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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **3 July 2017**

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

Membership:

Councillors Graham Snell (Chair), Victoria Holloway (Vice-Chair), Gary Collins, Clifford Holloway, Angela Sheridan and Aaron Watkins

Ian Evans (Thurrock Coalition Representative) and Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Tim Aker, Oliver Gerrish, David Potter and Joycelyn Redsell

Agenda

Open to Public and Press

Page

1. Apologies for Absence

2. Minutes **5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 15 March 2017.

3. Urgent Items

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

4. Declarations of Interests

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **23 June 2017**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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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.

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

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

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

1. Create a great place for learning and opportunity

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

2. Encourage and promote job creation and economic prosperity

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

3. Build pride, responsibility and respect

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

4. Improve health and well-being

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

5. Promote and protect our clean and green environment

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

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 15 March 2017 at 7.00 pm

Present:	Councillors Victoria Holloway (Chair), Graham Snell (Vice-Chair), Gary Collins, Angela Sheridan and Aaron Watkins Ian Evans, Thurrock Coalition Representative
Apologies:	Kim James, HealthWatch Roger Harris, Corporate Director of Adults, Housing and Health
In attendance:	Ian Wake, Director of Public Health Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group Ceri Armstrong, Senior Health and Social Care Development Manager Jeanette Hucey, Director of Transformation, Thurrock NHS Clinical Commissioning Group Jane Itangata, Head of Mental Health Commissioning, Thurrock NHS Clinical Commissioning Group Tania Sitch, Integrated Care Director for Thurrock, Thurrock Council and North East London Foundation Trust Neil Woodbridge, Chief Executive Officer, Thurrock Lifestyle Solutions Jenny Shade, Senior Democratic Services Officer

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.

43. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 17 January 2017 were approved as a correct record.

The Chair congratulated Mandy Ansell on her new job title.

44. Urgent Items

There were no items of urgent business.

45. Declarations of Interests

No interests were declared.

46. Items raised by HealthWatch

No items were raised by Healthwatch.

47. Thurrock Better Care Fund Section 75 Agreement

Ceri Armstrong introduced the report that informed Members that on the 9 March 2016, Cabinet approved Thurrock's Better Care Fund Section 75 Agreement between the Council and the NHS Thurrock Clinical Commissioning Group. The Agreement allowed the creation of a pooled fund with the purpose of promoting the integration of care and support services. The pooled fund was overseen by an Integrated Commissioning Executive made up of officers from the Council and the Clinical Commissioning Group. The Report set out the arrangements for 2017/18 and 2018/19.

Councillor Collins thanked all Officers involved in the report and asked whether closer integration and improved outcomes for patients would be a more joined up service. Ceri Armstrong stated that the Better Care Fund contained a number of different schemes and these schemes identified the services to be brought together. An example given was an older people health and wellbeing service which had brought together a pharmacist, general practitioner, nurse, occupational therapist amongst other health and care professionals to work together to provide enhanced support to care homes. Ceri Armstrong concluded that it was a broad range of services ranging from co-location and joined up working to integrated services and approaches.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee note the arrangements for entering into a Better Care Fund Section 75 Agreement for 2017-19.

48. Adult Social Care Local Account 2016

Tania Sitch introduced the report that was aimed at the local community and described how adult social care was performing in delivering the key priorities and the progress that had been made on the actions set out in the 2015 Local Account. Members were referred to the Appendix 1 that included the review of priorities and achievements for 2016 and the 10 key priorities for 2017.

The Chair thanked Officers for the excellent report.

Councillor Collins asked how much of the report had to be written following the budget announcement on adult social care. Tania Sitch stated that this announcement had not changed the priorities too much.

Councillor Collins questioned whether an external audit would be undertaken. Tania Sitch stated that peer reviews were undertaken and that findings could be shared with Members. The use of scorecards, own carer surveys and User-Led Organisation checks were undertaken on people's satisfaction.

Councillor Snell thanked Officers for the good news report and asked for clarification on the model of care for the new resource for falls prevention. Tania Sitch stated that additional funding via the Better Care Fund had been received to work on fall prevention. Work will be undertaken with care homes and members of the public to prevent falls, working alongside professionals including occupational health therapists. Early intervention of those at risk of falls was essential. Tania Sitch also clarified that work took place to reduce risk factors with people who had had a fall in addition to preventing falls from taking place in the first place.

Councillor Snell questioned the reason that Thurrock when compared to England statistics was worse for people using social care who received self-directed support that different local authorities had different interpretations of what should and should not be included. As part of the Care Act residents had to be made aware up front of an indicative budget. Tania Sitch stated that Thurrock had resisted doing this as it had found this had not always helped individuals to identify the best solutions for them. Instead, Thurrock undertook assessments that were outcome-focused and worked alongside residents to ensure that they were able to find the best solutions.

Councillor Sheridan asked for clarification on the number of staff in the adult social care teams mentioned within the Better Care Fund section of the Local Account. Tania Sitch stated that the:

- Hospital Social Care Team had 15 members of staff which included Team Manager, Deputies, Social Workers and Support Planners who dealt with the patient discharges from Basildon Hospital and also covered the three main community hospitals.

- The Joint Enablement Team was a larger team with Physiotherapists, Occupational Therapists, Nurse, Co-ordinators and 30 Carers who deliver the joint enablement.

Councillor Collins stated that good service improvements had been made.

Councillor Collins made reference to those National Key Performance Indicators that had gone down in the direction of travel and to ensure that the same services were being incorporated in each assessment. Tania Sitch that regular performance meetings were held chaired by Roger Harris to review and update the action plan. An increase of loneliness had been reported and that work was being undertaken to address this through services such as the Local Area Coordination Team.

Ian Wake stated that care should be taken when comparing statistics and trends from two different points as these were not always comparable.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee note the report.

49. Thurrock First project - Overview and Recommendations

Tania Sitch passionately introduced the report that described the creation of the “Thurrock First” single point of access for adult residents in Thurrock. Thurrock First was part of the Health and Adult Social Care Transformation Programme “For Thurrock in Thurrock”.

Thurrock First will be an integrated community physical and mental health and adult social care information, advice and assessment service which would be jointly delivered and funded by North East London Foundation Trust (NELFT), South Essex Partnership Trust (SEPT) and Thurrock Council. The service will be operationally co-ordinated by a manager who would be recruited by all three participating organisations.

The report described the Options considered and the steps being taken to develop the service and the service model with the proposed launch date of 1 June 2017.

The direct contact telephone number advertised will be for Thurrock residents only and be manned by team members from Thurrock who would be knowledgeable of the local area and be able to assist first hand.

Councillor Snell congratulated Officers on the fantastic news and how this service would make a difference to Thurrock.

Councillor Watkins asked how this service would be communicated to all residents. Tania Sitch stated that a lot of work had already been undertaken with HealthWatch and that local social media, posters and hearsay would be used to promote this service.

Councillor Watkins asked how internal targets would be monitored. Tania Sitch stated the key performance indicators would be set amongst the three executives which would then be agreed with the commissioner and published. It was important that these targets captured the outcomes.

The Chair thanked all for their commitment to “Thurrock First” and requested that the item be added to the work programme for 2017/18.

Councillor Collins thanked Officers for their hard work and commitment.

Councillor Sheridan questioned the costs for the pilot and could there be potential cuts in the future. Tania Sitch stated that it was first time that three executives (NELFT, SEPT and Thurrock Council) had shared set up costs. This was a one-off cost within the organisations of £200,000 and no targets had been set on savings. Tania Sitch stated that efficiencies were likely but that this would mean that more people could access the service. The service would be evaluated after a year.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee endorse proposals to establish a new single point of access service called "Thurrock First".

50. An Accountable Care Organisation for The Tilbury Locality and Update on Development of Thurrock Integrated Healthy Living Centres

Ian Wake introduced the Accountable Care Organisation report that detailed the two initiatives that had been designed to address current issues in the local Health and Social Care system. The Development of an Accountable Care Organisation for the Tilbury Locality and development of four Integrated Healthy Living Centres across Thurrock.

Thurrock remained one of the most "under doctored" areas in England in terms of the ratio between general practitioners and patients and there was an unacceptable level of variation in the clinical care of patients with long term conditions between different general practitioner practice populations.

The Annual Report of The Director of Public Health in 2016 considered the health and social care system sustainability in Thurrock and concluded that fragmentation within constituent parts of the system and inadequate capacity and quality of Primary Care was leading to preventable serious health events within our population and was a key underlying driver of system unsustainability.

Ian Wake updated Members on the development of Thurrock Integrated Healthy Living Centres. Due to the complexity of current National Health Service commissioning arrangements the implementation of the project had been slower than expected. A team of consultants from Currie and Brown have been appointed to move the project forward so that a business case could be presented to Cabinet to seek approval to borrow the required capital for construction to start and setting out how revenue would be recouped from the National Health Service. It was expected that the business case would be ready in late 2017.

Mandy Ansell expanded on the concept that was being piloted in Tilbury. Jeannette Hucey had been working on the concept of a new Lead Partner Model for 18 months built on learning from the Vanguard sites that had been given specific funding to develop new models of care. Jeanette Hucey had formed a "buddy" arrangement with Dudley in the West Midlands who are a Vanguard site and have been leading on new model development. The challenge in many cases has been getting the providers to work together and full credit should be given to local providers North East London Foundation Trust (NELFT), South Essex Partnership Trust (SEPT), and Basildon and Thurrock University Hospital Trust (BTUH), where there was now greater trust allowing for conversations around risk and gain share to emerge. Work continues on the Legal contract, which was incredibly complex and advice being sought from Hempsons in support.

Mandy Ansell stated that this was an incredible exciting project and those involved deserved a “big pat on the back”.

Ian Wake stated that this was one of the most exciting project he had worked on in his 22 year career.

The Chair thanked Officers for the continuing good news on the agenda.

Councillor Collins questioned whether the “double running” would result in the budget doubling over the period of time and for how long was this period of time. Ian Wake stated that it was likely that funding would be placed within the Better Care Fund. Additional government money for primary care will be providing additional funding in the short term to provide a mixed skills work force.

Mandy Ansell stated that one of the core documents worked to in the National Health Service was the Five Year/GP Forward View which allows for more investment into primary care.

Councillor Sheridan thanked Officers for the report and asked what contingencies would be put in place for all the new housing developments and the increase in population. Ian Wake stated that the proposed models had to be future proof with the health living centres being flexible to accommodate increases in population.

Councillor Watkins questioned the “quick wins” that were required to be addressed by the new Accountable Care Organisation and whether the business cases could be shared. Ian Wake stated that the wider picture had to be addressed. For example, blood pressure tests, and where these could be undertaken using the community assets instead of residents having to go to a hospital.

Councillor Snell thanked Ian Wake but asked when residents would see things happening. Ian Wake stated that in was work in progress and required the business case to be approved. The timescales that were minuted at the Health and Wellbeing Board on the 15 March 2017 was six to nine months.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee note the contents of this report.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee support the work of the Director of Public Health in conjunction with the Council’s key partners to develop and pilot an Accountable Care Organisation approach of integrated working for the Tilbury Locality.**

3. **That the Health and Wellbeing Overview and Scrutiny Committee continued to support the on-going work to develop the four integrated Healthy Living Centres.**

51. Learning Disability Health Checks

Jane Itangata, Senior Commissioning Officer, Clinical Commissioning Group, introduced the report that as of 1 April 2017, the Clinical Commissioning Group would enter into co-commissioning arrangements with the National Health Service Public Health England to deliver the Learning Disability Health Checks. This had facilitated the opportunity for an alternative service to undertake health checks for people who cannot access these from their general practitioner surgeries.

This co-commissioning between National Health Service England and Thurrock Clinical Commissioning Group had provided the opportunity to use evidence and co-production techniques to design the approaches that would enhance activities to support the health check delivery and create sustainable arrangements that would be maintained to ensure adequate coverage for delivery of quality health checks and implementation of subsequent plans.

Annual Learning Disability Health Checks are available for anyone with a learning disability who was aged 14 years of age or over. Under the Directed Enhanced Service all general practitioners contract holders across Midlands and East (East) would be given the opportunity to provide Learning Disability Health Checks.

Jane Itangata reported that as of 15 March 2017 the coverage of health checks was 63 per cent of eligible people having had their health checks completed with a target of 70 per cent by the end of the year.

The Chair thanked Officers for the clear improvement and the considerable work that had been undertaken.

Councillor Watkins questioned what work was being undertaken with Thurrock residents in schools outside the borough and how would work be carried out with those schools. Jane Itangata stated that this was work in progress work alongside HealthWatch and would start with the schools more aware of and then move out to outer borough schools. Jane Itangata explained to Members that data was manually collated as data supplied by National Health England was not always up to date and a proper picture would not be formed. Manual collated included ringing surgeries to encourage general practitioners to update their records.

Councillor Snell commented that the report demonstrated another Thurrock success and a good news update.

Councillor Collins asked Officers to explain a Health Action Plan. Jane Itangata stated that any young person or adult with learning disabilities should

have a Health Action Plan. These are prepared by a doctor, nurse or health worker or supported who help at home.

Neil Woodbridge stated that Essex Police as part of the Advisory Panel were offering “Ride Along Scheme” to improve public trust and confidence in Essex Police by ensuring the processes and procedures are transparent were allowing members of the public the opportunity to observe everyday policing activities. Members can contact Neil Woodbridge directly if interested.

Mandy Ansell updated Members on the work undertaken by Jane Itangata and Mark Tebbs with Essex Police on the procedure that from the 1 April 2017 anyone picked up with mental health issues or challenging behaviour would not be placed in police cells and that designated nurses would accompany Essex Police on these call outs. It was also noted that the Home Office had commented on the work done in Thurrock.

The Chair requested the Learning Disability Health Checks be added to the work programme for the next municipal year 2017/18.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee note the progress made on the work plan to improve the quality and uptake of health checks by people with Learning Disabilities in Thurrock.

52. Work Programme

The Chair stated that this was the last Health and Wellbeing Overview and Scrutiny Committee for this municipal year and that the work programme was now complete.

The Chair thanked Members and Officers for their contribution and their continued support to the Health and Wellbeing Overview and Scrutiny Committees.

The Chair asked Members if there were any items to be added or discussed for the work programme for the next municipal year.

RESOLVED

1. **That the item Thurrock First will be added to the work programme for 2017/18.**

2. **That the item Learning Disability Health Checks will be added to the work programme for 2017/18.**

3. **That the item Review of Careline will be added to the work programme for 2017/18.**

4. **That the item General Practitioner Five Year Forward Review will be added to the work programme for 2017/18.**

The meeting finished at 8.41 pm

Approved as a true and correct record

CHAIR

DATE

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3.	**HEALTH AND WELL-BEING OVERVIEW AND SCRUTINY COMMITTEE**
Appointed by: The Council under section 21, Local Government Act 2000	**Number of Elected Members:** Six, of whom none may be Cabinet Members or Members of the Health and Wellbeing Board
Chair and Vice-Chair appointed by: The Council	**Political Proportionality:** The elected Members shall be appointed in accordance with Political Proportionality
Quorum: Three elected Members	**Co-opted Members to be appointed by Council:** Two, non-voting

Functions determined by Council:

1 Provision, planning, management and performance of adult social services;

2 To review and scrutinise the planning, provision and operation of the health service in Thurrock;

3 Diversity and equality issues (other than the Authority's human resources policies);

4 Work in partnership and act as a member of regional, sub-regional and local health scrutiny networks;

5 Adult training and skills;

6 Scrutiny of the Health and Well Being Board

7 Public Health

Functions determined by Statute

All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000, Local Government and Public Involvement in Health Act 2007, Social Care Act 2001, the Health and Social Care Act 2012 and any subsequent regulations.

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3 July 2017	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Update on Mid and South Essex Success Regime / Sustainability and Transformation Partnership (STP)	
Wards and communities affected: All	**Key Decision:** For information and discussion
Report of: Andy Vowles, Programme Director, Mid and South Essex Success Regime	
This report is Public	

Executive Summary

This paper provides an update on current thinking and next steps for changes in local health and care across the Mid and South Essex Sustainability and Transformation Partnership (STP).

1. Recommendation(s)

1.1 The Committee is asked to note the update and to give views on: i. the emerging thinking local issues; and ii. future plans for public consultation.

2. Introduction and background

2.1 **Key events leading to our current position**

2015	NHS England and other national bodies designate Essex Success Regime, one of only three in the country.
1 March 2016	Outline plan published for health and care across mid and south Essex, including potential hospital reconfiguration.
March – May 2016 Early engagement	• Set up of clinical working groups to develop and lead change. • Three hospital trust boards agree joint committee • CCGs identify areas of collaboration • Engagement with health and wellbeing boards (HWBs), other stakeholders and service users. **Outcomes** • Clinicians (with service users) agree decision rules and criteria for potential hospital reconfiguration and service redesign. • Agreed objectives for hospital change: - Designate a specialist emergency hospital

	- Separate emergency and planned care - Identify where some specialist services could benefit from consolidation across three hospital sites.
June – Aug 2016 Developing options and decision-making criteria	• CCGs and partners collaborate on blueprints for joined up health and care in localities, frailty, end of life and other pathways. • Hospital clinicians refine potential options for reconfiguration and consult independent Clinical Senate. • Programme of staff workshops and focus groups with service users. Continued discussions with HWBs and other stakeholders **Outcomes** • Outline sustainability and transformation plan submitted to NHS England in June • Insight from service users and staff informs weighting of decision-making criteria and influences draft STP • Independent Clinical Senate supports direction of travel, advises on consideration of more radical options for emergency care, obstetrics and paediatrics.
Sep 2016 – Jan 2017 Engagement in STP and options for hospital service change	• Programme of public workshops and staff briefings provides insight on priorities for change and potential implications • Acute clinical leaders narrow down potential options for hospital reconfiguration to two broad models, one model with three variations and one model with two variations • Continued discussions with HWBs and other stakeholders **Outcomes** • Full STP published with public summary, influenced by service user feedback • Second review by independent Clinical Senate – commends clear case for change, supports direction, advises on pace of change, "*long term sustainable services should take priority over speed*" • Local clinicians advise further discussion – options appraisal shifted from November 2016 to February 2017.
Feb – March 2017 Options appraisal	• Discussions continue with staff, stakeholders and local groups – over 100 stakeholder meetings and events since March 2016 • Four panels (including service users) consider options for potential hospital reconfiguration **Outcome** • Options appraisal points towards a future model of three hospitals each providing different specialist services, while all three hospitals continue to provide around 95% of hospital care for their local population, including 24 hour A&E. • Local discussions highlight further work needed on operational and practical implications of change. **Quote from stakeholder briefing issued 15 March:**

	While the options appraisal process is an important part of evidence-based planning, there are also a great many operational and practical concerns to address, most of which will benefit from insights from front line staff and local people. This will include details of how a change could be implemented over the next three to four years through a carefully managed and staged approach so that patient safety and care quality is assured at every stage and alongside changes in community care.
April to date	• CCGs agree to form a joint committee to lead system-wide planning and joint commissioning. • Hospital clinical working groups continue to develop detailed clinical blueprints. • Programme Executive reviews timescales.

2.2 **Recap on the Mid and South Essex Sustainability and Transformation Plan**

- Plans are in progress to invest in GP, mental health and community services to develop innovation and early treatment that will help people stay well and avoid hospital emergencies. These are specific to each of the five CCGs (e.g. *For Thurrock in Thurrock*), but all five CCGs are working to broadly consistent models of care including:

    - Self-care programmes to support people to stay well for longer
    - Locality based joined up health and care services to extend the range of expertise and care in the community, including a shift from hospital to community where possible
    - Integrated services to provide support at the earliest possible stage to reduce the risk of serious illness, with priority development in complex care, frailty and end of life.
    - Development of urgent and emergency care pathways, including integrated 111, out of hours and ambulance services.
    - Integration and development of mental health services with primary, community and acute hospital care

- The three acute hospitals in Basildon, Chelmsford and Southend are working as one group to meet rising demands. As a group, the hospitals can save money by sharing corporate functions and support services, while clinicians are looking at the opportunities to improve patient care by centralising some specialist services at each hospital.

2.3 **Addressing current local concerns**

There has been considerable local engagement in Thurrock through the work of the CCG and Thurrock Council with *For Thurrock in Thurrock,* as well as the STP wide programme. We are extremely grateful for the support of Thurrock Healthwatch and other local groups.

From this engagement, there are a number of Thurrock service user representatives who are actively involved in the STP Service Users Advisory Group, which played a significant role in the appraisal of options for hospital reconfiguration earlier this year.

Feedback from discussions tends to focus on access to primary care, which informs Thurrock CCG plans, and the sustainability of high quality hospital emergency care.

Some of the main concerns around the potential hospital reconfiguration are addressed in summary below:

- There are no plans to close A&E at any of the three hospitals.

- In all options currently being discussed, there would continue to be an A&E department, supervised by consultants and open 24/7 at each of the three hospitals in mid and south Essex.

- Our A&E departments would continue to respond to unplanned needs, and manage a broad spectrum of illnesses and injuries. The approach to patients would continue, which is to assess, treat and transfer or discharge.

- Similar to current practice, a transfer may be:

    - Back to a GP or other service in the community
    - To another unit within the same hospital for further assessment and treatment
    - To an inpatient ward or specialist centre, which could be in the same hospital or in another hospital
    - In some instances, where it would be safer to do so, people could be taken by ambulance straight to a specialist centre, by-passing the local A&E. Current examples of this include major trauma, head injuries and acute heart attacks.

- The potential hospital configuration for the future includes 24 hour assessment units for older and frail people, children and people who may need surgical or medical care. These units would provide fast access to mental health and social care as well as acute hospital care. They could accommodate an overnight stay if necessary, but would aim to help people avoid a stay in hospital. This would ensure a faster and better response to most of the emergency needs of older people and children, linked to a range of community services for ongoing support if needed.

- All three local A&Es would retain the skills to provide immediate stabilisation and management of all emergencies that arrive at the hospital and, where appropriate, arrange onward transfer.

3. Issues, Options and Analysis of Options

3.1 What could be different in the future?

- Greater emphasis and capability in terms of prevention and early intervention to manage rising risks of serious illness.

- A wider range of expertise available in Thurrock, with joined up services and multi-disciplinary teams to improve capacity in primary and community care.

- A future hospital configuration where around 95% of hospital activity would continue at each hospital, while some specialist services, including some life-saving care, could be consolidated in one or two of the hospitals.

- Emergency inpatient care increasingly separated from planned inpatient care to improve capacity and avoid cancelled operations due to surges in emergencies.

- Current thinking identifies Basildon as having the greater potential to provide a specialist emergency hospital, Southend as having the greater potential to provide a centre of excellence for planned care and Broomfield providing a combination of emergency and planned care.

- The questions that clinicians and partners are currently investigating include:

    - What specialist services could be safely consolidated in a way that would improve patient care and outcomes? There is considerable scope to improve patients' chances of survival and rapid recovery in cardiac, vascular and stroke care, for example.

    - What would be the best way to access these services? When is it better to treat and transfer from a local A&E, and when is it better to transport patients directly to the specialist team?

    - What are the opportunities to consolidate planned inpatient care in one or two centres of excellence?

    - How could we improve patient pathways from preventative care and treatment closer to where people live through to hospital services when needed and back to rehabilitation and support?

3.2 **CCG Joint Committee**

- The CCG Joint Committee, which is due to meet for the first time in July, will lead the PCBC and public consultation.

- Commissioning functions of the CCG Joint Committee cover:
    - Acute services
    - NHS 111 and out of hours services
    - Ambulance services
    - Patient transport services
    - Services for people with learning disabilities
    - Services for people with mental health problems

- Strategic functions include:
    - Delivery of the STP local health and care strategy
    - Decisions on STP wide service configurations
    - Agreement of relevant STP wide patient pathways and restriction policies
    - Leadership of relevant public consultations that affect the whole STP area

3.3 **Next stages of development leading to public consultation**

- The Mid and South Essex Sustainability and Transformation Partnership is developing a pre-consultation business case (PCBC) that will present the case for change and proposed way forward, based on clinical evidence. It will include financial plans and proposed capital investment.

- Subject to national assurance, there would then follow a public consultation.

- The programme is now exploring a phased approach to implementation, where the vision (to separate elective and non-elective and consolidate services where it makes sense to do so) remains the same, but a step-by-step approach is taken to service change.

- Within the hospital trusts, some thirteen clinical working groups are developing patient pathways and clinical protocols for:

    - Emergency and A&E services, including assessment centres
    - Acute admissions e.g. vascular, stroke, renal, cancer surgery
    - Planned care e.g. urology, neurology, ophthalmology, orthopaedics, cancer surgery
    - Paediatrics

- There will be further opportunities for service users and local people to get involved in developing patient pathways before, during and after public consultation.

3.4 **Current timescales**

Discussions with stakeholders on draft PCBC	June – Sept 2017
Completion of PCBC	September 2017
Local regional and national assurance process	Oct – Nov 2017
Consultation programme	Dec 2017 – March 2018
Analysis of outcomes and review of proposals	April 2018
Decisions based on outcome of consultation	May 2018

4. Reasons for Recommendation

4.1 The Health and Wellbeing Overview and Scrutiny Committee is a key stakeholder with a statutory duty to scrutinise health services and public engagement in potential service change. We very much value members' views and advice to ensure meaningful consultation.

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

5.1 The Mid and South Essex STP will contribute to the delivery of the community priority 'Improve Health and Wellbeing'.

6. Implications

6.1 **Financial**

One of the objectives of the STP is to respond to the increasing NHS deficit across mid and south Essex. As a system-wide issue, partners from across the health and care system are involved in financial planning. This will help to ensure that any unintended financial consequences on any partners of what is planned are identified at the earliest opportunity and mitigated.

6.2 **Legal**

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

6.3 **Diversity and Equality**

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

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 seldom-heard groups 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.

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

None identified

Report Author:

Wendy Smith

Interim Communications Lead, Mid and South Essex Success Regime

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3 July 2017	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
Podiatry Services in Thurrock	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Mark Tebbs, NHS Thurrock CCG	
Accountable Head of Service: Mandy Ansell – Accountable Officer, Thurrock CCG	
Accountable Director: Mark Tebbs, NHS Thurrock CCG	
This report is Public	

Executive Summary

The CCG was asked to complete a report on CCG funded podiatry services. The report provides a broad overview of current local provision compared to The Society of Chiropodists and Podiatrists best practice guidance (2010).

Since April 1 2013, clinical commissioning groups (CCGs) were given the power to decide what footcare services to commission for their local area. Guidance by the National Institute for Health and Care Excellence (NICE) recommends that footcare services related to long-term conditions such as diabetes, peripheral arterial disease and rheumatoid arthritis should be available on the NHS.

However, there is no NICE guidance for foot health provision that is not associated with a long-term condition. This means that each individual CCG decides on what to make available on the NHS, depending on local need. The Thurrock CCG level of provision is the same as the neighbouring Basildon and Brentwood CCG.

NHS choices advises that if your condition is not affecting your health or mobility – such as a verruca that looks ugly, but doesn't hurt when you walk – you are unlikely to be eligible for NHS podiatry.

The report, therefore, provides a summary of CCG funded services and pathways.

1. Recommendation(s)

1.1 The committee are asked to note the content of the report.

2. Introduction and Background

2.1 The Society of Chiropodists and Podiatrists developed guidance (2010) in response to the challenges facing the NHS and Independent Practice to increase quality, innovation, productivity and prevention (QIPP) whilst continuing to deliver services in times of austerity.

This guide focuses on the importance and benefits of podiatry in:

- reducing secondary care intervention
- maintaining independence of vulnerable groups through good foot health
- preventing mobility difficulties through earlier intervention allowing patients to remain in their own homes.

The document offers commissioners and managers of healthcare services guidance on the different clinical aspects of podiatry provided in both in the NHS and the private sector.

The following diagram (Figure 1) illustrates the full spectrum of foot health care and each section in this document reflects the different levels of care shown. Foot health promotion is an integral part of delivery at all levels of podiatric care and will be considered under each section.

Figure 1.

3. Issues, Options and Analysis of Options

3.1 Table comparing Thurrock provision against The Society of Chiropodists and Podiatrists Best Practice Guidance:

Pathway	The Society of Chiropodists and Podiatrists Best Practice Guidance (2010)	Thurrock provision.
Self-Care	Many foot conditions can be appropriately and safely managed by individuals themselves without ever becoming 'patients' if they have the confidence to do this safely and are equipped with the necessary skills and knowledge. There are many foot health advice leaflets available from the Society of Chiropodists and Podiatrists (SCP) and other sources.	Links available via the Thurrock Council Website.
Foot Care	Simple footcare is defined as toenail cutting and skin care including the tasks that healthy adults would normally carry out as part of their everyday personal hygiene. For various clinical, medical and physical reasons some individuals are unable or it would be too risky for them to undertake this themselves. Footcare is therefore an extremely important aspect to support an individual's ability to remain at home, mobile and pain free whilst the regular check during appointments act as an early detection system ensuring prompt treatment and prevention of more serious foot health problems from developing.	Available via Age UK. Clinics are held at easily-accessible venues throughout Essex. (There is an initial registration fee of £5 and a charge of £15 every time you have your toenails trimmed). If you cannot attend toenail cutting clinics, they also offer home visits to people who live in Thurrock. (There is an initial £5 registration fee for toenail cutting home visiting service and each trim costs £20).
Podiatry Care	Core podiatry is defined as, the assessment, diagnosis and treatment of common and more complex lower limb pathologies associated with the toenails, soft tissues and the musculoskeletal	Referrals will be accepted by EPUT from primary, community and secondary care. The objectives of the EPUT Community Podiatry Service are to:

	system with the purpose of sustaining or improving foot health.	• Assess, monitor and treat those Service Users with long term conditions which compromise health and mobility and independence – diabetes, peripheral vascular disease, rheumatoid arthritis or structural deformity. • Provide a surgical option for acute/chronic nail pathologies • Provide biomechanical management of structural and mechanical abnormalities of the foot and lower limb in relation to gait and foot function. • Maintain mobility and independence • Provide podiatric specialist wound care and tissue viability advice and information • Provide health education information to Service Users around foot health, self-care, and signposting Service Users as appropriate to other information e.g. smoking cessation, nutrition and exercise materials and resources. • To assess nail health requirements and provide appropriate management of pathological nail conditions • Provide expert Podiatry advice and information to other professionals • In addition the individual will have a systemic medical condition, which may render them to be 'at risk' of ulceration, infection or amputation. Exclusion Criteria: The following services are outside the scope of this service level agreement and are not offered to Service Users: • Treatment of Verrucae
Orthotic and footwear	Musculo-skeletal biomechanics is an important component of podiatry practice and links with other areas of podiatric practice such as patients with diabetes, rheumatoid and osteo arthritis often involving multi and interdisciplinary work across primary,secondary and tertiary care. This collaboration can extend to hospital prosthetists and orthotists in surgical appliance and therapeutic footwear provision within secondary care.	
Specialist Podiatry	Specialist areas in podiatry relate mainly to long term conditions.	

		• Nail cutting for pathological nails other than in high risk groups. • Nail cutting for non-pathological nails • Non-disabling Keratoma • Sports Injury Services • Podiatric Surgery Services
Podiatric Surgery	Podiatric Surgery is the surgical treatment of the foot and its associated structures. It is carried out by a podiatric surgeon, usually as a day case procedure and under local anaesthetic. Podiatric surgery is available in many NHS trusts as well as in private hospitals and clinics. A podiatric surgeon manages bone, joint and soft tissue disorders.	Referrals to BTUH from primary, community and secondary care

4. Reasons for Recommendation

4.1 n/a

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

5.1 n/a

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

6.1 n/a

7. Implications

7.1 **Financial**

n/a

7.2 **Legal**

n/a

7.3 **Diversity and Equality**

n/a

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

n/a

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

The Society of Chiropodists and Podiatrists: A guide to the benefits of podiatry to patient care (2010).

9. Appendices to the report

n/a

Report Author:

Mark Tebbs

NHS England, CCG

3 July 2017	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
The Procurement of an Integrated Sexual Health Service for 2018-2023	
Wards and communities affected: All	**Key Decision:** Key Decision – spending above £500K
Report of: Ian Wake, Director of Public Health	
Accountable Head of Service: Ian Wake, Director of Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

The Health and Social Care Act (2012) mandates Local Authorities to commission Sexual Health Services for the populations they serve. Currently in Thurrock, the majority of sexual health services are commissioned from the North East London Foundation Trust (NELFT) with some small additional contracts with GPs/Pharmacies and other providers.

In March 2017, Cabinet agreed a one year extension for the NELFT contract which is due to end on 31st March 2018.

1. Recommendation(s)

Health and Wellbeing Overview and Scrutiny Committee is recommended to:

1.1 Comment on the plan to proceed to tender as set out in this report for the delivery of Integrated Sexual Health Services starting on 1st April 2018 prior to submission to Cabinet.

2. Introduction and Background

2.1 Sexual Health Services are currently delivered primarily by North East London Foundation Trust, supported by smaller elements from GPs, pharmacies and other providers. The service has been developed over the last two years to provide a more integrated offer, allowing patients to receive a seamless service for both prevention and treatment. The final elements to fully integrate the service are planned to come together to start in April 2018.

2.2 The current contract with NELFT ends on 31 March 2018. As this service has not previously been market tested, this provides an opportunity to identify if further savings can be made through competitive procurement.

2.3 This report therefore requests that HOSC comments on the proposal to proceed to tender to procure a fully Integrated Sexual Health Service to start from 1st April 2018.

Table 1. Sexual Health Contract Values

	Current Provider	**2017-18 Budget**
Sexual Health Service (including GUM Cross Charging and Chlamydia Screening Office)	NELFT	£1,530,000
Primary Care Services (GPs and Pharmacies)	Various providers Demand led – current budget	£60,000
Lab Testing	BTUH	£28,689
Chlamydia Online Screening	Preventx	£16,000
Total Spend		**£1,634,689**

3. Issues, Options and Analysis of Options

The Integrated Sexual Health Service

3.1 In line with national recommendations Thurrock Council commissions an open access service where all sexual health needs can be met at one location acting as a "one stop shop". Public Health has worked with the current provider (NELFT) to begin to start gradually integrating the Sexual Health Service. The cost of this and the other contracts can be seen in Table 1 above.

3.2 The past few years have seen significant integration of Sexual Health Services by combining multiple services in to one main contract. In 2016-17 a c. £200k budget saving was made with minimal impact on service delivery as a result of a carefully staged process of integration. The contract was amended for 2017-18 and saw further integration of the Sexual Health Service by incorporating smaller elements such as the Chlamydia Screening Office. Crucially, this contract also included the Genito-Urinary Medicine (GUM) Cross Charging[1] which is an area of considerable financial and legal risk, as well as administrative workload, for the Council. Thurrock was the first Council in the region to negotiate a risk sharing agreement which saw the provider

[1] GUM Cross Charging: where Thurrock residents choose to receive their sexual health treatment services (GUM) outside of the borough boundaries, the delivery organisation is entitled to charge "Cross Charge"Thurrock Council for the provision.

take on responsibility for administering all new cross charging claims. This facilitated a saving of £77K over the 2017/18 budget.

3.3 Subject to comment by HOSC and agreement by Cabinet, during 2017/18 a full procurement exercise will be undertaken for a new contract to start in April 2018. We are looking for a single provider to deliver all the services below which may include some subcontracted elements:

- Level 1, 2 and 3 Sexual Health Services (e.g. contraception, family planning, STI screening and GUM services)
- Sexually Transmitted Disease (STI) and HIV Home Testing kits that can be ordered on line
- Chlamydia Screening Office
- GUM Cross Charging
- Lab Testing
- Primary Care and Pharmacy Service Level Agreements: Chlamydia screening and treatment; Long Acting Reversible Contraception (LARC); Condom Distribution Scheme; and Emergency Contraception (commonly known as the “morning after pill”)
- Programmes to prevent the spread of sexually transmitted diseases and improve sexual health (e.g. Risky Behaviours Training for young people, community outreach programmes and face-to-face delivery)

3.4 Providers will be asked to submit their cost for delivering the services above to a maximum figure aligned to the three year future Public Health financial plan.

4. Reasons for Recommendation

4.1 This report is submitted to Health Overview and Scrutiny Committee for comment prior to seeking Cabinet approval to go out to tender and award with a whole life cost valued each above £750K. The total estimated value for this contract is a maximum of c. £8.5 million.

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

5.1 As part of the development of the service specification we will consult with service users, stakeholders and other relevant professionals.

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

6.1 The services aim to meet corporate priorities through the delivery of high quality services in all elements.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant

The procurement aims to secure a contract with additional integrated services within or below the current annual price. The contract will be flexible to enable it to adjust to priorities and changes in funding availability during the maximum 5 year term with the removal of the ring-fence for the Public Health Grant in 2018/19.

7.2 Legal

Implications verified by: **Paul O'Reilly,**

Projects Lawyer

7.2.1 This report is seeking approval from Cabinet to tender the contract noted in the report. The proposed procurement is estimated well above the EU threshold for services (£625K) within the new Light Touch Regime of the Public Contracts Regulations 2015, Section 7. This means that there is a legal requirement to competitively tender the contract via the Official Journal of the European Union (OJEU).

7.2.2 Taking the above into account, on the basis of the information in this report, the proposed procurement strategy should comply with the Regulations and the Council's Contract Rules.

7.2.3 The report author and responsible directorate are advised to keep Legal Services fully informed at every stage of the proposed tender exercise. Legal Services will be involved to advise on any legal and related issues that may arise in particular in drafting the final contract with the selected provider.

7.3 Diversity and Equality

Implications verified by: **Rebecca Price**

Community Development Officer

The Service will be available across the whole community, responsive to gender and or culturally specific need including specialist advice for young people. The Provider must demonstrate they are an equal opportunities

employer and will be expected to consider and demonstrate how they will provide additional social value through contract delivery. This will be tested as part of the tender process.

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

None

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

None

9. Appendices to the report

Appendix 1 - Procurement Stage 1 Form: Integrated Sexual Health Services

Report Authors:

Stefanie Seff
Corporate Procurement Strategy & Delivery Manager

Sareena Gill
Public Health Manager

Andrea Clement
Public Health Registrar

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thurrock.gov.uk

PROCUREMENT STAGE 1 – APPROVAL TO PROCEED TO TENDER

This form must be completed for all procurements above the tender threshold (£75,000 - Services and Supplies and £500,000 – Works)

If contract value is over Cabinet approval threshold (£750,000) this form shall be attached with the request to tender report to Cabinet. This form will be "Open" for Publication.

Section A: ABOUT THIS PROCUREMENT	
Title	Integrated Sexual Health Service
Directorate	Adults, Health and Commissioning
Procurement Reference Number	PS/2017/529
Contract Cost (Maximum Spend)	£9M over 5 years
Budget code(s)	PH12
Introduction and Background	The current contracts with all Sexual Health providers come to an end on 31 March 2018.
Proposed Contract Term	3 years initial term plus the option of two further years in any combination.
Political Sensitivity	N/A

Section B: COMMISSIONING REPORT	
Business Case	As stated, the current providers' contracts come to an end on 31st March 2018. Over the past few years significant efforts have been made to integrate the Sexual Health services in Thurrock. It is thought that there could be improvements generated in terms of integration and cost savings by testing the market. The current spend for these contracts is £1,634,689 per annum. Sexual Health Services are currently delivered primarily by the North East London Foundation Trust (NELFT) and supported by smaller elements from GPs, pharmacies and other providers. It is proposed that the smaller additional elements are included within this contract with a view to fully integrate the service. This will enable the provider to adapt the services to the needs of the population by working in a more joined up manner. This will also significantly reduce the administrative functions required by the Council's Public Health Team.
Key Deliverables (Draft Specification)	Achievement of a range of quality outcomes including Public Health England targets on prevention and recovery of substance misuse.
Quality v Price evaluation	60:40 Quality:Price
Social Value	Bidders will be asked to propose Social Value opportunities for their term – this may include volunteering opportunities for local people.
Current / Previous Contract details	The current service is part of the directly commissioned arrangement between the CCG and NELFT, of which Thurrock Council is an authorised signatory.

	FINANCIAL IMPLICATIONS						
Current / Previous Contract Cost	The current spend on sexual health services that will be included within this contract amounts to c. £1.64M per annum.						
Cost Breakdown	**Breakdown of Estimated Cost**	**18/19 £000's**	**19/20 £000's**	**20/21 £000's**	**21/22 £000's**	**22/23 £000's**	**Total £000's**
	Total Spend	**£1.634m**	**£1.634m**	**£1.634m**	**£1.634m**	**£1.634m**	**£8.170m**
Confirm Funding Breakdown Identified	Revenue Budget	£	£	£	£	£	£
	Capital Budget	£	£	£	£	£	£
	Other (Please State)	£	£	£	£	£	£
	Other (Please State)	£	£	£	£	£	£
	Total Funding	**£1.634m**	**£1.634m**	**£1.634m**	**£1.634m**	**£1.634m**	**£8.170m**
Budget Code(s)	PH12						
Unsupported borrowing?	N/A						
Other Financial Implications	The procurement will seek to achieve savings through further integration and market testing and support continued delivery post removal of the ring fenced Public Health budget.						

PROCUREMENT ROUTE ABOVE TENDER THRESHOLD (Choose 1(of A, B, C or D) only)		
A. COMPETITIVE PROCUREMENT (complete B if a Framework)		
Procurement Route	Light Touch EU (Social Care/Health)Under Section 7 of the Public Contracts Regulations 2015	
Procurement Justification	Health Service above EU Light touch threshold	
B. FRAMEWORK (Waiver in accordance with Rule 13.1 (c)		
Framework?	Is this a procurement from a Framework?	No
Title & Reference of Framework	N/A	
Framework Rationale	N/A	
C. REQUEST FOR QUOTE FROM RESTRICTED MARKET (Waiver in accordance with Rule 13.1 (d)		
Restricted Market?	Is this a request for quotes from a restricted market?	No
Rationale (only permitted below the EU threshold)	N/A	
D. SINGLE SOURCE REASON (Waiver in accordance with Rule 13.1 (a, b or d)		
Single Source	Is this Procurement a Single Source – One Quote/Tender *(Exceptional circumstances only and select reason below)*	No
Single Source justification below EU Threshold	*Select reason and explain your rationale* N/A	
Single Source justification above EU Threshold	If you are seeking a single tender above the EU threshold – using the "Negotiated Procedure without Call for Competition" route, this is only available in very exceptional circumstances. You must select the reason below and explain your rationale. N/A	
Single Source Rationale	N/A	

PROCUREMENT TIMETABLE, RISK, CONSULTATION AND MANAGEMENT

Milestones and target dates *(Draft)*	**Key Event**	**Date**
	Publication of Contract Notice or Advert	21 July 2017
	Return of PQQs (omit if not applicable)	N/A
	Issue of Invitation to Tender	21 July 2017
	Return of Tenders	04 September 2017
	Notification of Results	10 October 2017
	Standstill Period (omit if not applicable)	No less than 10 days between notification of decision and date of award
	Leaseholder Consultation (omit if not applicable)	N/A
	Expected date of Award	24 October 2017
	Contract Commencement	01 April 2018

Risk Management – Set out Main Risks and Mitigating Actions

Risk	**Likelihood (A – E)[1]**	**Impact (I – IV)[2]**	**Level of Risk (High to Lower[3]**	**Potential Negative Impact**	**Management / Mitigation of Risk**
Tender Process Risks					
Insufficient interest in the tender	D	II	Lower	Unable to award contract	There is a developed market in Sexual Health Treatment Services from both NHS and private sector organisations
Overrun Procurement	C	II	Lower	Service gap or requirement to extend	As much preparation will be done as possible, slippage will be minimised
Enter Risk	L	I	Level	Impact	Mitigation
Contract Performance Management Risks					
Service Performance failure	C	I	High	Service Users at risk, community safety impact	Strong contract management to be put in place. Regular monitoring and involvement of CCG for clinical governance issues.
Enter Risk	L	I	Level	Impact	Mitigation
Enter Risk	L	I	Level	Impact	Mitigation

Contingency Arrangements	Extension of the existing service is unlikely to be needed but will be agreed with the current incumbent prior to tender. Public Health will continue to work closely with the CCG and Primary Care providers should any failure take place during the contract term.
Consultation	As part of the development of the service specification we will consult with service users, stakeholders and other relevant professionals. The proposal will also be discussed at Health Scrutiny for comments.

[1] **Risk Likelihood:** A = Very High, B = High, C = Significant, D = Low, E = Very Low
[2] **Risk Impact:** I = Critical, II = Significant, III = Marginal, IV = Negligible
[3] **Risk Level:** High = AI, BI, AII, BII, CI,CII, all others lower

Project and Contract Management Proposals	The Contract will be managed directly by the Responsible Officer (Public Health Manager).
Procurement Comments	This is an opportunity to market test the delivery of sexual health services which will be further integrated to ensure a joined up service for recipients. There is potential for a small element of savings although this is not anticipated to be substantial. The size of this procurement means it is subject to the EU Light Touch Regime and the tender exercise will be conducted accordingly. The Corporate Procurement Manager will continue to support Public Health through this project.

Section C: LEGAL, FINANCE AND PROCUREMENT APPROVAL		
Procurement Services	**Name**	Stefanie Seff
	Signed *(Or obtain email of confirmation)*	
	Date	Click here to enter a date.
Legal Services **(Insofar as it relates to Legal implications)**	**Name**	Paul O'Reilly Project Lawyer
	Signed *(Or obtain email of confirmation)*	
	Date	23/05/2017
Finance **(Insofar as it relates to Finance implications)**	**Name**	Jo Freeman
	Signed *(Or obtain email of confirmation)*	
	Date	07/06/2017

Section D: APPROVAL TO PROCEED VALUE	
The Responsible Officer must sign the form, together with the Head of Service as a minimum. Delegated Authority Limits below.	
Approval Level	Over £750,000 - Cabinet

Section E: SIGN OFF APPROVAL TO PROCEED			
Confirmation by the Responsible Officer of Compliance with Contract Procedure Rules	The Responsible Officer **Sareena Gill** confirms that the procurement of **Integrated Sexual Health Services** and **PS/2017/529** has been carried out in accordance with Rule 5 of the Council's Contract Procedure Rules (Chapter 9, Part 2 of the Constitution) and in particular the following duties have been met by the Responsible Officer: • Compliance will occur with all regulatory or statutory provisions and the Council's decision making requirements • The Contract will be included on the Council's Contract Register • Value for Money will be achieved • Advice has or will be sought from the Director of Finance and Corporate governance as to an appropriate security bond or guarantee • Document Retention Policy has and will be complied with • Financial Evaluation will be made of all the proposed tenders including the recommended bidder • Advice has been and will be sought and followed from Procurement, Legal and Finance as necessary		
	Signed		
	Date		Click here to enter a date.
Approval to Proceed	In accordance with the Contract Procedure Rules, I/we confirm the accuracy of the information contained within this form and authorise this request to **Proceed to Tender** including, where relevant, the permitting of a Waiver from the Contract Procedure Rules in accordance with Rule 13		
Head of Service	**Name**		Click here to enter text.
	Signed *(Or obtain email of confirmation)*		
	Date		Click here to enter a date.
Corporate Director *I confirm that the Portfolio Holder has been consulted as required*	**Name**		Click here to enter text.
	Signed *(Or obtain email of confirmation)*		
	Date		Click here to enter a date.
Head of Corporate Finance *If waiver required*	**Name**		N/A
	Signed *(Or obtain email of confirmation)*		
	Date		Click here to enter a date.
Cabinet	**Approval Minute Number**		Click here to enter text.
	Date		12/10/2016
Now send complete form to Procurement Services signed and scanned (with emails if used)			

3 July 2017	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Southend, Essex and Thurrock Dementia Strategy 2017 - 2021	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Catherine Wilson Strategic Lead Commissioning and Procurement	
Accountable Head of Service: Les Billingham Head of Adult Social Care	
Accountable Director: Roger Harris Corporate Director Adults Housing and Health	
This report is Public	

Executive Summary

The Southend, Essex and Thurrock Dementia Strategy 2017-2021 is a collaborative piece of work between people living with dementia, their carers, the three Local Authorities and the seven CCG's within Greater Essex. The vision for future development detailed in the strategy is:

People living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain physically and emotionally healthy for as long as possible.

Dementia is a term which can cover a range of symptoms that have resulted in damage to the brain. This damage can affect memory, attention, communication, problem solving abilities and behaviour. People living with dementia may also experience depression, aggression, and wandering. Each person's experience of dementia is different and it's progression for each individual can be at very different paces.

The strategy is a response to a growing understanding that the range of support available for people living with dementia across Greater Essex is fragmented and perceived as difficult to access by those requiring it. The strategy sits alongside the Southend Essex and Thurrock Mental Health and Well Being Strategy supporting a comprehensive all age vision for positive mental health across Greater Essex.

The Southend, Essex and Thurrock Dementia Strategy is also building on the National Dementia Strategy: Living Well with Dementia published in 2009, which focused on improving the care and experiences of people with dementia and their carers.

1. Recommendation(s)

1.1 That Heath and Well Being Overview and Scrutiny Committee agree to recommend to Cabinet that Thurrock Council endorse the Southend, Essex and Thurrock Dementia Strategy 2017-2021

1.2 That Heath and Well Being Overview and Scrutiny Committee agree that a local Thurrock implementation plan is developed to deliver the Dementia Strategy in Thurrock.

1.3 That the implementation plan is brought back to Heath and Well Being Overview and Scrutiny Committee for consideration.

2. Introduction and Background

2.1 Thurrock Council and Thurrock CCG have and continue to be very proactive is raising awareness of dementia and supporting those living with dementia and their carers. The South Essex Dementia Strategy 2014 to 2017 has delivered and supported a number of initiatives in Thurrock. Thurrock is a dementia friendly Council and dementia friends training has been made available to all employees and Councillors, this has been widely taken up and has resulted in Thurrock Council being recognised as a Dementia Friendly Council. The training is ongoing delivered by the Alzheimer's Society and is open to anyone within Thurrock to attend. On the 22nd June 2017 the Alzheimer's Society held an awareness raising stall at the Civic Offices one of many events frequently held across Thurrock. Thurrock Council and Thurrock CCG jointly fund the Alzheimer's Society to deliver a number of services including a memory clinic, Dementia Café's, and a motivational men's group. The Alzheimer's workers are co-located in the Civic Offices within Adult Social Care. The funding for the Alzheimer's Society has recently been increased by Thurrock Council and Thurrock CCG recognising the growing need.

2.2 The new Southend, Essex and Thurrock Dementia Strategy has been developed to continue and expand on this positive work. There are five main elements that underpin the approach within the strategy; the first is that there are great benefits in working across Greater Essex to develop a strategic approach. The second area is the development of a new model of specialist support which will develop a clearer pathway from early intervention to diagnosis and ongoing support. The third element which clearly builds on our local successes is to ensure that support is personalised, empowering and delivered within local dementia friendly communities. Fourthly using assistive technology imaginatively and creatively can offer support around safety and independence within a family and community environment delaying and reducing the need for wider service intervention supported by the Care Act 2014. Finally the voice of those with lived experience is essential to develop the local implementation plans that will come from the overall strategy.

2.3 The Southend, Essex and Thurrock Dementia Strategy lays out nine priority areas of work which Thurrock Council and Thurrock CCG fully support. These

nine priorities are focused on improving the lived experience of those with dementia and their families and carers by addressing the fragmentation of response and lack of understanding of dementia. It is important that the pathway for those living with dementia is clear and where services are required accessible. Working across Greater Essex may offer some opportunities to work together particularly around timely diagnosis, building a knowledgeable and skilled workforce and reducing risk of crisis. As yet the local implementation plan has not been developed however it is clear that we would want to ask for support from Healthwatch and the wider voluntary sector to ensure that those living with dementia and their cares are guiding how support should be available in Thurrock, from statutory health and social care services to living well with dementia in local communities. The nine priorities are detailed on pages 9, 10 and 11 of the strategy attached at appendix 1. For reference the priorities are as follows, early intervention and prevention, making available good information and advice, developing a clear diagnostic pathway with ongoing support. Supporting people living with dementia to be full members of an understanding community, supporting carers and reducing risks with good education, training and emergency planning. Living well in long term care which may be residential care. Developing positive end of life planning and care. Ensuring the workforce has the skills to support those living with dementia. The delivery of these priorities are framed in measures of success, within our Thurrock Implementation plan we would want to build on these to have measures of success specific to Thurrock.

2.4 The implementation plan at the close of the strategy will require further revision once we have developed the Thurrock Local Implementation Plan and we are clear that a number of areas will be more locally focussed.

3. Issues, Options and Analysis of Options

3.1 The Southend, Essex and Thurrock Dementia Strategy 2017 – 2021 offers opportunities to work closely together across Greater Essex to utilise economies of scale for service development where appropriate.

3.2 There is no additional funding available and the Local Implementation Plan will need to address reinvestment of current resources creatively and imaginatively.

4. Reasons for Recommendation

4.1 That the Southend, Essex and Thurrock Dementia Strategy 2017-2021 is endorsed by Thurrock Council and Thurrock CCG as a positive response to the growing numbers of people living with dementia and the need to ensure a continued personalise approach to support and care.

4.2 The strategy will support the development of a locally focussed implementation plan enhancing what is already happening in Thurrock and developing that further.

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

5.1 The Strategy has been developed in consultation with individuals with lived experience of dementia and their carers together with the voluntary sector and other services across Greater Essex. This was not extensive in Thurrock and we are clear that as we move forward with the local implementation plan wider consultation will take place building on the nine priorities and focusing on what is important to people in Thurrock.

5.2 A report will be presented to Health and Well Being Board in July 2017.

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

6.1 Thurrock Council is already a Dementia Friendly Council meaning that Offices and Councillors are aware that dementia should be highlighted in the policies and priorities of the wider Council. Dementia Friends training is offered on a regular basis within the Council and to the wider Community which will support the implementation of the strategy as a key priority is a person living with dementia being part of their local community.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant (Social care and Commissioning) Corporate Finance

Currently there are no financial implications for this report. This will be reviewed as the Thurrock Implementation Plan is developed.

7.2 Legal

Implications verified by: **Roger Harris**

Corporate Director Adults Housing and Health

There are no legal implications for this report.

7.3 Diversity and Equality

Implications verified by: **Roger Harris**

Corporate Director Adults Housing and Health

It is important that Dementia is viewed as an integral part of the Community of Thurrock, that those living with Dementia are not disadvantaged by the condition and they have continued and where necessary supported access to

their everyday lives. The principles within the strategy are a positive foundation for the local implementation plan. The development of this plan will be monitored closely ensuring equality and diversity are central. It will be essential to ensure that in any future service development is underpinned by social value opportunities.

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

N/A

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

N/A

9. Appendices to the report

Appendix 1 - Southend, Essex and Thurrock Dementia Strategy 2017-2021

Report Author:

Catherine Wilson

Strategic Lead Commissioning and Procurement

Adults Housing and Health

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Southend, Essex and Thurrock Dementia Strategy (DRAFT)

2017-2021

Version 5.5

7th February 2017

Southend, Essex and Thurrock Dementia Strategy

Table of Contents

Living well with dementia in Southend, Essex and Thurrock,

This strategy is for everybody in Southend, Essex and Thurrock, (Greater Essex), who is living with dementia or supporting someone who is. It describes what we want support for people with dementia to look like in the future and identifies 9 priorities for action to make this happen.

The strategy has been developed in partnership between Essex County Council, Southend on sea Borough Council, Thurrock District Council, and Clinical Commissioning Groups across Greater Essex. It sits alongside Greater Essex's Mental Health and Wellbeing strategy, to form a new and comprehensive, all—age ambition for mental health and emotional well-being in our county.

There are real opportunities for change and innovation across Greater Essex to ensure that people have the best support available to live well with dementia. We want to make Greater Essex more inclusive for everyone living with dementia and empower people to live the life they want in the community for as long as possible.

Over the past year Essex County Council has worked with partners to talk extensively to people who live with dementia and worked to develop the understanding of people's current experience of dementia in Greater Essex. The Public Office also produced a report following a range of engagement activity in Greater Essex and this insight was used to inform this strategy.

Southend Borough Council also conducted a wide range of public and stakeholder consultation activities. The key themes identified reflected similar challenges and needs to those across Essex, with some local differences.

These engagement activities highlighted some challenging truths about existing systems, which involve all of the partners above who commission dementia services in their specific geographical areas:

- Systems are fragmented and bureaucratic. The "battle" to find what they need wears carers down and professionals find it difficult to navigate too.
- Services do not consider people as part of a family – or even in partnership with their carer.
- Support is not personalised – and doesn't enable people to maintain their capabilities, interests or relationships
- Systems rely heavily on the carer, but don't support them very well. Carers carry on until they can no longer cope, and then health or care services often need to intervene in the midst of a crisis.

- Carers are often unable to access services when they are available and have few options available over night and at weekends
- Current avenues of support don't help people and families to withstand the emotional pressures they face – stress, relationship breakdown, loneliness
- Existing systems push people towards residential care because they can't find the support they need in the community

These are stark revelations, but ones that emphasise the need and opportunity for change and innovation to ensure that people have the best support available to live well with dementia.

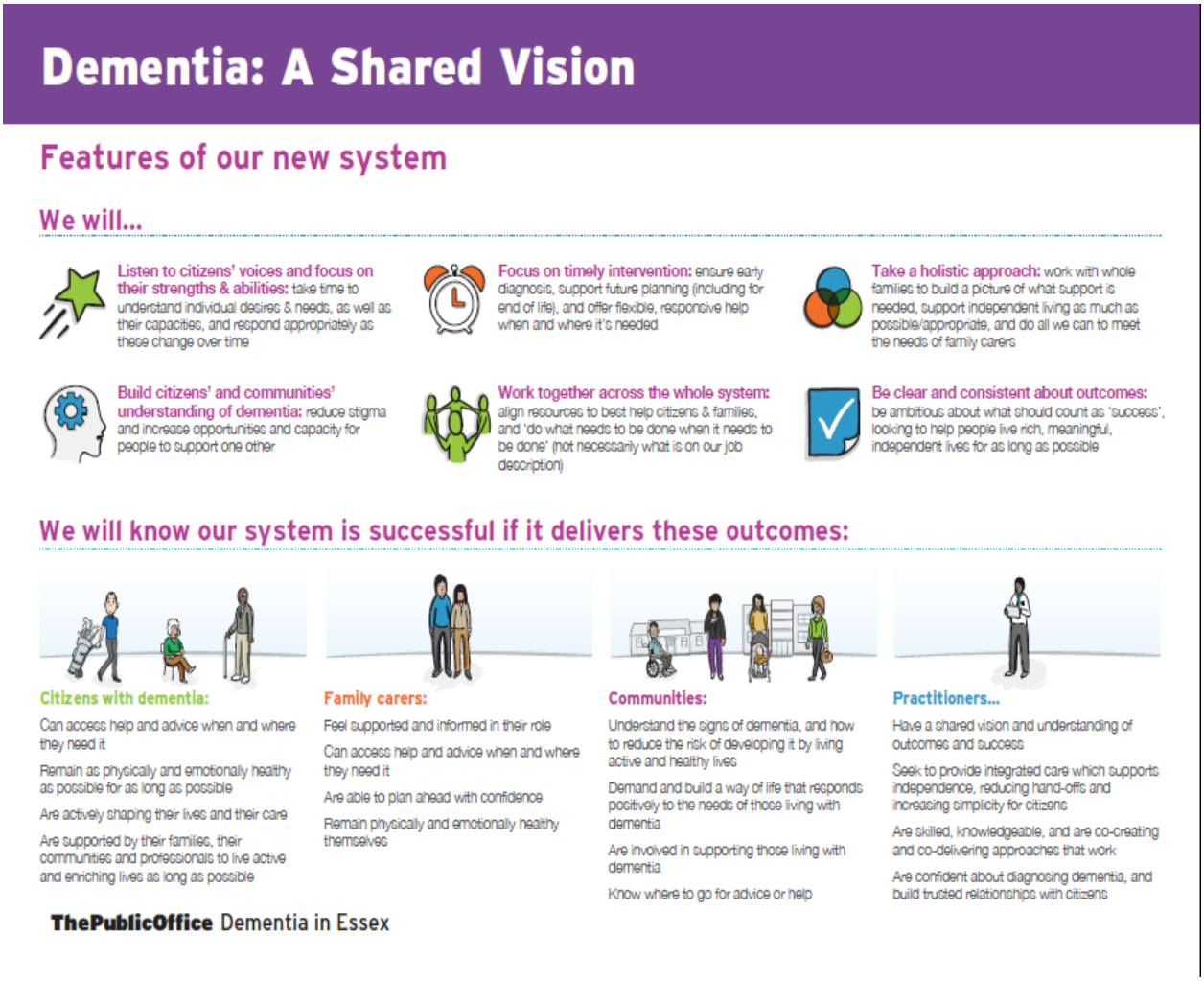
Rethinking dementia: A collaborative enquiry

Vision

Our vision for the future is one in which:

> **People living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain as physically and emotionally healthy for as long as possible.**

Our strategy to achieve this is organised around nine priorities that reflect specific aspects of people's life with dementia. However there are five key elements to our approach that underpin the whole strategy:



1. A joint strategic approach to dementia in Greater Essex

The range of support for people with dementia is fragmented; people often get lost trying to navigate an intricate web of information and services. We know people living with dementia face a spectrum of challenges and have a range of needs; so to achieve our vision it is vital that organisations work together to collectively transform the approach to dementia in Greater Essex.

Our vision aspires to create systems where organisations work towards the same goal; All localities are addressing challenges in both health and social care, and developing Sustainability and Transformation Plans setting the future direction for health and mental health services (including as part of the NHS Success Regime in Mid and South Essex). Supporting people living safely with dementia to remain as physically and emotionally healthy for as long as possible is key to this.

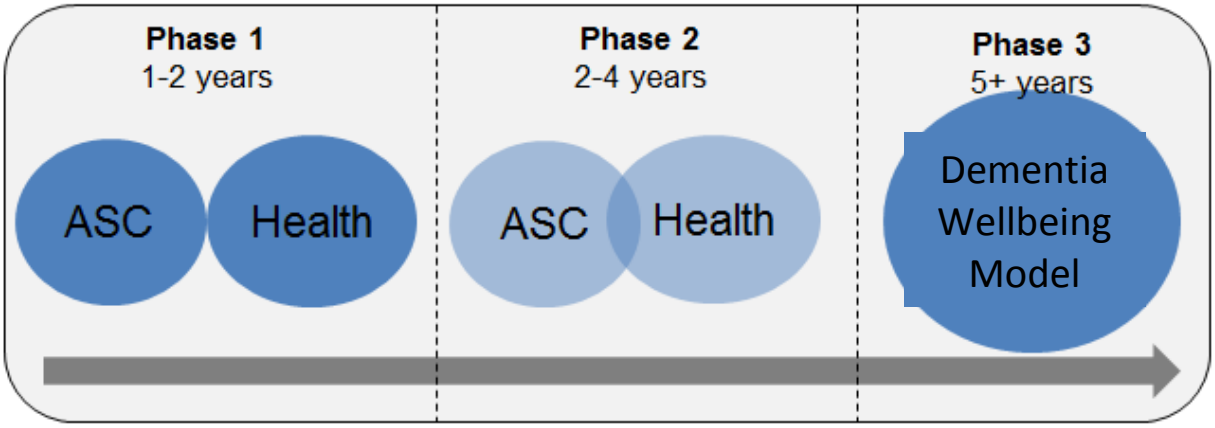
We aim to design systems that reflect the unique local and demographic needs of communities across Greater Essex but are able to;

- support people to receive a timely diagnosis,
- intervene earlier to inform and support people to adapt to a life with dementia and;
- develop communities that are inclusive to people living with dementia.

We want our systems to help families develop support networks to manage, or avoid times of crisis, explore independent living situations and not have to turn to hospital or long term care settings to manage. Collectively, our systems need to be structured to promote solutions that build upon people's strengths and support networks to achieve the outcomes they want, rather than impose service-based solutions.

A single dementia pathway that joins up health and social care services is the aspiration of this strategy; as we recognise the benefits this will bring to people living with dementia and the wider health and social care system. In an agreed locality, we aspire to having a single assessment, a single care plan and clear route to information and support that works around a person, their family and wider network

We recognise the vital role Primary Care play and strive to work with their skills, knowledge and expertise to develop a model that enables closer working between General Practitioners and the wider dementia care system. We recognise these aspirations are transformational changes and plan to approach these changes in phases, to achieve the aspiration of fully integrated models of dementia care within 5 years, across Greater Essex. Equally we recognise these changes should not happen in isolation to the wider health and social care system, and should align with the local priorities set out in Sustainable Transformation Plans as part of the Five Year Forward View.



2. A new model of specialist support

People with more complex needs or challenging behaviours cannot always find specialist advice or support when they need it. The lack of specialist advice can also lead to hospital or residential care admission when this might be avoided. Expertise on dementia tends to be concentrated in services for older people, which is not always appropriate for younger people with dementia or people with learning disability.

An integrated all-age dementia service for those with the most complex needs that will provide specialist advice and support across the Health and social care system in Essex, and possibly Southend , will support those that can sometimes be overlooked by the current system of support.

3. Support that is personalised and empowers people within an inclusive community

People living with dementia want information and support that enables them to adapt, but keep living the life they led prior to their diagnosis. They often feel isolated from the wider community and many feel scared to go out of their home. We think that a community-wide response is needed to address this problem.

Support should build upon a person's strengths, their skills, their qualities and their own resources. We want to empower people to embrace outdoor space, be physically active and take positive risks that enable them to live they life they want to lead. We recognise early intervention is a key part in achieving this; and strive to ensure people have access to timely intervention that enables it to happen. We need to change the culture of assessment, support planning and care, through the "Good Lives" approach (or Live Well, the approach used In Thurrock) to ensure that the person, and their family, are kept at the heart of what we do and enable them to live independently in the community for as long as possible. All people with dementia should be offered a personal budget, where applicable under the Care Act to give them maximum control over the kind of help they receive.

We have established a Pan-Essex Dementia Action Alliance to shape and influence a county wide response to dementia in Greater Essex; and worked with District Councils to form local alliances that can drive change in local towns, villages and Greater Essex Communities. We will continue to grow these alliances and aspire to engage a breadth of organisations across the private, public, community, third, health and social care sectors to commit to ways they will transform the lives of people living with dementia.

In Southend people living with dementia and their carers along with 44 businesses, services and community groups are working in partnership with Southend Borough Council to maintain the 'Working towards becoming Dementia Friendly' status awarded in March 2016. Southend is very fortunate to have a variety of members within the Southend Dementia Action Alliance (SDAA), including the UK's first dementia friendly airport, a committed community support approach from Essex Police Southend and Essex Fire & Rescue Southend. There are examples of dementia friendly support within Health, with a local GP Surgery working towards becoming a dementia friendly practice and a dedicated team of professionals within Southend Hospital creating dementia friendly wards through changing policies and cultures. Building on this work we feel confident that Southend will be a place where people affected by dementia can live their lives with access to the services and support they need to fully participate in community life.

We want Carers to feel supported in their own right and to be respected as partners in care. We will work with Carers to develop a network that enables their loved one but ensures they remain connected to information and support should they need it.

4. Maximise the use of technology

There are a growing number of ways that technology can be used to support people to remain independent, give Carers more freedom and peace of mind and reduce dependence on formal services all of which are outlined in the Dementia Technology. We will work with people to raise their awareness of technology as an enabler to independent living and we will create environments that enable the use of technology. We are working with partners to find and promote new tools that address some of the obstacles to independence faced by people with dementia and their Carers and will align with wider programmes of work taking place across Essex focused on developing digital response to health and social care needs.

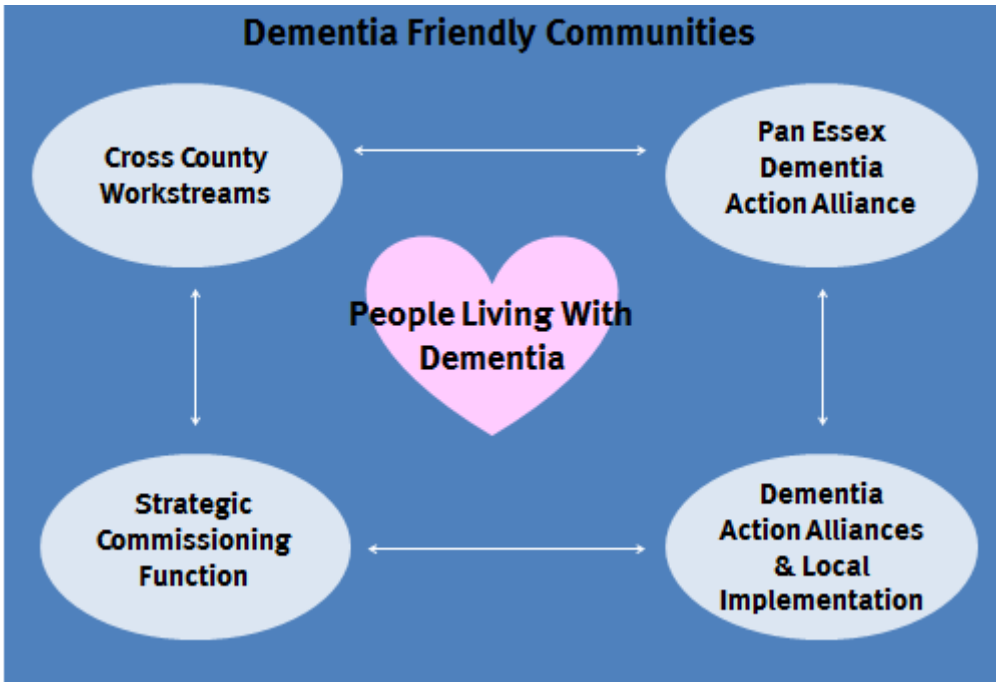
5. The voice of lived experience

We know to really meet the needs of people living with dementia, it's vital we listen to the voice of those living with the condition, not only to better understand the challenges they face but identify solutions to overcoming these challenges. We want to facilitate activity in the community that responds to need, and recognise the only way of doing so is to speak to those that are living with dementia day in, day out. We will involve those living with dementia in helping us achieve the aspirations set out in this strategy and continue to re-visit our vision to ensure the voice of lived

experience not only remains central to the transformation within the system, but helps to measure the impact of the new system. To underpin this strategy a sustainable way of engaging with people, in a relevant and meaningful way, will be developed. This, along with the community response, will be supported through the ongoing delivery of local Dementia Action Alliances and specific user groups to support engagement and to change the messaging around dementia in Greater Essex Communities.

To achieve our vision; and drive forward the actions set out in this strategy we recognise the need to bring together the five key elements listed above, to form a whole systems partnership function. A function that is responsible for mobilising activity, and implementing change but one that is accountable to the wider health and social care infrastructure that it works within.

Future partnership model:



Priorities

We have worked with our partners and through the Public Office engagement, to identify nine priorities that reflect key aspects of the lives of people living with dementia:

We want to intervene earlier to prevent needs from increasing and help people to continue to live independent lives, building on their strengths and the resources available to them within their personal network and the wider community.

For those who need ongoing support, we want to make sure this responds to the needs of individuals and supports the wider family network, with the offer of a personal budget to give them maximum control over their care and support.

Priority	Outcome	Success Measures
Prevention	People in Greater Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.	• Using the Making Every Contract Count approach, people understand the link between healthy and active lifestyles and are able to make positive changes in their lives • People have an increased awareness of Mild Cognitive Impairment • People are aware of how to access information and support should they be concerned about dementia • Increased percentage of people diagnosed with dementia receive an annual face to face review of their health needs, including medication, and whose vital health indicators are checked • People in BAME Greater Essex Communities have increased awareness of dementia and the warning signs. …. • Carers have access to annual health check and have access to Improved Access to Psychological Therapies
Finding information and advice	Everyone with dementia will have access to the right information at the right time.	• A comprehensive whole system Information and guidance offer is available. • People living with dementia will feel supported to navigate the system and access information and support that is relevant to them
Diagnosis and support	All people with dementia will receive appropriate and timely diagnosis and integrated support.	• GP's across Greater Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe • Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process • There is a clear referral pathway to diagnosis with appropriate information and support offered • BAME Greater Essex Communities are accessing assessment and diagnostic services • There is appropriate screening for people who are considered to be at high risk of dementia

		• People with dementia have access to post diagnostic support that is relevant and personalised • People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia, and plan for the future • People are offered a direct payment upon diagnosis of dementia where appropriate
Living well with dementia in the community	All people with Dementia are supported by their Greater Essex communities to remain independent for as long as possible	• There is a whole community response to living well with dementia • Environments and physical settings in the community are dementia friendly • People living with dementia are able to take advantage of open space and nature • The voice of lived experience helps to shape how Greater Essex Communities respond to dementia • People living with dementia are encouraged to access information and support that helps themselves to live well and independently • The lives of people living with dementia in the community are transformed through the DAA activity • Young people are part of the community support for people living with dementia • The market is able to respond to people living with dementia and support them to live well • People with dementia have awareness of alternative accommodation options
Supporting carers	Carers are supported to enable people with dementia to remain as independent as possible	• Carers are a driving force behind shaping the response to dementia in Greater Essex • Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia • Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy • Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges • Carers are able to access a range of opportunities to take a break from their role as a Carer
Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	• All hospitals to aspire to being dementia friendly care settings • People living with dementia, with complex needs such as co-morbidities are offered specialist information and support • Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively • Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments

		• The Community and Primary Care are able to respond to episodes of crisis in care homes appropriately
Living well in long term care	All people with dementia live well when in long term care	• All care homes for people with dementia in Greater Essex will be supported to be dementia friendly by 2020 • People living with dementia, their families and carers understand what high quality care looks like and where to find it • People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings through linking Dementia in to LD health checks • People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting • People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate
End of life	People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes	• People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP • People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate • People are not delayed in being discharged from hospital • People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose • Carers and families receive bereavement support at a time that is right for the individual or family
A knowledgeable and skilled workforce	All people with dementia receive support from knowledgeable and skilled professionals where needed	• There is a framework for dementia training across Greater Essex to ensure all people receive training relevant to their role • To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so. • To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well.

The stages of dementia

"Dementia" is a term that covers a range of symptoms that result from damage to the brain that can affect memory, attention, communication, problem-solving and behaviour. Every individual's "dementia journey" is very different. Some people may live for years without any obvious decline, while others experience rapid deterioration. However there are similarities in the challenges and pressures people experience as symptoms develop.

In the early stage, people may dismiss forgetfulness or difficulty concentrating as normal signs of ageing or attribute disorientation and mood swings to stress. Once symptoms begin to impact on normal life, diagnosis can be a relief but also lead to fear and denial about the future. People may feel a sense of loss, a loss of their identity and the person they believe they once were.

People with dementia say that it is important to feel that their life still has meaning. Some achieve this by maintaining relationships with important people in their lives or by keeping up interests. Others struggle through lack of opportunity, lack of confidence or other barriers. In the Alzheimer's Society Dementia 2014 survey, only 60% said that they left the house every day and 40% said that they felt lonely.

Dementia is a progressive condition which means that the symptoms will become worse over time. People's ability to make decisions about their lives or even day-to-day situations will decline. To compound these problems, a large proportion of people with dementia will also have other medical conditions or disabilities, such as arthritis, hearing problems, heart disease or mobility problems. The Alzheimer's Society found that 72% of respondents to their Dementia 2014 survey were living with another medical condition or disability – some were living with up to twelve conditions.

As the disease progresses, people gradually find normal activities challenging and may fear losing control as they become increasingly dependent on others. People may become depressed and anxious when diagnosed as well as when they begin lose their ability to do everyday things for themselves. In the late stage, people can become totally dependent on others for basic life tasks and this is often when they consider moving into a care home.

Ethnicity

Dementia among black, Asian and minority ethnic (BAME) Greater Essex Communities is significantly under-diagnosed and research by the Social Care Institute for Excellence has found that these groups are less likely to use dementia services. There are low levels of awareness, late diagnosis and a lack of culturally sensitive services. All of which makes it more difficult for people from these Greater Essex Communities to get the support they need. Greater Essex has a relatively small BAME population (5.7% in Essex and 13% in Southend) but the proportion of people receiving services is even smaller (1.2%) suggesting they are under-represented.

Early onset dementia

Care for younger people (ie under 65) with dementia is a challenge. Younger people with dementia face different issues, not least that they are more likely still to be working or have a young family. Support designed for older people with dementia is often not suitable for younger adults. This means that people with early onset dementia can find themselves isolated within the community. Those with more challenging needs can find it difficult to find suitable long term care options with the majority of solutions aimed either at older people or people with learning disability. The majority of people with dementia in Greater Essex are over 70 but 7.5% are younger than this and there are a few are under 30. In Southend 98% of people living with dementia are over 65 and just 38 people are registered under the age of 65.

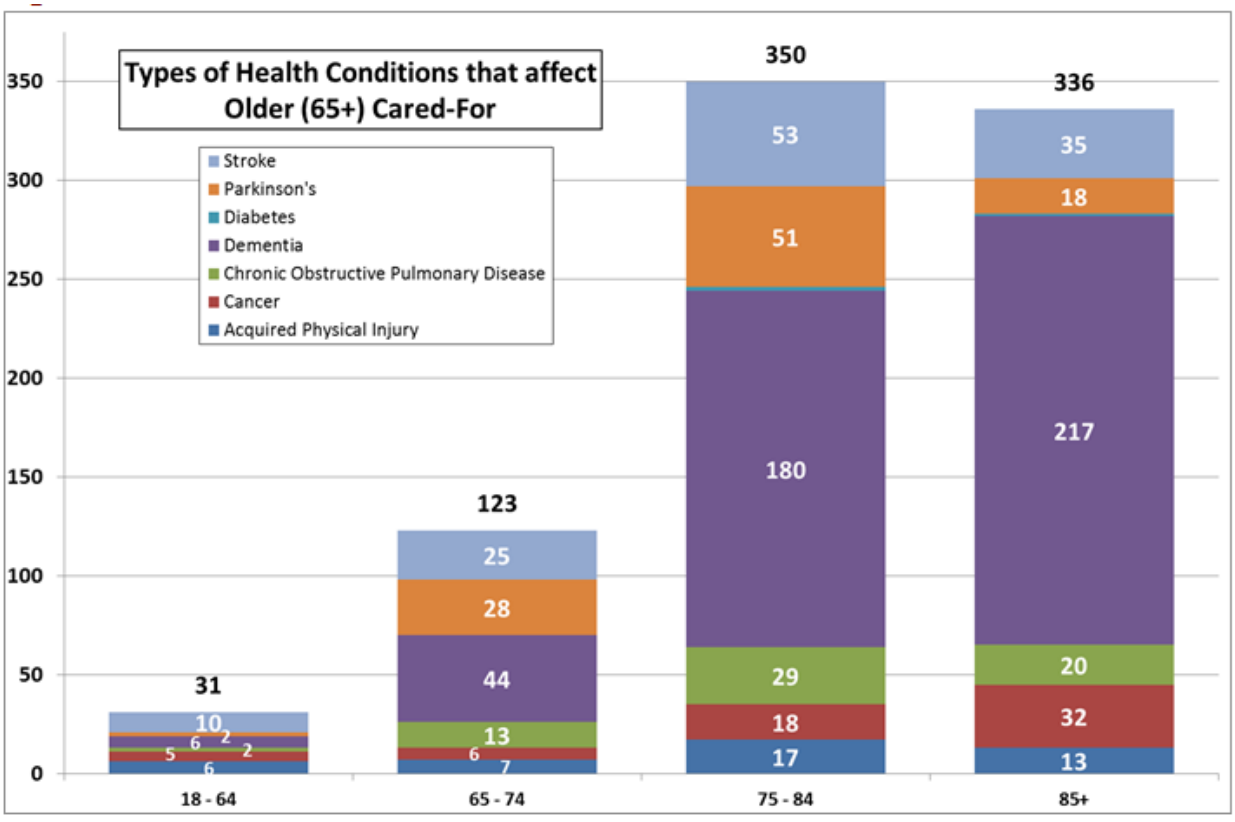
Learning disability and dementia

People with learning disabilities have a higher risk of developing dementia than other people and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s. Symptoms of dementia can present differently so that people often don't recognise changes as being dementia related. Because of this, opportunities for early intervention are lost. In Greater Essex we have found that mainstream diagnostic services are not geared up to assess people with learning disability, are not making reasonable adjustments and often refer people back to learning disability services. Likewise, mainstream dementia services are not geared to support people with learning disability or their carers.

Carers

Over 21 million people in the UK people know close friends or family affected by dementia and it is estimated that one in three people will care for a person with dementia in their lifetime (Prime Minister's Challenge on Dementia). Approximately one third receive no support from either social services or the voluntary sector. In Southend, Thurrock and Essex an estimated 145,000 provide care and support for someone who needs help (not specific to Dementia) with their day to day life of which about 32,000 are estimated to provide care for more than 50 hours per week. We know that over half of people who have approached ECC for a social care assessment have an unpaid family carer and there will be even more in the community who have not yet sought support from us (ECC Dementia Specialist Topic Needs Assessment (2015)). The support of family carers is often crucial to enabling people with dementia to remain in their community. They are often the first to spot changes in the person's health or behaviour and can support communication and sharing of information.

However carers of people with dementia can face a particularly challenging range of symptoms and behaviours that can persist over several years. Research shows that carers of older people with dementia experience greater strain and distress than carers of other older people (Carers Trust: The Triangle of Care: A guide to best practice in dementia care). In addition, many carers are themselves older people with physical frailty and health conditions of their own. The below graph has been taken from data provided at assessment:



Priority 1: Prevention

The issue

The risk of developing dementia increases with age. We estimate there are 19,000 people in Greater Essex with dementia, of which 55.4% are likely to have mild symptoms, while 12.5% are likely to have severe dementia requiring intensive levels of care and support. Most (81%) of people with dementia live in the community. A predicted 34% increase of dementia in Greater Essex (based on Office for National Statistics population projections (2014)) is larger than the national average and has huge implications for the local health and social care system.

According to Alzheimer's Society research (Dementia UK Update 2014), as many as 70% of people with dementia will also have other medical conditions or disabilities, such as arthritis, hearing problems, heart disease or mobility problems. Many will have one or two conditions, some will have far more. This emphasises the importance for people to receive advice and support that is tailored to their needs. The ability to measure awareness around cardio vascular risk factors, and general health and wellbeing will be key in supporting people to think in a preventative way.

The Blackfriars Consensus Statement (2014) made clear that the risk of some types of dementia can be reduced but it cannot be eliminated. There is growing evidence that cardiovascular factors, physical fitness, and diet have a major part to play in keeping the brain healthy and thus reduce the risk of developing dementia in later life. Other lifestyle choices such as not smoking, keeping low cholesterol and blood sugar can also help.

The economic impact of dementia is enormous. The Alzheimer's Society calculate the average annual cost per person with dementia as about £30,000 for those living in the community versus c. £37,000 for those in residential care. For people living in the community, three quarters of the cost relates to the indirect costs associated with the contribution of unpaid family carers. For those people in residential care, £32,700 relates to social care, this is £26.5bn a year, enough to pay for every household's energy bills in the UK. (Source Dementia 2015) Alzheimer's Society.

To maintain independence and quality of life as long as possible, it is essential we prioritise the health and wellbeing of people with dementia and that of their carers and support them to self-manage any co-existing health problems. Social isolation and loneliness can be a significant problem and can lead to anxiety and depression. However in Greater Essex the percentage of those diagnosed with dementia receiving an annual review from their GP or recording of vital health indicators is currently among the lowest in the country.

Outcome: People in Greater Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.

Success measures

- Using the Making Every Contract Count approach, people understand the link between healthy and active lifestyles and are able to make positive changes in their lives
- People have an increased awareness of Mild Cognitive Impairment
- People are aware how to access information and support should they be concerned about dementia
- Increase percentage of people diagnosed with dementia receive an annual face to face review of their health needs, including medication, and whose vital health indicators are checked
- People in BAME Greater Essex Communities have increased awareness
- Carers have access to annual health check and have access to Improved Access to Psychological Therapies

Priority 2: Finding information and advice

"There's so much information … where am I supposed to start?"

"I have been given a lot of information, cannot make head nor tail of it and not sure what it all means…"

"It is difficult for carers to find out what help is out there and how to access it." Counsellor

The issue

Information and advice is fundamental to enabling people, carers and families to take control of their care and make well-informed decisions about the support they need. We need to help people find and connect to resources and support that will help them get on with their life and develop technological solutions that make it easier for them to do this. However people tell us that they struggle to navigate the large amount of information available about dementia and identify the right support in their area. This can be really distressing when people are at a vulnerable point, such as when they have just received a diagnosis or when they have an immediate need for help. The offer of information and advice needs to be personalised because people will have different preferences for how they want to receive information.

GPs and their surgeries can be key sources of information but the quality and availability of information available is variable. From April 2015, everyone with dementia should have access to a named GP with overall responsibility for their care.

Outcome: Everyone living dementia will have access to the right information at the right time.

Success measures

- A comprehensive whole system Information and guidance offer is available.
- People living with dementia will feel supported to navigate the system and access information and support that is relevant to them

Priority 3: Diagnosis and assessment

"Getting a diagnosis took so long. It was a huge relief when it finally came … I knew then I wasn't

imagining it. We could start to make plans."

"I was given this devastating news, given a folder of stuff and left to get on with it in the darkness."

"At the point of diagnosis we need someone who is there for the family. Not just bits of paper and a crisis line. … We need practical, real advice from someone who knows what we're experiencing. … Someone who can walk you through it and who can say "well done" … Carer

The issue

Early diagnosis of dementia is vital because it helps people to understand what is happening to them, make plans and gain access to the most appropriate support and treatment. Some professionals can be reluctant to refer people for diagnosis because of a perceived lack of post-diagnostic support, amongst other reasons. In Essex, 52% of the estimated dementia population have a diagnosis. In Southend the diagnosis rate at December 2016 was 72.6%. The national target is 67%.

Some groups are at higher risk of not being diagnosed. Greater Essex has a relatively low BAME population (5.7%) but the proportion of people of BAME origin receiving services generally, is even lower (1.2%), suggesting they are underrepresented. In Southend the BAME population in the 2011 census was 13%

Early onset dementia can be harder to recognise and diagnose and people may still be working and have young children. In Greater Essex 7.5% of those with dementia are under 70 and a few are under 30. Finally, people with learning disabilities are at significantly higher risk of developing dementia and at a younger age. There are no specialist services for people with both LD and dementia in Greater Essex.

Following diagnosis, people need personalised ongoing support and advice both to understand their condition; the support available (including for their carers) and the importance of planning in advance. They should have an assessment of their needs and a personalised care plan covering both health and social care.

Outcome: All people with dementia will receive appropriate and timely diagnosis and integrated support.

Success measures

- GP's across Greater Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe
- Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process
- There is a clear referral pathway to diagnosis with appropriate information and support offered
- BAME Greater Essex Communities are accessing assessment and diagnostic services
- There is appropriate screening for people who are considered to be at high risk of dementia
- People with dementia have access to post diagnostic support that is relevant and personalised
- People living with dementia and their entire network are supported to draw on their strengths and assets to adapt to living a life with dementia, and plan for the future
- People are offered a direct payment upon diagnosis of dementia

Priority 4: Living well with dementia in the community

"People don't know what to say or do … your world gets very small all of a sudden."

"I'd love to jump on the bike and go for a 20 mile bike ride, but I couldn't see the carers doing that. You've got to tone yourself down to suit them, rather than the other way round."

"my mother … wishes to stay living in the home she has known for 40 years, where she is comfortable; where she is known. It is proving almost impossible both practically and financially … My mother is still very sociable and very active. She has many friends and loves her family and her community." Carer

"At first he didn't think "activity centres" were really for people like him. Who can blame him really? Who else is a grown up and goes to an "activity centre"?" Carer

"I don't want to spend my life doing too many dementia connected activities. And neither does Cathy. It's not fun for her. She wants to go to her sewing classes and for lunch." Carer

"Communities aren't ready. Most Communities are unaware, are fearful of dementia and shut their eyes to it … Other than the odd good neighbour; Communities are painfully unaware of dementia in their Communities." Social worker

"It should be possible for people to do what they can for as long as they can, not wrapped in cotton wool. This would also help avoid crisis point for relatives of people with dementia." Service provider.

The issue

Especially in the early stages, people with dementia tell us that they want to continue to live their life as normally as possible. This means staying in their own home, being included in their local community, maintaining friendships and interests. As people's symptoms worsen they become more dependent on others for transport and general help to be able to do this. Fear about becoming confused or getting lost also leads to people going out less and restricting themselves to less demanding activities, which can lead to them becoming more isolated from the community. Loneliness is an increasing problem and can lead to depression or anxiety – over half of those we support who have dementia are widowed and about 4% live alone.

We know that there are gaps in the support available for people with dementia in Greater Essex. Greater Essex is above average in providing equipment or adaptations to help people stay in their own homes but below average in its provision of home care. Services are also not personalised. They often group people together without taking account of their individual capability or their personal preferences, experiences or personality. There is a limited range of activity to choose from in some areas and few services at evenings or weekends. Transport is a problem, particularly in more rural parts of the county. There is little support to help people maintain friendships or relationships or make new ones.

The traditional approach to assessing people's needs can be too focused on assessing for services. In fact formal services are just part of a wider network of community support which encompasses other public services, voluntary and commercial services, local amenities and the informal help and support that Greater Essex residents give to each other.

We want to promote a more inclusive approach to help people live independently in their community, maintaining the relationships and activities that matter to them. We will do this by helping people and their families to use their existing strengths and resources and connect to things that will help them get on with their lives. Where people need more intensive support we will make sure this is tailored to their individual needs and preferences, with the option of a personal budget to give them maximum control over the kind of help they receive.

In a Dementia Friendly Community people are empowered to have aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them. But we know that there is still stigma and misunderstanding in our Greater Essex Communities and that people are not knowledgeable about dementia or how to help someone with the disease live well. Key services including blue light services, supermarkets, banks, etc. do not always have staff able to recognise and support people with dementia.

Outcome: People living with dementia feel able to access and contribute to their community, undertaking day to day tasks that supports them to remain as independent for as long as possible.

Success measures

- There is a whole community response to living well with dementia
- Environments and physical settings in the community are dementia friendly
- People living with dementia are able to take advantage of open space and nature
- The voice of lived experience helps to shape how Greater Essex Communities respond to dementia
- People living with dementia are encouraged to access information and support that helps themselves to live well and independently
- The lives of people living with dementia in the community are transformed through the DAA activity
- Young people are part of the community support for people living with dementia
- The market is able to respond to people living with dementia and support them to live well
- People with dementia have awareness of alternative accommodation options

Priority 5: Supporting Carers

"The diagnosis was a difficult experience … I walked in a daughter and walked out a carer." Carer

"We had a really bad night a few weeks ago. He was in one of his moods, and I was stressed out of my mind trying to deal with him… it was maybe 3am and I just wanted to be able to call someone – anyone – to get some advice or just to hear a friendly voice." – Carer

"**I have to stop myself from thinking about more than one day ahead because if you try, it overwhelms you. It destroys you."** Carer

"Carers find it really difficult to leave the people they are caring for … they feel guilty at taking time for themselves and worry about the person they have left … On a practical level it is sometimes impossible as Carers don't have anyone to stay with their loved one, of if they do it is for such short amounts of time and they need to reserve that time for essentials. This is more difficult for dementia carers because it is harder to find someone their loved one feels safe with." Counsellor

"[Carers] need better, easier information and they need the peace of mind that someone is there for them at any time … that does a huge amount. … they just want to know someone is there … it can be so worrying and stressful for a 70 year old caring for a partner." Social Worker

The issue

The impact on the family of a person diagnosed with dementia is significant, especially on family members who take on the responsibility of caring for the person. Diagnosis can be a difficult time for the carer as much as for the person with dementia. The condition can have a major impact on their relationship as the person becomes more dependent on their family for day to day support. Carers tell us they need help to understand the condition and how it is likely to affect their family member and may need help to find support for them both.

People with dementia become increasingly dependent on others and in the later stages may develop behaviours and psychological symptoms that make them among the most challenging to care for. Many carers gain personal satisfaction from caring and want to continue but caring comes at great personal cost. 40% of carers experience psychological distress or depression with those caring for people with behavioural problems experiencing the highest levels of distress (Carers Trust: Triangle of Care: Best practice for dementia care). Yet their ability to continue caring may be essential to the person being able to remain in the community. Carers tell us that they need practical support and reassurance in caring and someone to turn to when things get tough.

Carers find it difficult to take time for themselves, whether to take a break or for essential activities such as their own health appointments, because it can be hard to find others they trust who are willing or able to look after someone with dementia. Services are not always the best answer. They are often at the wrong time or place and may not offer things that people really want. But carers of people with dementia often end up relying on a narrow range of day services and dementia cafés for lack of alternative forms of support.

When it comes to longer breaks, carers evidently find it hard to find suitable options and gain access to them. In addition there are limited options for people with more complex needs or who are more challenging to care for. We need to work with people with dementia and their carers to understand what they need and examine the full range of options within their own network and the wider community that would allow them to take a break, whether on their own or with the person they care for.

It is also important that health and care professionals listen to the carer and work with them to support the person with dementia. As well as giving the carer peace of mind, working in partnership with the carer can achieve better outcomes for the person with dementia and ensure services have a fuller picture of the person's needs. Yet carers report feeling disconnected from the process and frustrated that they are not listened to.

Outcome: People caring for someone living with dementia feel informed and able to support their loved one, whilst able to maintain their own health and wellbeing

Success Measures

- Carers are a driving force behind shaping the response to dementia in Greater Essex
- Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia
- Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy
- Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges
- Carers are able to access a range of opportunities to take a break from their role as a Carer

Priority 6: Reducing the risk of Crisis

"I was so exhausted by it all I almost gave in and said "do what you want" but I managed to make it in the end" – Carer

"If you're kicking off at home because you don't recognise it is home, what help is it to be whisked into the middle of the night to be with complete strangers?" Carer

"She called us because she wanted someone to talk to. … As her condition was progressing she felt scared. She had gone into her local town shopping as she always had but had got lost and was found walking round the roundabout." Advice service

"It is so easy to get lost in the "firefighting" element of managing the disease on a day-to-day basis and not be more proactive in looking at how to develop coping techniques. … People need to be helped to have a "roadmap" of the progression of the disease and what problems they will face. … Care Manager

"People don't contact us until they're in crisis. And when they do contact us, there are often two people in crisis … the individual with dementia and their carer. We wait for people to come to us and by then the dementia has progressed quite far … we have to be more proactive." Social Worker

The issue

Dementia is not a generic condition. People with dementia can develop a wide range of symptoms that are particularly challenging for carers and put unprecedented demand on services. These can include aggression, agitation, delusions, wandering, night time waking, hoarding, loss of inhibition and shouting. Behavioural and Psychological Symptoms of Dementia (BPSD) can lead to crisis and care breakdown resulting in admission to acute services or residential care. Some people with dementia also have other conditions, such as learning disability or long term health problems, that can make their condition even more complex.

Other crises can occur as a result of the carer themselves becoming injured, ill or unable to continue caring, leaving the person with dementia unsupported. Carers can be at increased risk of becoming ill as a result of caring. Studies have shown that providing carers with breaks from caring, emotional support and access to training can significantly delay the need for the person receiving care to go into residential care. It may also prevent emergency hospital admission.

Finally, people with dementia can experience other physical or mental health problems which, if not identified and addressed, can lead to admission to acute hospital or mental health services. Nationally, 25% of hospital beds are thought to be occupied by someone with dementia (Fix Dementia Care; Hospitals Report 2016 (Alzheimer's society), and in Greater Essex we know that people living with dementia stay in hospital 50% longer than those without. Care Managers say that it can take days or even weeks for mental health services to respond to a referral. Social workers told us that mental health teams are focused on preventing escalation to residential and acute services but that we need to identify and support people earlier and look at the role of community psychiatric support to keep people out of hospital.

Outcome: All people with dementia receive support to reduce the risk and manage crisis

Success Measures

- All hospitals to aspire to being dementia friendly care settings
- People living with dementia, with complex needs such as co-morbidities are offered specialist information and support
- Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively
- Emergency planning, including clinical emergency planning is addressed as part of all carer's assessments
- Primary Care are able to respond to episodes of crisis in care homes appropriately

Priority 7: Living well in long term care

"I can't trust that they're going to follow his care plan … I can't switch off" – Carer

"I had to place someone four times due to his dementia. His behaviour wasn't difficult – he just needed personalised support. His behaviour deteriorated due to the transfers but this should have been anticipated." Social Worker

"The biggest impact … to assist those living with dementia is education. To educate people and eradicate the stigma that is related to care homes and dementia. There is not enough positive media reporting with care homes that focus on the positive good work that they do rather than the poor homes" Care Home Manager

"We'll always have a member of staff in the lounge who can make sure people don't get out of their chairs." Care Home

"Care homes need to be enabled to provide outings, passionate about taking people outside, but I accept care homes are not staffed to provide regular outings for people in their care. We need to find another way to ensure people have a life." Service manager

The issue

In 2014 the Care Quality Commission found that whilst many hospitals and care homes deliver excellent care, the quality of care for people with dementia varied greatly. A key issue was that some hospitals and care homes did not comprehensively identify all of a person's care needs and there was variable or poor staff understanding and knowledge of dementia care.

The government wants to avoid people with dementia requiring long term care by improving the provision of local community services, education and training. The majority (85%) of people with dementia say that they would prefer to remain in their own home. In Greater Essex over 80% of people with dementia live in the community but the proportion of people with dementia supported in residential care is still higher in this county than in similar local authorities.

There are currently 252 care homes and 81 nursing homes for people with dementia across the county. There is a lack of data about the quality of residential care in the market and carers and families tell us that they struggle to find appropriate care for the person they care for.

The government wants all hospitals and care homes to meet agreed criteria to become dementia friendly by 2020.

Outcome: All people with dementia live well when in long term care and able to access their community as appropriate

Success Measures

- All care homes for people with dementia in Greater Essex to be dementia friendly by 2020
- People living with dementia, their families and carers understand what high quality care looks like and where to find it
- People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings through linking Dementia in to LD health checks
- People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting
  People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate

Priority 8: End of life

"People's wishes are not known. We need to get this information earlier … " Social Worker

"People don't plan … we need to help people plan for the inevitable whilst they've still got the capability." Social Worker

The issue

It is important to have early conversations with people with dementia about advance planning and end of life care so that people can plan ahead and ensure that their wishes are known and acted upon. The government has said that all people with a diagnosis of dementia should be given the opportunity for advance care planning early on to ensure the person and their carer are fully involved in decisions on care at end of life.

The aim should be to maximise the person's quality of life and support carers. All people with dementia and their carers should receive coordinated, compassionate and person-centred care towards the end of their life. This includes palliative care for the person with dementia and bereavement support for carers.

Outcome: People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes

Success Measures

- People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP
- People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate
- People are not delayed in being discharged from hospital
- People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose
- Carers and families receive bereavement support at a time that is right for the individual or family

Priority 9: A knowledgeable and skilled workforce

"People think you can't communicate with people with dementia; there is a general lack of awareness." Support worker

"The biggest impact that could happen to assist those living with dementia is education. To educate people and eradicate the stigma … " Care home manager

The issue

If health and care professionals and all other care workers understand the complexity of dementia; its impact upon the person and their family and know how to provide effective help and support, this will improve the quality of information, advice and care that people receive in all areas. Poor quality care has a major, negative impact on the quality of life of the person with dementia and causes stress and anxiety for their carer. It can also lead to higher care costs when health and social care professionals do not know how to support people to maintain their independence and quality of life in the community.

Across health and social care there is a lack of consistency or a clear pathway around dementia training. Training is provided at different levels and there is no clear picture of what the training is meant to deliver.

Outcome: All people with dementia receive support from knowledgeable and skilled professionals where needed

Success Measures

- There is a framework for dementia training across Greater Essex to ensure all people receive training relevant to their role
- To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so.
- To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well.

Key Documents

Alzheimer's Society (2010). *My name is not dementia*

Alzheimer's Society (2013). *Building dementia-friendly Greater Greater Essex Greater Greater Essex Communities: a priority for everyone*

Alzheimer's Society (2014). *Dementia 2014: Opportunity for Change*

Carers Trust & Royal College of Nursing (2013). *The Triangle of Care: Carers Included: a Guide to Best Practice for Dementia Care*

Department of Health (February 2015): *Prime Minister's Challenge on dementia 2020*

Greater Essex County Council (April 2015). *Carers count in Greater Essex: Greater Essex Carers Strategy 2015-2020*

Greater Essex County Council (June 2015). *Dementia specialist topic needs assessment.*

Greater Essex County Council (June 2015): *Literature review of interventions to support the dementia needs assessment*

ESRO and ThePublicOffice (2015). *Living well with dementia in Greater Essex: ethnographic research findings*

Joint Commissioning Panel for Mental Health (2013). *Guidance for commissioners of dementia services*

National Institute for Health and Care Excellence (2006, modified March 2015). *Clinical Guideline 42: Dementia: supporting people with dementia and their carers in health and social care*

National Institute for Health and Care Excellence (April 2013). *Quality Standard 30: Supporting people to live well with dementia*

The Princess Royal Trust for Carers and the Royal College of General Practitioners (2011). *Supporting carers: an action guide for general practitioners and their teams*

Public Health England and UK Health Forum (2014). *Blackfriars Consensus on promoting brain health: reducing risks for dementia in the population.*

Royal College of General Practitioners (2013). *Commissioning for Carers*

Southend on sea borough Council (Jan 2016) Themes From the Consultation Workshops

Southend on sea Borough Council (December 2016)Dementia JSNA (draft)

Technology Charter https://www.alzheimers.org.uk/technologycharter

Glossary

ASC	Adult Social Care
BAME	Black and minority ethnic groups
BPSB	Behavioural and psychological symptoms of dementia
DAA	Dementia Action Alliance
GP	General Practitioner
LD	Learning Disability
MCI	Mild Cognitive Impairment
Good Lives	ECC approach to Social Care

Appendix – Implementation Plan

Business as Usual Delivery

The following can be achieved within the current budget envelope for the Dementia Service to contribute to delivering our vision for all people living with Dementia, their families and carers in Essex. You can see from the table how the activity links in to the priorities and outcomes outlined in the strategy as well as how we propose we will measure whether or not we are successful. The Transition states show how the emphasis for delivery will shift from Greater Essex led delivery (Pan Essex which includes Health) to Local Implementation (LI) and Community delivery:

Priority Area	Outcome	Success Measure	Measurement	Activity	Transition State 1 : Years 1-2				Transition State 2 : Years 3-4				Transition State 3 : Years 5+				Cost
					Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	
Prevention	People in Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.	People understand the link between healthy and active lifestyles and reducing their cardio vascular risk factor	Number of people who are able to identify ways to reduce their cardio vascular risk factor Number of people enaged in activity for mental wellbeing Number of people living active and healthy lifestyles	PH activity to increase understanding / Campaign	X				X				X				H
		People have an increased awareness of MCI	Number of people accessing MCI information	IAG offer developed	X				X				X				L
				Community awareness raising	X				X				X				L
		People are aware how to access information and support should they be concerned about dementia	Number of people accessing IAG Number of referrals to Community Agent+	As above	X				X				X				L
Finding Information and Advice	Everyone with dementia will have access to the right information at the right time.	A comprehensive whole system Information and guidance offer is available.	Is there one? What is its reach? Who is accessing it?	Definition of Comprehensive	X	X			X	X	X		X	X	X	X	L
				Development of Offer	X	X			X	X	X		X	X	X	X	L
				Linking in with Technology Enabled Care	X	X			X	X	X		X	X	X	X	H

		People living with dementia will feel supported to navigate the system and access information and support that is relevant to them		As above	X	X			X	X	X		X	X	X	X	L
Living well with Dementia in the community	All people with Dementia are supported by their communities to remain independent for as long as possible	There is a whole community response to living well with dementia	Number of Dementia Friendly Communities Coverage of DAA across Essex	Delivery of the DAA across Essex	X						X					X	L
				Commissioning a Dementia Friendly Co-ordinator to drive the demential friendly network	X						X					X	L
				Promotion of Dementia Friends in the communities of Essex	X						X					X	L
		Environments and physical settings in the community are dementia friendly	As above	As above	X						X					X	L
		People living with dementia are able to take advantage of open space and nature	Number of "green" commmunities with Dementia Friendly Number of people engagin with green spaces as part of their dementia support	Green prescription project focused on enabling communities to do this	X						X					X	L
		The voice of lived experience helps to shape how communities respond to dementia	Number of Lived Experience conversations to support shaping community action	Delivery of Lived Experience training	X						X					X	L
				Process by which commissioned services use this type of conversation to shape support	X						X					X	L
				Ongoing development of Healthwatch sustainable process for engaging with people with Dementia to shape their support and offer	X						X					X	L
		People living with dementia are encouraged to access information and support to help themselves	Number of people accessing the service that received low level support/signposting	Family Navigation and Information Support service delivery	X						X					X	L

		The lives of people living with dementia in the community are transformed through the DAA activity	Reduction in admission to hospital Reduction in admissions to long term care Number of people who feel their lives have improved since becoming involved with their communities	As above	X						X					X	L
		Young people are part of the community support for people living with dementia	Number of under 18's involved in community dementia support Number of under 18 dementia friendly	As above	X						X					X	L
		The market is able to respond to people living with dementia and support them to live well	Number of dementia champions within each provider setting Number of dementia Friendly Care settings	Delivery of Residential and Domicillary Provider forums	X						X					X	L
		People with dementia have awareness of alternative accommodation options	Number of people with Dementia accessing alternative accomodation options	Family Navigation and Information Support service delivery	X						X					X	L
Supporting Carers	Carers are supported to enable people with dementia to remain as independent as possible	Carers are a driving force behind shaping the response to dementia in Essex	Number of carers engaging in Dementia quality assurance Number of carers on design forum	Development of Dementia Carers network to assess all settings where Dementia support is offered	X				X		X				X		L
				Development of Dementia Carers service design forum for developing support where needed	X				X		X				X		L
		Carers are encouraged to build on their own support networks to live well and keep physically and emotionally healthy	Number of crisis for carers Number of carers who have accessed support networks following our intervention	Family information and support network developed to provide them with relevant information and timely appropriate support	X				X		X				X		M
				Development of community neighbourhood model	X				X		X				X		M

				Development of DAA to support carers	X				X		X				X		L
Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	All hospitals to aspire to being dementia friendly care settings	Number of dementia friendly hospitals	Collectively share best practise around supporting people with Dementia in an acute setting	X				X		X				X		L
				Explore contractual changes with acute settings	X				X		X				X		L
		People living with dementia, with complex needs such as co-morbidities are offered specialist information and support	Number of family group conferences carried out Number of hospital/long term care admissions	Identification of "high risk" people and working together to co-ordinate a care plan to support them	X				X		X				X		L
				Development of process for linking multiple condition systems	X				X		X				X		L
		Crisis situations are avoided or managed appropriately - Crisis situations are planned for and responded to effectively	Number of crisis plans developed Number of crisis Acute Admissions	Support Good Lives centres to support individuals to plan for and manage crisis	X				X		X				X		L
				An all age dementia offer developed for those who required their complex needs managed	X				X		X				X		H
				Develop Care Home response to Crisis and approaches for managing times of crisis	X				X		X				X		M
		Emergency planning is addressed as part of all carer's assessments	Number of carers assessment that incllludes emergency planning	As above	X				X		X				X		L
Living well in Long Term Care	All people with dementia live well when in long term care	All care homes for people with dementia in Essex to be dementia friendly by 2020	Number of Dementia Friendly Care Homes	Comms exercise to promote Dementia Friends programme and local alliance	X				X		X		X		X		M
				Explore contractual changes with Care Homes	X				X		X		X		X		L
		People living with dementia, their families and carers understand what high quality care	Number of people who are aware of the varying options they have for care	How we can work with carers to understand how their voice can support the quality of care	X				X		X		X		X		L

		looks like and where to find it		Development of a best practise guide for Carers to use when researching long term Dementia Care in Essex as part of IAG offer	X				X		X		X		X		L
		People with learning disabilities who have dementia, (or at risk of), are fully supported in long term care settings	Number of people with Learning Disabilities who have a holistic assessment of need	Ensure that Care settings are able to "Identify how best to meet individuals needs" especially for those considering "high risk" of developing dementia	X				X		X		X		X		L
				Developing a pathway link that supports people with learning disabilities to obtain a timely diagnosis	X				X		X		X		X		L
				Dementia Champions within LD care settings	X				X		X		X		X		M
		People with dementia in long term care are encouraged to build and maintain networks both in and out of the care setting	Number of People with Dementia accessing the Dementia Friendly network in Essex	Dementia friendly network in Essex developed to be inclusive	X				X		X		X		X		:L
				Support the care workforce to link with the dementia friendly network and to look outside of their setting to provide support	X				X		X		X		X		M
				Carers knowledge and confidence increased to allow them to become part of the network outside of the care setting	X				X		X		X		X		L
		People assessed as not having capacity, with no family or friends are referred to an Independent Mental Capacity Advocate as appropriate	Increase No. of MCA referrals	Process and guidance change/communication	X				X		X		X		X		L
End of Life	People with dementia and their families plan ahead, receive good end of life care	People assessed as not having capacity, with no family or friends are referred to an Independent	Increase No. of MCA referrals	Process and guidance change/communication	X				X		X		X		X		L

	and are able to die in accordance with their wishes	Mental Capacity Advocate as appropriate																
		People are informed of options about end of life and are given the appropriate support, respect and dignity to die in the place they choose	Number of people who "feel informed" about EOL options Number of people completing EOL Advanced Care Plans Number of people who die in their place of choice	Delivery of the above	X				X		X		X		X		-
		Carers and families receive bereavement support	Number of people who are offered berevement support following the death of a relative with Dementia	Determining current market offer for berevement support and forging links to sign post people to	X				X		X		X		X		
A Knowledgeable and Skilled Workforce	All people with dementia receive support from knowledgeable and skilled professionals where needed	There is a framework for dementia training across Essex to ensure all people receive training relevant to their role	Framework in place for training	Link in with Health Education England to see if there is an existing framework we can use	X				X				X				-
				Identify whether a national framework is useful for Essex	X				X				X				-
				Link Health and ECC Training programmes to map how what is currently delivered sits against the framework	X				X				X				-
				Task and finish group to identify gaps and solutions to improve this	X				X				X				L
		To develop a workforce across the dementia care system that has the right skills, behaviours and values to support people living with dementia, and is equipped to do so.		Development of the above framework	X				X				X				-

Additional Delivery

The following activity will help us delivery our aspirations and vision set out in the strategy but will required addition investment to deliver. It is expected that an Outline Business Case (OBC) will be developed to request the level of investment needed to improve the lives of people living with dementia, the families and carers. Again, you can see from the table how the activity links in to the priorities and outcomes outlined in the strategy as well as how we propose we will measure whether or not we are successful. At this time the level of investment/cost is not given as a financial figure as this will be part of the OBC:

Priority Area	Outcome	Success Measure	Measurement	Activity	Transition State 1 : Years 1-2				Transition State 2 : Years 3-4				Transition State 3 : Years 5+				Cost
					Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	Pan Essex	Health	LI	Community	
Prevention	People in Essex will have good health and wellbeing, enabling them to live full and independent lives for longer.	People are aware how to access information and support should they be concerned about dementia	Number of people accessing IAG Number of referrals to Community Agent+	Commissioning Integrated Offer of peri-diagnosis services			X				X						
		Increase percentage of people diagnosed with dementia receive an annual face to face review of their health needs, and whose vital health indicators are checked	Number of people diagnosed Number of f2f reviews Number of vital health indicator checks	Developing a clear pathway from Community to primary care			X				X						L
				Developing a clear pathways from primary to secondary care			X				X						M
				Development of an integrated model of care with Health	X	X			X	X							H
		People in BAME communities have increased awareness	Number of BAME accessing services Number of BAME diagnosed	Commissioning of Dementia Co-ordinato	X						X					X	L
				Development of Community Agent + service	X				X				X			X	M
				Dedicated promotion in these communities	X				X	X					X	X	M

		Carers have access to annual health check and have access to Improved Access to Psychological Therapies	Number of Carers having annual health checks Number of carers accessing Pychological Therapies	As above - pathways		X				X	X				X	X	L
Diagnosis and Support	All people with dementia will receive appropriate and timely diagnosis and integrated support	GP's across Essex understand the importance of a timely diagnosis and are aspiring to work with the wider system to diagnose within an appropriate timeframe	Number of GPs who use the identified process Number of people diagnosed before crisis by GPs Number of GPs maintaining a diagnosis rate of at least two thirds Waiting time between referral and diagnosis Number of memory clinic referrals	Work with Primary care to develop an integrated diagnostic model that is centred around GPs	X	X			X	X	X				X		H
				Develop compreheisve post diagnositc offer that can be accessed from the point of diagnosis	X	X			X	X	X				X		H
				Communication of Dementia within GP clinics	X	X			X	X	X				X		H
				Develop action plan for Increasing the numbers of people receiving dementia diagnosis within six weeks of GP referral	X	X			X	X	X				X		H
				Develop Community Agent + capacity to support	X	X			X	X	X				X		H
				Promoting timely diagnosis within GP training networks	X	X			X	X	X				X		H
		Professionals across the system are aware of referral pathways and are able to work together to best support the assessment and diagnostic process	Number of people using appropriate pathway	Development of a clear pathway across the dementia system that is visible to all including access/exit points	X	X			X	X	X				X		M
		There is a clear referral pathway to diagnosis with appropriate information and	Number of people using appropriate pathway	Development of Customer Journeys	X	X			X	X	X				X		H
				Investment in primary care to support timely diagnosis	X	X			X	X	X				X		H

		support offered		IAG with communities to understand the process for delivery	X	X			X	X	X				X		H
				Community Agent + resource within GP surgeries	X	X			X	X	X				X		H
		BAME communities are accessing assessment and diagnostic services	Number of BAME accessing services	Development of visible services that are communicated sensitively for those who wish to access it	X	X			X	X	X				X		L
				Development of DAA to support BAME communities	X	X			X	X	X				X		L
		There is appropriate screening for people who are considered to be at high risk of dementia	Number of people diagnosis from a high risk categeory	Identification of "high risk" people and working together to co-ordinate a care plan to support them	X	X			X	X	X				X		H
				Development of an All Age Dementia response service	X	X			X	X	X				X		H
		People with dementia have access to post diagnostic support that is relevant and personalised	Range of post-diagnosis support linked to the system	Range of tools developed to support people to access the level of support that is appropriate to them post diagnosis	X	X			X	X	X				X		M
				Agree an affordable implementation plan for the prime minister's challenge on dementia 2020, including to improve the quality of post diagnosis treatment and support	X	X			X	X	X				X		M
		People living with dementia and their entire network are supported to draw on their strengths and	Number of Family group conferences carried out Number of collaborative care plans	As above	X	X			X	X	X				X		L

		assets to adapt to living a life with dementia, and plan for the future															
		People are offered a direct payment upon diagnosis of dementia	Number of people with a direct payment following Diagnosis	As above	X	X			X	X	X				X		L
Supporting Carers	Carers are supported to enable people with dementia to remain as independent as possible	Carers of people living dementia are offered information and support relevant to their needs, throughout their experience with dementia	Number of referrals for carers assessments Number of carers offered support and guidance Number of carers on Carers registers	Family information and support model developed to take Carers views in to account and identifying opportunities to empower them to remain healthy	X				X		X				X		L
				Development of carers specific IAG offer	X				X		X				X		L
				Identifying how Primary Care currently support and record carers	X				X		X				X		M
				Working with primary care to develop carers registers	X				X		X				X		H
		Carers feel informed and equipped to care for someone living with dementia and able to plan, or flex to increased needs or challenges	Number of carers who feel informed and equipped	Access to relevant information and timely appropriate support from the point of concern developed and communicated to Essex	X				X		X				X		M
		Carers are able to access a range of opportunities to take a break from their role as a Carer	Number of opportunities available for Carers Number of carers actively taking a break from their role Number of carer breakdowns	Working with carer programme to identify an action plan to support carers of people living with Dementia	X				X		X				X		L
Reducing the risk of crisis	All people with dementia receive support to reduce the risk and manage crisis	Primary Care are able to respond to episodes of crisis in care homes appropriately	Number of acute admissions from Care Homes following Primary Care involvement	Development of response teams with GPs and the community to avoid hospital admissions from Care Homes because of crisis (Community Models)		X			X				X		X		H

End of Life	People with dementia and their families plan ahead, receive good end of life care and are able to die in accordance with their wishes	People living with dementia, their families and carers complete advanced care plans that are recorded and held by the GP	Number of advanced care plans completed Number of advanced care plans completed in consultation with people living with dementia	Agree a central system of recording Care plans	X				X		X				X		H
				Review existing care plans in localities and ensure that people with Dementia have had input	X				X		X				X		M
				Work with GPs to define requirements for system	X				X		X				X		M
				Define "end of life" champion approach to drive support where identified	X				X		X				X		L
				Improve Care Homes ability to respond to EOL	X				X		X				X		L
				Working with Advocacy network to ensure that best interest decisions take in to account the views of the most vulnerable	X				X		X				X		L
				Link in with EOL programmes to define best approach for Dementia	X				X		X				X		
				Link Dementia care in to hospice network to ensure advanced care plans are being adhered to	X				X		X				X		L
		People are not delayed in being discharged from hospital	Reduction in delayed discharge for people with dementia	Specialist Market Capacity developed that is responsive to need	X				X		X				X		M
				Develop dementia champions within the provider network	X				X		X				X		L
				Responsive family and information network to provide tailored support	X				X		X				X		M

				Integrated discharge teams work effectively to plan and effective discharge and links well in to how we can support someone at home for their long term needs not in hospital	X				X		X				X		M
A Knowledgable and Skilled Workforce	All people with dementia receive support from knowledgeable and skilled professionals where needed	To improve the quality of dementia care across the market, and support people to understand the benefit of positive risk taking to enabling a person to live well.	Difference in quality of care before and after implementation	Identifying current position of the market against the framework	X				X				X				M-H
				Workstream to develop detail action plan to work activtly with the market to collaboratively develop ways of improving dementia care	X				X				X				M-H
Partnershiopss	Integrated model	Fully integrated commissioning	Jointly commissioning provision and operational delivery	forming strategic commissioning partnership	X				X		X		X		X		
				Aligning commissioning intentions	X				X		X		X		X		
				Developing OBC to request investment to deliver Strategy	X				X		X		X		X		
				Desiging Local Implementation plans with DAAs	X				X		X		X		X		
				Commissioning of model	X				X		X		X		X		
				Delivery	X				X		X		X		X		

3 July 2017	ITEM: 11
Health and Wellbeing Overview and Scrutiny Committee	
Integrated Medical Centre Delivery Plan – Phase 1	
Wards and communities affected: Tilbury Riverside and Thurrock Park Tilbury St Chads Chadwell St Mary	**Key Decision:** Key
Report of: Rebecca Ellsmore, Regeneration Programme Manager	
Accountable Head of Service: Andy Millard, Head of Planning and Growth	
Accountable Director: Steve Cox, Corporate Director of Environment and Place Roger Harris, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

Tilbury is identified as one of the Council's six Growth Hubs. A number of planned and proposed housing schemes being brought forward by both the Council and the private sector are set to increase the local population over the coming years. The development of the London Distribution Park and Tilbury Port's broader expansion aspirations are increasing employment opportunities in the locality whilst Tilbury's good rail connections to London and beyond give access to a wider employment market.

However, Tilbury and Chadwell residents experience poor health outcomes in comparison to the rest of the Borough. Partners from the health sector and the Council have come together to with the aim of improving access to high quality health services and have developed an integrated model of care which aims to improve the quality of and access to services to reduce the health inequalities experienced by local residents.

Cabinet, through the Health and Well-Being strategy, has agreed a GP Standards Plan which aims to improve the capacity and the quality of Primary Care across the Borough. The development of Integrated Medical Centres forms one of the key planks of that Plan.

This report gives further detail on the proposed model of care, outlines the proposed delivery mechanism for the capital build project and considers the Council's role in

both delivering and occupying part of the facility. Building this meets the Cabinet's commitment to show Tilbury some love.

1. Recommendation(s)

Members of Overview and Scrutiny Committee are asked to:

1.1. Note the current status of the project and comment on the proposed mechanism for securing the delivery of the Tilbury and Chadwell IMC.

1.2. Support the Council in taking the role outlined within the report including the decision to tender and appoint the design team.

2. Introduction and Background

2.1. In March 2016 Cabinet gave in principle approval to the Council leading on the delivery of a Health Hub to be located in the Civic Square in Tilbury. The report highlighted that whilst the Council, CCG, NHS England and a range of health service providers were advocating the model of an integrated health centre, partners from the health sector were not in a position to secure the capital required to deliver such a facility. It was therefore proposed that the Council could act as lead developer and after constructing the centre could lease it back to a health partner.

2.2. The Integrated Medical Centre would form one of four hubs across the borough. The other three hubs will be:

- Corringham / Stanford le hope – North East London Foundation Trust (NELFT) are the lead provider for this Centre. The design process is ongoing and the Centre is expected to be open in 2019.

- Grays – Discussions ongoing but the Centre is likely to be on the site of the existing Thurrock Hospital in Long Lane

- Purfleet – The Purfleet IMC is anticipated to be located within the new Purfleet Town Centre development. This project is governed by a Development Agreement (DA) between the Council and Purfleet Centre Regeneration Ltd (PCRL). There is provision within the DA for a serviced site to be provided for the Health Centre. The development of the Purfleet IMC will follow a similar process to the Tilbury IMC at the appropriate time.

2.3. Since then discussions have continued with various health partners to develop the model and a proposed delivery mechanism for the scheme in Tilbury. This report summarises these discussions, describes a proposed delivery mechanism and seeks comments from Overview and Scrutiny Committee in advance of a report being presented to Cabinet in July 2017.

3. Issues, Options and Analysis of Options

The Model of Care

3.1. It is clear that prioritising the delivery of an integrated health facility would support the wider regeneration aims in Tilbury and Chadwell as well as the Council's Corporate Priorities. However, any proposed health facility must address the local health need and must be supported by partners from across the Health Sector.

3.2. The Public health team have reviewed a significant body of evidence to define the current health needs of the Tilbury and Chadwell community. Clear evidence suggests that the area experiences health inequalities in terms of access to services and has an urgent need for new facilities to address existing deficiencies as well as to provide additional capacity to accommodate the future growth in population that is expected in the area.

3.3. The poor access to services in the local community manifests itself in a range of indicators which have impacts across the Health Sector such as :

- High levels of attendances to Accident and Emergency (A & E) for conditions that could have been more effectively treated in a community setting – 10,368 of the 13,399 A & E attendances from Tilbury and Chadwell residents in 2015/16 either received the most minor category of investigation or treatment, or no significant investigation or treatment. This accounts for 77% of A & E attendances in this population.

- Higher prevalence of long term conditions - the recorded prevalence of long term conditions in the Tilbury and Chadwell locality is higher than the Thurrock average for almost all conditions. In addition, there are a large estimated number of patients with long term conditions yet to be diagnosed – up to 2,195 cases of Hypertension and 1,649 cases of Coronary Heart Disease may be present in residents but not yet being diagnosed or treated.

- Higher than average rates of unplanned care admissions. 453 of the unplanned care admissions in 2015/16 from Tilbury and Chadwell residents were due to conditions amenable to effective healthcare. The main cause for these admissions was influenza or pneumonia.

- Low levels of referral to community health services. Pulmonary Rehabilitation is a service offered to eligible patients with Chronic Obstructive Pulmonary Disease (COPD) to support them to manage their condition. However, only 20% of newly-diagnosed eligible patients were referred into the service in 2015/16.

- Low levels of referral to preventative support. The Rapid Response Assessment Service aims to provide rapid assessment and intervention to prevent residents entering either hospital or Adult Social Care Services unnecessarily; yet in Tilbury and Chadwell locality, the referral rate was nearly three times lower for adults aged 65+ than the Thurrock average in 2015/16 (9.71 per 1,000 adults compared to 27.7 per 1,000 adults in Thurrock).

3.4. To provide modern and effective health services, partners are advocating the development of a new model of Integrated Medical Centres (previously called Health Hubs and Integrated Healthy Living Centres) which co-locate a range of services and providers within one building. IMC's are expected to include services which not only address a primary care, secondary care, physical and mental health needs but also have a positive impact on the wider determinants of health by providing services related to areas such as education, employment and housing. This ambitious vision could transform health and social care provision but will need a range of diverse partners to work together to ensure that appropriate facilities can be developed and then effective services delivered from them.

4. Options for delivery of the Capital Build

4.1. Since the last Cabinet report, discussions have been ongoing with a number of Council departments, the CCG, NHS England and a range of health service providers. From these discussions it is clear that there remains widespread support for the IMC concept but that partners from the health sector are not in a position to design or construct the IMC themselves.

4.2. Partners to the scheme have identified the Civic Square in Tilbury as the ideal location for the IMC. The Council owns the majority of this land and already delivers a range of services from existing buildings on the Square. The precise location on the Square will be defined during the design process but options under consideration are either the redevelopment of the site of the existing Community Resource Centre (the former Fire Station building) or a potential extension to the Library building.

4.3. Whilst the Council has limited experience in delivering Health facilities it has significant experience in project management, capital developments and working with multi-disciplinary stakeholders. Coupled with a potential income stream from a service provider(s) the Council can borrow against this revenue stream to secure the capital needed for the development thereby allowing it to take on the role of lead developer and subsequently landlord.

4.4. As well as being an instrumental player in driving improved health provision there is clear regeneration benefits associated with the Council playing such a proactive role. In Tilbury the wider regeneration programme aims, amongst other things, to improve the quality of the environment and create a greater sense of place and local identity. By acting as developer the Council can ensure that the design quality of the buildings (on a key site within the Town

Centre) is high and successfully contributes to the place making agenda. In addition, the Council can have control over the other services to be included within the building. This offers the opportunity to deliver complementary Council services (such as social care or community hubs) from key sites. Public Health services are already a key component in the accommodation schedule but opportunities remain to expand the Council element of provision further to potentially include services such as Housing Officers, library services and the Community Hub. This opportunity is considered in further detail below.

4.5. Should the Council not be minded to take on the lead role it could dispose of the land to a third party who could commission the development directly. Colleagues from the health sector have suggested that this could be a very lengthy process and the delivery timescale would likely be lengthened. The IMC concept could still be realised but the Council's ability to influence the design, build quality or complementary uses on a key site in the Civic Square would be reduced. The regeneration impact achieved would therefore be lessened. This could present an alternative delivery method but the lengthened timescale and lower regeneration benefits mean that this option is not currently being pursued.

4.6. Given the clear benefits and the urgent need to improve facilities and service provision it is suggested that, subject to commercial viability being established, the Council takes on the role of developer. The following sections explain what this role will entail.

5. NHS Process

5.1. Whilst the CCG and health service providers are fully supportive of the scheme, commencing service delivery from the IMC will represent a change to patient care and therefore approval from NHS England will be required. This approval is secured in two phases. Initially an Outline Business Case must be submitted and if this is approved the project can then progress to a Full Business Case. Patient services cannot be delivered from the Centre without this approval.

5.2. The Outline Business Case requires an articulation of the model of care and patient pathways alongside outline building design. For the Full Business Case planning consent must be secured for the building. Whilst some of the information required to complete these submissions can be provided by the CCG, the design work and planning fee requires a level of cost which will be invested at risk by the Council. NHS England are engaged with the project and, given that the business case will not be requesting a capital commitment from the NHS, the risk of not receiving this approval is deemed to be low, however, the risk remains and should be noted.

6. Proposed Council Role

6.1. In recent months the Council and CCG have jointly funded a commission to translate the articulated health need into a schedule of accommodation for the IMC. This work is largely complete although detailed discussions on the level of accommodation required for Council services need to be completed.

6.2. A high level cost exercise to establish whether the anticipated rental income is likely to be able to pay back the capital cost and provide a return to the Council over a reasonable time period is now underway and will be completed before appointment of a design team. Without a detailed design and cost plan for the building viability cannot be definitively proven but an estimation is required before funding can be committed to progressing the design work.

6.3. Beyond this stage, in order to take on the role of developer, the Council will need to commit resource to move the project to the delivery stage and will have to comply with the NHS approval process highlighted above. Resource will be committed at risk until the project has received approval from the NHS via submission and agreement of the Full Business Case. The Full Business Case requires the building to be designed to RIBA Stage 3 (Developed Design) and planning permission secured therefore some element of cost will need to be incurred in advance of the necessary approval being secured. NHS England have been engaged throughout the discussions to date and have informally expressed support for the scheme and clearly stated that the new GP contracts being commissioned and other services eg the new Improving Access to Psychological Treatments (IAPT) programme for this area must operate out of the IMC building. At the point where the NHS has given approval of the Full Business Case the Council would seek to enter into a legal agreement with the head lessee before development would begin.

6.4. Subject to the high level cost/income plan demonstrating that the building could be viable the Council will commission a professional team to design the building. It is clearly desirable to retain the design team throughout the lifetime of the project to ensure continuity and clear responsibilities in terms of liabilities and warranties. To ensure that this is possible, whilst minimising the risk to the Council in the event of the project not proceeding, the commission will be tendered for the full lifetime of the design and construction process but awarded on a phased basis with the Council having the right to terminate the commission at the end of any completed phase without incurring any penalty.

6.5. The immediate commitment required will provide sufficient design detail (to RIBA stage 2) to inform an Outline Business Case to NHS England. This cost is expected to be in the region of £0.2m. On approval from NHS England the subsequent module will be commissioned to take the design to RIBA stage 3 and inform a Full Business Case submission to NHS England. The cost for this stage is likely to be a further £0.3m taking the Council's total level of investment at risk to approximately £0.5m.

6.6. This project has already been approved for inclusion in the Council's Future and Aspirational Proposals list which was signed off by Cabinet in February 2017. The list has a budget allocation of £2m and contains over 20 projects. Should the funding for the Tilbury IMC be approved a significant amount of this funding will be used.

6.7. The commission is expected to continue beyond the modules required to secure NHS approval and the total cost will therefore exceed the threshold for a Director level tender award. A report seeking approval to tender is therefore being presented to Cabinet in July.

6.8. Upon appointing the professional team the Council will manage this contract securing input and sign off from health partners as appropriate.

6.9. On completion of RIBA Stage 3, and assuming approval from NHS England, and confirmation of commercial viability, it is intended that the Council will use its prudential borrowing powers to secure the capital funding required to procure a developer to construct the building (a further report, supported by a detailed business case, will be presented to Cabinet to secure approval to borrow the funds and tender this contract at the appropriate point).

6.10. The Council will seek to appoint a Head Leaseholder for the whole building. The Head Leaseholder will be required to enter into an Agreement to Lease formally committing them to take on the lease of the building prior to the Council awarding the development contract.

6.11. A number of health partners have expressed an interest in taking on the Head Leaseholder role but firm commitments cannot be finally secured until the building is designed and costed to a sufficient level of detail to enable rental costs to be estimated. The principle for setting the rent level will be based on enabling the Council to pay back the capital cost plus make a return on the investment.

6.12. The rental levels agreed must cover the costs of the shared spaces as well as any void spaces. The CCG has agreed to specify in future contracts that their commissioned services must be delivered from the IMC. This will ensure that rental income will be available. Furthermore the CCG has agreed to underwrite the rental cost of void spaces which are allocated to the health services. The Council will be required to enter into a similar agreement for any void costs associated with accommodation dedicated to Council services.

6.13. The leaseholder will be permitted to sub-let parts of the building to particular service providers in line with the requirements of the services being delivered from the Centre. This will include spaces used to deliver any Council commissioned services. It should be noted that any organisation taking on this role is likely to apply a management charge which will represent an additional cost to the sub tenants.

7. Council Service Provision

7.1. There remains opportunity for Council services to be included in the Centre but to meet the proposed timescales decisions on which, if any, services are to be relocated need to be taken swiftly.

7.2. The Council service provision in the Civic Square is focused on the Library building to the western edge of the Square. This currently houses the Library, Community Hub and some Housing Office Services. Some or all of these services could be relocated into the IMC.

7.3. There are both benefits and disadvantages of a potential relocation. These services are complementary to the Health offer and could have a positive impact on the wider determinants of health, the offer would be strengthened by co-locating. The existing library building has recently been refurbished and the accommodation has been improved but the new facility could offer further improvements as well as offering access to flexible shared space. Better value on the build costs may be achieved by bringing more services into the building as additional accommodation is likely to be provided on additional storeys on the same building footprint. Relocation would, however, require rent to be paid for the new accommodation and would leave the Council with void space(s) to fill in the existing building.

7.4. The decision on whether any of these services is going to be included in the new facility needs to be taken quickly to ensure that the brief for the design team is complete from the outset of the commission. Whilst the decision relating to the Library and Housing Officers rests with the Council the Community Hub must be managed separately. The Council has worked hard to give true autonomy to the Community Hubs and the Hubs are now set up as an established charity, Community Hubs Thurrock. Much of the programme's success can be attributed to the volunteers having a genuine level of authority on the future development of the Hub Programme. Whilst moving into the IMC could present a real opportunity to enhance their offer the decision must rest with the Community Hubs Network Board.

8. Risks

8.1. There are a number of risks facing the effective delivery of this programme. A full risk register will be developed if the project is given approval to proceed but the main risks identified at this stage are highlighted below.

Risk	Impact	Probability	Mitigation
Funds must be committed in advance of securing approval from NHS England.	Funds could be lost if the project doesn't proceed.	Medium	Continue engagement with NHS England, ensure Outline Business Case clearly describes the project. Commission design team on a phased

			basis to limit exposure.
Brief for the design team is not clearly defined.	Increased project cost.	Medium	Continue engagement with CCG and Council to further develop brief. Do not award contract until all partners agree the brief.
Proposed Head Lease term longer than the CCG service delivery contracts.	Lack of security over future income stream.	Medium	The Head Lease will be for a term that is sufficient to payback the capital cost plus a return to the Council. An Agreement to Lease will be required before the construction contract is awarded.
Capital cost too high to be supported by the rental stream.	IMC is unaffordable and doesn't proceed. Development funds are lost.	Medium	Cost advice will be sought throughout the project and checked against affordability.

8.2. It is clear that by taking on the role of developer and landlord the Council is also taking on a significant element of risk in the early stages of the project development. Informal feedback from NHS England is that they are supportive of the proposals but formal approval must be secured in order for the project to proceed to the construction phase. A substantial investment will be required to develop the building design and achieve planning consent prior to this approval being secured. The Council will mitigate this risk as far as possible by ensuring that any contracts awarded have clear breaks at key phases allowing the Council to end the contract at the end of any completed phase. The dialogue with NHS England will be ongoing throughout to ensure that the project develops in line with NHS England requirements.

8.3. The IMC will be a bespoke facility and on completion will only be appropriate for occupation by Health service providers. These services are commissioned variously by either the CCG or Public Health and typically have contract durations which do not exceed 7 years. This will not be sufficient to pay off the capital cost of the building. The Council will mitigate this risk by leasing initially to a Head Leaseholder who can offer a commitment in excess of the length of individual contracts to service providers. This Head Leaseholder will be required to sign an Agreement to Lease in advance of the Council awarding the construction contract but significant investment in the design and planning process will have been made in advance of this. The CCG has committed in writing to make locating in the IMC a condition of contract award and will underwrite void costs in the event of breaks between contracts.

9. Reasons for Recommendation

9.1. There are clear benefits to the Council taking on a prominent role in the delivery of this project. O&S are asked to comment on the described role in order for a paper to be presented to Cabinet in July.

10. Consultation

10.1. In March 2016 Cabinet resolved to support the principle of the Council leading on the development of a Health Hub in Tilbury. Since this time consultation has been ongoing with the CCG and various service providers in order to inform the project to the position as described in this report.

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

11.1. This project supports the Council's corporate priority of improving health and wellbeing. In particular, it supports the four principles stated in the Thurrock Health and Wellbeing Strategy 2016-2021 and has a specific reference under 'Goal 4 Quality care, centred around the person' of the same strategy.

11.2. A Joint Strategic Needs Assessment has been produced to specifically inform the development of this project.

11.3. The project is fully aligned with the Council's stated Vision for Tilbury agreed by Cabinet in December 2013.

12. Implications

12.1. Financial

Implications verified by: **Mark Terry**

Senior Financial Accountant

In the first instance, Cabinet will be asked to approve the release of £0.5m of funding from the Future and Aspirational Proposals allocation approved by Cabinet in February 2017, to cover the design costs up to RIBA Stage 3 and planning application submission, before the project has final approval from NHS England. If the £0.5m is borrowed over a 5 year period, the repayment costs (with interest) would be £0.103m per annum. The risk that the Council would be taking at this stage is clearly outlined in this report. If the scheme were not to proceed after completion of the design stage, capital costs that have been incurred would have to be re-charged to the General Fund.

In the longer term, should the project receive all the necessary approvals and Cabinet give approval for the council to act as developer there will be a significant borrowing commitment that will be repaid (on commercial terms) over a long timeframe (20-25 years). Before the longer term commitment is

made a further report will be presented to Cabinet containing the full details of the business case and financing costs, and seeking approval to commit to borrowing the necessary funding.

12.2. Legal

Implications verified by: **Vivien Williams**

Planning and Regeneration Solicitor

There are no legal implications arising out of this report at this stage. As the project develops any contracts entered in to will be checked with legal services prior to award.

12.3. Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

This project has the potential to make a significant contribution to reducing health inequality in Tilbury. Should Cabinet approve the proposed delivery mechanism the architects brief will ensure that the building design meets the latest equality legislation.

13. Background papers used in preparing the report:

- Tilbury Regeneration Programme and Health Hubs http://democracy.thurrock.gov.uk/ieListDocuments.aspx?CId=129&MId=2565&Ver=4
- Thurrock Health and Wellbeing Strategy 2016-2021 https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy
- Joint Strategic Needs Assessment - Tilbury Integrated Healthy Living Centre https://www.thurrock.gov.uk/healthy-living/joint-strategic-needs-assessment

14. Appendices to the report

- None

Report Author:

Rebecca Ellsmore

Regeneration Programme Manager

Environment and Place

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Health Overview & Scrutiny Committee
Work Programme
2017/18

Dates of Meetings: 3 July 2017, 7 September 2017, 16 November 2017, 18 January 2018 and 22 March 2018

Topic	Lead Officer	Requested by Officer/Member
3 July 2017		
The Procurement of an Integrated Sexual Health Service for 2018-2023	Andrea Clement / Sareena Gill	Officer
Podiatry Services in Thurrock	Mark Tebbs	Cllr S Little
Update on Mid and South Essex Success Regime / Sustainability and Transformation Partnership (STP)	Wendy Smith	Members
Southend, Essex and Thurrock Dementia Strategy 2017 - 2021	Catherine Wilson	Officers
Integrated Medical Centre Delivery Plan – Phase 1	Rebecca Ellsmore	Officers
7 September 2017		
Living Well in Thurrock	Ceri Armstrong	Members
Cancer Deep Dive Update	Funmi Worrell (Public Health)	Members
Update on Collins House	Roger Harris	Members
Tilbury Accountable Care Partnership	Ian Wake	Officers
Primary Care Update	Rahul Chaudhari - CCG	Officers

Last Updated: April 2017

Joint Committee Across STP Footprint – Implications for Scrutiny Committee	Mandy Ansell	Officers
16 November 2017		
General Practitioner 5 Year Forward Review	Mandy Ansell, CCG	Officer
2018/19 Budget Setting Update	Carl Tomlinson	Officer
Fees & Charges Pricing Strategy 2018/19 (Adults)	Carl Tomlinson	Officer
18 January 2018		
Learning Disability Health Check	Jane Itangata, CCG	Members
Thurrock First	Tania Sitch	Members
22 March 2018		