

	• Public Health Team will work with key partners to facilitate the further development of action plans. This work will be supported by the Health and Wellbeing Board's Business Manager as appropriate.	**Action Public Health Team** (Ongoing action)
3.	**Health and Wellbeing Strategy Action Plans and indicators for A - E**	
	Executive Committee members noted that the action plans created to support the achievement Goal A, Opportunity for All have been considered by the Health and Wellbeing Board at their meeting in July. It was agreed that the Exec Committee will consider 1 Goal per Exec meeting. During discussions the following comments were made: **Action Plan B1, Create outdoor places that make it easier to exercise and be active** • The delivery date for action D has been achieved as part of the Active Places Strategy • Executive Committee members noted that action G is an emerging action to be included within the plan and that further consideration is necessary to establish a delivery date. **Action Plan B2 – Develop homes that keep people well and independent** • The delivery date for action B to be considered with a view to making it more stretching and potentially bringing the timescales forward. • The delivery date for action D to be considered to ensure that it remains realistic and achievable. • A new action should be included (action P) to set out that Thurrock will consider how to develop a local keyworker housing scheme to attract a wider range of key worker including GPs, Social Workers and Nurses. It was agreed that the action should be allocated to Richard Parkin in the first instance. No substantial changes were proposed to **Action Plan B3, Build strong, well connected communities**. Executive Committee members were advised that Thurrock's Air Quality Strategy, a key driver for **action plan B4, Improve Air Quality**, is subject to review. It was agreed that the action plan and presentation would be deferred until November's Health and Wellbeing Board meeting. Executive Committee members learned that Thurrock HealthWatch has been actively engaging members of the public about Air Quality issues. It was agreed that feedback will be provided to Helen Horrocks.	**Action Secretariat** **Action Kim James**
4.	**Draft Agenda for HWB meeting in September**	

	Agreed.	
5.	**Presenting Goal B to the Health and Wellbeing Board in September**	
	Executive Committee members were informed that secretariat had received presentations for action plans B1 and B3. A presentation for action plan B2 is expected shortly. Executive Committee members were advised about a new approach being adopted to ensure that engagement activity with the people of Thurrock can be considered and reflected in action plans prior to them being considered by the Health and Wellbeing Board. It was agreed that action plan owners for Goals C, D and E will be approached and asked to inform engagement activity. It was agreed that engagement activity will be presented to the Health and Wellbeing Board earlier on the agenda than action plan presentations at future meetings.	**Action Secretariat** **Action Secretariat (complete)**
6.	**Action Plan workshop**	
	Executive Committee members considered a paper setting out proposals to develop an action plan workshop. It was agreed that a workshop is not required at this time.	
7.8.9.	**For Thurrock in Thurrock** **Ofsted Safeguarding Inspection Action Plan** **Essex Success Regime Update**	
	Executive Committee members noted and agreed papers to be presented at September's Health and Wellbeing Board meeting.	
10.	**AOB**	
	a. The Chair advised Executive Committee members that Thurrock Council was experiencing acute challenges for providing Domiciliary Care. The situation is now critical and regular reports will come to the Exec. b. Executive Committee members were informed that it was proposed the DAAT's should come under the remit of the HWB Board.It was agreed that a paper being developed by Jim Nicolson should be considered at the next Executive Committee meeting	**Action Secretariat.**

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Health and Wellbeing Board and Executive Committee Forward Plan

Group / Board Name	Frequency of meetings	Date of meeting	Agenda Items	Agenda Item	Officials
			Introductions etc. Minutes and actions arising from July meeting		
			ESR		Andy Vowles
				Goal Sponsor	Steve Cox
				Action Plan B1	Grant Greatrex / Kirsty Paul
				Action Plan B2	Les Billingham
			Item in Focus Goal B.	Action Plan B3	Les Billingham
			Feedback on engagement exercise concerning Goal B		Kim James
			For Thurrock in Thurrock" Transformation Programme Update		Jeanette Hucey
			Ofsted Safeguarding Inspection Action Plan		Rory Patterson and/or Andrew Carter
			ICE Minutes		
Health and Wellbeing Board	**Bi-Monthly**	**15/09/2016. 1:00pm - 3:30pm**	**HWB Executive Committee minutes**		
			HWB Work Programme		

			Feedback on engagement activity for Goal C		Kim James
Health and Wellbeing Board	**Bi-Monthly**	**17/11/16**	**Item in Focus Goal C.**	Action Plan B4	Ann Osola
				Action Plan C1	
				Action Plan C2	
				Action Plan C3	
				Action Plan C4	
			HWB Strategy Performance Report		
			Air Quality Strategy (TBC)		TBC
			Active Places Strategy (TBC)		TBC
			Public Health Report		Ian Wake / Tim Elwell-Sutton
			Local Implementation Plan - five year view mental health		Jane Itangata (CCG)
			ICE Minutes		
			HWB Executive Committee minutes		
			Safeguarding Strategy (TBC)		Jill Moorman
			Work Programme		

Health and Wellbeing Board	**Bi-Monthly**	**05/01/17**	**Item in Focus Goal D.**	Goal Sponsor	
				Action Plan D1	
				Action Plan D2	
				Action Plan D3	
			ICE Minutes	Action Plan D4	
			HWB Executive Committee minutes		
			Work Programme		
Health and Wellbeing Board	**Bi-Monthly**	**16/03/2017 (Need to review commissioning timelines)**	**Item in Focus Goal E**	Goal Sponsor	
				Action Plan E1	
				Action Plan E2	
				Action Plan E3	
				Action Plan E4	
			ICE Minutes		
			HWB Executive Committee minutes		
			Work Programme		

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