

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

## Health and Wellbeing Board

The meeting will be held at **11.00 am – 1:30pm on 16 March 2018**

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

### **Membership:**

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

Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group

Dr Anjan Bose, Clinical Representative, Thurrock CCG

Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board

Steve Cox, Corporate Director Place

David Archibald, Independent Chair of Local Safeguarding Children's Board

Dr Anand Deshpande, Chair of Thurrock NHS CCG Board

Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG

Roger Harris, Corporate Director of Adults, Housing and Health

Kristina Jackson, Chief Executive Thurrock CVS

Kim James, Chief Operating Officer, Healthwatch Thurrock

Malcolm McCann, Executive Director of Community Services and Partnerships

South Essex Partnership Foundation Trust

Clare Panniker, Chief Executive Basildon and Thurrock Hospitals Foundation Trust

Rory Patterson, Corporate Director of Children's Services

Andrew Pike, Director of Commissioning Operations, NHS England - Essex and East Anglia Region

Julie Rogers, Julie Rogers, Director of Environment and Highways

Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust

Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust

Ian Wake, Director of Public Health

### **Agenda**

Open to Public and Press

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To note minutes of ICE meetings of November 2017 and 25 January 2018. To note the Health and Wellbeing Board Executive Committee minutes of 8 February 2018	

**Queries regarding this Agenda or notification of apologies:**

Please contact Darren Kristiansen, Business Manager - Commissioning by sending an email to [Direct.Democracy@thurrock.gov.uk](mailto:Direct.Democracy@thurrock.gov.uk)

Agenda published on: **8 March 2018**

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# DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

## Helpful Reminders for Members

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

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

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



Does the business to be transacted at the meeting

- relate to; or
- likely to affect

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

### Pecuniary

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

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

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

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

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

### Non- pecuniary

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



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

## Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay
  - High quality, consistent and accessible public services which are right first time
  - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
  - Communities are empowered to make choices and be safer and stronger together
  
2. **Place** – a heritage-rich borough which is ambitious for its future
  - Roads, houses and public spaces that connect people and places
  - Clean environments that everyone has reason to take pride in
  - Fewer public buildings with better services
  
3. **Prosperity** – a borough which enables everyone to achieve their aspirations
  - Attractive opportunities for businesses and investors to enhance the local economy
  - Vocational and academic education, skills and job opportunities for all
  - Commercial, entrepreneurial and connected public services

## Minutes of the Meeting of the Health and Wellbeing Board held on 30 January 2018 at 3.00 pm

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

David Archibald, Independent Chair of Local Safeguarding Children's Board  
Roger Harris, Corporate Director of Adults, Housing and Health  
Kristina Jackson, Chief Executive Thurrock CVS  
Kim James, Chief Operating Officer, Healthwatch Thurrock  
Rory Patterson, Corporate Director of Children's Services  
Julie Rogers, Director of Environment and Highways and Chair of Thurrock CSP  
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust  
Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust  
Ian Wake, Director of Public Health

**Apologies:** Dr Anjan Bose, Clinical Representative, Thurrock CCG  
Graham Carey, Chair of Thurrock Adults Safeguarding Board  
Steve Cox, Corporate Director of Environment and Place  
Jane Foster-Taylor, Executive Nurse, Thurrock CCG  
Malcolm McCann Executive Director of Community Services and Partnerships, South Essex Partnership Foundation Trust  
Clare Panniker, Chief Executive of Basildon and Thurrock University Hospitals Foundation Trust  
Andrew Pike, Director of Commissioning Operations, NHS England Essex and East Anglia

**In attendance:** Ceri Armstrong, Senior Health and Social Care Development Manager  
Nick Boulter, Sport England  
Grant Greatrex, Sports and Leisure Policy & Development Manager  
Tim Elwell-Sutton, Assistant Director and Consultant in Public Health  
David McHendry, KKP  
Linda Smart, Deputy Chief Nurse, Thurrock CCG  
Andrew Vowles, Programme Director, Mid & South Essex Sustainability & Transformation Partnership

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## **1. Minutes**

The minutes of the Health and Wellbeing Board held on 14 November 2017 were approved as a correct record.

## **2. Urgent Items**

There were no urgent items provided in advance of the meeting.

## **3. Declaration of Interests**

There were no declarations of interest.

## **4. Active Places Strategy**

A presentation was given to the Board on the Council's Active Place Strategy by Grant Greatrex (Sports and Leisure Policy and Development Manager), Nick Boulter (Sport England), and David McHendry (KPP).

The Board were made aware that the Active Place Strategy was in fact a suite of strategies consisting of Open Space; Active Travel; Playing Pitch; and Indoor Build Facilities. The Strategy would contribute in the main to the delivery of the Health and Wellbeing Strategy goal 'Healthier Environments' and the objective 'Create places that make it easy to exercise and be active' – although there were also links to many more goals and objectives.

Nick Boulter clarified the role of Sport England. It was the government agency responsible for setting and delivering the community sport strategy. The latest strategy had been launched in 2016 and shifted from being purely 'sports-driven' to focusing on improving health and wellbeing. For example investment principles included 'tackling inactivity'.

A key element of Thurrock's approach was the provision of sport and physical activity facilities. There was a discussion about what this might look like although there were no firm plans in place at this point in time.

Board members raised concerns about the breadth of community engagement – this included information and input from people with disabilities to ensure that the 'Active Place' was accessible to all. Engagement needed to include a wide range of community groups and needed to focus on what people wanted to do rather than what facilities they might want.

There was some discussion about linkages with Health and possible opportunities to integrate or co-locate.

It was important that plans took in to consideration the population increase that would be brought about by plans for 32,000 new homes. It was possible that section 106 monies could be used innovatively to contribute to the outcomes the Strategy wanted to achieve.

Resolved:

That the Board note the Active Place Strategy.

## **5. Annual Public Health Report**

Tim Elwell-Sutton, Assistant Director and Consultant in Public Health presented the 2017 Annual Report of the Director of Public Health. The focus of the report for 2017 was 'A Sustainable Children's Social Care System for the Future'.

Tim stated that the reason for the focus on children's social care was that the early years of a child's life was critical to their longer term health and wellbeing.

A key observation was that over the years, there had been a significant reduction in the amount spent on prevention, with a greater proportion of the budget being spent on placements. This was a scenario replicated nationally.

Tim commented that Thurrock's level of Looked After Children was high – but that it was difficult to explain why that was. The ability to invest in prevention, particularly if the focus was on working with families, might help to prevent children becoming 'looked after'.

Board members raised the benefits of the Edge of Care/Pause programmes. These intervened across multiple of areas of a family's life and could contribute towards reduce the risk of children becoming looked after.

The Corporate Director of Children's Services stated that there had been a slight reduction in Looked After Children as a result of changes made. The Pause programme was seen to be successful in reducing the number of court proceedings as it worked with mothers who had previously had children removed so that if they went on to have more children there was less risk of subsequent children being taken in to care.

Resolved:

That the contents and recommendations of the report be supported by the Board; and

That the Board note plans to hold a Mental Health summit to address emotional and mental health issues which contribute to the wider health and wellbeing issues amongst young people.

## **6. STP Consultation**

Andy Vowles, Programme Director for the Mid and South Essex Sustainability and Transformation Programme (STP) provided the Board with an update on the current consultation which was seeking views on:

- The overall plan for health and care;
- Proposals for hospital services in Southend, Chelmsford and Basildon; and
- Proposals to transfer services from Orsett Hospital to new centres closer to where people live.

The Board were asked to comment on proposals.

Concerns were raised by Board members about the accessibility of the consultation, and the Chair stated that Healthwatch had worked to bridge any gaps.

The Board were also concerned that the consultation about the future of Orsett Hospital had not been consulted on separately. In response, the Deputy Chief Executive of Basildon and Thurrock University Hospitals Foundation Trust (BTUH) stated that three further meetings were being organised specifically focused on Orsett Hospital. These would take place prior to the end of the consultation period.

The Chair stated that the process needed to be far more responsive to concerns being raised. For example the consultation on Orsett Hospital being part of the consultation on the proposals for hospital services in Southend, Chelmsford and Basildon despite a request for this not to happen.

Councillor Little wished to know how the Orsett site would be used, and the Deputy Chief Executive of BTUH responded that no decision had been made on the future of the site.

Resolved:

That the Board note the update and consider the proposals published for consultation.

## **7. Integrated Commissioning Executive and Health and Wellbeing Board Executive Committee minutes**

Resolved:

That the minutes of the Integrated Commissioning Executive 28 September 2017 and 26 October 2017 and the minutes of the Health and Wellbeing Executive Committee 23 November 2017 be agreed.

**8. Work Programme**

Resolved:

That the Board's future work programme be agreed.

**The meeting finished at 5.00 pm**

Approved as a true and correct record

**CHAIR**

**DATE**

**Any queries regarding these Minutes, please contact  
Democratic Services at [Direct.Democracy@thurrock.gov.uk](mailto:Direct.Democracy@thurrock.gov.uk)**

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<b>16 March 2018</b>		<b>ITEM: 6</b>
<b>Health and Wellbeing Board</b>		
<b>Thurrock Pharmaceutical Needs Assessment</b>		
<b>Wards and communities affected:</b> All	<b>Key Decision:</b> Non-key	
<b>Report of:</b> Ian Wake, Director of Public Health		
<b>Accountable Head of Service:</b> Emma Sanford, Strategic Lead – Health and Social Care Public Health		
<b>Accountable Director:</b> Ian Wake, Director of Public Health		
<b>This report is</b> Public		

## Executive Summary

Every Health and Wellbeing Board has the statutory responsibility to carry out and publish a Pharmaceutical Needs Assessment (PNA) every 3 years. This is to include information from a number of sources including inputs from local pharmaceutical service providers, local intelligence, references to existing plans and strategies and patient views.

This Pharmaceutical Needs Assessment (PNA) provides a comprehensive report on the needs for and provision of pharmaceutical services (as defined by legislation) in Thurrock. It will be used by NHS England to decide upon applications to open new pharmacies, change hours, relocate existing pharmacies or merge pharmacies, and will inform commissioners regarding the commissioning of pharmaceutical services.

As PNAs are central to decision-making regarding commissioned services and new pharmacy openings, it is essential that they comply with the requirements of the regulations, that due process is followed in their development and they are kept up-to-date. The existing PNA will cease to be valid from 1<sup>st</sup> April 2018, and it is proposed that this new PNA will be formally adopted from that date.

Any changes to provision that occur after publication of this new PNA will result in a Supplementary Statement being issued, outlining the details of this change. Depending on the expected impact, this may result in a revised assessment if it is deemed relevant to the granting of any future pharmacy applications. The Health and Wellbeing Board should note that one Thurrock pharmacy has given their 90 days' notice of closure to NHS England, and therefore a Supplementary Statement will be published after this PNA has been adopted.

## **1. Recommendation(s)**

- 1.1 That the contents of the PNA be noted by the Health and Wellbeing Board.**
- 1.2 That the Health and Wellbeing Board approve the publication of this document, thereby fulfilling their statutory obligation.**
- 1.3 That the Health and Wellbeing Board note the upcoming closure of one pharmacy and the need for a future subsequent Supplementary Statement after publication of this document.**

## **2. Introduction and Background**

- 2.1 The Pharmaceutical Needs Assessment (PNA) provides a comprehensive report on the needs for and provision of pharmaceutical services (as defined by legislation) in Thurrock. It will be used by NHS England to decide upon applications to open new pharmacies, change hours, relocate existing pharmacies or merge pharmacies, and will inform commissioners regarding the commissioning of pharmaceutical services.
- 2.2 Every Health and Wellbeing Board has the responsibility to carry out and publish a PNA every 3 years. This is to include information from a number of sources including inputs from local pharmaceutical service providers, local intelligence, references to existing plans and strategies and patient views.
- 2.3 The previous Thurrock PNA was undertaken during 2014 and formally adopted in early 2015, meaning that the new PNA must be in place by the end of March 2018.
- 2.4 It is stipulated in the [NHS \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#) that a draft version of the PNA must be released for public consultation for a minimum of 60 days prior to formal publication and adoption. This took place for 61 days between 18<sup>th</sup> October 2017 and 17<sup>th</sup> December 2017, and a summary of the responses received can be found in section 9.6 of the main document.
- 2.5 This document was primarily authored by the Public Health team, with wider stakeholder inputs on an ongoing basis from the CCG, LPC (Local Pharmaceutical Committee), LMC (Local Medical Committee) and NHS England. These stakeholders were collectively known as the PNA Steering Group. The PNA Steering Group have confirmed the scope and contents of the PNA are in accordance with the legislative requirements.

## **3. Summary of key findings**

3.1 The main finding of the PNA document was that the current number of pharmacies is sufficient to meet future pharmaceutical needs of residents over the lifetime of this document (3 years).

3.2 Other key points from the PNA include:

- There are 34 pharmacies and 2 distance-selling pharmacies located in Thurrock. The number of high street pharmacies has not changed since the last PNA document.
- In addition, the locations of current pharmacies are distributed relatively evenly across the borough, with those most likely to need pharmaceutical services (e.g. residents in the most deprived areas and older people) having more provision available to them. Pharmacies in Thurrock are accessible to the majority of residents by walking or by bus (70.4% walking and 96% by bus within 30 minutes during the week), and all residents are within a 20 minute car journey of a pharmacy.
- The PNA found that dispensing activity has increased by 9.05% between 2013-14 and 2016-17, but that this has been absorbed in current provision of pharmacy services. An increase was seen in the proportion undertaken by distance-selling pharmacies, with two contractors in Leeds and Peterborough responsible for 15.95% of all out of area activity.
- There was found to be sufficient coverage of Advanced Services [e.g. Medicines Use Reviews, New Medicines Service Reviews and Flu Vaccinations] across Thurrock which particularly benefit the older population and those with long term health conditions.
- Findings from the recent Community Pharmacy Patient Questionnaire (CPPQ) highlighted that patients felt that pharmacies could offer more lifestyle support and advice.
- Information from Thurrock patients indicate that the majority of them choose to visit their particular pharmacy (70%) and Thurrock's pharmacies as a whole have a high public satisfaction rating (90%).

#### **4. Reasons for Recommendation**

4.1 This PNA fulfils a statutory duty set down by the Health and Social Care Act 2012 for all Health and Wellbeing Boards (HWBs) to publish and keep-up-to-date a statement of the needs for pharmaceutical services for the population in its area.

4.2 The existing PNA will not remain valid after the 1<sup>st</sup> April 2018, which means the Council will be in breach of its statutory duty after this date.

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

- 5.1 The PNA was produced with contributions from key stakeholders as listed in the reports' acknowledgements section.
- 5.2 The draft report was available for public consultation for 61 days between 18<sup>th</sup> October 2017 and 17<sup>th</sup> December 2017.

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

- 6.1 The PNA aligns with the Council's three new priorities for People, Place and Prosperity by demonstrating the activity and current status of community pharmacies. It shows our commitment to high quality and accessible public services, and partnership working to improve health and wellbeing.
- 6.2 Pharmacy actions also support the delivery of the Thurrock Health and Wellbeing Strategy 2016-21 and the 'For Thurrock In Thurrock' initiative which is jointly run by the Council and CCG, and aims to encourage more neighbourhood-based care.

## **7. Implications**

### **7.1 Financial**

Implications verified by: Jo Freeman  
Management Accountant Social Care

There are no financial decisions that relate to this report.

### **7.2 Legal**

Implications verified by: Ian Wake  
Director of Public Health

There is potential for legal challenges associated with the PNA if the Council had not met its duties around consultation of the draft PNA or from contractors who believe they are affected by the findings of the PNA; however the risk for receiving these challenges is minimal.

Failure to publish a revised pharmaceutical needs assessment by 1<sup>st</sup> April 2018 would put the Council in breach of Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012.

### **7.3 Diversity and Equality**

Implications verified by: Rebecca Price  
Community Development Officer

The PNA outlines the locations of services with respect to key population groups most likely to require them. It also contains information on public views captured from a range of respondents.

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

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):

- Detailed references are given in the main report.

9. **Appendices to the report**

- Thurrock Pharmaceutical Needs Assessment 2017/18

**Report Author:**

Maria Payne  
Senior Public Health Programme Manager – Health Intelligence  
Public Health Team

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# Thurrock Pharmaceutical Needs Assessment 2017/18

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DRAFT FOR APPROVAL

## Acknowledgements

<b>Authors:</b>	Maria Payne, Senior Programme Manager – Health Intelligence Funmi Worrell, Strategic Lead in Public Health Nicola Smith, Public Health Intelligence Analyst Kelly Clarke, Public Health Information Support Officer Kareema Olaleye, Public Health Graduate Trainee
<b>Other Contributions:</b>	Karen Samuel-Smith, Contractor Development Manager, Essex LPC Katie Clark, Senior Analyst, NHS Thurrock CCG Denise Rabbette, Head of Medicines Management, NHS Thurrock CCG Georgina Shanley – Primary Care Commissioning Officer, NHS England Cathy Pedder – Liaison Manager, Essex Local Medical Committee Navtej Tung – Principal Transport Planner, Thurrock Council  <i>With thanks to the 34 Thurrock pharmacy contractors who returned data required for this PNA.</i>

DRAFT FOR APPROVAL

## 1. Executive Summary

This Pharmaceutical Needs Assessment (PNA) provides a comprehensive report on the needs for and provision of pharmaceutical services (as defined by legislation) in Thurrock. It will be used by NHS England to decide upon applications to open new pharmacies, change hours, relocate existing pharmacies or merge pharmacies, and will inform commissioners regarding the commissioning of pharmaceutical services.

Every Health and Wellbeing Board has the responsibility to carry out and publish a PNA every 3 years. This is to include information from a number of sources including inputs from local pharmaceutical service providers, local intelligence, references to existing plans and strategies and patient views. A formal public consultation on this document lasting 61 days took place between 18<sup>th</sup> October 2017 and 17<sup>th</sup> December 2017.

### Local Population

There are a number of demographic factors that affect the need for pharmaceutical services. The population of Thurrock is 167,025, and this is expected to increase by 27% by 2039. The borough has a relatively young population compared to the rest of England, although the proportion of older people is set to increase at a faster rate than the all age population. Thurrock is an area with stark inequalities – between the most and least deprived areas, the life expectancy gap in males is 9.4 years and females is 6.5 years.

### Pharmacy Services

There are 34 pharmacies and 2 distance-selling pharmacies located in Thurrock. This equates to a rate per 100,000 population of 21.2. The number of high street pharmacies has not changed since the last PNA document. There are also 3 dispensing doctors. Analysis of dispensing activity indicates that some Thurrock residents also use certain pharmacies located in neighbouring areas. The PNA concludes that the current number of pharmacies is sufficient to meet future pharmaceutical needs of residents over the lifetime of this document. In addition, the locations of current pharmacies are distributed sufficiently across the borough, with those most likely to need pharmaceutical services (e.g. residents in the most deprived areas and older people) having more provision available to them. The PNA has found pharmacies in Thurrock to be accessible to the majority of residents by walking or by bus (70.4% walking and 96% by bus within 30 minutes during the week), and all residents are within a 20 minute car journey of a pharmacy.

### Provision of Services

The PNA found that dispensing activity has increased by 9.05% between 2013-14 and 2016-17, but that this has been absorbed in current provision of pharmacy services. An increase was seen in the proportion undertaken by distance-selling pharmacies, with two contractors in Leeds and Peterborough responsible for 15.95% of all out of area activity. There was found to be sufficient coverage of Advanced Services across Thurrock, with all contractors declaring they were undertaking Medicines Use Reviews, 31/34 undertaking New Medicines Service Reviews and 26/34 undertaking the Flu Vaccination service. 3/34 provide Stoma

Appliance Customisation, 4/34 provide Appliance Use Reviews and 8/34 are signed up to the NHS NUMSAS pilot programme offered as an Advanced Service up to March 2018. The PNA concludes that there is sufficient coverage of these services which particularly benefit the older population and those with long term health conditions. Whilst the provision of locally commissioned services was outside of the scope of this PNA, it was noted during the development of this work that there is capacity and opportunities for existing community pharmacy contractors to meet certain health needs – something that was also noted in the recent Community Pharmacy Patient Questionnaire Results (CPPQ) where patients highlighted pharmacies could offer more lifestyle support and advice. Addressing of these opportunities will be picked up in local work directly with existing contractors.

### **In conclusion**

Whilst Thurrock has an ambitious future growth agenda, much of the large expected population increase will occur beyond the lifespan of this PNA. The local strategies and plans to reduce demand in secondary care and increase patient capacity to self-care could lead to further opportunities for community pharmacies; however many of these plans also continue past the lifespan of this PNA. Information from Thurrock patients indicate that the majority of them choose to visit their particular pharmacy (70%) and Thurrock's pharmacies as a whole have a high public satisfaction rating (90%). It is therefore the finding of this PNA that the current pharmaceutical service provision is sufficient for the population for at least the next three years.

## 2. Introduction/Context

### 2.1 What is a PNA?

The Health and Social Care Act 2012 places a statutory duty on all Health and Wellbeing Boards (HWBs) to publish and keep-up-to-date a statement of the needs for pharmaceutical services for the population in its area. These statements are referred to as Pharmaceutical Needs Assessments (PNAs). The responsibility to produce the PNA was previously held by Primary Care Trusts which were abolished in April 2013. The PNA is a structured approach to identifying unmet pharmaceutical needs, and can be an effective tool to enable Health and Wellbeing Boards to identify the current and future commissioning of services required from pharmaceutical service providers<sup>1</sup>.

The PNA is used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements regarding opening hours, services or location. The Health and Social Care Act 2012 transferred responsibility for using PNAs as the basis for determining “market entry to a pharmaceutical list” from PCTs to NHS England. Of note, decisions on whether to open new pharmacies are not made by the HWB. Applicants must submit a formal application to NHS England whereby the relevant local Pharmaceutical Services Regulations Committee will then review the application and decide if there is a need for a new pharmacy in the proposed location. When making the decision NHS England is required to refer to the local PNA. Such decisions are appealable to the NHS Litigation Authority’s Family Health Services Appeal Unit (FHSAU), and decisions made on appeal can be challenged through the courts.

The PNA will also inform decisions by local commissioning bodies including Local Authorities, NHS England and Clinical Commissioning Groups (CCGs) as to which NHS funded services are provided locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services). The preparation and consultation on the PNA should take account of the health needs of the population defined in the local Joint Strategic Needs Assessments (JSNAs) and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public. This PNA should therefore be viewed in conjunction with the Thurrock JSNA reports which are accessible online at: [www.thurrock.gov.uk/jsna](http://www.thurrock.gov.uk/jsna).

As PNAs are central to decision-making regarding commissioned services and new pharmacy openings, it is essential that they comply with the requirements of the regulations (further information in [this appendix](#)), that due process is followed in their development and they are kept up-to-date. Section 2.3 describes the process for development of this PNA.

This PNA was developed using the following regulations:

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<sup>1</sup> Department of Health. ‘Pharmaceutical needs assessments: Information Pack for local authority Health and Wellbeing Boards.’ May 2013. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/197634/Pharmaceutical\\_Needs\\_Assessment\\_Information\\_Pack.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197634/Pharmaceutical_Needs_Assessment_Information_Pack.pdf)

- National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) (Amendment) Regulations 2013
- Pharmaceutical Needs Assessment, Information Pack for Local Authority Health and Wellbeing Boards

## 2.2 What are pharmaceutical services?

Community Pharmacies provide three tiers of Pharmaceutical Services commissioned by NHS England:

- **Essential Services** – These services are offered by all Community Pharmacies as part of the Community Pharmacy Contractual Framework
- **Advanced Services** – There are 6 Advanced services within the Community Pharmacy contract, most of which are to support patients with safe use of medicines as well as a flu vaccination service;
- **Enhanced Services** – These are services that can be commissioned locally by NHS England. Local Authorities and Clinical Commissioning Groups (CCGs) can commission ‘locally commissioned services’.

These types of services are defined in the *NHS Regulations*<sup>2</sup> and are briefly described below.

### 1. Community Pharmacy Essential Services

The essential services offered by all pharmacy contractors are specified by a national contractual framework that was agreed in 2005, with some amendments in 2012. The following description of these services is an excerpt from a briefing summary on NHS Community Pharmacy services by the Pharmaceutical Services Negotiating Committee (PSNC)<sup>3</sup>:

#### Dispensing Medicines

Pharmacies are required to maintain a record of all medicines dispensed, and also keep records of any interventions made which they judge to be significant. The Electronic Prescription Service (EPS) has also been implemented as part of the dispensing service.

[see section 6.2 for dispensing activity analysis across Thurrock]

#### Dispensing Appliances

Pharmacists may regularly dispense appliances in the course of their business, or they may dispense such prescriptions infrequently, or they may have taken a decision not to dispense them at all. Whilst the Terms of Service requires a pharmacist to dispense any (non-blacklisted) medicine ‘with reasonable promptness’, for appliances the obligation to dispense arises only if the pharmacist supplies such products ‘in the normal course of his business’.

<sup>2</sup> The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: [http://www.legislation.gov.uk/ukxi/2013/349/pdfs/ukxi\\_20130349\\_en.pdf](http://www.legislation.gov.uk/ukxi/2013/349/pdfs/ukxi_20130349_en.pdf)

<sup>3</sup> Pharmaceutical Services Negotiating Committee . Available at: <http://psnc.org.uk/>

### **Repeat Dispensing/electronic Repeat Dispensing (eRD)**

At least two thirds of all prescriptions generated in primary care are for patients needing repeat supplies of regular medicines, and since 2005 repeat dispensing has been an Essential Service within the Community Pharmacy Contractual Framework (CPCF).

Under the repeat dispensing service pharmacy teams will:

- dispense repeat dispensing prescriptions issued by a GP
- ensure that each repeat supply is required; and
- seek to ascertain that there is no reason why the patient should be referred back to their GP.

Originally this service was mainly carried out using paper prescriptions, but as the Electronic Prescription Service (EPS) has developed, the majority of repeat dispensing is now carried out via EPS release 2 and is termed electronic Repeat Dispensing (eRD), which is much more efficient and convenient for all involved.

This means that pharmacy teams need to identify appropriate patients and provide them with information about the repeat dispensing/eRD service, with the aim that there is a significant increase in the use of the service by patients. Appropriate advice can be given to patients in a number of ways such as:

- verbally explaining about the service and its benefits to patients; and
- providing patients with a leaflet describing the service when they are collecting a prescription.

This requirement is part of a broader programme to increase use of the service, which will also engage GP practices and other stakeholders such as Clinical Commissioning Groups (CCGs).

All pharmacies are encouraged to work with their Local Professional Network (LPN), LPC and other local partners to support activities to increase uptake of repeat dispensing/eRD by prescribers in their area. These could include:

- identifying and notifying prescribers of suitable patients; and
- seeking to transfer patients already using managed repeats to repeat dispensing/eRD.

### **Disposal of unwanted medicines**

Pharmacies are obliged to accept back unwanted medicines from patients.

### **Public Health (Promotion of Healthy Lifestyles)**

Each year pharmacies are required participate in up to six campaigns at the request of NHS England. This may include the display and distribution of leaflets provided by NHS England. In addition, pharmacies are required to undertake prescription-linked interventions for patients who appear to have diabetes, a risk of coronary heart disease, who smoke or appear to be overweight.

[see section 6.1 for adoption of these across Thurrock pharmacies]

## **Signposting**

NHS England and other organisations provide pharmacies with lists of sources of care and support in the area. Pharmacies are expected to help people who appear to need assistance by directing them to the most appropriate source of help.

## **Support for Self Care**

Pharmacies help manage minor ailments and common conditions, by the provision of advice and where appropriate, the sale of medicines, including dealing with referrals from NHS 111. This support also includes ongoing support for patients with long term conditions. Records will be kept where the pharmacist considers it relevant to the care of the patient.

*NHS England is responsible for monitoring pharmacies so that they deliver all of the essential services as specified.*

## **2. Advanced Services**

In addition to essential services, the community pharmacy contractual framework allows pharmacies to opt to provide any of six nationally-commissioned advanced services to support patients with the safe use of medicine, which currently include:

- Seasonal Flu Vaccination Service
- Medicines Use Reviews (MUR)
- Appliance Use Reviews (AUR)
- New Medicines Service (NMS)
- Stoma Appliance Customisation (SAC)
- NHS Urgent Medicine Supply Advanced Service (NUMSAS) – pilot until March 2018

[see section 0 for adoption of these across Thurrock pharmacies]

## **3. Enhanced Services**

The third tier of Pharmaceutical Service that can be provided from pharmacies are the Enhanced Services. These are services that can be commissioned locally from pharmacies by NHS England. Examples of enhanced services include:

- Anticoagulation monitoring
- Care home service
- Disease specific medicines management service
- Gluten free food supply service
- Independent prescribing service
- Home delivery service
- Language access service
- Medication review service
- Medicines assessment and compliance support
- Minor ailment service
- On demand availability of specialist drugs

- Out of hours service
- Patient group direction service
- Prescriber support service
- Schools service
- Supplementary prescribing service.

These services can only be referred to as Enhanced Services if they are commissioned by NHS England. If local services are commissioned by CCGs or local authorities, they are referred to as locally commissioned services.

**\*\*It should be noted that locally commissioned services are outside of the scope of this PNA. Further details on the adoption of and need for these across Thurrock pharmacies will be found in separate analyses.\*\***

### *Dispensing Doctors*

NHS legislation provides that in rural areas classified as 'controlled localities' general practitioners may apply to dispense NHS prescriptions as 'dispensing doctors'. The provisions to allow GPs to dispense were introduced to provide patients access to dispensing services in rural communities not having reasonable access to a community pharmacy. Dispensing GP practices can make a valuable contribution to dispensing services although they do not offer the full range of pharmaceutical services offered at community pharmacies.

There are three dispensing practices in Thurrock – further information on their activity can be found in section 6.2.3.

#### **2.2.1 Roles and Responsibilities of varying organisations**

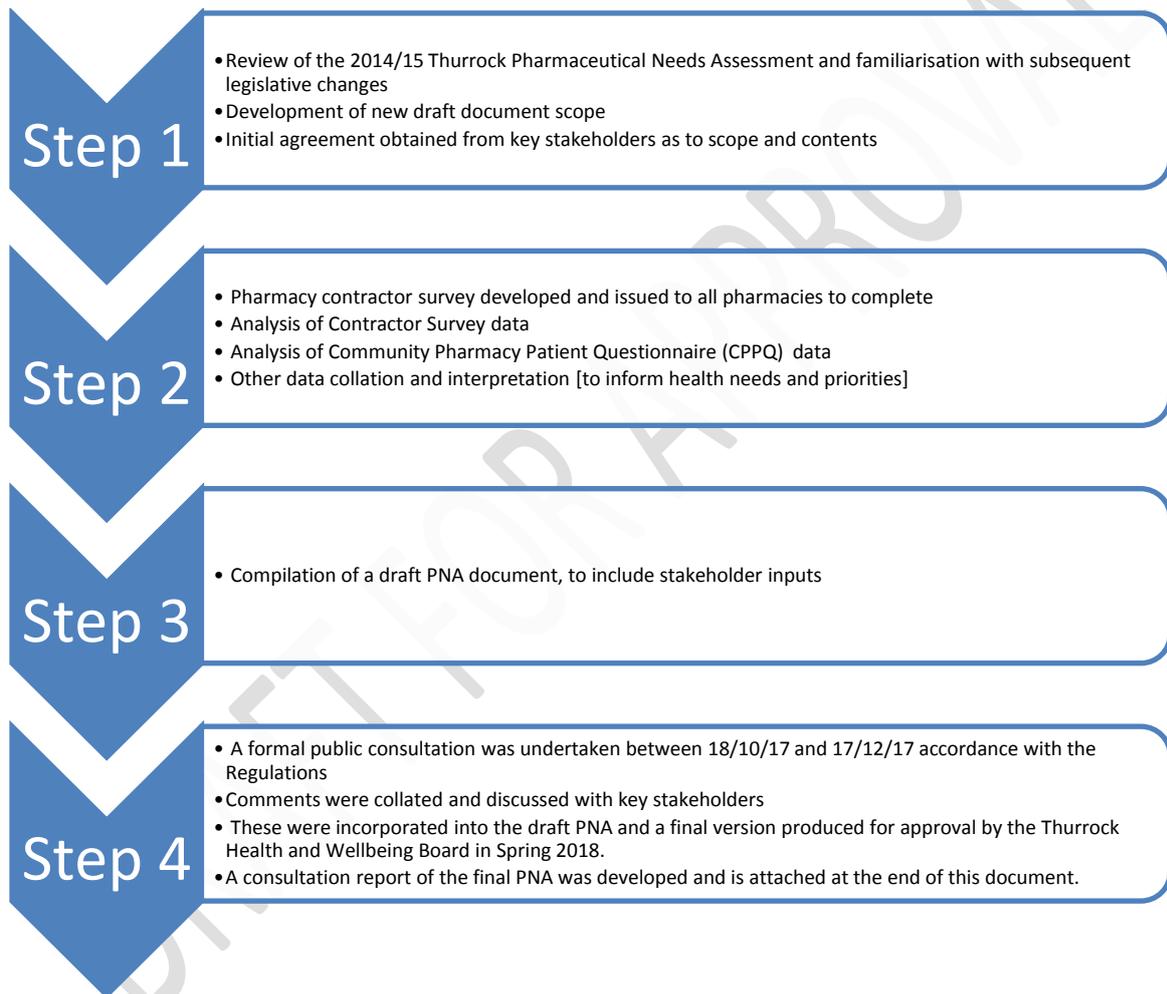
The Health and Social Care Act 2012 influences both the need and delivery of pharmaceutical services. A range of health and care organisations work in partnership to deliver under this Act.

- *Local Authority* - The local authority has responsibility for Public Health and social care.
- *Clinical Commissioning Group* - CCGs have a role to commission most NHS services. CCGs are responsible to secure improvements in service, involve patients, reduce health inequalities and promote research and development.
- *Health and Wellbeing Board* - Each upper tier Local Authority has established a Health and Wellbeing Board (HWB) that brings together a range of leaders from health and care organisations to improve the health and wellbeing of their local population and reduce health inequalities. Each HWB has developed a HWB strategy that will provide the local framework for commissioning, integration and coordination of services in order to meet local need.
- *NHS England* - NHS England is a national body that has the responsibility for commissioning primary care core contracts, offender health, military health and specialised commissioned services.

- *Public Health England* - Public Health England (PHE) is a national body that has the responsibility to protect the health of the nation and address inequalities. The main focus of PHE work is around delivery and informing health improvement, health protection, commissioning and research and development.

## 2.3 Process followed in developing the PNA

This PNA was developed using a range of methods including consultation with stakeholders and local pharmaceutical service providers. The steps below summarise the main activities undertaken during this process:



## 2.4 Local Context

### 2.4.1 Mid & South Essex Sustainability and Transformation Partnership (STP)

The NHS has outlined a new approach to help ensure that health and care services are planned by place rather than around individual institutions. To do this, local health and care

systems have come together in STP ‘footprints’. The health and care organisations within these geographic footprints will work together to narrow the gaps in the quality of care, their population’s health and wellbeing, and in NHS finances. Each ‘footprint’ had to publish a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the [Five Year Forward View](#) vision.

Thurrock is part of the Mid and South Essex STP footprint. The Mid and South Essex STP aims to:

- Invest in innovation and expertise that can help people stay well for longer
- Join services together to provide more care closer to people and where they live
- Redesign our hospitals to meet rising demands with the best quality emergency and specialist care for everyone who needs it

Further information on the Mid and South Essex STP can be found [here](#).

#### 2.4.2 Thurrock Health and Wellbeing Strategy 2016-21

The latest Health and Wellbeing Strategy is in place from 2016-2021. It sets out five strategic goals that focus on the areas within which we can make the most difference to the health and wellbeing of Thurrock’s people. Each goal has a named sponsor who sits on the Health and Wellbeing Board, and four objectives underneath which all require a high level of partnership working to be achieved. The list of goals and objectives is shown below.

GOALS	1. OPPORTUNITY FOR ALL	2. HEALTHIER ENVIRONMENTS	3. BETTER EMOTIONAL HEALTH & WELLBEING	4. QUALITY CARE CENTRED AROUND THE PERSON	5. HEALTHIER FOR LONGER
OBJECTIVES	1A. All children in Thurrock making good educational progress	2A. Create outdoor places that make it easy to exercise and to be active	3A. Give parents the support they need	4A. Create four integrated healthy living centres	5A. Reduce obesity
	1B. More Thurrock residents in employment, education or training	2B. Develop homes that keep people well and independent	3B. Improve children’s emotional health and wellbeing	4B. When services are required, they are organised around the individual	5B. Reduce the proportion of people who smoke
	1C. Fewer teenage pregnancies in Thurrock	2C. Build strong, well-connected communities	3C. Reduce social isolation and loneliness	4C. Put people in control of their own care	5C. Significantly improve the identification and management of long term conditions
	1D. Fewer children and adults in poverty	2D. Improve air quality in Thurrock	3D. Improve the identification and treatment of depression, particularly in high risk groups Amended to: Improve the Identification and treatment of mental ill-health, particularly in high risk	4D. Provide high quality GP and hospital care to Thurrock	5D. Prevent and treat cancer better

Source: Thurrock Health and Wellbeing Strategy, 2016-2021

#### 2.4.3 For Thurrock in Thurrock

*For Thurrock In Thurrock* is a joint brand between NHS Thurrock CCG and Thurrock Council which focuses on partnership working with communities and individuals to improve health and wellbeing outcomes for Thurrock residents. It proposes a new model of health care that would place greater emphasis on neighbourhood based care in communities. Health and

social care teams will work closely together to deliver care closer to home, moving away from the current more complex system.

Future programmes of work within this include:

- Bringing intermediate beds back into the area, from 49 spread across Essex to 37 solely in Thurrock;
- Investing £800,000 in enhancing community services;
- Developing a blueprint for new services with Thurrock residents including addressing root cause of bad health, improving social and mental wellbeing, managing long term health issues and bringing the hospital into the community;
- Establishing four integrated medical centres at Purfleet, Tilbury, Corringham and Grays

### **3. Thurrock's Population**

Thurrock is located in the south of Essex and lies to the east of London on the north bank of the River Thames with an area of 165 square kilometres (km<sup>2</sup>). It has a diverse and growing population [further details in the section below]. The borough comprises of 20 wards, with areas in the central and eastern parts that are most affluent and have the healthiest residents in the borough.

The Regulations state that the Health and Wellbeing Board define the localities by which it will assess the pharmaceutical needs of its population. Thurrock has four locality areas used across the health and social care landscape. These can be defined by both the wards that fit into each locality, and the GP practices situated in each locality area. Both the wards and GP practices situated in each locality are listed in the table below.

Table 1: Locality Areas

	Corringham	Grays	South Ockendon	Tilbury
<b>Wards</b>	Corringham and Fobbing Stanford East and Corringham Town Stanford-le-Hope West The Homesteads	Chafford and North Stifford Grays Riverside Grays Thurrock Little Thurrock Blackshots Little Thurrock Rectory Orsett South Chafford Stifford Clays	Aveley and Uplands Belhus Ockendon West Thurrock and South Stifford	Chadwell St. Mary East Tilbury Tilbury St. Chads Tilbury Riverside and Thurrock Park
<b>GP Practices (Code and Name)</b>	F81644 – Ash Tree Surgery F81177 – Neera Medical Centre F81697 – The Sorrells Surgery F81198 – The Surgery, Horndon-on-the-Hill F81088 – Southend Road Surgery F81153 - Hassengate Medical Centre	<b>F81742 - Acorns</b> F81113 – Chafford Hundred Medical Centre F81219 – The Dell Medical Centre F81155 – Balfour Medical Centre F81137 – The Surgery, Orsett F81192 – The Health Centre, Stifford Clays F81218 – The Grays Surgery F81641 – The Milton Road Surgery F81211 – East Thurrock Road Medical Centre F81623 - Kadim Primecare Medical Centre <b>Y00999 - St Clements Health Centre</b> Y02807 - Thurrock Health Centre F81659 – Oddfellows Hall Health Centre	F81669 - Derry Court Medical Practice F81134 – Pear Tree Surgery F81197 – Sancta Maria Centre F81010 – Aveley Medical Centre F81632 – The Health Centre, South Ockendon Y00033 - Purfleet Care Centre	F81698 - Dilip Sabnis Medical Centre F81084 – Chadwell Medical Centre F81652 – Medic House F81110 – Tilbury Health Centre F81691 - East Tilbury Medical Centre F81708 - Sai Medical Centre F81082 - The Rigg-Milner Medical Centre <b>F81206 – Commonwealth Health Centre</b>

Source: Thurrock Council

NB – the three highlighted practices will have since closed or the populations redistributed since analyses were undertaken.

Thurrock shares its border with the following neighbouring HWB areas:

- Essex
- Havering
- Medway

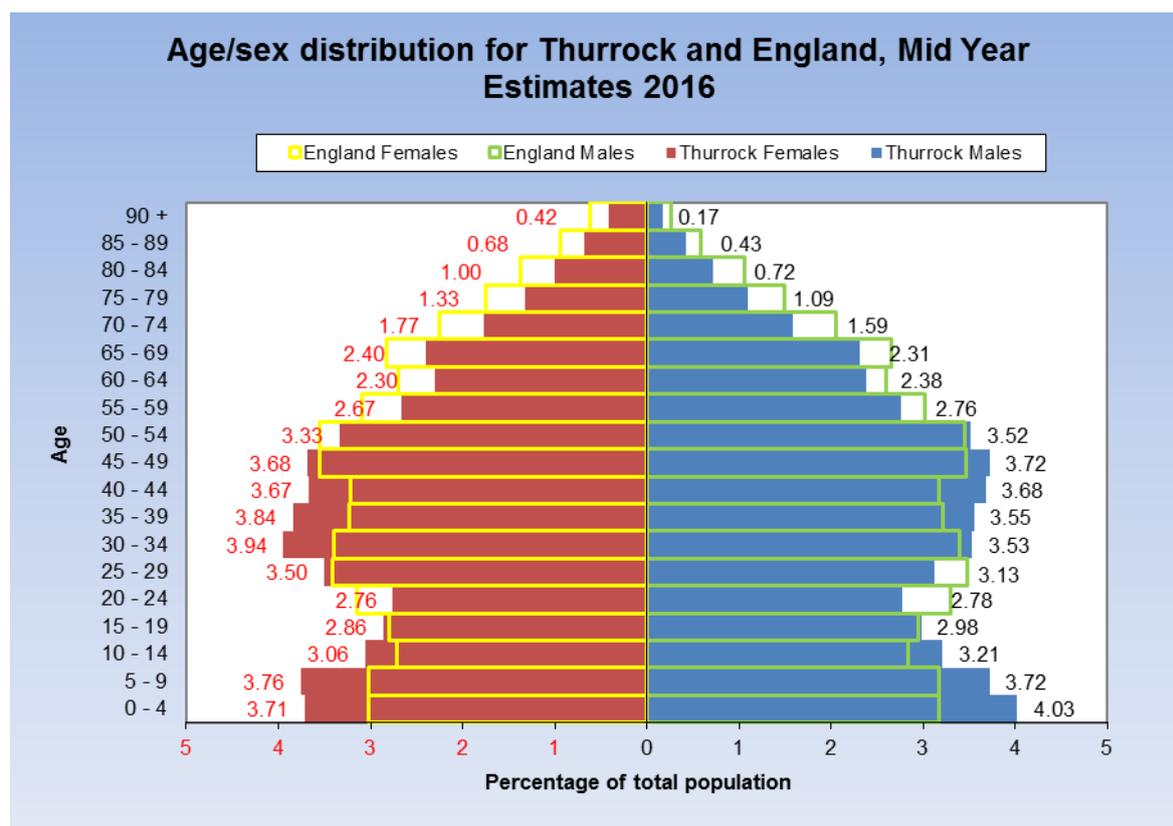
### 3.1 Current population distribution

The most recent mid-year estimates show the population of Thurrock (as of June 2016) is 167,025, an increase of 1841 people since the previous year, representing a percentage rise of 1.11%. This increase is consistent with recent trends and is mainly due to the difference between births and deaths (there were 2514 births and 1203 deaths). The rest is attributable to migration: a total of 7298 residents moved into the borough from other parts of England and Wales and 7082 moved out; whilst a total of 1181 people moved into the borough from areas outside England and Wales and 866 moved out. The most significant increases from the previous year are in the 10-14 year age band at 4.3%; and the 70-74 year age group at 6.9%.

The population density and distribution in Thurrock varies considerably from low density in the more rural areas to high density in the urban areas.

The figure below is a population pyramid depicting the age structure of Thurrock in 2016 compared to that of England. It is clear that Thurrock has a relatively young population with almost all the age groups below 50 years forming a greater proportion of the total population than England; this is inversely true of population aged 50+ years plus, where Thurrock has a lower proportion in the total population compared to England.

Figure 1: Age/sex distribution of Thurrock's population, 2016



Source: Office for National Statistics

When considering differences at sub-Thurrock level in population distribution, the four localities can be summarised as per table below. It can be seen that Grays is the largest of the localities (63,107 residents) and Corringham the smallest (28,726 residents). Corringham locality has the largest proportion of its residents who are over 65 years (21.28%) whilst Tilbury has the largest proportion of its residents aged 0-19 years (27.99%). Older and younger age groups can be more frequent users of pharmaceutical services.

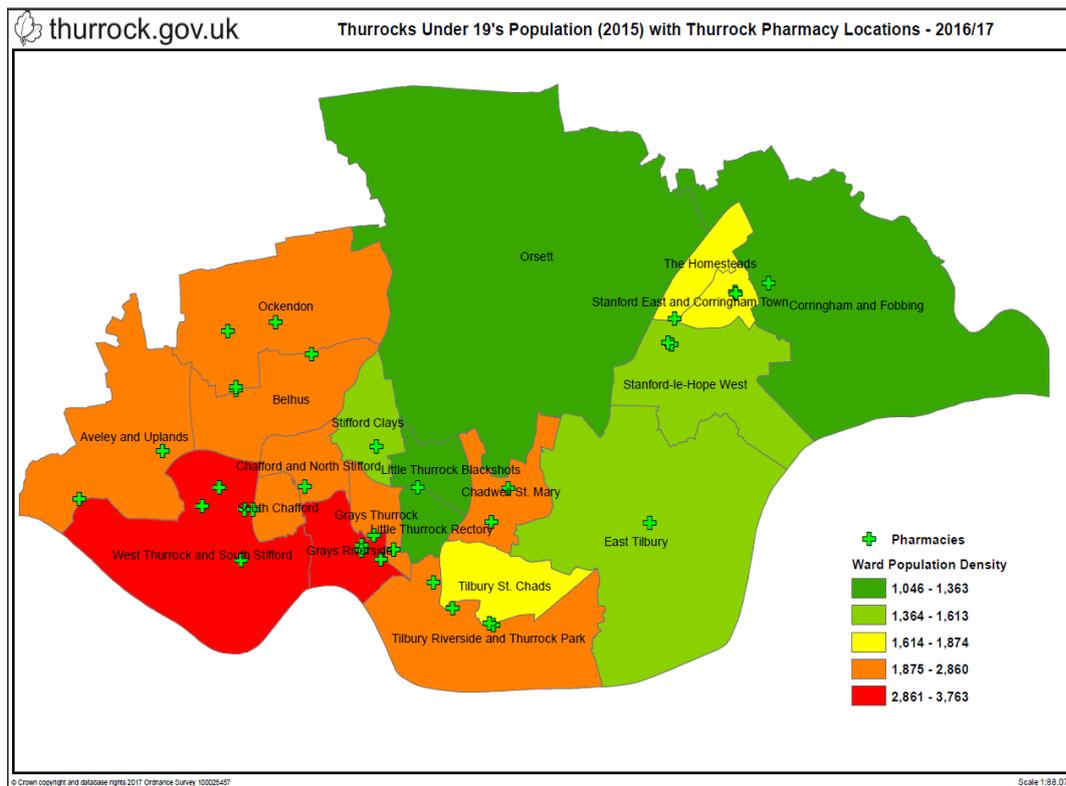
Table 2: Locality Populations, 2015

Locality	Total number of residents	% 0-19 years	% 20-64 years	% 65+ years
Corringham	28,726	21.78%	56.94%	21.28%
Grays	63,107	26.04%	61.27%	12.69%
South Ockendon	43,192	27.51%	62.00%	10.49%
Tilbury	30,159	27.99%	58.12%	13.89%

Source: Office for National Statistics

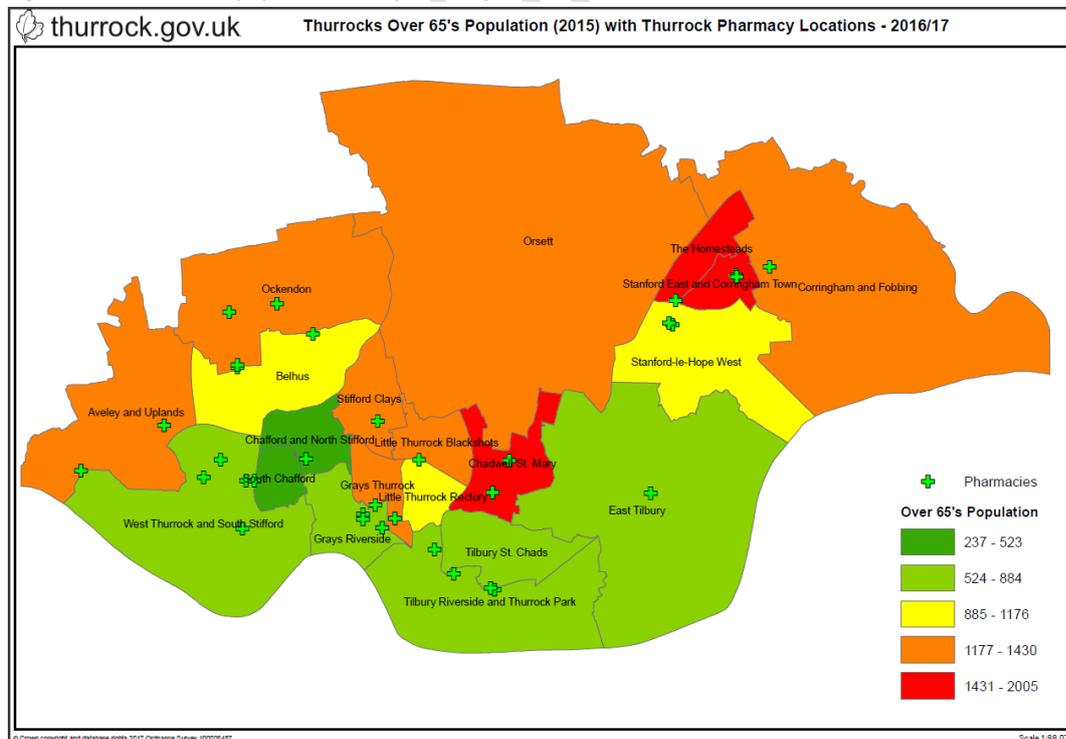
The two maps below depict the distributions of younger and older people across Thurrock in relation to locations of pharmacies. It can be seen that there is sufficient provision accessible by both age groups.

Figure 2: 0-19 Thurrock population and pharmacy locations



Source: Office for National Statistics and Thurrock Contractor Questionnaire 2017

Figure 3: 65+ Thurrock population and pharmacy locations

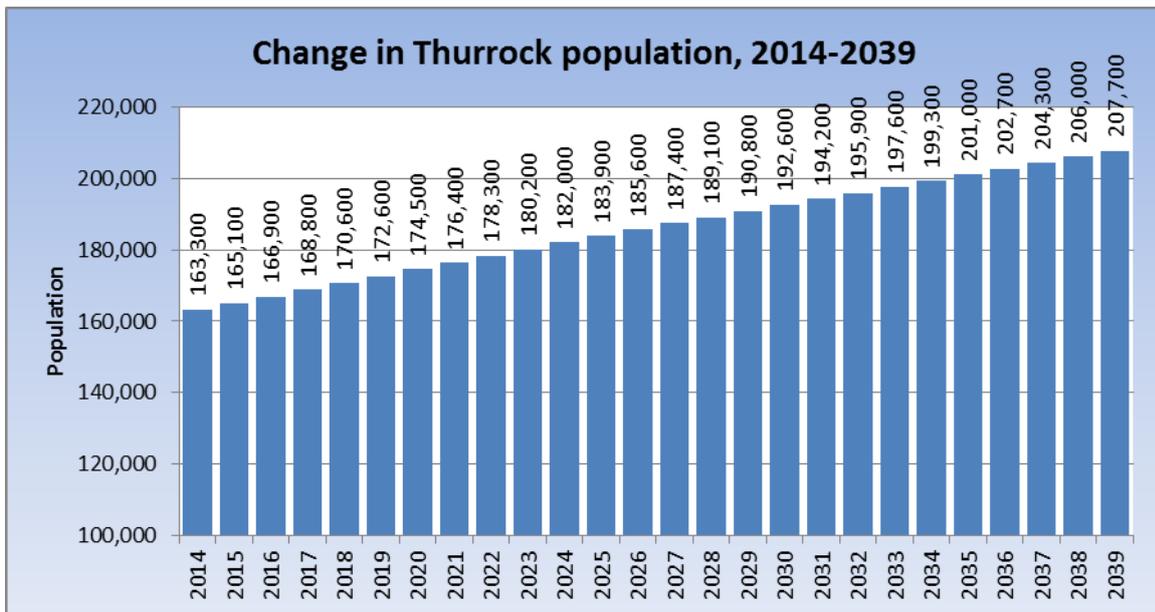


Source: Office for National Statistics and Thurrock Contractor Questionnaire 2017

### 3.2 Population Projections

The figure below shows population projections from 2014 to 2039. The population of Thurrock is projected to grow to 187,400 by 2027 and 207,000 by 2039. This equates to an increase of 27% in a 25 year period.

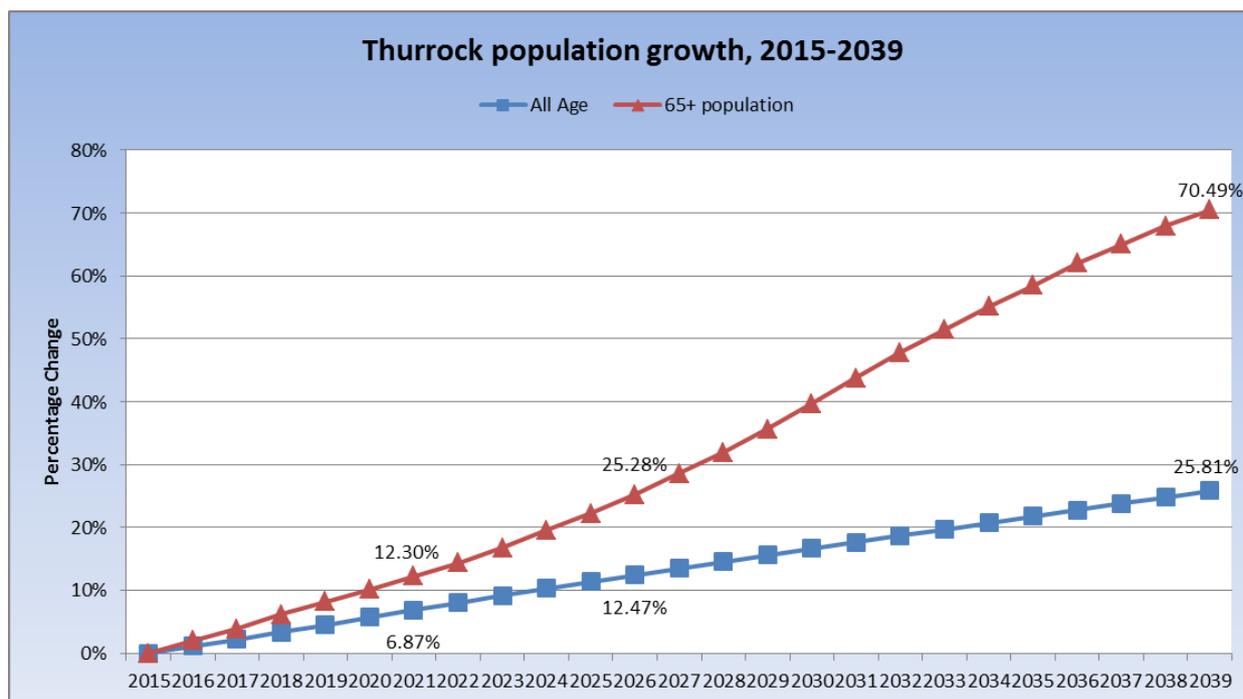
Figure 4: Predicted population growth, 2014-2039



Source: Office for National Statistics

Whilst the population of Thurrock will increase as shown above, the proportion of the population who will be aged 65+ will increase at an even higher rate. Quantifying this, there are an estimated 22,839 people aged 65+ in Thurrock in 2015; this is expected to increase to 25,649 by 2021 and 28,612 by 2026. *[Note that these estimates do not incorporate planned housing and regeneration development within the borough as accurate numbers and timelines are not yet known. The true rate of growth could be even higher once these are accounted for].* Those aged 65+ are the highest users of Adult Social Care and wider health services and are also more likely to develop multiple long term conditions, which results in increased demand for health and social care services with fewer working age people that can be taxed to pay for this increased demand.

Figure 5: Thurrock projected population increase, all-age and 65+ population, 2015-2039



Source: ONS Sub-National Population Projections, 2014

### 3.3 Ethnicity

The table below shows the proportions of the population in each ethnic group in 2011 and 2001. It can be seen that the proportion of White British/White Irish residents has decreased since 2001, and all other ethnic groups have increased their proportion of residents, particularly Black residents (increase from 1.2% in 2001 to 7.8% in 2011).

Table 3: Ethnic Groups, 2011

Ethnic Group	% of total population - 2011	% of total population - 2001
White British & White Irish	81.60%	93.90%
White Other	4.30%	1.40%
Mixed	2.00%	0.90%
Asian	3.80%	2.40%
Black	7.80%	1.20%
Other	0.60%	0.20%

Source: Census 2001 and 2011

The table below shows the main languages that are spoken by the Thurrock population. Almost 6% of the local population uses a language other than English as their main language. The pharmacists in Thurrock provided information on the languages other than English that they spoke as part of the Contractor Questionnaire, and this is also shown in the table below. It can be seen that no pharmacy employs staff who speak Polish at the time of

the survey, although this is the second most common language used as a main language in Thurrock.

Table 4: Main languages spoken and pharmacies with staff who speak them, 2017

Language	% of residents with this as their main language	Number of pharmacies with staff who speak the language
English	94.03%	34
<i>Polish</i>	1.42%	0
Panjabi	0.25%	5
Yoruba	0.22%	2
Bengali (with Sylheti and Chatgaya)	0.22%	1
Portuguese	0.18%	1
Romanian	0.17%	1
Urdu	0.13%	5
French	0.12%	2
Gujarati	0.08%	8
Cantonese Chinese	0.07%	2
Hindi	0.02%	10
Swahili/Kiswahili	0.02%	2
Mandarin Chinese	0.02%	1
Hebrew	0.00%	1
Lingala	0.00%	1

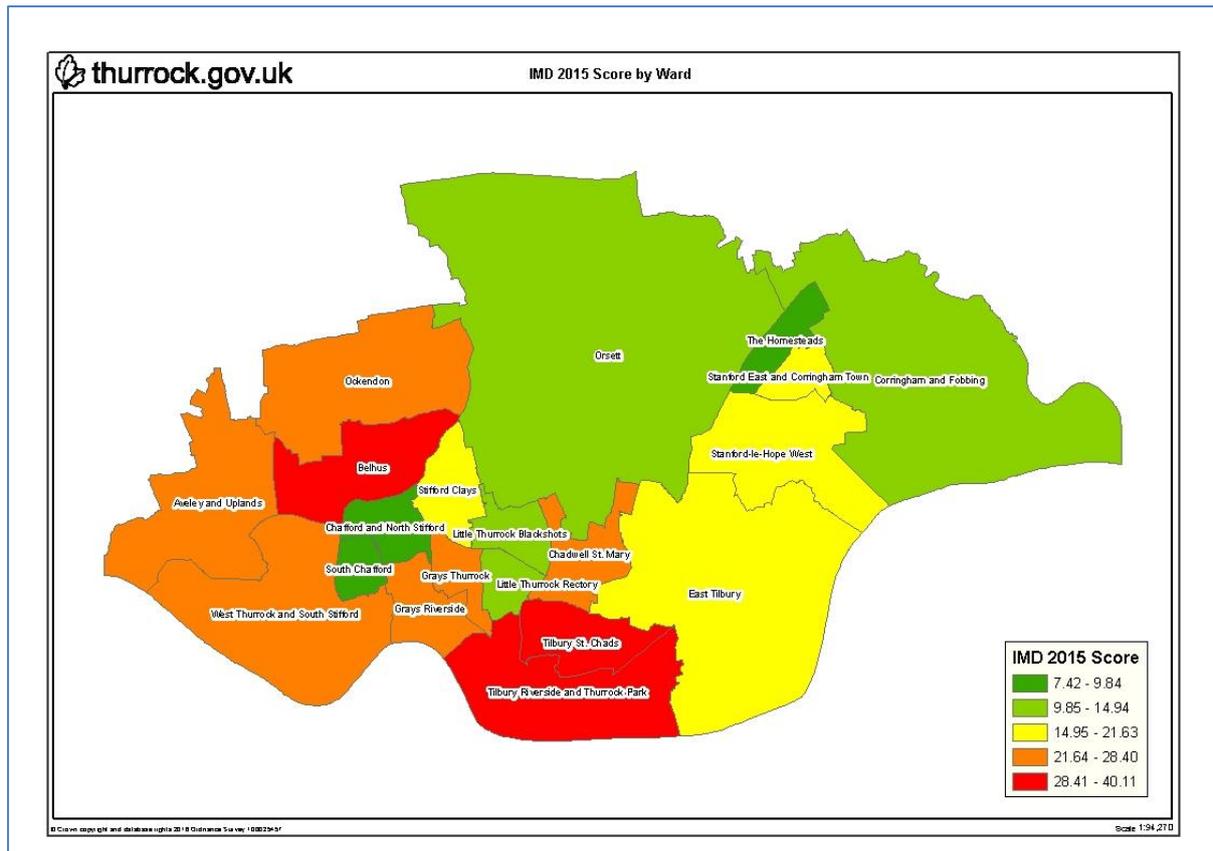
Source: Census 2011 and Thurrock Contractor Questionnaire 2017

### 3.4 Deprivation and Life Expectancy

There is a strong positive correlation between deprivation and higher rates of illness and poor health outcomes. Deprivation is a major factor of health inequalities, as a result of the unequal distribution of power, money and resources. Indices of Multiple Deprivation (IMD) are weighted summary measures of seven domains with the income and employment domains taking up the strongest weight. The higher the IMD score, the more deprived the area. In 2015, Thurrock's score was 21.6 which was similar to the England score of 21.8.

When considering deprivation within the borough, it can be seen that the wards of Tilbury St Chads, Tilbury Riverside and Thurrock Park [both within the Tilbury locality] and Belhus [South Ockendon locality] have the highest deprivation scores. The Homesteads [Corringham locality], South Chafford and Chafford and North Stifford [Grays locality] have the lowest deprivation scores. Some parts of Thurrock are within the 20% most deprived areas in England – 13.3% of our residents live within these areas.

Figure 6: IMD by ward, 2015



Source: Department for Communities and Local Government

The difference in life expectancy in Thurrock between those that live in 10% of the most deprived and 10% of the most affluent areas vary significantly. In males there is a life expectancy gap of 9.4 years and a 6.5 year gap between females (2012-14).

The Life expectancy for Males in Thurrock was estimated at 79.3 years and Females 82.6 years, the estimate for England is 79.5 and 83.2.

The conditions that have contributed to the gap in life expectancy between the most and least affluent areas in Thurrock are circulatory disease, particularly coronary heart disease, (CHD) lung (and other) cancers and chronic obstructive pulmonary disease (COPD).

### 3.5 Working patterns

Thurrock offers employment to over 19,000 workers who commute in from other areas. The majority are coming from the geographically close authorities such as Basildon, Havering, Barking and Dagenham, Dartford and Chelmsford.

Thurrock has a higher number of its workforce that commute to other areas for employment than those who commute in – nearly 32,000 Thurrock residents commute to other authority areas for employment. The majority commute into London, although substantial numbers also commute to the neighbouring areas of Basildon and Dartford.

*What does this mean for pharmacies?*

This is likely to mean that some of Thurrock's population working out of area may access pharmacies in other boroughs during working hours. However it could also mean they may require certain services to be provided locally during evenings and weekends.

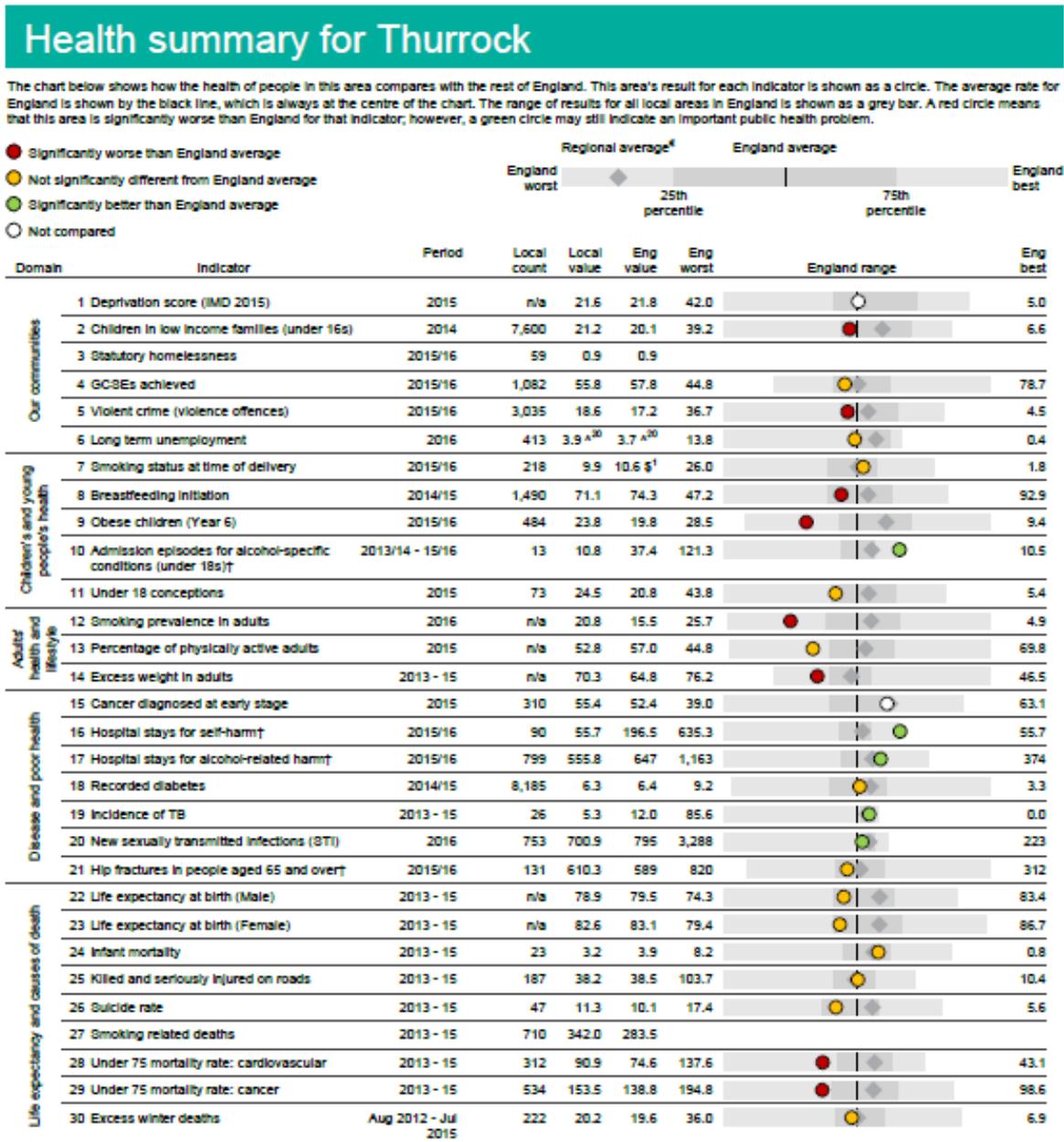
#### **4. Local Health Issues**

Thurrock has a number of health issues relating to aspects of healthy lifestyle and long term conditions that pharmacists can provide locally commissioned/enhanced services to support. Further information on these is provided in other published documents – however this is presented separately as the provision of locally commissioned services is out of the scope of this PNA.

A snapshot of Thurrock's key health and wellbeing issues can be seen in Public Health England's Health Profile 2017 below. Some of the main health issues include breastfeeding initiation, childhood and adult excess weight/obesity, smoking prevalence and premature mortality for cardiovascular disease and cancer.

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Figure 7: Thurrock Health Profile 2017



Source: Public Health England

## 5. Current pharmaceutical service provision

### 5.1 Geographical distribution of service providers

Thurrock has a rate of 21.2 pharmacies per 100,000 population. This varies slightly across localities - from 25.47 per 100,000 in South Ockendon locality, to 14.26 per 100,000 in Grays locality. The data shows that there is some choice of pharmacy in half the wards, with the exception of Belhus, Little Thurrock Blackshots, Orsett and The Homesteads that have no pharmacies, and Chafford and North Stifford, Stifford Clays, South Chafford, Little Thurrock Rectory, East Tilbury and Corringham and Fobbing that have one pharmacy each.

Nevertheless, residents in all wards are able to access one or more pharmacies located close to or on the border of an adjacent ward. It should also be noted that there are three dispensing GP practices providing dispensing services – two are located in Orsett ward and one in Ockendon ward.

Viewing this in conjunction with data on access to pharmaceutical services (see [section 5.2](#)), it is observed that not having a pharmacy in every ward does not mean there is a gap in provision as Thurrock residents can still access a pharmacy close to their homes.

Table 5: Pharmacy provision by ward and IMD rank

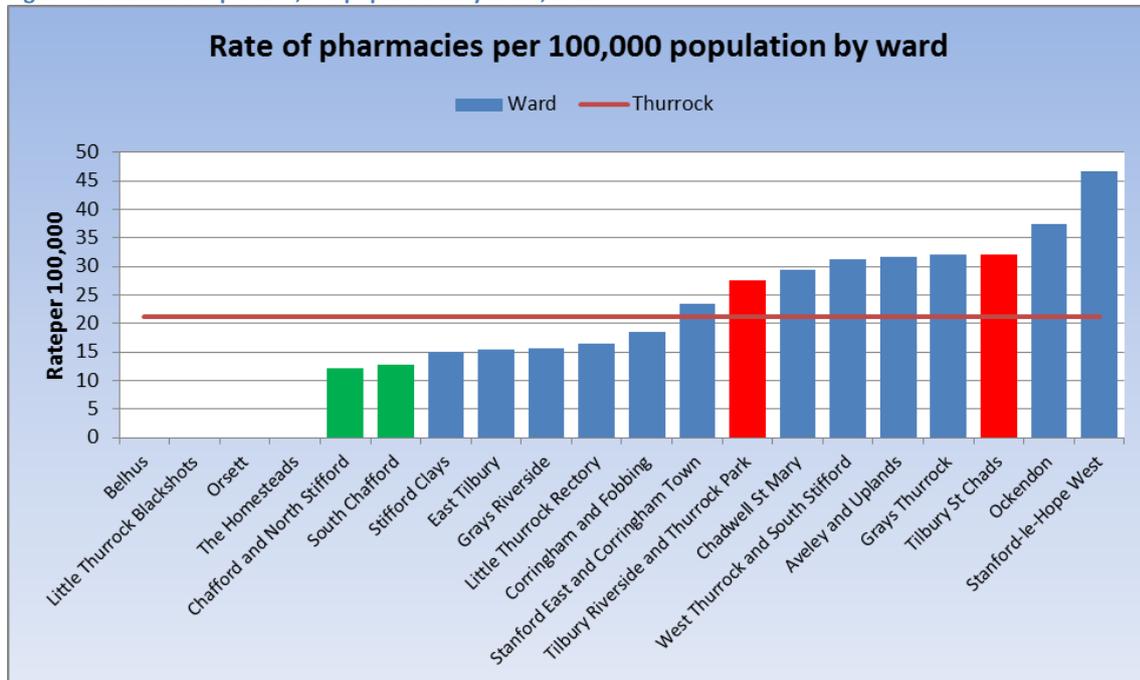
Locality	Ward	Rank of IMD within Thurrock	Number of pharmacies [Dispensing GPs in brackets]	Ward Population	Rate of pharmacies per 100,000	Locality Number of pharmacies	Locality Rate of pharmacies per 100,000
Corringham	Corringham and Fobbing	15	1	5,385	18.57	6	20.89
	Stanford East and Corringham Town	10	2	8,517	23.48		
	Stanford-le-Hope West	13	3	6,437	46.61		
	The Homesteads	18	0	8,387	0		
Grays	Chafford and North Stifford	19	1	8,248	12.12	9	14.26
	Grays Riverside	7	2	12,806	15.62		
	Grays Thurrock	9	3	9,345	32.1		
	Little Thurrock Blackshots	14	0	6,059	0		
	Little Thurrock Rectory	16	1	6,097	16.4		
	Orsett	17	0 [2 DGPs]	6,108	0		
	South Chafford	20	1	7,816	12.79		
	Stifford Clays	12	1	6,628	15.09		
South Ockendon	Aveley and Uplands	6	3	9,483	31.64	11	25.47
	Belhus	3	0*	10,256	0		
	Ockendon	8	4 [1 DGP]	10,691	37.41		
	West Thurrock and South Stifford	5	4	12,762	31.34		
Tilbury	Chadwell St Mary	4	3	10,195	29.43	8	26.53
	East Tilbury	11	1*	6,469	15.46		
	Tilbury Riverside and Thurrock Park	2	2	7,274	27.5		
	Tilbury St Chads	1	2	6,221	32.15		

Source: Thurrock Council and ONS Mid-Year Ward Estimates 2015

\*The distance-selling pharmacy contractors are situated in these wards; however they are excluded from this analysis as they do not provide face-to-face services.

The figure below depicts the same information as the table above, but it also highlights the position of the two most deprived and least deprived wards in terms of their pharmacy provision. It can be seen that both of the most deprived wards have rates that are higher than the Thurrock average, whilst the two least deprived wards have rates that are below the Thurrock average – meaning that residents in the most deprived areas have more provision.

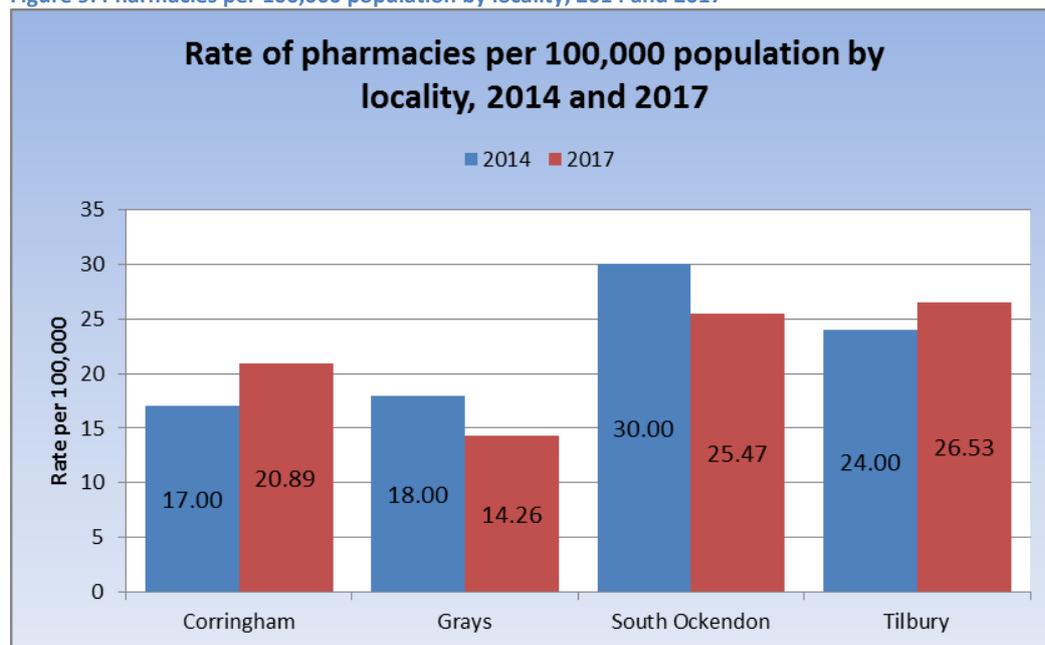
Figure 8: Pharmacies per 100,000 population by ward, 2017



Source: Thurrock Council and ONS Mid-Year Ward Estimates 2015

It should be noted that whilst the number of community pharmacy premises has not changed since the previous PNA was produced, the ward population figures have changed, resulting in slightly different figures for locality rates (see figure below). It can be seen that the rates have decreased in two of the four localities, reflecting population increases across those areas. However it is still felt that there is adequate provision of pharmacies in Thurrock.

Figure 9: Pharmacies per 100,000 population by locality, 2014 and 2017



Source: Thurrock Council

## 5.2 Access to pharmacies

### 5.2.1 Opening hours

This section explores the impact of pharmacy opening hours on access to services and patient choice.

Community pharmacies have an obligation to be open for a minimum of 40 core hours unless it has been granted a contract under the “100 hour exemption” or NHS England has granted a contract on the basis of more than 40 core hours under the current market entry system. Additional hours, over and above core hours are termed “supplementary hours”. A pharmacy may not amend its core hours without seeking permission from NHS England; but it is entitled to provide NHS England with 90 days’ notice if it wishes to change its supplementary hours.

In Thurrock, there are six “100 hour” pharmacies located in the Tilbury (3), Grays (2) and Corringham (1) localities.

#### Weekdays

On weekdays, 33 out of the 34 pharmacies in Thurrock are open between the hours of 9:30am to 5:00pm with the majority (33/34) of pharmacies open on or before 9am, and one pharmacy which closes at 4:00pm in the Corringham locality. One pharmacy closes at 1:00pm on Wednesdays, which is located in the Tilbury locality. Eight pharmacies close for lunch on weekdays (One pharmacy is closed for 30 minutes and seven are closed for an hour), thus potentially reducing choice during this period for clients.

With regards to extended hours:

- 10 pharmacies are open by 8:30 am (two at 7am; four at 8am and 8:30am respectively), with at least one pharmacy opened by 8:00am in all localities.
- 9 pharmacies remain open after 7:00pm, with the latest closures of two pharmacies at 11:00pm

### **Saturdays**

On Saturdays, 74% (24/34) of the pharmacies are open between 10:00am – 1:00pm. As the day progresses, pharmacies start to close although 56% (19/34) remain open until 5:00pm

With regards to extended hours:

- Three pharmacies open at 7:00am (one in the Grays locality and the other two in Tilbury locality)
- Two pharmacies open at 8:00am (one each in the South Ockendon and Corringham localities)
- 21% (7/34) of pharmacies remain open until 7pm or later, of these:
  - Two remain open until 8:00pm (South Ockendon Locality)
  - One remains open until 9:00pm (South Ockendon Locality)
  - Three remain open until 10:00pm (Two in the Tilbury Locality and one in Corringham Locality)
  - One remains open until 11:00pm (Grays Locality)

### **Sundays**

On Sundays, 35% (12/34) of pharmacies are open for between 3 and 11 hours; with 11 of these opening for 6 or more hours. It is felt that there is a reasonable level of coverage across Thurrock throughout the day.

Table 6 below outlines opening hours for all pharmacies per ward and locality for weekdays, Saturdays and Sundays.

Table 6: Pharmacy Opening Hours by Ward and Locality, 2017

Locality	Ward	Weekday Opening					Saturday Opening			Sunday Opening
		8am or earlier	9:30am-5pm	7pm or later	Early Closing	Closed for lunch	10am-1pm	5pm or later	7pm or later	
Corringham	Stanford East and Corringham Town	0	2	0	0	0	2	2	0	1
	Corringham and Fobbing	0	1	0	1	0	1	0	0	0
	Stanford-le-Hope West	1	3	1	0	0	2	1	1	1
Grays	Grays Riverside	1	2	1	0	0	2	1	0	2
	Chafford and North Stifford	0	1	0	0	0	1	1	0	1
	Little Thurrock Rectory	0	1	0	0	0	1	1	0	0
	Grays Thurrock	0	3	0	0	1	0	0	0	0
	Stifford Clays	0	1	0	0	0	1	0	0	0
	South Chafford	1	1	1	0	0	1	1	1	1
South Ockendon	Aveley and Uplands	0	3	0	0	2	2	0	0	0
	Ockendon	0	4	0	0	3	2	0	0	0
	West Thurrock and South Stifford	1	4	2	0	0	3	3	3	3
Tilbury	Chadwell St Mary	1	3	1	1	2	2	1	1	1
	East Tilbury	0	1*	0	0	0	1	0	0	0
	Tilbury Riverside and Thurrock Park	1	2	1	0	0	2	2	1	2
	Tilbury St Chads	0	2	0	0	0	1	0	0	0
<b>Thurrock Total</b>		<b>6</b>	<b>34</b>	<b>7</b>	<b>2</b>	<b>8</b>	<b>24</b>	<b>13</b>	<b>7</b>	<b>12</b>
<b>Percentage</b>		<b>18%</b>	<b>100%</b>	<b>21%</b>	<b>6%</b>	<b>24%</b>	<b>71%</b>	<b>38%</b>	<b>21%</b>	<b>35%</b>

Source: Contractor Questionnaire, 2017

\*From September 2017, there will also be a new distance-selling contractor open in this ward

## 5.2.2 Access to services (by walking & public transport)

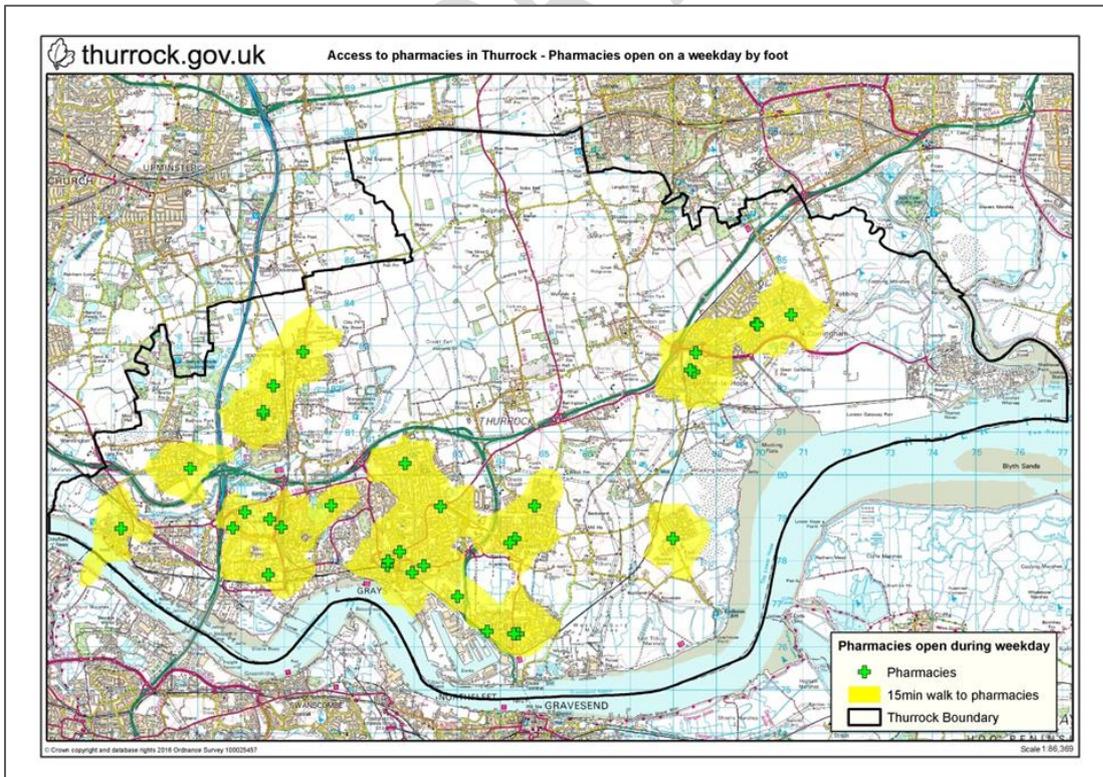
Following the breakdown of pharmacies into their respective CCG Locality areas, a review of the accessibility to the pharmacies was undertaken using the software modelling tool TRACC, and mapped out with the GIS Mapping Tool. The TRACC Software<sup>4</sup> creates a representation of the transport network within an area, and is able to calculate how easily accessible a destination is from a given location, and can provide details based on different modes of transport. The 34 pharmacies in Thurrock are the given destinations for the purpose of this analysis, and the modes of accessibility calculated were for 15 minutes walking and public transport (Buses).

### Accessing a pharmacy by walking

This mode of transportation has been considered for the cohort of the population who do not have access to a private car, are unable to access or afford public transport or choose not to use public transport.

Figure 10 below shows the proportion of the population who live within the walking threshold from a pharmacy open during the week. On weekdays, 70.4% (111,028) of the population live within a 15 minutes' walk from a pharmacy. The map further illustrates those who live in the highest population density areas are able to access a pharmacy within the 15 minutes walking threshold.

Figure 10: Access to pharmacies via walking - weekdays

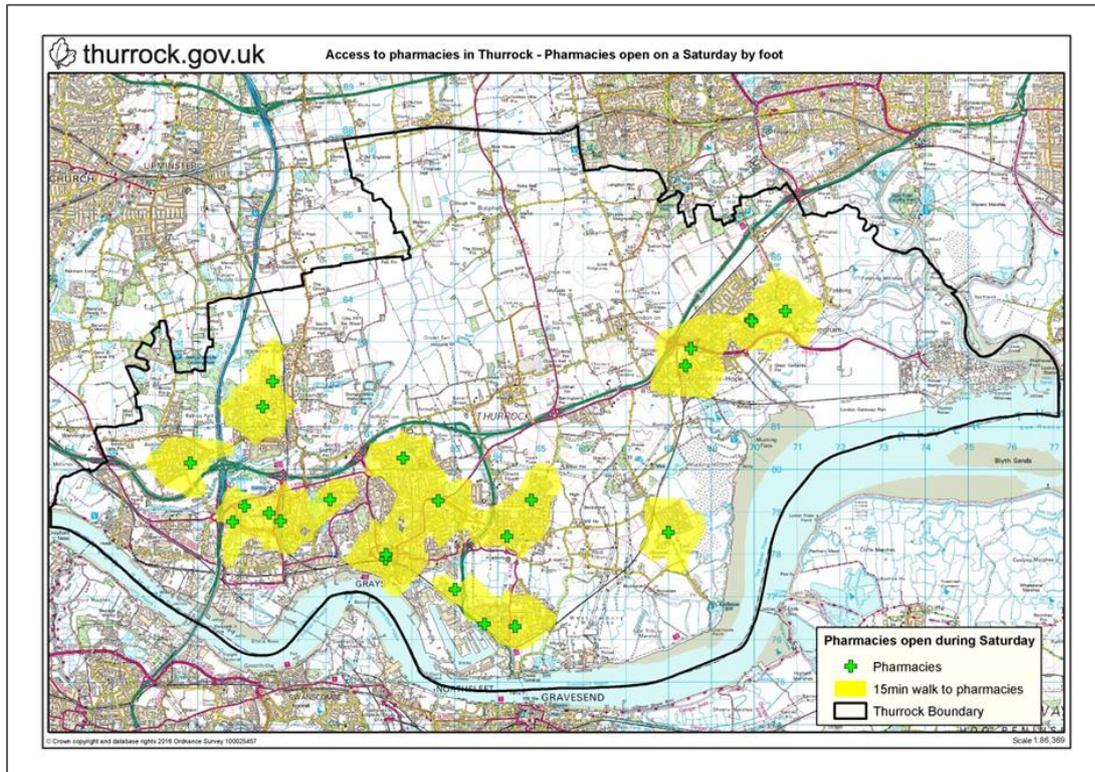


Source: Thurrock Council

<sup>4</sup> TRACC calculations have been carried out using the 2011 census population data

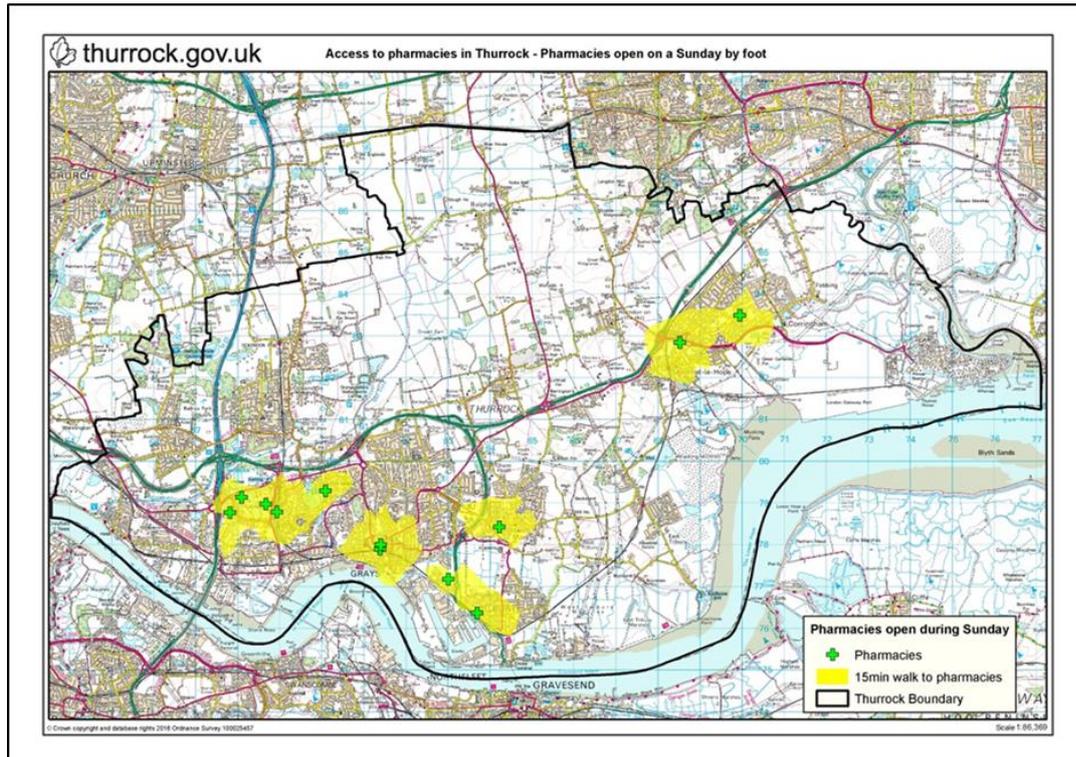
On weekends, 60.5% (95,482) and 29.8% (47,043) of the population live within a 15 minute walk from an open pharmacy on Saturday and Sunday respectively (as shown in figures Figure 11 & Figure 12).

Figure 11: Access to pharmacies via walking - Saturdays



Source: Thurrock Council

Figure 12: Access to pharmacies via walking - Sundays



Source: Thurrock Council

### Accessing a pharmacy by Public Transport (Buses)

Thurrock has quite a good network of bus services which run locally and to neighbouring boroughs. Analysis of public transport (bus running times) shows a majority of Thurrock population can access a pharmacy using a bus.

On weekdays, three scenarios and four travel durations have been considered in calculating the proportion of the population that can access a pharmacy using public transport. For the weekends, calculations have been carried with consideration of the core operating hours (i.e. between 10am – 1pm) of pharmacies during the weekends.

As shown in Table 7 below, and depicted in Figures 13, 14 and 15 – 96% of the population can access a pharmacy via public transport in 30 minutes on weekdays and Saturdays, and 92% of the population on a Sunday.

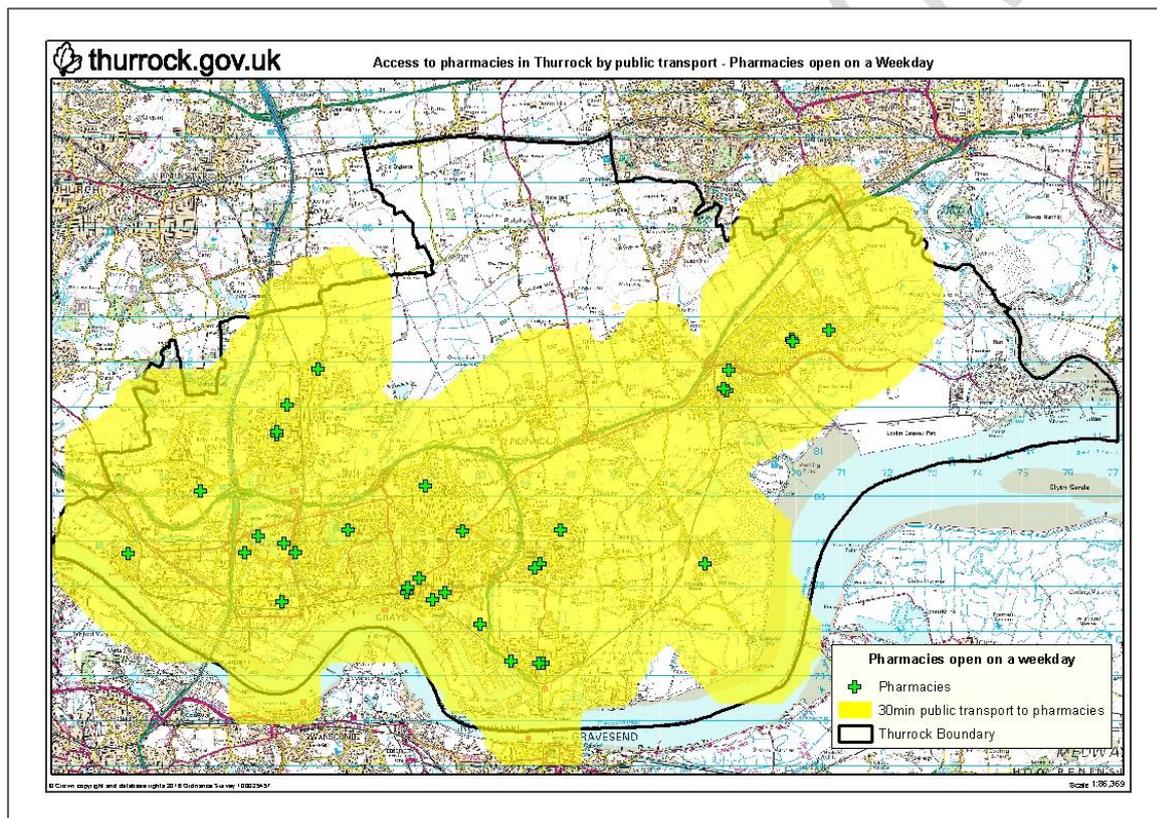
It is generally recognised that 100% of the population are within 20 minutes of a community pharmacy by car. Considering this journey time for public transportation in Thurrock, between 81% - 96% of the population are within 20 minutes of a community pharmacy by public transport.

Table 7: Number and proportion of population who can access a pharmacy via public transport by length of time, 2017

Pharmacy Opening Times	Public Transport Journey Time (minutes) / % of population			
	10	20	30	60
Weekday 10am – 12noon	140,549 (89%)	150,940 (96%)	152,185 (96%)	152,326 (97%)
Weekday before 9am	89,492 (57%)	148,542 (94%)	152,185 (96%)	152,326 (97%)
Weekday after 6pm	82,123 (52%)	143,818 (91%)	151,674 (96%)	152,326 (97%)
Saturday	124,877 (79%)	151,054 (96%)	151,583 (96%)	151,656 (96%)
Sunday	67,347 (43%)	128,447 (81%)	144,371 (92%)	146,209 (93%)

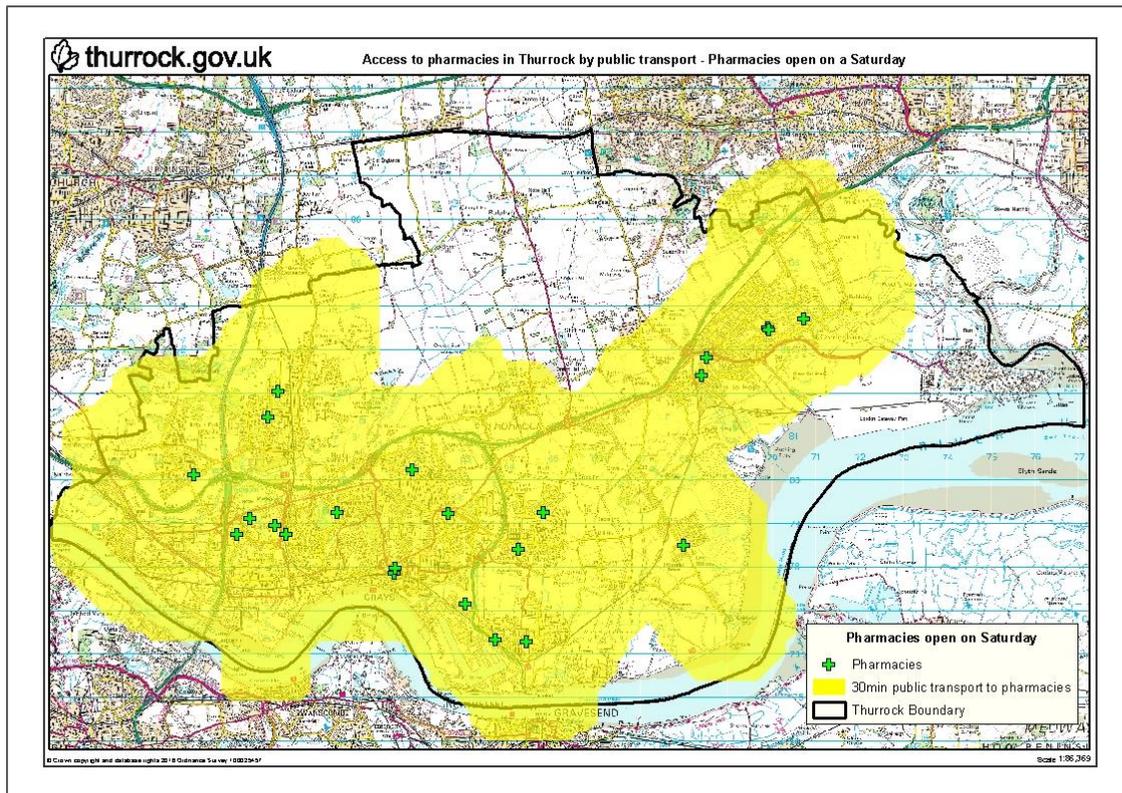
Source: Thurrock Council

Figure 13: Access to Pharmacies via public transport on a weekday



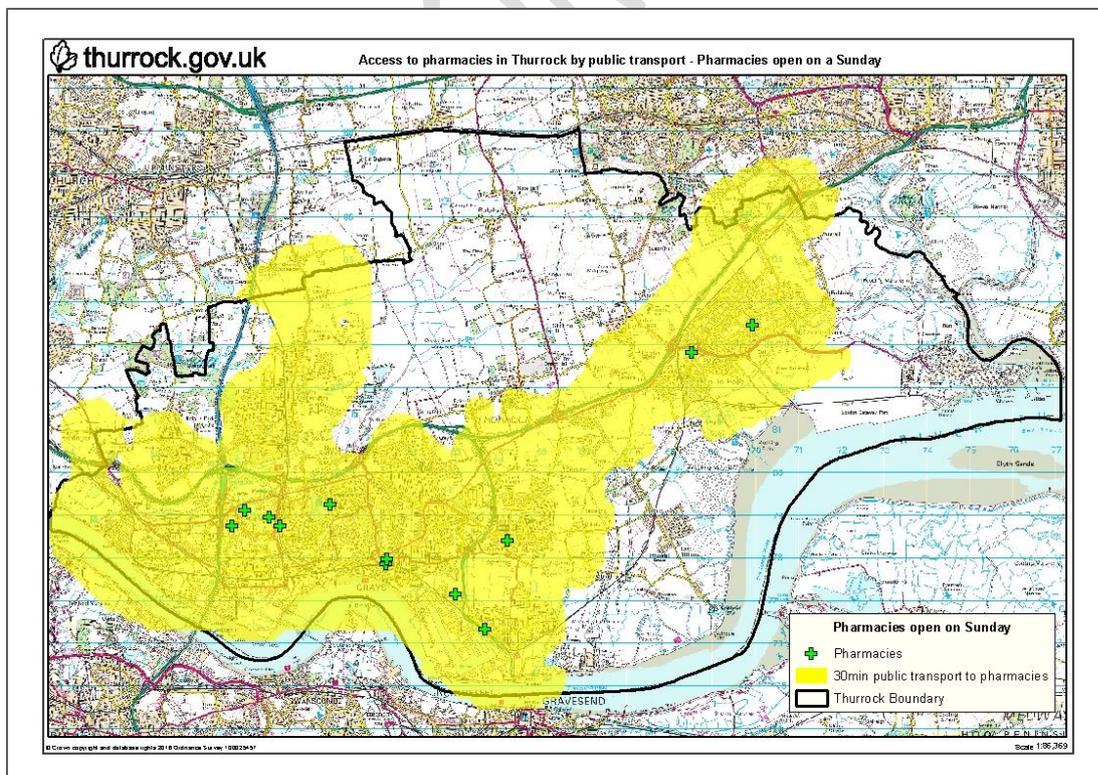
Source: Thurrock Council

Figure 14: Access to Pharmacies via public transport on a Saturday



Source: Thurrock Council

Figure 15: Access to Pharmacies via public transport on a Sunday



Source: Thurrock Council

### 5.2.3 Access to Consultation Rooms

Pharmacies are encouraged to have at least one private consultation area within their premises. In order for pharmacies to carry out Advanced Services, consultation areas must meet the following requirements:

- The patient and the pharmacist can sit down together;
- They can talk at normal speaking volumes without being overheard by staff or customers; and
- The area is clearly signed as a private consultation area

It is best practice for consultation rooms to be wheelchair-accessible also. In the Contractors questionnaire, pharmacies were asked whether the premises had access for wheelchairs to the consultation area. The table below summarises the responses and shows that 24/34 (71%) of Thurrock pharmacies have consultation rooms that are accessible to wheelchair users. The locality with the highest percentage of pharmacies with rooms that are accessible to wheelchair users is Corringham (83%).

Table 8: % of pharmacies with accessible consultation rooms by locality, 2017

Locality	Wheelchair accessible consultation room	Consultation room - no wheelchair access	Consultation room planned in the next 12 months	% of pharmacies in locality with a wheelchair accessible consultation room
Corringham	5	1	0	83%
Grays	6	2	1	67%
South Ockendon	7	2	1	64%
Tilbury	6	1	0	75%

Source: Thurrock Contractor Questionnaire, 2017

### 5.2.4 ICT facilities

Pharmacies are able to request a shared NHSmail account and to have the NHS Summary Care Record enabled. Enabling of the NHS Summary Care Record in community pharmacy is one of the criteria for the [QPS scheme](#). The aim of this quality criterion is to encourage pharmacies to access information about the patient to support clinical decision-making. To claim for the quality criterion in either review period pharmacies must have access to the summary care records (SCRs) and must have accessed the SCR on at least one more occasion in period 2 compared to period 1.

The findings from the Contractor Questionnaire show that 21 pharmacies are currently using NHS mail and 32 have the NHS summary care record enabled.

## 6. Essential Services

### 6.1 Public Health Promotion

Since publication of the previous PNA, NHS England has run the following Public Health campaigns in pharmacies across Thurrock:

- Stop Smoking (2014)
- Skin Cancer
- Sexual Health
- Blood In Pee
- Under The Weather
- Breathlessness
- Stop Smoking 2015
- Alcohol Awareness
- Well In Winter (2015)
- Dry January (2016)
- Stoptober (2016)
- Stay Well This Winter (2016)
- One You (2017)

These will have been key opportunities for communicating healthy lifestyle messages to the public and potentially increasing interventions such as quit attempts. **The Local Authority and CCG should continue to work with NHS England's Local Pharmaceutical Network and the Essex LPC in supporting participation in future campaigns.**

#### 6.1.1 Healthy Living Pharmacies (HLP)

The Healthy Living Pharmacy (HLP) framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. The HLP framework is underpinned by three enablers:

- Workforce development – a skilled team to pro-actively support and promote behaviour change, improving health and wellbeing.
- Premises that are fit for purpose.
- Engagement with the local community, other health professionals (especially GPs), social care and public health professionals and local authorities.

#### *What does this mean for pharmacies?*

Findings from the Community Pharmacy Patient Questionnaires (CPPQ) indicate that the public feel that pharmacies could improve in their healthy lifestyles signposting and delivery of advice on topics such as smoking cessation, exercise and alcohol reduction. This is something that HLP accreditation could support with.

Of the 34 pharmacy contractors that responded to the questionnaire, 12% (four) of pharmacies had achieved HLP Status and 74% (twenty five) were currently working towards this status.

**Table 9: Status of Healthy Living Pharmacy (HLP) accreditation in Thurrock**

Locality	The pharmacy is not currently working towards HLP status	The pharmacy is working towards HLP status	The pharmacy has achieved HLP status	Pharmacy did not comment
Corringham	-	6	-	2
Grays	1	9	1	-
South Ockendon	-	5	1	1
Tilbury	1	5	2	-

Source: Thurrock's Contractor Questionnaire 2017

The Quality Payments Scheme (QPS) (2017/18) has eight criteria eligible for payment under QPS – one of which is to become a Level 1 Healthy Living Pharmacy (HLP) (see further information [elsewhere](#) in the document), which is likely to have impacted on the numbers with or working towards accreditation. The above breakdown shows that within Grays, there are nine potential pharmacies working towards HLP status. If they all achieve this, it would result in 91% of Grays pharmacies achieving HLP status. This is a different picture in Corringham, where there are currently no pharmacies with HLP Status and six working towards this; this would be 75% of all Corringham pharmacies with HLP Status.

Table 10: Proportion of pharmacies working towards or already achieved HLP accreditation

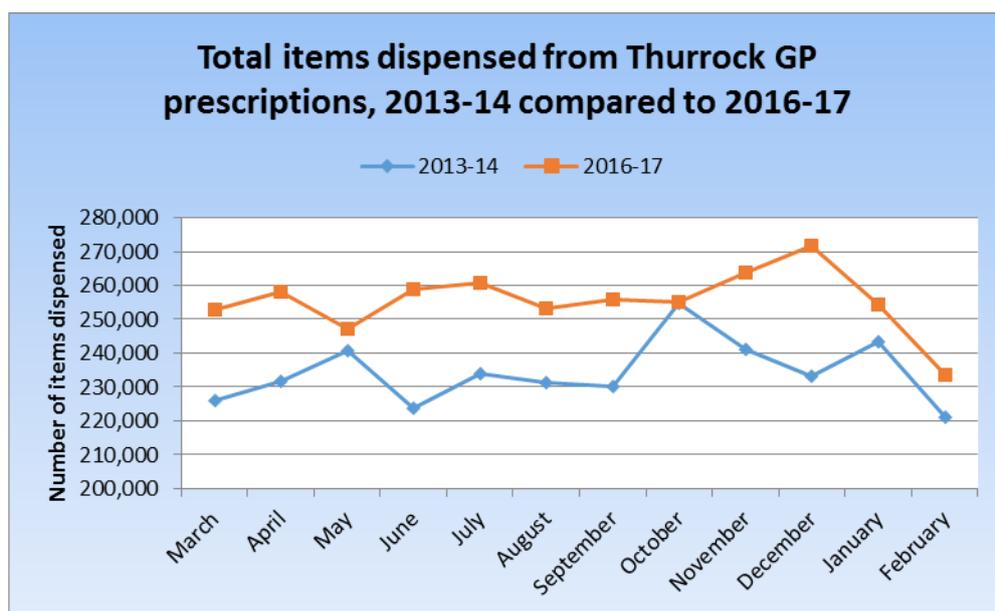
Locality	Locality totals	Locality Pharmacies %	Thurrock Pharmacies Overall %
	(Working Towards and Already Achieved)		
Corringham	6	75%	21%
South Ockendon	6	86%	21%
Tilbury	7	88%	24%
Grays	10	91%	34%

Source: Thurrock's Contractor Questionnaire 2017

## 6.2 Prescribing activity

There were 3,065,694 items dispensed following a prescription from Thurrock GPs from March 2016 to February 2017. 97.28% of these were dispensed from within Thurrock. [Analyses of where the remaining 2.72% were dispensed from are shown in the section below] The number of items dispensed has increased since the previous PNA was produced. In the period from Mar 2013 to Feb 2014, 2,811,159 items were dispensed, meaning the activity has increased by 9.05% in 3 years. The figure below shows the monthly variation for both years, and it can be seen that for every month, more items were dispensed in 2016-17. Dispensing peaked in December 2016, with 271,852 items being dispensed. It is felt that this increase in items dispensed is managed sufficiently within existing pharmaceutical provision.

Figure 16: Total items dispensed following Thurrock GP prescriptions, 2013-14 and 2016-17



Source: ePACT, accessed by Thurrock CCG

### 6.2.1 Repeat dispensing activity

The ePACT data found that repeat dispensing activity accounted for 7.45% of all items dispensed in 2016-17. This varied slightly per month (in April 2016, 8.39% of items were repeats whilst in July it was 6.91%).

### 6.2.2 Locality variation

When considering variation in prescribing activity across Thurrock, it can be seen that 38.16% of the items were prescribed by GPs within the Grays locality. The variation is roughly in line with the population distribution across the borough – this can be seen in the table below.

Table 11: GP Prescribing activity by locality, 2016-17

Area	Total Items	% of total items	% Population split
Corringham	484986	15.82%	14.93%
Grays	1169904	38.16%	41.71%
South Ockendon	715344	23.33%	21.30%
Tilbury	677012	22.08%	22.06%
Unknown	18448	0.60%	
<b>Total</b>	<b>3065694</b>	<b>100.00%</b>	<b>100.00%</b>

Source: ePACT data and NHS Digital

### 6.2.3 Dispensing GP activity

There are three dispensing doctors in Thurrock – at Peartree, Orsett and Horndon surgeries. Of the 3,065,694 items dispensed, the three dispensing doctors dispensed 104,459 of them, accounting for 3.41% of the total number of items dispensed. Thurrock GPs were identified as the dispenser for 132,058 items in total, meaning that the three dispensing doctors accounted for 79.1% of activity by GPs. The remaining 20.9% is likely to be items personally administered by GPs.

### 6.2.4 Out of Area dispensing activity

When considering where the out of area dispensing is taking place, it can be seen that the main areas in which these pharmacists are based are Barking & Dagenham (13.44% of OOA activity) and Basildon (13.30%), but with large proportions also originating from further areas such as Leeds and Peterborough. [The large number of items dispensed from these areas is due to distance-selling pharmacies] The main areas dispensing Thurrock prescriptions but who are based out of area are shown in the table below.

Table 12: Main areas outside of Thurrock dispensing Thurrock prescription items, 2016-17

Area	Total Items dispensed	% of all out of area activity
Barking & Dagenham	11185	13.44%
Basildon	11071	13.30%
Southend	6751	8.11%
Leeds	6394	7.68%
Peterborough	6048	7.27%
Castle Point & Rochford	5086	6.11%
Havering	2466	2.96%
Gravesend	1841	2.21%
Romford	1728	2.08%
Brentwood	1645	1.98%
East London	1407	1.69%
Other	27611	33.17%
<b>Total Out of Area Dispensing</b>	<b>83233</b>	<b>100.00%</b>

Source: ePACT, accessed by Thurrock CCG

## 7. Advanced Services

### 7.1.1 Community Pharmacy Seasonal Influenza Vaccination Advanced Service

Each year from September through to March the NHS runs a seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus.

The eligible groups are:

- all people aged 65 years and over
- people aged from 18 to less than 65 years of age with one or more of the following medical conditions:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis;
  - chronic heart disease, such as heart failure;
  - chronic kidney disease at stage three, four or five;
  - chronic liver disease;
  - chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability;
  - diabetes;
  - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment); or
  - splenic dysfunction
- pregnant women aged 18 or over (including those women who become pregnant during the flu season);
- people aged 18 or over living in long-stay residential care homes or other long-stay care facilities;
- carers aged 18 or over; or
- household contacts of immunocompromised individuals who are aged 18 or over.

In addition from the 1<sup>st</sup> September 2017 morbidly obese people (>40kg/m<sup>2</sup>) who are aged 18 to 65 will also be eligible to receive the flu vaccination.

This pharmacy-commissioned service sits alongside the nationally commissioned GP vaccination service, giving patients another choice of venue for their vaccination and helping commissioners to meet their local NHS vaccination targets.

The aims of the national programme are:

- to sustain and maximise uptake of flu vaccine in at risk groups by building the capacity of community pharmacies as an alternative to general practice;
- to provide more opportunities and improve convenience for eligible patients to access flu vaccinations; and

- to reduce variation and provide consistent levels of population coverage of community pharmacy flu vaccination across England by providing a national framework.

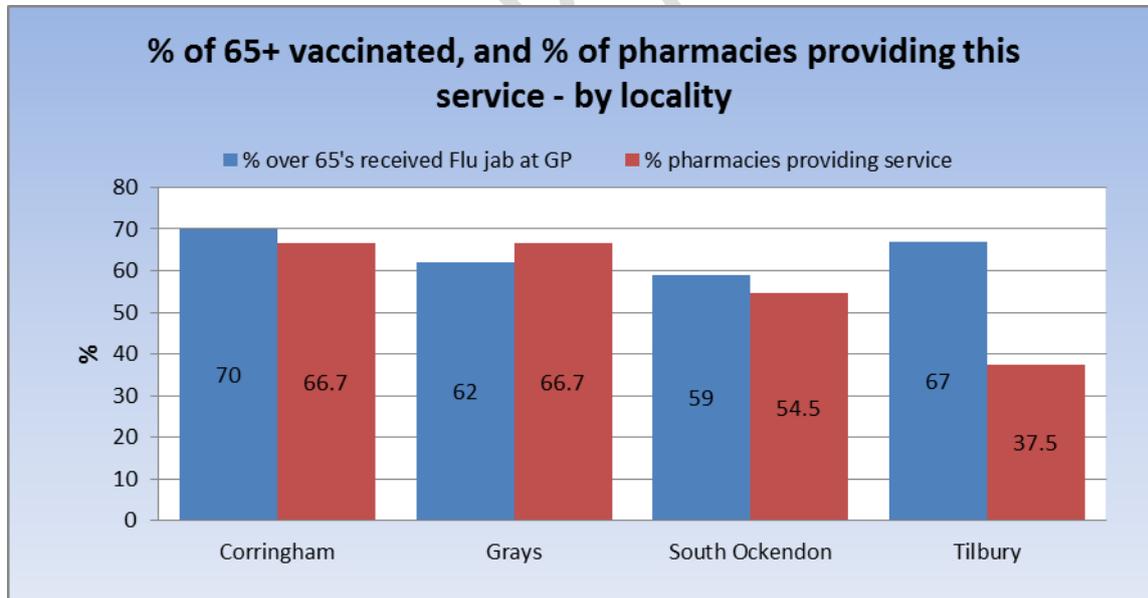
The service can be provided by any community pharmacy in England that fully meets the requirements for provision of the service and has notified NHS England of their intention to begin providing the service.

*What does this mean for pharmacies?*

According to the contractor survey, there are currently 26 pharmacies that provide the seasonal flu vaccination service for those eligible under the NHS programme, and a further 5 pharmacies said they were intending to provide this within the next 12 months. Only 1 pharmacy stated they were not providing this service.

Looking at the uptake of flu vaccinations in vulnerable groups by locality and the proportion of pharmacies providing this service, a general estimation of areas with higher likely need can be generated. The two figures below show the proportion of over 65s vaccinated and the proportion of other at risk groups vaccinated, both against the proportion of pharmacies currently providing this service per locality.

Figure 17: 65+ receiving flu vaccinations (2016/17), and proportion of pharmacies offering seasonal service

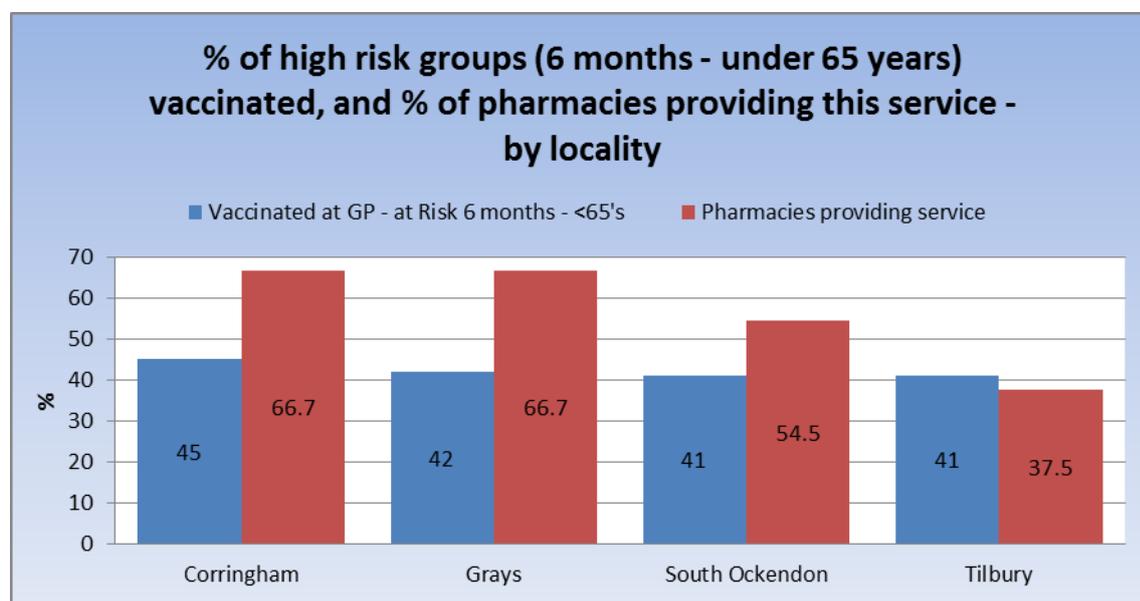


Source: Immform and Contractor Questionnaire 2017

The figure above shows the percentage of over 65's who had a flu vaccination in 2016/17 and the percentage of pharmacies who provide this service by locality. It can be seen that South Ockendon locality has the lowest proportion of over 65's having received a flu jab, but there are also only just over 50% of pharmacies in the locality who provide this service. In

Tilbury, a lower proportion of pharmacies (37.5%) offer this as a service, but just over two thirds of the 65+ population received their flu vaccination from their GP.

Figure 18: At risk groups receiving flu vaccinations (2016/17) and proportion of pharmacies offering seasonal service



Source: Immform and Contractor Questionnaire 2017

The figure above shows those under 65 in the 'at risk' groups who received their flu jab at their GP and in contrast the percentage of pharmacies that provide this service. South Ockendon and Tilbury localities only had approximately 40% of those eligible vaccinated at the GPs, and particularly for Tilbury, a relatively low proportion of pharmacies provide this service.

### 7.1.2 Medicines Use Reviews (MUR)

This service consists of pharmacies undertaking structured adherence-centred reviews with patients who are on multiple medicines, in particular those who are taking medication for long term conditions. [Changes](#) to the targeting of MURs were agreed for implementation in 2014/15. Since September 2014 at least 70% of MURs completed must be directed at the national target groups that include:

- Patients taking high risk medicines as specified in the directions.
- Patients recently discharged from hospital that has had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge; and
- Patients with respiratory disease.
- Patients at risk of, or diagnosed with Cardiovascular disease and regularly being prescribed at least four medicines.

An MUR is a way to:

- improve patients' understanding of their medicines;
- highlight problematic side effects and propose solutions where appropriate;
- improve adherence; and
- reduce medicines wastage, usually by encouraging the patient only to order the medicines they require.

### *What does this mean for pharmacies?*

In Thurrock all 34 pharmacies offer a medicine use review service according to the contractor questionnaire.

The PSNC releases data showing the number of MURs completed per pharmacy. Taking activity data from 2016/17, and looking at the number completed as a proportion of the maximum each pharmacy can complete (400 per pharmacy), the table below shows that there is variation across the borough - the pharmacies in the South Ockendon locality are undertaking less than 60% of their potential total, although this is due to a couple of pharmacies completing very few or no MURs, thereby skewing the average.

**Table 13: Proportion of potential MURs completed by locality, 2016/17**

Locality	% MUR's completed out of potential total
Corringham	97.08
Grays	83.5
South Ockendon	58.68
Tilbury	75.63

Source: PSNC

As MURs are targeted towards those with long term health conditions at greater need of support, and analyses published in the [2016 Annual Public Health Report](#) has indicated a likely high level of need in the South Ockendon locality area, pharmacists in this area should be encouraged to increase their provision of these.

### **7.1.3 Appliance Use Reviews (AUR)**

Whilst dispensing of appliances is an Essential pharmaceutical service – responses to the Contractor Questionnaire indicated that 76.5% dispense all types of appliances, 14.7% only dispense dressings and 2.9% dispenses everything but stoma appliances, use reviews are an Advanced service.

AURs can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any specified appliance by:

- establishing the way the patient uses the appliance and the patient's experience of such use;

- identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient;
- advising the patient on the safe and appropriate storage of the appliance; and
- advising the patient on the safe and proper disposal of the appliances that are used or unwanted

It should also be noted that whilst they are outside the scope of this PNA, Dispensing Appliance Contractors also provide a range of services associated with dispensing of appliances which may meet patients' needs.

According to the contractor questionnaire, 4 pharmacies offer this service - 2 of these are within the Tilbury locality and 2 in South Ockendon. 21 pharmacies are not intending to offer this service and 4 are intending to within the next 12 months.

#### 7.1.4 New Medicines Service (NMS)

This service provides support for people who have an eligible condition who have been newly prescribed a medication. It enables them to understand the new medication they are taking and to help them get the most from it.

It was hoped the successful implementation of NMS would:

- improve patient adherence which will generally lead to better health outcomes;
- increase patient engagement with their condition and medicines, supporting patients in making decisions about their treatment and self-management;
- reduce medicines wastage;
- reduce hospital admissions due to adverse events from medicines;
- lead to increased Yellow Card reporting of adverse reactions to medicines by pharmacists and patients, thereby supporting improved pharmacovigilance;
- receive positive assessment from patients;
- improve the evidence base on the effectiveness of the service; and
- support the development of outcome and/or quality measures for community pharmacy.

According to the Contractor Questionnaire, 31 out of the 34 pharmacies offer the New Medicines Service.

#### 7.1.5 Stoma Appliance Customisation (SAC)

The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in [Part IXC of the Drug Tariff](#).

According to the Contractor Questionnaire, 3 pharmacies in Thurrock provide this service - 1 in Tilbury and 2 in South Ockendon. 3 more pharmacies intend to deliver this service within the next 12 months - 1 in Grays and 2 in Corringham.

However appliance prescriptions can also be dispensed by Dispensing Appliance Contractors and supplied to patients, which may be the preferred option for some Thurrock patients.

#### **7.1.6 NHS Urgent Medicine Supply Advanced Service (NUMSAS)**

On 20th October 2016, the Department of Health (DH) and NHS England announced that as part of the 2016/17 and 2017/18 community pharmacy funding settlement, money from the Pharmacy Integration Fund (PhIF) would be used to fund a national pilot of a community pharmacy Urgent Medicine Supply Service. The service is being commissioned as an Advanced Service and it will run from 1st December 2016 to 31st March 2018 with a review point to consider progress in September 2017.

The objectives of the service are to:

- manage appropriately NHS 111 requests for urgent medicine supply;
- reduce demand on the rest of the urgent care system;
- resolve problems leading to patients running out of their medicines; and
- increase patients' awareness of electronic repeat dispensing

According to the contractor questionnaire, 8 Thurrock pharmacies currently provide this service, with all localities having at least 1 pharmacy that provides it.

At the time of writing this PNA, data was not available to demonstrate the impact of the pilot programme.

## 8. Future Opportunities

### 8.1 Regeneration and Planning in Thurrock

There are a number of large regeneration programmes planned for the borough to ensure future population growth is sustainable and that the regeneration benefits the entire borough. The 6 growth 'hubs' are:

- [Purfleet](#) - home of High House Production Park and soon a new town centre
- [Lakeside and West Thurrock](#) - already a major retail and leisure destination and set to expand to become a regional town centre
- [Grays](#) - the administrative hub of Thurrock will build upon the current projects to improve economic growth and enhance the public realm
- [Tilbury](#) - a new vision will build on the strengths of the close community and expansion of the port
- [London Gateway](#) - the largest inward investment project in the UK saw DP World's high tech deep-sea container port open in 2013 and become home to a high tech logistics business park, creating thousands of new jobs
- [Thames Enterprise Park](#) - creating an Environmental Technologies and Energy hub alongside a new import/export and blending facility for oil products on the site of the former Coryton Oil Refinery, it will include the world's first bio jet fuel plant converting landfill waste into jet fuel in a partnership between Solena Fuels and British Airways

It is important to note that whilst the borough's regeneration will result in an increased number of dwellings – in particular the Purfleet development, this will not take place within the lifetime of this PNA document. Further information on the proposals and development timescales can be found on the relevant webpage for each development (see above hyperlinks).

The authors of this PNA are not aware of any evidence to suggest a generic *population trigger point* for which a new pharmacy provider would be required, nor is there a measure for how much population growth an existing contractor can accommodate. Factors to consider when assessing the need for a new service provider are likely to include:

- Average household size of new developments
- Demographics of new residents (e.g. older populations may have more health and social care needs)
- Existing pharmaceutical service provision, both locally and access to distance-selling contractors
- Capacity of existing pharmacy contractors to increase their provision of services
- Health inequalities and needs of existing residents

### 8.2 QPS scheme

A Community Pharmacy Quality Payments Scheme has been introduced which forms part of the Community Pharmacy Contractual Framework (CPCF) from 1 December 2016 until 31

March 2018.. The Quality Payments Scheme will reward community pharmacies for delivering quality criteria in the following quality dimensions:

- Clinical Effectiveness
- Patient Safety
- Patient Experience
- Digital
- Public Health
- Workforce

Payment will depend on how many of the quality criteria the pharmacy achieves. For a pharmacy to become eligible for any payment under the Quality Payments Scheme it must have first met four gateway criteria prior to April 2017:

- I. the contractor must be offering at the pharmacy Medicines Use Reviews (MURs) or the New Medicine Service (NMS); or must be registered for the NHS Urgent Medicine Supply Advanced Service (NUMSAS) Pilot; and
- II. the NHS Choices entry for the pharmacy must be up to date; and
- III. pharmacy staff at the pharmacy must be able to send and receive NHSmail; and
- IV. the pharmacy contractor must be able to demonstrate ongoing use of the Electronic Prescription Service (EPS) at the pharmacy premises.

There are two review dates during the year at which quality payments can be claimed: 28 April 2017 and 24 November 2017.

Further information on the QPS pilot scheme can be found in [this guidance document](#).

## 9. Appendices

### 9.1 Legal PNA regulations

#### *Definition of a PNA*

A PNA is defined in the Regulations as:

*“The statement of the needs for pharmaceutical services which each HWB is required to publish by virtue of section 128A of the 2006 Act(1) (pharmaceutical needs assessments), whether it is the statement of its first assessment or of any revised assessment, is referred to in these Regulations as a “pharmaceutical needs assessment”.*

The pharmaceutical service to which each pharmaceutical needs assessment must relate are *“all the pharmaceutical services that maybe provided under arrangements made by NHS England”* and encompass pharmacies that are included on the Pharmaceutical list.

#### *Role of the Health and Wellbeing Board*

The legal duties of the Health and Wellbeing Board are to:

- **Publish and maintain the PNA**

HWBs must have published their first PNA by April 2015, with each PNA having a maximum lifetime of three years.

- **Maintain and keep the PNA up to date**

In response to changes in the availability of pharmaceutical services, HWBs are required to determine whether there is a need to revise the PNA or, where this is considered to be a disproportionate response, to issue and keep up to date supplementary statements describing the changes in pharmaceutical services.

- **Respond to a consultation by a neighbouring HWB**

HWB have a further responsibility to respond to a draft PNA when consulted by a neighbouring HWB. The HWB must consult with the Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC) for the area (unless the LPC and LMC service both areas) before making its own response to the consultation.

#### *Minimum requirements for the PNA*

Schedule 1 of the Regulations sets out the minimum information that must be included in the PNA, these are:

- Necessary services that meet the need for pharmaceutical services in its area. This should include current provision (within the HWB area and outside the area) as well as any current or future gaps in provision.
- Relevant Services that are not necessary to meet the needs for pharmaceutical services in its area, nevertheless have secured improvements, or better access to pharmaceutical services. This should include current provision (within the HWB area and outside the area) as well as any current or future gaps in provision.
- Other NHS Services provided or arranged by the Local Authority, HWB, Public Health England, NHS England, a CCG, an NHS Trust or Foundation Trust that affects the current or future need for pharmaceutical services, or would secure

improvement, or better access to current or future pharmaceutical services within its area, or that have unforeseen benefits.

- A map identifying the premises at which pharmaceutical services are provided in the area of the HWB. The regulations specify the keeping up to date of this map, in so far as is practicable.
- An explanation of how the assessment is carried out including:
  - How localities were determined.
  - How different needs of different localities have been taken into account.
  - How the needs of different groups who are a similar protected characteristic (defined in the Equality Act 2010) has been considered.
- A report on the consultation undertaken.

Regulation 9 sets out the following matters HWBs must have regards to when developing their PNAs as far as practicable to do so:

- The demography of its area, as set out in the Joint Strategic Needs Assessment (JSNA)
- Whether there is sufficient choice with regards to obtaining pharmaceutical services
- Any differing needs of different localities in its area
- The pharmaceutical services provided in neighbouring HWB which affect the need for pharmaceutical services in its area, or whether further provision of pharmaceutical services would secure improvements or better access to pharmaceutical services within the area
- Other NHS services provided in or outside the area that affect the need for pharmaceutical services, or whether further provision of pharmaceutical services would secure improvements, or better access to pharmaceutical services within the area
- Likely future pharmaceutical needs

### *Consultation requirements for the draft document*

As part of developing PNAs, HWBs must undertake a consultation for a minimum of 60 days. The 2013 Regulations list those persons and organisations that the HWB must consult. This list includes:

- Any relevant Local Pharmaceutical Committee (LPC) for the HWB area
- Any Local Medical Committee (LMC) for the HWB area
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area
- Any local Healthwatch organisation for the HWB area
- Consumer and community groups which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area
- Any NHS trust or NHS foundation trust in the HWB area
- NHS England
- Any neighbouring HWB

### 9.1.1 Secretary of State Directions

#### Market entry regulations

*Please note: Existing pharmacy contractors (i.e. persons already on a pharmaceutical list) who have queries on the Market Entry system, can seek support from their Local Pharmaceutical Committee (LPC). Persons who are not already pharmacy contractors should seek their own legal advice, since PSNC and LPCs are unable to offer support. The following are links to the relevant regulations and guidance.*

Since 1 April 2013, pharmaceutical lists have been maintained by NHS England and so applications for new, additional or relocated premises must be made to the local NHS England Area Team. Most routine applications for a new pharmacy will be assessed against the Pharmaceutical Needs Assessment for the area, prepared either by the Local Authority, or the Health and Wellbeing Board (HWB). The [NHS \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#) set out the arrangements for pharmaceutical lists and the applications that may be made, and the Department of Health has issued [guidance](#) on these. For help navigating the 2013 regulations, contractors may find [page 15 of the HSCIC's \(now NHS Digital\) General Pharmaceutical Services report](#) helpful.

#### The Secretary of State Directions

The Secretary of State Directions provide the regulatory framework for the Advanced Services and the Enhanced Services.

[The Pharmaceutical Services \(Advanced and Enhanced Services\) \(England\) Directions 2013](#)

[The Pharmaceutical Services \(Advanced and Enhanced Services\) \(England\) \(Amendment\) Directions 2013](#)

[The Pharmaceutical Services \(Advanced and Enhanced Services\) \(England\) \(Amendment\) Directions 2014](#)

[The Pharmaceutical Services \(Advanced and Enhanced Services\) \(England\) \(Amendment\) \(No. 2\) Directions 2014](#)

[The Pharmaceutical Services \(Advanced and Enhanced Services\) \(England\) \(Amendment\) Directions 2015](#)

[The Pharmaceutical Services \(Advanced and Enhanced Services\) \(England\) \(Amendment\) Directions 2016](#)

[The Pharmaceutical Services \(Advanced and Enhanced Services\) \(England\) \(Amendment\) \(No. 2\) Directions 2016](#)

At the time of writing this Pharmaceutical Needs Assessment, the Directions for 2017 had not yet been published.

### 9.1.2 Regulation 26A regarding mergers

As part of the consultation on community pharmacy 2016/17 and beyond, PSNC proposed changes to the [National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#) (the 2013 Regulations) to prevent a new pharmacy stepping in straight away if two pharmacies merge. These proposed changes were accepted by the Department

of Health as part of the two year funding package imposed upon community pharmacy in England and [announced](#) on 20th October 2016.

On 5 December 2016, [amendments](#) to the 2013 Regulations came into force which facilitated pharmacy business consolidations from two sites on to a single existing site. Importantly, a new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes. This would protect two pharmacies that choose to consolidate on a single existing site. NHS England can only approve consolidations where this does not create a gap in provision.

DRAFT FOR APPROVAL

## 9.2 List of pharmacies and dispensing practices in Thurrock

Below is the list of the 34 high street pharmacies and the one distance-selling pharmacy (in italics). This list was correct as of May 2017:

ODS Code	Pharmacy	Street	Town	Post Code	Locality
FK026	Allcures Pharmacy	23 High Street	STANFORD-LE-HOPE	SS17 0HD	Corringham
FGW47	Allcures Pharmacy	16 Kings Parade	STANFORD-LE-HOPE	SS17 0HP	Corringham
FT060	Hassengate Pharmacy*	Southend Road	STANFORD-LE-HOPE	SS17 0PH	Corringham
FA673	Unicare Pharmacy	22 St. Johns Way	CORRINGHAM	SS17 7LJ	Corringham
FQ578	Boots UK Ltd	83-85 St Johns Way	CORRINGHAM	SS17 7LL	Corringham
FQV22	Allcures Pharmacy	19-21 Lampits Hill	CORRINGHAM	SS17 9AA	Corringham
FCJ06	Vision Pharmacy*	11 Crammavill Street	STIFFORD CLAYS	RM16 2AP	Grays
FQY84	Well Pharmacy	16 Crammavill Street	STIFFORD CLAYS	RM16 2AP	Grays
FD776	Lloyds Pharmacy inside Sainsbury's*	Burghley Road	CHAFFORD HUNDRED	RM16 6QQ	Grays
FNT96	Armada Pharmacies Ltd	1 Drake House, Drake Rd	CHAFFORD HUNDRED	RM16 6RX	Grays
FQG23	Unicare Pharmacy	89 Orsett Road	GRAYS	RM17 5HH	Grays
FLQ07	Lloyds Pharmacy Ltd	31 Lodge Lane	GRAYS	RM17 5RY	Grays
FAL12	Steve's Chemist	36 Bridge Road	GRAYS	RM17 6BU	Grays
FA736	Allcures Pharmacy*	62 High Street	GRAYS	RM17 6NA	Grays
FMX69	Boots UK Ltd	35-41 High Street	GRAYS	RM17 6NB	Grays
FMM25	Allcures Pharmacy	34 East Thurrock Road	GRAYS	RM17 6SP	Grays
FTK09	Ohms Pharmacy	32 High Street	AVELEY	RM15 4AD	South Ockendon
FM809	Well Pharmacy	22 High Street	AVELEY	RM15 4AD	South Ockendon
FNT35	Hemants Chemist	10 Derwent Parade	SOUTH OCKENDON	RM15 5EE	South Ockendon
FQQ40	Boots UK Ltd	17 Derwent Parade	SOUTH OCKENDON	RM15 5EF	South Ockendon
FF646	Allcures Pharmacy	Allcures House, Arisdale Avenue	SOUTH OCKENDON	RM15 5TT	South Ockendon
FKL83	South Road Pharmacy	1 South Road	SOUTH OCKENDON	RM15 6NU	South Ockendon
FT715	<i>Pharmacyshoponline</i>	<i>Unit 10, Little Mollands Farm, Mollands Lane</i>	<i>SOUTH OCKENDON</i>	<i>RM15 6RX</i>	<i>South Ockendon</i>
FKK05	Dave's Chemists	The Purfleet Care Centre, Tank Hill Road	PURFLEET	RM19 1SX	South Ockendon
FJ599	TESCO Instore Pharmacy	Cygnets View, Lakeside Retail Park	WEST THURROCK	RM20 1TX	South Ockendon
FKD78	Boots UK Ltd	74-75 Lakeside Shopping Centre	WEST THURROCK	RM20 2ZG	South Ockendon

<b>FC682</b>	St Clements Pharmacy	643 London Road	WEST THURROCK	RM20 3HD	South Ockendon
<b>FNC41</b>	Boots UK Ltd	Unit 1B, The Junction Retail Park, Western Avenue	THURROCK	RM20 3LP	South Ockendon
<b>FPY31</b>	Riverview Pharmacy	22 River View	CHADWELL ST MARY	RM16 4BJ	Tilbury
<b>FDY66</b>	Dip's Chemist	12 Defoe Parade	CHADWELL ST MARY	RM16 4QR	Tilbury
<b>FDT05</b>	Asset Chemist*	128 Dock Road	TILBURY	RM18 7BJ	Tilbury
<b>FFP86</b>	Asda Pharmacy*	Thurrock Park Way	TILBURY	RM18 7HJ	Tilbury
<b>FTR41</b>	Chapharm Ltd	2-3 Civic Square	TILBURY	RM18 8AD	Tilbury
<b>FHF78</b>	Boots UK Ltd	2 St. Chads Road	TILBURY	RM18 8LB	Tilbury
<b>FG775</b>	Allcures Pharmacy	1 Stanford House, Princess Margaret Rd	EAST TILBURY	RM18 8YP	Tilbury

\*100 hour pharmacies are marked with an asterisk

*In September 2017, Thurrock Council were advised that a second distance-selling premises would open during weekdays only. Details are below:*

<b>FWT56</b>	Primary Health Solutions Ltd, T/A Essex Pharmacy Online	Unit 54A Thames Industrial Park, Princess Margret Road	EAST TILBURY	RM18 8RH	Tilbury
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The below are the three dispensing GP practices:

Practice Code	Name	Locality
<b>F81134</b>	PEARTREE W HORNDON SURGERIES	South Ockendon
<b>F81137</b>	ORSETT SURGERY	Grays
<b>F81198</b>	HORNDON-ON-THE-HILL SURGERY	Corringham

### 9.3 Blank contractor questionnaire

## PNA Pharmacy Questionnaire Thurrock Health and Wellbeing Board

### Premises Details

Contractor Code (ODS Code)	
Name of contractor (i.e. name of individual, partnership or company owning the pharmacy business)	
Trading Name	
Address of Contractor pharmacy	
Is this pharmacy one which is entitled to Pharmacy Access Scheme payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possibly
Is this pharmacy a 100-hour pharmacy?	<input type="checkbox"/> Yes
Does this pharmacy hold a Local Pharmaceutical Services (LPS) contract? (i.e. it is not the 'standard' Pharmaceutical Services contract)	<input type="checkbox"/> Yes
Is this pharmacy a Distance Selling Pharmacy? (i.e. it cannot provide Essential Services to persons present at or in the vicinity of the pharmacy)	<input type="checkbox"/> Yes
Pharmacy email address	
Pharmacy telephone	
Pharmacy fax (if applicable)	
Pharmacy website address (if applicable)	
Can the LPC store the above information and use it to contact you?	<input type="checkbox"/> Yes

### Core hours of opening

Day	Open from	To	Lunchtime (From – To)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Saturday			
Sunday			

### Total hours of opening

Day	Open from	To	Lunchtime (From – To)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

### Potential changes to hours of opening

Please indicate if you are planning to reduce your opening hours between now and publication of the PNA in March 2018? (note that this response is not binding)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possibly
If yes, please list the potential changes below.	

### Consultation facilities

There is a consultation area (meeting the criteria for the Medicines Use Review service) (tick as appropriate)

On premises	None, or	<input type="checkbox"/>
	Available (including wheelchair access), or	<input type="checkbox"/>
	Available (without wheelchair access), or	<input type="checkbox"/>
	Planned within the next 12 months, or	<input type="checkbox"/>
	Other (specify)	
Where there is a consultation area, is it a closed room?		<input type="checkbox"/> Yes

During consultations are there hand-washing facilities	In the consultation area, or	<input type="checkbox"/>
	Close to the consultation area, or	<input type="checkbox"/>
	None	<input type="checkbox"/>

Patients attending for consultations have access to toilet facilities	<input type="checkbox"/> Yes
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Off-site	The pharmacy has access to an off-site consultation area (i.e. one which the former PCT or NHS England local team has given consent for use)	<input type="checkbox"/> Yes
	The pharmacy is willing to undertake consultations in patient's home / other suitable site	<input type="checkbox"/> Yes

Languages spoken (in addition to English)	
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### IT Facilities

Select any that apply.

Electronic Prescription Service Release 2 enabled	<input type="checkbox"/>
NHSmail being used	<input type="checkbox"/>
NHS Summary Care Record enabled	<input type="checkbox"/>
Up to date NHS Choice entry	

### Healthy Living Pharmacies (HLP)

Select the one that applies.

The pharmacy has achieved HLP status	<input type="checkbox"/>
The pharmacy is working toward HLP status	<input type="checkbox"/>
The pharmacy is not currently working toward HLP status	<input type="checkbox"/>

### Services

Does the pharmacy dispense appliances?

Yes – All types, or	<input type="checkbox"/>
Yes, excluding stoma appliances, or	<input type="checkbox"/>
Yes, excluding incontinence appliances, or	<input type="checkbox"/>
Yes, excluding stoma and incontinence appliances, or	<input type="checkbox"/>
Yes, just dressings, or	<input type="checkbox"/>
Other [identify]	
None	<input type="checkbox"/>

### Advanced services

Does the pharmacy provide the following services?

	Yes	Intending to begin within next 12 months	No - not intending to provide
Medicines Use Review service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New Medicine Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appliance Use Review service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoma Appliance Customisation service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu Vaccination Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NHS Urgent Medicine Supply Advanced Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Enhanced<sup>5</sup> and Other Locally Commissioned Services

Which of the following services does the pharmacy provide, or would be willing to provide?

	Currently providing under contract with the local NHS England Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Anticoagulant Monitoring Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-viral Distribution Service <sup>(6)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Home Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia Testing Service <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia Treatment Service <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive service (not EC) <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>				
<b>Disease Specific Medicines Management Service:</b>					
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>5</sup> 'Enhanced Services' are those commissioned by the local NHS England Team. CCGs and Local Authorities can commission Other Locally Commissioned Services that are equivalent to the Enhanced Services, but for the purpose of developing the PNA are called 'Other Locally Commissioned Services' not 'Enhanced Services'

<sup>6</sup> These services are not listed in the Advanced and Enhanced Services Directions, and so are not 'Enhanced Services' if commissioned by the local NHS England Team. The local NHS England Team may commission them on behalf of the CCG or Local Authority, but when identified in the PNA they will be described as 'Other Locally Commissioned Services' or 'Other NHS Services'

	Currently providing under contract with the local NHS England Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Alzheimer's/dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes type I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state)					
Emergency Contraception Service <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Supply Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten Free Food Supply Service (i.e. not via FP10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Delivery Service (not appliances) <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Independent Prescribing Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If currently providing an Independent Prescribing Service, what therapeutic areas are covered?					
Language Access Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Review Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Currently providing under contract with the local NHS England Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Medicines Assessment and Compliance Support Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor Ailment Scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUR Plus/Medicines Optimisation Service <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If currently providing an MUR Plus/ Medicines Optimisation Service, what therapeutic areas are covered?					
Needle and Syringe Exchange Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity management (adults and children) <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not Dispensed Scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On Demand Availability of Specialist Drugs Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out of Hours Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Group Direction Service (name the medicines covered by the Patient Group Direction)				<input type="checkbox"/>	<input type="checkbox"/>
Phlebotomy Service <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescriber Support Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schools Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screening Service					
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Currently providing under contract with the local NHS England Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Gonorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. pylori	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HbA1C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state)					
Seasonal Influenza Vaccination Service <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other vaccinations <sup>(2)</sup>					
Childhood vaccinations	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (at risk workers or patients)	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HPV	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel vaccines	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other – (please state)					
Sharps Disposal Service <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop Smoking Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervised Administration Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplementary Prescribing Service (what therapeutic areas are covered?)				<input type="checkbox"/>	<input type="checkbox"/>
Vascular Risk Assessment Service (NHS Health Check) <sup>(2)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Non-commissioned services**

Does the pharmacy provide any of the following?

Collection of prescriptions from GP practices	<input type="checkbox"/>
Delivery of dispensed medicines – Free of charge on request	<input type="checkbox"/>
Delivery of dispensed medicines – Selected patient groups (list criteria)	
Delivery of dispensed medicines – Selected areas (list areas)	
Delivery of dispensed medicines - Chargeable	<input type="checkbox"/>
Monitored Dosage Systems – Free of charge on request	<input type="checkbox"/>
Monitored Dosage Systems – chargeable	<input type="checkbox"/>

**Way of working**

Please indicate if you are working in a 'hub and spoke' model.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe below.	

Is there a particular need for a locally commissioned service in your area? If so, what is the service requirement and why.	<input type="checkbox"/>
---	--------------------------

**Details of the person completing this form:**

Contact name of person completing questionnaire, if questions arise	Contact telephone number

## 9.4 Summary report of contractor questionnaire responses

A questionnaire was sent out to all 35 pharmacies in Thurrock in April 2017. 34 out of these 35 returned a response, although it should be noted they did not all answer every question [the tables below show the response rate per question]. The pharmacy that did not return a questionnaire was PharmacyShopOnline, for which some of these questions would not have been relevant in any case.

### Opening Hours

The analysis on contractor opening hours can be found in [this section](#) of the full PNA document.

### Contractor Type

Question	Responses
Is this pharmacy one which is entitled to Pharmacy Access Scheme payments?	Of 34 responses: 6 (17.6%) said yes 21 (61.7%) said no 7 (20.6%) said possibly
Is this pharmacy a 100-hour pharmacy?	Of 34 responses: 6 (17.6%) were 100-hour pharmacies
Does this pharmacy hold a Local Pharmaceutical Services (LPS) contract? (i.e. it is not the standard Pharmaceutical Services contract)	Of 34 responses: 4 (11.8%) have LPS contracts
Is this pharmacy a Distance Selling Pharmacy?	Of 34 responses: 1 (2.9%) said they were a Distance Selling Pharmacy
Please indicate if you are working in a 'hub and spoke' model.	Of 34 responses: 3 said they were working in this way. Of the free text explanations given, one was the distance selling pharmacy, one had their MDS done at Head Office, and the other had the repeat prescription service done in Preston.

The analysis on languages spoken can be found in [this section](#) of the full PNA document.

### Consultation Facilities

Question	Responses
Is there a consultation area on site?	Of 34 responses: 24 (71%) have a consultation area with wheelchair access 7 (20.6%) have a consultation area without wheelchair access 2 (5.9%) have a consultation area planned within the next 12 months
If yes, is it a closed room?	Of 34 responses: 17 (50%) have the consultation area in a closed room
Does the pharmacy have access to an off-site consultation area?	Of 34 responses: 1 (2.9%) has access to an off-site area
Is the pharmacy willing to undertake consultations in patient's home/other suitable	Of 34 responses: 18 (52.9%) are willing to undertake

site?	consultations in patient's home or elsewhere
During consultations, are there hand-washing facilities?	Of 34 responses: 23 (67.7%) have hand-washing facilities within the consultation area 8 (23.5%) have hand-washing facilities close to the consultation area 3 (8.8%) have no hand-washing facilities
Do patients attending for consultations have access to toilet facilities?	Of 34 responses: 15 (44.1%) have access to toilet facilities

### IT Facilities

Question	Responses
Is Electronic Prescription Service Release 2 enabled?	Of 34 responses: 34 (100%) have EPS release 2 enabled
Does the pharmacy use NHSmail?	Of 34 responses: 21 (61.8%) are using NHSmail
Is the NHS Summary Care Record enabled?	Of 34 responses: 32(94.1%) have the SCR enabled
Does the pharmacy have an up to date NHS Choices entry?	Of 34 responses: 30 (88.2%) have an up to date NHS Choices entry

### Essential Services

Question	Responses
Does the pharmacy dispense appliances?	Of 33 responses: 26 (78.8%) dispense all types 1 (3.03%) dispense all excluding stoma appliances 5 (15.2%) dispense just dressings 1 (3.03%) said they dispensed <i>other</i> -

### Advanced Services

Question	Responses
Does the pharmacy provide the Medicines Use Review service?	Of 34 responses: 34 (100%) said yes
Does the pharmacy provide the New Medicines service?	Of 34 responses: 31 (91.2%) said yes 2 (5.9%) said they intend to begin within the next 12 months 1 (2.9%) said no - they were not intending to provide
Does the pharmacy provide the Appliance Use Review service?	Of 29 responses: 4 (13.8%) said yes 4 (13.8%) said they intend to begin within the next 12 months 21 (72.4%) said no - they were not intending to provide
Does the pharmacy provide the Stoma Appliance Customisation service?	Of 28 responses: 3 (10.7%) said yes 3 (10.7%) said they intend to begin within the

	next 12 months 22 (78.6%) said no - they were not intending to provide
Does the pharmacy provide the Flu Vaccination service?	Of 32 responses: 26 (81.3%) said yes 5 (15.6%) said they intend to begin within the next 12 months 1 (3.1%) said no - they were not intending to provide
Does the pharmacy provide the NHS Urgent Medicine Supply Advanced service?	Of 32 responses: 8 (25%) said yes 16 (50%) said they intend to begin within the next 12 months 8 (25%) said no - they were not intending to provide

### *Enhanced and Other Locally Commissioned Services*

<b>Question</b>	<b>Responses</b>
Does the pharmacy provide anticoagulant monitoring service?	Of 33 responses: No pharmacies are currently providing this 25 (75.8%) are willing and able to provide if commissioned 8 (24.2%) are not willing or able to provide
Does the pharmacy provide antiviral distribution service?	Of 30 responses: No pharmacies are currently providing this 24 (80%) are willing and able to provide if commissioned 6 (20%) are not willing or able to provide
Does the pharmacy provide Care Home service?	Of 29 responses: 1 (3.5%) is currently providing 18 (62.1%) are willing and able to provide if commissioned 10 (34.5%) are not willing or able to provide
Does the pharmacy provide Chlamydia testing service?	Of 34 responses: 5 (14.7%) are currently providing 25 (73.5%) are willing and able to provide if commissioned 4 (11.8%) are not willing or able to provide
Does the pharmacy provide Chlamydia treatment service?	Of 34 responses: 5 (14.7%) are currently providing 25 (73.5%) are willing and able to provide if commissioned 4 (11.8%) are not willing or able to provide
Does the pharmacy provide Contraceptive service (non-emergency)?	Of 33 responses: 3 (9.1%) are currently providing 24 (72.7%) are willing and able to provide if commissioned 6 (18.2%) are not willing or able to provide
Does the pharmacy provide Emergency Contraception service?	Of 33 responses: 10 (30.3%) are currently providing 20 (60.6%) are willing and able to provide if commissioned 3 (9.1%) are not willing or able to provide

Does the pharmacy provide Emergency Supply service?	Of 33 responses: 6 (18.2%) are currently providing 24 (72.7%) are willing and able to provide if commissioned 3 (9.1%) are not willing or able to provide
Does the pharmacy provide Gluten Free Food Supply Service (i.e. not via FP10)?	Of 28 responses: No pharmacies are currently providing this 22 (78.6%) are willing and able to provide if commissioned 6 (21.4%) are not willing or able to provide
Does the pharmacy provide Home Delivery service (not appliances)?	Of 28 responses: 6 (21.4%) are currently providing 16 (57.1%) are willing and able to provide if commissioned 6 (21.4%) are not willing or able to provide
Does the pharmacy provide Independent Prescribing service?	Of 28 responses: No pharmacies are currently providing this 19 (67.9%) are willing and able to provide if commissioned 9 (32.1%) are not willing or able to provide
Does the pharmacy provide Language Access service?	Of 28 responses: No pharmacies are currently providing this 16 (57.1%) are willing and able to provide if commissioned 12 (42.9%) are not willing or able to provide
Does the pharmacy provide Medication Review service?	Of 33 responses: 18 (54.5%) are currently providing 11 (33.3%) are willing and able to provide if commissioned 4 (12.1%) are not willing or able to provide
Does the pharmacy provide Medicines Assessment and Compliance Support service?	Of 27 responses: No pharmacies are currently providing this 19 (70.4%) are willing and able to provide if commissioned 8 (29.6%) are not willing or able to provide
Does the pharmacy provide Minor Ailment Scheme?	Of 32 responses: 2 (6.3%) are currently providing 27 (84.4%) are willing and able to provide if commissioned 3 (9.4%) are not willing or able to provide
Does the pharmacy provide MUR Plus/Medicines Optimisation service?	Of 29 responses: 2 (7%) are currently providing 21 (72.4%) are willing and able to provide if commissioned 6 (20.7%) are not willing or able to provide
Does the pharmacy provide Needle and Syringe Exchange service?	Of 31 responses: 9 (29.0%) are currently providing 11 (35.5%) are willing and able to provide if commissioned 11 (35.5%) are not willing or able to provide
Does the pharmacy provide Obesity Management service (adults and children)?	Of 32 responses: No pharmacies are currently providing this 28 (87.5%) are willing and able to provide if commissioned

	4 (12.5%) are not willing or able to provide
Does the pharmacy provide Not Dispensed Scheme?	Of 27 responses: 2 (7.4%) are currently providing 18 (66.7%) are willing and able to provide if commissioned 7 (25.9%) are not willing or able to provide
Does the pharmacy provide On Demand Availability of Specialist Drugs service?	Of 26 responses: No pharmacies are currently providing this 19 (73.1%) are willing and able to provide if commissioned 7 (26.9%) are not willing or able to provide
Does the pharmacy provide Out of Hours services?	Of 28 responses: No pharmacies are currently providing this 19 (67.9%) are willing and able to provide if commissioned 9 (32.1%) are not willing or able to provide
Does the pharmacy provide Patient Group Direction (PGD) services?	Of 10 responses: 8 (80%) gave examples of specific PGDs covering flu vaccination, travel vaccines (e.g. malaria), Meningitis, Erectile Dysfunction, Champix [stop smoking] and emergency contraception 2 (20%) are willing and able to provide if commissioned
Does the pharmacy provide Phlebotomy service?	Of 26 responses: No pharmacies are currently providing this 15 (57.7%) are willing and able to provide if commissioned 11 (42.3%) are not willing or able to provide
Does the pharmacy provide Prescriber Support service?	Of 28 responses: 21 (75%) are willing and able to provide if commissioned 7 (25%) are not willing or able to provide
Does the pharmacy provide Schools service?	Of 27 responses: No pharmacies currently provide this 18 (66.7%) are willing and able to provide if commissioned 9 (33.3%) are not willing or able to provide
Does the pharmacy provide Sharps Disposal service?	Of 30 responses: 5 (16.7%) are currently providing 16 (53.3%) are willing and able to provide if commissioned 9 (30%) are not willing or able to provide
Does the pharmacy provide Stop Smoking service?	Of 33 responses: 20 (60.6%) are currently providing 12 (36.4%) are willing and able to provide if commissioned 1 (3%) are not willing or able to provide
Does the pharmacy provide Supervised Administration service?	Of 30 responses: 7 (23.3%) are currently providing under NHS England contract 5 (16.7%) are currently providing under CCG contract 2 (6.7%) are currently providing under Local

	Authority contract 9 (30%) are willing and able to provide if commissioned 7 (23.3%) are not willing or able to provide
Does the pharmacy provide Supplementary Prescribing service?	Of 4 responses: 2 (50%) are willing and able to provide if commissioned 2 (50%) are not willing or able to provide
Does the pharmacy provide Vascular Risk Assessment Service (NHS Health Check)?	Of 32 responses: 2 (6.3%) are currently providing 25 (78.1%) are willing and able to provide if commissioned 5 (15.6%) are not willing or able to provide

The analysis on Healthy Living Pharmacies can be found in [this section](#) of the full PNA document.

#### *Locally commissioned services – Disease-Specific Management Service*

<b>Question</b>	<b>Responses</b>
Does the pharmacy provide this service for Allergies?	Of 32 responses: No pharmacies currently provide this 27 (84.4%) are willing and able to provide if commissioned 5 (15.6%) are not willing or able to provide
Does the pharmacy provide this service for Alzheimer's/Dementia?	Of 34 responses: No pharmacies currently provide this 27 (79.4%) are willing and able to provide if commissioned 7 (20.6%) are not willing or able to provide
Does the pharmacy provide this service for Asthma?	Of 34 responses: 1 (2.9%) is currently providing under NHS England contract 28 (82.4%) are willing and able to provide if commissioned 5 (14.7%) are not willing or able to provide
Does the pharmacy provide this service for CHD?	Of 32 responses: No pharmacies are currently providing this 26 (81.3%) are willing and able to provide if commissioned 6 (18.8%) are not willing or able to provide
Does the pharmacy provide this service for COPD?	Of 33 responses: No pharmacies are currently providing this 27 (81.8%) are willing and able to provide if commissioned 6 (18.2%) are not willing or able to provide
Does the pharmacy provide this service for Depression?	Of 32 responses: No pharmacies are currently providing this 24 (75%) are willing and able to provide if commissioned

	8 (25%) are not willing or able to provide
Does the pharmacy provide this service for Diabetes Type I?	Of 31 responses: No pharmacies are currently providing this 24 (77.4%) are willing and able to provide if commissioned 7 (22.6%) are not willing or able to provide
Does the pharmacy provide this service for Diabetes Type II?	Of 31 responses: No pharmacies are currently providing this 26 (83.9%) are willing and able to provide if commissioned 5 (16.1%) are not willing or able to provide
Does the pharmacy provide this service for Epilepsy?	Of 31 responses: No pharmacies are currently providing this 23 (74.2%) are willing and able to provide if commissioned 8 (25.8%) are not willing or able to provide
Does the pharmacy provide this service for Heart Failure?	Of 29 responses: No pharmacies are currently providing this 20 (69%) are willing and able to provide if commissioned 9 (31%) are not willing or able to provide
Does the pharmacy provide this service for Hypertension?	Of 31 responses: No pharmacies are currently providing this 26 (83.9%) are willing and able to provide if commissioned 5 (16.1%) are not willing or able to provide
Does the pharmacy provide this service for Parkinson's Disease?	Of 29 responses: No pharmacies are currently providing this 21 (72.4%) are willing and able to provide if commissioned 8 (27.6%) are not willing or able to provide

#### *Locally commissioned services – Screening Services*

<b>Question</b>	<b>Responses</b>
Does the pharmacy provide Alcohol Screening?	Of 33 responses: No pharmacies are currently providing this 21 (63.6%) are willing and able to provide if commissioned 12 (36.4%) are not willing or able to provide
Does the pharmacy provide Cholesterol Screening?	Of 33 responses: No pharmacies are currently providing this 28 (84.9%) are willing and able to provide if commissioned 5 (15.2%) are not willing or able to provide
Does the pharmacy provide Diabetes Screening?	Of 32 responses: No pharmacies are currently providing this 27 (84.4%) are willing and able to provide if commissioned 5 (15.6%) are not willing or able to provide
Does the pharmacy provide Gonorrhoea	Of 32 responses:

Screening?	No pharmacies are currently providing this 19 (59.4%) are willing and able to provide if commissioned 13 (40.6%) are not willing or able to provide
Does the pharmacy provide H. pylori Screening?	Of 32 responses: No pharmacies are currently providing this 24 (75%) are willing and able to provide if commissioned 8 (25%) are not willing or able to provide
Does the pharmacy provide HbA1C Screening?	Of 32 responses: No pharmacies are currently providing this 23 (71.9%) are willing and able to provide if commissioned 9 (28.1%) are not willing or able to provide
Does the pharmacy provide Hepatitis Screening?	Of 31 responses: No pharmacies are currently providing this 18 (58.1%) are willing and able to provide if commissioned 13 (41.9%) are not willing or able to provide
Does the pharmacy provide HIV Screening?	Of 30 responses: No pharmacies are currently providing this 15 (50%) are willing and able to provide if commissioned 15 (50%) are not willing or able to provide

#### *Locally commissioned services – Other Vaccinations*

<b>Question</b>	<b>Responses</b>
Does the pharmacy provide childhood vaccinations?	Of 30 responses: 1 (3.3%) is currently providing 20 (66.7%) are willing and able to provide if commissioned 9 (30%) are not willing or able to provide
Does the pharmacy provide Hepatitis vaccinations (at risk workers or patients)?	Of 30 responses: No pharmacies are currently providing this 21 (70%) are willing and able to provide if commissioned 9 (30%) are not willing or able to provide
Does the pharmacy provide HPV vaccinations?	Of 28 responses: No pharmacies are currently providing this 20 (71.4%) are willing and able to provide if commissioned 8 (28.6%) are not willing or able to provide
Does the pharmacy provide travel vaccinations?	Of 30 responses: 1 (3.3%) is currently providing 25 (83.3%) are willing and able to provide if commissioned 4 (13.3%) are not willing or able to provide
Does the pharmacy provide the Seasonal Influenza vaccination service?	Of 34 responses: 21 (61.8%) are currently providing 11 (32.4%) are willing and able to provide if commissioned 2 (5.9%) are not willing or able to provide

### *Non-NHS funded services*

<b>Question</b>	<b>Responses</b>
Does the pharmacy provide collection of prescriptions from GP practices?	Of 34 responses: 34 (100%) said yes
Does the pharmacy deliver dispensed medicines?	Of 34 responses: 29 (85.3%) deliver free of charge on request  Of those who indicated they restricted delivery of dispensed medicines to selected patient groups or areas, the pre-requisites were mainly to elderly or housebound patients, although 5 (14.7%) said they would deliver to all.
Does the pharmacy provide Monitored Dosage Systems?	Of 34 responses: 30 (88.2%) said they provided them free of charge upon request 1 (2.9%) said they provided them for a charge

### *Pharmacists Views*

Pharmacists were asked if they felt there was a particular need for a locally commissioned service in their area, and if so, why they felt that was. Of the 17 that provided responses (1 provided 2 suggestions):

- 9 supported a need for Minor Ailments services
- 2 supported a need for Hypertension detection
- 1 supported a need for weight management
- 1 supported a need for Alzheimers/Dementia services
- 1 supported a need for pregnant/breastfeeding services
- 1 supported a need for glucose testing
- 1 supported a need for Cystitis under a PGD
- 1 supported a need for EHC under a PGD
- 1 supported a need for Home MURs

## 9.5 Summarised feedback from Community Pharmacy Patient Questionnaires

In 2016/17, pharmacies nationally asked their customers for their views via completion of Community Pharmacy Patient Questionnaires (CPPQ). Whilst pharmacies were asked to publish their results on their NHS Choices page in 2017, there was no mandated proforma for displaying the results, nor was there a requirement to publish the responses for every question asked.

Below is a summary of the key themes that emerged from the Thurrock pharmacists responses:

### **Top five areas customers reported high levels of satisfaction with:**

- Pharmacy Layout (results shown for 9 pharmacies – average 83%)
- Service received from pharmacists (results shown for 16 pharmacies – average 83%)
- Service received from other staff (results shown for 13 pharmacies – average 81%)
- Efficient (results shown for 14 pharmacies – average 84%)
- Advice on health problem (results shown for 10 pharmacies – average 73%)

### **Areas customers suggested improvements for:**

- Advice on healthy lifestyles
- Not many patients had actually accessed the pharmacist for smoking cessation, exercise or healthy eating advice
- Some contractor-specific comments (e.g. to improve product range, the automated doors etc)

Customers were asked as part of the CPPQ why they had selected that particular pharmacy, in order to give an idea of whether customers had a preferred pharmacy or whether it was just convenient on the day.

Of the 12 pharmacies that provided data on this:

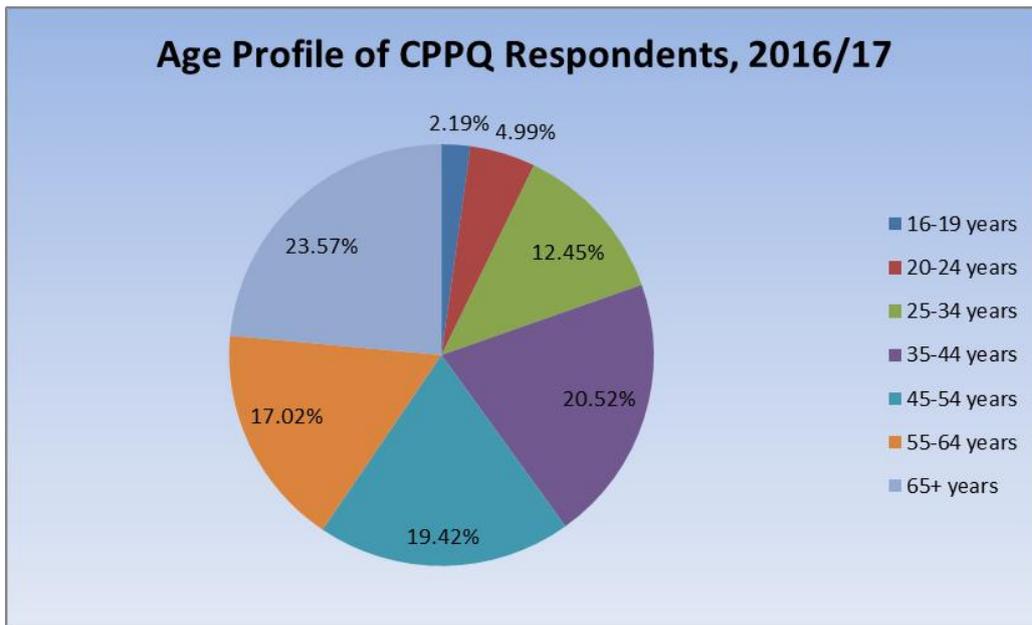
- 70% chose that pharmacy
- 17% said it was one of several they used
- 14% used that one because it was convenient

Of 18 pharmacies, the average overall satisfaction rating with their pharmacy was 93%.

### **Customer profile:**

12 pharmacies provided an age breakdown of respondents as seen below. It can be seen that the largest proportion were aged 65+ (23.57%), and that the proportion of responses from younger adults was quite small (only 2.19% were aged 16-19 years and 4.99% aged 20-24 years) – yet there are a number of services offered out of pharmacies that may be particularly beneficial for them, so it is important to ensure we have their feedback recorded.

Figure 19: Age Profile of CPPQ Respondents, 2016/17



Source: CPPQ Results published on NHS Choices

DRAFT FOR APPROVAL

## 9.6 Public Consultation responses

The draft PNA document was released for a period of public consultation for 61 days between 18<sup>th</sup> October 2017 and 17<sup>th</sup> December 2017. It was published on Thurrock Council's online consultation portal, along with a short questionnaire asking for views on the document. The questions asked are listed below:

- 1) Has the purpose of the PNA been sufficiently explained? (Y/N)
- 2) Is the scope clearly identified? (Y/N)
- 3) Does the document provide a reasonable description of the services that are provided by pharmacies and dispensing doctors in Thurrock? (Y/N/Not Sure)
- 4) Do you know of any pharmaceutical services that are not described in the PNA? (Y/N/Not Sure)
- 5) Do you feel that the needs for pharmaceutical services in the Thurrock population have been adequately identified? (Y/N/Not Sure)
- 6) Do you agree with our conclusion that we have a sufficient number of pharmacies across Thurrock? (Y/N/Not Sure)
- 7) Is there any other feedback on aspects of this PNA that you would like to give? (open ended)

The draft document was also discussed at various CCG committees and publicised by the LPC during this period.

A total of 7 responses were received to this consultation questionnaire. 5 of these came from local pharmacies, with the other responses from Thurrock CCG and Essex LMC.

The majority of questions had 100% of respondents answering affirmatively. For the questions where a couple of respondents answered 'not sure', no further detail was provided as to why they had selected this response.

The conclusion from this consultation period was that no changes to the draft should be made, and it would be submitted for Health and Wellbeing Board approval in early 2018.

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<b>16 March 2018</b>	<b>ITEM: 7</b>
<b>Health and Wellbeing Board</b>	
<b>Adult Mental Health Joint Strategic Needs Assessment</b>	
<b>Wards and communities affected:</b> All	<b>Key Decision:</b> Non-key
<b>Report of:</b> Tim Elwell-Sutton, Assistant Director and Consultant in Public Health	
<b>Accountable Head of Service:</b> Tim Elwell-Sutton, Assistant Director and Consultant in Public Health	
<b>Accountable Director:</b> Ian Wake, Director of Public Health	
<b>This report is Public</b>	

## Executive Summary

The Joint Strategic Needs Assessment (JSNA) is intended to provide a shared, evidence-based consensus about key local priorities and drive planning and commissioning to improve health and well-being outcomes and reduce inequalities. The focus of this JSNA is Common Mental Health Disorders in Adults.

This report makes a series of recommendations for action across a broad spectrum of areas, departments and partners to be undertaken to have a population level impact on improving mental health in Thurrock.

### 1. Recommendation(s)

- 1.1 That the contents of the JSNA document be approved by the Health and Wellbeing Board including the recommendations found in the report and that Board members use the contents and recommendations of this JSNA product to drive adult mental health commissioning strategy.**
- 1.2 That the Health and Wellbeing Board approve the publication of this JSNA document.**

### 2. Introduction and Background

- 2.1 The Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and social care needs of the local community – these are needs that could be met by the local authority, Clinical Commissioning Groups (CCGs), or NHS England. It is intended to provide a shared, evidence-based consensus about key local priorities and support

commissioning to improve health and well-being outcomes and reduce inequalities.

2.2 This JSNA focuses on the prevention, detection and treatment of mental ill-health in the adult population of Thurrock. This JSNA aims to:

- Understand the full estimated level of need
- Understand the variation in access and quality of treatment
- Identify mental health priorities for Thurrock

2.3 According to the World Health Organisation, mental health disorders are the leading cause of disability worldwide and one in four people in the UK will experience a mental health disorder at some point in their lives. While the document focuses on adults, this is an issue which exists across the life-course.

### **3. Issues, Options and Analysis of Options**

3.1 These are detailed within the JSNA report itself.

3.2 The report highlights the different parts of the health and social care system that are involved in the prevention, detection and treatment of mental ill-health, and how the various stakeholders need to work together towards better outcomes for the Thurrock population.

### **4. Reasons for Recommendation**

4.1 The JSNA highlights a number of inequalities in mental health experienced by our local residents. This work will drive the necessary changes across the wider health and social care system in order to improve the prevention, detection and treatment of mental health conditions on a population level.

4.2 The publication of this JSNA will be very timely in order to feed into a wider ongoing programme of work around redesigning of Adult Mental Health services, both locally and across the county.

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

5.1 The JSNA was produced with contributions from key stakeholders as listed in the reports' acknowledgements section.

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

6.1 The JSNA aligns with the Council's three new priorities for People, Place and Prosperity by demonstrating our commitment to high quality and accessible public services, and partnership working to improve health and wellbeing.

6.2 The recommendations in the JSNA also support the delivery of the Thurrock Health and Wellbeing Strategy 2016-21 – in particular Goals C (Better

Emotional Health and Wellbeing), D (Quality Care Centred Around the Person) and E (Healthier for Longer).

## **7. Implications**

### **7.1 Financial**

Implications verified by: Jo Freeman

Management Accountant Social Care

The report details a series of opportunities for tackling inequalities in mental ill-health in the population which should contribute towards reducing demand on primary and secondary health care and adult social care services. Decisions arising from recommendations of the JSNA that may have a future financial impact for the council would be subject to the full consideration of the cabinet before implementation, and in the case of the NHS, by the relevant Boards of NHS Thurrock CCG and provider foundation trusts. Detailed business cases will have to be worked up before any investment decisions will be made and these will go through the usual governance routes.

### **7.2 Legal**

Implications verified by: Ian Wake

Director of Public Health

Under the Health and Social Care Act 2012, JSNAs and Joint Health and Wellbeing Strategies form the basis of clinical commissioning groups, NHS England and local authority commissioning plans, across all local health, social care, public health and children's services. There are no legal implications; this report has been compiled to support and inform local planning and commissioning.

### **7.3 Diversity and Equality**

Implications verified by: Natalie Warren

Strategic Lead – Community Development and Equalities

The analysis and evidence base in this report seeks to understand inequalities in health in the borough and makes recommendations to further understand and take action to tackle these. It should be noted that a community impact assessment will be completed in the near future.

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

**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):

- Detailed references are given in the main report.

**9. Appendices to the report**

- Adult Mental Health Joint Strategic Needs Assessment
- Adult Mental Health Joint Strategic Needs Assessment Executive Summary

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Public Health Team

# Thurrock Joint Strategic Needs Assessment for Common Mental Health Disorders in Adults

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## **Acknowledgements**

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With thanks to all those who have helped us with this document. We particularly thank Jane Itangata (TCCG), Karen Balthasar, Kelly Clarke, Kareema Olaleye, Nicola Smith, Kevin Malone, Sarah Hurlock, Katie Clark (TCCG), Mandy Moore, Ian Kennard and Kim James (Healthwatch Thurrock) for their hard work in providing data and helping to pull together this JSNA product.

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# 1 Introduction

## Key Points

- Mental health is the leading cause of disability worldwide.
- One in four people will experience mental ill health in their lifetime
- Improving emotional health is one of the five high level goals set out in the Health and Wellbeing Strategy 2016-21 for Thurrock.
- Improved mental health and wellbeing is associated with a range of better physical and social outcomes for people of all ages and backgrounds.
- The cost of mental ill health to the NHS is £105 billion per year

*“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”*

World Health Organization, 2014

*“[Mental health is] a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.*

World Health Organization, 2014

## 1.1 Scope and purpose of the document

This Mental Health Joint Strategic Needs Assessment (MH JSNA) has been written in order to understand the level of need for mental health services, to understand the variation in access and quality of treatment and to identify mental health priorities for Thurrock residents.

It focusses on Common Mental Health Disorders (CMHDs) in adults as well as Serious Mental Illness (SMI). It excludes specific mental health disorders such as Dementia and Learning Disabilities. Details of Mental Health in children will be detailed in a separate product due for publication by the Public Health Team later in 2018.

This document is structured around a series of key questions:

- Who is affected by mental illness?
  - The scale of the problem
  - The trends
  - High risk groups
- What are the causes and consequences of mental illness?
- What services are provided for those with mental illness?
  - Primary care
  - Secondary care
  - Social care
- What do residents think of mental health services in Thurrock?

## 1.2 Definitions of Health and Mental Health

Common Mental Disorders (CMHDs)	Includes: depression, anxiety, panic disorder, obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), phobias, post-traumatic stress disorder (PTSD). CMHDs do not generally exist in isolation to each other. Mixed anxiety and depression being the most commonly diagnosed CMHD.
Serious Mental Illnesses (SMIs)	Includes conditions characterised by psychosis (losing touch with reality) or requiring high levels of care. Two of the most common are: schizophrenia and bipolar disorder (manic depression). Also known as <i>Severe Mental Illness</i> .
Improving Access to Psychological Therapies (IAPT)	A national programme to increase the availability of 'talking therapies' on the NHS. IAPT is primarily for people who have mild to moderate mental health difficulties.
Early Intervention in Psychosis (EIP)	Early Intervention in Psychosis (EIP) teams provide specialist treatment and care for people who have signs of psychosis. The teams are made up of a number of different health and social care professionals.

## 1.3 National Context of Mental Health in England

Current figures suggest that 1 in 4 people will experience poor mental health at some point in their lives and that 1 in 6 adults are experiencing mental health difficulties at any one time. Moreover, 1 in 10 children aged between 5-16 years of age will have a mental health condition with many of these individuals continuing to experience poor mental health in adulthood.

Estimates suggest that between a quarter to half of mental health issues experienced in adulthood could be averted with effective early interventions in childhood (COI, 2011). Linking to this is the need to focus on the perinatal mental health of pregnant women, as mental health issues during pregnancy increase the risk of both adverse pregnancy outcomes and also neurodevelopmental problems for the child both before and after birth. This sets a precedent for the importance of early intervention and prevention programmes as well as the crucial need to reduce pressure on the NHS in providing emergency care to those facing crisis.

The cost of mental illness for the NHS in England is £105 billion of which £30 million is allocated to work related sickness. This is due to increase and double over the next 20 years. The costs to Social Care for people with mental health collates to £2 billion annually and is also likely to continue to increase if mental health services are not re-organised and managed more effectively (COI, 2011). This will put ever more pressure on an already overstretched NHS and Social Care system.

## 1.4 Local context of mental health in Thurrock

Thurrock is the fourth most under-doctored Local Authority within England. This affects the number of people being diagnosed with mental health conditions as GPs often do not have the time to explore whether physical symptoms are related to underlying mental health disorders and vice versa (Thurrock Council, 2016). In general, 90% of mental health conditions are managed within Primary Care. However, under-doctoring in Thurrock compared to other areas leads, to increased waiting times for appointments and subsequent referrals to specialist services. Some individuals are likely to experience deterioration in their condition due to wait times for treatment (Mental Health Taskforce, 2016 2016).

## 1.5 Benefits of improving mental health in the population

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. For the health and social care system these include:

- Improved physical health and life expectancy,
- Increased self-management of mental health and Long Term Conditions (LTCs),
- Increased rates of recovery from ill health and reduction on demand for services,
- Reduced health risk behaviours such as smoking and alcohol misuse,
- Reduced risk of self-harm and suicide,
- Reduced hospital admissions and therefore savings to NHS and Social care.

Benefits for society include:

- Better educational achievement,
- Improved employment rates and productivity,
- Increased employment skills,
- Breaking the intergenerational cycle of mental ill health,
- Reduction in health inequalities within communities,
- Stronger, more socially cohesive communities,
- Reduced anti-social behaviour and criminality

The ability to cope with the normal stresses of life as outlined in the World Health Organisation's definition of mental health reflects upon an individual's psychological resilience. The American Psychological Society (APA) defines resilience as: "The ability to cope with, and adapt in the face of adversity, trauma or stress and the ability to 'bounce back' from such difficult experiences" (2017). Building the resilience of individuals and communities within Thurrock will be one of the key ways in which mental health can be improved in Thurrock.

## 1.6 Thurrock's Health and Wellbeing Strategy 2016-21

Thurrock's Health and Wellbeing Strategy 2016-21 includes a focus Better Emotional Health and Wellbeing (Goal C). However, improving mental health is a common thread running through the entire strategy as mental health is linked to strong communities and environments (Goal B) wider determinants such as education and employment (Goal A) as well as putting people in control of their own care (Goal D) for example if they have long term conditions, which we know affects mental health.

Table 1: Thurrock Health and Wellbeing Strategy, 2016- 21.

GOALS	A. OPPORTUNITY FOR ALL	B. HEALTHIER ENVIRONMENTS	C. BETTER EMOTIONAL HEALTH AND WELLBEING	D. QUALITY CARE CENTRED AROUND THE PERSON	E. HEALTHIER FOR LONGER
OBJECTIVES	A1. All children in Thurrock making good educational progress	B1. Create outdoor places that make it easy to exercise and to be active	C1. Give parents the support they need	D1. Create four integrated healthy living centres	E1. Increase the number of people in Thurrock who are a healthy weight
	A2. More Thurrock residents in employment, education or training.	B2. Develop homes that keep people well and independent	C2. Improve the emotional health and wellbeing of children and young people.	D2. When services are required, they are organised around the individual	E2. Reduce the proportion of people who smoke.
	A3. Fewer teenage pregnancies in Thurrock.	B3. Building strong, well-connected communities	C3. Reduce social isolation and loneliness	D3. Put people in control of their own care	E3. Significantly improve the identification and management of long term conditions
	A4. Fewer children and adults in poverty	B4. Improve air quality in Thurrock.	C4. Improve the identification and treatment of depression, particularly in high risk groups.	D4. Provide high quality GP and hospital care to Thurrock	E4. Prevent and treat cancer better

## 2 Who is affected by mental illness? The Scale of the Problem

### 2.1 Prevalence of CMHDs in England

It is now commonly accepted that 1 in 4 adults and 1 in 10 children will be affected by a mental health condition at any one point in their lifetime. In 2011, the National Institute for Health and Care Excellence (NICE) found that these CMHDs may affect up to 15% of the population at any one time. The table below shows estimates of specific mental health disorders in the population.

**Table 2: Estimated Lifetime Prevalence of mental health disorders, 2011.**

Condition	Estimates Lifetime Prevalence (%)
Specific Phobias	12.5
Social Anxiety Disorder	12.1
Major Depression	4 to 10
Post-Traumatic Stress Disorder (PTSD)	6.8
Generalised Anxiety Disorder (GAD)	5.7
Dysthymia	2.5 to 5
Obsessive Compulsive Disorder (OCD)	1.6
Panic Disorder	1.4

Source: NICE 2011

#### **Prevalence of mental ill health by age and gender**

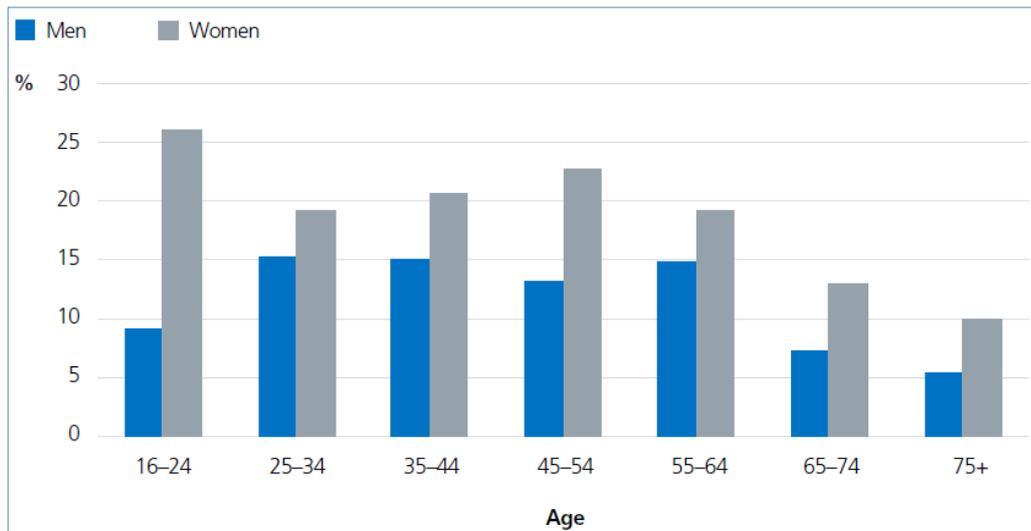
Statistics and research have identified a gap between rates of CMHD between men and women as well as across age groups. According to the Adult Psychiatric Morbidity Survey (APMS) 2014<sup>1</sup>, in England women are more likely to have a CMHD than men with 1 in 5 women with CMHD symptoms compared with 1 in 8 men with CMHD symptoms – which correlated with previous findings (McManus, 2016; Martin-Merino *et al*, 2009)

The pattern of association between age and CMHD symptoms is different for men and women. As shown in Figure 1, rates of CMHD symptoms in women peaked in the youngest group (26% of 16 to 24 year olds) – which was three times the rate for 16 to 24 year old men (9.1%). Overall working-age people were around twice as likely to have symptoms of CMHD as those aged 65 and over.

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<sup>1</sup> Adult Psychiatric Morbidity Survey 2014

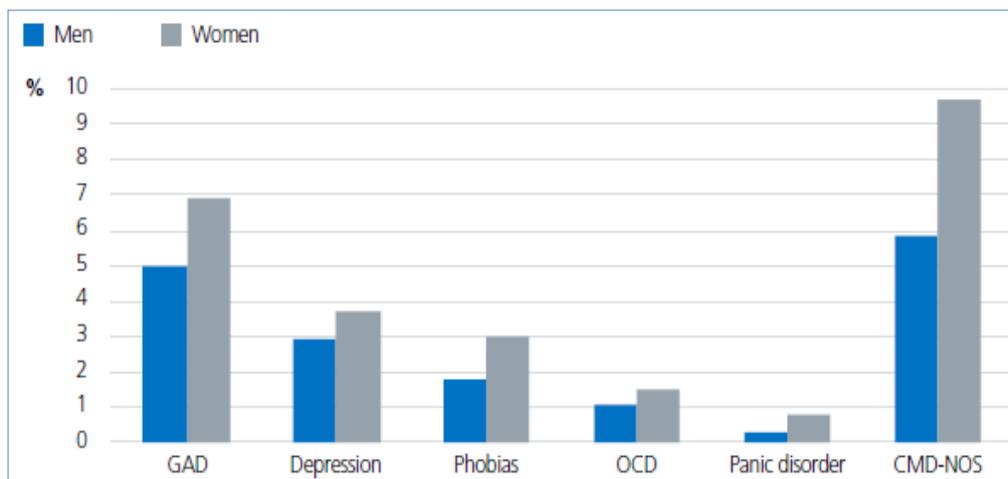
Figure 1. Prevalence of Common Mental Health Disorders by age and gender (age 16+), 2016



Source: APMS, 2016

All types of CMHDs were more prevalent in women than in men, with differences by gender reaching statistical significance for Generalised Anxiety Disorder (GAD), phobias, panic disorder and Common Mental Disorders Not Otherwise Specified (CMD-NOS) (Figure 2).

Figure 2. Prevalence of CMHDs by Gender, 2016



Source: APMS, 2016

The significant difference in prevalence across the CMHDs between women and men could represent an increased likelihood for women to report symptoms compared to men (Kovess-Masfety *et al*, 2014), or an increase in risk factors for CMHDs in women such as exposure to domestic violence (Trevillion *et al*, 2012), increased work and home stressors such as caring (Pinquart & Sorensen, 2006), financial problems, unemployment or social isolation (Clark *et al*, 2012).

## 2.2 Local Context of Mental Health in Thurrock

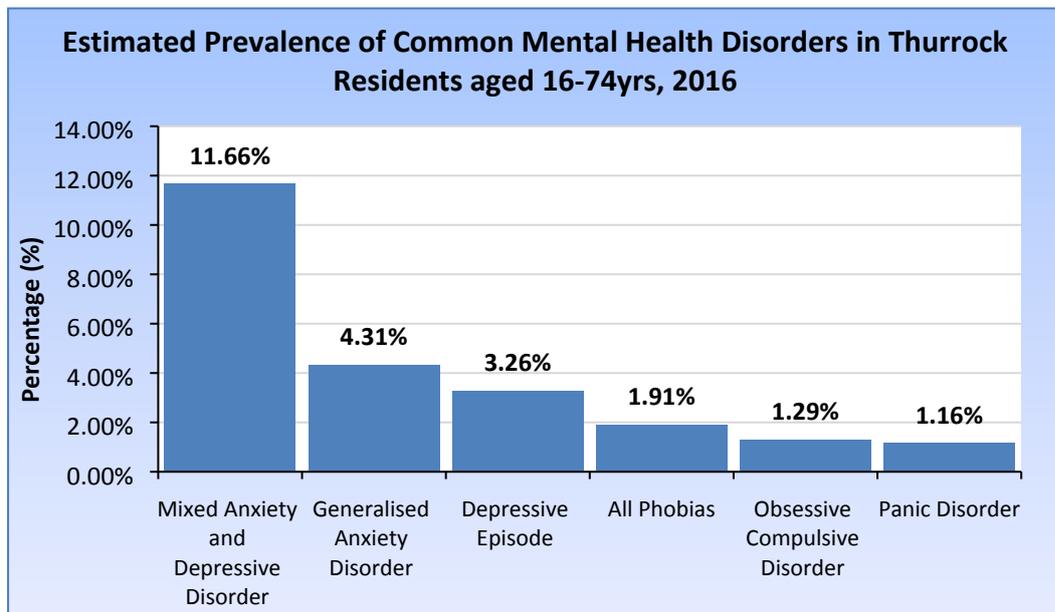
### Population Projections

The population projection for Thurrock suggests that with a significant rise in those aged 50-59 years, we should expect to see more women with mental ill health in the years to come.

Population projection data shows that the numbers of people with mental health disorders are due to increase steadily over the next 15 years, which means that the need and demand for mental health services will increase in coming years.

The prevalence of common mental health disorders in Thurrock varies across condition types and age range. Figure 3 below illustrates the estimated prevalence of some common mental health disorders for residents aged between 16-74 years living in Thurrock in 2016. Some caution needs to be taken when interpreting this data as there are some issues with the quality of the data.

Figure 3: Estimated prevalence of Common Mental Health Disorders in residents aged 16-74 years living in Thurrock, 2016

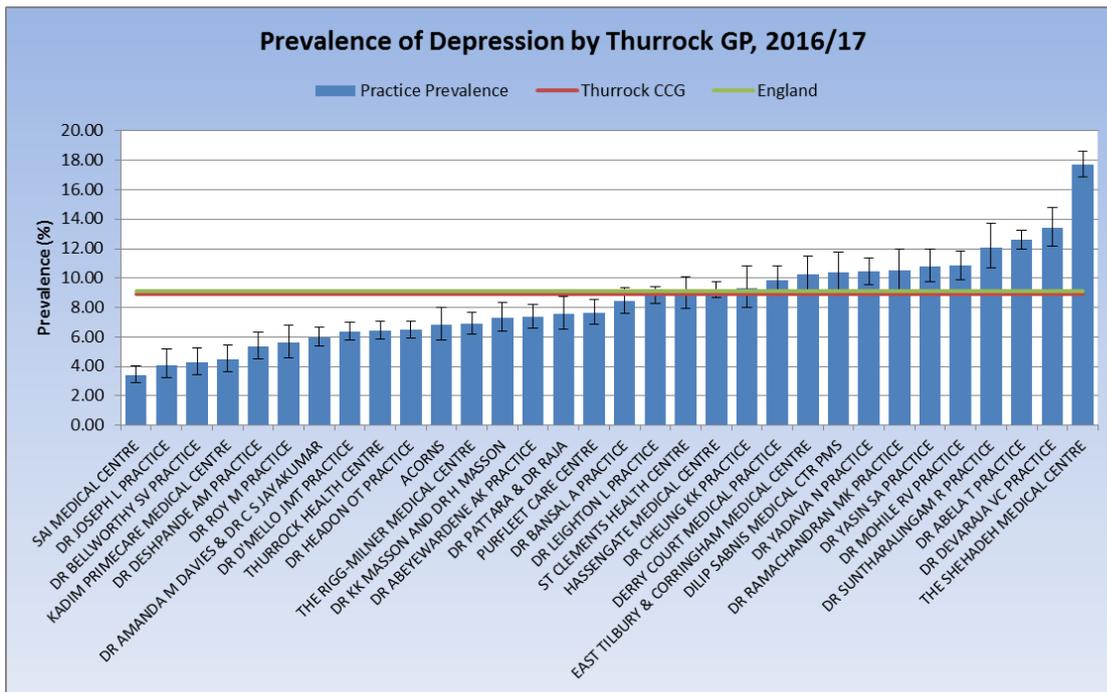


Source: - PHE Fingertips – Common Mental Health Disorders – Prevalence profile (2016)

## 2.3 Quality and Outcome Framework (QOF) Prevalence of Depression in Thurrock by GP Practice

In 2016/17, there were 11,689 patients registered on the Thurrock GPs QOF register for depression. This equates to a prevalence of 8.9%. Variation can be seen in the chart below – diagnosed prevalence ranges from 3.41% (Sai Medical Centre) to 17.71% (Shehadeh Medical Centre).

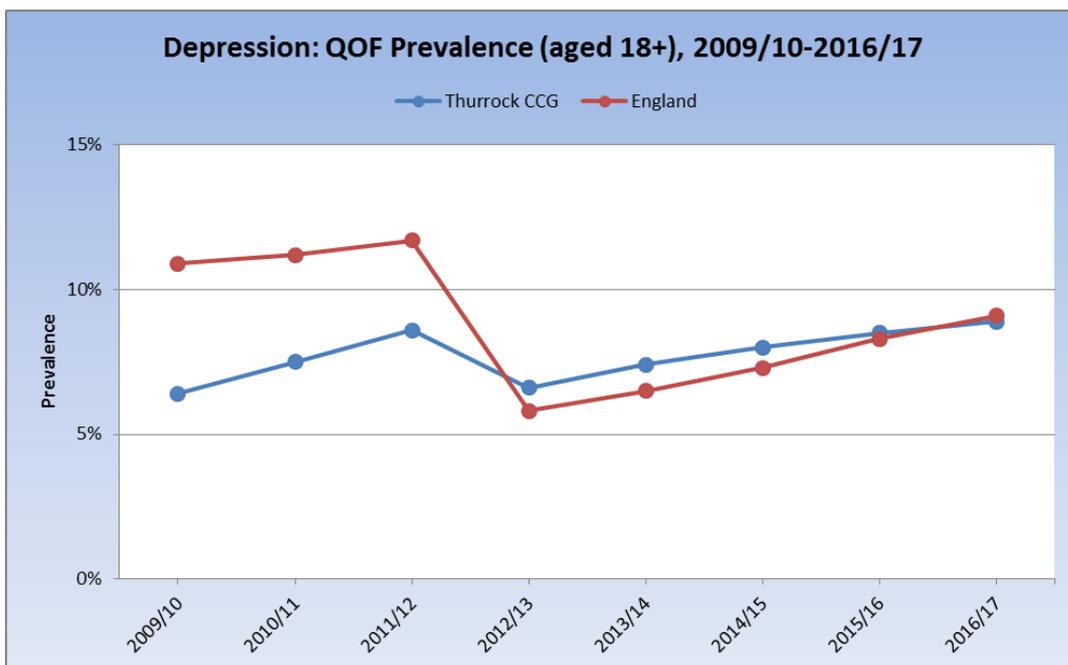
Figure 4: Depression prevalence in Thurrock by GP practice, 2016/17.



Source: QOF 2016/17

In general, prevalence of depression appears to have increased since 2012. Prior to this, Thurrock's prevalence of depression was significantly below the national average but followed a similar pattern to the national trend. This can be seen in Figure 5 below.

Figure 5: Depression: QOF Prevalence (in those aged 18+), 2009/10 – 2016/17

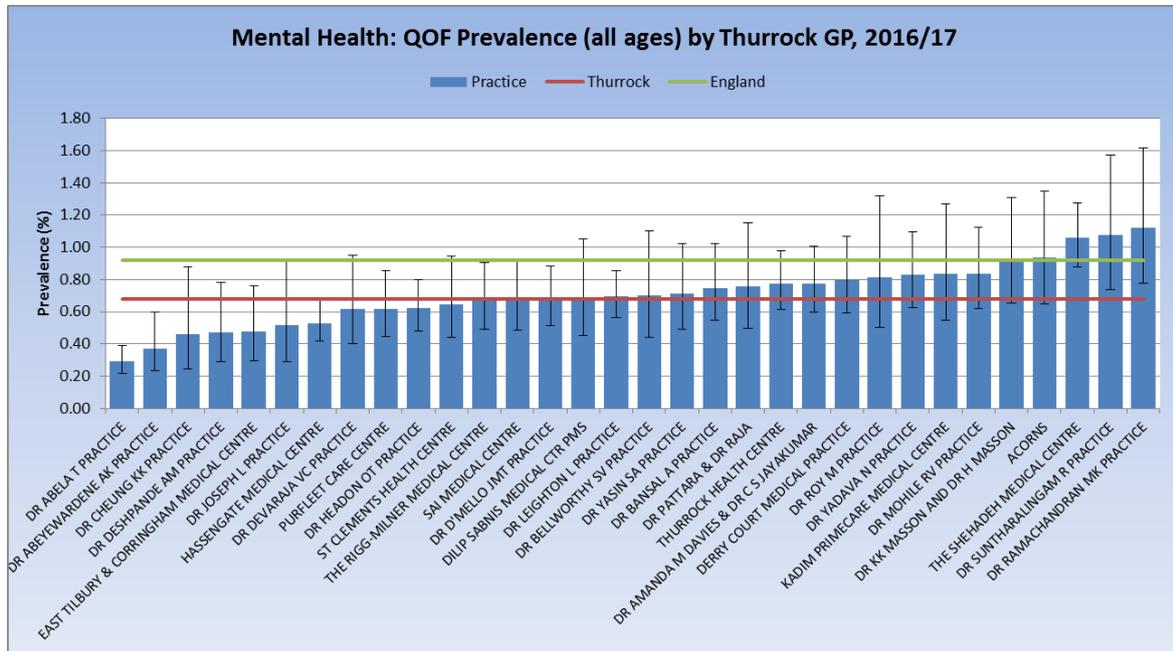


Source: QOF 2009/10 – 2016/17

## 2.4 Serious Mental Illness prevalence

Prevalence of serious mental illness (SMI) is much lower (~0.7%) but this also varies by GP practice as shown in Figure 6 below.

Figure 6: Mental Health: QOF Prevalence (across all ages) By Thurrock GP, 2016-17.

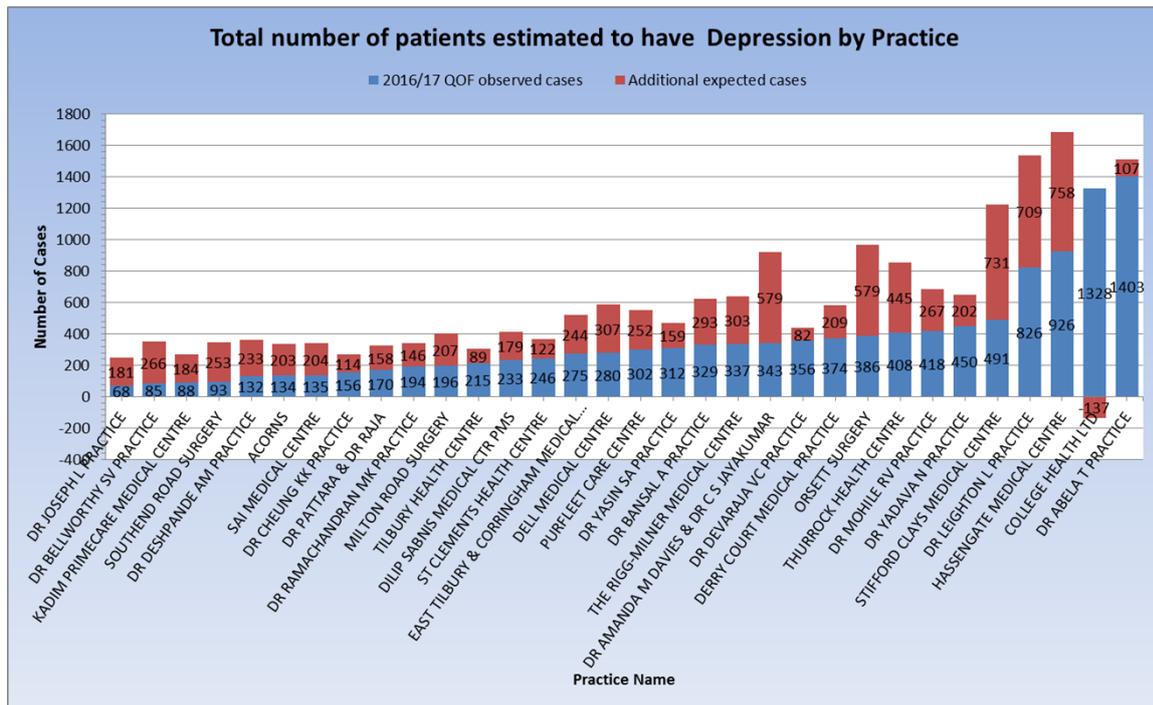


Source: QOF 2016/17

## 2.5 Observed vs estimated prevalence of depression in Thurrock by GP Practice

The latest modelled estimates from Public Health England (2016) found there are likely to be as many as 21,317 patients who have depression in Thurrock - which is a difference of 8,628 from the number diagnosed. These estimates were generated using a range of variables relating to the demographics of the population (e.g. age, sex, ethnicity etc.), known risk factors for depression (e.g. BMI, alcohol consumption etc.) and wider determinants such as employment status. A model was built for every practice population in the country to estimate the true likely prevalence of depression – which would include some already diagnosed.

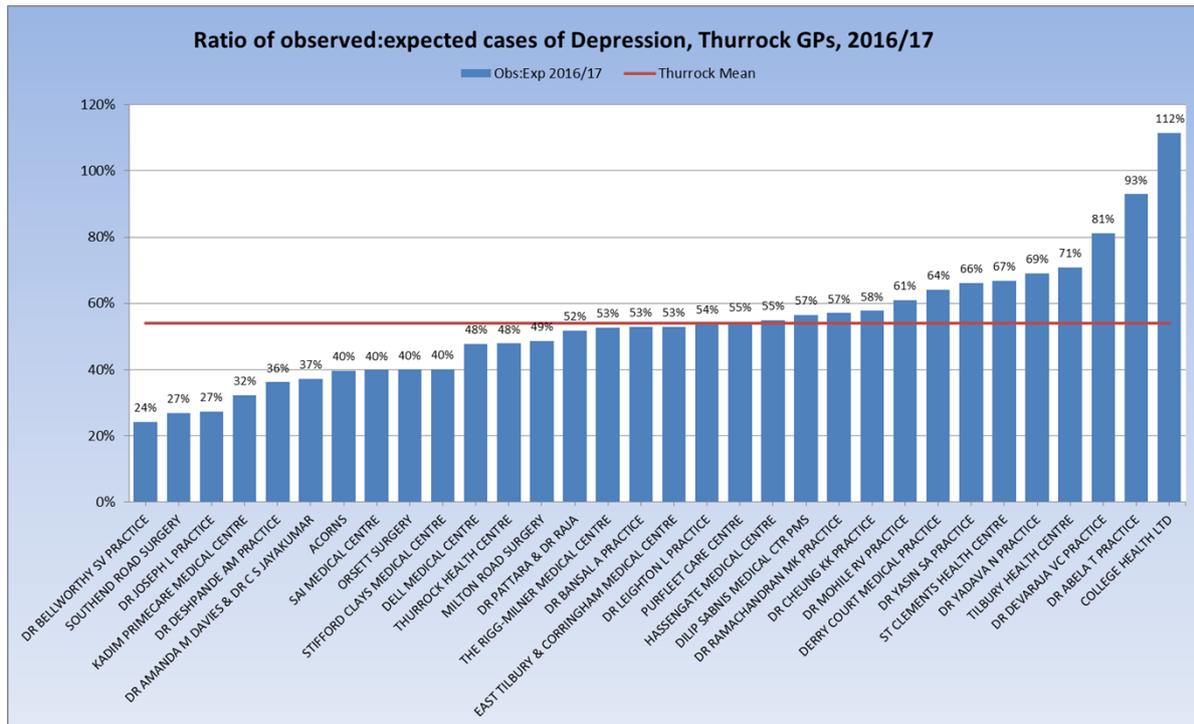
Figure 7: Observed and estimated number of patients with Depression by Thurrock GP, 2017.



Source: PHE 2016, QOF 2016/17

When comparing the number diagnosed to the number estimated at practice level, there is a large amount of variation within the borough - whilst the Thurrock ratio of those diagnosed: estimated is 54%, practices such as Dr Bellworthy and Southend Road Surgery have extremely low ratios (24% and 27%) whereas College Health Ltd appears to be diagnosing more than estimated (112%). This information indicates there is a large opportunity in terms of case finding and treating undiagnosed patients with depression.

Figure 8: Ratio of Observed vs Expected Numbers of Patients with Depression by GP Practice in Thurrock, 2016-17.



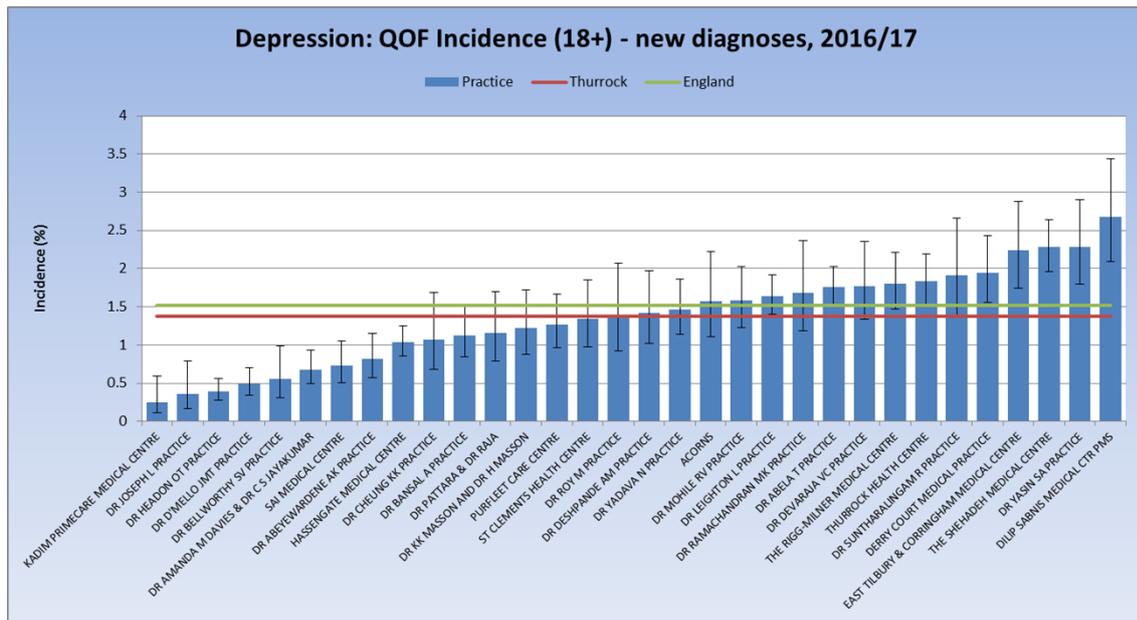
Source: QOF and PHE model data, 2016/17

## 2.6 Incidence of depression in Thurrock

### Incidence of common mental health disorders

Incidence is defined as the number of newly diagnosed people with the condition being measured within a certain time period e.g. a year. Figure 9 below shows incidence of new diagnoses of depression in adults (18+) by GP practice in Thurrock for 2016/17. Although the Thurrock CCG average 1.4% is similar to the national average 1.5%, there is a wide range between the GP practices with the lowest and highest being 0.3% and 2.7% respectively.

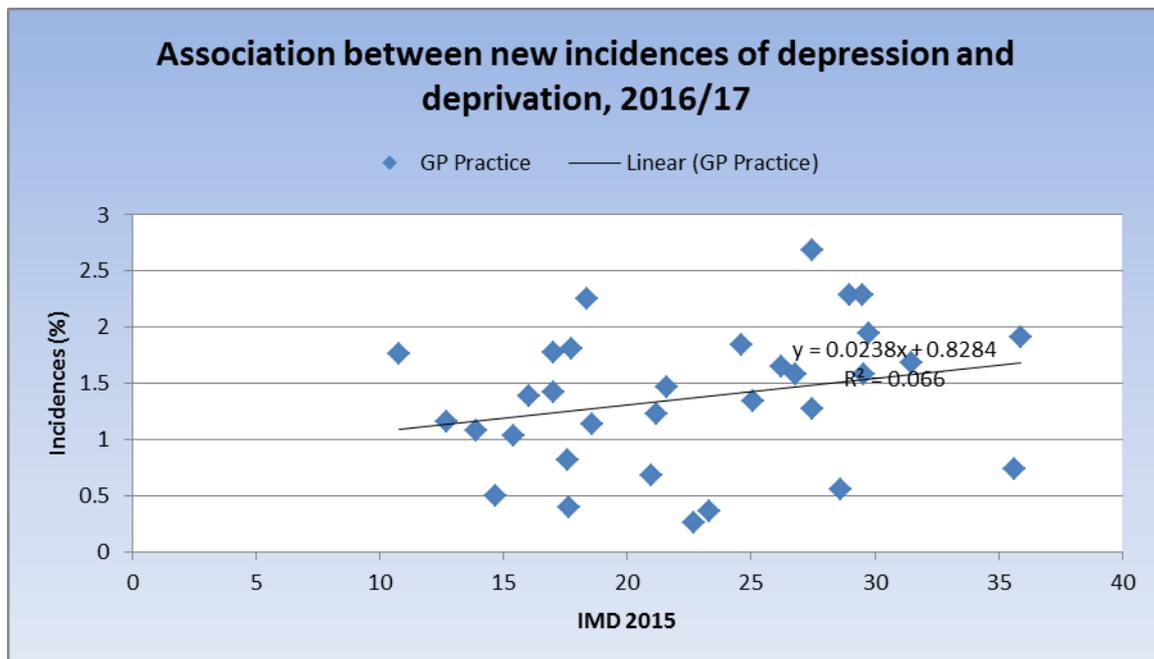
Figure 9: Depression: QOF Incidence of new diagnosis in 18+ year olds, 2016/17



Source: QOF 2016/17

When seeking to understand reasons behind this variation, it was hypothesised that practice-level deprivation may impact upon this. However, it can be seen from the chart below that no association could be seen between new incidences of depression and deprivation at practice level ( $R^2 = 0.07$ ). However, this may be due to diagnosis failures or recording/coding issues.

Figure 10: Association between new incidences of depression and deprivation, 2016/17.



Source: QOF and IMD 2015

## 2.7 The role of Local Area Co-ordinators (LACs)

Local Area Coordinators work with Thurrock residents to prevent them accessing a higher level of support in the future. This could range from signposting to services, or accompanying them to visits until they feel empowered to attend services alone. The local data captured is limited, although work is in process to strengthen the data captured. For 2015/16, the LACs received 1,066 referrals, of which 100 stated mental ill health as the reason for referral.

**Table 3: Age Group of Thurrock Residents accessing LAC support with mental ill health as reason for referral, 2015-16.**

Age group	Number of individuals
18-35 years	20
36-55 years	38
56-75 years	20
76+ years	5
Not known	17
<b>Grand Total</b>	<b>100</b>

Source: Thurrock Council 2015-16.

Of the 100, 29 were referred by Adult Social Care, 27 by Mental Health services and 12 by Housing. The fact that 27% came from Mental Health services indicates that these individuals are already being helped by a service, but that they may need further support than their statutory service can provide.

## 2.8 Recommendations

Modelled data tell us that there is a huge opportunity to identify and diagnose thousands of patients with (CMHDs) in Thurrock. Therefore, Public Health should work in collaboration with primary care and social care colleagues in order to identify those undiagnosed patients with CMHDs. As under-doctoring is a major problem in Thurrock, other healthcare professionals could be useful in assisting with this work.

Working together the public health team, CCG primary care team, CCG medicines management team and GP practices should improve the identification of the many thousands of undiagnosed residents who have common mental health disorders. Strategies to achieve this could include:

- Using community and GP practice pharmacists to support the work to identify undiagnosed depression in the community and in primary care by increasing screening for depression using the PHQ9 depression screening tool.
- Carrying out audits on practice registers to make sure that those prescribed antidepressants for mental health issues i.e. depression, are on the depression register.
- Preparing services/the workforce to increase their capacity in anticipation of an increase in diagnosed mental ill health from population predictions of increases in population sizes. There will also be an increase in diagnosed mental ill health if recommendations are implemented.
- Using modelled data on observed vs estimated prevalence of depression by GP practice to target those practices where more could be done to find and treat patients with undiagnosed depression.

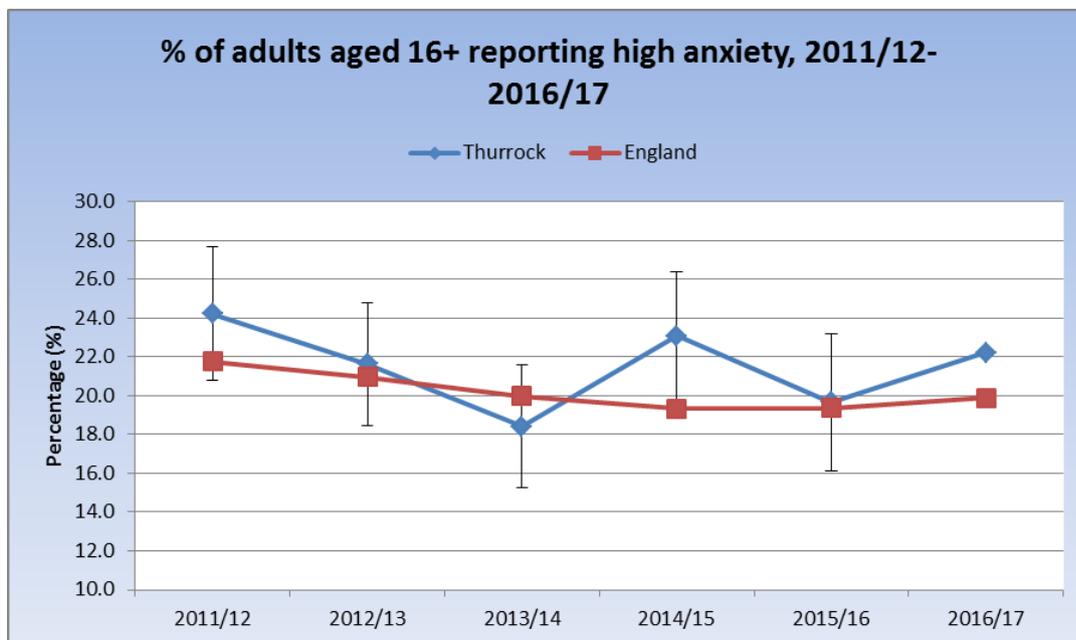
### 3 Who is affected by mental illness? The Trends

#### 3.1 Trends in wellbeing

The Annual Population Survey contains a number of measures relating to personal wellbeing at local authority level. Data from 2016/17 indicates that 22.2% of Thurrock respondents reported themselves as having a high level of anxiety, which is a similar level to the national average of 19.9%.

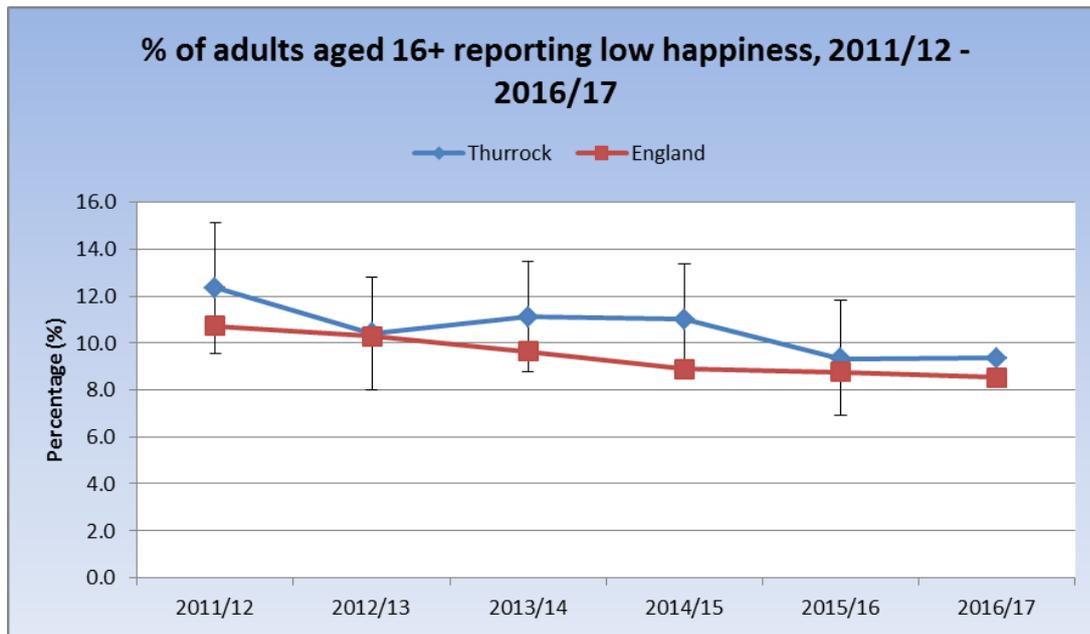
In Thurrock 9.4% of respondents reported having low level of happiness, which was also statistically similar to the national average of 8.5%. Both the measures for anxiety and happiness have remained consistent across surveys since 2011/12, meaning data can be compared to previous years. It can be seen from the figures below (Figure 11 and Figure 12) that, with the exception of anxiety in 2014/15 which was significantly higher in Thurrock than nationally, all values are similar to the national average for all years.

Figure 11: Percentage of adults (aged 16+) reporting high anxiety, 2011/12-2016/17.



Source: ONS

Figure 12: Percentage of adults (aged 16+) reporting low happiness, 2011/12-2015/16.

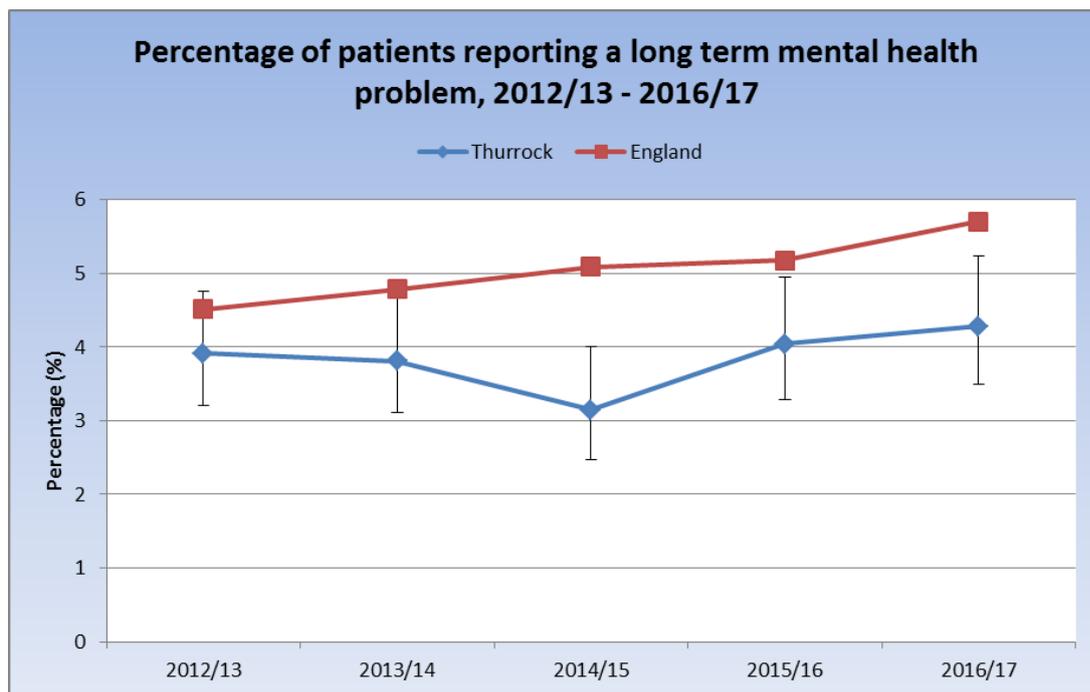


Source: ONS

### 3.2 Self-reported prevalence of mental health conditions

Another possible measure of understanding likely need could come from the GP Patient Survey. Data from 2016/17 found that 4.3% of Thurrock respondents reported to have a long-term mental health problem, which was significantly below the England average was 5.7%. This has been observed for the last few years. The data is also published at GP practice level; however due to the small sample of respondents per practice, the large confidence intervals mean that none were significantly higher or lower than the national average. Association was tested with both IMD and case-finding ratio, but neither were found to be correlated with the variation in mental health problems from the survey. The general trend at national level is upwards and, with some variation, this appears to be the case in Thurrock as well.

Figure 13: % of patients reporting a long-term mental health problem, Thurrock and England, 2012/13 – 2016/17.

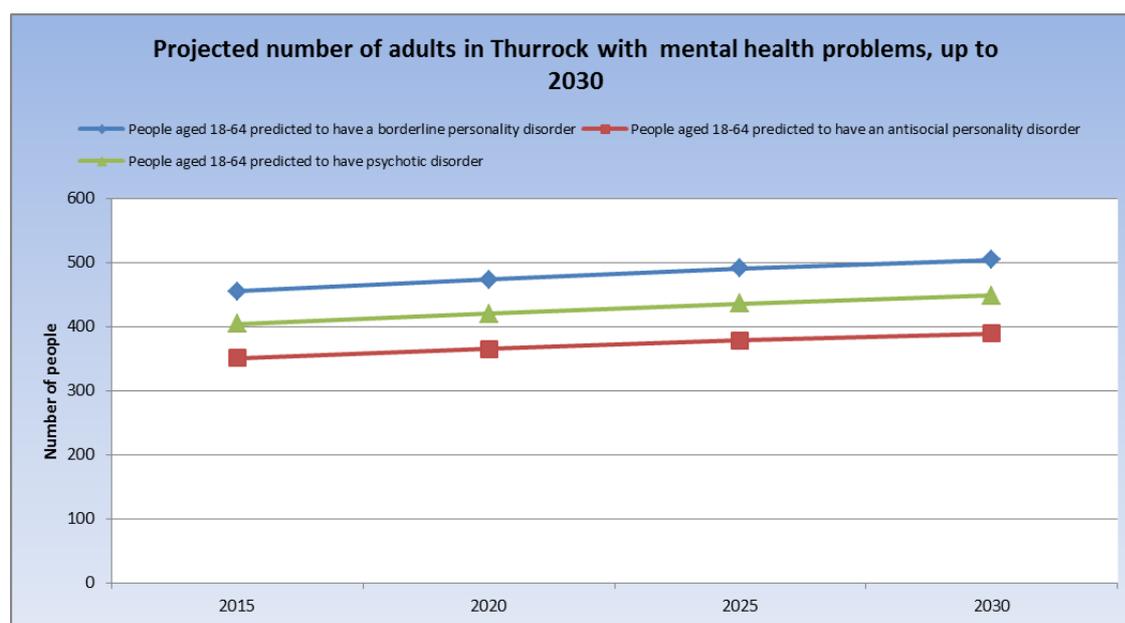


Source: GP Patient Survey

### 3.3 Projections for the number of residents with a mental health condition in future

It is possible to make estimates about future trends in mental health conditions by making assumptions about future population growth and changes in health and wellbeing. Estimates made by the Projecting Adult Needs and Services Information (PANSI) suggest that 16,270 adults aged 18-64 in Thurrock had a common mental health disorder (includes diagnosed and undiagnosed) in 2015. This is projected to increase to 18,029 by 2030 – an increase of 10%. Figure 14 below shows increases for specific conditions – borderline personality disorder, psychotic disorder and anti-social personality disorder. All conditions are projected to increase by around 10% by 2030. All three of these conditions can have serious impacts on wider health and wellbeing also. Someone with borderline personality disorder for example is likely to differ significantly from an average person in terms of their feelings and thoughts towards others, which could result in impulsive behaviour and emotional instability. Someone with psychotic disorder might experience hallucinations or delusions, which again could have a profound impact on their day to day life. And someone with anti-social personality disorder could be at risk of losing control of their temper, potentially leading to dangerous situations for themselves and others.

Figure 14: Projected number of adults in Thurrock with mental health problems, up to 2030.



Source: PANSI

In addition, the number of adults with two or more psychiatric disorders is projected to increase from 7,267 in 2015 to 8,052 by 2030 – an increase of 10.8%. [Calculated using prevalence estimates of 6.9% males having two or more conditions, and 7.5% females]

### 3.4 Projections for the number of residents with depression in future

It is known that older adults are a population group with a higher risk of depression (see section above). The estimates below (Table 4) are national prevalence estimates by age and sex for older people, and it can be seen that older females are particularly at risk. This could be associated with them living alone for longer periods (due to extended life expectancy compared to males).

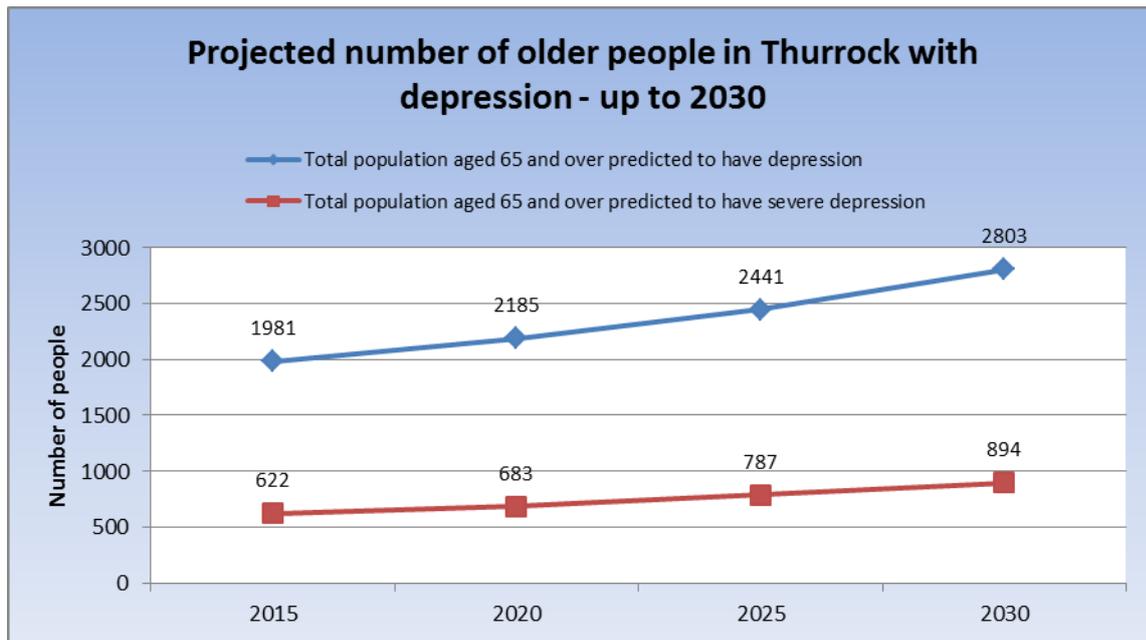
Table 4: National Depression Prevalence estimates by age and sex for older people, 2014.

Age range	% males	% females
65-69	5.8	10.9
70-74	6.9	9.5
75-79	5.9	10.7
80-84	9.7	9.2
85+	5.1	11.1

Source: POPPI (Projecting Older People Population)

Applying these estimates to the Thurrock population, it currently appears that we have 1981 older adults with depression – these could include diagnosed and undiagnosed. This is estimated to increase to 2803 older adults by 2030, which is an increase of 41.5%. Whilst the population projections shown earlier in the document predicts a large increase in older people, this is a faster rate of increase than can just be attributed to population growth. In addition, the number of older adults predicted to have severe depression is set to increase from 622 in 2015 to 894 in 2030 – a rise of 43.7%. These can be seen in Figure 15 below.

Figure 15: Projected number of older people in Thurrock with depression, up to 2030.



Source: POPPI

## 4 Who is affected by mental illness? High Risk Groups

### Key Points

- There are several demographic groups that have been identified as being at increased risk of developing mental ill health
- Deprivation is linked to employment, housing and other predictors of ill mental health
- Some people are at risk of multiple disadvantage, further increasing their risk of ill mental health
- Employment is a protective factor for good mental health and unemployment is predictive of mental ill health

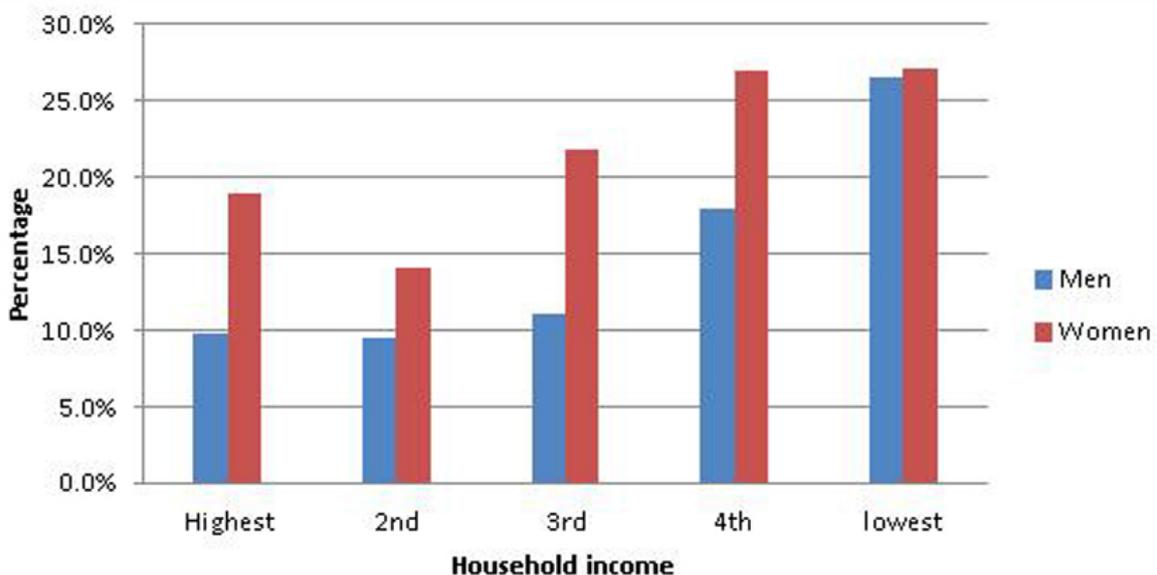
The causes of poor mental health are multifactorial and complex; however there are often specific groups of individuals who may be at an increased risk of experiencing mental health disorders. These include those living in deprivation, individuals who are unemployed, carers, mothers and fathers experiencing perinatal and/or post natal depression, black and minority ethnic groups (BMEs), young men at risk of suicide, those who experience social isolation, LGBT individuals and young women at risk of self-harm, those who misuse substances and those with LTCs and learning disabilities (LDs).

### 4.1 Deprivation

Deprivation can include social exclusion, unemployment (or lack of engagement in meaningful activities), under-employment, low income, homelessness and housing problems.

There is a correlation between household income and the prevalence of common mental health disorders in both men and women. Figure 16 below shows that, as household income rises, the prevalence of common mental health disorders generally falls for both men and women.

Figure 16: Common mental health disorders by household income and gender, 2011.



Source: National Institute for Health and Care Excellence, 2011

Poverty and mental health are considered to interact in an intergenerational cycle (Department for Health, 2011). For example a review conducted in 2010 illustrated a clear relationship between socioeconomic status and mental health difficulties in children and young people. Children living in deprivation are 3 times more likely to experience depression than their more affluent peers (Department for Health, 2011).

In Thurrock in 2014, 13.3% of residents were living in the 20% most deprived wards in England and in 2014 the prevalence of children under 16 living in poverty was 21.2%.

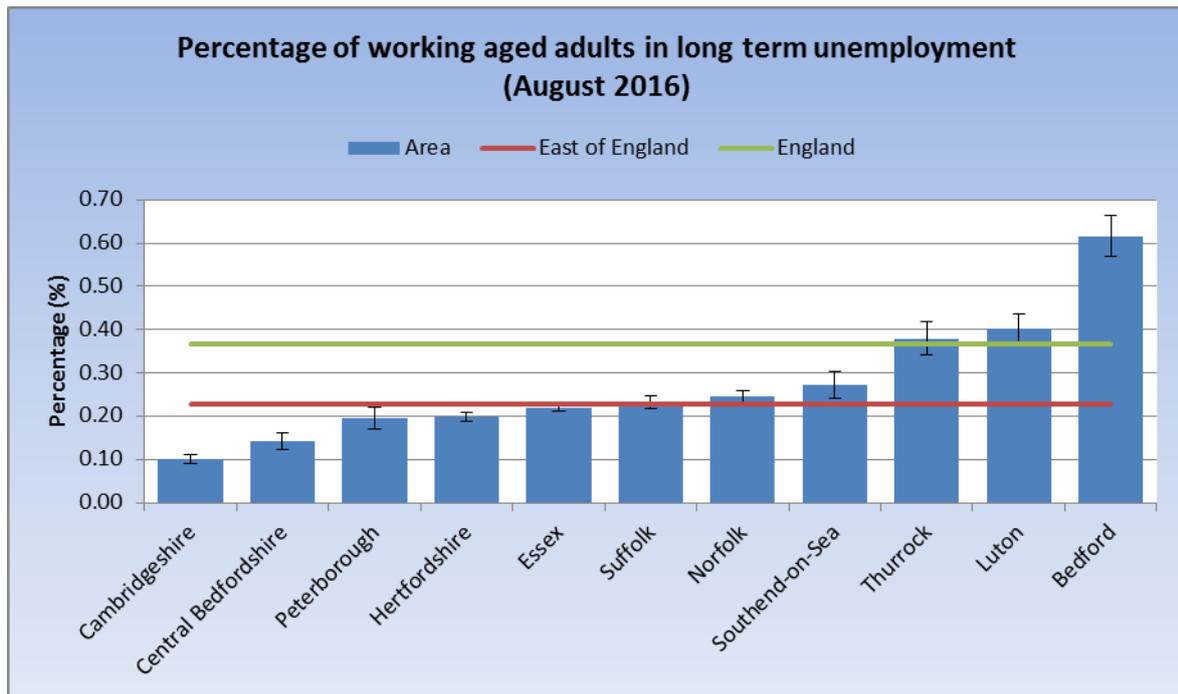
CMHDs are more likely to persist in people in lower socioeconomic groups such as people who are on low incomes, long-term sick or unemployed. The Marmot report, Fair Society, healthy lives (2010) showed that, among other factors, poor housing and unemployment increase the likelihood that people will experience mental health disorders and affect the course of any subsequent recovery. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

## 4.2 Unemployment

Unemployment is closely linked to deprivation. There is evidence to show that being employed is protective of good mental health and wellbeing. The workplace provides important opportunities for building resilience, self-esteem and development of social networks. Unemployed people may feel a lack of purpose as well a lack of social opportunities for development of self-esteem. This can lead to some experiencing mental health disorders such as depression and anxiety. In accordance with a review commissioned by the Health Work and Wellbeing Programme, people in England who are unemployed are between 4 and 10 times more likely to experience depression and/or anxiety. Based on this evidence, employers can play an important role in supporting the health and wellbeing of their employees by providing healthy workplaces which are supportive of their employees' mental health and that are adaptable to meet individuals' health needs to encourage them to remain in employment, a bidirectional relationship, with the Job Centre Plus teams supporting people on ESA back into work.

In 2015 6.9% of people of working age were unemployed in Thurrock. Long Term unemployment can be defined as those of working age claiming a benefit (formerly Job Seekers Allowance) for 12 months or more. In 2016, Thurrock had 0.38% of its working aged population in this position, which when compared to the other LAs in the East of England, shows Thurrock to have the third highest proportion in the region.

Figure 17: Long-term unemployment: % of working age population, 2016.

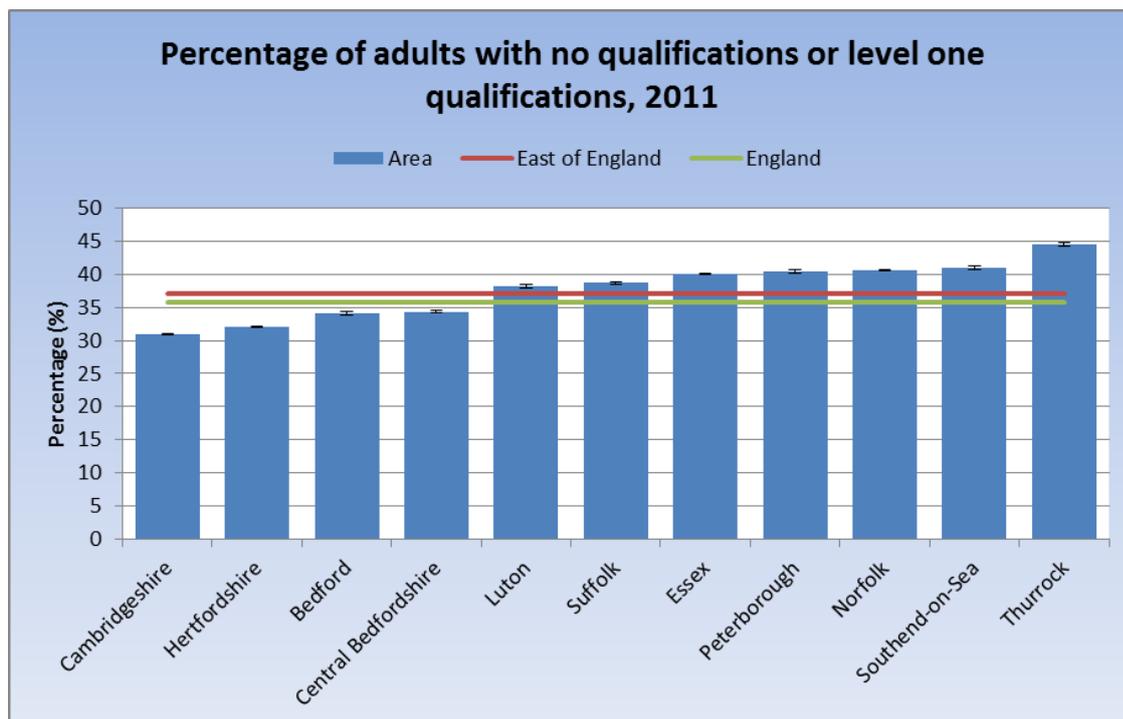


Source: ONS NOMIS/PHE Fingertips

### 4.3 Education

Education is a strong predictor of health; poor education is linked to poorer health outcomes. Almost half of adults in Thurrock have no qualifications or level one qualifications. Thurrock is the worst performer for this indicator in East of England and is also worse than the England average. Educational attainment is strongly linked to income as well as deprivation levels therefore this indicator may be a strong predictor for mental ill health in Thurrock.

Figure 18: Adults with low education: % of adults that have no qualifications or level one qualifications (2011).



Source: PHE Fingertips, 2011 data

#### 4.4 Carers

Caring for a family member with a health condition can impact on the mental health of the person who is providing care. This can lead to carers suffering from emotional distress or stress in general. This in turn increases the risk of poor physical health. Carers may not be able to find time to undertake healthy behavioural practices such as eating healthily, or exercising regularly due to their felt need to prioritise the care of their loved one. Factors that impact on carer's mental health and wellbeing, based on self-reports within the UK Carers' survey (2015) included inability to get a good night's sleep (74% of those surveyed reported this). Nearly 50% of participants reported that they find it hard to maintain a balanced diet. Additionally, 78% reported experiencing anxiety and 55% reported suffering from depression. (Carers UK, 2015). If carers' are experiencing poor mental health this is likely to impact on their ability to care for their loved ones and could create a cycle of poor mental or physical health outcomes for both individuals. Within Thurrock there is a prevalence of 2.42% of unpaid carers (Public Health England, 2011-16). Therefore, providing appropriate support at the right time is vital to ensuring that the health of carers is not adversely affected by their caring responsibilities.

#### 4.5 Perinatal/postnatal depression (affecting mothers and fathers)

Suicide is the second leading cause of maternal death and may be due to women experiencing undiagnosed/untreated perinatal depression (Mental Health Taskforce, 2016 and WHO, 2018).

For mothers who experience perinatal mental health during pregnancy, there is an increased risk of poor pregnancy outcomes as well as neurodevelopmental difficulties for the child both before and after birth. Additionally, mothers who experience postnatal depression may struggle to care for both themselves and their child which increases the risk of the child experiencing adverse outcomes and is linked to a five-fold increased risk of them developing a mental health condition later in life. Conversely, positive relationships between a child and their father are correlated with positive outcomes for the child (COI, 2011).

#### **4.6 Black and Minority and Ethnic (BME) Groups**

BME groups are much less likely to, or may be excluded from accessing services in relation to their mental health and wellbeing. (McManus et al 2016). Thurrock has a diverse range of ethnic groups within its population. This group is of relevance in Thurrock because we know that it has grown in size between the 2001 and 2011 census, as discussed in section 3 of this document.

Based on the growing number of people from BME groups who reside in Thurrock there is a need to examine the underlying reasons why this group are not accessing support around their mental health, with the aim of encouraging such individuals to seek and access treatment. Understanding the barriers will support professionals to develop more effective pathways to access, with the aim of reducing health inequalities and enhancing good mental health and wellbeing for this subgroup of the population.

#### **4.7 Those “At Risk” of Suicide**

The suicide rate for men is higher than the rate for females (HM Government et al, 2012). This is evident in Thurrock with men being three times more likely to commit suicide than women. Between 2013-15 the age standardised suicide rate for males was 15.7 per 100,000 whereas data could not be calculated for females as the number was too low. (Public Health England, 2013-15). This could be related to the fact that fewer men are receiving treatment for CMHDs than their female counterparts. This creates missed opportunities for diagnosis and treatment. Furthermore, men are less likely to report previous suicide attempts than women (McManus, et al 2016). Similarly, in relation to self-harming behaviours in 2014, only 8% of men aged between 16-24 years reported that they had self-harmed at one point in their lives compared to 20% of women of the same age. Data for the prevalence of self-harming behaviours in Thurrock is not clearly known due to miscoding issues in secondary care (see section 8.4). McManus, et al (2016) suggest that for individuals who engage in self-harming behaviours from a young age, there is a greater tendency for this to become embedded as a long term coping strategy. Additionally, for those who exhibit greater levels of self-harming behaviours there is the increased risk that this may lead to suicidal behaviours.

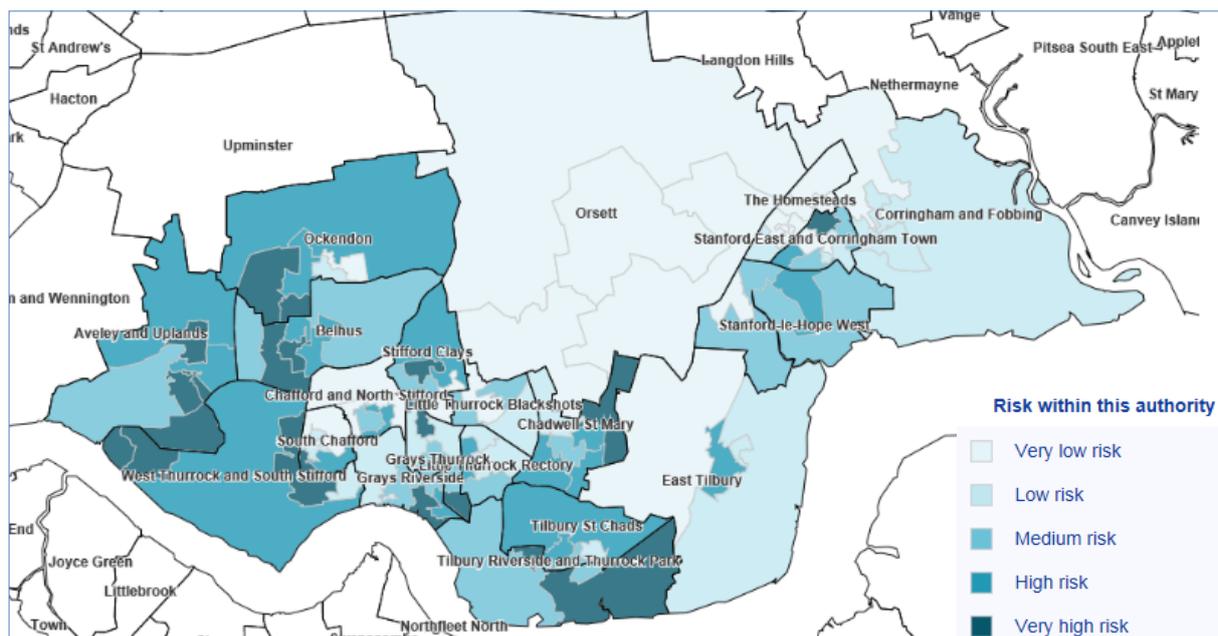
#### **4.8 Those living in Loneliness and Social isolation (especially those aged 65+)**

There are strong links between the older community and depression. It has been stated that about 40% of older people living in nursing/care services suffer depression in comparison to those living in their own homes with contact maintained with their families (Mental Health Taskforce, 2016). Living in a nursing home away from family and in some cases far from home seems to have an impact on older people. It can lead to them experiencing social isolation which in turn can lead to depression. The No Health without Mental Health report (COI, 2011) found that older people's needs are often neglected with older people not seeking treatment. Difficulties may also be related to access issues. As Thurrock has a growing older population, services targeted to this cohort need to be

implemented to support the older residents within the borough to maintain healthier lives for longer in line with Thurrock's Health and Wellbeing Strategy (Thurrock Council, 2016-21). In addition, developing interventions and services aimed at this population group should ensure more effective support for the future and create more cohesive communities.

Within Thurrock, we are aware of parts of the borough where it is more likely that the older residents there will feel lonely. Age UK have produced a map at LSOA level, ranking the risk of loneliness across the country. It can be seen from Map 1 below that parts of Tilbury Riverside, West Thurrock, Belhus, Ockendon, Grays, Chadwell and Corringham all have pockets where residents are deemed to be at high risk of loneliness.

**Map 1: Depiction of parts of Thurrock by relative risk of older people likely to feel loneliness.**

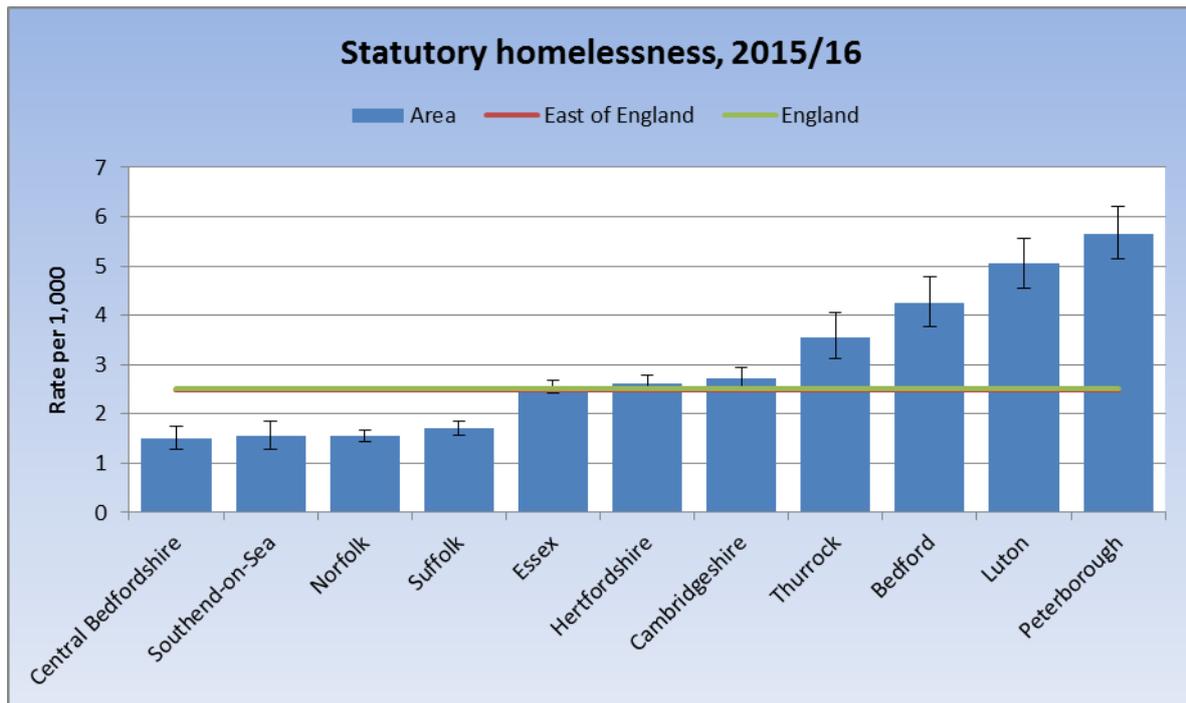


Source: Age UK

#### 4.9 Those who experience housing problems or are homeless

There is evidence to show that mental health disorders are more common among homeless and vulnerably housed people than in the general population. In several cases, mental health disorders play a significant part in the circumstances that cause people to lose their accommodation. The mental health disorder may then be exacerbated by the stresses associated with being homeless, which in turn will make it even harder for the person to achieve stability in their housing (NICE 2011). Studies suggest that although the largest group of homeless people are white men, the proportion of homeless people with a mental health disorder who come from black and minority ethnic groups is disproportionate in relation to their proportion in the general population.

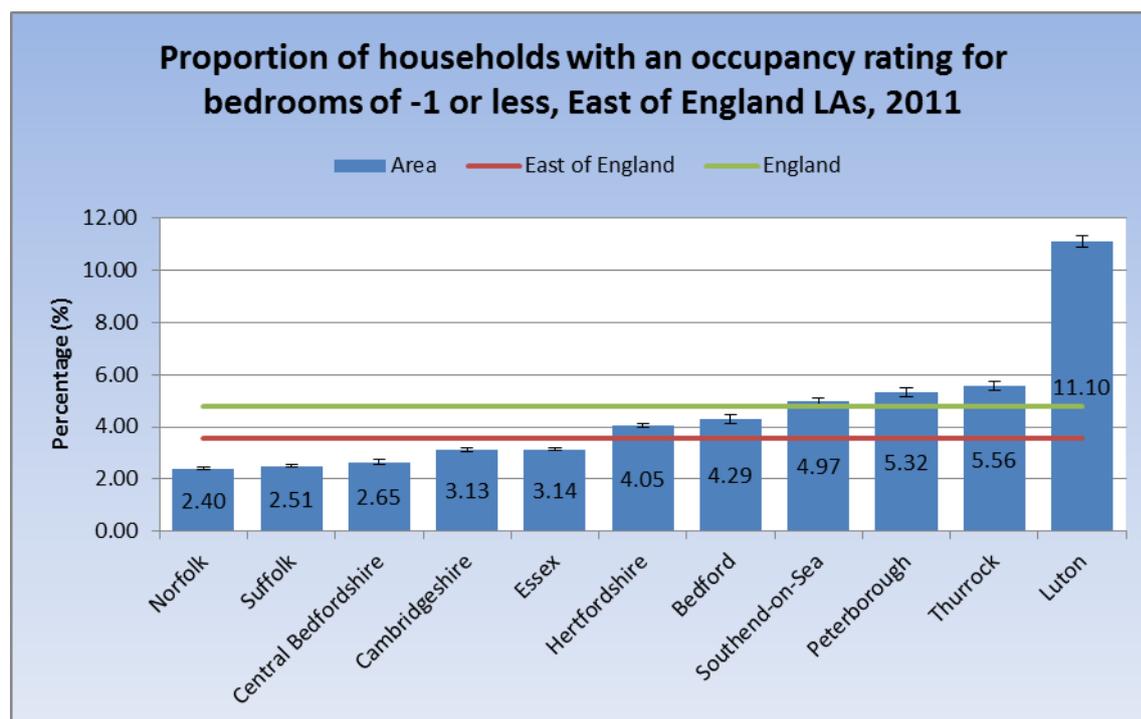
Figure 19: Statutory Homelessness – Rate per 1000 households, 2015/16.



Source: Department for Communities and Local Government

The chart above shows that Thurrock had the fourth-highest rate of statutory homelessness in the East of England region, in 2015/16. Statutory homelessness can be defined in various ways and does not mean that people are sleeping on the street, as this is only one type of homelessness. In 2015/16 the statutory homelessness rate within Thurrock was 3.6 per 1000 households which is higher than both the regional and national averages. People who are homeless are between 40-50 times more likely to experience poor mental health than the general population, as well as 40 times less likely to be registered with a GP which creates issues in relation to access to services and care, including A+E attendance at a cost to the NHS (COI, 2011). Based on this promotion of re-housing services that incorporate a holistic approach such as Housing First need to be prioritised, to reduce health inequalities and promote access to services for this population. In turn this will reduce the number of individuals within this subgroup attending A+E which places a burden on the NHS and will increase access to appropriate community based services. In Thurrock this action is supported by the objectives set out in Thurrock’s Health and Wellbeing strategy in relation to goals C, D and E, better health and wellbeing, quality care centred around the person and healthier lives for longer respectively (Thurrock HWB Strategy, 2016-21).

Figure 20: Household overcrowding: % of households with occupancy rating for bedrooms of -1 or less.



Source: Census 2011

The chart above shows the proportion of households with occupancy rating for bedrooms of -1 or less expressed as a percentage of all households. An occupancy rating of -1 implies that a household has one fewer bedrooms than the standard requirement. The chart shows that Thurrock has the 2<sup>nd</sup> highest proportion of such households, compared to other areas in the East of England.

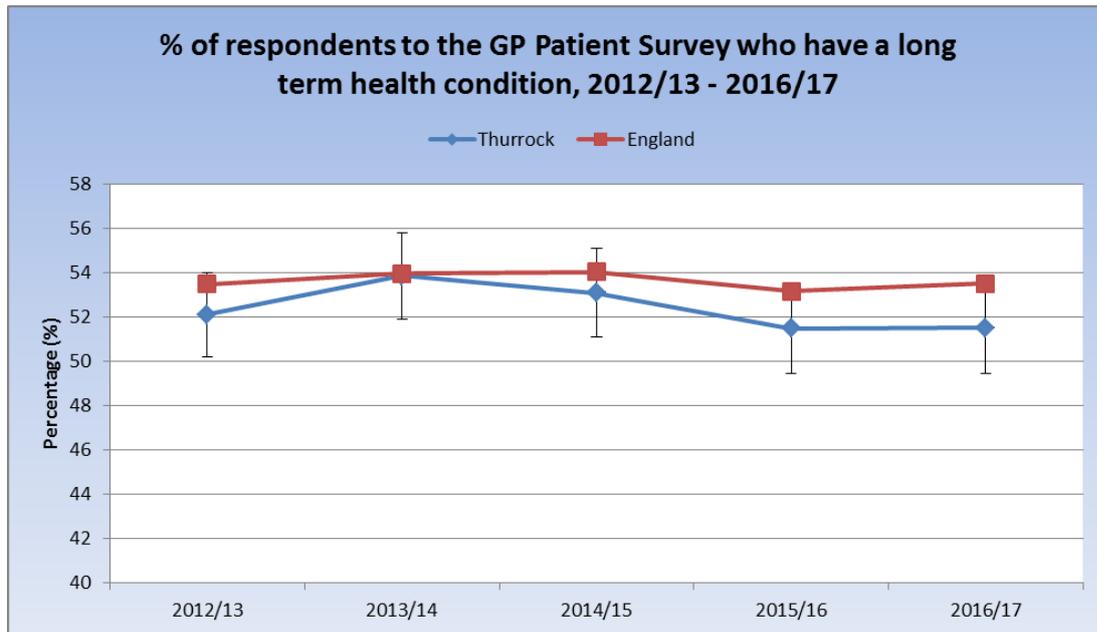
#### 4.10 Those with Long Term Conditions (LTCs)

There are clear links between physical and mental health and there are shared risk factors for physical and mental illnesses. People with physical illnesses frequently present with both psychological and physical symptoms. Being physically ill, particularly with Long Term Conditions and disability, often affects mental health negatively.

People with two or more long-term conditions, such as cardiovascular disease or diabetes, are seven times more likely to have comorbid depression than those without long-term conditions. Depression has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for.

There is also evidence that people with mental health problems smoke much more than the rest of the population, consuming 42% of all cigarettes smoked in England. This increases their risk of developing chronic physical health problems, such as chronic obstructive pulmonary disease (COPD), which in turn increases their risk of developing depression or anxiety. Studies show that a significant proportion of people with COPD have depression or anxiety.

Figure 21: Long-term conditions or disability: % of people who report to have a long term health condition, 2012/13 – 2016/17



Source: GP Patient Survey

The chart above indicates that just over half of the respondents to the GP Patient Survey state that they have a long term health condition, which is similar to the national average. Whilst the survey sample can be viewed as selective (as patients with more regular access to their GP might be more likely to return it), it gives an indication that there are a large number of residents in Thurrock with long term conditions.

More information on the overlap between mental health and LTCs is found below (Section 5.1)

#### 4.11 Recommendations

The social patterning of mental illness creates an opportunity for prevention and treatment to be targeted at those most at risk. Thurrock's strong community development work programme, including Local Area Coordinators, is a good example of preventative work, building on community assets and creating social connections which protect against poor mental health.

There is scope for case-finding and support work to be better targeted through:

- Health professionals in primary care reviewing patients with Long Term Conditions on a regular basis using the NICE approved PHQ9 questionnaire which screens for common mental health disorders (anxiety and depression).
- The roll out of social prescribing across the Borough but focussing on areas of highest deprivation.

## 5 What are the causes and consequences of mental illness?

### Key Points

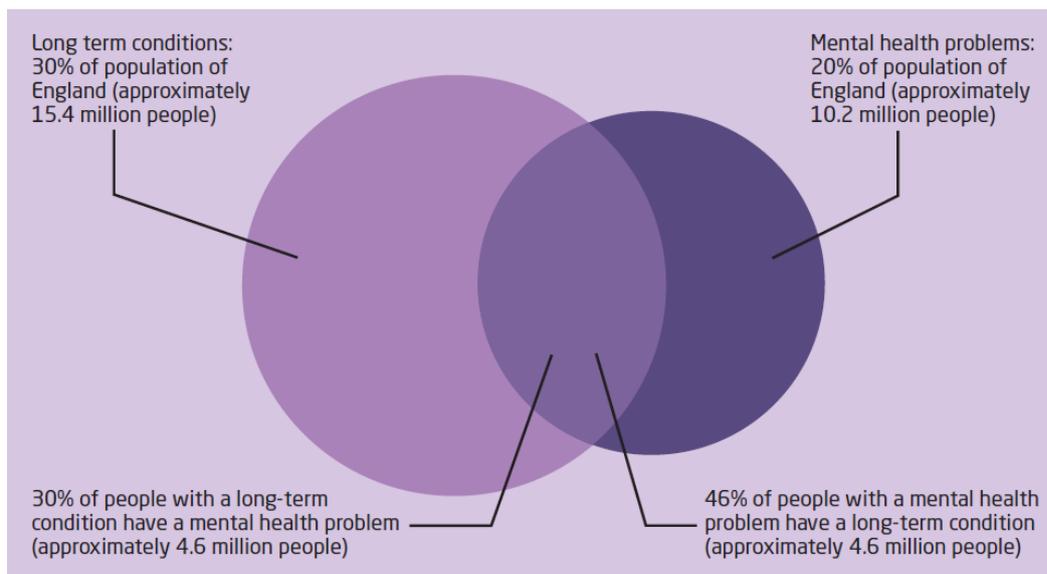
- Mental illness interacts in complex ways with physical health conditions and health-related behaviours.
- CMHDs are strongly linked with obesity, substance misuse and LTCs.
- It is estimated that by 2026 up to a third of those diagnosed with depression will also be obese.
- In Thurrock the smoking prevalence of adults with an SMI is 45.5%.
- 30% of people with a physical LTC also had a CMHD, whilst 40% of those with CMHD had a physical LTC.
- In 2010 the DH estimated that between £8-13billion of NHS spend in England is attributable to comorbid CMHDs with LTCs.

Mental health interacts with physical health and health-related behaviours, such as smoking, in complex ways which may reinforce one another. Poor physical health can increase the risk of mental illness, such as depression, while being depressed may also make physical health worse. This can create a vicious cycle. Conversely, it is possible for a virtuous cycle to be created through interventions and services which address both physical and mental health. Some of the key links to physical health and health-related behaviour are explored below.

### 5.1 Mental Ill Health, Long Term Conditions (LTCs) and Learning Disabilities (LDs)

The Department of Health estimates that long-term conditions account for around 70 per cent of total health spending (Department of Health, 2010). After subtracting expenditure on research and training, this means that between £8 billion and £13 billion of NHS spending in England is attributable to co-morbid mental health problems among people with long-term conditions. Evidence suggests that between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions. Costs of mental health to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem (Naylor et al, 2012). Putting this in terms of individual patient costs, the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year.

Figure 22: The overlap between LTCs and MH problems in England, 2012.



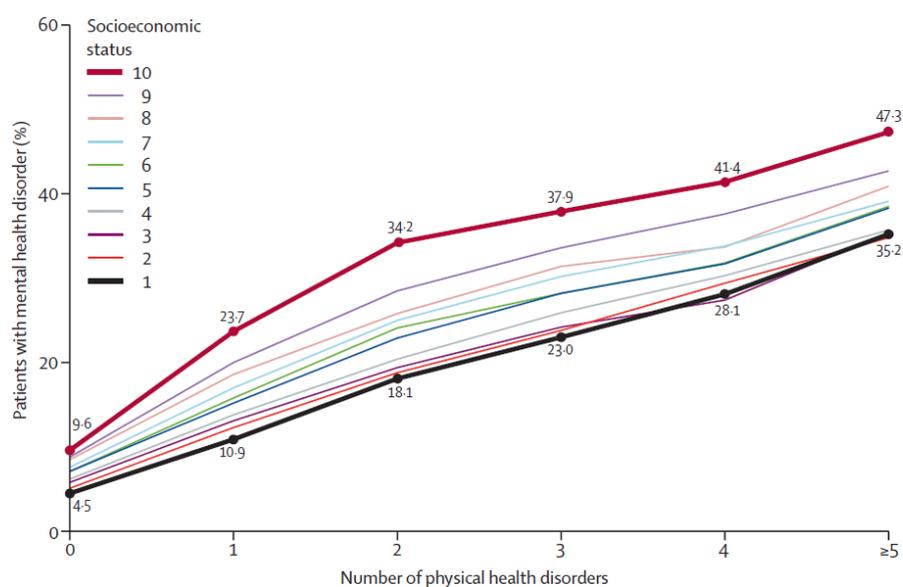
Source: Naylor et al, 2012

Co-morbid mental health problems are particularly common among people with multiple long-term conditions. Data from the World Health Surveys indicate that people with two or more long-term conditions are seven times more likely to have depression than people without a long-term condition (Moussavi *et al* 2007). A 2012 report by The King's Fund found that 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health problem (Naylor et al, 2012).

Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively. A significant part of the explanation for poorer clinical outcomes is that co-morbid mental health problems can reduce a person's ability to actively manage their own physical condition and are associated with unhealthy behaviours such as smoking. Self-management is at the core of effective treatment for long-term conditions – but this is impeded significantly by poor mental health, which can reduce the motivation and energy needed for self-management, and lead to poorer adherence to treatment plans (DiMatteo *et al* 2000).

The figure below shows the relationship between mental health and physical health co-morbidity (Barnett et al, 2012). As the number of physical health disorders increases, so does the proportion of patients with MH problems.

**Figure 23: Relationship between mental health and physical co-morbidity, 2012.**



The strong relationship between mental health and LTCs suggests that care for large numbers of people with LTCs could be improved by the better integration of MH support with primary care LTC management programmes. The challenge is to integrate interventions for MH within physical health management protocols rather than merely overlaying MH interventions on top of existing protocols.

An estimate of the number of people affected by both mental health problems and LTCs in Thurrock is given below in Table 5:

**Table 5: Numbers affected by LTCs and MH in Thurrock, 2017.**

Thurrock parameters	Numbers (nearest 100)
Population (all age)	173,400
Long-term condition (30%)	52,000
Mental health problem (20%)	34,700
30% of people with a LTC also have a MH problem	15,600
46% of people with a MH problem also have a LTC	16,000

Population source = registered population 01.01.17 (NHS digital)

### **Depression Screening**

Screening to detect depression in patients with LTC is recommended by NICE. However, depression screening alone is not enough. Screening must be linked to effective treatment services and must ideally be done in conjunction with new approaches to LTC management. For example, Katon et al (2010) found improved outcomes over usual care in the control of LTC and depression in an intervention which involved a nurse who provided guideline-based patient-centred management of depression and the chronic disease(s).

The purpose of depression screening in patients with one or more long-term conditions is to achieve:

- Better management of the LTC(s),
- Earlier identification and management of MH problems,
- Better quality of life (physical and mental health outcomes),
- Increase in life expectancy.

## 5.2 Mental Ill Health and Obesity in England

The connection between obesity and common mental health disorders is an important public health issue. Current research suggests that obesity is more prevalent among adults with serious mental illnesses (SMIs) than those in the general population (Bradshaw et al 2014; Compton et al, 2006). Both these conditions have major implications for the UK health care system and account for a significant proportion of the global burden of disease (World Federation for Mental Health, 2010). Individuals who suffer from both obesity and common mental health disorders may also face particular risks to health and well-being, as people with mental disorders are more vulnerable to the health risks associated with obesity such as type 2 diabetes, heart disease, stroke, high blood pressure, high cholesterol, and premature death (De Hert et al, 2011; Markowitz et al, 2008).

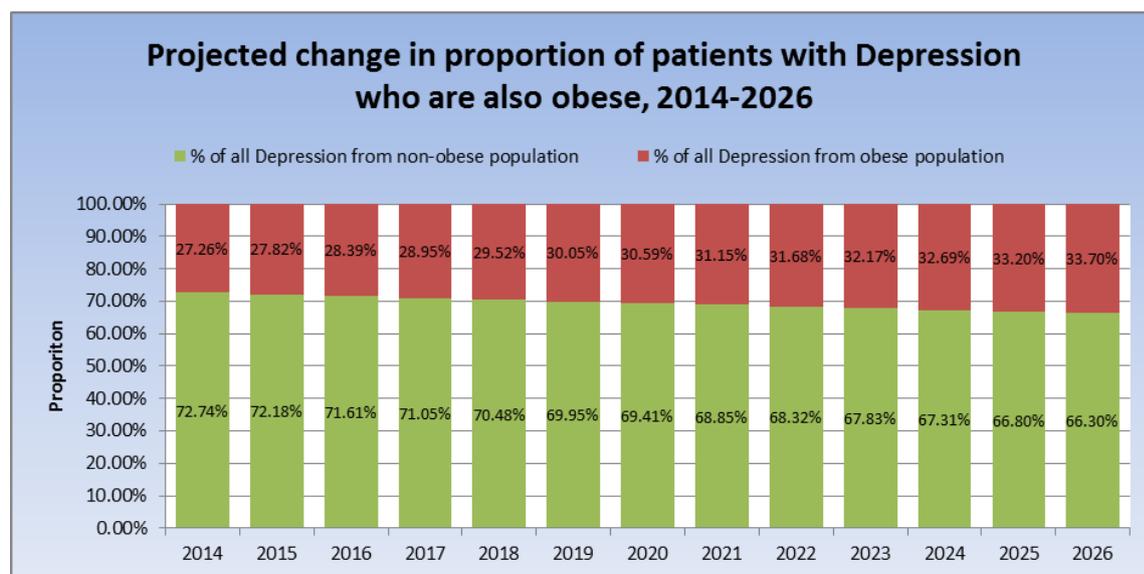
Research studies around the world are providing evidence of the bi-directional associations between depression and obesity. Luppino et al (2010), concluded that 'obese persons had a 55% increased risk of developing depression over time, whereas depressed persons had a 58% increased risk of becoming obese'. It has been suggested that poor mental health can lead to unhealthy lifestyle choices and increased appetite. A combination of the biological effect of increased stress alongside poor adherence to weight loss programmes, binge eating, negative thoughts and reduced social support, may make it difficult for a depressed person to avoid weight gain (Markowitz et al, 2008). There is also evidence that people with chronic or repeated episodes of depression are a particular risk of subsequent obesity (Kivimaki et al, 2009).

The bi-directional association between obesity and common mental health disorders is complex and multi-factorial. Gender, severity of obesity, socioeconomic status and level of education, age and ethnicity have all been suggested as potentially important risk factors that could affect the direction and/or strength of the association between the two conditions. There is also a wide range of behavioural, biological, social and psychological moderating factors that could help explain the relationship (Gatineau et al, 2011).

It has been recommended that the risk for co-morbidity should be considered in the treatment of the obese and depressed, with care providers made aware that in depressive patients, weight should be monitored and in overweight or obese patients, mood should be monitored (al, 2010; Luppino et al, 2010). Also strategies to enhance self-worth and develop self-efficacy can help overweight patients to take control of their well-being (Gatineau et al 2011).

Although there are no published local estimates of those with poor mental health and obesity, some modelled estimates have been produced with the support of Norfolk County Council. This estimates that as of 2016, approximately 28.4% of those on the depression register are also likely to be obese. Projecting this forward, it is likely that, if the current obesity trends continue, the proportion of patients with depression and obesity will increase, with an estimated 33.7% of them by 2026. This can be seen in Figure 24 below.

Figure 24: Projected change in proportion of patients with Depression who are also obese, 2014-2026.



Source: ONS, Foresight report, and Norfolk County Council

Estimates are also available for other mental health conditions and obesity. These can be seen in Table 6 below, along with the estimated additional number of mental health patients with obesity over the 10 year period.

Table 6: Percentage of patients estimated to be obese and experiencing a CMHD in 2016-2026.

	% patients estimated to be obese in 2016	% patients estimated to be obese in 2026	Additional Number of Obese patients
<b>Neurotic Disorder</b>	28.3%	33.5%	2000
<b>Personality Disorder</b>	28.5%	34.1%	555
<b>Psychotic Disorder</b>	28.5%	33.9%	69
<b>Dementia</b>	28 %	32.7%	211

Source: ONS, Foresight report, and Norfolk County Council

The impact of increased numbers of patients with mental health conditions who are also obese will increase the health and social care costs, with obese patients estimated to have approximately 30% higher medical costs than non-obese patients<sup>i</sup>. Research by Public Health England (2016)<sup>ii</sup> also found that severely obese people are over 3 times more likely to require social care than those of a normal weight, with examples of requirements including housing adaptations, carers or provision of appropriate transport and facilities. The same research also showed that obesity reduces life expectancy by an average of 3 years, and severe obesity could reduce life expectancy by an average of 8-10 years.

Average treatment costs for all of the above mental health conditions were difficult to source in the literature. However, an approximation of the increased cost impact can be made for psychotic disorder. Using the above assumption of a 30% increase in treatment costs for obese psychotic patients, and an average annual treatment cost of £8,250 per patient<sup>iii</sup>, an additional 69 obese psychotic patients could increase costs from £569,250 [standard treatment costs] to £740,025 [treatment costs including the additional impact of obesity].

### 5.3 Poor Mental Health and Substance Misuse

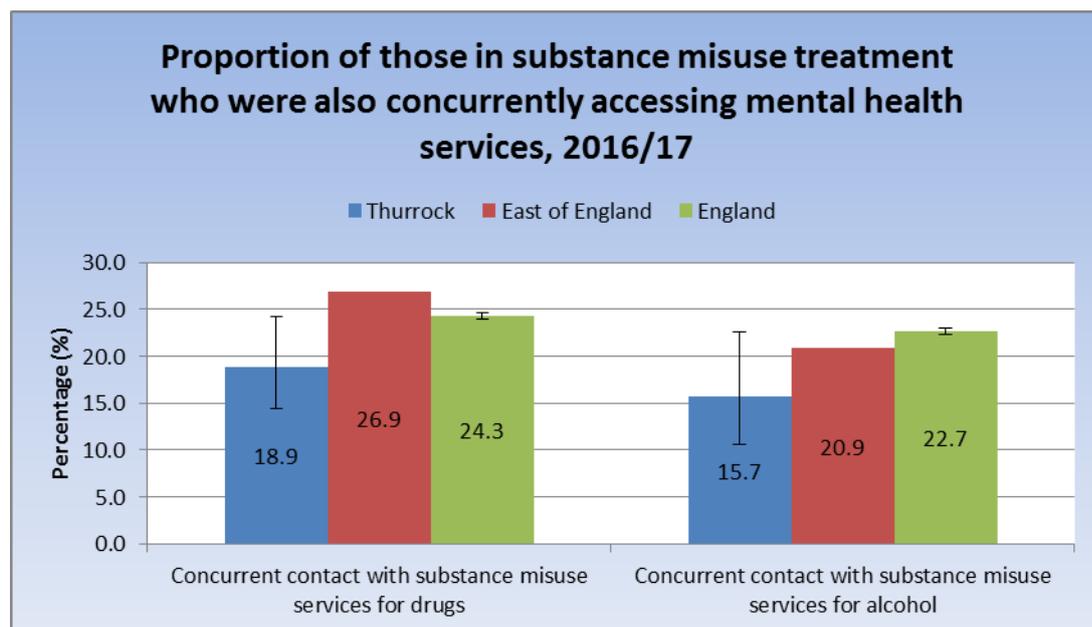
It has been shown in various studies that large proportions of people with substance misuse problems also experience major depression and other common mental health disorders. Heavy use of alcohol or illicit substances can cause symptoms of depression. Conversely, some individuals with depression misuse substances as a coping mechanism.

#### Drugs and Alcohol

Drug misuse and drug dependence are more prevalent in adults with various psychiatric problems, from common mental disorders to personality disorders and severe psychotic illness (Coulthard et al. 2002; CMH et al. 2011) The 2002 Comorbidity of Substance Misuse and Mental Illness Collaborative study concluded that 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems (Weaver et al 2003)

The number of admissions to NHS hospitals with a primary diagnosis of drug-related mental health or behavioural disorder has risen since 2012/13 but is still lower than ten years ago; in 2013/14 there were 7,104 (HSCIC, 2014). This is an 8.5% (555) increase from 2012/13 when there were 6,549 such admissions. Overall, however, between 2003/04 and 2013/14 admissions have decreased by 11% (Roberts et al, 2016).

**Figure 25: Proportion of those in substance misuse treatment who were also concurrently accessing mental health services, 2016/17.**



Source: Public Health England 2016/17

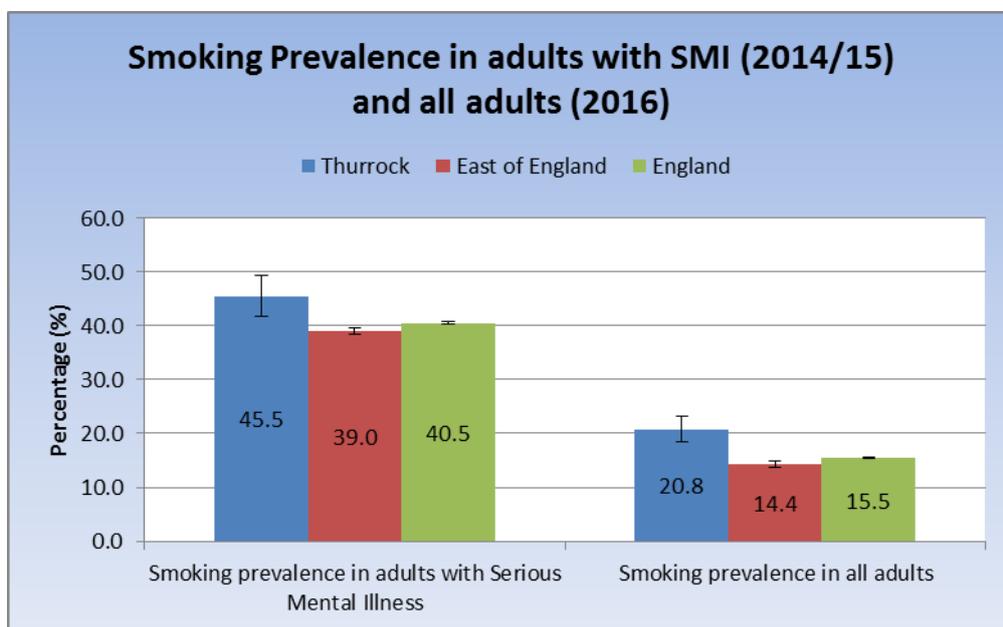
Figure 25 above shows the level of concurrent contact with mental health services and substance misuse services for drug and alcohol misuse respectively. The concurrent contact with mental health services and substance misuse services for drug misuse in Thurrock (18.9%) was below the national average (24.3%), and for alcohol misuse, Thurrock (15.7%) was similar to the national average of 22.7% (significance could not be calculated against regional values). Putting this another way, around one in six of those accessing alcohol treatment, and almost one in five of those accessing drug treatment are also accessing mental health services for support.

The Thurrock Drug and Alcohol Action Team (DAAT), reporting to the Health and Wellbeing Board and the Thurrock Community Safety Partnership Strategic Board, commissions a range of local treatment services in response to the harms caused by drugs and alcohol.

### Smoking

It is known that there is a higher prevalence of smoking in those with a serious mental health condition than the wider population. This can be seen in Figure 26 below for Thurrock, East of England and England, where the prevalence in those with serious mental ill-health is approximately double that of those without - 45.5% of Thurrock residents with a serious mental health condition were smokers, compared to 20.8% of all adults. In addition, smoking prevalence in adults with serious mental illness in Thurrock (45.5%) is significantly higher than the national (40.5%) and regional average (39.0%).

**Figure 26: Smoking Prevalence in adults with SMI and all adults, 2014-15 and 2016.**



Source: Public Health England 2014/15

### E-cigarettes

Abstinence from smoking is always the best option. Inhaling nicotine and water vapour produced by electronic cigarettes, commonly referred to as e-cigs, offer an enormous harm-reduction opportunity for smokers who wish to reduce the amount of combustible tobacco cigarettes they smoke or quit smoking completely. ASH recently stated that there are now 2.9 million e-cig users in the UK and of these just over half, 1.5 million, no longer smoke cigarettes. Public Health England has endorsed the evidence that shows these devices are 95% safer than combustible tobacco cigarettes.

There is considerable debate about the use of e-cigarettes in healthcare settings. Some health and mental health trusts permit vaping on their grounds and in single occupancy rooms whereas others still hold a level of scepticism towards e-cigs and ban them, treating them the same as combustible tobacco cigarettes.

Given the high prevalence of smoking rates across people who suffer from mental ill health these devices offer a real opportunity to significantly improve the health of this population, increasing life expectancy and typically halving the amount of medication patients require, which is better for the

patient and saves money for the health sector (ASH Briefing: Health inequalities and smoking, June 2016 & NCSCT Briefing 10: Stop Smoking Services and Health Inequalities, 2013).

#### 5.4 Recommendation

- Strong connections between long-term conditions and mental illness need to be recognised in the organisation and integration of services. There is a huge opportunity for mutual benefits to be realised by offering integrated physical and mental health care. The new model of care being developed and implemented in Thurrock presents a huge opportunity to create a health and social care system which addresses physical and mental health issues together.

## 6 What services are provided for those with mental illness? Primary Care

### Key Points

- There are a large number of newly diagnosed patients who are not receiving the appropriate review 10-56 days after diagnosis.
- There is widespread variation at GP practice level in care and treatment for serious mental illnesses (SMIs).
- Two thirds of those referred into IAPT services are women
- There appears to be no association between deprivation, depression prevalence and referral into IAPT services.
- The number of antidepressants prescribed has increased over the last four years although the total cost has decreased.
- Both the number and cost of drugs prescribed for serious mental illness have decreased over the last four years, with the largest reductions seen in the cost of antipsychotic drugs.
- The percentage change in items and costs for both antidepressants and SMI drugs over the last four years vary considerably across GP practices.

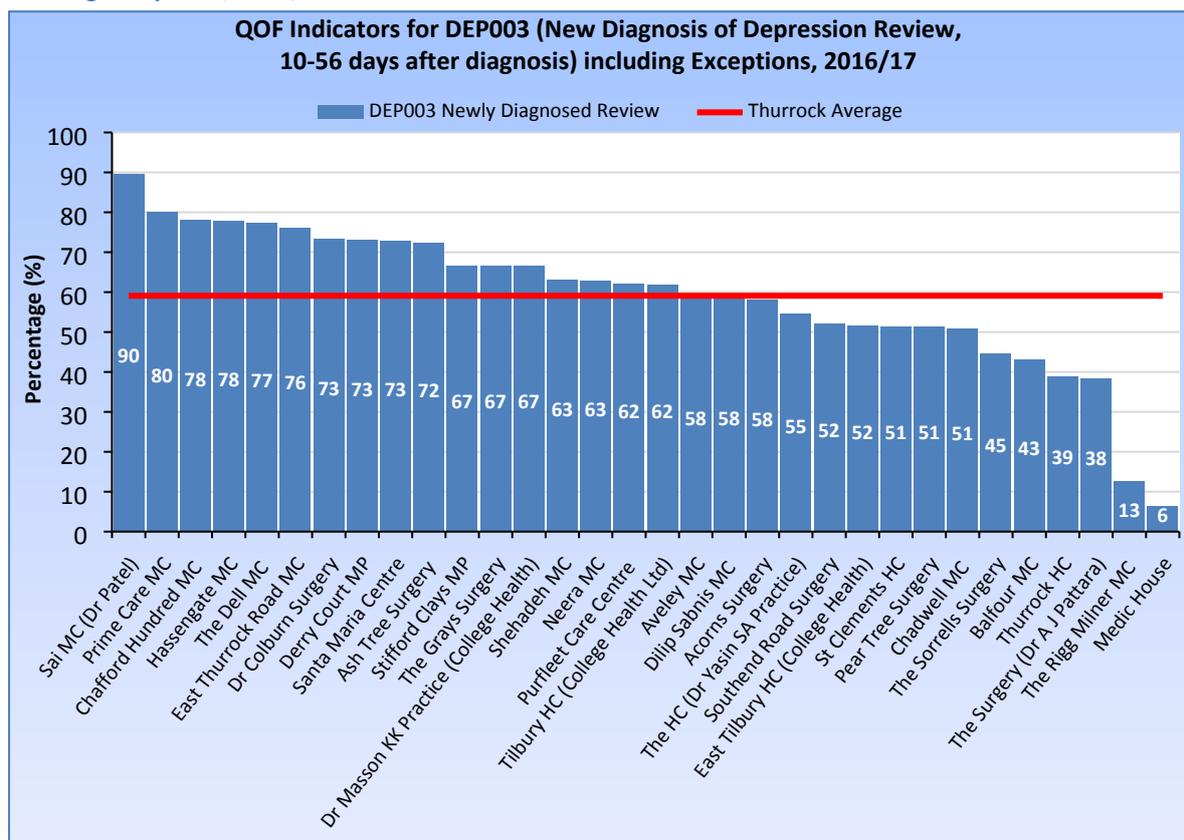
The majority of treatment for mental illness occurs in primary care which, for the purpose of this report, includes GP practices and IAPT (Increasing Access to Psychological Therapies) services, which offer access to talking therapies in the community.

### 6.1 Management of Depression in Primary Care

A number of care standards and targets are set out for GPs as part of the Quality Outcomes Framework (QOF) which forms an essential part of GP payment calculations. As well as recording patients diagnosed with depression and serious mental health conditions on QOF prevalence registers, QOF sets out a number of key care processes for GPs to follow. For example, Figure 27 below shows the variation by GP in achievement of QOF points for patients with a new diagnosis of depression receiving a review 10-56 day after diagnosis. Whilst the Thurrock average is 59%, achievement appears to range from 90% to 6%.

Translating this to numbers, it means that in 2016/17, 742 patients newly diagnosed with depression did not receive their review within 10-56 days post-diagnosis (this includes some who were exception reported). Work is currently in process to explore the possibility for a 'stretched QOF' in order to incentivise GPs to identify and review more of these patients.

Figure 27: QOF indicators for DEP003 (new diagnosis of depression review 10-56 days after diagnosis) including Exceptions, 2016/17



Source: QOF 2016/17

## 6.2 Management of Serious Mental Illness (SMI) in Primary Care

The six figures below analyse the performance of all Thurrock GP practices on the six QOF indicators that consider how effectively the practices are diagnosing and managing serious mental ill-health. The GREEN element of the bar shows the number of patients practice level that have received and/or been successfully treated against the indicator and the amount of financial reward received by the practice because of successful treatment under QOF.

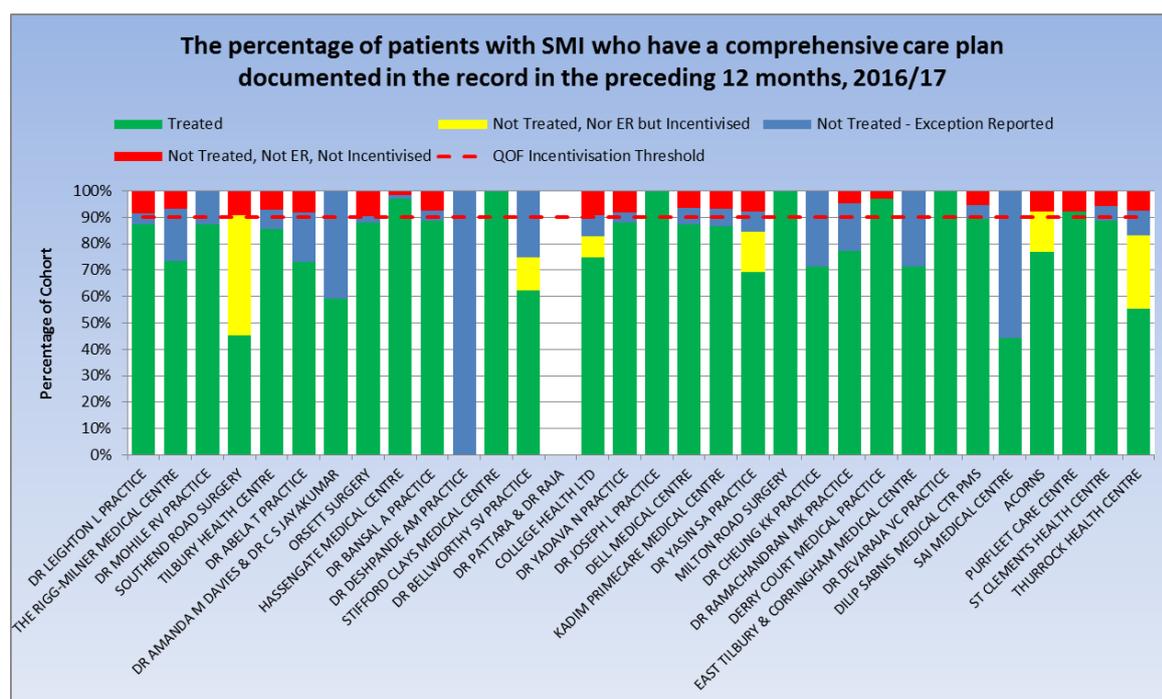
The BLUE element of the bar shows the number of patients that the practice has 'exception reported'. Patients who are 'exception reported' are removed from the cohort of patients relating to the indicator for the purposes of calculating incentive payments against QOF performance. Hence exception reporting patients makes it easier for a GP practice to claim maximum QOF financial rewards.

The YELLOW element of the bar shows patients that were neither treated nor exception reported but for whom the GP practice could have received financial reward for had they done so because the practice has failed to hit the maximum QOF payment threshold. It could be hypothesised that a GP practice with large elements of yellow within their bar has capacity issues or is failing to run its long term conditions management programme as efficiently or effectively as it could, as it is missing out on funding available to treat patients with LTCs.

The RED element of the bar shows the number of patients that were neither exception reported nor treated, but for whom QOF provides no additional financial incentive to treat. QOF provides a maximum payment threshold for each indicator. Once the GP practice hits this % threshold of treated patients, no further funding is provided. The maximum threshold varies between indicators but is never 100%. As such, QOF provides a perverse incentive to stop managing a cohort of patients with LTCs. Practices with a large proportion of their bar shown in red would potentially respond to a "stretched QOF" programme. This would be a local contract commissioned by the CCG that would financially incentivise GP practices to treat the patients that they do not currently get financially rewarded to treat under the current QOF contract.

The 1st figure below (Figure 27/Figure 28) shows practices such as Southend Road Surgery and Thurrock Health Centre to have large proportions of yellow bars, indicating that they are failing to ensure these patients have comprehensive care plans in place despite being financially incentivised to do so. In addition, Dr Deshpande has a completely blue bar, indicating they are exception reporting all of their patients.

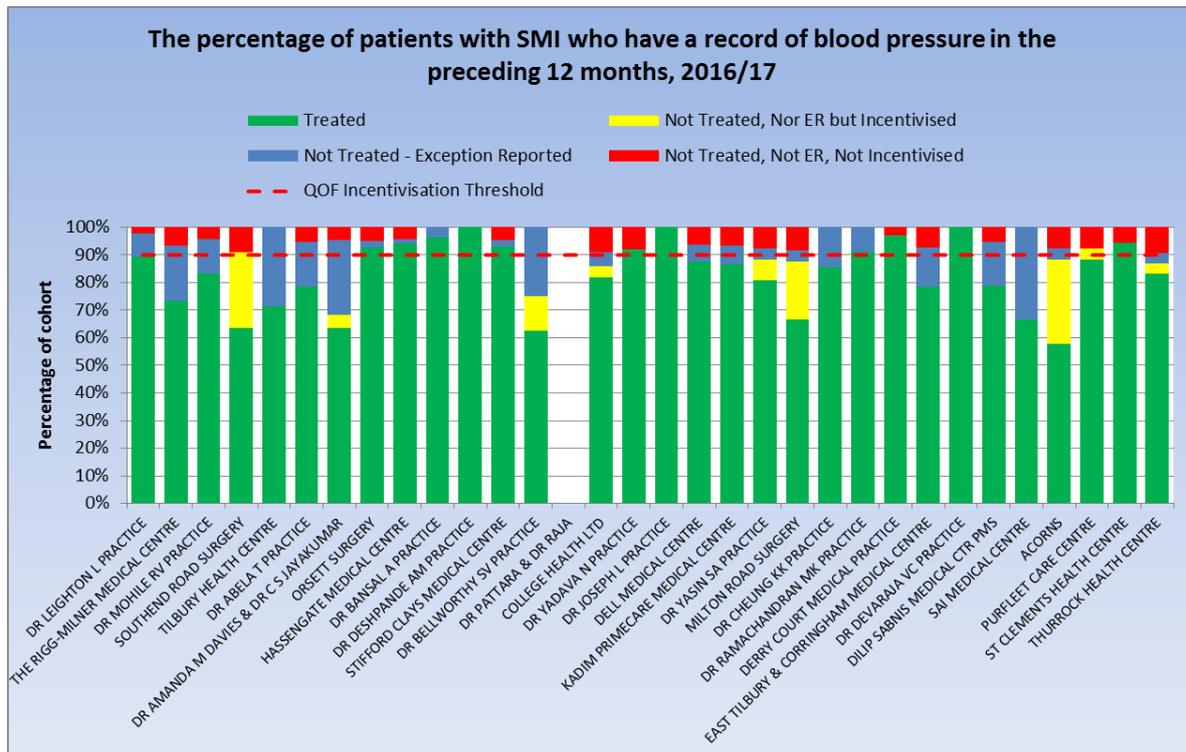
**Figure 28: Percentage of patients with SMI who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate, 2016-17.**



Source: QOF

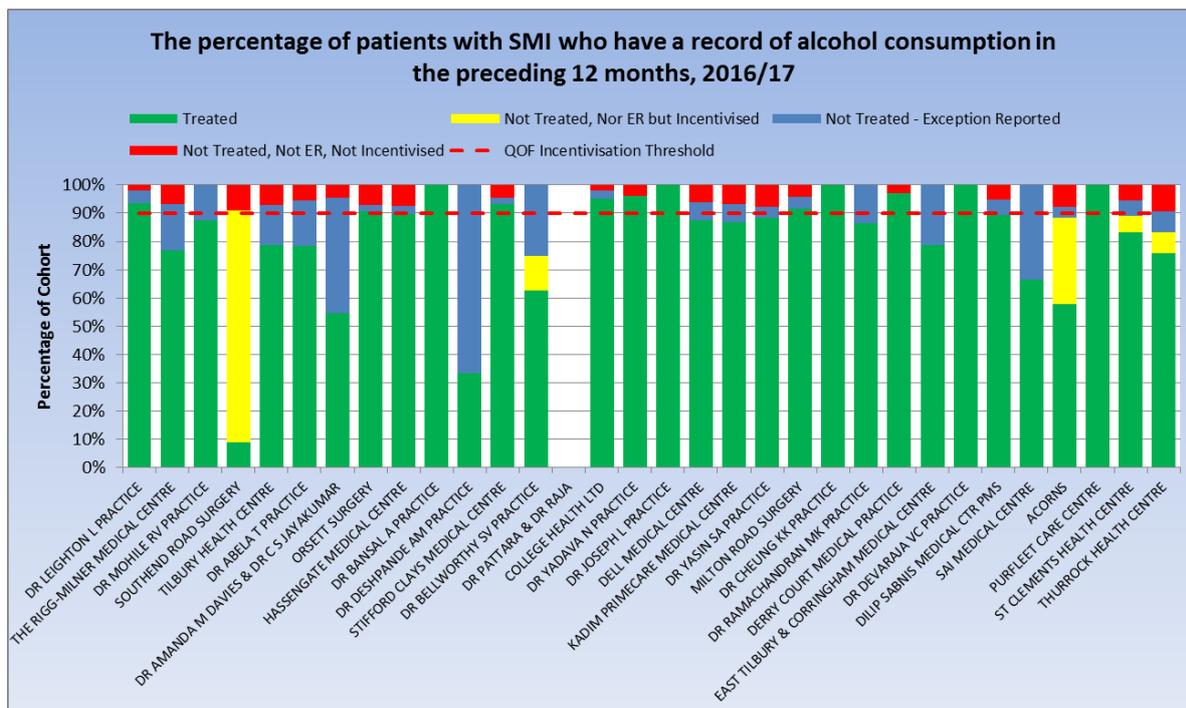
The two charts below show that the majority of practices are treating a lower proportion of patients than the QOF incentivisation threshold of 90%. The large number of practices with red proportions in their bars indicates they may respond favourably to a stretched QOF programme which would incentivise them to treat these patients. The Public Health Team have built a modeller enabling this opportunity to be calculated for all long term conditions, and which also apportion costs per practice. This is being explored further as part of the Tilbury ACP work.

Figure 29: The percentage of patients with SMI who have a record of blood pressure in the preceding 12 months, 2016-17.



Source: QOF

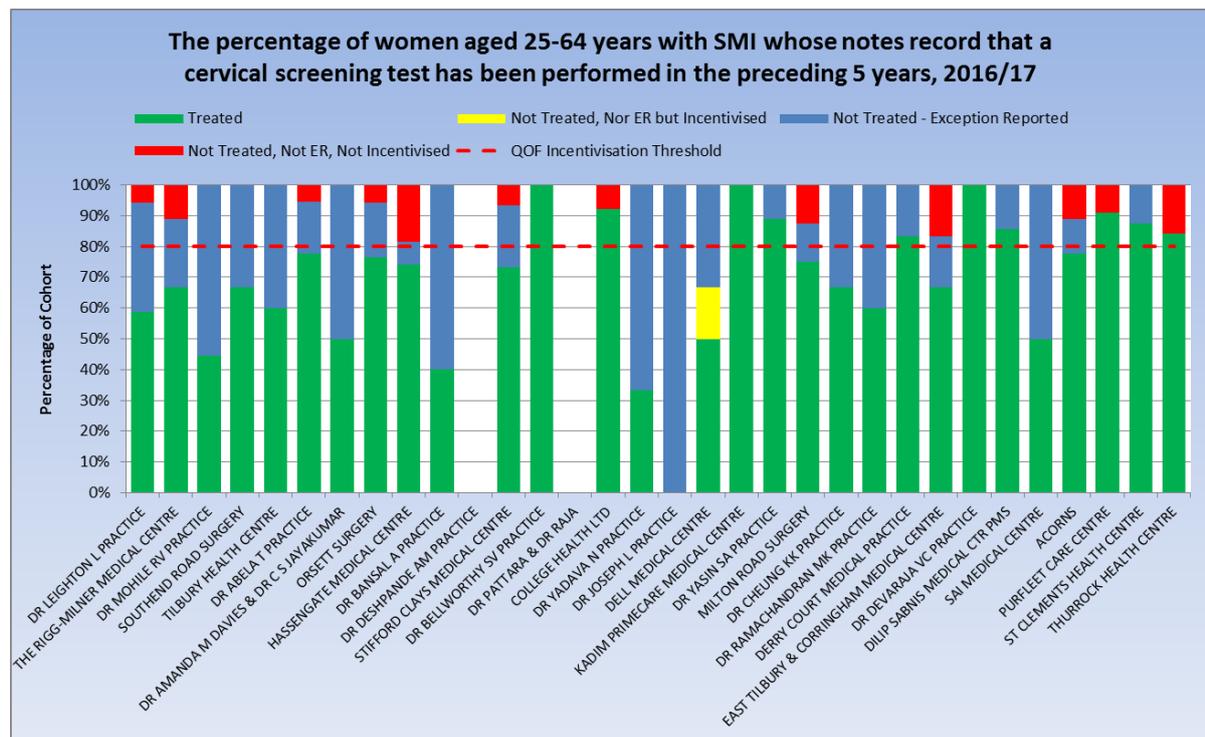
Figure 30: The percentage of patients with SMI who have a record of alcohol consumption in the preceding 12 months, 2016-17.



Source: QOF

As with the two charts above, the chart below shows that the majority of practices are treating a lower proportion of patients than the QOF incentivisation threshold of 80%. In addition, many practices have large proportions of patients being exception reported, and it is not clear why that might be the case.

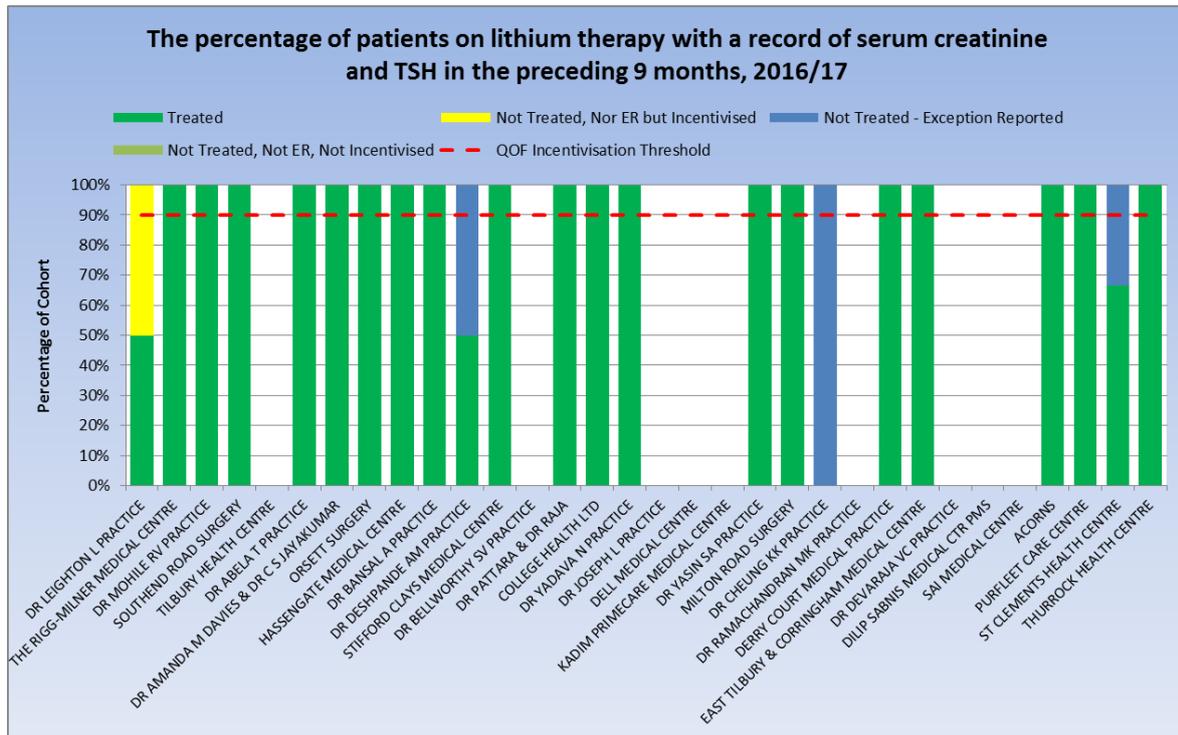
**Figure 31: The percentage of women aged 25 or over and who have not attained the age of the 65 with SMI whose notes record that a cervical screening test has been performed in the preceding 5 years, 2016-17.**



Source: QOF

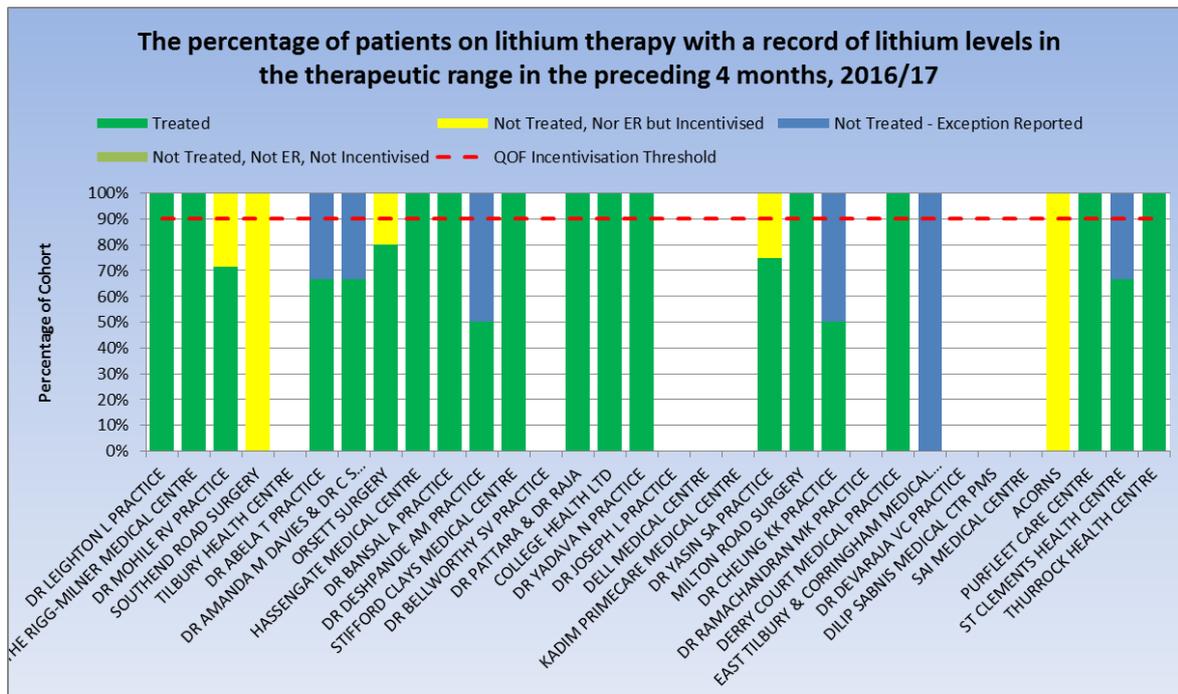
The two charts below have several practices with no eligible patients. Of the ones that do, the majority of them are receiving treatment. These two charts should be viewed with caution in light of the small denominator sizes of the registers.

Figure 32: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, 2016-17.



Source: QOF

Figure 33: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months, 2016-17.



Source: QOF

### 6.3 Improving Access to Psychological Therapies (IAPT)

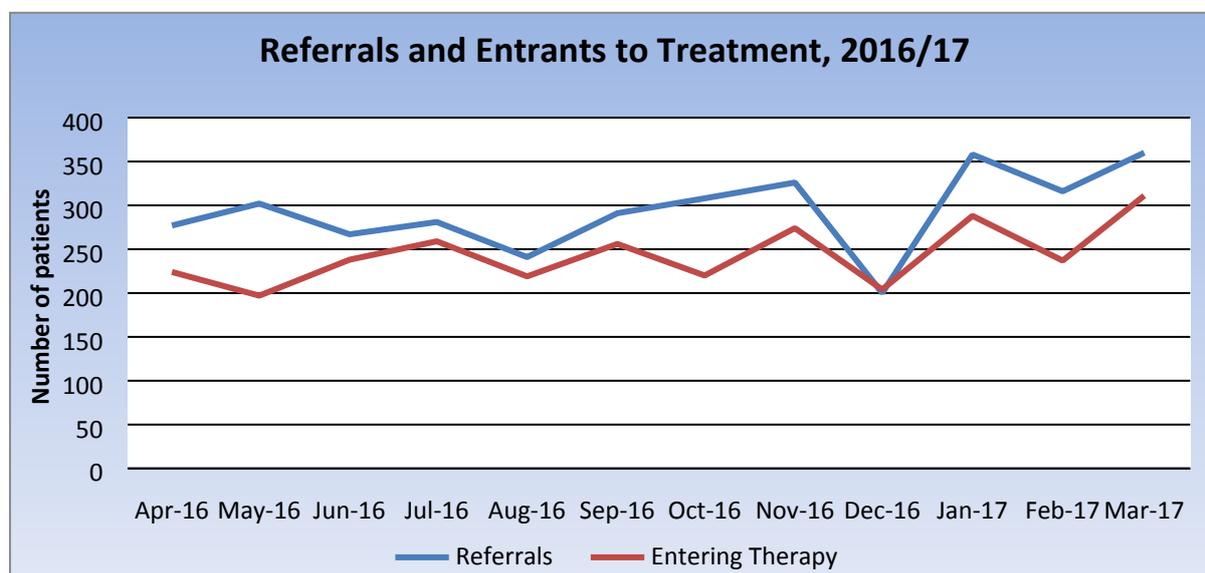
IAPT services are an evidence-based method of treating mental health disorders via talking therapies. The National Institute for Health and Care Excellence (NICE) recommends the use of IAPT for mental ill health and the Five Year Forward View for Mental Health Implementation Plan will see increases to the provision of IAPT services nationally in its 5 year plan. A new IAPT provider was commissioned to provide IAPT services from April 2016.

#### 6.3.1 Who is accessing IAPT services?

In 2016/17 there were 3,527 referrals made to the Thurrock IAPT service. As part of the Five Year Forward View, all IAPT services are being set targets to work towards having 25% of the patients estimated to have anxiety/depression accessing IAPT services by 2020/21. Converting the referrals into a proportion of the estimated patients with anxiety/depression, this would indicate that 17.11% of these patients received a referral to IAPT.

Of those 3,527 referrals, 2,927 went on to enter treatment – equating to 83%. Both the number of referrals and treatment entrants fluctuated by month, which can be seen in the chart below. It should be noted however that due to waiting times between referrals and treatment, it is not the same patient cohorts at each monthly stage.

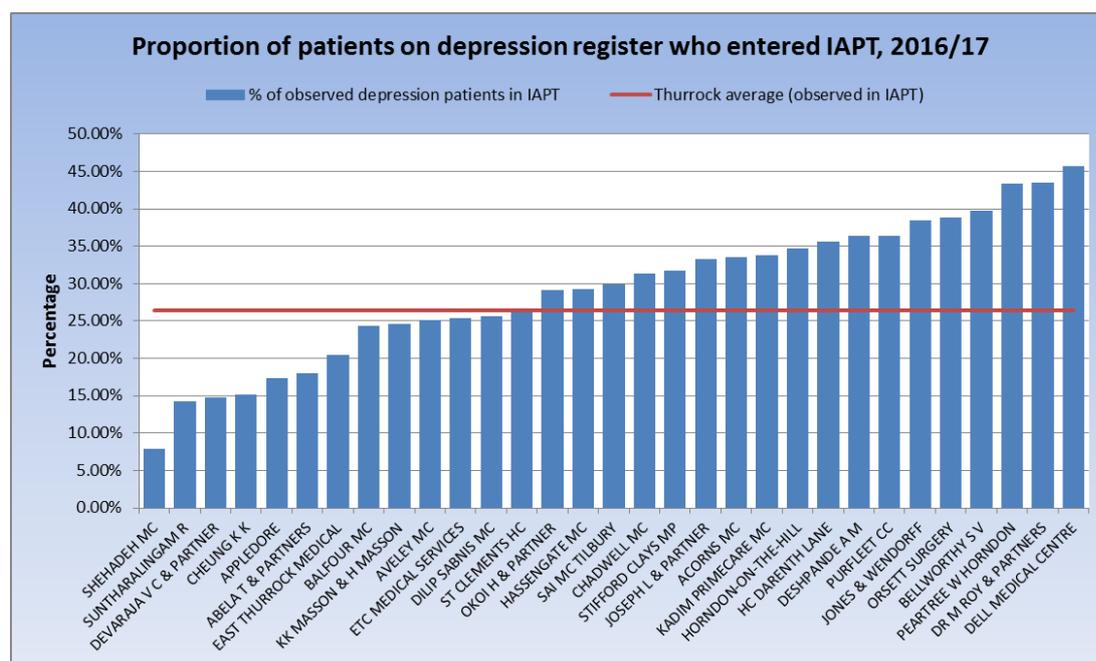
Figure 34: IAPT referrals and treatment entrants, 2016/17



When looking at the age of entrants to treatment, it could be seen that the majority of entrants are aged 17-64 years, with 154 of the 2,927 aged over 65 (7.05%). Evidence suggests that those over 65 are more likely to suffer from depression and common mental health disorders. This age group is also more likely to suffer from isolation and those aged 65+ are more likely to have at least one long term condition; these are strong predictors of mental ill health.

Referrals and entrants into IAPT services varied per GP practice. Below we have considered IAPT entrants in two ways – one as a proportion of all known depression patients (whilst not all IAPT entrants would access the service due to depression, it is an approximate measure of known need), and also as a proportion of the total estimated number of depression patients (using the 2016 PHE estimates referred to earlier in the document). The variation in entrants can be seen in the two charts below. Whilst the Thurrock average for IAPT entrants as a proportion of known depression patients is 26.38%, activity ranges from 7.87% (Shehadeh Medical Centre) to 45.67% in Dell Medical Centre.

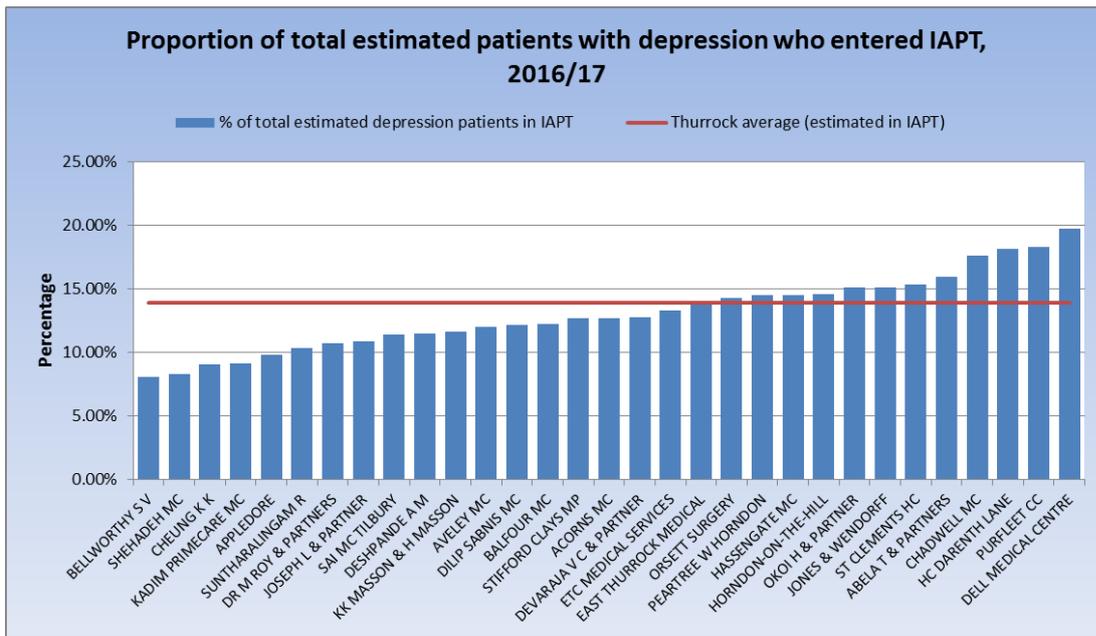
Figure 35: IAPT entrants as a proportion of those on the QOF depression register, 2016/17.



Source: IAPT and QOF 2016/17

The national ambition is for 25% of patients estimated to have anxiety or depression to be accessing IAPT by 2020/21. Due to the large estimated number of undiagnosed patients with depression in Thurrock, the latest data indicates that there is a large proportion of patients likely to have depression who are not accessing IAPT. The chart below shows entrants to IAPT as a proportion of the total estimated practice population with depression, and it can be seen that the Thurrock average is now 13.91%, with practices varying from 8.11% (Bellworthy S V) to 19.78% (Dell Medical Centre). It is also of note that it is not always the same practices with the highest proportions of known patients accessing IAPT as the total estimated patients – for example, Dr Bellworthy appears to have a relatively high proportion of known depression patients accessing IAPT (39.73%), but a low proportion of total estimated depression patients accessing IAPT (8.11%) – reflecting the variation in diagnosing behaviour described elsewhere in the document.

Figure 36: IAPT entrants as a proportion of the total estimated population with depression, 2016/17.

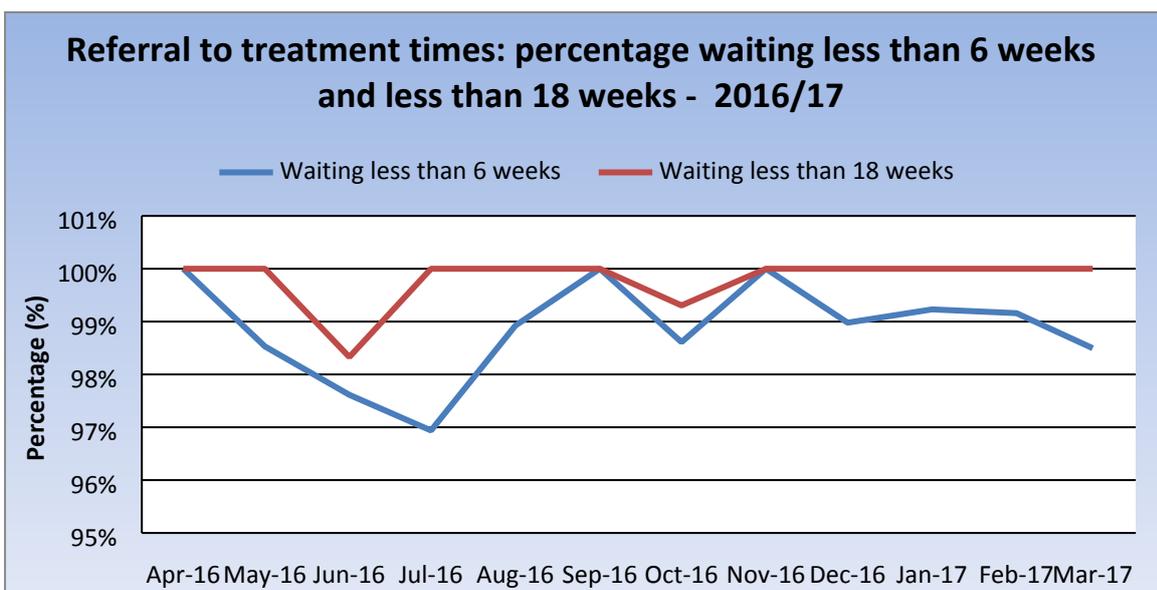


Source: IAPT 2016/17 and PHE 2016

### 6.3.2 Waiting Times

There are two key national targets in place with regard to patients waiting for IAPT treatment. It is expected that 75% of all patients completing IAPT treatment each month should have had a referral-treatment waiting time of less than 6 weeks, and that 95% of completers each month should have had a referral-treatment waiting time of less than 18 weeks. The chart below shows this for Thurrock for 2016/17, and it can be seen that for every month, more than 95% of patients are seen within 6 weeks and almost 100% every month are seen within 18 weeks.

Figure 37: Referral to treatment times, 2016/17

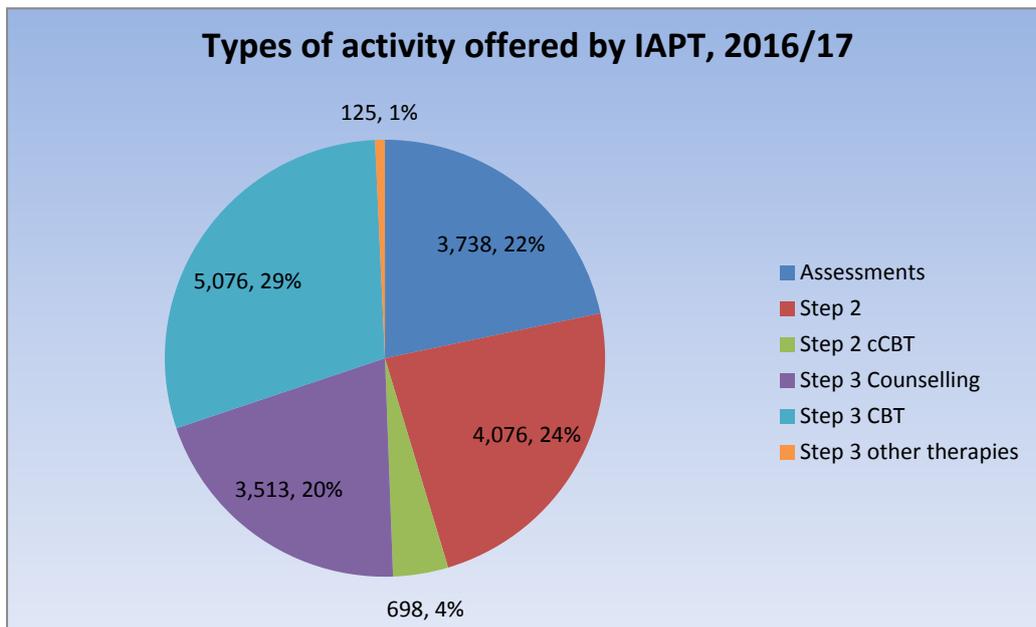


*It should be noted that the current provider (Inclusion) took on the contract from April 2016 with a backlog to work through. Interrogating the waiting time data further showed a large number of patients who had waited more than 18 weeks for their second treatment appointment in April and May 2016; however these figures were not seen for the rest of the year.*

### 6.3.3 Treatment Activity

When considering the type of activity that IAPT offered, it can be seen that 50% of their activity relates to step 3 therapies (Counselling, CBT or other therapies), which gives an indication of the complexity of patients being seen by the service.

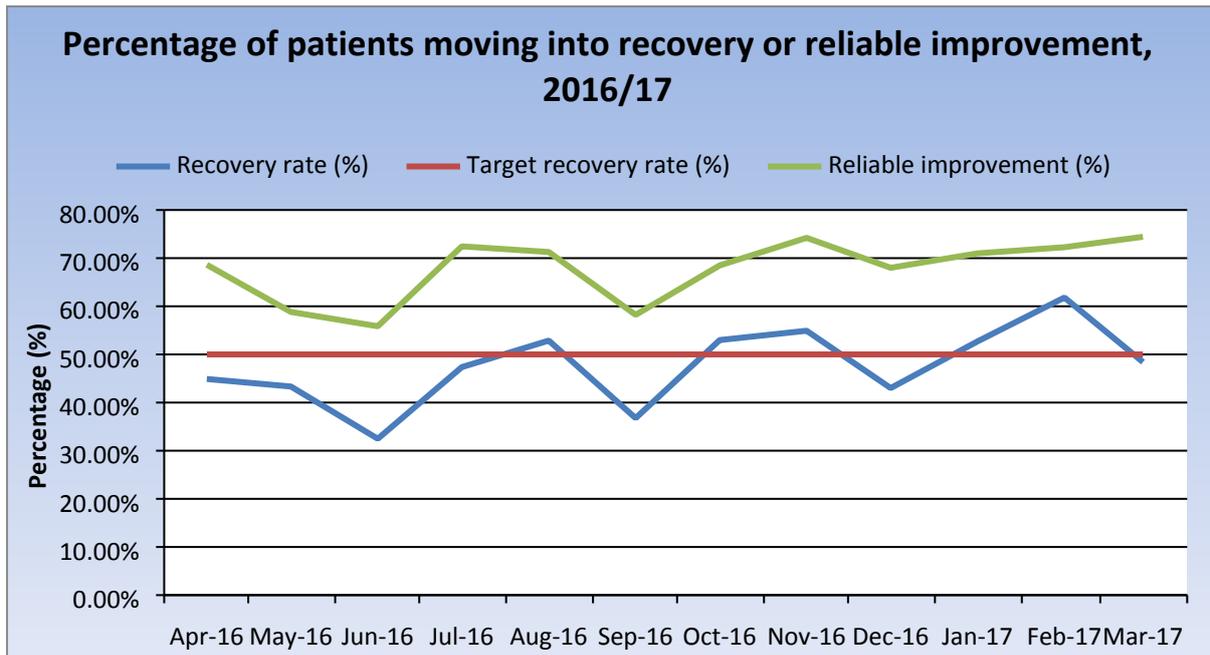
Figure 38: IAPT Treatment Activity Offered, 2016/17



### 6.3.4 Outcomes

The aim is for 50% of patients completing treatment each month to be moving into recovery. In 2016/17, this varied on a monthly basis, but for the year was 45.43%. The percentage of patients recorded as seeing a reliable improvement is also recorded as an indication of how effective treatment has been. 65.71% of patients completing treatment in 2016/17 were classified within this category, although this also varied within the year. This can be seen in the figure below.

Figure 39: Percentage of patients moving into recovery or reliable improvement, 2016/17



## 6.4 Prescribing Data

### Key Points

- Antidepressants were the area with largest increase in prescription items in 2016 (NHS Digital)
- Four year data trends tell us that in general the total costs and items of mental health prescribing data have been decreasing (except for antidepressant items and hypnotics costs)
- There was an increase in the total cost of hypnotic drugs between 2015/16 and 2016/17 of £25,000, which may be because GPs are prescribing more expensive types of these drugs, as the number of items have decreased
- There are some limitations to what prescribing data tell us, including the fact that many people with mental health disorders have mixed presentations and therefore use various mental health drugs and also mental health drugs can be used for other indications such as pain

Data on prescribing by GPs and independent or supplementary prescribers for NHS patients (usually on green FP10 prescriptions) is collected by an online system called ePACT. Five years of prescribing data can be analysed in different levels of detail. However, the data cannot be linked directly to individual patients. We have looked at Thurrock CCG's ePACT for the four years including 2013/14 to 2016/17 for mental health prescribing. The broad categories that have been analysed include: antidepressants, hypnotics, benzodiazepines and antipsychotics.

Antidepressants are used for the treatment of moderate to severe depression (and should not be used routinely in mild depression). They can also be used for other indications such as neuropathic pain and migraine. Depression and anxiety do not always occur independently of each other therefore a patient could be prescribed an antidepressant for co-existing conditions such as mixed depression and anxiety or mixed depression and psychotic episodes. There are several types of antidepressants such as Serotonin Selective Re-uptake Inhibitors (SSRIs) e.g. citalopram, fluoxetine and paroxetine. Other types include tricyclic antidepressants e.g. amitriptyline, and monoamine oxidase inhibitors (MAOIs) such as phenelzine.

Hypnotic drugs are often used for insomnia and other sleep disorders. Benzodiazepines are a type of hypnotic drug and are often used for short-term treatment of anxiety. They may be helpful in the initial stages of treatment for behavioural disturbance or agitation; however they should not be used for long periods due to risk of dependence. Examples include lorazepam, temazepam and zopiclone.

Antipsychotic drugs are used for serious mental illness (SMI) such as psychosis, mania and hypomania. Examples include olanzapine, quetiapine or risperidone. If the response to antipsychotic drugs is inadequate, lithium or valproate may be added. NICE recommends that clozapine is started if a patient remains unresponsive to 1<sup>st</sup> and 2<sup>nd</sup> line antipsychotic drugs. In elderly patients with dementia, antipsychotic drugs are associated with a small increased risk of mortality and an increased risk of stroke or transischaemic attack (TIA). Therefore there are lots of

considerations that clinicians must take before prescribing drugs for mental health disorders and it is important that NICE guidance is adhered to, for best clinical practice.

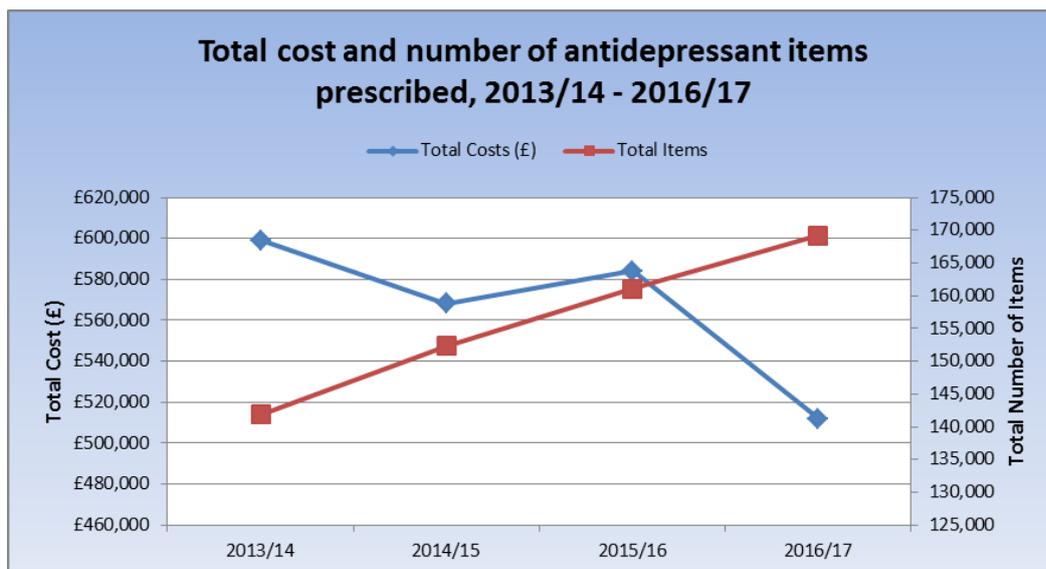
The section below presents analyses of prescribing data for mental health conditions split into two groups – those categorised as antidepressant items (although it should be acknowledged that these can be taken by patients with a range of conditions), those for hypnotics and benzodiazepines and those for more serious mental health conditions (antipsychotics).

### Antidepressants

The total number of items dispensed in 2016 for antidepressants showed the greatest numeric rise since 2015. They increased by 3.7 million items (6% increase) – NHS Digital. The number of antidepressants prescribed in Thurrock has increased from 161,038 items in 2015/16 to 169,202 items in 2016/17 (5% increase) – ePACT. Although the dates are different, NHS Digital being January to December 2016 whilst ePACT is by financial year, it shows that the increase in Thurrock is generally in line with the national increase. Over the last four years, from 141,875 in 2013/14 to 169,202 in 2016/17, there has been a 19% increase in numbers of antidepressant items prescribed.

In reverse to numbers prescribed, the total cost of antidepressants prescribed in Thurrock has decreased over the last four years, with the largest decrease between 2015/16 and 2016/17. In 2016/17 the total cost was £511,934, which was a 15% decrease from the 2013/14 cost. The decrease in cost could be due to wider changes to pricing of medication (e.g. if certain drugs came off patent), changes to prescribing guidance or work by the local CCG Medicines Management team – or a combination of all of these factors. The increase in items could be interpreted as an increase in need (and diagnosis), although also likely influenced by GP prescribing preferences and population growth.

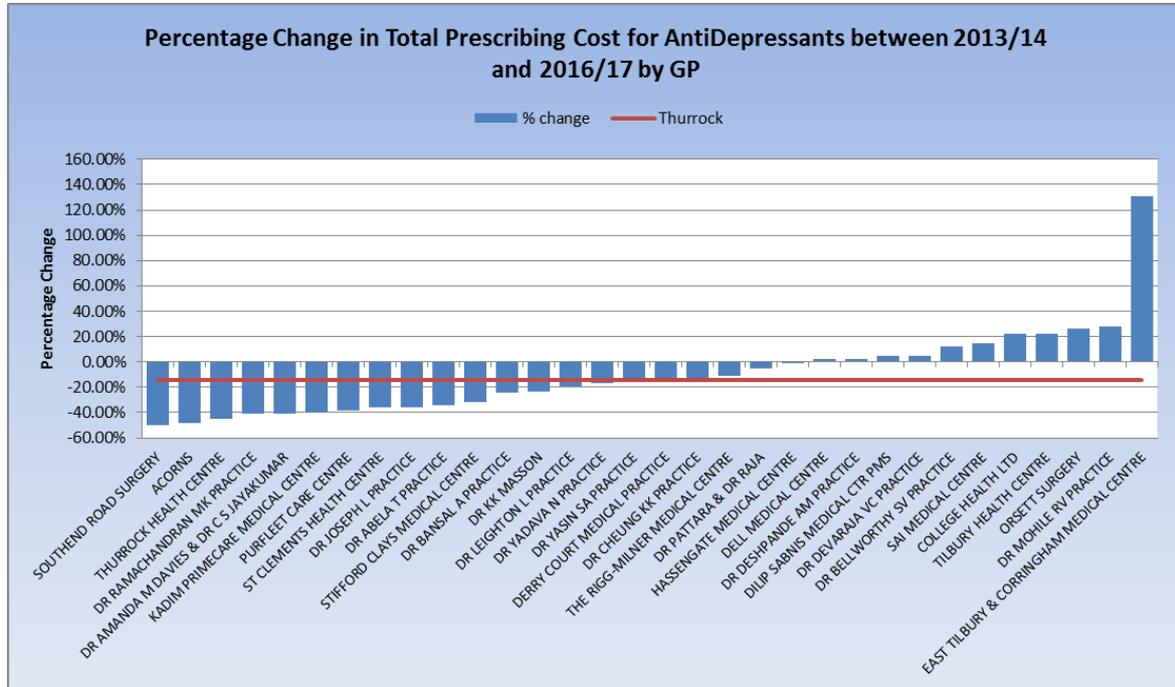
Figure 40: Cost and Number of Antidepressants prescribed, 2013/14 - 2016/17.



Source: ePACT

Analyses of the percentage change in total cost between 2013/14 and 2016/17 at practice level shows a large amount of variation of antidepressant prescribing practice, ranging from a 50% decrease (Southend Road Surgery) to a 131% increase (East Tilbury Medical Centre).

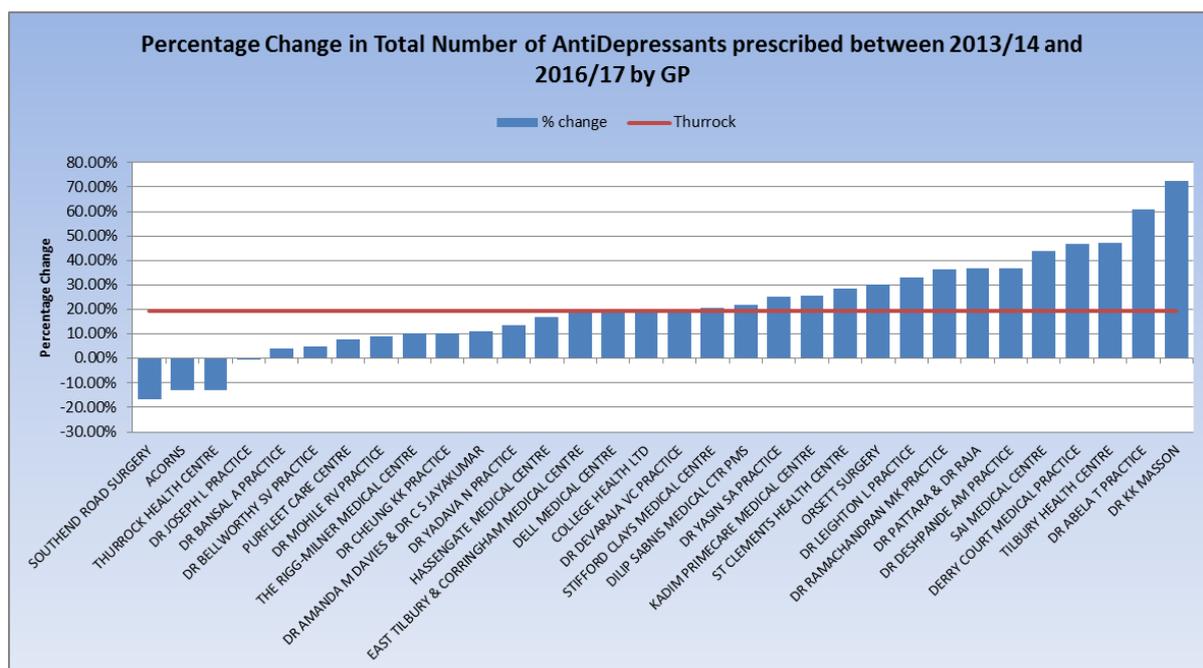
Figure 41: Percentage change in prescribing cost for antidepressants, 2013/14 - 2016/17 by GP.



Source: ePACT

There is also a large amount of variation in the percentage change in items from 2013/14 to 2016/17 at practice level – ranging from a 72% increase (KK Masson) to a 17% decrease (Southend Road Surgery).

Figure 42: Percentage change in prescribing for antidepressant items, 2013/14 - 2016/17 by GP.



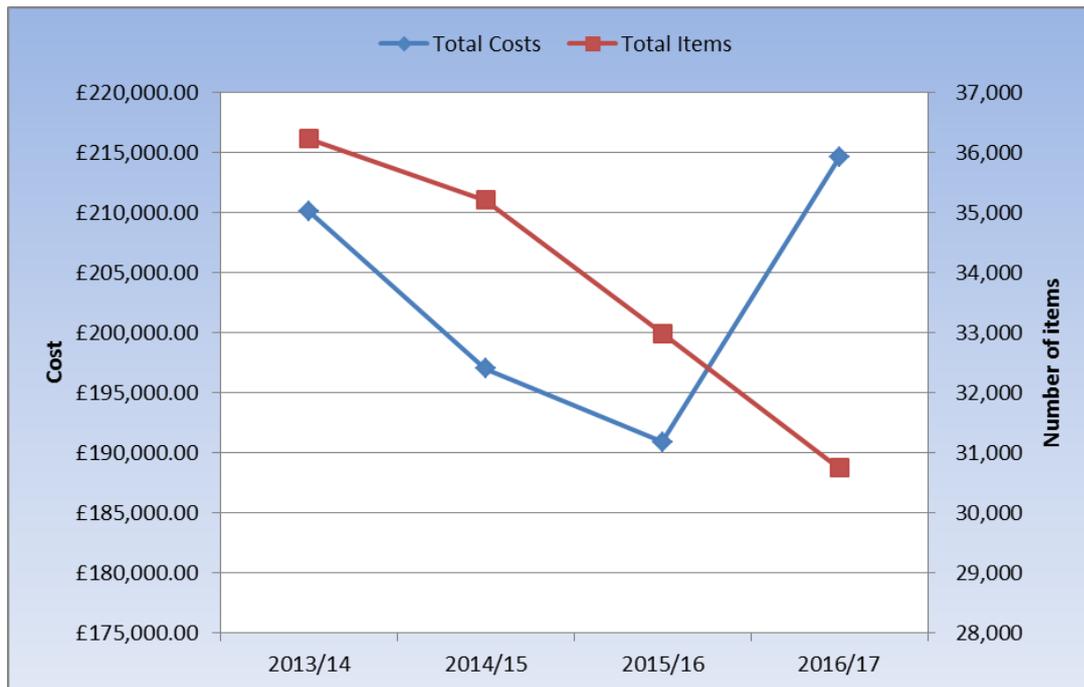
Source: ePACT

The variation in prescribing patterns could be due to a number of things. As mentioned at the start of this section, antidepressants can be prescribed for a variety of indications, including mixed diagnoses of mental health conditions or other conditions such as pain. There might be differences in the practice depression register size, levels of deprivation per area – we would expect to see larger depression registers in more deprived areas. GPs might also have different prescribing preference or choose to use other services such as IAPT before prescribing antidepressants, depending on whether patients are presenting with mild or moderate to severe depression.

### Hypnotics

Over the last four years, the main trend for the prescribing of hypnotic drugs was a reduction in total costs and total items prescribed. However, between 2015/16 and 2016/17, there was an increase in total costs, which went from just over £190,000 to around £215,000, an increase of £25,000 in a year. However, overall, there has been a decrease in the number of hypnotics by 15% over the last four years. Therefore, the likely explanation is that a smaller number of more expensive hypnotics have been prescribed by GP practices in the last year.

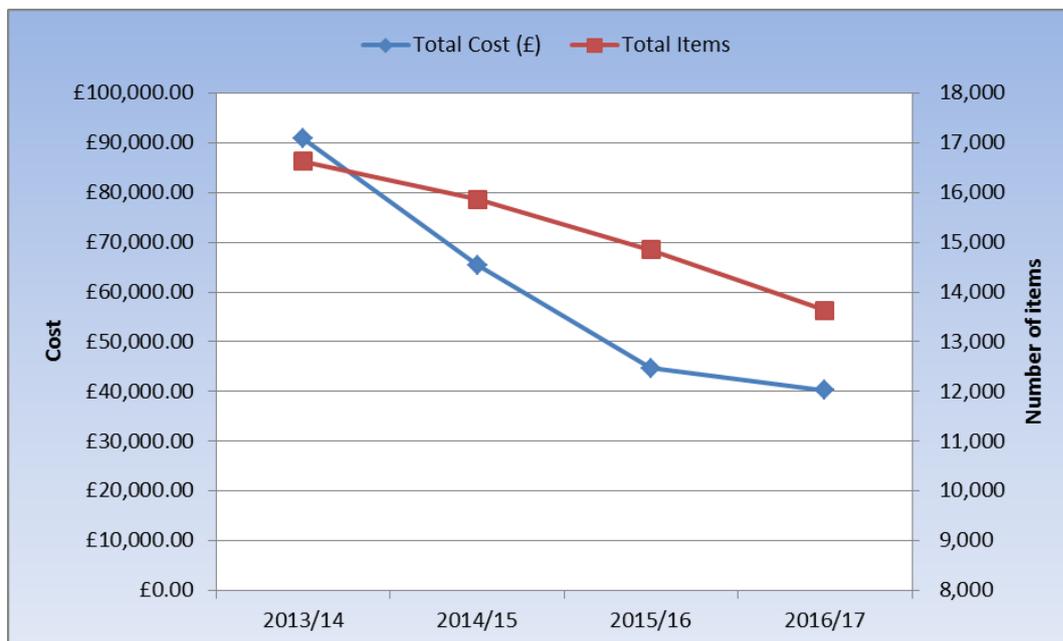
Figure 43: Total Cost and number of items prescribed for hypnotics, 2013/14 - 2016/17.



### Benzodiazepines

The trend seen in the prescribing of benzodiazepines over the four year period is that there has been a reduction in the total costs and items prescribed.

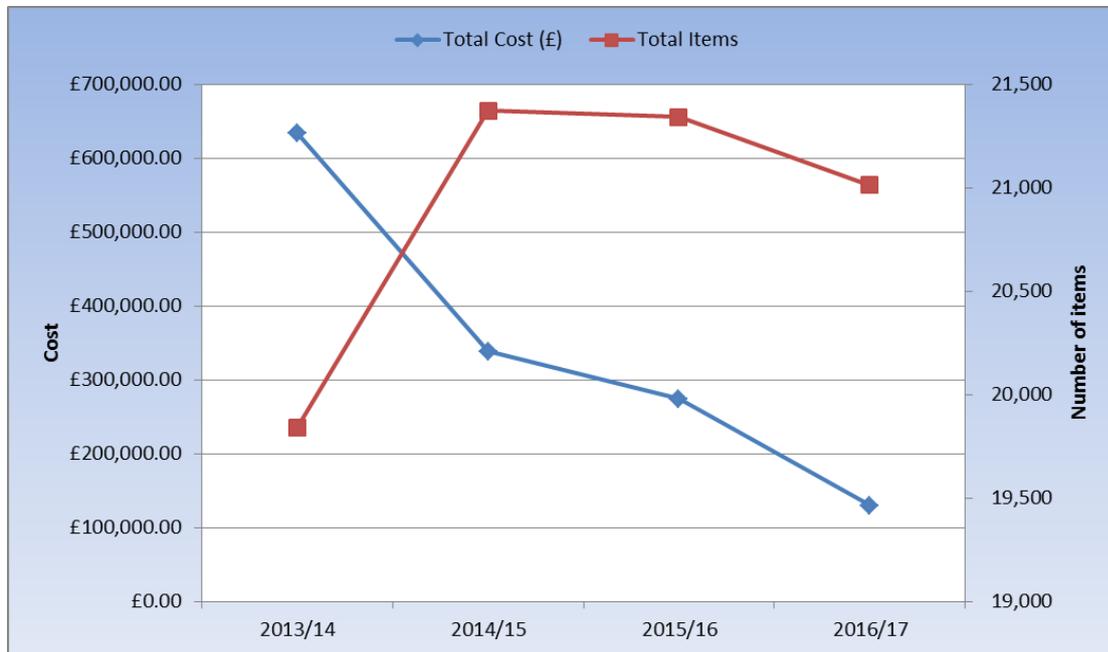
Figure 44: Total Cost and number of items of benzodiazepines prescribed, 2013/14 - 2016/17.



### Drugs for treatment of Serious Mental Illness (SMI) - Antipsychotics

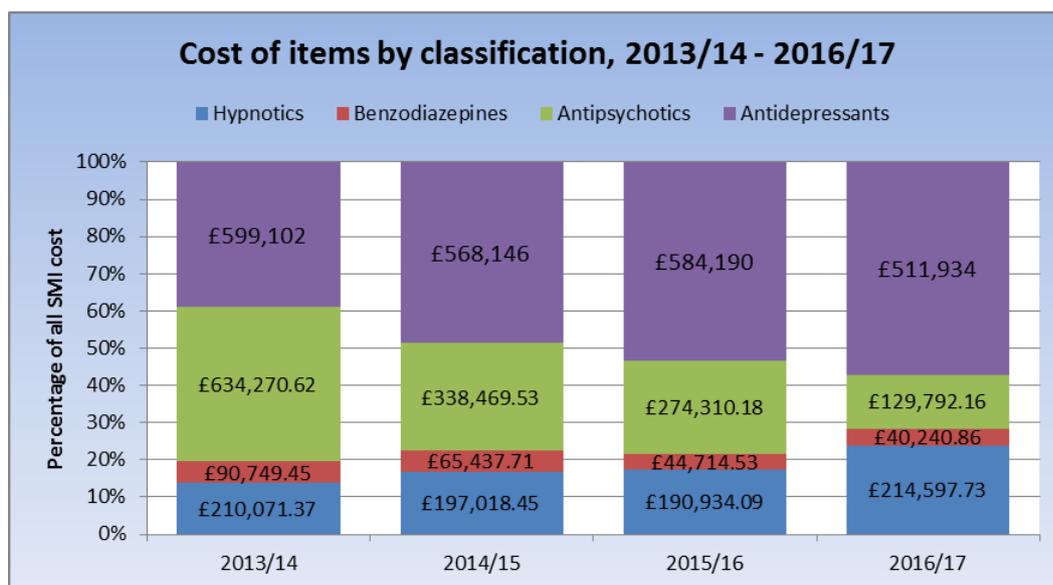
Over the last four years it can be seen that whilst the number of antipsychotic items has increased and then levelled off, the cost of these items has decreased, potentially due to a combination of the reasons described above.

Figure 45: Total Cost and number of items prescribed for SMI, 2013/14 - 2016/17.



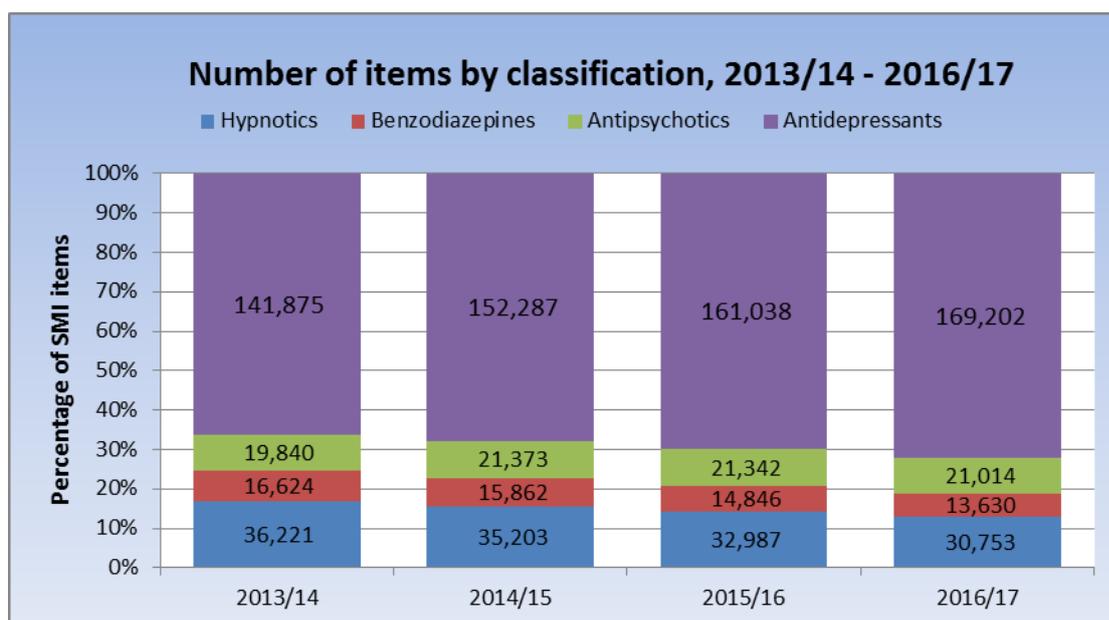
Source: ePACT

Figure 46: Total cost of items prescribed of mental health drugs by category and year 2013/14-2016/17.



Source: ePACT

Figure 47: Total number of items prescribed for SMI by category and year 2013/14-2016/17.



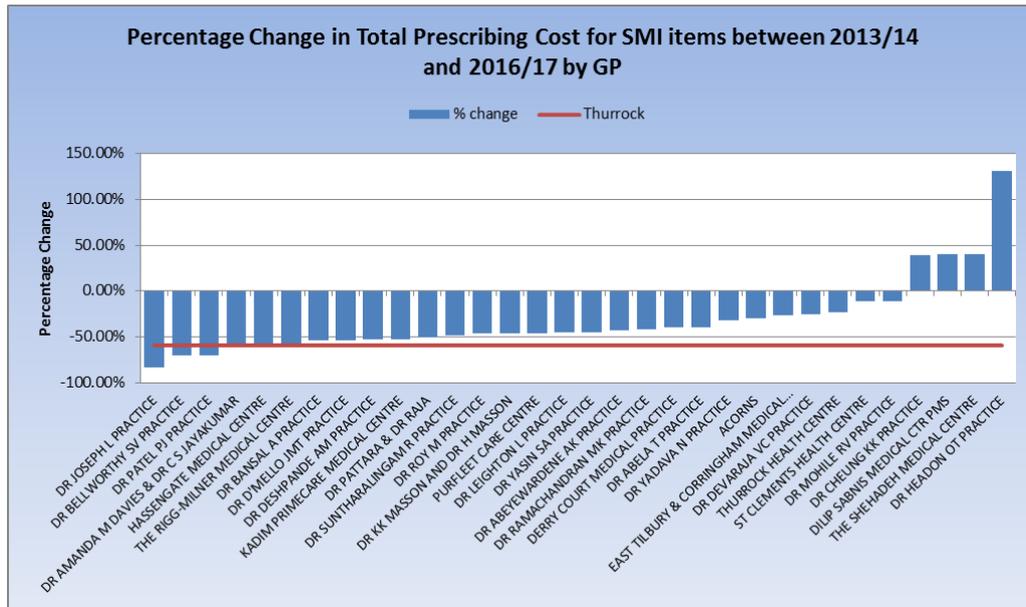
Source: ePACT

Analyses of the percentage change between 2013/14 and 2016/17 for both cost and number of items indicate some variation at GP practice level. In terms of cost, whilst the Thurrock total percentage change was a 59% decrease, the average of the 32 GP practices is actually a 31.64% - the difference is due to a large reduction in costs associated with the Walk In Centre which closed between these two periods but which is not shown on the charts below. It can be seen that the majority of GP practices reduced their prescribing costs, with the exception of four. The practice

with a largest increase was Dr Headon (131.43%), and the practice with the largest percentage decrease was Dr Joseph (83.61%).

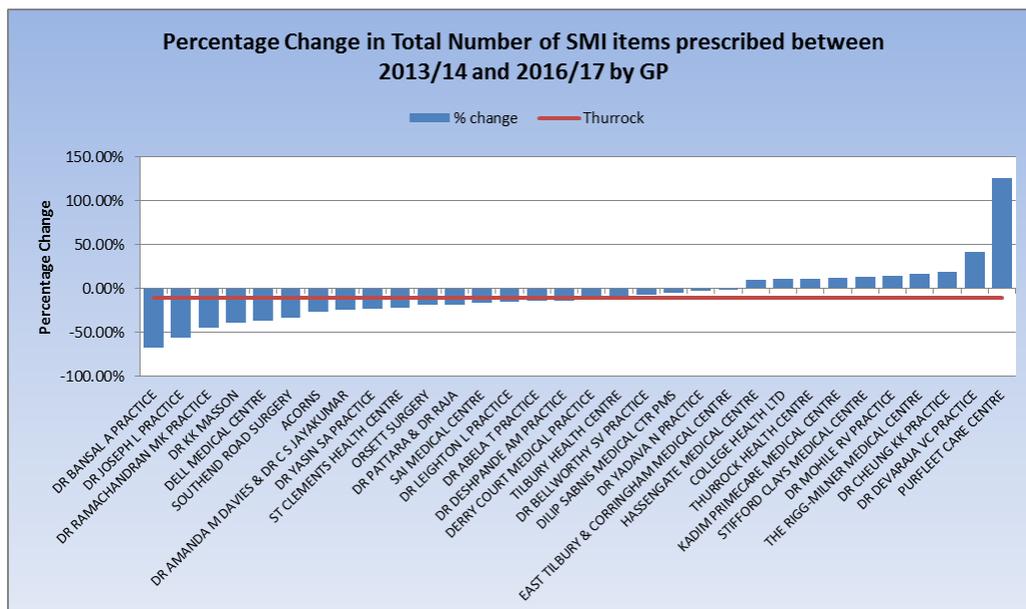
Whilst the total percentage change for Thurrock for items prescribed was 10%, this ranges from a 68% decrease (Dr Bansal) to a 126% increase at Purfleet Care Centre. These are illustrated in the two charts below.

Figure 48: Percentage change in total prescribing cost for SMI items between 2013/14 and 2016/17 by GP.



Source: ePACT

Figure 49: Percentage change in total number of SMI items prescribed between 2013/14 and 2016/17 by GP.

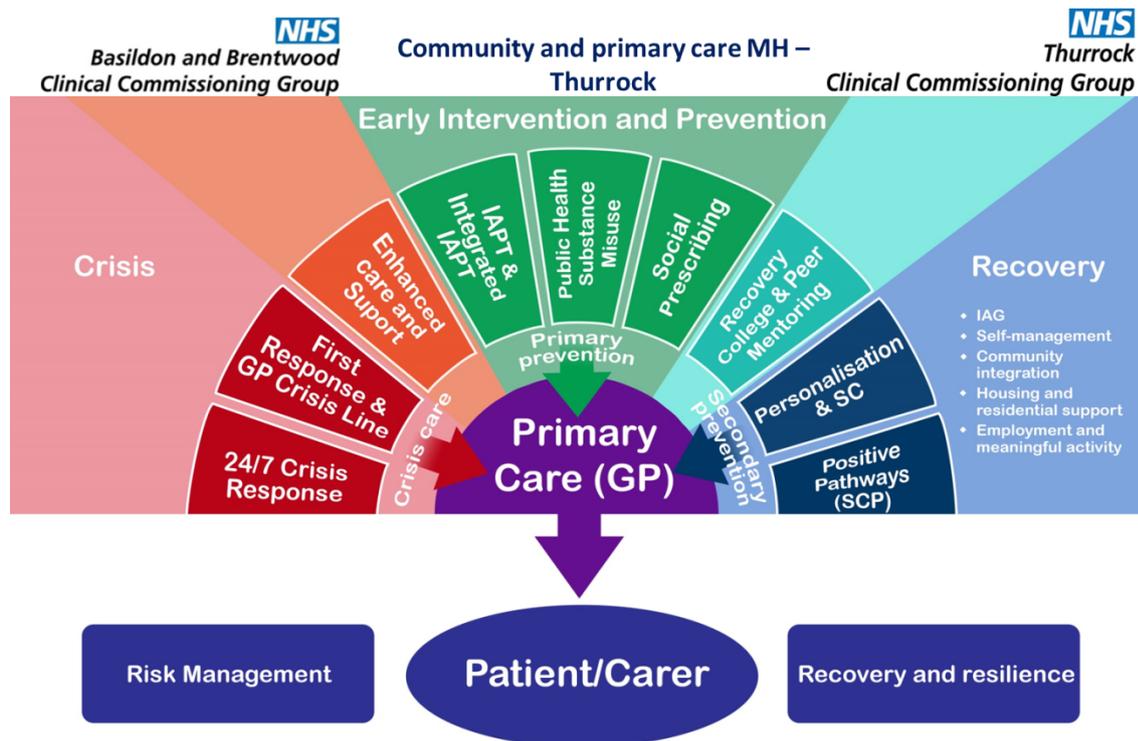


Source: ePACT

## 6.5 Integrating primary and community services

The sections below detail ways in which the current primary care system treats and manages mental illness. It is important to note, however, that work to integrate services is currently underway which means that the service landscape is likely to change rapidly over the next year or two. Working closely with a neighbouring CCG and with Thurrock's public health team, Thurrock CCG have developed a vision for integrating community and primary mental health care in Thurrock. This is set out below in Figure 50.

Figure 50. Thurrock Mental Health Transformation: Integrated Community and Primary Care



A clinical leadership and oversight group has been set up bringing together key clinicians and in primary and community services with commissioners from the CCG and local authority to drive this integration agenda. The aims of the group are to:

- Improve urgent and emergency care
- Integrate social, mental and physical health providing care closer to home
- Promoting good mental health and preventing poor mental health

## 6.6 Recommendations

### General Practice

Significant opportunities to improve the quality of care and management of mental health conditions in General Practice have been identified in this report. Improving these areas will require changes in clinical practice in primary care, supported by the CCG and public health teams.

- There is strong evidence that after starting patients on anti-depressant treatment, GP practices are often not carrying out a patient review within the timeframe set out in the QOF guidelines (10 – 56 days). This is a significant opportunity to improve the management of depression in primary care. This has been included as part of practice profile cards and public health needs to work with practices to audit and review patients in a timely way.
- Review those on the SMI QOF register and ensure that their records are up to date and action taken where necessary e.g. recommending smoking cessation and referring into exercise and other lifestyle services.
- Greater use of depression screening of high risk groups in primary care would to identify some of those who are currently undiagnosed.

### Prescribing

- The CCG medicines management team should continue to ensure that mental health prescribing is appropriate and according to NICE guidance in primary care:
- The CCG medicines management team and practice pharmacist should audit patient databases in GP practices with a view of adding patients to QOF registers appropriately and also auditing medicines use e.g. for antidepressant drugs.
- The increase in the costs and volumes of mental health drugs is likely to continue to increase. These should be monitored against expected levels of SMI and/or other mental ill health so that the prescribing of the right drugs in appropriate volumes continue across primary care in Thurrock.
- The variable prescribing practices between GP practices must be monitored by the medicines management team, where the practice is not due to numbers on the QOF depression register alone.

## 7 What services are provided for those with mental illness? Secondary Care

### 7.1 Accident and Emergency Data - The National Context

There is an increasing gap between needs of mental health patients with complex problems and community resources accessible to these patients. Consequently, these unmet needs result in an increasing number of individuals repeatedly using a considerable number of mental health resources, especially emergency visits (Kalucy et al, 2005).

The demographic profile of patients who use A&E departments has remained relatively stable when compared to previous years. In 2015-16, there were approximately 20.5 million A&E attendances recorded in the UK, with 49.2% (10.1 million) male and 49.9% (10.2 million) female attendances. Attendances from April to December increased by 2.2% from 14.9 million in 2014-15 to 15.2 million in 2015-16. Attendances from January to March increased by 12.2% from 4.6million in 2014-15 to 5.2million in 2015-16 (HSCIC, 2017).

Studies have shown that those who are young, unemployed, males, living in transient accommodations, and having a psychiatric disorder, are more likely to use emergency departments (Vandyk et al, 2013; Meng et al, 2017). Studies have also consistently shown that substance abuse and other mental health problems are significantly associated with emergency room visits (Fahimi et al, 2015; Brenda et al, 2011; Vu et al, 2015).

Deprivation is strongly associated with emergency care use. In 2013/14, the most deprived people with mental ill health visited A&E 1.8 times more than the least deprived and had 1.5 times more emergency inpatient admissions (Dorning et al, 2015).

The HSCIC (2013) reports users of mental health services were twice as likely to have attended A&E more than non-users. They were also likely to attend more frequently. For common inpatient procedures, people with mental ill health were more likely to have an emergency admission rather than a planned one, stay longer in hospital and be admitted overnight (Dorning et al, 2015). Similarly, people with chronic physical conditions and mental illness are more likely to use emergency services and have higher total, outpatient, and pharmaceutical expenditures than those without mental illness (Shen et al, 2008).

**Table 7: Attendance by Mental Health service users (aged 18+), 2012-13.**

Patients who accessed A&E services at least once 2012/13	Average number of A&E attendances per patient	Percentage accessing A&E services (at least once)
All Patients	1.56	21.3%
Non-MH Service users	1.49	20.6%
MH Service users	2.43	43.1%

Source: HSCIC, 2013

People with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14. Visiting A&E or having an emergency admission

can be distressing for patients and carers, is associated with a greater risk of mortality and longer-term morbidity, and is expensive to the healthcare system (Blunt, 2014). People with mental health problems using more emergency care than people without are particularly troubling given the poor healthcare outcome of people with mental health problems.

Preventing emergency admissions for people with mental health problems could improve the quality of care, reduce the amount of distressing unplanned care for the patient, and provide potential cost savings. Moreover, providing appropriate primary or community care to this group could result in further improvements. (Dorning et al, 2015).

Improving Access to Psychological Therapies (IAPT), principally the provision of brief interventions and access to cognitive behavioural therapy, has been provided by the NHS in England (Clark et al, 2009). Research shows that IAPT may have a role in helping to reduce attendances at A&E departments. Referral of people with long term conditions and common mental health problems to an IAPT service was associated with increased antidepressant medication and less use of the emergency departments (de Lusignan et al, 2011; 2013).

## 7.2 Early Intervention in Psychosis (EIP)

### Key Points:

- From 1 April 2016 more than 50% of people experiencing first episode psychosis (FEP) should be treated with a NICE-approved care package within two weeks of referral
- The current cost of psychosis to society is estimated to be £11.8 billion per year
- EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes.
- There are 8 NICE Quality Standards that should be followed to measure the quality of for EIP services
- Currently, none of the NICE Quality Standards (which take the holistic view of the patient into consideration using care co-ordination) are being reported from the EIP service provider.

The access and waiting time standard for early intervention in psychosis (EIP) services requires that, from 1 April 2016 more than 50% of people experiencing first episode psychosis (FEP) would be treated with a NICE-approved care package within two weeks of referral. The standard is targeted at people aged 14-65.

There are significant personal, social and health impacts of psychosis when treatment and support is not effective. The cost of not intervening early can often be poor health outcomes and lengthy, costly use of mental health services. The current cost of psychosis to society is estimated to be £11.8 billion per year resulting from direct healthcare costs, lost productivity due to unemployment or death and informal costs to families and carers. EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes.

Despite this, in recent years, there has been evidence of disinvestment in EIP services including the absorption of some EIP services into generic community mental health services, with consequent impact on the timeliness, quality and effectiveness of treatment. We know that currently far too few individuals experiencing or at high risk of first episode psychosis are receiving the ‘right care’ at the ‘right time’ and there can be very long delays in accessing some of the key effective interventions recommended by NICE. For example, only 10% of those with schizophrenia who could benefit from services receive appropriate psychological treatment<sup>7</sup> and only 33% receive recommended physical health checks. These poor levels of access and long waits are unacceptable both in terms of quality of care and effective use of NHS resources.

NHS England commissioned NICE to oversee delivery of an enabling programme of work to support the development and implementation of evidence-based treatment pathways in mental health, including the introduction of access and waiting time standards. NICE commissioned the National Collaborating Centre for Mental Health (NCCMH) to develop this guide.

**Table 8: NICE Quality Standards for Early Intervention in Psychosis (NICE QS80).**

<b>Quality Statements</b>	<b>Action (in adults)</b>
Maximum waiting time from referral to treatment	Adults with FEP start treatment in EIP services within 2 weeks of referral
Psychological therapy	Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp)
Psychological therapy	Family members of adults with psychosis are offered family intervention
Medicines management	Adults with schizophrenia that has not responded adequately to treatment with at least two antipsychotic drugs are offered clozapine.
Education, Employment and Training	Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.
Support for Carers and families	Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

Source: NICE Psychosis and Schizophrenia in Adults, Feb 2015

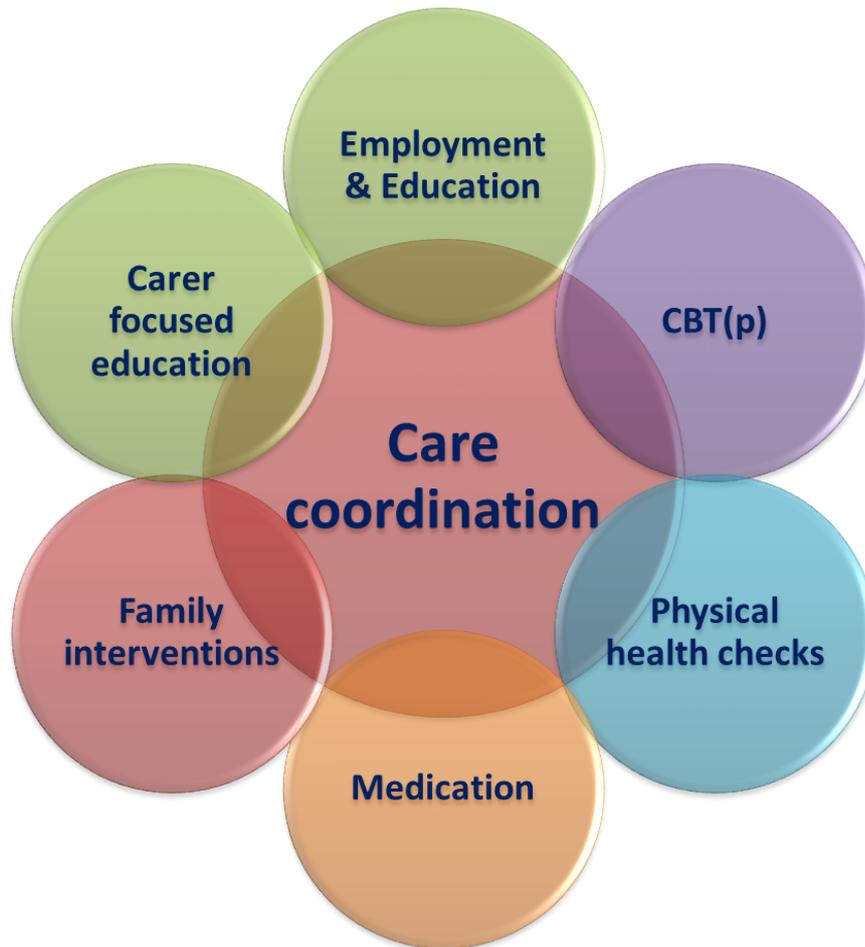
**Provider Performance against NICE Quality Statements in Thurrock:**

It is recommended that adults with FEP start treatment in EIP services within 2 weeks of referral; the current target is 50% and is due to increase to 60% by 2021. Currently, this is reported in Thurrock

as 0%. The rationale behind this is stated as: the Trust is not commissioned / funded to provide a NICE recommended package (Vocational programmes not funded and carer focused education not funded but covered where possible by Care Coordinators).

For all of the other NICE Quality statements listed above, the provider does not collect the data and therefore there is no evidence that the statements are being adhered to by the Provider in Thurrock.

Figure 51: Case Management and Care Co-ordination:



Source: NICE guidance and Thurrock CCG, 2017

Case management is a process of planning, coordinating and reviewing care around the individual. It refers to a package of care which covers a range of activities that can vary widely between different programmes.

**Core Components include:**

**Case finding:** E.g using predictive modelling / Integrated datasets, combined with clinical judgement.

**Assessment:** In terms of current level of ability and physical, mental and social care needs. This must be holistic.

**Care planning:** Addressing an individual's full range of needs, taking into account their health, personal, social, economic, educational, MH and cultural/ethnic circumstances. Recognises needs

are wider than medical and should include housing. Care plan should result that supports the case manager in providing a structure to the individual's care and ensure the goals of all the different services are aligned and monitor progress. It is a live document.

**Care coordination** (usually undertaken by a case manager in the context of a multi-disciplinary team) including but not limited to:

- Medication Management
- Self-care support
- Advocacy and negotiation
- Psycho-social support
- Monitoring and review

**Case closure** (e.g. When recovery is achieved)

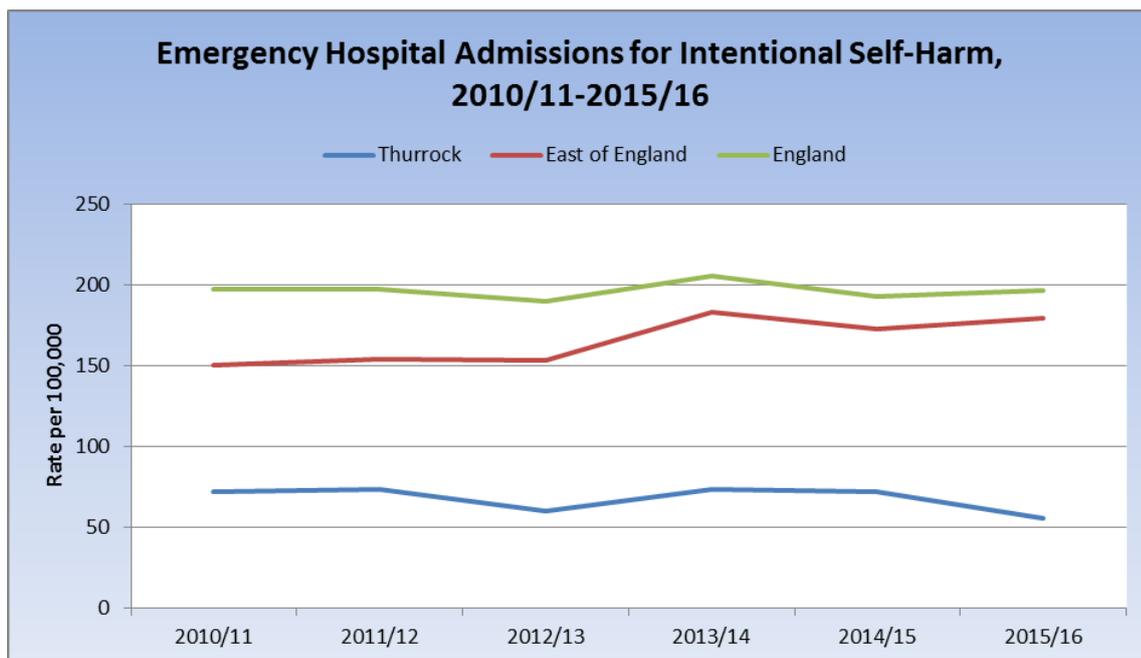
### 7.3 Emergency Hospital Admission and Self-harm

#### Key Points

- Hospital admissions due to self-harm are low in Thurrock
- This is most likely due to poor coding practices
- More needs to be done with secondary care colleagues to make sure that the true picture of self-harm in Thurrock is being accurately captured.
- Hospital A&E attendance data should be gathered and analysed when available

Emergency Admission data show that there is a data coding issue around self-harm and intentional poisoning. Of the almost 12,000 emergency admissions there are none that have a primary diagnosis code of X65-X84 which are the codes for self-harm and intentional poisoning. There are only a few that are recorded with this as a secondary diagnosis (around 15).

Figure 52: Emergency hospital admissions for intentional self-harm, 2010/11-2015/16.



Source: Public Health England

Thurrock is consistently coded as having low rates of admissions for intentional self-harm. Taking the chart above at face value, it would appear that Thurrock does not have an issue, with rates consistently below the regional and national averages. However, this does not mean that we don't have a problem in Thurrock. It is clear that we have a coding issue in Thurrock where self-harm attempts leading to hospitalisation are not well recorded. More work needs to be done with colleagues in secondary care to ensure that coding is done correctly, so that the problem of self-harm can be accurately described and appropriate interventions recommended.

#### 7.4 Recommendations

- The Provider must become NICE compliant as soon as possible.
- The Provider must review their workforce to make sure they can address the physical health and healthy lifestyle issues that patients might have.
- The CCG mental health commissioner should work more closely with BTUH to understand the limitations of coding data by following patient journey through A&E and admissions by their coding data.
- The CC mental health commissioner should be working closely with BTUH to look at re-admission rates (frequent flyers) to determine what can be done to reduce these rates.
- The CCG commissioner should be working more closely with patients and their carers to understand why they attend A&E services rather than other available mental health services. This can be done by completing questionnaires and organising focus groups to gather qualitative data.
- More secondary care data should be collected and analysed so we have more information about the epidemiology of those with a CMHD who access secondary care in Thurrock. This might be possible using Mede analytics data.
- More work should be done with secondary care colleagues to identify and code appropriately those who self-harm as this group is very high risk of CMHDs, and especially for self-harm and suicide. This can be done by:
  - Working with Mede analytics to analyse available data on the characteristics of those who attend A&E for mental health disorders.
  - Working with BTUH to improve smoke-free services in the acute trust by removing smoking shelters and replacing with evidence based best practice e.g. e-cigarette stations such as done in the Maudsley Hospital (SLAM) in London.

## 8 What services are provided for those with mental illness? Social Care

Users of social care services are generally at high risk of having poor mental health. As explored above, there are strong links between the social and physical health problems which lead people to need social care support and mental illness.

### 8.1 Depression screening in Adult Social Care via social care workers

Depression screening involves the use of a standardised depression questionnaire to identify those who have (or are likely to have) depression, allowing them to be referred into treatment services. This is approved by the National Institute for Health and Care Excellence (NICE) as an effective, evidence-based intervention. Adult social care clients are known to be at high risk of depression. This can interact with physical health needs (See Section 5) and, therefore, increase their need for social care. There is also evidence that depression frequently goes undiagnosed among social care clients. Depression screening by social care workers, therefore, has the potential therefore, not only to improve the mental health of some of the most vulnerable adults in the community, but also to have a positive effect on their physical health and social care needs. For example, identifying and treating depression more systematically and earlier in social care clients is likely to delay admission to residential care for some clients and result in cost savings.

Depression screening is included as one of the Health and Wellbeing Strategy objectives for Thurrock under Goal C: Better emotional health and wellbeing. The specific objective is: "Identification and treatment depression will be improved, particularly for those at greatest risk." The action associated with the objective is to: "Increase % of ASC clients over 65 screened for depression by frontline Thurrock Council social care staff."

Depression screening of appropriate social care clients began as a pilot in July 2016. A mid-pilot evaluation was carried out in autumn 2016. It identified issues that social care staff were coming across as they undertook depression screening and aimed to resolve these issues. The pilot ended in March 2017 and depression screening continues to be recommended as an evidence based intervention that is effective in improving outcomes for the target population.

At present, however, there is no systematic monitoring of the implementation of this intervention so it is unclear how widespread its use is.

**Recommendation:** That the extent of depression screening in adult social care be systematically monitored with feedback to social care managers. Monitoring could involve collecting data on referrals into IAPT from adult social care and/or data being collected by the adult social care system. It is recommended that the Mental Health Operational Group consider the best way of monitoring this objective.

### 8.2 Adult Social Care Data Analysis

In 2015-16, there were a total of 9,958 packages provided to 2,492 clients aged 18+ in Thurrock. The majority of the clients were in the 78-87yrs (703) and 88-97yrs (687) age bands, which accounted for over 50% of the total client count.

There were 15 service level categories (packages), further broken down by 9 primary support reasons (shown in

Table 9 below). The total cost of packages provided in 2015/16 was £37,097,751. With the exclusion of five ASC packages with £0 cost attribution (equipment, residential short break, carers service,

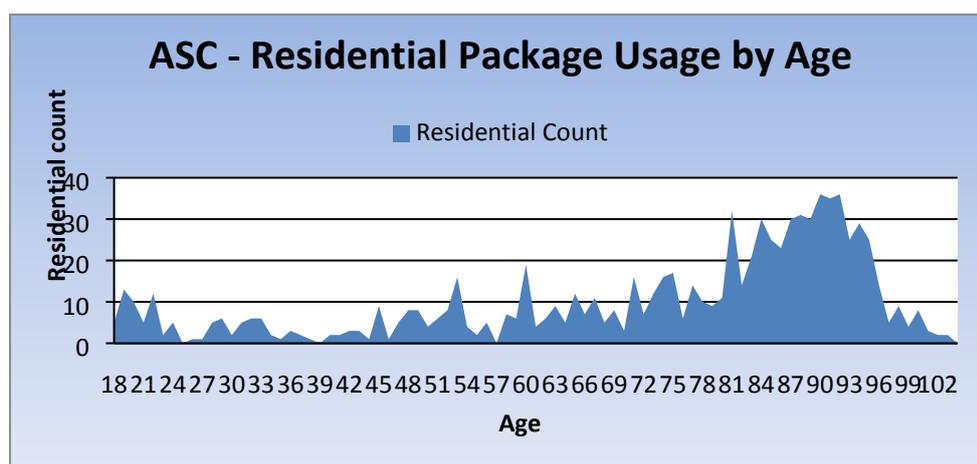
meals on wheels and field work), the top two highest spend was for residential and homecare packages (£21,541,631 and £5, 851,032 respectively).

Looking at spend in terms of primary support reason, the top two highest spend were on personal care support and learning disability support (£11,845,317 and £13,775,107 respectively), followed by mental health support with a total spend of £3,755,206.

**Table 9: Number of ASC Packages (Service Level Category) and Primary Support Reason.**

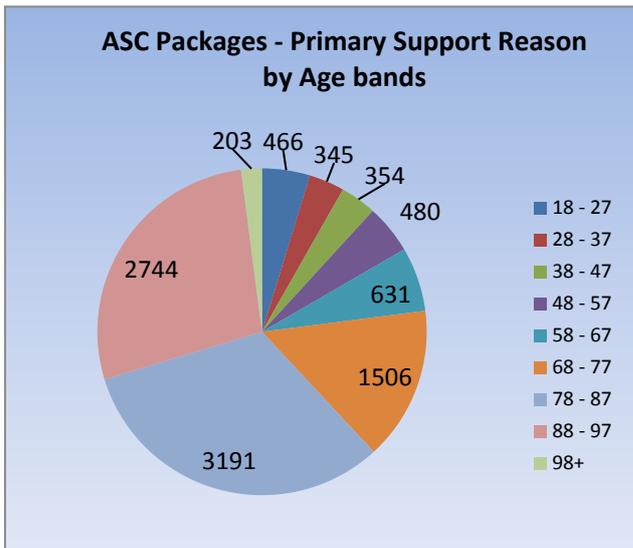
Service Level Category	Number	Primary Support Reason	Number
Homecare	3362	Physical Support - Personal Care Support	4901
Equipment	2688	Physical Support - Access and Mobility Only	1789
Residential	869	Support with Memory and Cognition	1160
Direct Payment	713	Learning Disability Support	1136
Supported Living	508	Mental Health Support	566
Residential Short Break	579	Social Support - Support for Social Isolation /	228
Transport	311	Other	
Day care	320	Sensory Support - Support for Visual	79
Carers service	84	Impairment	
Meals on Wheels	248	Sensory Support - Support for Hearing	41
Intermediate care	177	Impairment	
Nursing	76	Sensory Support - Support for Dual Impairment	15
Fieldwork	6	Social Support - Substance Misuse Support	4
Extracare	9	Social Support - Support to Carer	1
Interpreter	7		
Misc.	1		
<b>TOTAL</b>	<b>9,958</b>		<b>9,920</b>

**Figure 53: ASC Residential Package Usage by Age.**



Of the total ASC package spend in 2015/16; residential packages accounted for 58.1% of the total spend. A breakdown of the residential package usage by age, (Figure 54) showed that clients within the ages of 81-95years had the highest residential package usage.

Figure 54: ASC Package - Age bands usage by primary support reason.



As shown in Figure 54, the three highest users of ASC packages by primary support reasons are clients in the 78-87years (3191), 88-97years (2744), and 68-77years (1506) age bands. Further breakdown by Mental Health Support as the primary support reason, also reflects the highest usage by the three age bands identified above.

The chart below shows that 11.2% of those in the 68-77years age bands are accessing ASC packages primarily for Mental Health support whilst less than 10% of those in all other age bands are accessing ASC packages for mental health support.

Figure 55: ASC Package - Age Bands Usage by Mental Health Support.

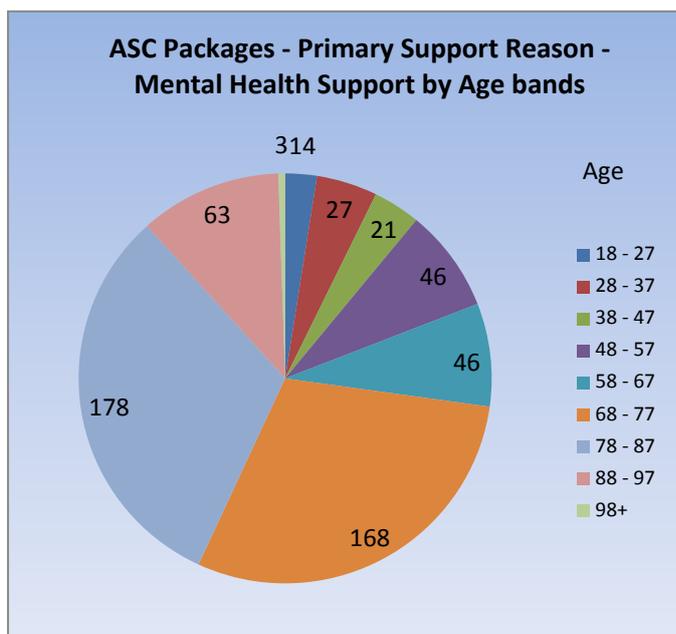
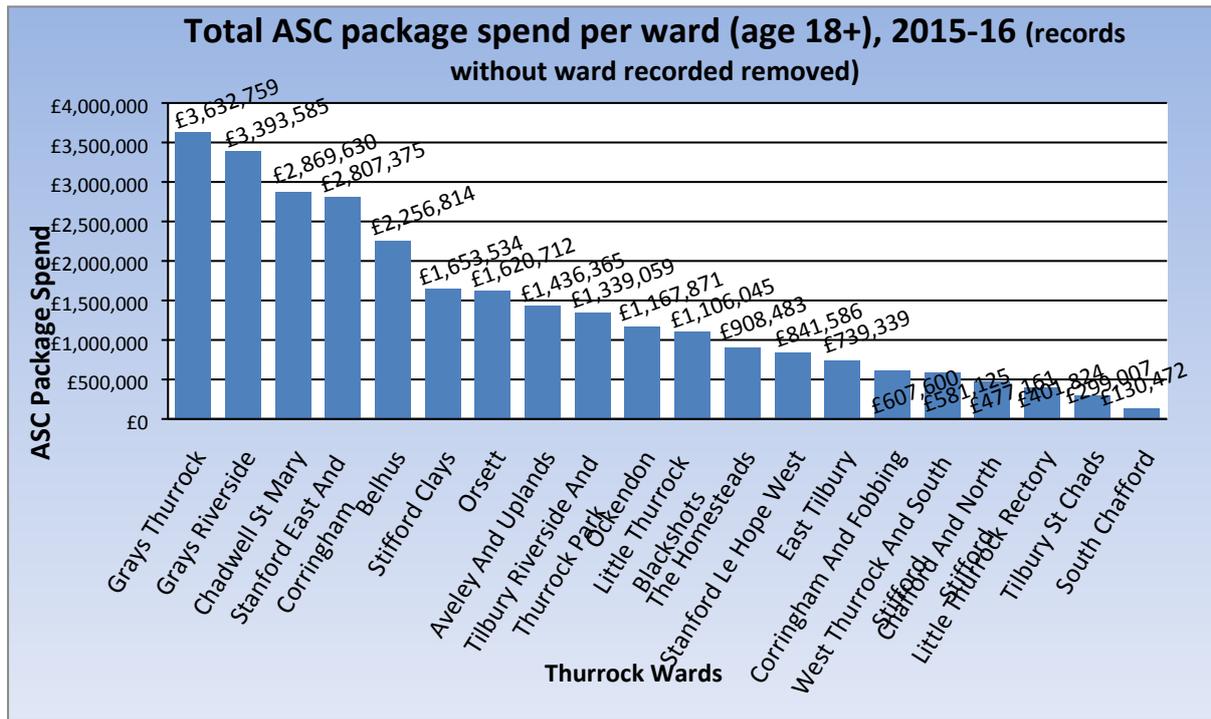
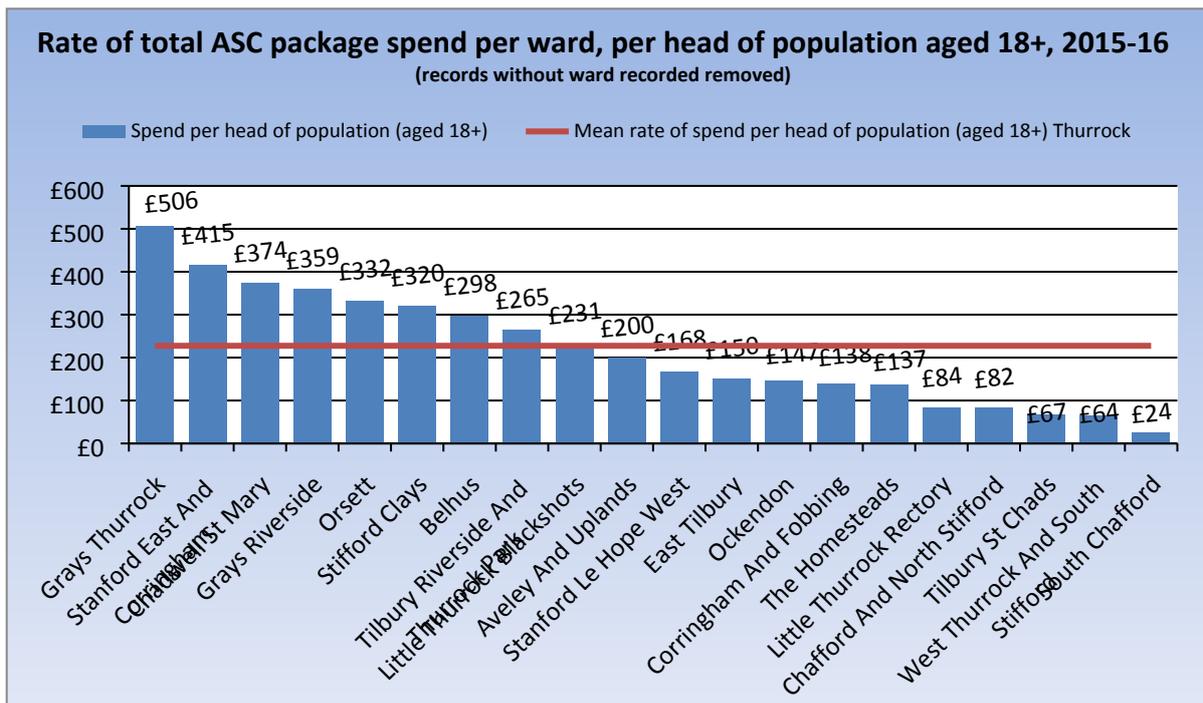


Figure 56: ASC Package spend by Thurrock wards 2015/16.



The figure above (Figure 56) shows ASC package spends by wards in Thurrock. ASC package spend varied widely within the Thurrock Wards, the highest spend was recorded for Grays Thurrock and Grays Riverside (£3,632,759 and £3,393,585 respectively) and the lowest spend for South Chafford and Tilbury St Chads (£130,472 and £299,007 respectively).

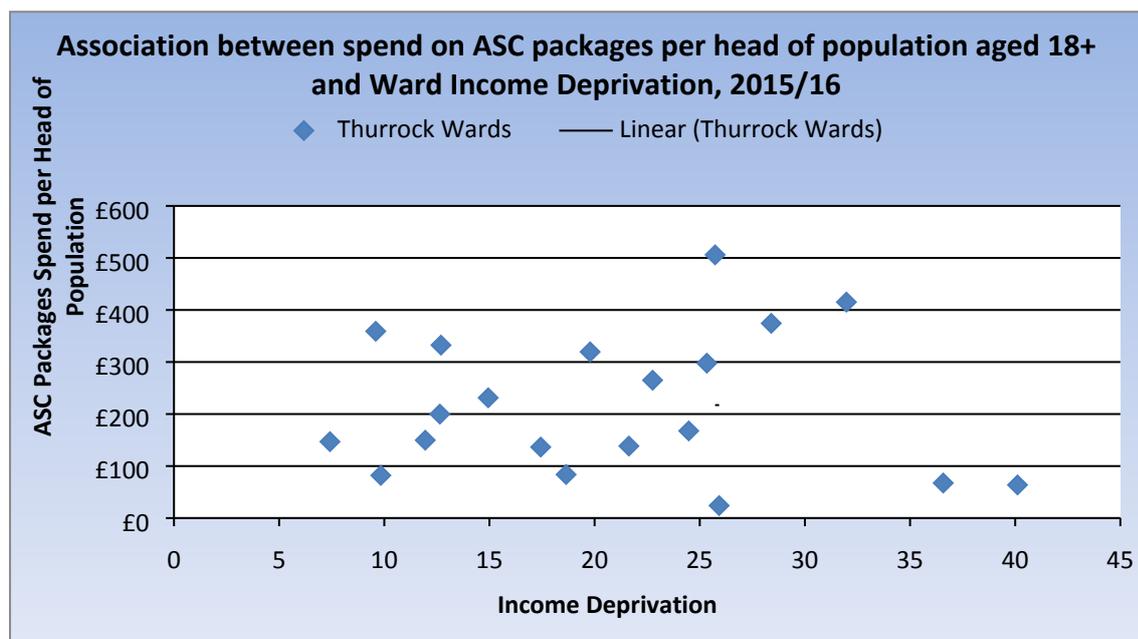
Figure 57: Rate of total ASC package spend per ward, per head of population (aged 18+), 2015-16.



As shown in Figure 57 above, the Thurrock mean rate of ASC spend per head of population aged 18+ was £228, however Grays Thurrock (£506) and Grays Riverside (£425) had the highest rate per head, with the lowest rates recorded for South Chafford (£24) and Tilbury St Chads (£64).

Further analysis to explore an association between ward spend on ASC packages per head of population and ward income deprivation (Figure 58), showed there was no association ( $R^2 = 0.0001$ ).

**Figure 58: Association between spend on ASC packages per head of population (aged 18+) and ward income deprivation, 2015-16.**



### 8.3 Demographics of Social Care Clients

Social care data show that there are currently 4376 clients accessing social care for services and care packages. Of the 4376, there are 280 (6%) individuals whose primary reason for accessing social care services is recorded as being due to mental health issues.

**Table 10: Gender of all clients accessing social care, 2016.**

Gender	Numbers	Proportions
Males	1519	35%
Females	2856	65%
Unknown	1	0%
Total	4376	100%

Source: Social Care Team, TC 2016

The table above shows that there roughly a third of males (35%) and two thirds of females (65%) accessing social care packages.

The range of start dates on these packages range from March 1993 to March 2016.

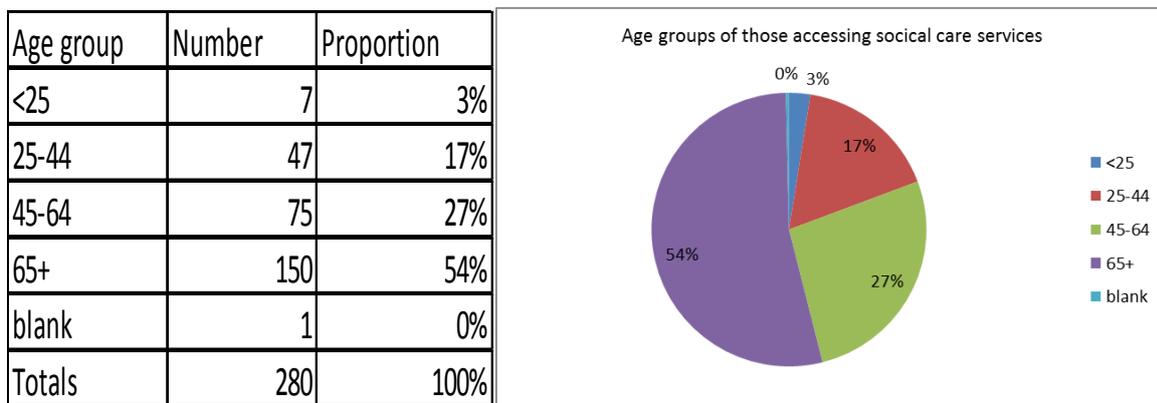
**Table 11: Gender of those clients accessing social care due to mental health reasons, 2016.**

Gender	Numbers	Proportions
Males	126	45%
Females	154	55%
Totals	280	100%

Source: Social Care Team, TC 2016

We can see from Table 11 above that more women (55%) compared to men access social care services due to mental health reasons.

**Figure 59: Age groups of those accessing social care services.**



Over half of those accessing social care services (54%) are aged 65+. This is interesting as it is in direct contrast with those who access mental health services via IAPT; those patients are in the younger age groups. Therefore, we can see that for those with mental health conditions accessing care, older people are more likely to access social care whilst younger people are more likely to access IAPT services. This might also reflect a trend for older people to access social care services but not access health care for diagnosis and treatment of a mental health condition. There could be various explanations for these trends, not purely mental health alone.

### Ethnicity

No ethnicity data is collected with mental health data by social care so it is impossible to comment on whether those accessing the service are reflective of the population make up by ethnicity.

**Table 12: Employment**

Employment status	Numbers	Proportions
Unemployed	30	11%
Blanks	187	67%
Retired	61	22%
Totals	278	100%

Out of the 280 clients reviewed, 278 were accounted for. Two thirds of the clients did not have an employment status filled in so it is unclear whether these people are employed or unemployed. Retired or unemployed clients made up a third of clients.

**Table 13: Costs of packages.**

Cost	Numbers	Proportions
Blank	79	28%
Zero (0)	26	9%
Cost stated	175	63%
Totals	280	100%

The costs of social care packages are enormously varied. They are reported with a weekly cost figure. Over a third (37%) listed with a blank figure or zero, which does not mean that they cost nothing; for these clients, the figure is recorded this way because the actual cost cannot be separated out from the package cost e.g. for occupational therapy packages. This makes accounting for financial spend in social care very difficult to do.

For those clients with weekly costing information supplied, there is a huge range of costs which vary from £3.90 a week to £2440.20 a week. This equates to a range of £203 and £116,500 spend a year for individual clients.

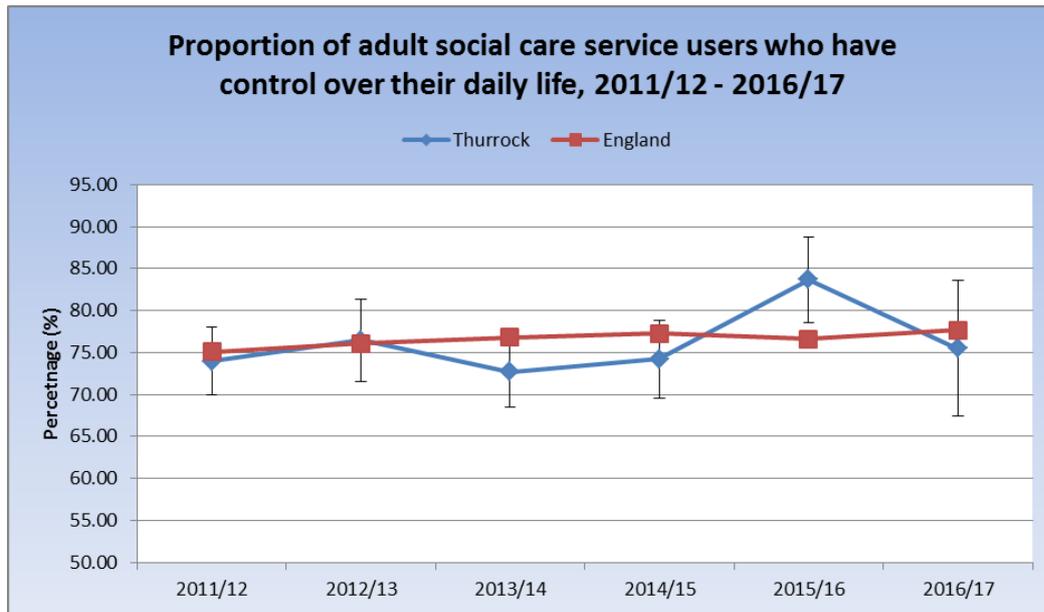
The client with the highest spend (£116,500 a year) is aged under 30 and unemployed with no further details about why their package of care is so expensive.

### **8.3.1 Adult Social Care Outcomes Framework**

The Adult Social Care Outcomes Framework contains a number of measures from the Adult Social Care Service User survey. These are asked to a sample of those accessing all types of social care service aged 18+. The two measures shown below give some insight into the mental health and wellbeing of those accessing social care for support in Thurrock and England. Figure 60 shows the trend in service users feeling they have control over their daily life. In 2016/17, this was 75.5% in Thurrock, which was similar to the national average of 77.7%. With the exception of the previous year, Thurrock has generally been similar to the national average.

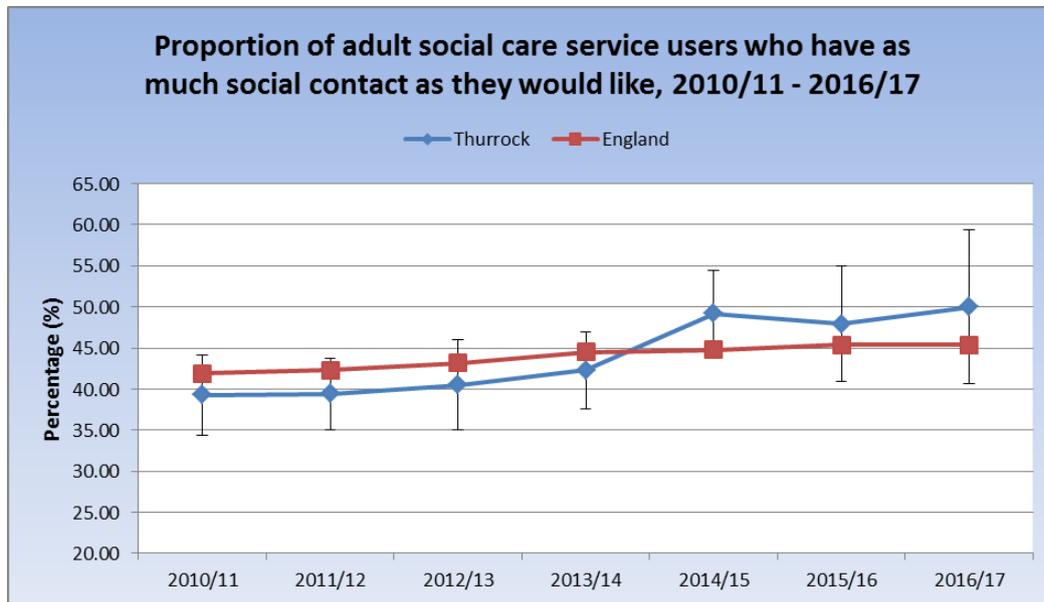
Figure 61 shows the trend in service users who feel they have as much social contact as they would like. In 2016/17, this was 50.0% for Thurrock, which was statistically similar to the national average of 45.4%. This has been statistically similar to the national average for all years since 2010/11. Enabling people to retain a sense of control is vital in helping them to remain independent for longer and maintain good health and wellbeing.

Figure 60: Proportion of adult social care service users who have control over their daily life, 2011/12-2016/17.



Source: Adult Social Care Outcomes Framework

Figure 61: Proportion of adult social care service users who have as much social contact as they would like, 2010/11-2016/17.

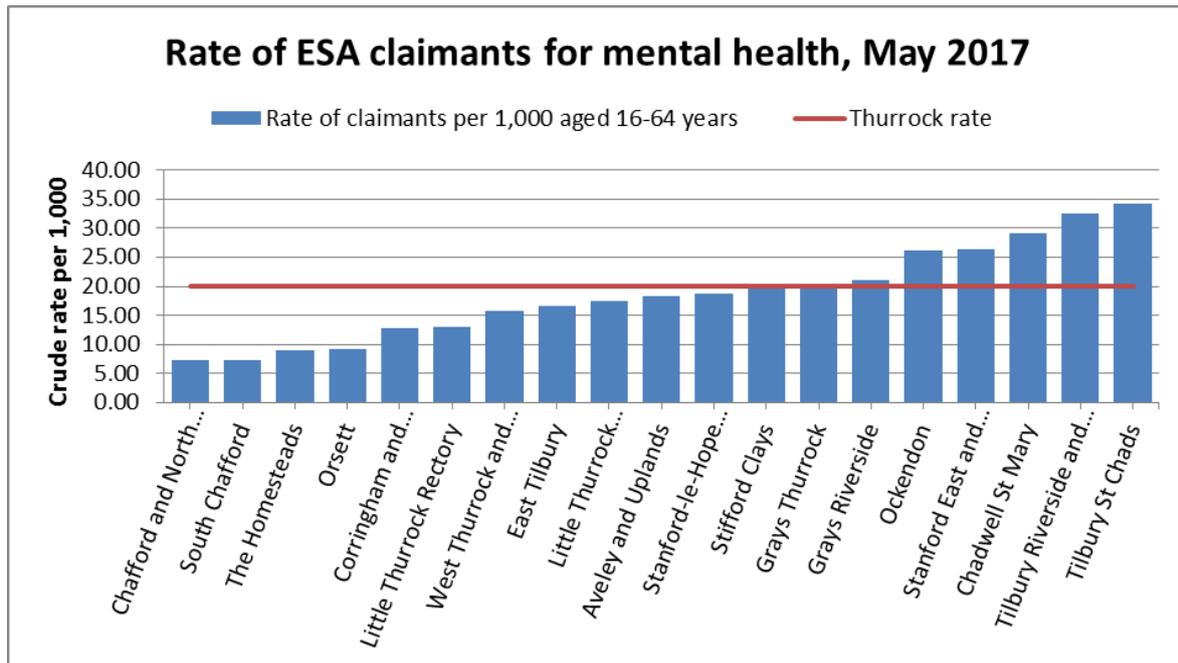


Source: Adult Social Care Outcomes Framework

**Employment and Support Allowance (ESA) Claimants for Mental Health reasons:**

The Employment and Support Allowance (ESA) is a benefit for people who are unable to work due to illness or disability. Poor mental health is a common reason nationally for claiming this type of benefit.

Figure 62: Rate of ESA claimants for mental health, May 2017.



Source: NOMIS, 2017

The chart above shows the rate of ESA claimants for mental health by ward category in Thurrock. The rate of ESA claimants varies widely within the Thurrock wards - the highest rate of claimants live in Tilbury St. Chads where 34.19 per 1000 residents aged between 16-64 claim benefits compared to Chafford and North Stifford where 7.23 per 1,000 of the 16-64 age group claim ESA benefits. The 3 highest areas are 62%-81% higher than the Thurrock average of 20 per 1000 residents in the 16-64 age group. It should be noted that this was the most recent data available due to the transition to Universal Credit in 2017.

## Recommendations for social care

- Integrated commissioning: Plans for joint commissioning across health and social care in Thurrock should include integration of mental health commissioning between the local authority and CCG. Joint commissioning should be used as a platform to drive the integration of services around the individual. An appropriate system of governance to oversee joint mental health commissioning needs to be put in place under the Integrated Commissioning Executive.
- Integrated service delivery: The piloting of Wellbeing Teams to deliver social care in 2018 should be used as an opportunity to test new ways of delivering mental health support as part of a holistic approach to care. It is important that lessons about mental health are captured when these pilot schemes are evaluated. This should include learning about how the teams can and should interact with mental health specialists and what specialist mental health support they need.
- Data quality: commissioners should work with the providers of social care mental health services to determine the costs of services per package as these are currently unavailable.
- Depression screening: The extent of depression screening in adult social care is currently unknown. It should be systematically monitored with feedback to social care managers. Monitoring could involve using IAPT data to monitor the number of referrals coming in from adult social care and/or data being collected by the adult social care system. It is recommended that the Mental Health Operational Group establish a system for monitoring this objective.
- Addressing the social determinants of mental health: Plans to develop four Integrated Medical Centres and implement a new model of care across Thurrock offer an excellent opportunity to integrate employment and housing services into front-line health and social care settings. A focus on reducing the burden of mental health and targeting groups at high risk of mental health should be included in plans for these projects.

## 9 What do residents think of mental health issues in Thurrock?

Healthwatch Thurrock is an independent Health and Social Care service organisation that represents the people of Thurrock. They gather views on local services in order to paint a picture of health and social care services; where they are doing well and where improvements are required.

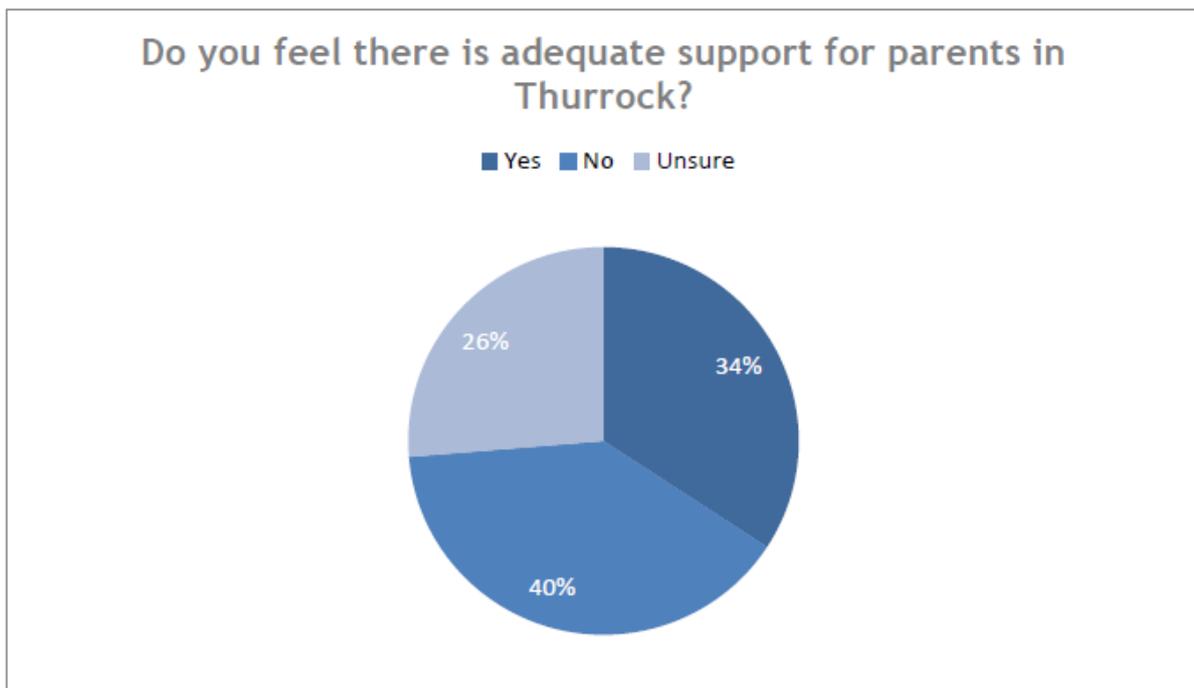
As part of Thurrock Health and Wellbeing Strategy, Healthwatch was asked to engage with the community in Thurrock and ask them questions around emotional health and wellbeing, as related to the Health and Wellbeing Strategy 2016-2021. The views of both young and older people were gathered.

### Goal C: Better Emotional Health and Wellbeing

1. Give parents the support they need
2. Improve children's emotional health and wellbeing
3. Reduce social isolation and loneliness
4. Improve the identification and treatment of depression, particularly in high risk groups

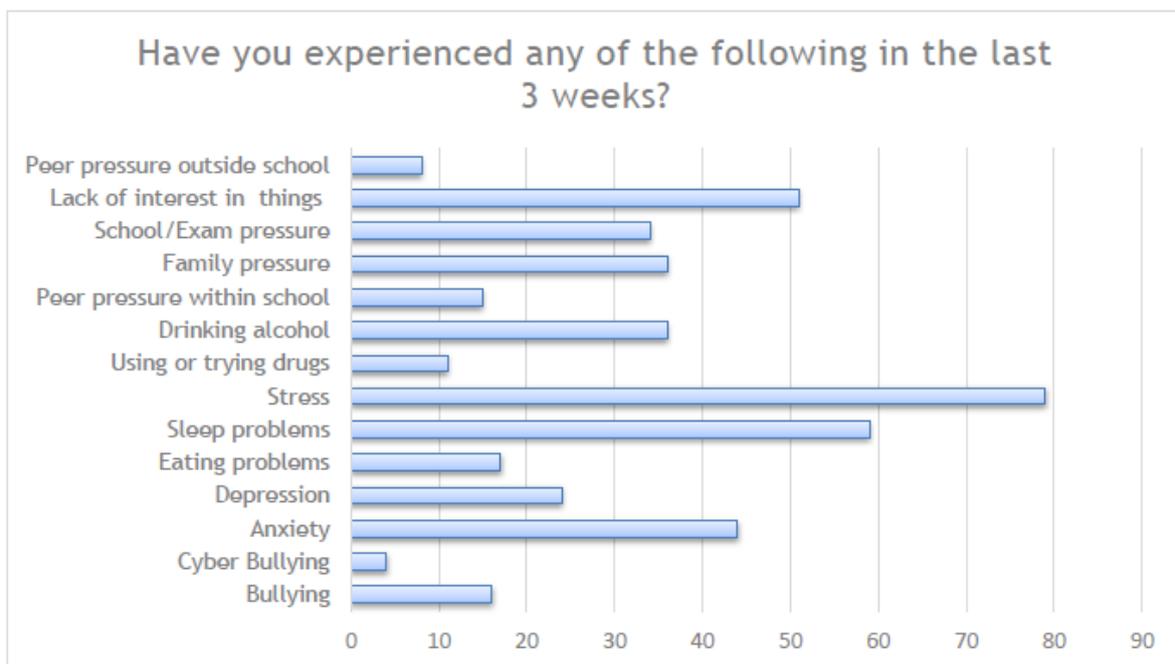
Using on-line and face-to-face methods, a survey was carried out including 126 young people aged 10-18 years and 62 adults aged 19-82 years. Of the adults included in the survey, 77% were female. Areas targeted included educational establishments, community hubs, a children's centre and a Stroke support group.

### Giving parents the support they need:

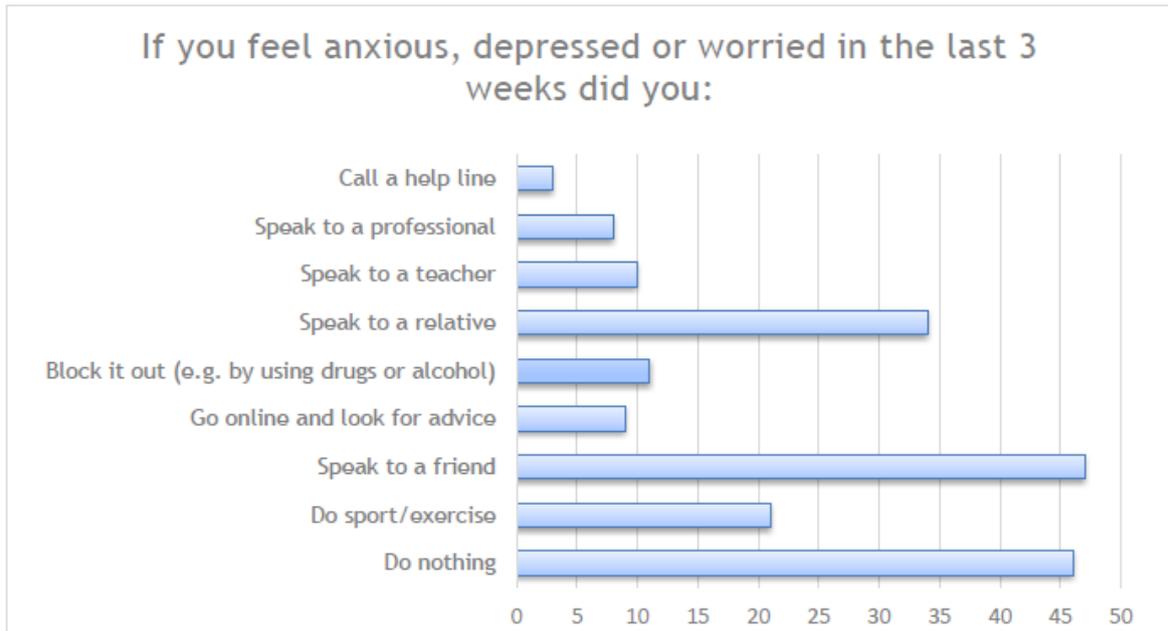


- “I think there is plenty of support for parents and children under 5 years. Once they start school there isn’t as much help available.”
- “If there were more playgroups for new parents as everything seems to be closed.”
- “Referral streams should be made easier. Getting the word out there as to what support parents can access.”
- “If there were Children Centres nearer to where I live as they are only in Tilbury.”
- “I believe my daughter who has downs syndrome received the support she needs but I feel some of the teams need a deeper understanding of Downs Syndrome children and their needs.”
- “I was told my son who has special educational needs couldn’t attend children centre activities - hard to find any groups locally. There seems to be little support here.”
- “There used to be hydrotherapy available for a short term for children with disabilities however once this is over there isn’t much else. I go to a Sunday swimming session at Impulse Leisure Centre with my child which is for disabilities. Would be good if there were more available activities like this.”

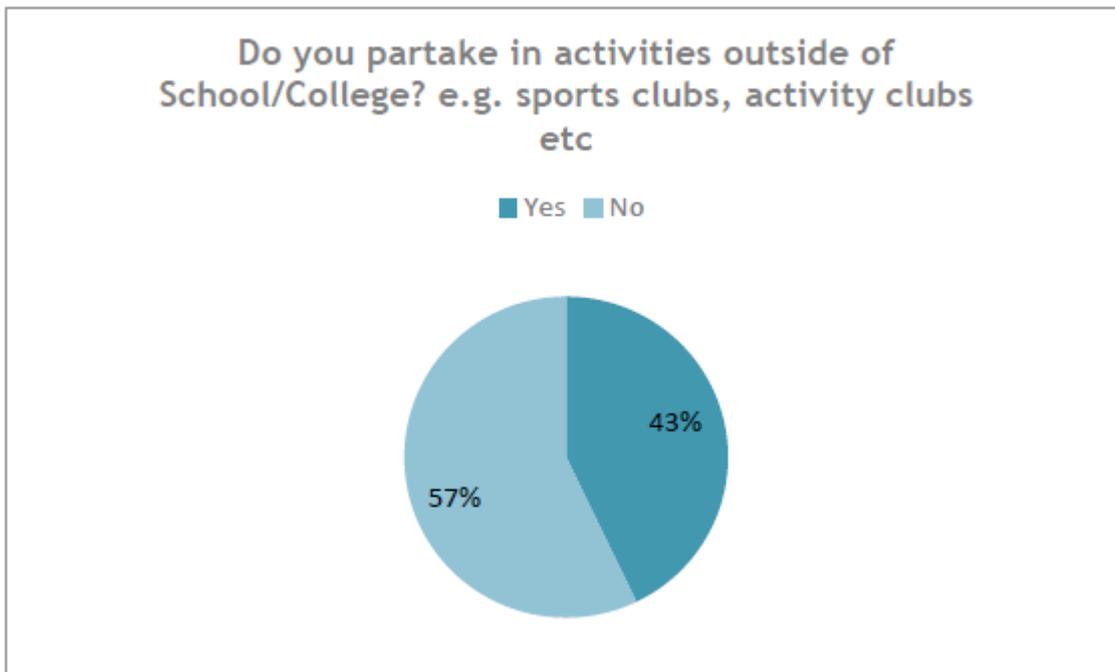
**Improving Children’s Emotional Health and Wellbeing:**



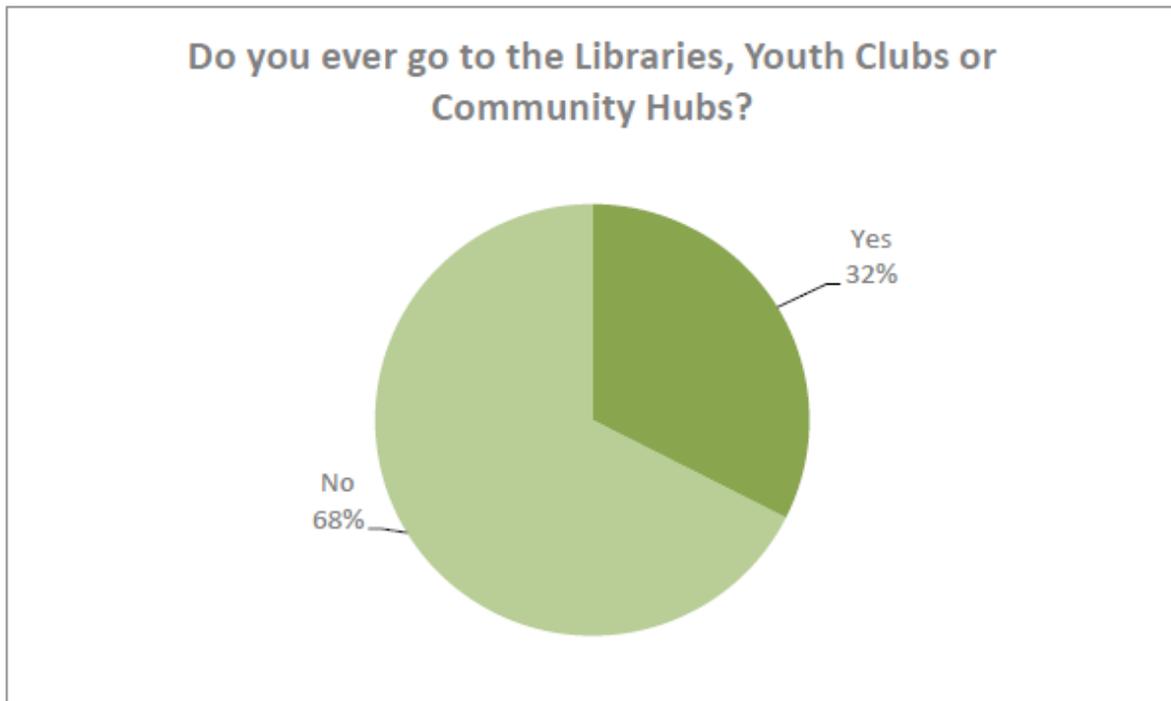
The most common mental health issue identified by young people was stress. This was followed by problems sleeping, a lack of interest in things and then anxiety.



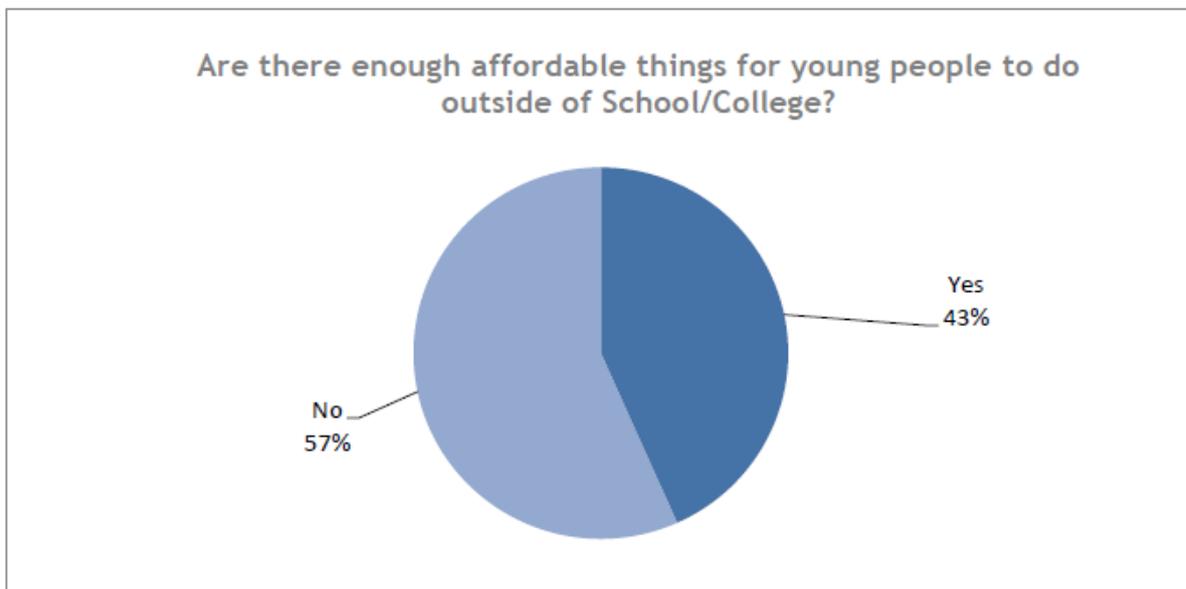
The majority spoke to a friend when feeling anxious, depressed or worried. However, the second most common response was to do nothing.



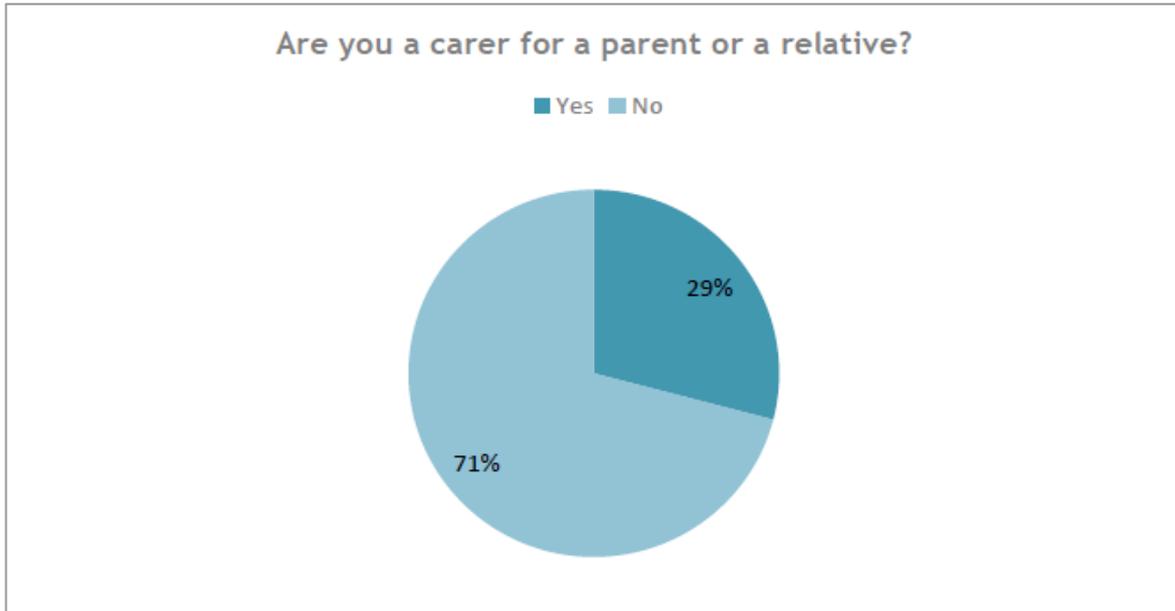
The majority do not take part in activities outside of school or college.



Two thirds of the young people interviewed do not go to libraries, youth clubs or community hubs. However, this might be because some hubs are only open during school hours, which might prevent access to them.



Most do not feel that there are enough affordable things for young people to do outside of school or college. This might be a cause of social isolation and possible antisocial behaviour.

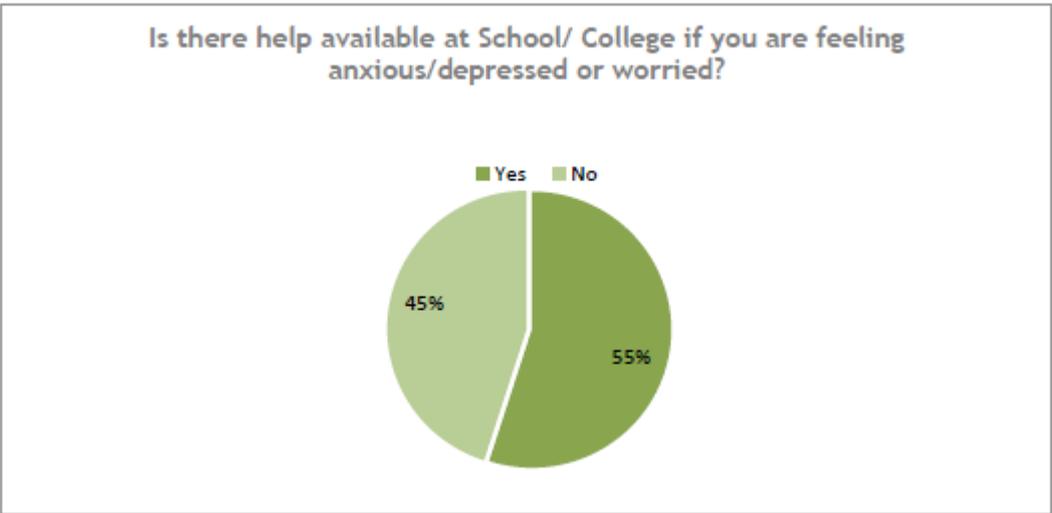


Less than a third are a carer for a parent or relative. Carers have been identified as a group that are at higher risk of having mental (and physical) health disorders.

Comments on mental health services:

• More assistance and people to talk to about mental health.
• More support for those with mental health issues.
• Youth groups, more things for young people what won't cost money
• Mental Health professionals to listen to their patients.
• Health Professionals should listen to their patients more.
• More investment in Mental Health Services.
• Easier access to adult care.
• Moral support.
• More help/support for young depressed people.
• Help create less of a stigma around mental health and using the services.
• Longer opening times (e.g. at the doctors)
• Listen to young people more - be less dismissive etc.
• Counselling on problems we experience in school and outside of school.
• I would like to see better medication and treatment for mental health
• More services available e.g. more confidential online services
• I would like to see a centre that children/teens experiencing neglect can go to.
• Prevent using medication and just pill taking. People need more support than that.

- More youth groups - don't close them!
- Advice and assistance
- Campaign against the stigma of mental health illness.
- More support for the carers of the people with the health issue.
- Better provision of Youth Clubs in Thurrock e.g. Youth Zone with youth facilities ([www.youthzone.com](http://www.youthzone.com)).



More than half of those surveyed felt there was help available at school or college if they were feeling anxious/depressed or worried.

When asked where they would go for help, responses were as follows:

Category	Number	Proportion (%)
GP	28	28
Family support	22	22
School support	21	21
Healthcare services	11	11
Friend support	8	8
Unsure	3	3
A quiet place eg bedroom	2	2
on-line support	2	2
Outside school/college clubs	2	2
Totals	99	100

Just over a quarter of those surveyed would seek help from their GP (28%), although another 11% would go to healthcare services. Just over a fifth (22%) would rely on family for help and a similar proportion (21%) would access school support services.

## Reducing social isolation and loneliness

Around half (51%) of the adults surveyed were aware of Local Area Co-ordinators.

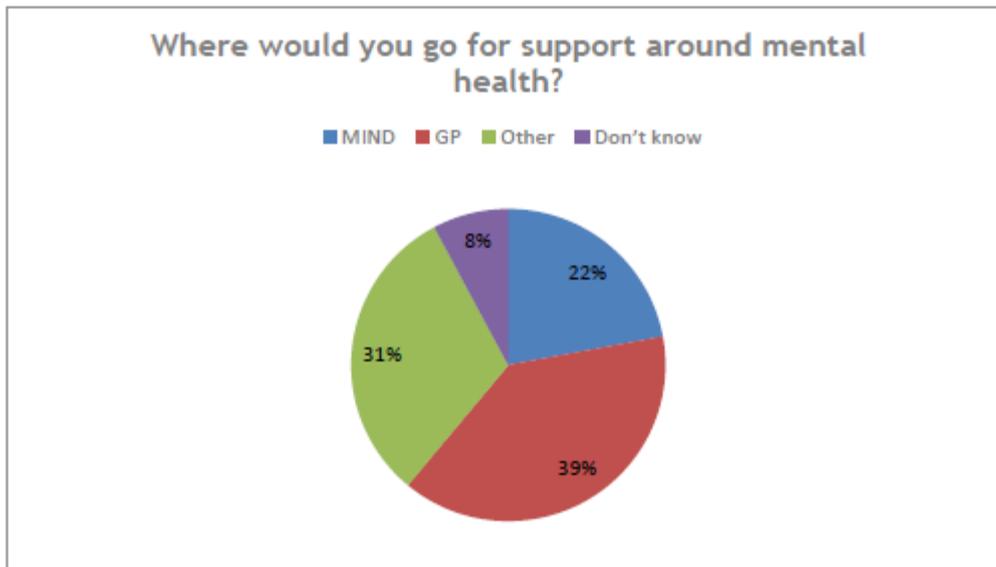
Comments on how to reduce social isolation and loneliness:

<ul style="list-style-type: none"><li>• “More publicity of community hubs and events. Better times for events that do take place. Events and hubs being held in central/clearly accessible areas.”</li></ul>
<ul style="list-style-type: none"><li>• “Information on what’s happening in the area, better advertisement of this.”</li></ul>
<ul style="list-style-type: none"><li>• “I’m elderly now. But I am interested in joining Waterstones book club at Lakeside. It is just the getting there.”</li></ul>
<ul style="list-style-type: none"><li>• “Being able to find out about activities and groups. I work so don’t have much time.”</li></ul>
<ul style="list-style-type: none"><li>• “I am new to area. Accessing the groups etc. Working out of the Borough so it’s hard to find out what is going on locally sometimes.”</li></ul>
<ul style="list-style-type: none"><li>• “Being more aware of community groups and the community hubs in Thurrock and ways to become more involved.”</li></ul>
<ul style="list-style-type: none"><li>• “If information about community groups was put on notice boards - in the flats, in doctors surgeries etc.”</li></ul>
<ul style="list-style-type: none"><li>• “More awareness of what’s going on and volunteering opportunities. If I had more time I would volunteer.”</li></ul>
<ul style="list-style-type: none"><li>• “I would use the community hubs and I have planned to but not got round to it yet.”</li></ul>

<ul style="list-style-type: none"><li>• “I work and the community hubs are not open in the evening, therefore I have not visited my local hub.”</li></ul>
<ul style="list-style-type: none"><li>• “I work 40 hours a week but do my best to be an active member of the community through social media and always help out neighbours.”</li></ul>
<ul style="list-style-type: none"><li>• “Now both my children are in full time education, I could help volunteer.”</li></ul>
<ul style="list-style-type: none"><li>• “I would like to try to get more involved in my neighbourhood groups in my community.”</li></ul>

It seems that increasing awareness of available groups and activities is something that Thurrock residents think is important in reducing social isolation and loneliness.

## Improving the identification and treatment of depression, especially in high risk groups



Although the majority (39%) would go to their GP for support around mental health, almost a quarter (22%) would rather go to MIND. Another 39% would either go elsewhere or don't know where to go. Some of the places listed in other included: Inclusion, SEPT, Healthwatch, Children's centre, Cariads, Samaritans, Health Visitor, Local Area Co-ordinator, hospital, Samaritans and the community and older people's mental health teams.

### Comments on mental health services:

<ul style="list-style-type: none"> <li>I was referred to them by social services. My mentor was Heidi at Open Door she was brilliant. I recommended Heidi to my mum for my brother.</li> </ul>
<ul style="list-style-type: none"> <li>It was awful. We had Family Therapy because of my eldest daughter's behaviour, especially towards her younger sister. After four sessions of enabling my elder daughter to vilify and verbally abuse my younger daughter and the therapists telling me to be quiet every time I objected, the two "professionals" announced rather smugly that it's common for step sisters to clash. They were full siblings. Your "professionals" hadn't even bothered to read the referral and subsequently put my already abused child through utter hell. Disgraceful!</li> </ul>
<ul style="list-style-type: none"> <li>I am trying to get word out in Thurrock that we have a running club and running is an amazing way of overcoming anxiety and depression.</li> </ul>
<ul style="list-style-type: none"> <li>I was supposed to go see someone by now about my emotional wellbeing but never heard back from them.</li> </ul>
<ul style="list-style-type: none"> <li>Counselling in GP service (Pre Therapy For You) was great. Low intensity CBT good. High intensity CBT did more harm than good - partly down to CBT (limited to one type of therapy rather than person centred), partly due to therapist. Too long to wait for the first appointment. Set number of (maximum) sessions is restrictive.</li> </ul>

<ul style="list-style-type: none"> <li>• There should be more health centres open. For people with mental health issues, somewhere they can meet and talk out their problems and maybe get advice on any issues troubling them, whether mental health, financial or medical advice. After the closure of our local hospital in Ockendon that dealt with people with mental health issues, it seems the council and government have turned their backs on these people. They have rights and needs just as much as anyone else, but nobody has spoken to them or advised them on what's available in the local area. These sorts of issues need to be addressed and hopefully remedied sooner rather than later.</li> </ul>
<ul style="list-style-type: none"> <li>• To be truthful at the time (of having treatment for mental health) I was not too forthcoming with how actually I felt. This was my fault; it is hard to tell with mental health.</li> </ul>
<ul style="list-style-type: none"> <li>• I was in a place I didn't want to be on during my early path of recovery from stroke I attend Mind at Bridge Road, Grays. I didn't think it could be helped; I wasn't to forth coming with the truth of how I actually felt. But on hindsight I think it helped me.</li> </ul>
<ul style="list-style-type: none"> <li>• SEPT is incompetent virtually.</li> </ul>
<ul style="list-style-type: none"> <li>• IAPT inclusions were friendly helpful people who were willing to help.</li> </ul>
<ul style="list-style-type: none"> <li>• Mental health illness is a problem that people often feel they cannot share and they find it hard to talk about. I would love for a breakthrough to be in place to help others get help they need or to encourage family members to get help</li> </ul>
<ul style="list-style-type: none"> <li>• There is a lack of information and resource around mental health</li> </ul>
<ul style="list-style-type: none"> <li>• Make more info available about them</li> </ul>
<ul style="list-style-type: none"> <li>• I had a service I waited for but never got an appointment.</li> </ul>
<ul style="list-style-type: none"> <li>• Lack of empathy and proper support</li> </ul>
<ul style="list-style-type: none"> <li>• In the past I have paid privately for support regarding Mental Health conditions (depression).</li> </ul>
<ul style="list-style-type: none"> <li>• Phoned for counselling, spoke to someone who didn't know what they were on about, (call centres), they offered a group session but that was not what I was looking for.</li> </ul>
<ul style="list-style-type: none"> <li>• I think more should be done to help people become more confident in approaching professionals about mental health. To break down barriers of stigma or mental health. There should be more services for mums and families with Post Natal Depression.</li> </ul>
<ul style="list-style-type: none"> <li>• My treatment was mostly satisfactory but I could tell the service was understaffed and overworked.</li> </ul>

## Views of those interviewed that have a Long Term Condition (Stroke)

- *Working out personal independent payment (PIP) and other benefits that are continually cut, or requires appealing puts enormous pressure on people. These financial worries can cause anxiety and/or depression.*
- *Not assuming people are depressed because of a LTC and physical issues. But to have the option of an assessment or simply be asked by the relevant health professionals.*
- *People don't always realise they are suffering from depression and may need to be prompted to get help.*
- *Why is nobody picking up depression at the start of any long term illness, when hospitals, doctors, nurses and often adult social care are involved?*
- *Having a LTC can lead to reduced income, loss of money and not being able to work can have a great impact on someone's life, and then can lead to depression.*
- *To overcome feeling low with a LTC it helps to join clubs, get out, mix with people, and recover by going to a gym but most of these things cost.*
- *Men who have LTCs are less likely to discuss depression.*

## Summary of Recommendations made by Healthwatch:

### C1: Give parents the support they need

#### C1 Recommendations

- Increase the awareness of support for parents with children who have disabilities and make it easier for parents to access this support.
- Provide disability support groups and ensure sessions at the Thurrock Children Centres are suitable and accessible to children with a disability.

### C2: Improve children's emotional health and wellbeing

#### C2 Recommendations

- To ensure that activities such as youth clubs, groups and sports for young people are equitable across the Borough. Some areas now do not have a youth club e.g. Aveley. Also, these resources should link in well with each other in order to fulfil the wide range of young people's needs. E.g. academic support, getting into employment, mental health support, promoting healthy lifestyles and fun activities.
- Over half the young people we spoke to (57%) do not feel there are enough affordable activities for young people to do. LA should consider voucher schemes or encourage better promotion of student discounted opportunities such as reduced fees for train fares and bus fares.
- Some of the young people we spoke to (45%) did not know about the offer of help available within their school or college for mental health concerns. This suggests

that more needs to be done within schools/colleges to raise the profile of the help available and to promote a culture of asking for help when needed rather than doing nothing. Make it easy for people to seek help, e.g. through use of social media or an app.

### **C3: Reduce social isolation and loneliness**

#### **C3 Recommendations (as cross referenced with B3 findings and recommendations)**

- Publication/notification of local community activities. Many people in the community are not aware of everything that is going on.
- Continue to strengthen social relationships and opportunities for community connection for individuals and families, especially those in greatest need e.g. the most vulnerable and isolated. For example through use of the local area coordinators.
- Work on how to strengthen relationships between communities and health and social care agencies.

### **C4: Improve the identification and treatment of depression, particularly in high risk groups**

#### **C4 Recommendations**

- Counselling services should be able to recognise and understand the links between LTCs and mental health. It was suggested (by Stroke Group) that often counsellors do not understand that having a LTC can be the main cause of depression. Living with a LTC greatly impacts on a person's quality of life and can lead to mental health conditions.

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## Appendix A

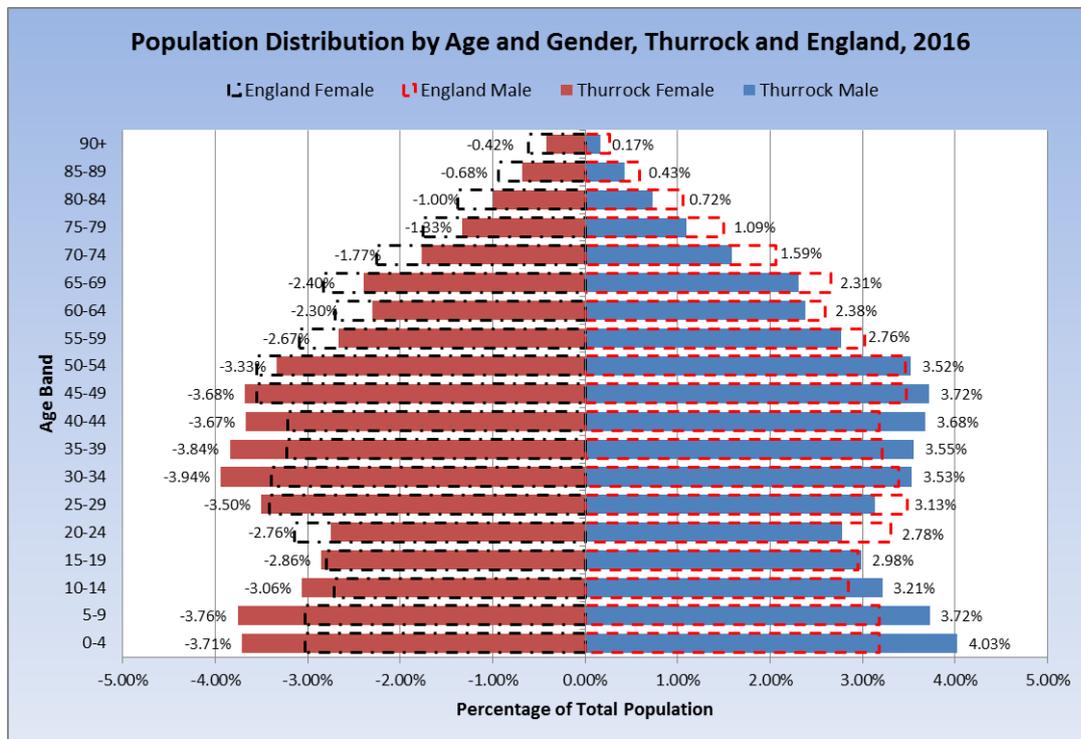
### 11 Demographics of the Thurrock Population

#### Key Points

- The population of Thurrock is set to increase at a faster rate than the national average. By 2039, there will be approximately 27% more residents in Thurrock than in 2014, which is around 44,400 additional residents (compared to the national growth of 17% in the same time frame).
- Thurrock’s population is growing rapidly, especially in the very young and very old (0-14 years and 70+)
- The southern and central areas of Thurrock have the highest population density as well as the highest levels of deprivation
- Thurrock is the 4<sup>th</sup> most deprived area in the East of England region
- Thurrock is becoming more ethnically diverse with a White British population of 82% at the 2011 census compared to nearly 90% in 2001.

#### 11.1 Thurrock Population Pyramid

Of the 167,025 people living in Thurrock, 82,374 (49.3%) are males and 84,651 (50.7%) females.  
**Figure 2: Thurrock vs England Population Pyramid, 2016.**

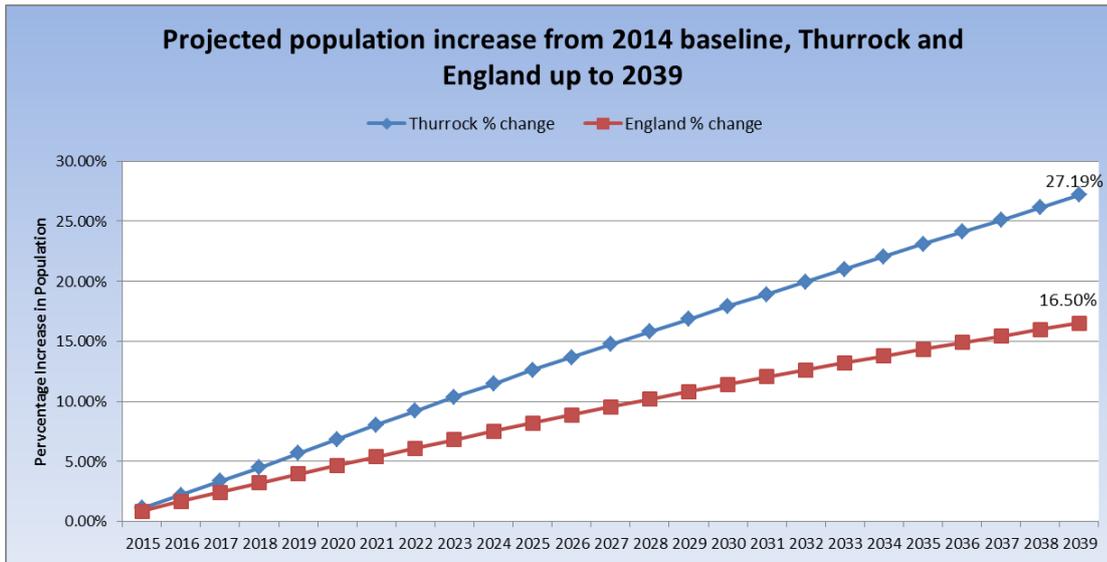


Source: Thurrock Public Health Team, 2017

## 11.2 Thurrock Population Projections

The population of Thurrock is set to increase at a faster rate than the national average. According to the Office for National Statistics, by 2039, there will be approximately 27.19% more residents in Thurrock than in 2014, which is around 44,400 additional residents. To set this in context, the anticipated rate of national growth is around 16.5% over the same 15-year period. It should be noted that the Thurrock growth rate could be even larger than this if the ambitious regeneration plans in growth areas such as Purfleet and Tilbury are realised. Further work is underway to more accurately quantify the impact of the proposed developments on these population projections.

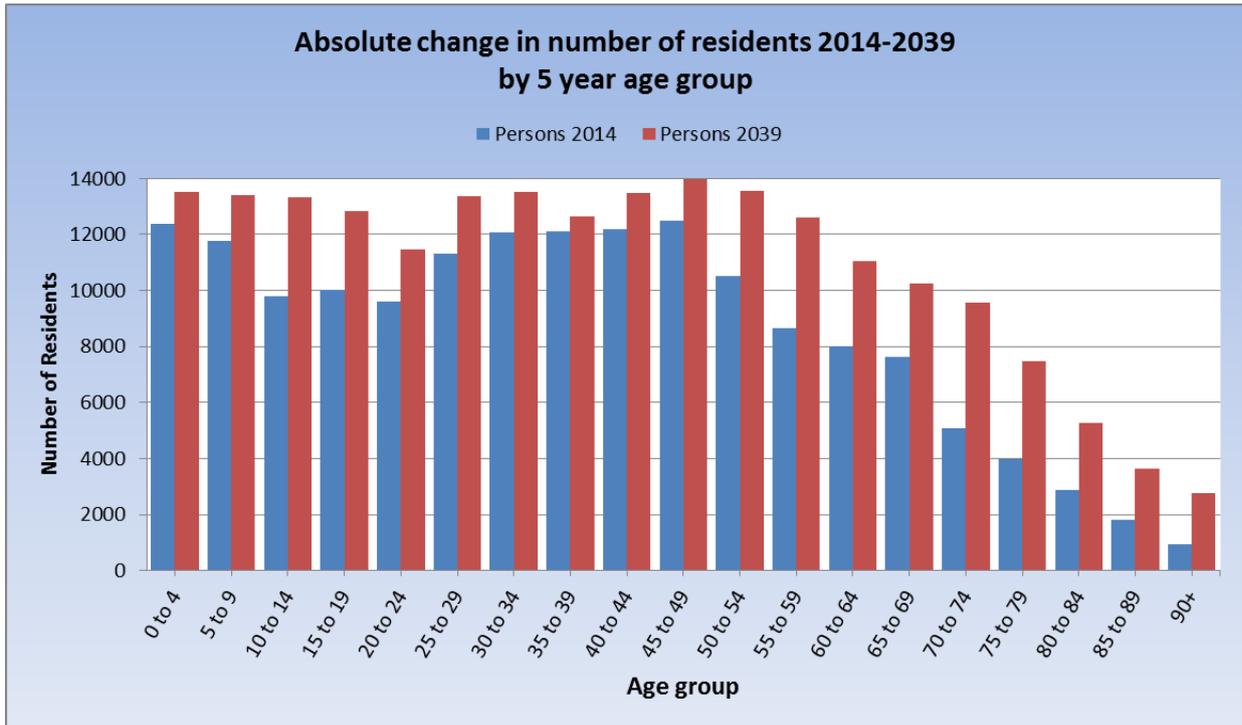
Figure 63: Projected Population Increase from 2014 to 2039.



Source: ONS

Figure 64 below depicts the expected change by age group, and it can be seen that, whilst increases are expected in all age groups, the largest differences can be seen in the older age groups. This is likely to have a substantial increase on future health and social care services – further details on this can be found in the Thurrock 2016 Annual Public Health Report.

Figure 64: Absolute Change in Number of Residents from 2014 to 2039 in Thurrock.

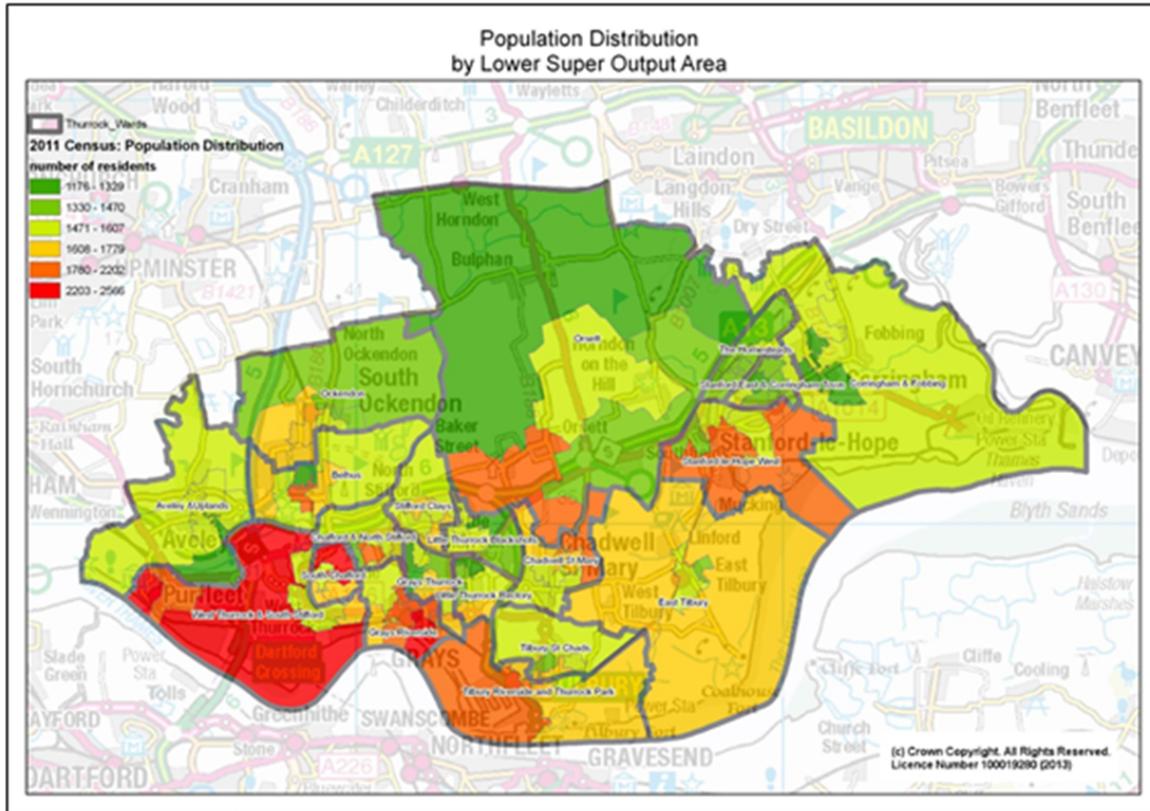


Source: ONS 2014

### 11.3 Population distribution of Thurrock residents

The population density and distribution in Thurrock varies considerably from low density in the more rural areas to high in the urban areas. At the time of the 2001 Census, the average population density in Thurrock was measured at 8.8 persons per hectare compared to 9.7 persons per hectare in the 2011 census, demonstrating the recent increase in population density. Map 2 below highlights that generally the southern and central areas of Thurrock have the wards with the largest numbers of residents, often in quite small, built up areas such as within the Grays Riverside ward. Evidence shows that people are more likely to suffer from mental ill health in inner cities and build up areas with higher population densities, therefore we would expect to a higher prevalence of mental ill health in areas such as Grays Riverside ward.

Map 2: Population Distribution by Lower Super Output Area (LSOA), 2016.

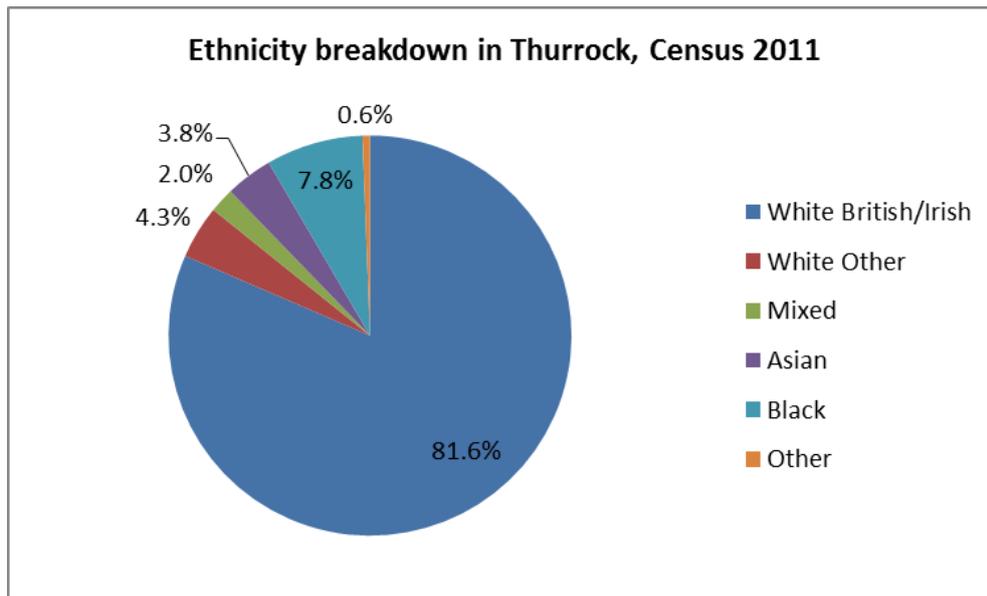


Source: Thurrock Public Health Team, 2016

### 11.4 Ethnicity of Thurrock Residents

Thurrock’s population is becoming more ethnically diverse; in 2001, 94% residents were White British and Irish. In 2011, this proportion had decreased to 82%. The largest population increases are within the Black and Other White Groups. These are the groups that are known to have prevalence of mental ill health, especially in the Black groups.

Figure 65: Ethnicity Breakdown in Thurrock, 2011.

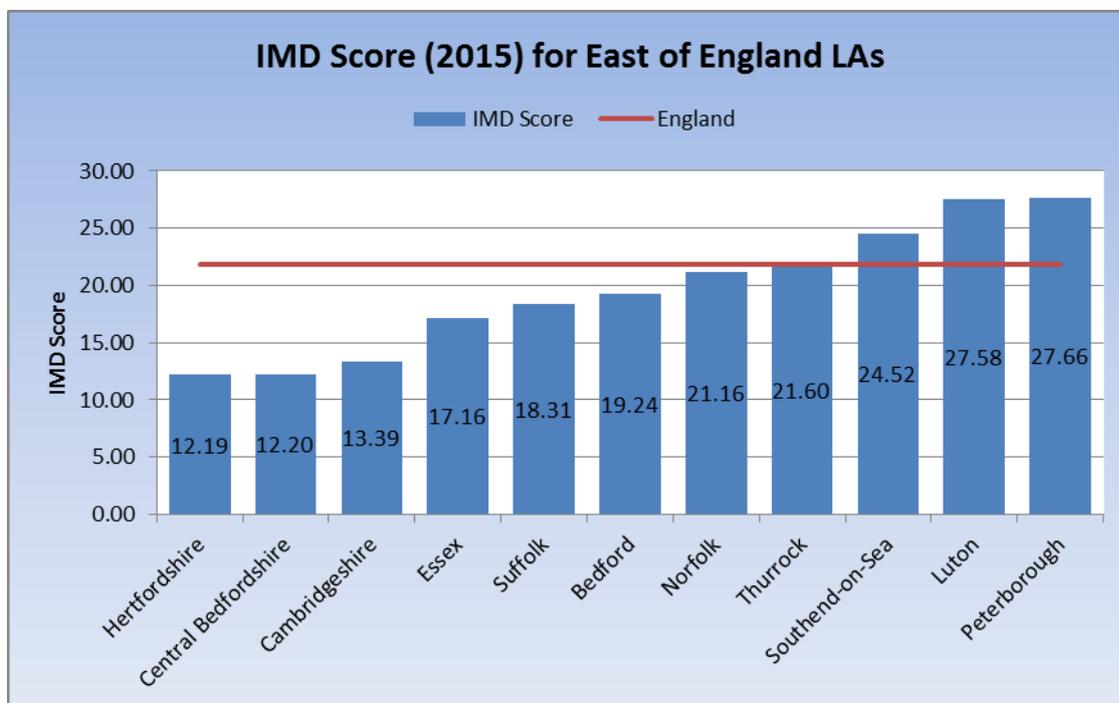


Source: Census data, 2011

### 11.5 Socioeconomic Status

The chart below compares Thurrock with other areas in the region and against the national IMD score. It shows that Thurrock is the 4th most deprived area in the East of England.

Figure 66: Socioeconomic deprivation: overall Index of Multiple Deprivation (IMD) Score, 2015.

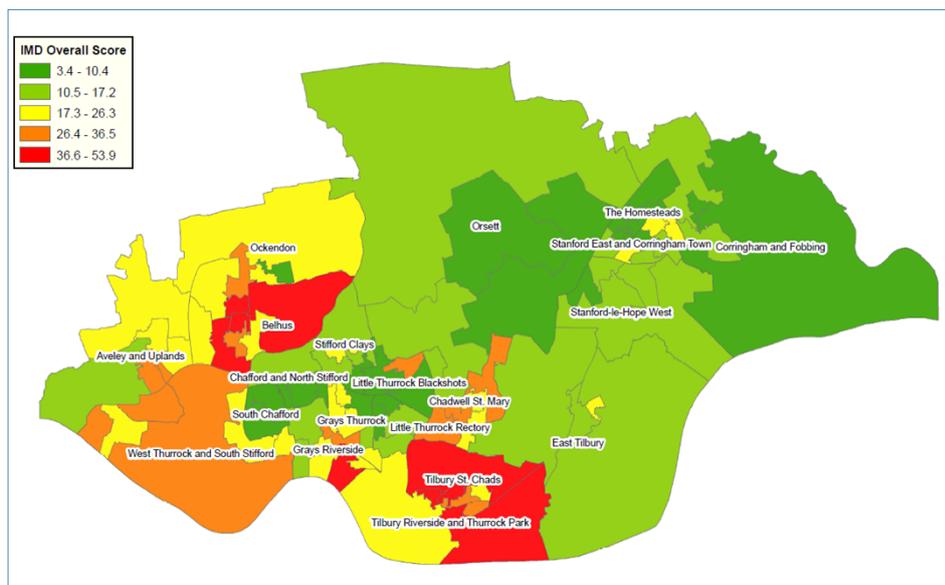


Source: PHE Fingertips

Looking at the whole of Thurrock, it appears that it is not an area that is particularly deprived, as the IMD score is lower than the England average. However, when we take a closer look at the different wards in Thurrock, we can see a more detailed picture.

Deprivation can be measured using the Index of Multiple Deprivation. An overall score is calculated for each Lower Super Output Area [Thurrock has 98] taking into account 7 different domains. Map 3 below depicts the scores within Thurrock – with those areas in red having the highest deprivation scores and falling into the most deprived quintile in England. These are around the areas of Tilbury, Belhus and Grays Riverside. We would therefore expect to see a higher prevalence of mental ill health in these more deprived areas.

**Map 3: Index of Multiple Deprivation (IMD) Overall Score for Thurrock, 2015.**



Source: Public Health Team, 2016

<sup>i</sup>The State of Obesity. *The Healthcare Costs of Obesity*. Available from: <http://stateofobesity.org/healthcare-costs-obesity/>

<sup>ii</sup> Public Health England. Making the Case for Tackling Obesity – why invest. 2015. Available from: [http://www.noo.org.uk/securefiles/161102\\_1758//Making%20the%20case%20for%20tackling%20obesity%20Reference%20sheet-0308116.pdf](http://www.noo.org.uk/securefiles/161102_1758//Making%20the%20case%20for%20tackling%20obesity%20Reference%20sheet-0308116.pdf) [Accessed August 2016]

<sup>iii</sup> NHS England Investment in Mental Health 2015/16. Available from: <https://www.england.nhs.uk/wp-content/uploads/2014/11/payment-systs-mh-note.pdf> [Accessed June 2017]

# Thurrock Joint Strategic Needs Assessment for Common Mental Health Disorders – Executive Summary

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# Key findings and recommendations

Findings	Summary Recommendations
<p><b>System Fragmentation</b> The current mental health prevention and treatment system is highly fragmented with a large number of services operating at different levels and commissioned in parallel</p>	<p><b>Integration of commissioning:</b> Plans for joint commissioning across health and social care in Thurrock should include integration of mental health commissioning between the local authority and CCG. Joint commissioning should be used as a platform to drive the integration of services around the individual.</p> <p><b>Integrated Service Delivery:</b> The development of new models of care provides a huge opportunity to try doing things differently. Mental health needs to be integrated into the delivery of new models of primary care and wellbeing teams delivering social care in the community. There are also important opportunities to integrate services addressing the social determinants of mental health such as housing and employment into these new models of care.</p>
<p><b>Under-diagnosis</b> A large proportion of those with mental ill health are never diagnosed or treated. Depression is particularly poorly diagnosed and there is wide variation between GP practices in the extent of case finding.</p>	<p><b>Reduce unwarranted variation between GP practices in case finding.</b> Building on the work of the GP practice profiles produced by the public health team there is an opportunity to reduce variation and find the 8000+ people estimated to have undiagnosed depression in Thurrock.</p> <p><b>Make better use of depression screening.</b> There is a strong evidence base to support the use of depression screening amongst front-line staff working with high risk groups (e.g. use by social workers or health professionals in long term condition clinics). Current use of this tool appears to be minimal and is not consistently monitored. Joint work between the local authority and CCG is needed to promote this.</p>

# Key findings and recommendations

Findings	Summary Recommendations
<p><b>Quality of Care</b> Even when people are identified as having a mental illness they are often not referred for treatment or their treatment is not in line with the highest quality standards.</p>	<p><b>Reducing unwarranted variation between GP practices.</b> Variation in referrals into IAPT services and reviews of newly diagnosed depression are examples of two quality standards which could be improved through joint working between GP practices and the public health team.</p> <p><b>Commissioners working to improve standards.</b> Redesign of CCG-commissioned services of some existing services is underway and standards are expected to improve. This must be monitored closely by commissioners.</p> <p><b>Improve quality of service data.</b> Commissioners in the local authority and CCG are working with providers to improve the quality of the service data they receive. New indicators need to be designed with are meaningful and focussed on patient outcomes, including wider social outcomes.</p>
<p><b>Risks Associated with Mental Health</b> There are well-known wider health risks associated with mental health including high rates of smoking, obesity and long-term conditions (LTCs).</p>	<p><b>Improve understanding of links between mental health and LTCs.</b> Feedback from residents with LTCs suggests that clinicians do not always appreciate these connections. Education of health professionals would be beneficial.</p> <p><b>Promote smoking cessation in those with serious mental illness.</b> Work is ongoing between public health and mental health provider services to promote smoking cessation even in in-patient settings. This needs to be brought to completion and monitored.</p> <p><b>Promote referral of mental health patients into healthy lifestyles services commissioned by public health.</b></p>

# Background

## Abbreviations

CMHDs	Common Mental Disorders
SMIs	Severe Mental Illnesses
IAPT	Improving Access to Psychological Therapies
EIP	Early Intervention in Psychosis
PTSD	
OCD	
MH	Mental Health
JSNA	Joint Strategic Needs Assessment
APMS	Adult Psychiatric Morbidity Survey
CMS-NOS	Common Mental Disorder – Not Otherwise Specified
GAD	Generalised Anxiety Disorder

## Definitions

Common Mental Disorders (CMHDs)

Includes: depression, anxiety, panic disorder, obsessive-compulsive disorder (OCD), phobias, post-traumatic stress disorder (PTSD). CMHDs do not generally exist in isolation to each other. Mixed anxiety and depression being the most commonly diagnosed CMHD.

Serious Mental Illnesses (SMIs)

Includes conditions characterised by psychosis (losing touch with reality) or requiring high levels of care. Two of the most common are: schizophrenia and bipolar disorder (manic depression). Also known as *Severe Mental Illness*.

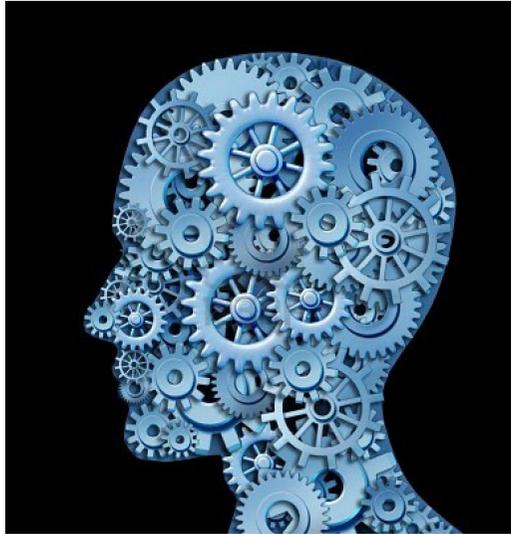
Improving Access to Psychological Therapies (IAPT)

A national programme to increase the availability of 'talking therapies' on the NHS. IAPT is primarily for people who have mild to moderate mental health difficulties.

Early Intervention in Psychosis (EIP)

Early Intervention in Psychosis (EIP) teams provide specialist treatment and care for people who have signs of psychosis. The teams are made up of a number of different health and social care professionals.

# Background



## Purpose and Scope

This JSNA aims to:

- Understand the full estimated level of need
- Understand the variation in access and quality of treatment
- Identify mental health priorities for Thurrock

It includes both Common Mental Health Disorders (CMHDs) and Serious Mental Illness (SMI)

*Mental health is “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to made a contribution to her or his community.”*

World Health Organization

There is a growing recognition of how common mental health disorders are. Mental health disorders are the leading cause of disability worldwide (WHO) and one in four people in the UK will experience a mental health disorder at some point in their lives. While the document focuses on adults, this is an issue which exists across the life course. We know that many adult mental health disorders begin in childhood and that up to half of them could be averted with effective childhood interventions (COI, 2011).

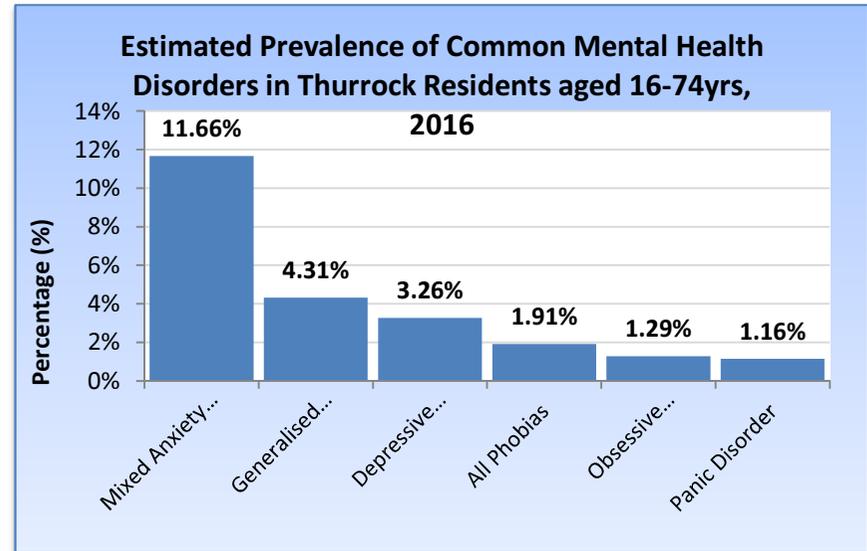
Historically, mental health disorders has been severely stigmatised. As a result many mental health problems have gone unrecognised and untreated, mental health treatment has been treated in a separate silo from physical health and has suffered from a lack of investment. This JSNA aims to improve our understanding and build a better system.



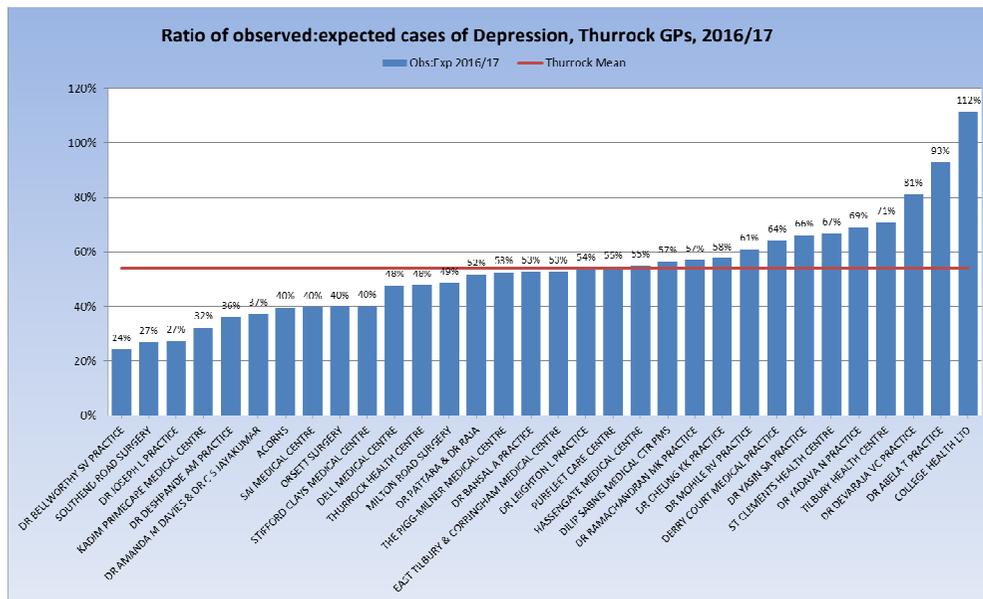
# Who is affected? The scale of the problem

## Prevalence of Common Mental Health Disorders

- One in four people will be affected by mental illness at some point in their lives
- Up to 15% of the population are affected by CMHDs at any one time at any one time
- Mixed Anxiety and depression is the most common CMHD, estimated to affect 11.66% of adults in Thurrock.



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## Diagnosis of depression

- Many people with mental illness are never diagnosed or, therefore, offered treatment.
- For example, it is estimated that there are 8,628 people in Thurrock with undiagnosed depression.
- There is huge variation in the diagnosis of depression between GP practices in Thurrock. This suggests that some practices are better than others at spotting and diagnosing depression.

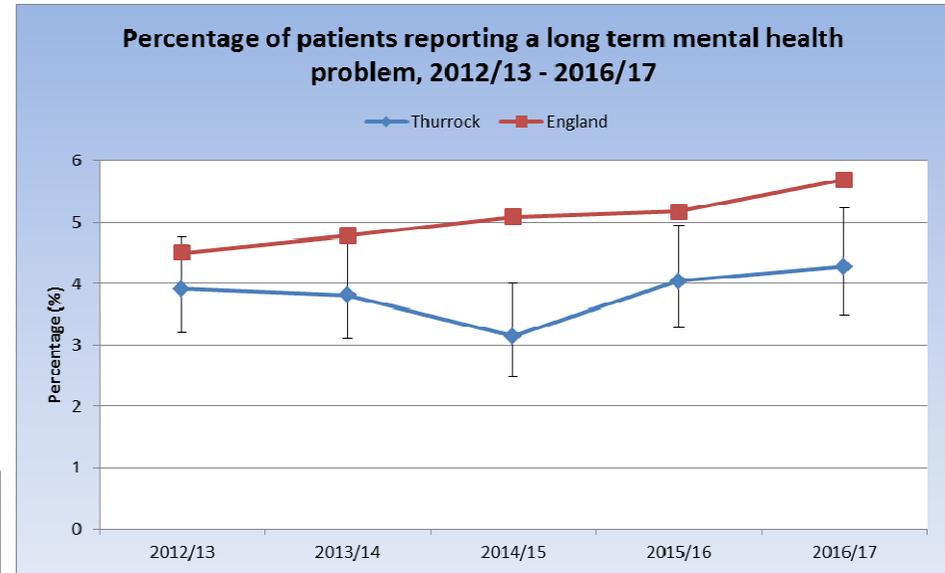
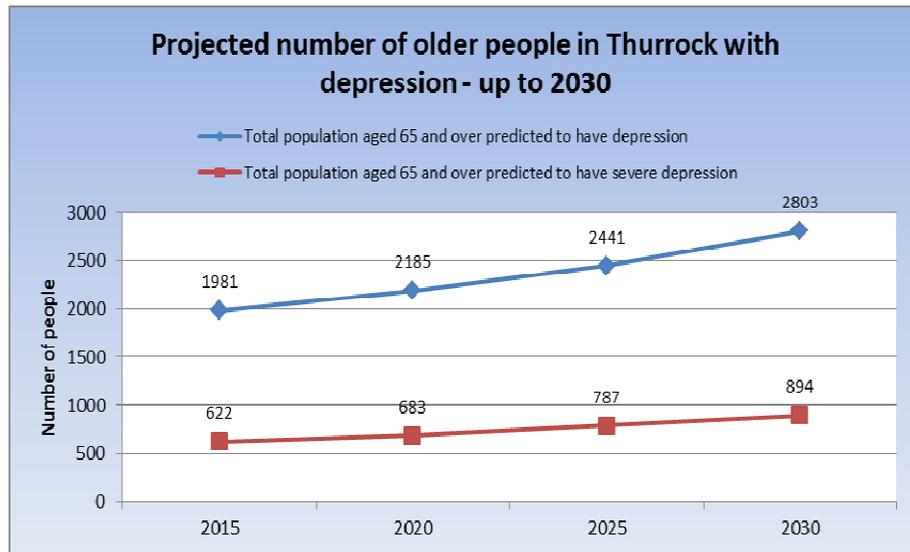
**Key point: There is a huge opportunity to identify and treat thousands of people with undiagnosed mental illness**

# Who is affected? Trends

## Trends in Long Term Mental Health

- Nationally, the proportion of people reporting that they have a long term mental health condition is on the rise.
- Rates in Thurrock are slightly below the national level but the upward trends appears to be affecting Thurrock too.
- More positively, other data show that the proportion of adults reporting low levels of happiness declined in Thurrock from just over 12% in 2011/12 to under 10% in 2016/17. This suggests that rates of mental illness may be increasing partly due to greater recognition of mental health issues and that rates of increasing illness is not necessarily incompatible with improvements in quality of life.

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## Projecting trends into the future

- Estimates made by the Projecting Adult Needs and Services Information (PANSI) suggest that the number of adults with a CMHD in Thurrock will increase by 10% between 2015 and 2030.
- Increases are likely to be steeper in the older population. For example, the number of older people (65+) with depression is likely to increase from 1,981 to 2,803 between 2015 and 2030

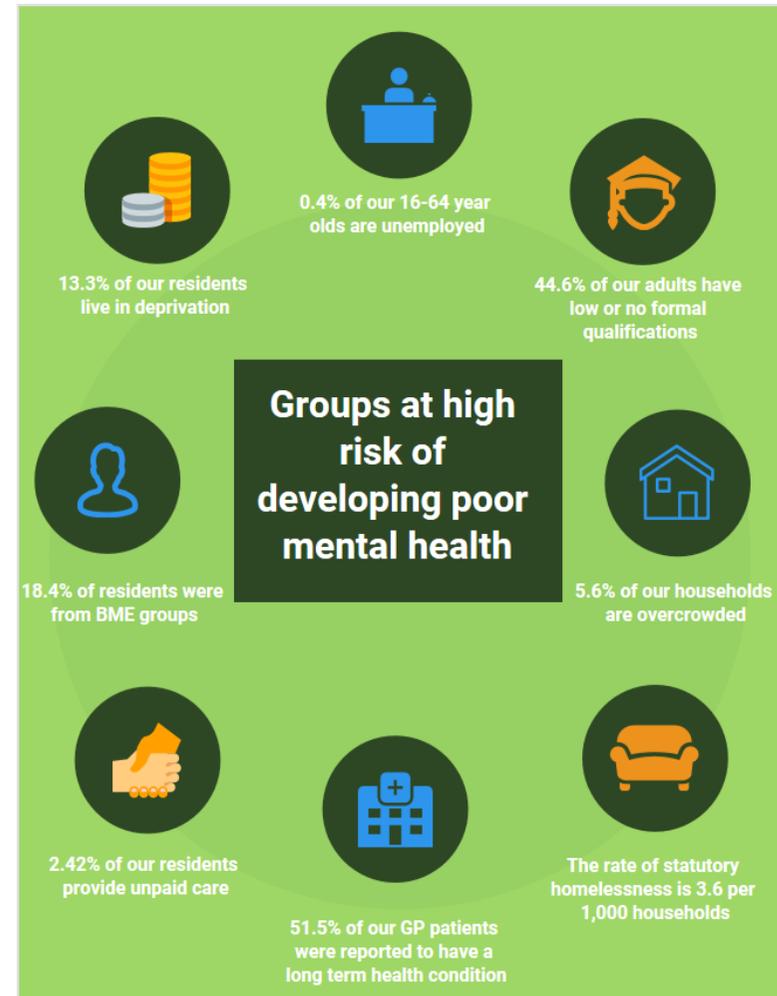
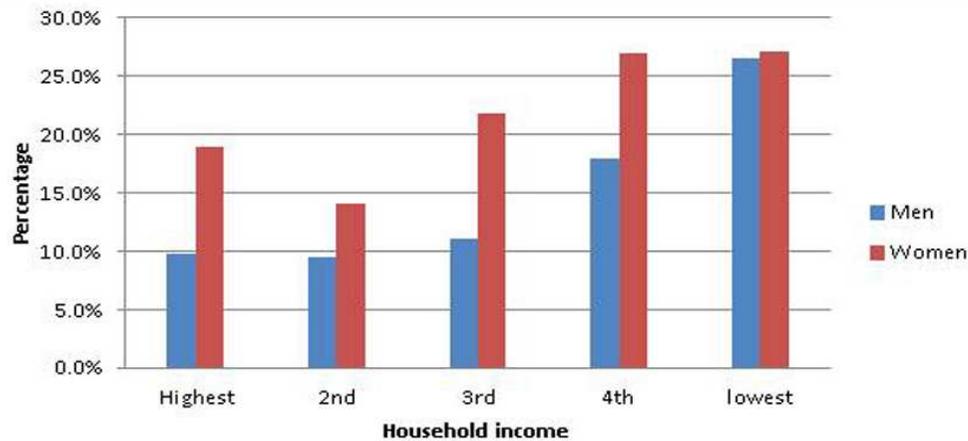
**Key Point: the number of people affected by mental illness is growing, particularly in vulnerable groups such as older people. Some of this may be due to better recognition of mental illness.**

# Who is affected by MH? High risk groups

## High Risk Groups

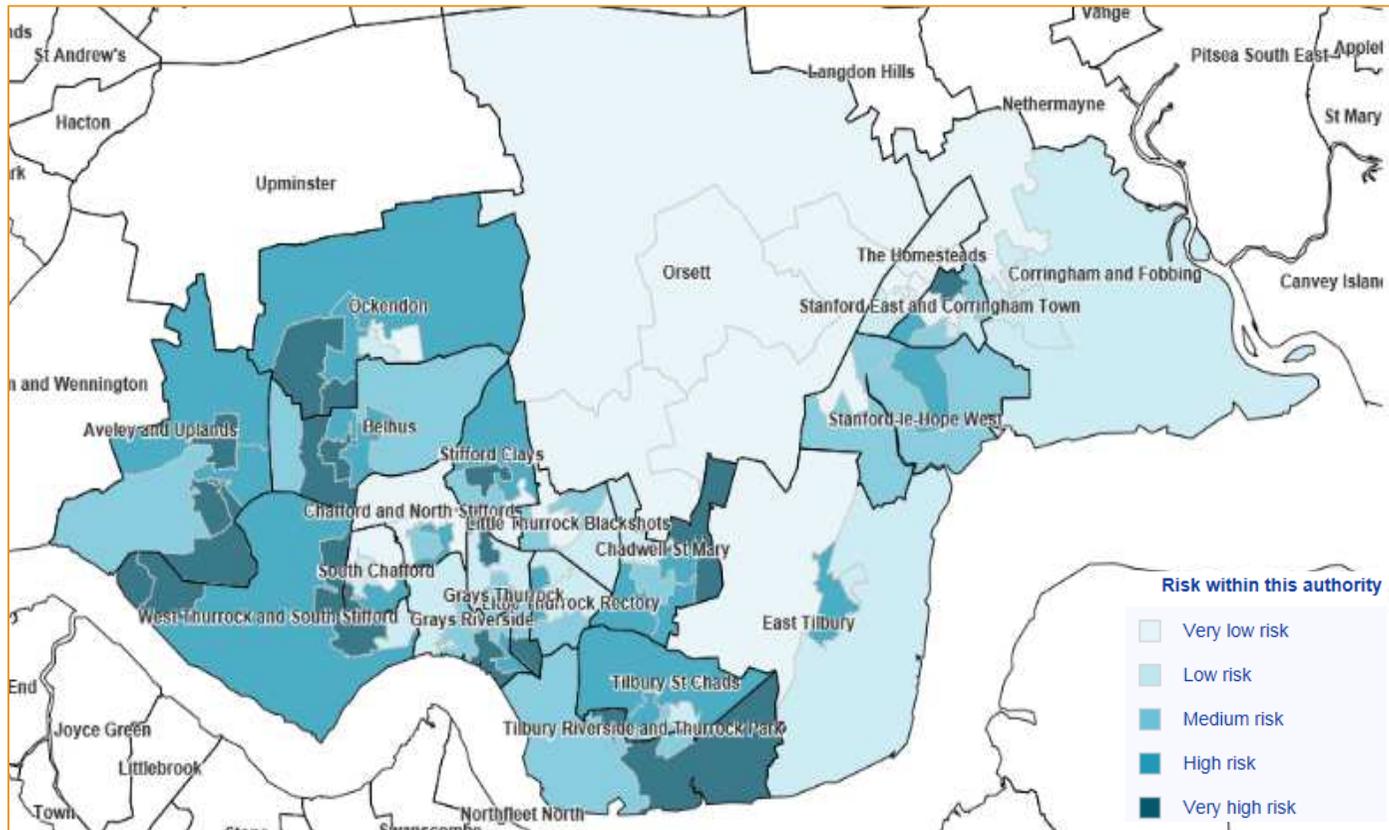
- The causes of poor mental health are complex; however it is known that there are specific groups at high risk of mental health illness.
- Some of the key risk groups are shown in the infographic to the right.
- The strong association between income and mental health is illustrated by the chart below, using national data.
- Some people fit into several of the risk categories shown here. They are at particularly high risk of having poor mental health.
- There is also evidence of intergenerational cycles in mental health. Children whose parents have mental illness are, themselves, more likely to suffer from poor mental health.
- Other factors protect against mental illness: especially employment and strong community connections.

Common mental health disorders by household income and gender, 2011.



# Who is affected? High risk groups

Part of Thurrock by relative risk of older people likely to feel loneliness.



## Social Isolation

- There are strong links between the older community and depression.
- 40% of older people living in nursing/care services suffer depression in comparison to those living in their own homes with contact maintained with their families (Mental Health Taskforce, 2016).
- The map to the left illustrates the geographical patterning of social isolation in Thurrock, using analysis done by Age UK.
- There is a strong link between social isolation and deprivation.

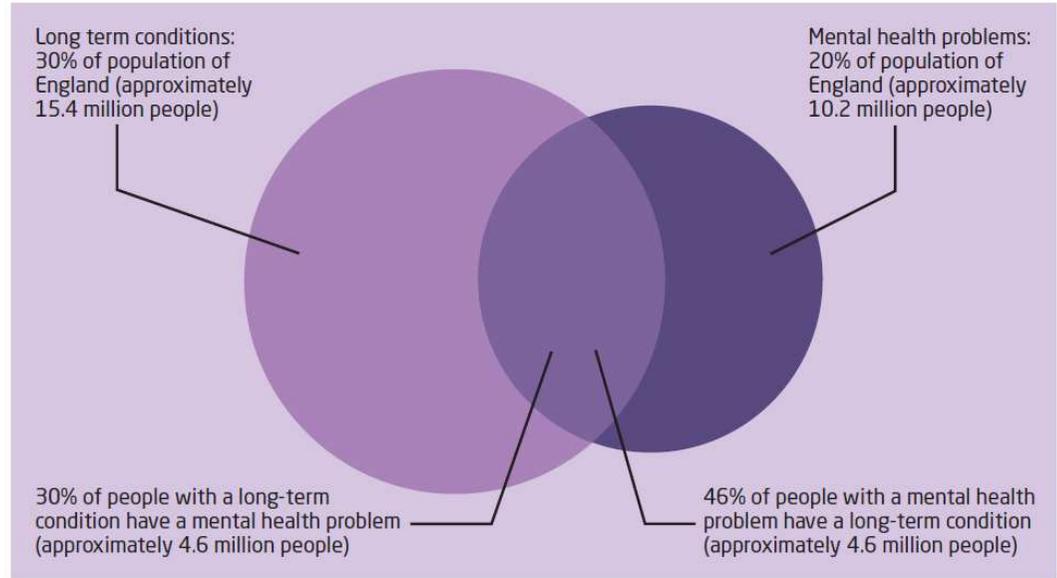
**Key point: strong family and community connections are a strong protective factor against mental illness.**

Source: Age UK

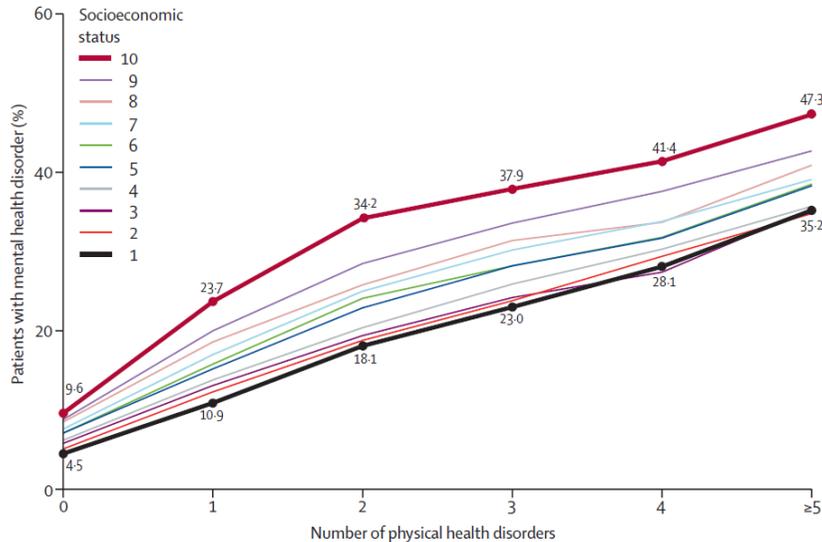
# What are the causes and consequences of poor mental health?

## Interactions with physical health

Mental health interacts with physical health and health-related behaviours in complex ways. Poor physical health can increase the risk of mental illness, such as depression, while being depressed may also make physical health worse. This can create a vicious cycle. Conversely, it is possible for a virtuous cycle to be created through interventions and services which address both physical and mental health.



Relationship between mental health and physical co-morbidity, 2012.



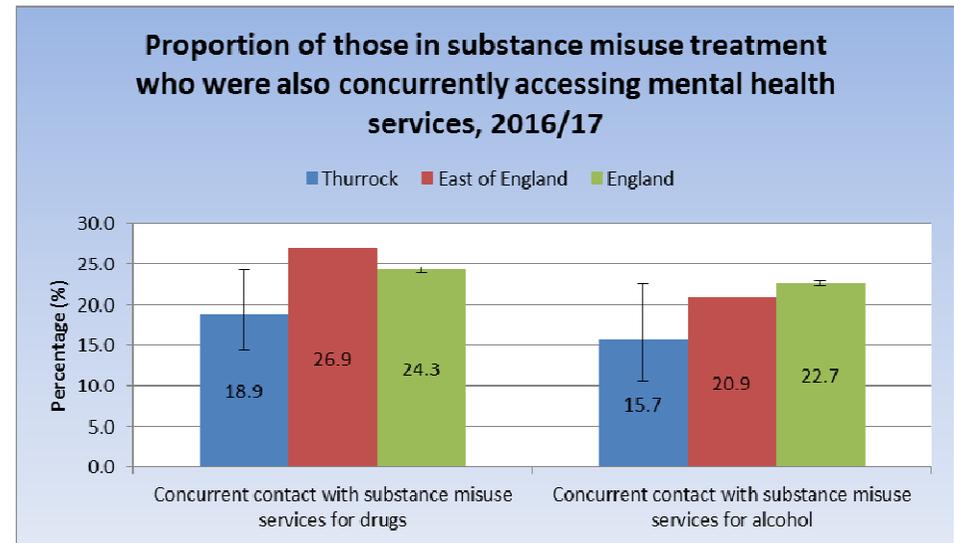
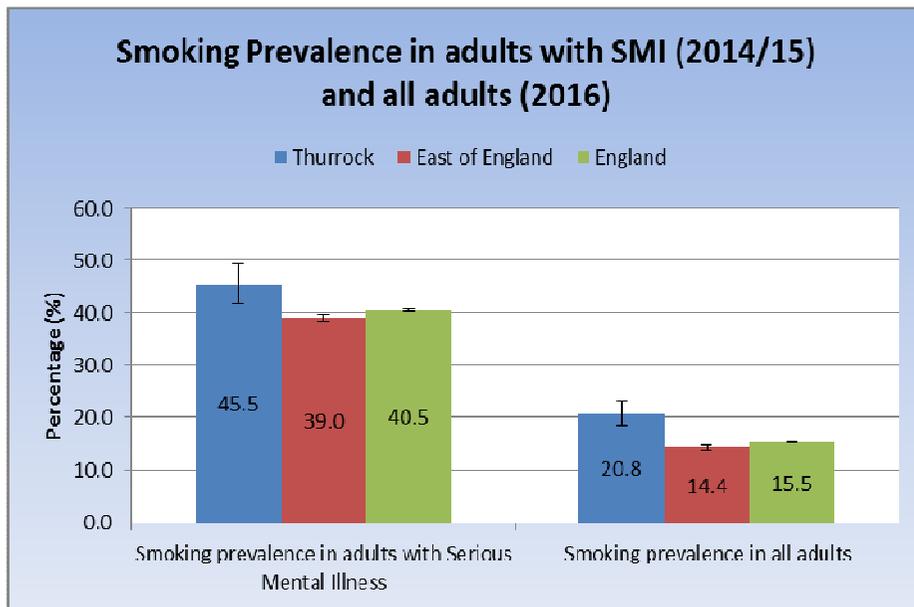
## Long Term Conditions (LTCs)

- The presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year
- 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health (see above)
- People with two or more long-term conditions are seven times more likely to have depression than people without a long-term condition (Moussavi *et al* 2007).

# What are the causes and consequences of poor mental health?

## Other key interactions with mental health

- A high proportion of people misusing drugs and alcohol also suffer from mental illness (see top right)
- There is a strong association between obesity and poor mental health. The rising rates of obesity in the Thurrock population mean that the co-occurrence of obesity and mental illness will become increasingly common (see bottom right)
- Those with serious mental illness have extremely high rates of smoking (see bottom left)



Percentage of patients estimated to be obese and experiencing a CMHD in Thurrock 2016-2026

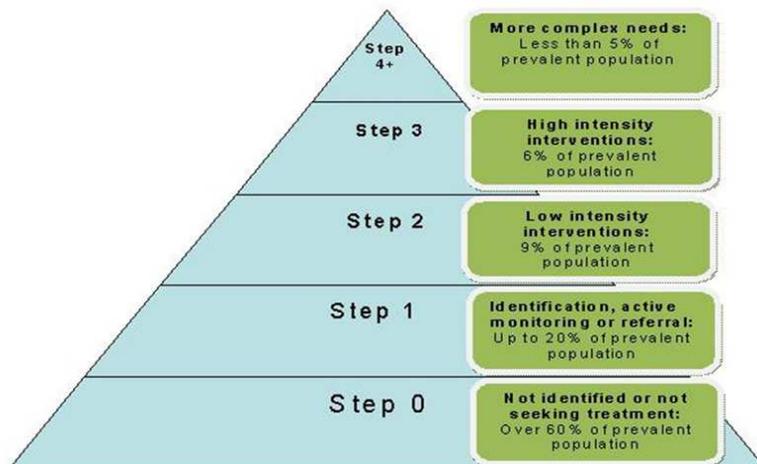
	% patients estimated to be obese in 2016	% patients estimated to be obese in 2026	Additional Number of Obese patients
Neurotic Disorder	28.3%	33.5%	2000
Personality Disorder	28.5%	34.1%	555
Psychotic Disorder	28.5%	33.9%	69
Dementia	28 %	32.7%	211

# What services exist? Overview

## The Mental Health Care System

- The treatment of mental illness occurs in a wide range of settings including: General Practice, IAPT (Improving Access to Psychological Therapies), hospitals, community services and specialist mental health hospital services. It is a fragmented and often confusing system for the public.
- Traditionally, the system has been divided into tiers, as represented by the diagram below which also shows the proportions of those likely to use different levels of service.
- The infographic to the right gives some key figures on the treatment of mental health in Thurrock.

Estimated proportion of the prevalent population with common mental health disorders who will enter each step of care – National Picture



Source - NICE

## Thurrock's Mental Health Treatment by Numbers

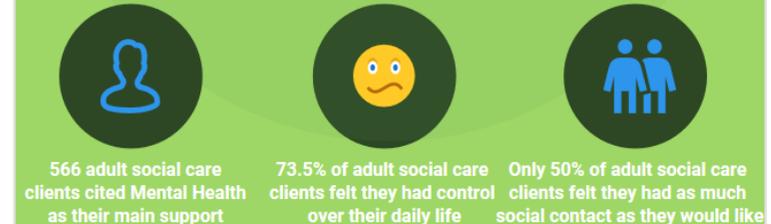
### Some of our patients are treated in Primary Care



### Some of our patients were treated with prescribed medications



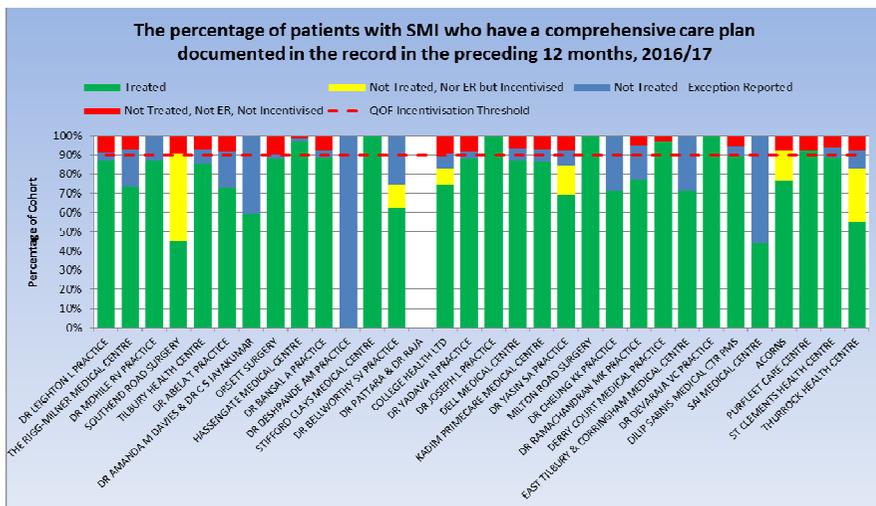
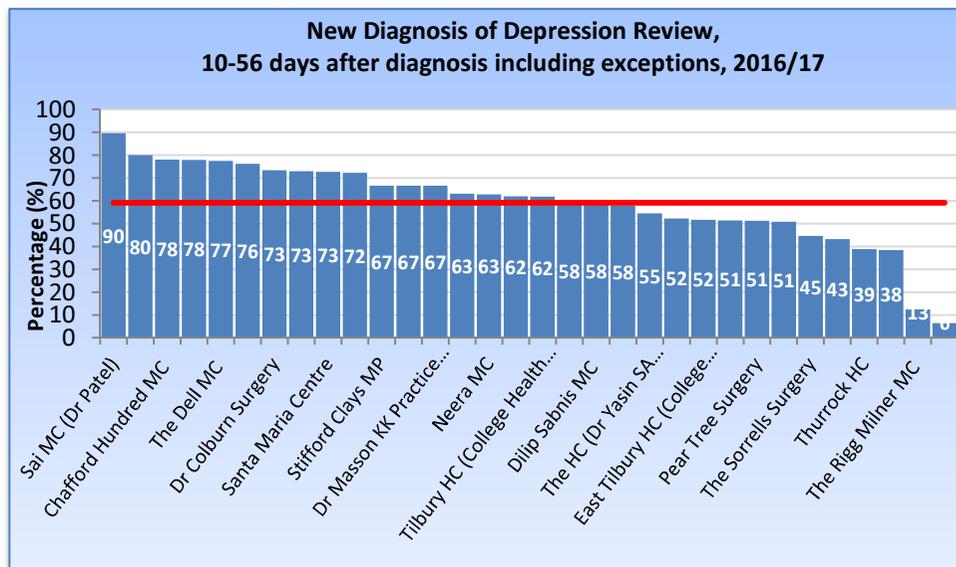
### Some of our patients received support from Adult Social Care



# What services exist? Primary care

## Treatment in General Practice

- It is clear that there is huge variation between practices in the rate at which they identify and treat common mental health problems such as depression (see above);
- However, it is also clear that for those who are diagnosed, the type and quality of treatment they receive may vary significantly between practices. For example, the 10 – 56 day review after diagnosis (a national guideline) is very variable (see right).
- Similarly the treatment of Serious Mental Illness varies significantly between practices (see below).

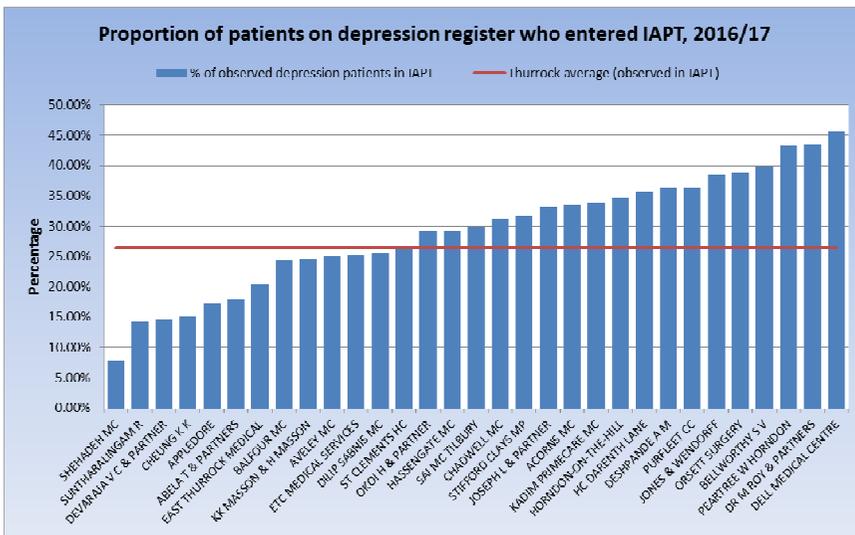
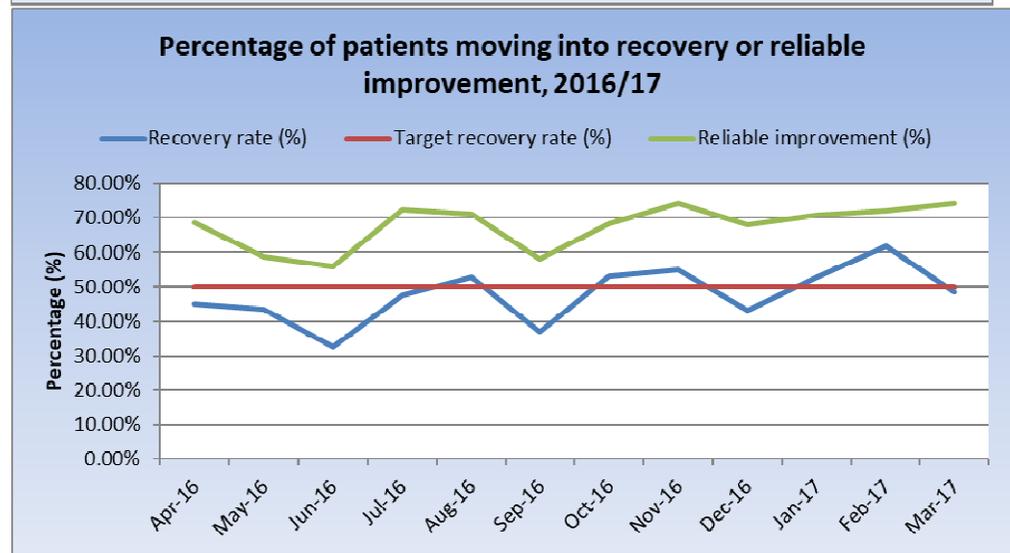
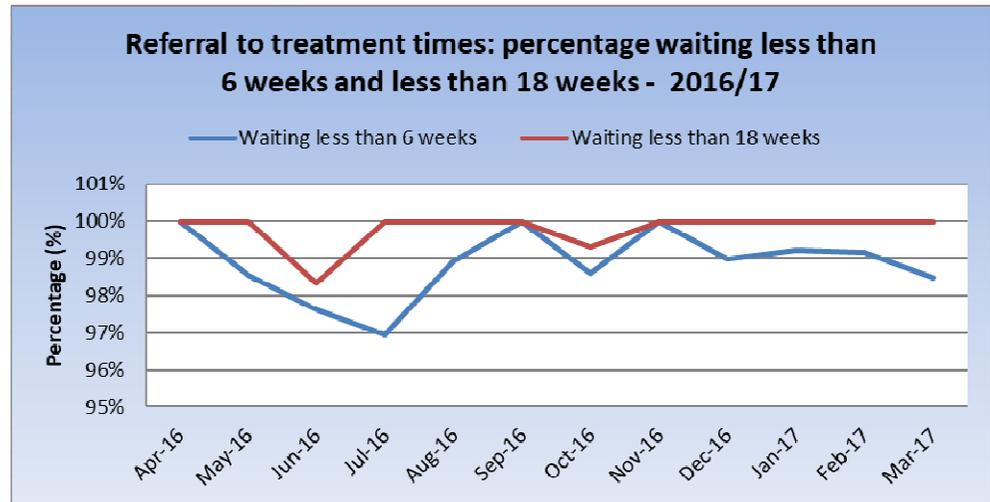


**Key Point**  
*In addition to variations in identification of mental illness there are wide, and preventable, variations in the treatment and management of mental illness in primary care. More could be done to ensure that all patients receive the highest quality of care.*

# What services exist? Primary care

## IAPT

- The current IAPT service is providing high quality generally surpassing national targets for waiting times (top right);
- Though there is scope for improvement, the recovery rates for those who complete IAPT treatment are generally good and appear to have been improving over time;
- However, there is wide variation between GP practices in the proportion of those identified as having depression who enter IAPT treatment. This suggests that a significant number of people who would benefit from IAPT are not accessing it. The reasons for this need to be investigated further but variation by practice suggests that referral may be a key factor.



# What services exist? Integrating primary and community Care

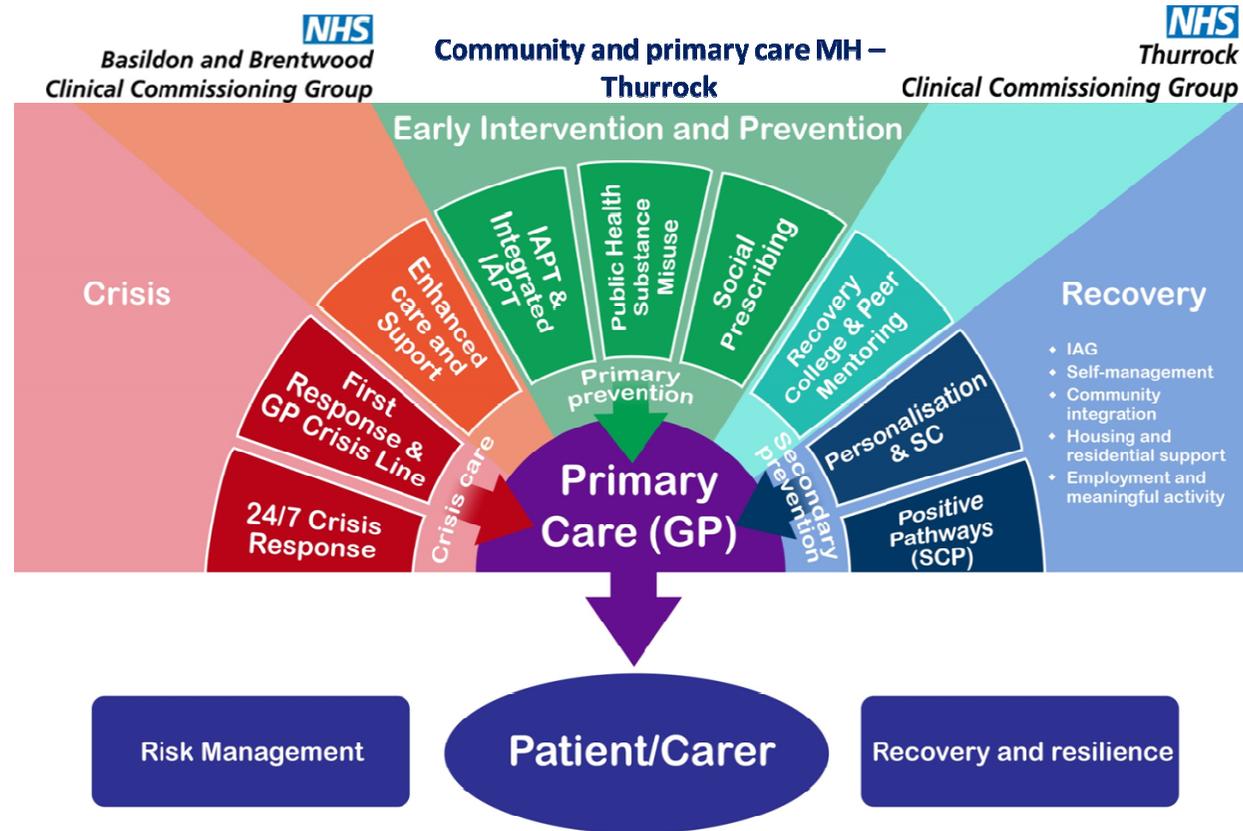
## The integration agenda

The current fragmentation of services is recognised by commissioners and a programme of integration work (Thurrock Mental Health Transformation) is underway.

The vision for this work is represented diagrammatically on the right.

A clinical leadership and oversight group has been established to drive this agenda forward with the specific aims of:

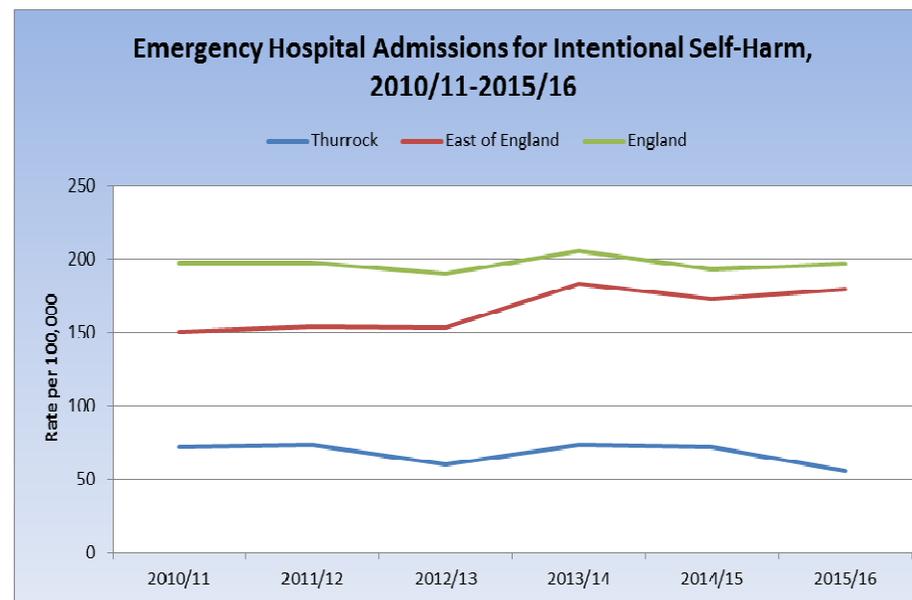
- Improving urgent and emergency care
- Integrating social, mental and physical health and providing care closer to home
- Promoting good mental health and preventing poor mental health



# What services exist? Secondary care

## A&E and self-harm

- When mental health conditions are not identified or appropriately treated in the community, patients attend A&E when they reach a crisis point. These attendances can be seen, to some extent, as reflecting the effectiveness of the wider mental health treatment system.
- The table below shows that 43.1% of mental health service users attend A&E, twice as many as patients without mental health problems.
- Better identification and treatment (e.g. more extensive use of IAPT) has the potential to reduce demand on A&E.
- One area of particular concern is emergency admissions due to self harm (see right). The low numbers found in Thurrock are likely due to problems with data collection and coding practices. This means that the true extent of this problem is currently unknown.



### Attendance by Mental Health service users (aged 18+), 2012-13.

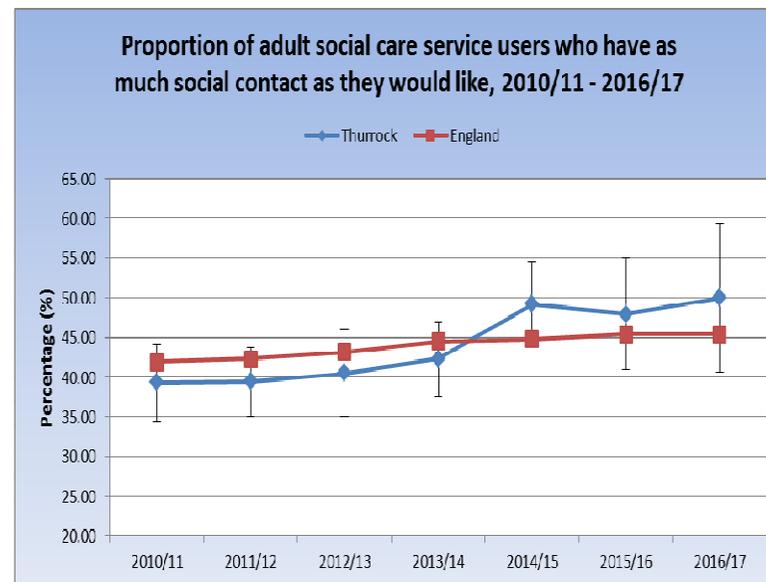
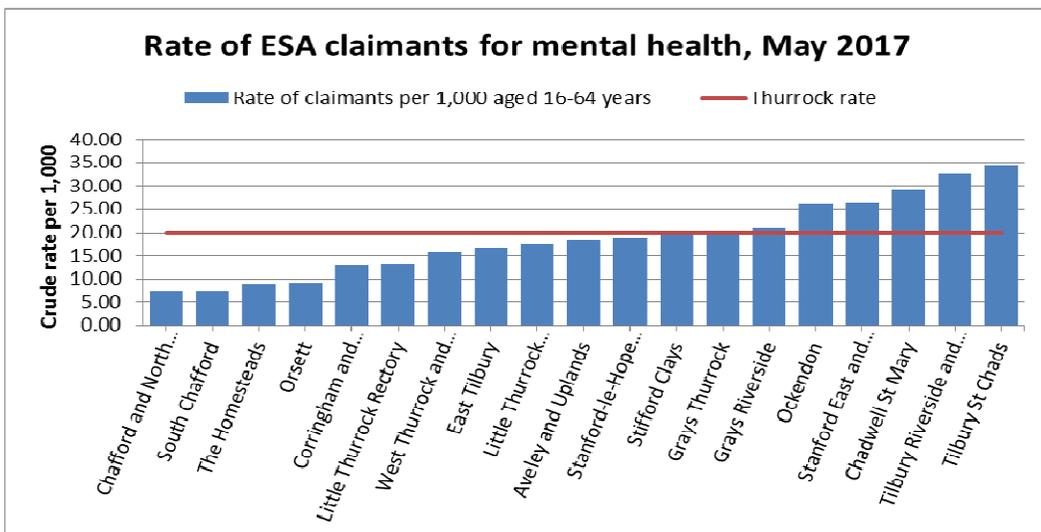
Patients who accessed A&E services at least once 2012/13	Average number of A&E attendances per patient	Percentage accessing A&E services (at least once)
All Patients	1.56	21.3%
Non-MH Service users	1.49	20.6%
MH Service users	2.43	43.1%

# What services exist? Social care

## Mental health in social care users

- Users of social care services are generally at high risk of having poor mental health. As explored previously, there are strong links between the social and physical health problems which lead people to need social care support and mental illness. As a result the Council's Adult Social Care Service commissions a range of mental health programmes and works closely with NHS treatment services.
- Mental illness can be a primary reason for social care utilisation or a secondary issue.
- 54% of those accessing social care for mental health conditions are aged 65 and over.
- Poor mental health is a common cause of people being unable to work (see below).
- 37 per 1000 residents (3.7%) in Belhus claim ESA payments due to mental health conditions; this represents a large proportion of people who would benefit from improved mental health, if employed.

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## Opportunities for integration

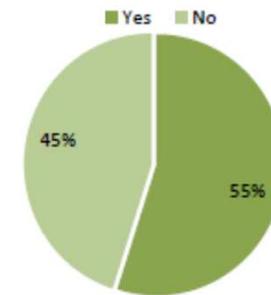
- The existing cooperation between local authority and NHS commissioners could and should be deepened in future;
- The establishment of new Wellbeing Teams to deliver social care in the community is an opportunity to learn lessons about operational integration of mental health support for vulnerable residents. There are opportunities for prevention, identification and treatment of services.

# What do residents think of mental health issues in Thurrock?

## Mental health in social care users

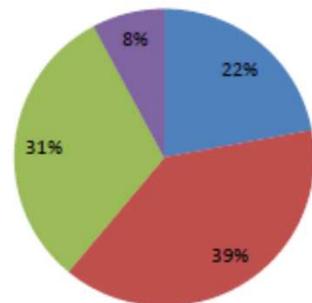
- Healthwatch Thurrock is an independent Health and Social Care service organisation that represents the people of Thurrock.
- As part of Thurrock Health and Wellbeing Strategy, Healthwatch was asked to engage with the community in Thurrock and ask them questions around emotional health and wellbeing linked Goal C: Better Emotional Health and Wellbeing. The four themes were:
  1. Give parents the support they need
  2. Improve children’s emotional health and wellbeing
  3. Reduce social isolation and loneliness
  4. Improve the identification and treatment of depression, particularly in high risk groups

Is there help available at School/ College if you are feeling anxious/depressed or worried?



Where would you go for support around mental health?

■ MIND ■ GP ■ Other ■ Don't know



Where would you go for help with mental health problems?

Category	Number	Proportion (%)
GP	28	28
Family support	22	22
School support	21	21
Healthcare services	11	11
Friend support	8	8
Unsure	3	3
A quiet place eg bedroom	2	2
on-line support	2	2
Outside school/college clubs	2	2
Totals	99	100

# What do residents think of mental health issues in Thurrock?

## Recommendations made by Healthwatch

<p><b>Give parents the support they need</b></p>	<p><b>Improve children’s emotional health and wellbeing</b></p>
<ul style="list-style-type: none"> <li>- Increase awareness of support for parents and children who have disabilities and make it easier to access</li> <li>- Provide disability support group</li> </ul>	<ul style="list-style-type: none"> <li>- Ensure that activities such as youth clubs, groups and sports for young people are equitable across the Borough</li> <li>- Consider subsidising activities for young people</li> <li>- Colleges and schools to raise the profile of the support they offer</li> </ul>
<p><b>Reducing social isolation and loneliness</b></p>	<p><b>Improve the identification and treatment of depression in high risk groups</b></p>
<ul style="list-style-type: none"> <li>- Publication of local community activities as many people do not know what is going on.</li> <li>- Continue to strengthen social relationships an opportunities for community connection (E.g. through LACs)</li> <li>- Work on how to strengthen relationships between communities and health and social care agencies</li> </ul>	<ul style="list-style-type: none"> <li>- Counselling services should be able to recognise and understand the links between LTCs and mental health. The Stroke Group felt that counsellors often did not understand that having a LTC can be the main cause of depression.</li> </ul>

<b>16 March 2018</b>	<b>ITEM: 8</b>
<b>Health and Well- being Board</b>	
<b>‘Open Up, Reach Out’ – Children’s Mental Health Local Transformation Plan Refresh</b>	
<b>Wards and communities affected:</b> ALL	<b>Key Decision:</b> To endorse the refreshed five year transformation plan ‘Open Up, Reach Out’, as set out in Appendix 1. This is the refresh for year 3.
<b>Report of:</b> Paula McCullough – Commissioning Officer – Emotional Well Being and Mental Health	
<b>Accountable Head of Service:</b> Sheila Murphy	
<b>Accountable Director:</b> Rory Patterson	
<b>This report is Public</b>	

## Executive Summary

The purpose of this report is to present the refreshed ‘Open Up, Reach Out’ the Southend, Essex and Thurrock Children’s Mental Health Local Transformation Plan to the Health and Wellbeing Board for endorsement. The plan was approved in 2015, we are therefore not seeking re-approval.

### 1. Recommendation(s)

**1.1 To endorse the refreshed five year transformation plan ‘Open Up, Reach Out’, as set out in Appendix 1. This is the refresh for year 3.**

### 2. Introduction and Background

2.1 In March 2015 NHS England and the Department of Health published Future in Mind, a national ambition to transform the design and delivery of local services for children and young people with mental health needs. This was followed by the 5 year Forward View for mental health. The focus of these documents is on transforming the system through early intervention, evidenced-based treatment and measurable outcomes. Additional investment was made available subject to areas producing a 5 year Local Transformation Plan setting out how they would respond to the transformation.

2.2 Health and social care partners across Thurrock, Essex and Southend had agreed to jointly commission an Emotional Wellbeing and Mental Health

Service (EWMHS) for children and young people. Simultaneously the new service commissioners collaborated with NELFT (the EWMHS provider), a range of stakeholders and young people to develop our Local Transformation Plan 'Open Up, Reach Out'. Our plan was one of only 6 nationally to be rated as green in all categories. The new service and our transformation plan launched in November 2015 with endorsement from the three Health and Wellbeing Boards. Local areas are required to refresh their transformation plan each year and seek endorsement from the relevant Health & Wellbeing Board/s.

2.3 Our aims, set out in 'Open up, Reach out' are to improve access and equality, build capacity and capability in the system and build resilience in the community. These aims are supported by 6 principles:

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

2.4 Significant progress was made during the first year:

- Established a single phone number and point of access.
- Opened up to self-referrals, and referrals from parents, schools and others – not just professionals.
- Developed procedures to provide early help, advice and support.
- Set detailed performance regimes to monitor waiting times for assessments and treatments.
- Referral criteria have been simplified and are less restrictive.
- We have successfully moved away from a fragmented and multi-tiered service by implementing a single integrated service for children and young people across Southend, Essex and Thurrock.
- The single integrated service has made it simpler to publish information via a single website, publicity and referrals information.
- The new single point of access teams gives better information and signposting to other local services and where to get help. A new website The Big White Wall is designed to provide helpful information for children and young people
- We worked with Rerezent to develop an Essex based a radio station run by young people for young people. The service has worked with local schools to devise a training programme so that schools' staff may improve their support to children and young people

- Capacity increased through additional staffing and is supporting around double the number of children compared with previous years. (The national ambition is to expand the numbers of children and young people accessing services by 35% by 2020/2021)

**2.5.** In Year 2 we continued with our aims to improve access and equality, build capacity and capability in the system and build resilience in the community. Year 2 also focused on embedding new procedures and protocols and undertaking further reviews to shape our services around the needs of children and families. Our joint strategic needs assessment highlighted mental health care for children and young people with learning disabilities and support for people moving between services as areas of need and these have been included as areas for action from 2017/18 onwards.

The new Emotional Wellbeing & Mental Health Service was embedding in the community with great progress on; recruitment and mobilisation of the staff and teams, the promotion of the open access supported referrals into the service from a wide range of; Children, Young People, their families/ carers, Schools and other professionals.

Other areas of progress included:

- Investment into the crisis service and extend home treatment
- Engagement with children and young people through Rerezent, a monthly forum attended by young people from across Essex and events such as the Young People's Parliament
- One of the most significant reviews was a second service needs assessment, which included the voice of children, young people and others.
- Training to improve response to self-harm
- Improving Access to Psychological Therapies (IAPT) training roll out
- Improved services for Eating Disorders
- New online counselling support commissioned to provide earlier support (KOOOTH)
- Suicide and self-harm prevention – a review of the Suicide Prevention Guidance for schools led to the development and launch of a Self-Harm Management Toolkit for Schools
- Improvements in medicines management
- Weekly, monthly and quarterly monitoring – enhancing available data and information to inform service improvement initiatives and inform commissioning
- Single point of access (SPA) review and joining together the SPA so that Southend and Thurrock SPA's are co-located with Essex
- Building resilience in communities - pilot with schools to offer consultation, training to build awareness of common disorders and supervision training and support
- Development of a web-portal for schools with resources, links to other services and toolkits to use in lessons from trusted sources

- Further developed relationships with Voluntary and Community Sector providers
- A conference was held for schools and partners in November 2017 attended by nearly 300 people where the resources that had been developed were launched. There was also representation from partners, national and regional speakers on Children's Mental Health and market stalls showcasing some of the support available from local Voluntary and Community Sector organisations and other early intervention services such as
- The contract with EWMHS was extended to November 2020

### 3. Issues, Options and Analysis of Options

3.1 Year 1 was a year of transition with both the EWMHS service and the transformation. EWMHS was launched with around 200 staff from four previous provider organisations transferred into a new single emotional wellbeing and mental health service for children and young people across Thurrock, Essex and Southend. Recruitment activity has been ongoing and the vacancy rate has reduced.

3.2 At the end of year 2 (March 2017) the EWMH service had approximately **6,300 open cases** (circa **60% higher** than when the service launched in 2015) and 80 cases within the crisis team. The initial surge in demand from launching the new service has subsided and the presenting problems have changed. The top three presenting problems across Thurrock were:

- Emotional Disorder
- Conduct Disorder
- Deliberate Self-Harm

In year 2 (April 2016- March 2017), a total of over 10,000 referrals were received to the single points of access, this is an average of 850 referrals per month. The average acceptance rate across Southend, Essex and Thurrock was 90%. The national average is 75%. Work is underway to understand the factors impacting on a higher than expected rate as we appear to be an outlier. A capacity and demand review is also underway which will inform future commissioning decisions.

3.3 The substantial increase in demand and the increase in caseload is a significant success but systems challenges around workforce have impacted on capacity. Waiting times are within the national standards however there are variances across some localities. The provider has reported an increase in the complexity of needs being presented which also has an impact on service delivery. There have been improvements and stretch targets are in place to drive improvements. The increase in demand and pressures around workforce and waiting times are a national challenge. NHS England made some additional money available to tackle waiting times however more needs to be done to build capacity in the community and ensure early intervention

support is available to prevent children and young people's needs escalating leading to the need for more specialist services.

- 3.4. We have seen an increase in suicides against previous years since the beginning of 2017. Essex Children's Safeguarding Board have recently led a Thematic Review to understand any common themes and missed opportunities which will inform future work around suicide prevention. This will include a system wide learning event in the Spring/Summer 2018 . The new prevention guidance and toolkit for schools, colleges and other agencies working with Children and Young People has been developed and was launched in November 2017.

### **Priorities for year 3**

- 3.5 As we enter year 3 of our five-year local transformation plan, there is still a major challenge to achieve our aspirations. Year 3 is a year of continuation in providing, developing and delivering on the areas that have improved and still require improvement.

We will:

- Continue to Build Community Resilience by providing additional support to schools and the voluntary sector – evaluation of the current schools pilot and continuation of roll out
- Review and re-model the Crisis Service
- Develop and pilot a Transition Service- supporting young people 18-25 years who need some extra support when leaving/moving services
- Continue to improve and build on our CYP and family engagement and communication
- Develop the Neurodevelopmental Provision for CYP & families for CYP with Mental Health and Learning Disability, Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD)
- Continue to develop, integrate and work with the wider children's service system to provide a seamless offer (Tier 4 inpatient, Education Health & Social Care, Transforming Care Plans)
- Paediatric care, Children Looked After & Children in Need
- Improving Access to Psychological Therapies (IAPT) for children and young people - Improving Access to Psychological Therapies (IAPT) is a transformation project run by NHS England. It offers training and development for all staff working in mental health services for children and young people, to promote evidence-based interventions and measurable outcomes. We want to sustain a culture of continuous evidence-based, outcomes focused service improvement delivered by a workforce with the right mix of skills, competencies and experience. Commissioners are committed to supporting NELFT to release staff for CYP IAPT training year on year, working to achieve 100% coverage across Thurrock by end of 2018

- Suicide and self-harm prevention – continue learning from the most recent suicide's, hold a learning event and produce and launch new suicide prevention guidance
- Better waiting times standards for eating disorders
- Further development of technologies for service users including continuing to pilot Online Counselling Service (KOOOTH)
- Mental Health Learning Disability Expansion Pilot
- Review and future plan of the EWMH service ahead of commencing commissioning of new service from 2020

A copy of the refreshed 'Open Up, Reach Out' is attached as Appendix 1 for endorsement. This is the transformation plan for the emotional wellbeing and mental health of children and young people in Thurrock, Essex and Southend. This refreshed Plan is published on West Essex CCGs website and Thurrock Council's website and made available for other stakeholders to publish.

#### **4. Reasons for Recommendation**

- 4.1 Future in Mind included additional investment for Children's Mental Health, this is subject to local areas producing Local Transformation Plans and refreshing them each year for review. The Local Plans are required to be endorsed by the Health & Wellbeing Board and are subject to review by NHS England. Failure to produce an appropriate plan could put the additional investment at risk.

#### **5. Consultation**

- 5.1 Service commissioners collaborated with NELFT (the EWMHS provider), a range of stakeholders and young people to develop our Local Transformation Plan 'Open Up, Reach Out'.

#### **7. Implications**

##### **7.1 Financial**

- 7.2 Future in Mind provided Thurrock Clinical Commissioning Group with additional funding to invest in Children's Mental Health subject to developing a Local Transformation Plan. In line with our collaborative commissioning arrangements a single transformation plan and approach has been developed.

- 7.3 In 2017/18 the funding amounted to £3.30m of additional investment across Thurrock, Essex and Southend. In 2018/19 the additional estimated investment just under £5.4m. The original combined investment for Children's Mental Health was £13.20m. Details of how the funds are due to be spent to support the aims of the Local Transformation Plan can be seen in appendix 1; Open Up, Reach Out, year 3 report, page 134.

- 7.4. Endorsement of the refreshed 'Open Up, Reach Out' Local Transformation Plan does not commit Thurrock Council to any additional spend, so there are no direct financial implications for Thurrock Council or the Health and Wellbeing Board.

Implications verified by: **Nilufa Begum**  
**Management accountant**

#### 7.5 **Legal**

- 7.6 The NHS England requires CCGs and Local Authorities to seek endorsement from the relevant Health & Wellbeing Boards for the Local Transformation Plan

- 7.7 There is no direct legal implication for Thurrock Council or the Health and Wellbeing Board

Implications verified by: Lindsey Marks  
Deputy Head of Legal (Adult, Education and Social Care) Law and Governance Deputy Monitoring Officer

#### 7.8 **Diversity and Equality**

- 7.9 The Equality Act 2010 and Public Sector Equality Duty...applies to the Health and Wellbeing Board when it makes decisions. The duty requires it to have regard to the need to:

- (a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination *etc.*, on the grounds of a protected characteristic unlawful
- (b) Advance equality of opportunity between people who share a protected characteristic and those who do not.
- (c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

- 7.9.1. One of the key aims of Open Up, Reach out is to improve access and equality. Significant progress has been made through establishing a single point of access and opening up the referrals process.



# OPEN UP, REACH O'UT

IN YEAR 3

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



UPDATED FOR  
2017-2020

Published November 2017



## Document status

### Ownership

Collaborative Commissioning Forum for the Emotional Wellbeing and Mental Health of Children and Young People in Southend, Essex and Thurrock

Chair: Chris Martin, Commissioning Deirector - Children, Essex County Council

### Senior Responsible Officer

Jessica Thom, Assistant Director CAMHS Commissioning, NHS West Essex Commissioning Group (CCG)

### Author

Jessica Thom, Assistant Director CAMHS Commissioning and Dawn Bolingbroke, Essex CAMHS Commissioning Manager NHS West Essex CCG

### Date of approval

31 October 2017

Approved by the three Health and Wellbeing Boards of Southend, Essex and Thurrock and regional arm of NHS England Specialised Commissioning

### For national review

Submitted to NHS England for review on 18 October 2017

### Versions of the plan

Initial local transformation plan published December 2015

Refreshed plan year 2 published October 2016

Refreshed plan year 3 currently in draft version as at 18th October 2017

### Publication status

Refreshed year 3 plan due for publication by 31 October 2017

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# Open up, Reach out

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

→ Improve access and equality

→ Build capacity and capability in the system

→ Build resilience in the community

# New plan reaches double the number of children in its first year

In November 2015, we launched an ambitious transformation plan to open up our services and reach out to children and young people with mental health problems. We increased funding by an additional £3.3 million every year and launched a new service across Southend, Essex and Thurrock to improve the mental health and emotional wellbeing of children and young people. Now two years on, we are already ahead of the national goal to provide more care.

On 1 November 2015, we were supporting around 3,200 children and young people, but the evidence at that time told us that more children and young people were in need of mental health care. By opening up the channels for children, parents and schools to call on professional help, we are now providing care for around 6,000 children and young people.



**Chris Martin**  
Commissioning Director  
- Children  
*Essex County Council*



**Deborah Fielding**  
Accountable Officer  
*NHS West Essex Clinical  
Commissioning Group*

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# EXECUTIVE SUMMARY



## Open up, Reach out – in year 3

Our five-year local transformation plan, **Open up, Reach out**, is making big changes in Southend, Essex and Thurrock to improve the emotional wellbeing and mental health of children and young people.

In year 1 of the plan, we launched a single integrated service across seven clinical commissioning groups (CCGs) and three local authorities. We are aiming to give all children and young people the best possible support for their mental health and emotional wellbeing with more services available and consistent high quality care.

We increased the annual budget by around 25% with an additional £3.3 million a year to make it easier to get expert help when needed. Children and young people, parents and schools can now contact mental health services directly through a single telephone number or email address. Before 1 November 2015, only a professional such as a GP or social care team could make a referral.

Some 200 staff have made the move from four previous organisations and a fragmented tiered system to a single new service with much more emphasis on prevention, early intervention and resilience for children, families and communities.

**Year 1** had a great start by supporting double the number of children and young people compared with the previous year, the transition to a new system saw some challenges but began to see great service improvements.

In **year 2** the new Emotional Wellbeing & Mental Health Service was embedding in the community with great progress on; recruitment and mobilisation of the staff and teams, the promotion of the open access supported referrals into the service from a wide range of; Children, Young People, their families/ carers, Schools and other professionals.

We continued to invest in children and young people's services with investment into the crisis service, engagement with children and young people and schools support.

This document is a refresh of the local transformation plan, showing what has been achieved so far and the priorities for action over the next three years.

To contact the **emotional wellbeing** and **mental health service** for Southend, Essex and Thurrock:

Call **0300 300 1600** 9am-5pm Monday to Friday

Or email **NELFT-EWMHS.referrals@nhs.net**

For support in a **crisis** at any time of day or night, call **0300 555 1201** and ask to be put through to **Crisis Support**.

## National context

The transformation of emotional wellbeing and mental health services for children and young people has a high national profile and the support of significant additional funding.

The national guidance, *Future in Mind*, which was published in March 2015, set the challenge and provided the steer for local service transformation. The focus is on early intervention, evidenced-based treatment and achieving measurable outcomes for children and young people with mental health problems.

In July 2016, NHS England published further guidance on improving mental health services - *Implementing the Five Year Forward View for Mental Health*. The first chapter of this guidance sets out the national objectives for improvements by 2020/21 in children and young people's mental health.

Some of the main national objectives are:

- By 2020/21, a significant expansion (at least 35%) in access to high quality mental health care for children and young people.
- By 2020/21, evidence-based community eating disorder services in place in all areas ensuring that 95% of all children in need receive treatment within one week for urgent cases, and four weeks for routine cases.
- By 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay and will be as close to home as possible. To achieve this there should be improvements in community-based services, 24/7 crisis resolution and more home treatment.

*Future in Mind*

<https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>

*Implementing the Five Year Forward View for Mental Health*

<https://www.england.nhs.uk/mentalhealth/taskforce/imp/>

## Sustainability and Transformation Plans (STPs)

Our local transformation plan is a county-wide strategy across Southend, Essex and Thurrock, which crosses three STPs:

- Mid and South Essex
- Hertfordshire and West Essex
- Suffolk and North East Essex

All three plans align and are signed up to the Southend, Essex & Thurrock Mental health & Wellbeing Strategy; Lets Talk about mental health 2017-2021. The Lets Talk about Mental Health strategy supports and interfaces with our Open Up, Reach Out transformation plan.

Open up Reach out will continue to plan on its countywide basis and all three STPs have incorporated our local transformation plan.

Our strategic direction is reflected in the wider STPs to:

- Deliver more care closer to home, working in localities that bring together physical, mental health and social care
- Place a greater emphasis on prevention and early treatment to avoid crises and hospital stays and to avoid longer term serious problems
- Work with multi-agencies and professionals in a joined-up way to wrap services around individuals and their needs
- Work together to develop community resilience, including working partnerships with voluntary sector and other public services
- Empower people and families by involving them in decisions about their own care and by improving access to information to support self-care.

STP links:

<https://www.healthierfuture.org.uk/sites/default/files/publications/2016/December/A-Healthier-Future-Final.pdf>

<http://www.successregimeessex.co.uk/latest-plans/overall-plan-summary/>

<http://www.nessexccg.nhs.uk/sustainability-and-transformation-plan>

**Mental health & Wellbeing Strategy; Lets Talk about mental health:**

[https://www.livingwellessex.org/media/470330/MH\\_Strategy\\_Lets\\_Talk.pdf](https://www.livingwellessex.org/media/470330/MH_Strategy_Lets_Talk.pdf)

# Summary of the transformation plan

## Our plan is to:



## Principles

The plan is built upon six agreed principles:

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



## Year 1

The original local transformation plan highlighted a number of common themes from local engagement with children and young people.

Our response to those main themes was as follows:

### You said

### We did

**Difficult to access the service**

- Established a single phone number and point of access.
- Opened up to self-referrals, and referrals from parents, schools and others – not just professionals.
- Developed procedures designed to provide early help, advice and support.
- Set detailed performance regimes to monitor waiting times for assessments and treatments.

**Confusing process and variable eligibility**

- Referral criteria have been simplified and are much less restrictive than before.
- We have successfully moved away from a fragmented and multi-tiered service by implementing a single integrated service for children and young people across Southend, Essex and Thurrock.

**We need better information**

- The single integrated service has made it simpler to publish information via a single website, publicity leaflets and referrals information.
- The new single point of access teams give better information and signposting to other local services and where to get help.
- A new website *The Big White Wall* is designed to provide helpful information for children and young people.
- Looking to the future, the service is piloting new digital technologies, such as an app that enables young people to talk to their therapist at any time.

**More people are needed to help tackle problems at an earlier stage**

- The service has worked with local schools to pilot a training programme for schools' staff.
- In future years of our plan, the intention is to extend training to other local services to build knowledge and resilience in local communities.
- Capacity has increased through additional staffing and is supporting around double the number of children compared with previous years.

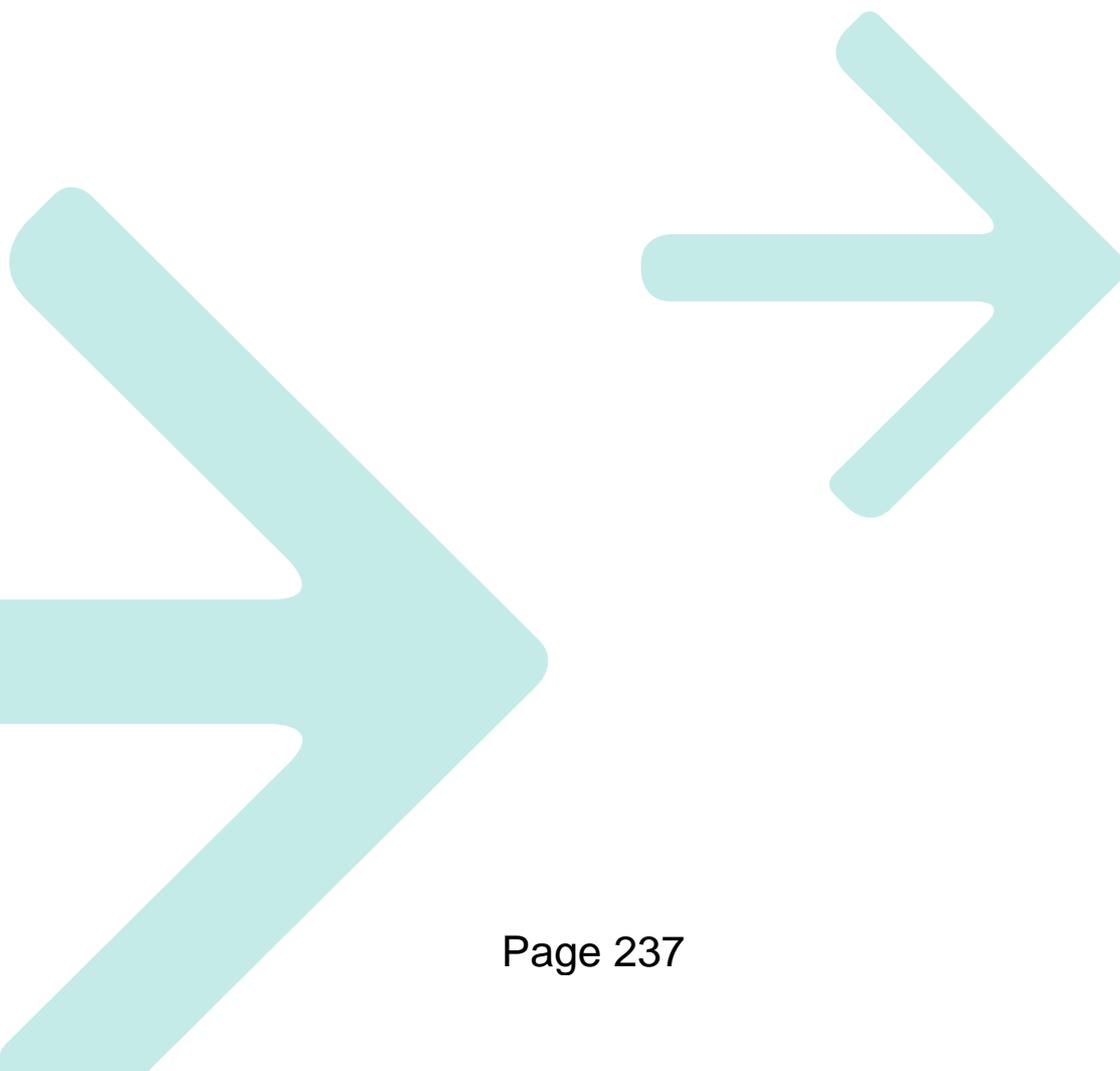
**Year 1** was a year of transition. Some 200 staff from four previous provider organisations transferred on 1 November 2015 to a new single emotional wellbeing and mental health service for children and young people across Southend, Essex and Thurrock. Recruitment to new posts is not yet complete, but we expect the new service to reach full establishment by the end of 2016.

**Year 2** was a year of embedding new procedures and protocols and undertaking further reviews to shape our services around the needs of children and families.

One of the most significant reviews was a second service needs assessment, which included the voice of children, young people and others.

Here are the main themes of areas that needed further improvement:

- **Raising awareness** – young people still reported that they have never received information about mental health, either generally or via their school.
- **Support for children and young people who move between services** – the transition from children’s services to adult mental health services, for example is very variable across our area
- **Early intervention** – A quarter to a half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence.
- **Vulnerable groups** – Vulnerable young people felt they are sometimes being treated for symptoms and not the cause of their problems
- **Utilising technology** – evidence showed that children and young people respond well to digital technologies as a way of managing problems.



## Challenges still to tackle

As we enter year 3 of our five-year local transformation plan, there is still a major challenge to achieve our aspirations.

**Year 3** is a year of continuation in providing, developing and delivering on the areas that have improved and need improving. We will:

- **Build Community Resilience** by providing additional support to schools and the voluntary sector
- Review and re-model the **Crisis Service**
- Review and pilot a **Transition Service**- supporting young people 18-25 years who need some extra support when leaving/moving services
- Continue to improve and build on our CYP and family **engagement and communication**
- Develop the Neurodevelopmental Provision for CYP & families for CYP with **Mental Health and Learning Disability, ASD and ADHD**
- Continue to **Develop, Integrate and Work** with the wider children's service system to provide a seamless offer (Tier 4 inpatient, Education Health & Social Care, Transforming Care Plans, Paediatric care, Children Looked After & Children in Need)



## Vision

All children and young people in Southend, Essex and Thurrock are supported to live well, resilient to life's challenges and have the best possible mental health. The emphasis is on prevention and early action to avoid more serious problems in the longer term.

Everyone involved in the life of a young person – family, school, health and care services, and including the child or young person themselves – should have the information and the support they need to play their part.

### How our emotional wellbeing and mental health service is working to achieve this vision:

- By working with communities and schools to develop a better understanding of the risks to mental health and how to manage them.
- By making it simple for families and professionals to find out where to get help quickly and have the support and tools they need for self-help.
- Where extra help is needed, services are ready to step in at an early stage, in convenient, friendly places where young people feel safe, listened to and respected.
- Workers within services have the confidence and skills to understand needs early on and give the right support.
- Children and young people have a say about their own care and in the design and development of services.
- Expert help for long term and serious problems will expand across Southend, Essex and Thurrock over the next four years.
- Experts will be ready to act quickly in a crisis, whenever and wherever that may be.

### The emotional wellbeing and mental health service for Southend, Essex and Thurrock:

#### Support in daily life

- Information and advice for children and young people, available from our website and places in the community
- Information and advice for parents and carers
- Training and support for schools and others

#### Help from local services

- Services working with families at home
- Services in schools, GP surgeries, and community
- Evidence-based interventions and therapies for children, young people and families
- A confident and empowered children's workforce

#### Expert help from specialists

- Specialist help for long-term and serious problems
- Joined-up services for several problems
- Referral to more specialised services

#### Help in a crisis

- Fast response with support at home
- Links with other emergency services
- Overnight and short-term specialist services, if needs be

## Measurable outcomes

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

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

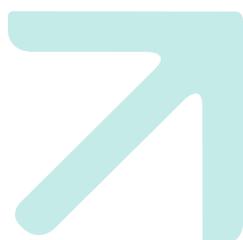
## Plan of action

**In year 1 (2015/16)** – we mobilised the new single service on 1 November 2015, with new referral criteria, better access to services and new ways of working.

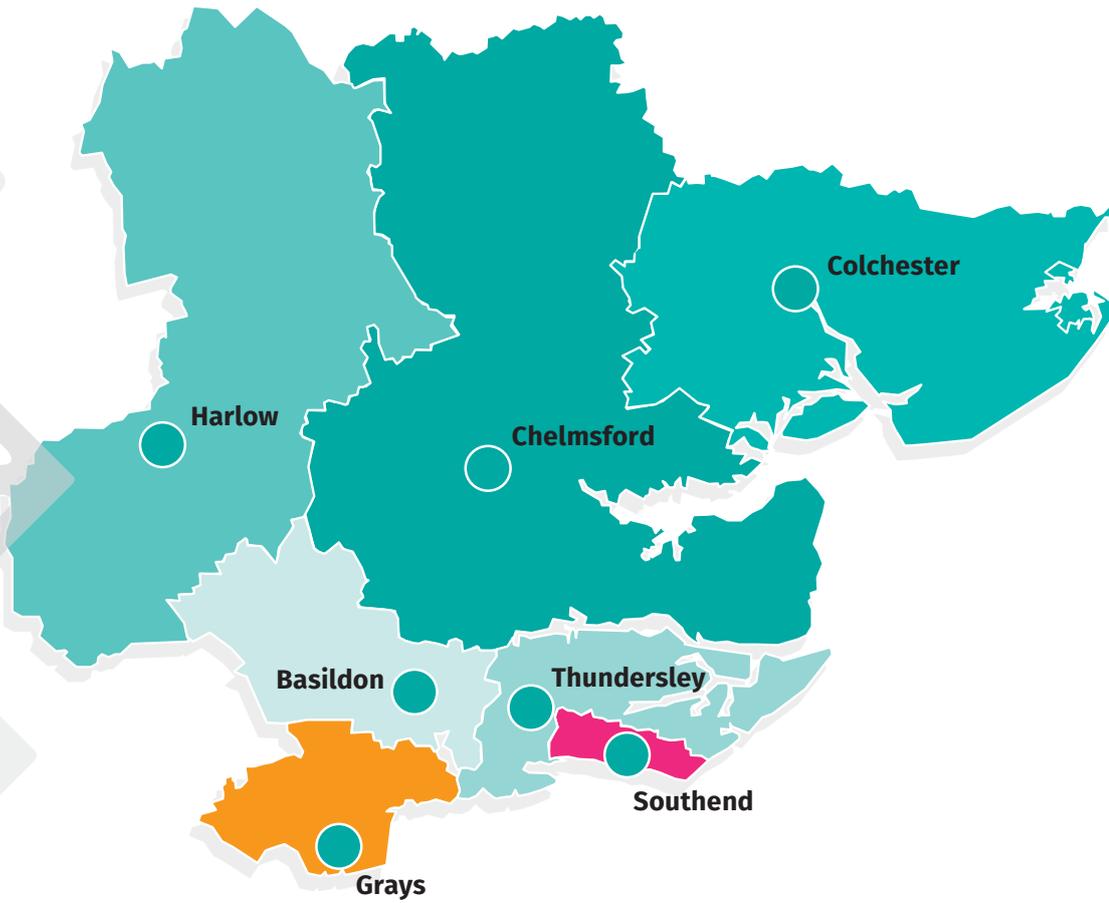
**In year 2 (2016/17)** – we learnt from a second service needs assessment and a number of service reviews and pilots, aiming for full implementation in years 2 and 3. We introduced a new community eating disorder service. We continued to invest in staff and rolled out new schemes, like the digital offers of the Big White Wall and the MyMind App. Further works on engagement with local schools on their priorities for the local support offer.

**In year 3 (2017/18)** – we are implementing the Learning Disability CAMH service across Southend, Essex & Thurrock, piloting the Kooth online counselling service, producing the Self-Harm Toolkit, entering into phase one of the EWMHS School-education programme and reviewing our Crisis and Transitions offer.

**In years 4 & 5** – We will evaluate the pilots and further implement the priorities set out in this plan. We will refresh this local transformation plan each year and continue to develop new and better services in response to our evaluations and service reviews.



## Building capacity and capability in our seven locality teams



With additional investment and new ways of working we are increasing the number of people and skills in locality teams.

The following table summarises the main developments over the five years of the local transformation plan:

Identified gaps in services	Increase in staffing and skills
Services for eating disorders	Increase in clinical and support staff to cover all localities.
Specialist services to help with developmental and behavioural problems, including ADHD	Review of a new therapeutic model with funds to invest in new services.
Improving access to psychological therapies (IAPT)	Investing in clinical psychology leadership. New posts in each locality.
Faster access to help for low to moderate needs	Recruitment and training for lower grade clinical staff.  Additional resources to support locality teams and their work with partners within the community e.g. schools, children's centres, GPs, voluntary sector.
Faster access to advice, information, support and assessment where needed.	More staff for single points of access in Southend, Essex and Thurrock.

## Specific service developments described in the transformation plan

### Improving access and equality

- Single point of access for each of the three local authority areas, supported by an increased workforce and workforce development
- Enhanced crisis services and extended home treatment.
- Extended children's and young people's IAPT, with the aim of achieving 100% coverage by 2018
- Increased capacity to respond to complex needs (such as those of children with learning disabilities and mental health needs)
- A significant investment in the development of eating disorder services
- Continuing improvement in early intervention in psychosis
- Improvements in support for vulnerable and disadvantaged children and young people
- Improvements in transitions between services e.g. for long term needs of young people moving into adulthood
- Medicines management review

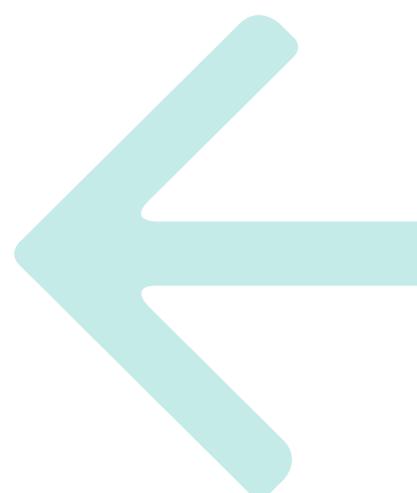
### Building capacity and capability in the system

- Additional posts
- Upgrading for some posts
- Wide scale workforce development and training
- Improvements in data and IT systems
- Improvements in performance monitoring

### Building resilience in the community

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

Implementation of the local transformation plan is supported by a programme management office and improved performance and outcomes monitoring.



## Investment

The new service started on 1 November 2015 with a contract value of just over £13 million.

During 2015/16, we invested in excess of £1.5 million to develop local services. This translates to a planned full year investment of just over £3.3 million.

Our updated plan raises our investment from £3.3 million per year to just under £5.4 million a year with effect from 2017/18.

# WHERE WE ARE NOW



## Our young population and their mental health needs

In year 1 of our local transformation plan, we completed a second joint strategic needs assessment (JSNA) to take a detailed look at our population of children and young people and their emotional wellbeing and mental health needs.

This section draws from some of the main findings of the joint strategic needs assessment.

### A picture of Southend, Essex and Thurrock

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

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

By 2025, there could be 8.1% more children in Southend, Essex and Thurrock and 10.7% more by 2035.

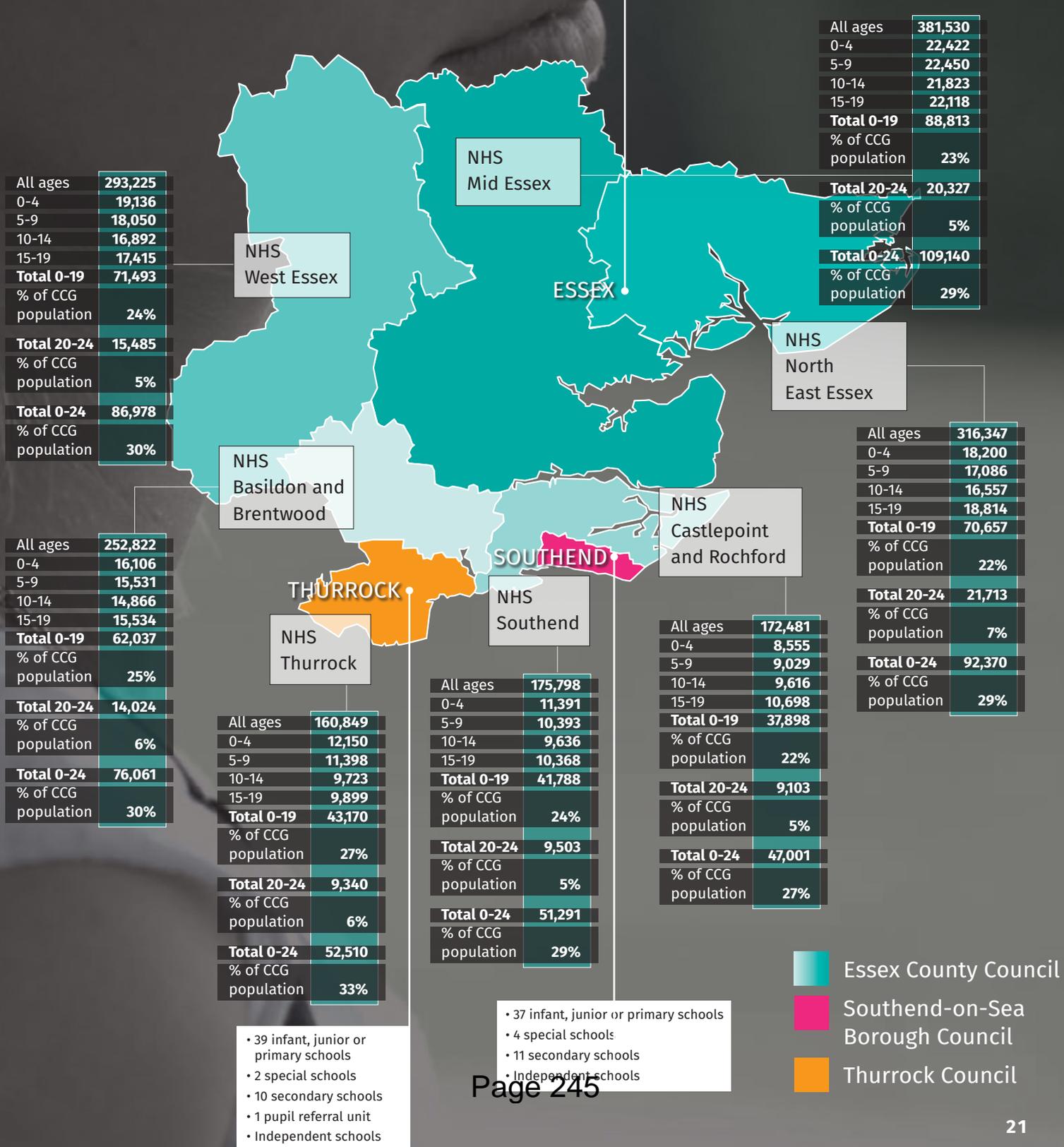
1.75 million population



under 19



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



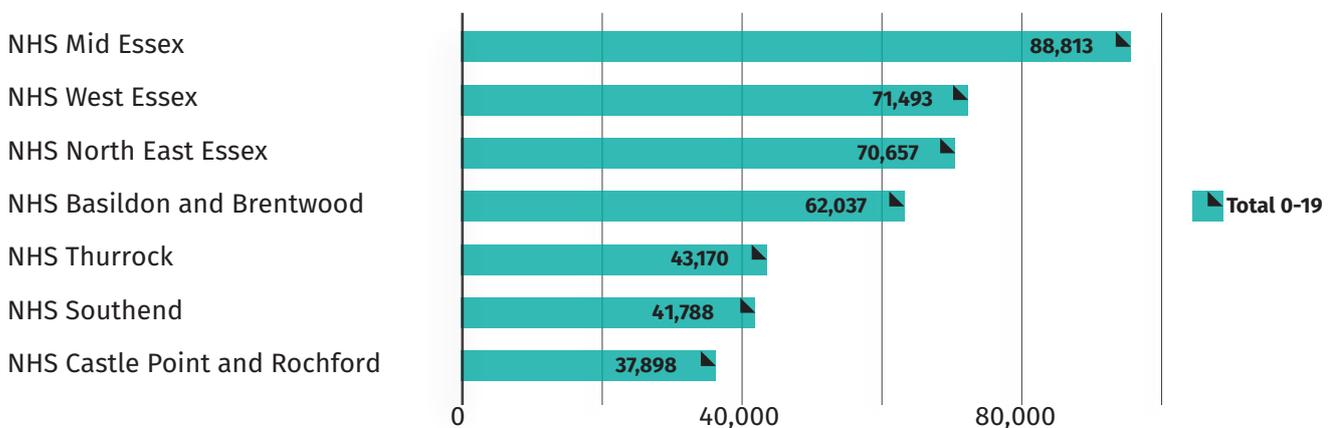
Thurrock has the lowest all age population; however Thurrock has the largest population of under 19 year olds, equating to 27% of the local population. Basildon and Brentwood, Southend, Thurrock and West Essex have larger populations aged 0-4 years. North East Essex CCG and Castle Point and Rochford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

## 0-19 years population

415,856

Essex

### Total 0-19 population by CCG



### Estimated number of children and young people that could be affected by mental health issues (2014)

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

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

# Estimates of young people experiencing mental health problems

## Broad indicators from national data

Ref. National Child and Maternal Health Intelligence Network (ChiMat) <http://www.chimat.org.uk>



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

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

relationships, as well as affecting life chances and physical health.

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

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

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

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

→ 22,500

Mental health disorders are more common in boys (11.4%) compared to girls (7.8%) and rates increase with age. Among 5-10 year olds 5% of girls and 10% of boys may have a mental health disorder. Among 11-16 year olds the rates were 10% for girls and 13% for boys.

The most common type of mental health problems in children and young people are conduct and emotional disorders with higher rates of conduct disorders in boys and higher rates of emotional disorders in girls.

**National estimates of prevalence of disorders in children and young people:**

Emotional disorders (anxiety and depression)	4% (3% and 0.9%)
Conduct disorders	6%
Severe attention deficit hyperactivity disorder (ADHD)	1.5%
Autism spectrum disorder	0.9%
Rarer disorders, including tics, eating disorders and selective mutism	0.4%

The rate of ADHD in boys is much higher than in girls (2.6% compared to 0.3%).

Children with poor emotional wellbeing have a much more negative view of their lives when compared to all children. They are twice as likely to be afraid to go to school because of bullying, twice as likely to say their school deals badly with bullying and are more likely to have been a victim of crime. They are significantly less likely to say that their views are listened to and taken seriously at home or at school. They are more likely to say that they have been drunk at least once in the last month or have ever taken drugs. They are significantly less likely to enjoy school or try their best at school, and are more likely to want more help from teachers, plus they are more likely to need better information to help plan their future.

See [Appendix 1](#) for further information extracted from the ChiMat website

# What children and young people say

## Essex health and wellbeing survey 2015

A wellbeing survey across schools in Essex is now in its tenth year. In 2015, the survey reached 9,690 pupils in primary schools, 3,796 pupils in secondary schools and 37 pupils in one special school.

From this survey, children in Essex have told us that good emotional wellbeing and mental health means 'feeling safe and secure', 'being satisfied with life' and 'feeling worthwhile'.

### Some of the main points from the survey

- ▶ Over half of primary and secondary pupils say that when they are really worried they talk to someone or ask for help
- ▶ The main worries for secondary school pupils are
  - // SATs and other tests
  - // what other people think about them
  - // the way they look
  - // school work/homework
- ▶ 75% of primary and 82% of secondary pupils say that adults listen to their views and take them seriously at home but they are somewhat less positive about being listened to at school, particularly secondary pupils
- ▶ Pupils with poor emotional wellbeing and those who are bullied are significantly less likely to say their views are listened to at home.
- ▶ Primary young carers, pupils receiving free school meals and BME pupils, and secondary pupils with special needs or a police warning are also less likely to say this.

For more information, visit Essex Schools InfoLink  
<https://schools-secure.essex.gov.uk/data/SHEU/Pages/SHEUSurveySupportingTheWellbeingOfChildrenAnd.aspx>

## YEAH!2

YEAH! stands for **Young Essex Attitudes on Health and Social Care**, an exercise run by the independent organisation, Healthwatch Essex, which gathers young people’s lived experience of health and care in Essex.

The first YEAH! report from March 2015 helped to inform our local transformation plan, Open up, Reach out. In 2015, Healthwatch Essex engaged young people a second time, this time reaching 865 young people representing a range of backgrounds from across Essex.

The study took place before our new service launched on 1 November 2015, but NELFT, the new service provider, took part in YEAH!2 and listened to the feedback on former services with the aim of using this information to develop the new service.

### Some of the key findings from YEAH!2



9 in 10 participants felt that being informed about mental health was important



7 in 10 participants had not received information on mental health



6 in 10 participants thought that a lack of awareness created stigma around issues such as mental health, which could lead to bullying or isolation.

### Awareness

Around half of the participants had read about mental health online, while others had gained some knowledge from TV or their own experiences. Some participants (around 3 in 10) had received information about mental health. Of those who had, around half had learned from enrichment days or information in school or college. Most participants (around 9 in 10) felt it was important to learn about mental health in school or college.

“Luckily, my **friends** told the **school teachers** who were informed about my **family situation** and got me **help**. I think schools should strive to **be informed** about their pupils’ family situations and ensure anyone **affected** by someone’s problems is **checked** and **supported**.”

“A woman came in and **taught** us about **self-harm** and **suicide**. It was really **informative, relevant** and **direct** information.”

“I think **parents** should be **educated** on **mental health** so they **understand** what to **do** in the situation.”



## Access to help

Over 4 in 10 participants said they or someone they knew had experienced mental health issues. The main perception was that help can be difficult to secure and services slow to respond. Improving access to services should remain a top priority for our local transformation plan.

“Doctors and **counsellors** always make me feel like they have **no time** for me. Mental health gets **overlooked** and **isn’t taken seriously**. It took **4 months** to start therapy, and at that point I was **suicidal**.”



“I was diagnosed with **OCD, Tourette’s Disorder, depression, anxiety** and a **sleep disorder**. For a while I was **not believed** or **taken seriously**, which made it **worse** as well as harder to **trust** people. When I was finally admitted to a service it took a **long time** before treatment.”

### Support and services

Participants who had sought help for mental health problems had most commonly approached a GP or a member of staff at school. Several participants spoke about positive experiences of approaching school staff, feeling the person they spoke to did their best to help and referred them to the relevant service.

“I **self-harmed** for **3 years** and my high **school** was **helpful...** especially the head of year who made it **clear** who you could **talk to**, and that **free counseling** services existed”

“I was told **nothing could be done** apart from **anti-depressants**. I refused to take them, so I was **sent home**. There should be a **better solution!**”

“I have **ADHD** [Attention Deficit Hyperactivity Disorder] and I’m on some **tablets** to help me **concentrate** more. It **helps a lot**, and helped me concentrate in my **exams**. I wish I’d been **diagnosed earlier.**”

Some participants spoke about their experience of being prescribed medication for mental health problems. Some had good experiences and others held strongly negative views of medication as a form of treatment.

Listening to what young people have said about services in the past, we are very aware of the way in which young people would appreciate being listened to and taken seriously. We have also heard about the need for consistency and have discussed with young people ways of improving this with smartphone technology through which a young person receiving support can maintain their contact and relationship with the professional who is supporting them.

“... they **don’t see you outside** of sessions when you’re having a **‘down’** moment.”

Almost half of the YEAH!2 participants suggested that raising awareness would reduce stigma and encourage young people to access services earlier.

**Young people hope to see more promotion of mental health services that they can refer to directly, a campaign targeting young people and including a specifically targeted campaign towards boys, possibly in partnership with local football clubs, for example.**

For more information and to see the full YEAH!2 report, visit Healthwatch Essex <http://www.healthwatchessex.org.uk/what-we-do/topics/yeah-2/>



## SWEET!

### Services we experience in Essex today

In the spring and summer of 2015, Healthwatch Essex joined forces with a sport-for-development charity, *Achievement Through Football*, a charity based in south Essex, to capture the views of vulnerable young people living in areas of recognised deprivation.

The exercise reached 203 young people (aged 11-25) who were at risk of exclusion from education. This included young people from seldom-heard groups, such as Eastern European and migrant communities, gypsy, traveller and Roma communities, young ex-offenders and young people living in social housing and/or foster care.

During discussions, SWEET! participants talked about the importance of having a sense of worth and something to achieve which would form part of the solution to preventing them from involvement in crime. They also felt that sharing a joint goal could bring troubled families together. While participants spoke a lot about the mental health of their parents, they seemed unaware that they themselves could experience mental health issues, despite often speaking about the emotional challenges they faced.

They wanted to feel more informed about mental health and to receive information about the range of services that may be available to them.

For more information and to see the full SWEET! report, visit Healthwatch Essex <http://www.healthwatchessex.org.uk/what-we-do/topics/sweet/>

## Identifying risks and inequalities in Southend, Essex and Thurrock

### Risks to mental health in children and young people

In our previous local transformation plan, we highlighted the needs of disadvantaged children. Our 2013 joint strategic needs assessment identified the following main groups of children with a greater risk of developing mental health problems:

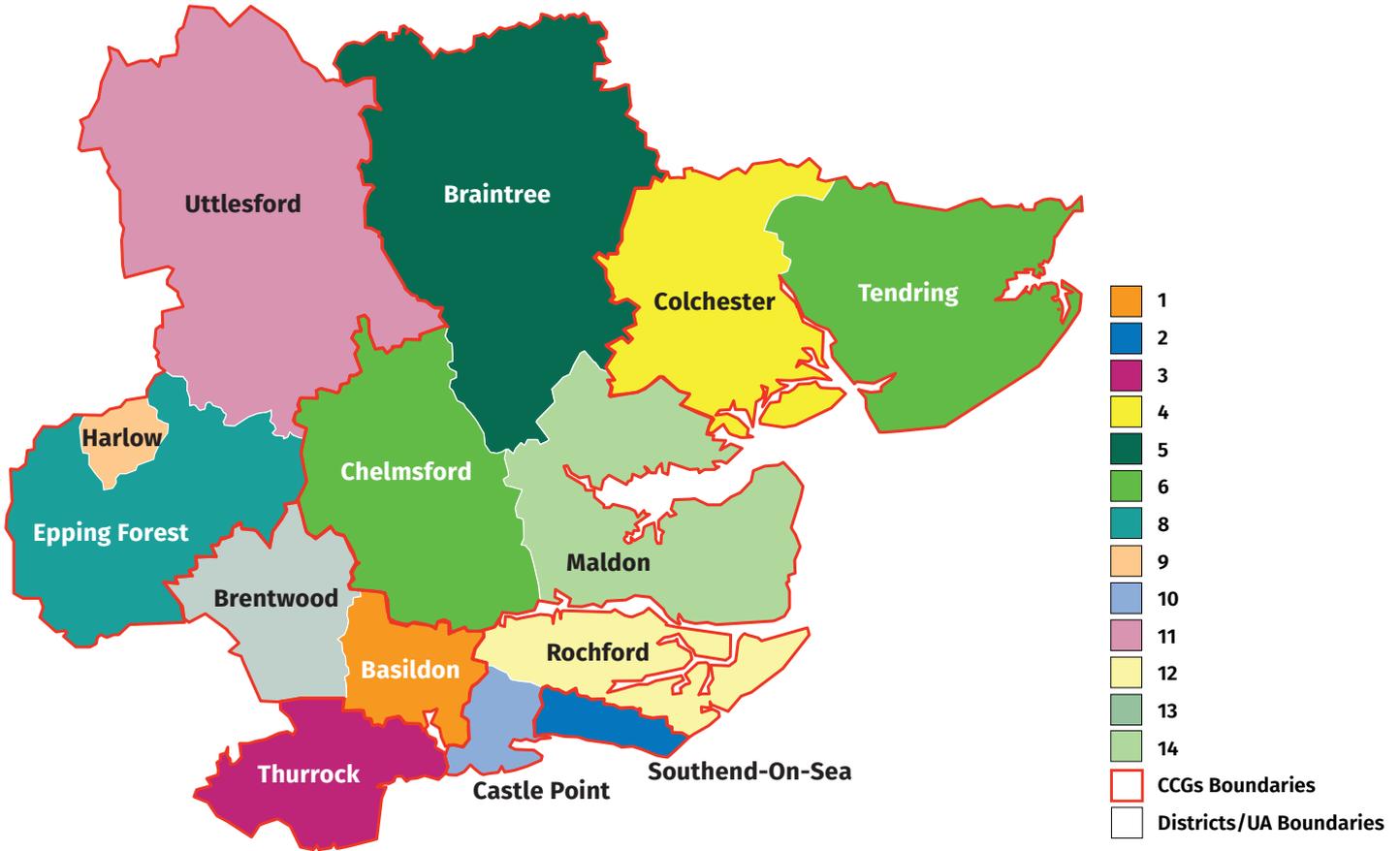
- Children with learning difficulties and disabilities, developmental disorders and children in residential schools
- Children in short stay schools
- Children on a child protection plan
- Children in care and looked after children

Our second joint strategic needs assessment in 2015 estimated numbers of children with potentially higher risks of mental health issues by looking at the following ten risk factors:

- Lone parent households
- Underweight and obese children (reception year)
- Underweight and obese children (Year 6)
- Children under 16 in poverty
- Teenage pregnancy
- Children aged under 15 who provide unpaid care
- Young people aged 16-24 who provide unpaid care
- Young people aged 16-24 who provide more than 20 hours of unpaid care per week

**The results provided further indications of where demands may rise over the next five years for each of our seven locality teams and services. We also considered this information in planning and prioritising our work with schools and communities to build resilience and early intervention.**

## Mental Health Risk Indicators Overall Rank



The map and table above shows that Basildon, Southend and Thurrock are ranked the highest in terms of the number of children at greatest risk across the ten mental health risk factors.

- **Basildon is ranked the highest** in terms of the number of children at greatest risk across all ten mental health risk factors and ranked 1st in six of the risk factor indicators. These are: lone parent, underweight children (Year 6), Children under 16 in poverty, under 18 pregnancy, young people aged 16-24 providing care and young people 16-24 providing more than 20 hours of care.
- **Southend is ranked second** across all ten mental health risk factors and is ranked 1st in two of the risk factors. These are: under 18 pregnancy and children under 15 providing care.
- **Thurrock is ranked third** across all ten mental health risk factors and is ranked 1st in three risk factors. These are: underweight children (Reception year), obese children (Reception year) and obese children (Year 6).



## Ranking of mental health risk factors for each district and unitary authority

	Lone Parent Rank	Underweight children (reception year) Rank	Obese children (reception year) Rank	Underweight children (year 6) Rank	Obese children (Year 6) Rank	Children under 16 in Poverty Rank	Under 18 Pregnancy Rank	Children <15 Providing Care Rank	Young People 16-24 Providing Care Rank	Young people 16-24 providing Considerable Care Rank	Combined Rank
Basildon	1	3	3	1	2	1	1	2	1	1	1
Braintree	6	5	5	3	7	6	6	4	7	6	5
Brentwood	11	9	14	13	13	12	14	14	11	11	13
Castle Point	10	11	9	10	10	10	9	9	10	10	10
Chelmsford	7	8	4	1	6	7	8	7	5	7	6
Colchester	3	7	5	6	4	5	5	5	2	3	4
Epping Forest	8	5	7	5	9	9	12	8	8	9	8
Harlow	9	2	10	12	8	8	6	10	9	8	9
Maldon	14	11	13	7	14	13	12	13	14	12	14
Rochford	12	14	12	14	11	11	10	11	12	13	12
Southend-on-Sea	2	3	2	4	3	3	1	1	3	5	2
Tendring	5	10	8	9	5	4	4	6	6	3	6
Thurrock	4	1	1	7	1	2	3	3	4	2	3
Uttlesford	13	11	11	10	12	14	10	11	13	14	11

### Lone Parents

Family breakdown can have a damaging effect on the mental health of children.<sup>3</sup> From national evidence, it is estimated that children brought up by single parents and in step families may be three times as likely to suffer from mental health problems compared with two-parent families.

There are an estimated 46,550 dwellings in Southend, Essex and Thurrock with a lone parent. This would suggest that there could be over 40,000 children at some risk of mental health issues.

### Children under 16 in poverty

Children living in low-income households are nearly three times as likely to suffer mental health problems as their more affluent peers.<sup>4</sup>

Around 54,570 children under 16 across Southend, Essex and Thurrock are estimated to be in poverty and could be at risk of mental health problems. The areas with the highest number of children in poverty and at greatest risk are Basildon, Thurrock and Southend.

## Young carers

The pressures of caring for parents and siblings frequently leads to anxiety, feelings of anger, frustration, guilt, resentment and stress. Young carers are likely to experience problems with school, such as regular lateness, difficulty completing assignments on time, disruptive behaviour, difficulty making friends, being bullied and leaving without any formal qualifications.

Young carers are more likely than others to be afraid to go to school because of bullying and to say their school deals badly with bullying. They are more likely to have been a victim of crime. Primary young carers have lower than average scores for overall wellbeing and are more likely to have poor emotional wellbeing.

### **Young carers - under 16 who provide unpaid care**

An estimated 3,465 children under 16 years old provide unpaid care across Southend, Essex and Thurrock and could be at risk of mental health problems. The areas with the highest number of children under 16 who provide unpaid care are Southend, Basildon and Thurrock.

### **16-24 year olds providing unpaid care**

8,070 children and young people aged 16 to 24 provide unpaid care across Southend, Essex and Thurrock and could be at risk of mental health problems. The areas with the highest number of children and young people providing unpaid care are Basildon, Colchester and Southend.

### **16-24 year olds providing 20+ hours a week unpaid care**

Of the 8,070 children and young people providing unpaid care across Southend, Essex and Thurrock, 2,143 (26.5%) of them provide 20 or more hours unpaid care. The areas with the most children and young people at risk are Basildon, Thurrock, Colchester, Tendring and Southend.

## Identifying priority needs in Southend, Essex and Thurrock

### Self-harm

There are usually a number of different reasons that lead to someone self-harming, but there are generally two main reasons. The first is the experience of intense and distressing emotions. These may be related to particular experiences, such as sexual or physical abuse. The second reason is the absence of the right kind of emotional support. In other words, the child or young person is not provided with the assistance to recognise and understand their responses to the events they are experiencing. The absence of recognition and support in the context of extreme and distressing events leads to a sense of powerlessness, and an inability to understand and manage painful feelings.<sup>5</sup>

The Young Minds charity reports that between one in 12 and one in 15 children and young people are thought to deliberately self-harm.<sup>6</sup>

If this is the case, the potential number of 10-19 year olds in Southend, Essex and Thurrock who self-harm could be between 19,000 and 38,000.

#### Perceptions and experiences of self-harm in Essex

During the summer of 2015, the Essex County Council Involvement Team spoke with over 200 young people about their perceptions and experiences of self-harm in Essex.

- Nearly half of the young people thought that bullying causes young people to self-harm.
- 39% of participants thought the best support was having someone to talk to or discuss things with, someone they could trust or who would keep things confidential.
- Over 70% of the young people thought that carers, parents and teachers may need more information and support about self-harm, and 64% thought that young people themselves may need this.

## Teenage suicide

Since April 2013, the suicide rate for those aged from 12 to 17 years old in Southend, Essex and Thurrock is 8 per 100,000. As is the case nationally, the Essex figures show that 70% of teenage suicides in Essex were male compared with 30% female.

**The Government strategy *Preventing Suicide in England (2012)* identifies the following groups as being vulnerable to suicide:**

County / UA	Children in the Youth Justice System (2013/14)	Children Leaving Care (2014/15)	Looked After children (2014/15)
Essex	914	515	1025
Southend	190	105	230
Thurrock	114	130	280
<b>SET Total</b>	<b>1218</b>	<b>750</b>	<b>1535</b>

## Children with learning difficulties, disabilities and developmental disorders

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

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

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

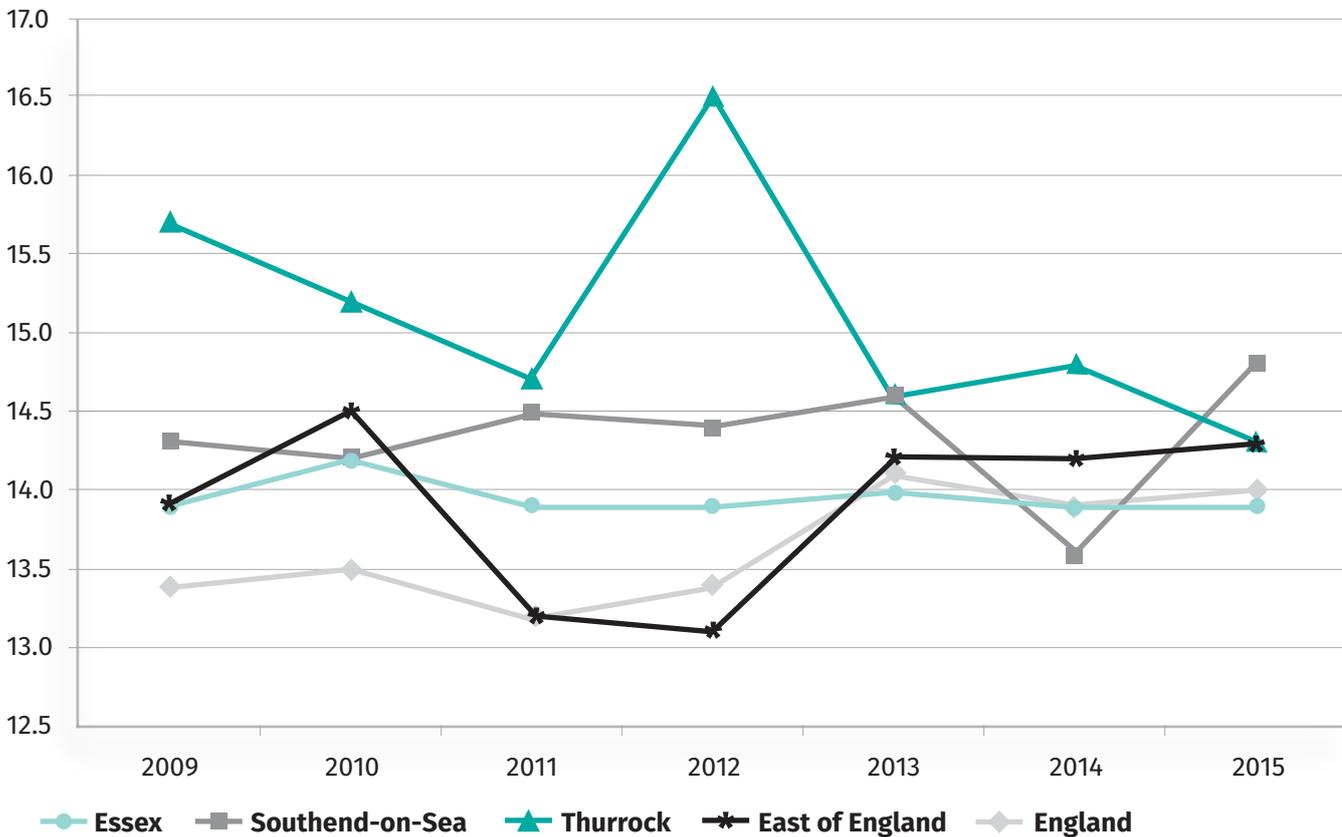
## Children in care and looked after children

It is estimated that almost half of children in care have a diagnosable mental health disorder, with looked-after children four times more likely to have a mental health condition. Carers continue to report that they find it difficult to access appropriate child and adolescent mental health services.

The Department for Education collects outcomes data for looked after children, which includes emotional and behavioural health. The findings are based on information gathered from a strengths and difficulties questionnaire covering emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and poor social behaviour.

The results of the strengths and difficulties questionnaire in 2015 showed levels of emotional wellbeing amongst looked after children as highest in Southend and lowest in Essex, as shown in the table below.

**Emotional and Behavioural Health of Looked After Children**



A House of Commons Education Select Committee recently published a report into the mental health and wellbeing services provided to looked after children.<sup>7</sup> The report recommended that looked-after children should have priority access to mental health assessments by specialist practitioners, a recommendation that we have taken up with the new emotional wellbeing and mental health service for children and young people in Southend, Essex and Thurrock.

## Unaccompanied children seeking asylum

Children seeking asylum may have experienced war-related trauma and various dangers in their journeys to the UK. Challenges continue upon arrival, as these children must cope with the stresses of living in a new country with a new language and all without the support of their parents.

Such children are considered at high risk for psychological distress, including sleep disturbances, attention and concentration difficulties and flashbacks of previously experienced trauma. For example, it is estimated that one-third of asylum-seeking Afghan children who arrive in the UK without their parents are likely to experience symptoms associated with post-traumatic stress disorder.<sup>8</sup>

In Essex around 70 children seeking asylum started a period in care in 2015/16.

Our open access emotional wellbeing and mental health service will offer services to support our vulnerable children and young people; we have an agreed quality indicator with our provider to support vulnerable groups through multi-agency consultation when referred.

Our priorities within this transformation plan seeks to further support our vulnerable children, young people and families through ensuring services are inclusive and resourced to work with individual needs.

<sup>8</sup>Bronstein, I., Montgomery, P., & Dobrowolski, S. (2012), 'PTSD in Asylum-Seeking Male Adolescents From Afghanistan', *Journal of Traumatic Stress*, 25(5), p551-557

## How children and young people are using our new service (1 November 2015 – March 2016)

See [Appendix 2](#) for further information on activity in 2016/17, including activity for eating disorder services.

One of our aims in year 1 of the local transformation plan was to improve our data on children and young people who are referred for support. Since 1 November 2015, our information about children receiving services is much more consistent and more accurate than before.

The national aim is to treat 70,000 more children a year from 2020/21 onwards. For Southend, Essex and Thurrock this means supporting 600 more children a year by 2021, starting with an increase of 179 children a year by the end of 2016/17. We will review this at the end of year 3, but current indicators suggest that we may be well on course to exceed the national target.

### Who is using the service and the nature of problems

#### Year 1

In the first five months of launching the new service for children and young people, we saw a surge in demand. The caseload doubled from 3,200 cases on 1 November 2015 to over 6,432 at the end of March 2016. Similarly, the crisis team caseload went from 109 at the end of November 2015 to 210 at the end of March 2016.

The top three presenting problems were:

- Emotional Disorder
- Conduct Disorder
- Deliberate Self-Harm

#### Year 2

At the end of year 2 (March 2017) the EWMH service has approximately 6,300 open cases and 80 cases within the crisis team, the initial surge in demand from launching the new service has subsided and the presenting problems has changed.

The top three presenting problems across Essex were:

- Emotional Disorder
- Conduct Disorder
- Deliberate Self-Harm

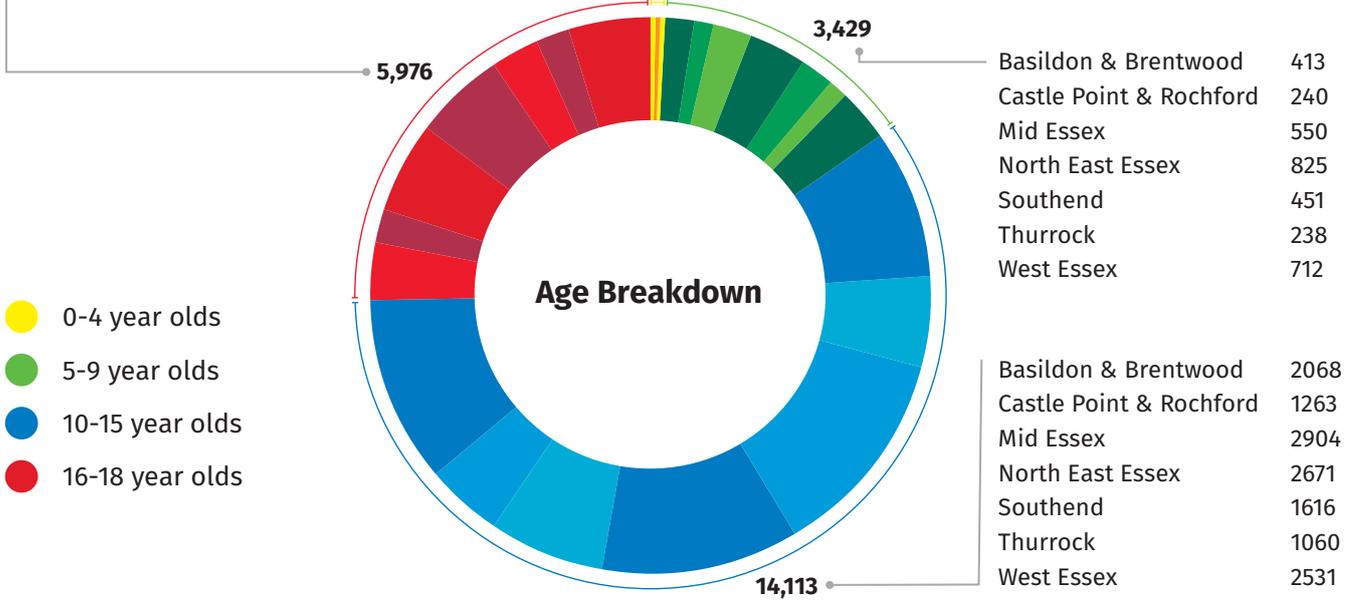
Further detailed information can be found in [Appendix 2](#).



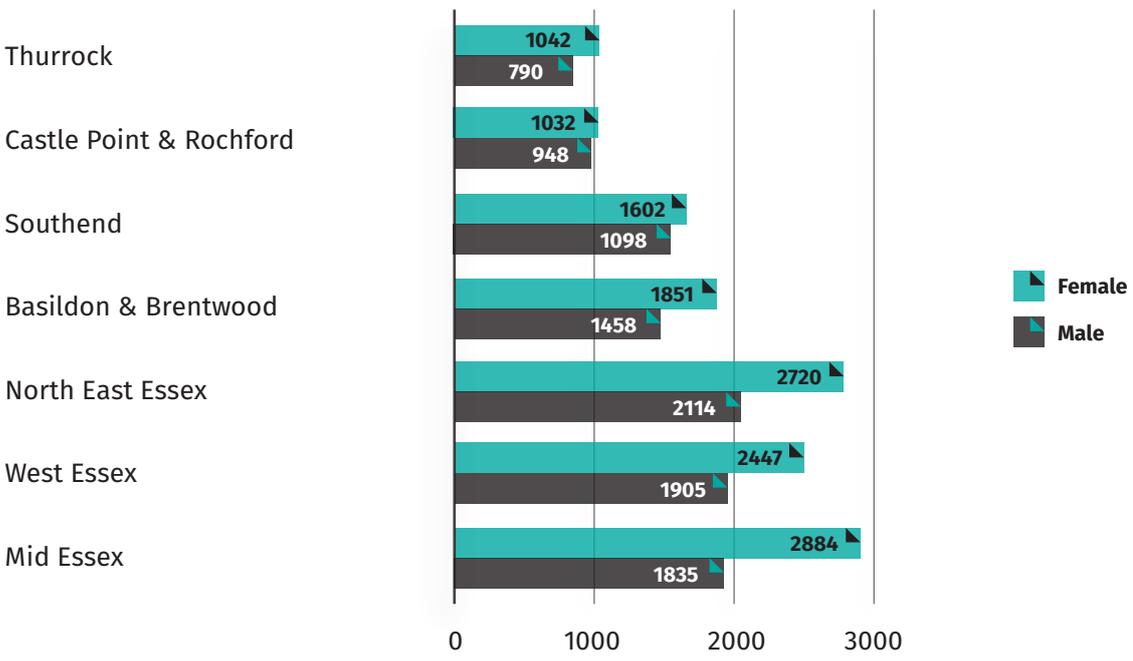
**Other information from activity April 2016 – March 2017:**

Basildon & Brentwood	801
Castle Point & Rochford	467
Mid Essex	1230
North East Essex	1284
Southend	613
Thurrock	518
West Essex	1063

Basildon & Brentwood	27
Castle Point & Rochford	9
Mid Essex	33
North East Essex	53
Southend	24
Thurrock	17
West Essex	45



**Gender Breakdown**



## Referral rates

### Year 1

Between November 2015 and March 2016, there was an average of around 1,000 referrals a month received at the single points of access. The highest referral rate was in mid and north east Essex – around 235-240 referrals per month.

An important national indicator is that around 79% referrals received should be accepted for services of some kind. Our average acceptance rate across Southend, Essex and Thurrock was 85%, with a consistent rate across the patch. This is a significant improvement on the variances of 2014/15. However, the number of referrals accepted remains low compared with current ChiMat estimates of needs.

### Year 2

In year 2 (April 2016- March 2017), a total of over 10,000 referrals were received to the single points of access this is an average of 850 referrals per month. The highest referral rate was in North East Essex followed by Mid Essex.

Our average acceptance rate across Southend, Essex and Thurrock was 90%.

The table below, shows actual referrals received and accepted across all entry points (SPA and other) by each CCG from April 2016 - March 2017.

Community EWMHS			
CCG Activity April 2016 - March 2017			
CCG	Refferals Recieved	Refferals accepted	% acceptance rate
Basildon & Brentwood	1654	1423	86%
Castle Point & Rochford	1128	999	89%
Mid Essex	2138	1919	90%
North East Essex	2395	2163	90%
Southend	1210	1116	92%
Thurrock	1029	948	92%
West Essex	1745	1545	89%
<b>Essex</b>	<b>11299</b>	<b>10113</b>	<b>90%</b>

# Summary of findings

The national estimates calculated by ChiMat and the risk factors that were highlighted by our own joint service needs assessment all suggest that there are significant unmet needs for support and services for the emotional wellbeing and mental health of children and young people.

We are still a long way off closing the gap, but in the first few months of launching a new single integrated service across Southend, Essex and Thurrock, we have opened up to more referrals and started to reach out to children, young people and families. We have in year 2 seen a slight improvement in an increase in the number of children being treated. We expect this improvement to continue every year for the next three years of our local transformation plan.

Our experience of the problems that we are seeing in Southend, Essex and Thurrock suggests similar trends to those nationally, and we are reasonably confident that we are planning the right level of resources to manage demands.

In year 1 the feedback we heard from children and young people determined many of our planning priorities, in particular the need to improve information, awareness and access to services. In year 2, we have seen evidence of an improved service making an impact on the perceptions of children and young people, we expect further improvements in years 3, 4, and 5.

The percentage of referrals accepted for services at around 90% is high compared with the national benchmark of around 72%. We see this as a good sign, given that we are aiming to reach more children by being more open to referrals.

We will continue to measure our outcomes year on year and listen to feedback to help shape new services being implemented and refresh our local transformation plan.

# REFRESH OF OUR TRANSFORMATION PLAN

How we will continue to transform over the next three years...

→ Improve access and equality - by continuing to develop and improve the new single integrated service across Southend, Essex and Thurrock

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

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

## What drives our plan - six principles

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

# The Emotional Wellbeing & Mental Health Service

## The Emotional Wellbeing and Mental Health Service for the children and young people of Southend, Essex and Thurrock

On 1 November 2015, we launched a new emotional wellbeing and mental health service for children and young people in Southend, Essex and Thurrock.

The service is provided by North East London NHS Foundation Trust (NELFT). It works from seven locality teams with health and social care workers who specialise in mental health services for children and young people.

They provide a full range of services from information and support to specialist help for long-term and serious mental health problems.



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

Call **0300 300 1600** 9am-5pm Monday to Friday  
Or email **NELFT-EWMHS.referrals@nhs.net**

For support in a **crisis** at any time of day or night, call **0300 555 1201** and ask to be put through to **Crisis Support.**

	Support in daily life	Help from local services	Expert help from specialists	Help in a crisis
Aims	Mental health is everyone’s business at home, at school and in our local communities.	Easily accessible and effective at the earliest possible time.	Easily accessible and able to reduce the effects of serious problems.	There when needed and able to avoid hospital admissions
Services	<p>Information and advice for children and young people, parents and others, available from our website and locality teams.</p> <p>Training and support for schools, health and care professionals and community groups.</p>	<p>Range of evidence-based interventions for mild to moderate needs, including psychological therapies (IAPT) and brief interventions.</p> <p>One to one, professional support for families</p> <p>Assessment, care plans and review.</p>	<p>Services to meet severe and complex needs, suicide prevention, help for self-harm</p> <p>Anxiety disorders Challenging behaviour.</p> <p>Eating disorders ADHD Learning disabilities</p> <p>Joined up services where there are several problems</p> <p>Referral to more specialised services, if needs be.</p>	<p>Fast response teams, available 24 hours a day to work with children and families at home to avoid a hospital admission.</p> <p>On call for accident and emergency units and police.</p> <p>Overnight and short stays in specialist services, if needs be</p>

Working relationships with schools, public health, GPs, pharmacists, children’s centres, children’s health services, police, youth justice teams, services for substance misuse and a range of local voluntary organisations.

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



Easy to find support by telephone, Internet and email

Easy to get to services and convenient opening times

Services in a safe place, no stigma

Services that are responsive in the right way for you

Guaranteed standards

Immediately available information and advice

Connections with other services and shared information with your permission

Support for the whole family

## Goals for the **system**



Whole family approach

Whole system approach

Skilled and confident workforce

Early intervention

Evidence-based interventions

Measurable outcomes and improvement

Better use of resources, less duplication

Smooth transition between services and specialists

Reduced demand on emergency and specialised services

# Measurable outcomes

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

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

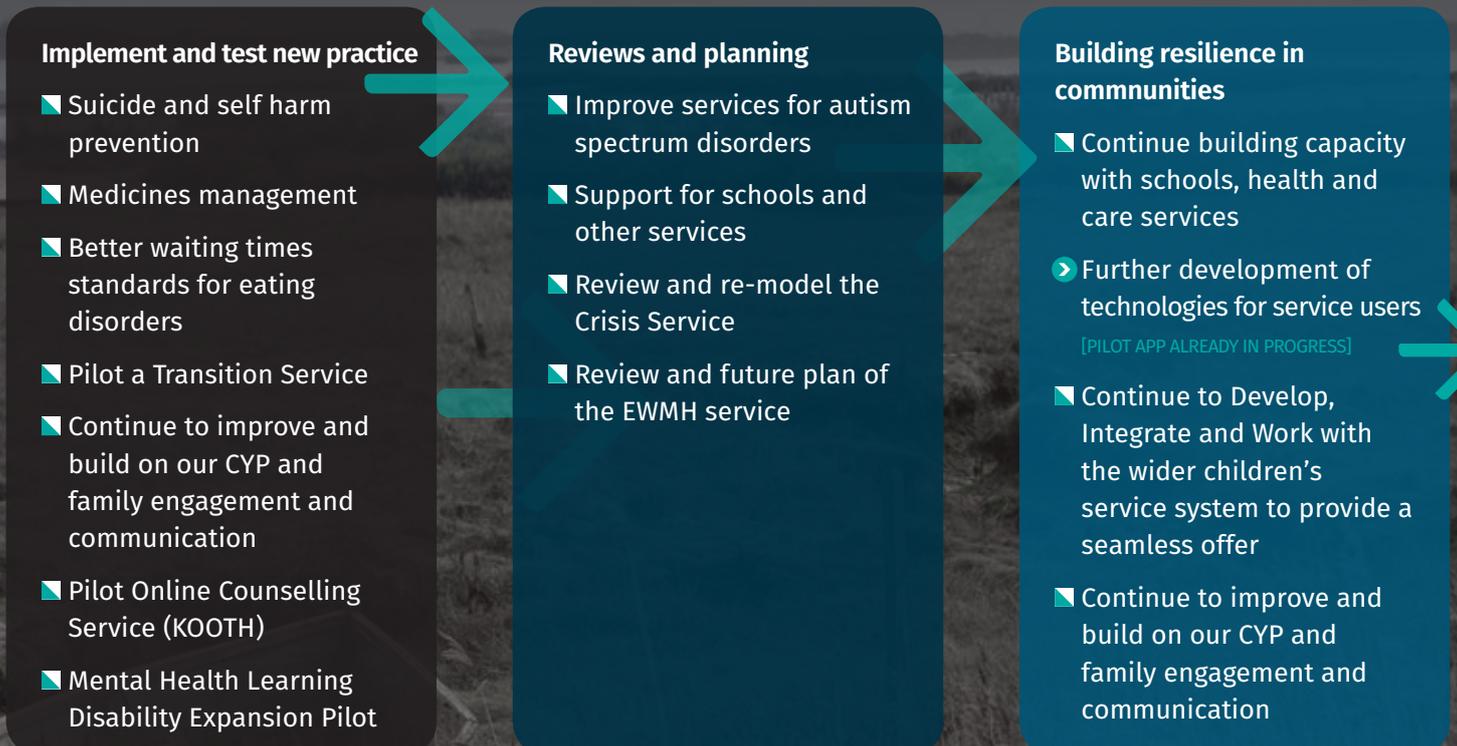
## Years 1 and 2 - Transition to the new service



## Year 2 – Transformation in 2016/17



## Year 3 and beyond



## Month by month improvements in mental health and services

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

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

**In the next section, *Priorities for Action*, we highlight progress and refreshed plans in further detail.**



# PRIORITIES FOR ACTION

## Further needs assessment

By June 2016, we had completed a more detailed and local joint needs assessment of the emotional wellbeing and mental health of children in Southend, Essex and Thurrock. Our joint service needs assessment highlighted mental health care for children and young people with learning disabilities and support for young people moving between services as significant service gaps.

We therefore updated our investment plan to increase the funds for children's learning disability services to ensure a consistent and equitable service offer across Southend, Essex and Thurrock. We also have plans to fund additional community support for the transition of young people who continue to need services but might not meet the criteria for adult mental health services.

## Investment

### Year 1

#### Our plan

The new service commenced on 1 November with a contract value of just over £13 million.

During 2015/16, we invested in excess of £1.5 million to develop local services. This translates to a planned full year investment of just over £3.3 million.

The table below gives a detailed breakdown of our actual spend on service developments during 2015/16.

Workstreams	CAMHS Actual Spending 15/16 CCG share of Total Allocation								
		Basildon and Brentwood CCG	Castle Point and Rochford CCG	Mid Essex CCG	North East Essex CCG	Southend CCG	Thurrock CCG	West Essex CCG	Total
		14.39%	10.21%	19.96%	19.12%	10.95%	8.85%	16.52%	100.00%
Expansion of services for Eating Disorders	-	24,463	17,357	33,932	32,504	18,615	15,045	28,084	<b>169,998</b>
Deeper Dive needs analysis	Non-Recurrent	21,585	15,315	29,940	28,680	16,425	13,275	24,780	<b>150,000</b>
Publication of the LTP	Non-Recurrent	2,655	1,884	3,683	3,528	2,020	1,633	3,048	<b>18,449</b>
Engagement with Children and Young People	-	16,549	11,742	22,954	21,988	12,593	10,178	18,998	<b>115,002</b>
Improved IM&T infrastructure	Non-Recurrent	33,241	23,585	46,108	44,167	25,295	20,444	38,161	<b>230,999</b>
Project Management office for Transition	Non-Recurrent	20,434	14,498	28,343	27,150	15,549	12,567	23,458	<b>141,998</b>
Suicide and self-harm audit and training	Non-Recurrent	14,390	10,210	19,960	19,120	10,950	8,850	16,520	<b>100,000</b>
Medicines Management review	Non-Recurrent	7,195	5,105	9,980	9,560	5,475	4,425	8,260	<b>50,000</b>
Enhanced crisis services to cover 9am - 9pm Seven days a week	-	22,017	15,621	30,539	29,254	16,754	13,541	25,276	<b>153,002</b>
More staff in local teams to improve Single Point of Access	-	4,317	3,063	5,988	5,736	3,285	2,655	4,956	<b>29,999</b>
More senior clinicians in psychological services	-	-	-	-	-	-	-	-	-
More practitioners in psychological services	-	-	-	-	-	-	-	-	-
More staff in locality teams to respond to low to moderate needs	-	-	-	-	-	-	-	-	-
Extra management capacity	-	-	-	-	-	-	-	-	-
Training for therapy services (CYP IAPT)	-	11,800	8,372	16,367	15,678	8,979	7,257	13,546	<b>81,997</b>
Local partnership development sessions	-	3,022	2,144	4,129	4,015	2,300	1,859	3,469	<b>21,001</b>
Support and training for schools	-	-	-	-	-	-	-	-	-
Transformation support costs	-	34,120	24,209	47,327	45,335	25,963	20,984	39,170	<b>237,108</b>
Paediatric Liaison Pilot	Non-Recurrent	-	20,500	-	-	20,500	-	-	<b>41,000</b>
		<b>215,786</b>	<b>173,603</b>	<b>299,312</b>	<b>286,715</b>	<b>184,701</b>	<b>132,711</b>	<b>247,726</b>	<b>1,504,553</b>

## Our Progress

The new service commenced on 1 November 2015 with a contract value of just over £13 million.

### Year 2

A growth in national funding created the opportunity to increase our additional investment from £3.3 million per year in 2016/17 to £5.3 million in year 3 (2017/18) of our plan.

The table below shows actual additional transformation funding for 2017/18 and indicative allocations for 2018/19 and 2019/2020 for Essex CCGs.

### Transformation Funding

Financial Year 2017-18								
CCG	Basildon and Brentwood CCG	Castle Point and Rochford CCG	Mid Essex CCG	North East Essex CCG	Southend CCG	Thurrock CCG	West Essex CCG	Total
Eating Disorder allocation Revised	141,000	95,000	187,000	187,000	100,000	85,000	160,000	<b>955,000</b>
CAMHS Transformation allocation Revised	660,198	442,467	873,214	873,884	467,369	397,768	745,314	<b>4,460,214</b>
<b>Total allocation Revised</b>	<b>801,198</b>	<b>537,467</b>	<b>1,060,214</b>	<b>1,060,884</b>	<b>567,369</b>	<b>482,768</b>	<b>905,314</b>	<b>5,415,214</b>
<b>Total previously notified allocation</b>	<b>805,114</b>	<b>539,591</b>	<b>1,064,889</b>	<b>1,065,705</b>	<b>569,959</b>	<b>485,080</b>	<b>908,914</b>	<b>5,439,253</b>
<b>Movement (increase)/decrease</b>	<b>3,917</b>	<b>2,124</b>	<b>4,675</b>	<b>4,822</b>	<b>2,590</b>	<b>2,312</b>	<b>3,600</b>	<b>24,039</b>

Financial Year 2018-19								
CCG	Basildon and Brentwood CCG	Castle Point and Rochford CCG	Mid Essex CCG	North East Essex CCG	Southend CCG	Thurrock CCG	West Essex CCG	Total
Eating Disorder allocation	141,000	95,000	187,000	187,000	100,000	85,000	160,000	<b>955,000</b>
CAMHS Transformation allocation	801,669	537,281	1,060,331	1,061,144	567,520	483,004	905,024	<b>5,415,947</b>
<b>Total allocation</b>	<b>942,669</b>	<b>632,281</b>	<b>1,247,331</b>	<b>1,248,144</b>	<b>667,520</b>	<b>568,004</b>	<b>1,065,024</b>	<b>6,370,974</b>

Financial Year 2018-19								
CCG	Basildon and Brentwood CCG	Castle Point and Rochford CCG	Mid Essex CCG	North East Essex CCG	Southend CCG	Thurrock CCG	West Essex CCG	Total
Eating Disorder allocation	141,000	95,000	187,000	187,000	100,000	85,000	160,000	<b>955,000</b>
CAMHS Transformation allocation	895,983	600,491	1,185,076	1,185,985	634,287	539,828	1,011,498	<b>6,053,148</b>
<b>Total allocation</b>	<b>1,036,983</b>	<b>695,491</b>	<b>1,372,076</b>	<b>1,372,985</b>	<b>734,287</b>	<b>624,828</b>	<b>1,171,498</b>	<b>7,008,148</b>

Our joint strategic needs assessment highlighted mental health care for children and young people with learning disabilities and support for young people moving between services as significant service gaps.

We therefore updated our investment plan to increase the funds for children's learning disability services to ensure a consistent and equitable service offer across Southend, Essex and Thurrock. We also identified funding additional community support for the transition of young people who continue to need services but might not meet the criteria for adult mental health services.

The table below gives a detailed breakdown of our planned spend on service developments during 2016/17.

Scheme Number	Description of work stream	R/NR	Provider	Submission (Open Up and Reach Out)	Tracker Submission FYE 2016/17	2016/17 Cost
LTP 1	Expansion in local services for specialist community Eating Disorders	R	NELFT	953,000	0	693,288
LTP 3	Development and publications of the Essex wide Local Transformation Plan (LTP) with an accessible version for CYP and their families. The plan is required to be refreshed and published annually	R	Other	-	-	3,530
LTP 4	Active engagement with CYP in partnership with Repezent	NR	Repezent	-	-	100,000
LTP 6	Project Management Officer (PMO) function to deliver transformation workstreams	R	NELFT	-	-	74,849
LTP 10	Enhanced crisis service cover across Southend Essex and Thurrock and building capacity in the teams to provide more intensive care at home	R	NELFT	430,000	0	431,060
LTP 11	Enhanced staffing capacity in the Single Point of Access team to ensure better information, consultation and support, and signposting to local services	R	NELFT	144,000	0	110,794
LTP 12	Enhanced senior psychology posts across each locality to ensure high quality supervisions	R	NELFT	76,000	0	141,976
LTP 13	Increased junior psychology posts at a local level to enhance service delivery	R	NELFT	421,000	190,000	375,550
LTP 14	Additional staffing capacity in all locality teams with a specific focus on low to moderate needs and increased capacity for greater access	R	NELFT	598,000	241,060	570,698
LTP 15	Increase medical capacity (5 junior doctor posts)	R	NELFT	208,000	0	-
LTP 16	Enhanced management capacity at a local level, Southend Essex and Thurrock	R	NELFT	104,000	28,877	289,904
LTP 17	Additional local bespoke CYP IAPT training programmes over and above the national IAPT programme, with a specific focus on Primary Mental Health Workers	R	NELFT	100,000	76,181	50,000
LTP 19	Building community resilience by providing additional support to schools and the voluntary sector	R	NELFT	310,000	597,780	145,464
LTP 20	Transformation Support Cost	-	Other	-	-	288,367
LTP 21	Communication and Engagement	R	Other	-	-	37,500
LTP 22	Care and treatment review	N/R	Other	-	-	61,609
LTP 23	Transitions - support for young people leaving leaving childrens services gap	R	Other	-	-	62,500
LTP 24	LD - additional capacity and equitable offer across county	R	Other	-	-	100,000
	<b>Total</b>	-	-	<b>3,344,000</b>	<b>1,133,898</b>	<b>3,474,125</b>
	Eating disorders					693,288
	Other transformation projects					2,780,837
	<b>Total planned spend</b>					<b>3,474,125</b>

See Appendix 3 for details of actual spend in 2016/17 and planned investments for 2017/18.

The following shows planned funding investments for 2017/18.

Estimated extra £1 million investment for developments from 2018/19 onwards

The following shows investments that are in addition to the original budget of £13.2 million per year.

Expansion in local services for specialist community Eating Disorders	<b>£953,000</b>
Development and publication of the Essex wide Local Transformation Plan (LTP) with an accessible version for CYP and their families	<b>£12,000</b>
Enhanced crisis service cover across Southend Essex and Thurrock and building capacity in the teams to provide more intensive care at home	<b>£431,000</b>
Enhanced staffing capacity in the Single Point of Access team to ensure better information, consultation and support, and signposting to local services	<b>£140,000</b>
Support team for service transformation	<b>£108,000</b>
Enhanced senior psychology posts across each locality to ensure high quality supervision	<b>£76,000</b>
Increased junior psychology posts at a local level to enhance service delivery	<b>£421,000</b>
Additional staffing capacity in all locality teams with a specific focus on low to moderate needs and increased capacity for greater access	<b>£598,000</b>
Increase support for CYP with Complex needs. i.e. SEN, ASD, LD etc.	<b>£208,000</b>
Enhanced management capacity at a local level, Southend Essex and Thurrock	<b>£290,000</b>
Additional local bespoke CYP IAPT training programmes over and above the national IAPT programme, with a specific focus on Primary Mental Health Workers	<b>£100,000</b>
Building community resilience by providing additional support to schools and the voluntary sector	<b>£310,000</b>
Communication and Engagement	<b>£100,000</b>
Transitions - support for young people leaving children's services gap	<b>£400,000</b>
LD - additional capacity and equitable service offer across county	<b>£350,000</b>
Online Counselling Service	<b>£200,000</b>
Crisis re-modelling Match funding	<b>£674,000</b>
<b>Total</b>	<b>£5,371,000</b>

# IMPROVING ACCESS AND EQUALITY

The national target for the NHS of reaching at least another 70,000 more children and young people annually from 2020/21 is expected to deliver increased access from meeting approx. 25% of those with a diagnosable condition locally, to at least 35%. These additional children and young people will be treated by NHS funded community services.

For Essex, this will mean that the NHS has a local target of reaching at least 600 more children and young people annually from 2020/21.

The table below sets out an indicative trajectory for increased access. We have already exceeded this target.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of children and young people with a mental health condition receive treatment from an NHS-Funded Community mental health service	28%	30%	32%	34%	35%
Number of additional children and young people to be treated over 2014/15 baseline	179	298	417	537	596

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

### Our plan

To make it easier for children and young people to get access to mental health care and support through a single point of access that would ensure a consistent response to needs.

## Our progress - Year 2

For all children, young people, parents, schools or health and care workers there is one telephone number and one email address for referrals. These are open to all and publicised in patient information and websites.

The number directs people towards their local single point of access, one of three teams based in Southend, Colchester and Grays. These teams are able to give:

- telephone advice and support
- triage, signposting, preventative planning and an early offer of help
- allocation of the referral to a locality team, where an expert service is needed

The new single point of access offers wider eligibility criteria than before and with enhancements, such as clinical triage, the teams are able to respond to a higher volume of calls.

Opening up the referral criteria has demonstrated the success of the single point of access, we decided to review how this part of the service during year 2. The findings of the review will help us to adapt and improve the single point of access over the next 3 years.

**The total number of referrals received by the single point of access and accepted by the service was over 10,000 by the end of March 2017.**

## Updated plan 2017-2020

We will ensure a sustained workforce for the three teams that provide the single point of access. The nature of the work can be stressful at times. Working with NELFT, our provider organisation, the aim is to explore innovative approaches to the roles, such as the development of rotational posts and learning from the single point of access service review.

## Improving crisis services

### Our plan

To enhance crisis teams with additional trained and experienced staff so that the service can operate 9am-9pm seven days a week across all localities in Southend, Essex and Thurrock.

### Our progress - Year 2

Previously there were mental health services available 24 hours a day to do emergency assessments. The work was mainly in hospital A&E departments and paediatric wards, but actual crisis intervention and home treatment was only offered in north Essex.

Three crisis teams now offer assessment and support for families, as well as working in hospitals. As part of the team there is a dedicated consultant working out of hours to give telephone advice to both families and professionals such as A&E and hospital doctors.

In addition we have added access to a national telephone advice service out of hours, called *Mental Health Direct*. We have also developed a CAMHS consultant on-call Rota for CAMHS Out-of-hours.

Most crisis situations come to our attention in A&E departments. In Colchester Hospital and Broomfield Hospital in Chelmsford, we are delivering specialist nurse support available 8pm to 8am. The service in Broomfield is also covering The Princess Alexandra Hospital in west Essex.

We analysed and reviewed our current crisis model and held a systems leadership event to discuss how we can better meet the needs of our children and young people in crisis. Children and young people who are supported by emotional wellbeing and mental health services do have a clear crisis management plan as part of their overall care plan.

**As at March 2017, 99.4% of assessments were completed in A&E within 4 hours.**

See [Appendix 2](#) for further information showing current crisis referrals in Southend, Essex and Thurrock during the period April 2016 to March 2017.

## Updated plan 2017-2020

Over the period of our transformation plan, the aim is to offer intensive treatment at home or wherever a young person needs help, rather than having to go into hospital or a specialised service.

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

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

In year 3, we will develop a system-wide crisis offer that will build on an intensive home treatment model and utilise the findings of our system leadership event and crisis model review.

We will continue over the next two years to develop home treatment for young people in crisis, with the aim of having a full “hospital at home” type service to prevent the need for a hospital stay.

## Crisis Care Concordat Mental Health

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

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

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



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

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

### A national transformation project

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

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

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

## Our plan

To expand and train our workforce to ensure a sustained culture of evidence-based care with an emphasis on outcomes and to make more therapy available in a range of places, such as schools and children’s centres. Our aim is that staff are released for IAPT training year on year so that we achieve 100% IAPT coverage across our mental health service by 2018.

## Our progress - Year 2

In spite of a number of workforce challenges associated with transition, NELFT has successfully released 23 practitioners to the national IAPT training programme. During year 2 NELFT planned to release a further 38 trainees for academic year 2016/17 with plans in place for more to follow in year 3.

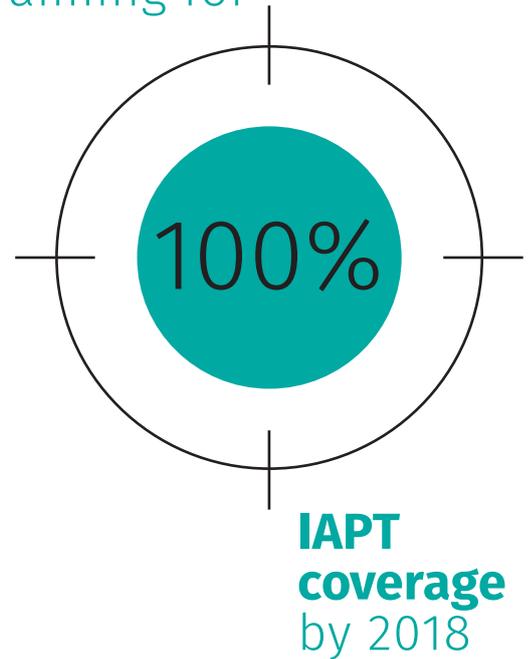
NELFT have been focused on delivering care pathway treatments and reducing the treatment waiting times. In 2016/2017 it was necessary to strike a balance between training, meeting the exacting supervision requirements of the courses and delivering treatment to children, young people and their families and meeting the demands of the service.

There are currently three clinicians on the IAPT management and Leadership course with four due to attend the 2017/2018 course.

There are currently eight clinicians attending the Enhanced Evidence-Based Practice (EEBP) for Children and Young People course.

There are two clinicians attending the Systemic Family Practice; two clinicians attending the ASD/LD course; and two are attending the Systemic Supervision module; one clinician is attending the Interpersonal Psychotherapy for Adolescents (IPTA) and another the Cognitive Behavioural Therapy course.

We are aiming for



The Conduct and Behaviour pathway leads within the locality teams have attended Triple Parent training for Teens and Primary age and these interventions are being offered by the service. These pathway leads will also be undertaking Managing Emotional Triggers (MET) training in September 2017, which will ensure that this pathway is able to offer NICE recommended treatments for all age groups.

During 2016/17 there was no take up of the recruit to train option. It was decided that it would not be advantageous to the service to take up the recruit to train option during 2016/17 as the service was focused on delivering care pathway treatments and reducing the treatment waiting times.

There were four candidates for the new PWP option in 2016/2017 - Psychological Wellbeing Practitioner and a further four for 2017/18.

LTP investment had enabled development of a bespoke in-house training programme for Band 5 & 6 clinicians on Assessment and Treatment of Depression in Young People and Parent-Led CBT for Child Anxiety. These were very well attended and feedback from both the facilitators and attendees was very positive. The service continues to develop training within the pathways to meet the needs of young people and their families, while further skilling up the workforce in evidence based treatments.

The CYP IAPT Steering Group, attended by senior clinicians and Team Managers aims to assure IAPT principles are embedded throughout the service and to support the training being developed and disseminated. The service strives to ensure the balance between having clinicians attend courses, while meeting the demands of the service.

**The new emotional wellbeing and mental health service for Southend, Essex and Thurrock has a formal status with the London and South East Learning Collaborative, which provides IAPT training.**

### Updated plan 2017-2020

Essex commissioners want to sustain a culture of continuous evidence-based, outcomes focused service improvement delivered by a workforce with the right mix of skills, competencies and experience.

To do this we will work with our provider to support workforce training opportunities offered by CYP IAPT Transformational Programme to ensure CYP IAPT principles are embedded in psychological therapies and that EWMHS practitioners are trained in the CYP IAPT evidence based interventions.

Commissioners are committed to supporting NELFT to release staff for CYP IAPT training year on year, working to achieve 100% coverage across Essex by 2018

Our service provider has identified a potential 28 candidates for the academic year 2017/18 and commissioners will continue to commit resources through the LTP to support the transformation agenda within the service and the dissemination of IAPT principles internally.

## Attention Deficit Hyperactivity Disorder - ADHD

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

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

### Our plan

In *Open up Reach out*, our local transformation plan, we identified Attention Deficit Hyperactivity Disorder (ADHD) as a target for improving access to specialist care. It was our original intention to tackle this with five new posts for junior doctors.

### Our progress - Year 2

We reviewed the proposed medical model of care in year 1 and concluded that there were other innovative ways to improve care, through psychological therapies for example.

We have changed our approach, but with the same commitment to increasing our services and improving early intervention for children and young people. This work now interfaces with the mental health learning disability pilot/priority and the Transforming Care, a programme to improve health and care for people with learning disabilities, so that we can improve services for a broader range of autistic spectrum disorders.

### Updated plan 2017-2020

Our plan for 2017-20 is linked to Transforming Care, a programme to improve health and care for people with learning disabilities, autistic spectrum disorders and challenging behavior. We want to improve services to cover a broader range of autistic spectrum disorders, more information under Learning disability section on this plan.

## Creating a community service for eating disorders

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

Prior to the start of our new service for the emotional wellbeing and mental health of children and young people, specialist services for eating disorders were available in north Essex, but not in the south.

### Our plan

To invest in a new community-based specialist service in line with NICE Guidance for eating disorders. This will provide intensive support for families at home and in the communities of Southend, Essex and Thurrock.

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

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

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

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

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

Assuming 50% of children and young people with an eating disorder will seek treatment, we estimate 156 new referrals per year. Based on this level of activity, the workforce capacity needed to meet the waiting time standard across Essex is shown in the table below.

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

## Our progress - Year 2

The new eating disorder service across Southend, Essex and Thurrock is up and running. Whilst the new service is in development, our provider organisation, NELFT continues to draw upon the expertise of its well-established eating disorders Lifespan service, which serves four London boroughs.

A specialist community based eating disorder service has been developed. It is a multidisciplinary service covering all of Essex offering community based NICE (National Institute for health and Care Excellence) concordant treatment. Intensive community support and specialist family based treatments are a core component. The specialist team comprises medical and non-medical staff with significant eating disorder expertise and appropriate capacity and skill-mix to meet the Access and Waiting Time Standard.

The service is committed to the principles of children and young people's improving access to psychological therapies (CYP-IAPT; evidence-based practice, routine outcome measures, high quality clinical supervision and increased young people's participation. The team offers direct access to treatment through self-referral and primary care services (GPs, schools, colleges and voluntary sector services).

The service in Essex offers treatments in family based interventions for anorexia nervosa and bulimia nervosa and specifically adapted forms of cognitive behaviour therapy (CBT) for bulimia nervosa, in particular CBT-Enhanced (CBT-E) (Fairburn, 2008). Guided self-help for some presentations of bulimia nervosa is also available.

The service has strong local links with paediatrics where shorter acute admissions will be arranged for children and young people, and there are well established relationships with providers of adult eating disorder services in order to improve outcomes and support transition between services.

The service meets the standards set out in the Access and Waiting Time Standard for Children and Young People with Eating Disorders. NICE concordant treatments start within 4 weeks of first contact with a healthcare professional and within 1 week for urgent cases.

Our provider is a member of the Quality and Accreditation Network for CEDS-CYP linked to QNCC, which will enable our provider to assess and continue to improve the quality of care they provide, and ultimately become accredited services.

In appendix 2 you are able to see the performance monitoring data. The table below details the caseload as @ 31st March 2017.

CCG	Active Caseload
Basildon Brentwood Wickford	9
Castle Point and Rochford	4
Mid Essex	31
North East Essex	21
West Essex	17

### Updated plan 2017-2020

Our provider is taking advantage of the training being offered at a national level to improve clinical and management skills specifically to meet the needs of children and young people with an eating disorder, and the needs of their family where appropriate. CYP IAPT principles embedded in established accreditation processes for individual therapists, and modality courses.

Our provider is planning to release 3 trainees to attend the two-year PG Dip in CYP IAPT Therapy due to start in January 2018 for Systemic Family Practice for adolescent Eating Disorders.

The service also has representatives from the Essex eating disorder team on the newly constituted East of England wide Children and Young People's Eating Disorders Network which focuses on quality improvements to the eating disorders pathway across the East of England.

One of our priorities is communications and engagement and a commitment to involve children and young people, their families and carers, in service delivery and design to help us ensure that our model of care meets their immediate and future needs.

Monthly monitoring of the access and waiting time standard will continue during 2017/18, to ensure that treatment starts within four weeks, and within one week for urgent cases with the aim of achieving 95% of those referred for assessment or treatment receive NICE concordant treatment with the ED standard RTT by 2020

Commissioners will continue to monitor, review, and track service improvements through our appropriate governance structures i.e. monthly contract management meetings, and quarterly performance briefings to the Collaborative Commissioning Forum to ensure that the service continues to meet the national specification with appropriately qualified and supervised staff to deliver high-quality, evidence-based care.

## Early intervention in psychosis

*Ref. Implementing the early intervention in psychosis access and waiting time standard: Guidance published April 2016 by NHS England and National Institute for Health and Care Excellence (NICE) <https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf>*

Psychosis may involve hallucinations, delusions and losing touch with reality. It can cause huge stress and disability for a young person and their family. The evidence is that people can recover from psychosis and that early treatment has a greatly beneficial impact on preventing further problems and illness in the longer term.

From 1 April 2016, NHS England set a national standard that more than 50% of people experiencing a first episode of psychosis should receive care within two weeks of referral, in line with NICE guidance.

### Our plan

Early intervention in psychosis is commissioned as part of adult mental health services. It is provided by EPUT based in Essex who work together with NELFT, which provides children's mental health services. Early intervention in psychosis services cover the age range 14 years upwards.

The early intervention in psychosis teams work to national waiting time standards and offer care as recommended by the National Institute for Health and Care Excellence (NICE).

### Our progress

Both adult mental health service providers are currently meeting the national access and waiting time targets, but further work is needed to comply fully with NICE recommendations.

### Updated plan 2017-2020

Services continue to deliver their improvement plans, which include a phased expansion in capacity and skills to deliver a fully compliant Early Intervention in Psychosis service in year 3 of our local transformation plan.

Essex Partnership University Foundation Trust (EPUT) continue to perform well against the national target and there is evidence of good joint working with the children's Emotional Wellbeing and Mental Health Service (EWMHS). The newly merged Essex partnership NHS trust is currently reviewing clinical pathways and the future service model

## Children's learning disability services

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

### Our plan

With our additional money for transformation, we intend to offer specialist mental health learning disability services to the whole of Southend, Essex and Thurrock. We will also work with the Transforming Care programme and adult mental health services to support young people, if they need it, up to the age of 25 and further development of the learning disability/ASD service offer.

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

### Our progress - Year 2

We have seen some delays in the completion of the learning disabilities review, we anticipate this to be completed in November 2017. The delay has not prevented us from working to our plan and we have:

- Agreed funding to recruit a children and young people's care, education and treatment manager and a coordinator across Southend, Essex and Thurrock
- Plan and agreed to extend the specialist mental health learning disability service in the south across Southend, Essex and Thurrock as well as increase the age range upto 18 years

This work will directly support children and young people who aligned to the Transforming care plan. The care, education and treatment manager (CETR) will lead community care, education and treatment reviews to prevent hospital admissions where possible and coordinate packages of care in the community to support children, young people and their families. The CETR manager will also participate in CETR's of children and young people who have needed to be admitted to hospital for treatment of their mental health, learning disability and/or ASD to support returning home/back into the community with a package of care.

Extending the specialist mental health learning disability service to 18 years and across Southend, Essex and Thurrock ensures children and young people who have mental health and learning disability and/or ASD receive a specialist service to meet their needs. Increasing the age range and the area covered ensure our population receive an equal service and evaluating the pilot after one year offer us the opportunity to make changes to the service to meet our populations needs and further the wider transforming care agenda.

## Updated plan 2017-2020

We are using the learning from our individual care and treatment reviews to inform our service model for children with learning disabilities, in conjunction with developments in the wider service for children with learning disabilities / ASD, which is implementing the national Transforming Care programme.

We have identified funds for investment in year 3 of our plan to support children with learning disabilities who need mental health care. The children and young people's mental health learning disability service will support children and young people across Southend, Essex and Thurrock up to the age of 18 years, this will be piloted for 1 year and evaluated for future service planning.

## Support for vulnerable and disadvantaged children and young people

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

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

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

### Our plan

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

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

## Our progress - Year 2

**The single point of access teams identify referrals for children in care and other vulnerable groups and are fast-tracked for assessment. We recruited to a criminal justice liaison and diversion post in North Essex.**

- A mental health clinician is seconded to each of the six youth offending teams across Essex.

### Youth offender health

The Essex Youth Offending Service works to prevent offending and reoffending by children and young people, and to ensure that custody for them is safe, secure, and addresses the causes of their behavior.

Our mental health worker within each team brings in additional support, as required, from telephone advice to specialist and sometimes crisis services.

During 2015/16, organisations in south Essex, including South Essex Partnership University NHS Foundation Trust (SEPT), Essex County Council, Southend-on-Sea Borough Council and Thurrock Council, ran a successful criminal justice liaison and diversion pilot. This is a scheme to support at the earliest possible opportunity vulnerable people of all ages who enter the criminal justice system.

Our experts in mental health services for children and young people are providing:

- A clinical lead for children and young people
- Training and development to upskill staff within liaison and diversion teams
- A single point of access for referrals to further care
- Continuity of aftercare for young people leaving custody

## Updated plan 2017-2020

In year 3 (2017/18) we will:

- Pilot an online counselling service to target hard to reach and seldom heard children and young people
- During year 3, we will review our service offer for vulnerable groups with a view to implementation of new developments in years 4 and 5.



## Support for children and young people who move between services

*Open up Reach out* is driven by principles of early action and a focus on outcomes to help children and young people with mental health problems so that they do not endure serious problems in later life. However, some children and young people, particularly those with lifelong neurodevelopmental difficulties, will need continuing support throughout their adult life.

Making the transition from one service to another is not always straightforward and requires careful planning to prevent any breaks in continuity of care and support. Such planning requires a good understanding of the structures and protocols between different agencies and professionals, such as:

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

### Our plan

It was our intention in year 1 of our transformation plan to review the national model transfer of and discharge from care protocol for young people with mental health problems. The aim was to establish whether the guiding principles could be applied locally to establish a consistent protocol across Southend, Essex and Thurrock.

We have agreed to implement improvements in transitions as follows:

- To pilot a transitions model
- To extend service eligibility for children and young people with extra vulnerabilities, such as those with special educational needs and disabilities
- To improve access to information and signposting
- To consider the use of transition coordinators
- To develop co-designed, individualised transition plans
- To improve communication, including follow up after transition.

## Our progress - Year 2

The transitions work stream was established but experienced some delay in progressing work. The work stream was revived in June 2017 and will oversee delivery and implementation of:

- ▶ The Transitions priority work stream identified within the Essex Local Transformation Plan (LTP) for improving emotional wellbeing and mental health outcomes for children and young people.
- ▶ The national Transitions CQUIN for children and young people

Work has started on reviewing the national service model, alignment with the national CQUIN scheme 'transitions out of children and young people's mental health services (CYPMHS), looking at best practice, and consideration of transitions service models in order to inform service delivery locally.

In year 2 (2016/17) we:

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

## Updated plan 2017-2020

In year 3 (2017/18) we will:

- ▶ Pilot a transition model
- ▶ Evaluate the model and feedback from young people and families
- ▶ Ensure young people and their families contribute their expertise and experience in development of local transition processes
- ▶ Consider the needs of those young people with a wide range of developmental disorders
- ▶ Consider the needs of care leavers
- ▶ Provide resources, information and choices
- ▶ Consider arrangements for follow up and monitoring for those leaving services.

## Medicines management review

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

### Our plan

A full-scale medicines management review to include; looking at how we can achieve more from services working together, including children's health specialists, GPs and the role of community nurses in prescribing medicine.

### Our progress - Year 2

**A pharmacist was appointed and the review has been completed.**

### Updated plan 2017-2020

We will use the learning and recommendations of the review to lead to improvements in medicines awareness and clinical knowledge across health professionals, for example through:

- Use of a formulary to ensure accuracy and consistency in the use of medicines
- Shared care protocols with GPs
- Nurse-led prescribing within the emotional wellbeing and mental health service

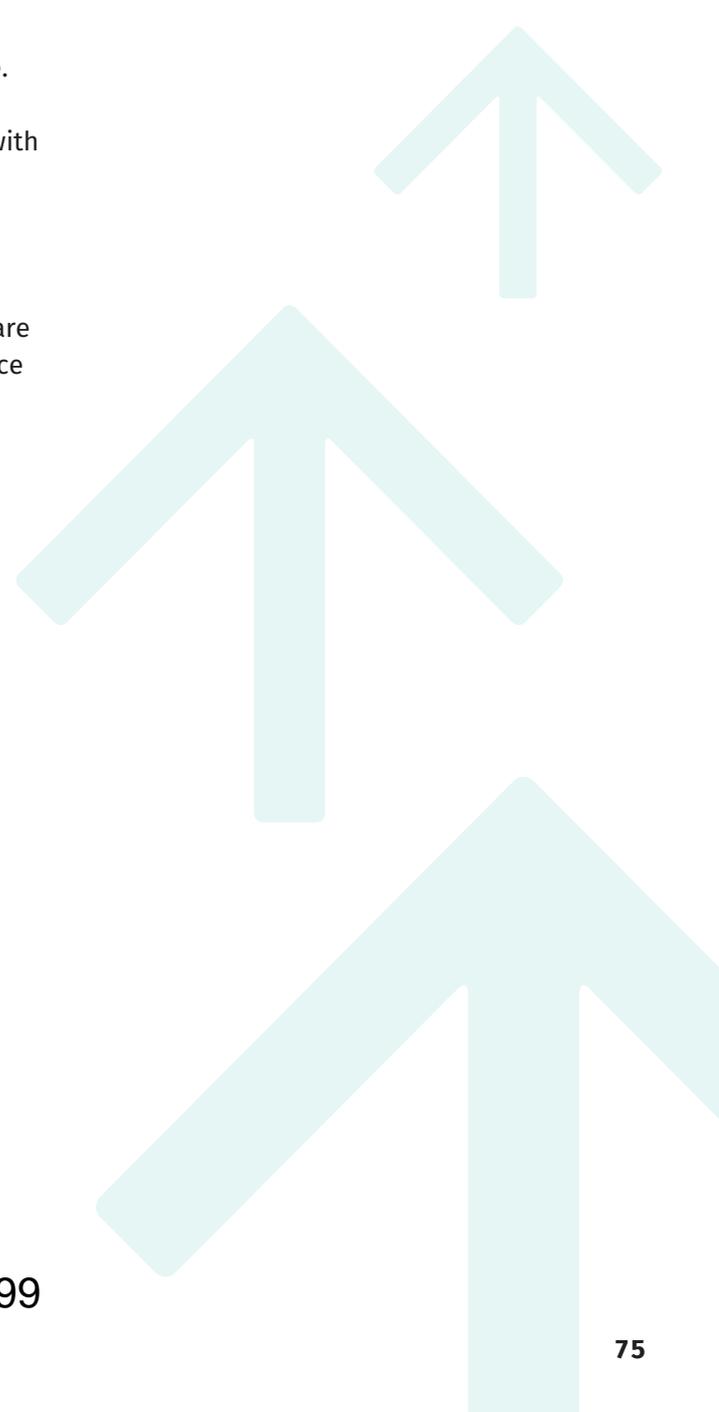
## Action for equality

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

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

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

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



# BUILDING CAPACITY AND CAPABILITY IN THE SYSTEM

Building capacity and capability in our seven locality teams

Our local transformation plan is founded on the creation of a consistent, high quality service for children and young people across Southend, Essex and Thurrock through a single, integrated service. In one major step, we have brought together health and social care working with other public sectors to strengthen universal services and specialist support for the emotional wellbeing and mental health of our children and young people.

Implementation of our plan started on 1 November 2015 with the transition of over 200 staff from four previous service providers to a single provider organisation. Now working from seven locality teams, professionals are mainly out in the community, working closer to children and young people. The service opens wider and reaches further with new technology. With additional investment, new ways of working and a comprehensive training programme, we are increasing both the number of staff and the level of skills in our seven locality teams over the next four years.

## Workforce

### Our plan

#### The main points:

- Transition to a new single integrated service
- Development and establishment of new teams, including assertive recruitment and links to national programmes Recruit to Train, Talent for Care and Widening Participation
- Development and training for new protocols and ways of working
- Roll out of training, including progress towards 100% staff trained in Improving Access to Psychological Therapies (IAPT)
- Building relationships with other services and communities

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

During year 2, there were several review processes to assess needs and the case for change. These processes, focusing on a particular service area, listened to staff views and involved staff in developing new protocols.

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

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

## The priority areas for workforce development

Identified gaps in services	Proposed improvements
Services for eating disorders	Increase in clinical and support staff to cover all localities across Essex.
Specialist services to help with developmental and behavioural problems	Investment funds identified, workforce plans to be agreed
Improving access to psychological therapies (IAPT)	Investing in clinical psychology leadership. New posts in each locality.
Faster access to help for low to moderate needs	Recruitment and training for lower grade clinical staff.  Additional resources to support locality teams and their work with partners within the community e.g. schools, children's centres, GPs, voluntary sector.
Faster access to advice, information, support and assessment where needed.	More staff, including clinical support, for single points of access in Southend, Essex and Thurrock.

## Timescales

Year 1 – 2015/16	<ul style="list-style-type: none"> <li>■ Transition from four previous provider organisations to a single integrated service, involving the transfer of over 200 staff.</li> <li>■ Recruitment to single points of access teams and start of recruitment to other services</li> <li>■ Ongoing training and IAPT, including adoption of new technology</li> </ul>
Year 2 – 2016/17	<ul style="list-style-type: none"> <li>■ Recruitment to and development in crisis services</li> <li>■ Recruitment to and development in services for eating disorders</li> <li>■ Ongoing training and IAPT, including adoption of new technology</li> <li>■ Building community relationships and joint training with schools, including new training to address self-harm</li> </ul>
Year 3 and beyond	<ul style="list-style-type: none"> <li>■ Recruitment to and development in services to support children and young people with developmental and behavioural problems, including Attention Deficit Hyperactivity Disorder (ADHD)</li> <li>■ Ongoing training, 100% staff trained in IAPT, continued development in technology</li> <li>■ Building community relationships and continued support for schools and roll-out of training to address self-harm</li> <li>■ Develop a Multi-agency workforce plan</li> </ul>

## Our progress

### Year 1

On 1 November, we completed the transfer of staff to the new service for the children and young people of Southend, Essex and Thurrock.

Staff consultation followed in January 2016 and has been extended to a second round of consultation to take full account of feedback. The new service presents significant clinical and culture changes for staff and has required more time for discussion and consultation than we had previously envisaged.

In order to ensure that staff are fully supported and able to adapt to their new roles, the transition process has taken longer than planned. Some of the issues involved:

- Staff adapting to agile working to reach out to children and families at home or in a range of community settings, where previous workplaces were fixed.
- Changing information and recording systems from paper-based to new digital technologies
- Changing working practice to meet the requirements of new protocols
- Building new relationships with a wider range of people and services
- Building new relationships with children and young people themselves and those around them.

**There were early signs of improvements, such as the new service being able to offer support to double the number of children and young people compared with previous services.**

A major improvement in staffing is the establishment of 28 clinical lead roles across the seven locality teams, to which 26 people have so far been appointed.

Each clinical leader is responsible for service delivery across one of the following four pathways:

- Emotional disorder (including the 0 – 5 parent-infant mental health pathway)
- Neurodevelopmental
- Complex cases
- Behavioural difficulties and conduct disorder

This ensures supervision, quality assurance and support to ensure that staff continue to provide high quality, evidence-based treatment.

In spite of a number of workforce challenges associated with transition, NELFT successfully released 23 practitioners to the national IAPT training programme.

### Year 2

The caseload remains consistent and in year 2 and 3 the service has continued to support double the number of children and young people compared to the numbers that transferred in November 2015.

- Following development and mobilisation of the three crisis teams across Essex with extended hours of operation, a review and evaluation of the current service model was undertaken during the January 2017.

- LTP monies has enabled a rapid expansion of staff numbers within the crisis teams which are currently staffed with a combination of consistent agency, bank and permanent staff. Recruitment to crisis management posts and crisis worker posts is challenging and on-going during year 3 but we have achieved established consistent crisis team staff, allowing recruitment to be staged to ensure quality and consistency is maintained.
- It was a requirement of the newly designed service model to offer a Single Point of Access (SPA) in each of the three local authority areas across Essex, co-located and linking with existing Early Help and Advice services in that locality. Capacity has been increased in the Essex SPA and an Essex SPA Manager appointed.

However, recruitment and retention of staff has proved challenging for the Single Point of Access (SPA) function in the CCG localities of Southend and Thurrock. A review of the function was undertaken in March 2017 to identify future service delivery options, for consideration and implementation during year 3.

- During 2016/17 commissioners have supported NELFT with the development and mobilisation of the Eating Disorder service across all seven Essex CCGs and expansion to a county wide service from previous limited provision. Recruitment to such a specialist team has again proved challenging but following a huge recruitment drive vacancies within the team are now minimal.
- A programme to build capacity and capability in schools was one of the most important actions in our transformation plan. In discussion with education leaders and head teachers a EWMHS and schools collaboration has been developed to support the drive for early-intervention in schools and foster cultural change in the way schools tackle mental health problems and mental wellbeing.

This collaboration will support school staff to develop their knowledge of mental wellbeing and the problems affecting young people, the symptoms to look for and strategies for supporting children with early signs of mental and emotional stress before a referral to EWMHS is needed.

As part of our collaboration, schools have asked to appoint a Mental Wellbeing Champion who is responsible for liaising with EWMHS for consultation, supervision and access to training. EWMHS have recruited a Schools Operational Lead from within their cohort of Locality Team Managers, and together with Essex County Council have collaborated to employ an EWMHS Schools Clinical Lead from the ECC Educational Psychology Team.

- During year 2 NELFT planned to release a further 38 trainees for academic year 2016/17 with plans in place for more to follow in year 3.

NELFT have been focused on delivering care pathway treatments and reducing the treatment waiting times. In 2016/2017 it was necessary to strike a balance between training, meeting the exacting supervision requirements of the courses and delivering treatment to children, young people and their families and meeting the demands of the service.

For further details, see our previous section on *Improving Access to Psychological Therapies*.

See [Appendix 4](#) for further details on staffing in 2016/17.

### Updated plan 2017-2020

We have agreed an additional investment of £108k per year starting in year 2 of our plan to fund a transformation team, which will support workforce development and cultural change.

£100k for IAPT training remains ring-fenced for investment in both national training and our own internal bespoke IAPT training. We will continue to embed the principles of IAPT across the service with large numbers of clinical staff, supervisors and leaders enrolled or enrolling in IAPT training.

We have also identified a need for training for GPs and other primary care staff, and schools, with a particular focus on self-harm. Work began during year 2 with the development of a self harm management toolkit for educational settings. Work will continue into year 3 and beyond. A county wide engagement event is planned for November 2017 to enable a shared understanding on the emotional wellbeing and mental health support and resources on offer locally.

Availability of training and clinical supervision for school staff on how to identify, understand and help a child or young person with varying emotional, psychological or social needs will also continue into year 3 and beyond.

Continuing into year 3 our provider and commissioners are working collaboratively to determine a revised model of service delivery based on best practice outlined in the East of England Mental Health Crisis Care Toolkit published in February 2017.

During 2018/19 we will draft a multi-agency workforce plan to support the future planning and workforce across the children and young people's system in health, social and education care.

# Improving data and IT

## Our plan

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

## Our progress

Our service provider, NELFT, has installed a new electronic patient record system, which holds a single record for every child and young person who receives care. This is a major improvement on previously held multiple paper-based records.

All staff have been issued with tablets carrying a measurement tool called iCAN. iCAN allows children, young people and families to use an iPad to rate the services they receive. This allows NELFT to collect information routinely and track outcomes progress. The child or young person can also see how they are progressing and this in itself can be important to achieving good outcomes.

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

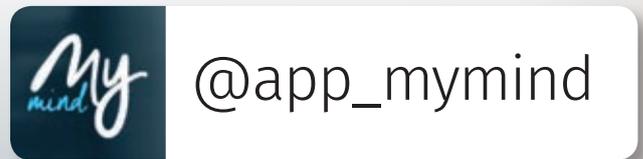
Mandatory data required for national monitoring is submitted by NELFT. This data covers information on patient demographics, referrals, care contacts and GP details.



## Updated plan 2017-2020

A rolling programme of training for the iCAN system will embed new technologies into routine practice.

NELFT continues to explore innovative opportunities. My Mind, for example, a new application for smart phones and tablets, is currently being piloted with some young people. This offers a channel for young people to communicate in real time directly with their therapist or support worker. Sometimes people may prefer to communicate in this way for certain issues. Any exchanges are directly linked to the electronic patient record.



# Governance and Performance Framework

## Our plan

### Collaborative Commissioning Forum

Each of the ten commissioners, the three local authorities and seven clinical commissioning groups responsible for children and young people's care are statutorily accountable for the delivery of the local transformation plan, Open up, Reach out.

Through a legally binding agreement, the ten commissioners have established a Collaborative Commissioning Forum, which is delegated to set budgets, authorise spending and manage operational delivery of the five-year transformation plan.

### The Collaborative Commissioning Forum:

- Act as the strategic forum for CYP EWMH transformation
- Act as the strategic forum to agree and mobilise LTP priorities and agree release of LTP funding
- Share information that enables collective understanding of any gaps in locally commissioned services that are impacting on children and young people.
- Use information to inform future commissioning intentions. This may include both the EWMHS services and also where there are gaps in local pathways at CCG/LA level.
- Oversee the production of a CYP EWMH strategy and transformation plan
- Monitor subsequent delivery of CYP EWMH strategy and transformation plan
- Discuss matters relating to the CYP EWMH commissioning contract and the pursuit of the objectives and performance of the function of the Collaborative.
- Monitor performance of the provider against contract and KPIs
- Monitor mobilisation plans of the new provider

The Forum Chair is Chris Martin, Commissioning Director- Children, Essex County Council. Each of the commissioners has one appointed representative.

We reviewed our governance arrangements in July 2017 and strengthened our terms of reference and membership of the forum to include children's commissioners and senior representatives from all ten partners.

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

# Performance and quality framework

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

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

## Improved emotional wellbeing



Staff monitor individual clinical outcomes using IAPT validated outcome tools. Real time sessional outcomes monitoring will be phased in year 2. (ICAN)  
 Performance monitoring will look at the number and percentage of service users with improving validated outcome scores between start of treatment and up to 6 months.  
 Targets for further improvements to be agreed for year 3 onwards.  
 Information is by locality  
 6 monthly reports

## Satisfaction with services



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

## Easier access



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

## Prompt response to crisis



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

## Proactive outreach



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

## Our progress

### Year 1

Part way through year 1 of our plan, we reviewed our governance arrangements and made some changes that were better fitted to delivery and transformation after moving on from the initial mobilisation of a new service.

We replaced a Transformation Planning Steering Group with a Strategic Oversight Group, which ensures that all 10 partners are involved at senior level.

Performance reports are produced quarterly, but it is too early to see trends in outcomes. We expect to report on these early in year 2.

In March 2016, the most striking improvement was in the increasing number of referrals received and accepted compared with 2015/16. The caseload transferred on 1 November 2015 increased from 3,200 to 6,432 by the end of March 2016.

### Year 2

At the end of April 2016, NELFT started reporting on a quarterly basis the outcomes of the Friends and Family Test, showing whether people were likely to recommend the service. At the end of June 2016, 83% of people answered that they were likely or extremely likely to recommend the service.

Waiting times have improved across the service and we continue with a detailed performance regime to drive down waiting times. During year 2 further recruitment to the new staff establishment has impacted on the development of the new service and waiting times.

### Year 3

As of the end of March 2017, NELFT have embedded their monitoring reporting practices and show that 87% of people are reporting satisfaction with services received.

Waiting times have significantly improved across the service during year 2, we are now 2.83% above the Referral to Treatment waiting time standard and just 5% were waiting longer than 12 weeks compared to 38% waiting over 12 weeks at the end of July 2016. We recognise that the increase in demand of the service will impact on waiting times and we are planning a demand and capacity working group during 2017/18 to further plan for service needs.

See [Appendix 2](#) for further details on activity and [Appendix 5](#) for further details on governance structures.

## Key links with other strategies

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

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

Our plans are in line with the Winterbourne View – Time for Change and Transforming Care, national plans to transform commissioning of services for people with learning disabilities and / or autism. Also the Southend, Essex & Thurrock Mental health & Wellbeing Strategy; Lets Talk about mental health 2017-2021, supports and interfaces with our Open Up, Reach Out transformation plan.

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

### Sustainability and Transformation Plans (STPs)

Our local transformation plan is a county-wide strategy across Southend, Essex and Thurrock, which crosses three STPs:

- Mid and South Essex
- Hertfordshire and West Essex
- Suffolk and North East Essex

All three plans align and are signed up to the Southend, Essex & Thurrock Mental health & Wellbeing Strategy; Lets Talk about mental health 2017-2021. The Lets Talk about Mental Health strategy supports and interfaces with our Open Up, Reach Out transformation plan.

*Open up Reach out* will continue to plan on its countywide basis and all three STPs have incorporated our local transformation plan.

Our strategic direction is reflected in the wider STPs to:

- Deliver more care closer to home, working in localities that bring together physical, mental health and social care
- Place a greater emphasis on prevention and early treatment to avoid crises and hospital stays and to avoid longer term serious problems
- Work with multi-agencies and professionals in a joined-up way to wrap services around individuals and their needs
- Work together to develop community resilience, including working partnerships with voluntary sector and other public services
- Empower people and families by involving them in decisions about their own care and by improving access to information to support self-care.

# Implementing the Mental Health Forward View

## Collaborative and Place Based commissioning

During 2015/16, work began to plan for better, more responsive and accessible mental health services. These have included new access and waiting times for psychological therapies and early intervention in psychosis which came into force from April 2016, with eating disorder services for young people following in April 2017.

Immediate priorities for service redesign:

- to increase access to specialist perinatal care
- to reduce the number of out of area placements for children, young people and adults through the provision of more care closer to and at home
- to increase access to crisis care liaison services in emergency departments and inpatient wards
- suicide prevention.

Essex CCGs are committed to working with NHSE specialised commissioning to develop local seamless in-patient pathways across the three Essex STP footprints. Our continued investment of LTP funding in new models of care in the community will need to evidence the impact on Tier 4 CYP inpatient care and 'step up' 'step down' pathways i.e. development of specialised community eating disorder services and 24/7 crisis services/home treatment services.

It is expected by 2020/21 that overall bed usage will have decreased and inappropriate out of area placements largely ended; with consequent savings to be reinvested in community-based services, including specialist outreach, to improve access and reduce waiting times.

We are in the early stages of this development work with specialised commissioning, with support from the East of England CAMHS Clinical Network meeting bi-monthly as the CYP MH FiM regional Steering Group.

We will work collaboratively with our acute trusts and NHSE specialist commissioning colleagues to draft trajectories and collect metrics that will allow us to report on:

- Seamless pathways to reduce the need for admission, prevention of inappropriate/unnecessary admissions, and admission avoidance schemes
- A reduction in length of stay (LOS)
- better discharge planning arrangements on admission to facilitate safe and timely/early discharge back to the community
- a need to manage pathways closer to home reducing the numbers of CYP placed out of area
- A reduction in re-admission rates

Agreement will need to be made with our colleagues from these organisations to work towards a timeline to deliver the data reporting, agree year on year trajectories and how we can measure these outcomes.

# BUILDING RESILIENCE IN THE COMMUNITY

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

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

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



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

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

# Engagement

Our local transformation plan is built on engagement with children and young people on many levels.

We listened to children and young people right from the start when we were first designing the specification for a new single integrated service across Southend, Essex and Thurrock. Young people were involved in the procurement of a single provider.

Children and young people's views are a major part of the two joint strategic needs assessments that have helped to inform our plans. The outcomes of several engagement exercises have influenced service redesign, in particular the view of young people in the two Healthwatch YEAH! reports that featured earlier in this document.

As we continue to implement Open up, Reach out, we continue to listen to what children and young people say, both at an individual level, where young people are able to influence their own care, and at a service level in a way that tackles any stigma and raises awareness of mental health issues.



Here are just a few examples of how we have responded:

### You said

**Difficult to access the service**

### We did

- Established a single phone number and point of access.
- Opened up to self-referrals, and referrals from parents, schools and others – not just professionals.
- Developed procedures designed to provide early help, advice and support.
- Set detailed performance regimes to monitor waiting times for assessments and treatments.

**Confusing process and variable eligibility**

- Referral criteria have been simplified and are much less restrictive than before.
- We have successfully moved away from a fragmented and multi-tiered service by implementing a single integrated service for children and young people across Southend, Essex and Thurrock.

**We need better information**

- The single integrated service has made it simpler to publish information via a single website, publicity leaflets and referrals information.
- The new single point of access teams give better information and signposting to other local services and where to get help.
- A new website *The Big White Wall* is designed to provide helpful information for children and young people.
- Looking to the future, the service is piloting new digital technologies, such as an app that enables young people to talk to their therapist at any time.

**More people are needed to help tackle problems at an earlier stage**

- The service has worked with local schools to pilot a training programme for schools' staff.
- In future years of our plan, the intention is to extend training to other local services to build knowledge and resilience in local communities.
- Capacity has increased through additional staffing and is supporting around double the number of children compared with previous years.

## Our plan

Our overall engagement plan as part of *Open up, Reach out* included the following main points:

- Continued events and exercises to involve children and young people in service commissioning
- Each of the seven locality teams to build their intelligence of relationships with services and people in their locality
- The seven locality teams to be available to schools and other public services
- The use of technology and online tools to involve and engage children and young people, responding to strong messages in our earlier engagement that social media and online resources work well for children and young people
- Engagement built-in to the care and support that is provided for every individual
- The launch of **Reprezent**, an innovative and far-reaching approach to continuing engagement for children and young people

## Our progress

### Year 1

#### Engagement in commissioning

South Essex Children's Partnership Board delivered training for 11-14 year old commissioners. The young commissioners had a small budget to improve services locally.

Youth Assemblies held commissioners to account at events such as 'Question Time' style panels.

### Year 2

#### Localities engagement

NELFT has undertaken significant engagement work with schools over the last year including attending head teachers briefings, behaviour and attendance groups in schools and liaising with relevant staff in education in our three councils regarding intervention in schools.

#### Innovation

NELFT has contracted *The Big White Wall* app for 16-25 year olds promoting self-help and expanding the digital offer to young people.

The *My Mind* app has been launched, the app was developed with the involvement of young people during 2015/16.

# REPREZENT

## ***Reprezent* – a new engagement channel to build resilience for young people**

All 10 NHS and local authority commissioners from across Essex have invested in an innovative and ambitious pilot to transform engagement and build resilience with children and young people. We created a new youth media channel, including a radio station, an APP and website. Engagement is based around music and sharable content owned and created by young people themselves. Children and young people taking part received training in radio programming and digital communications.

*Reprezent* was set up in year 1 and in year 2 the pilot delivered media (e.g. social media, music streaming, events, digital) to find the best approaches. The campaigns work to tackle stigma and improve general understanding of mental health issues.



**The achievements of the pilot:**

- Built awareness, communication skills, self-help knowledge and resilience
- Acted as an agent to bridge the gap between those who experience mental health issues and those who have not had such experience.
- Encouraged responsibility and develop a trigger for behaviour change to deal with problems early and avoid crisis situations
- Created unique opportunities to identify unmet needs
- Gave commissioners earlier insight into changing patterns of behaviour over time – including impact on others, such as parents
- Enabled new ideas, new perspectives and real co-production
- Created a new media talent pipeline in Southend, Essex and Thurrock of young people who go through the training and peer mentoring programme, helping to build self-esteem and workplace learning.

The project also included a unique and distinctive promotional programme aimed at making a big impact in a way not always associated with the public sector.

Reprezent, as an innovative and peer-led engagement model has given children and young people an exciting opportunity to be heard through a route that suits them. It enabled them to discuss on their own terms issues that are real to them, which then was fed through to commissioners, as well as to their peers. This gave children and young people a genuine influence over commissioning decisions

**Summary of activities Reprezent delivered**

- Launch of app
- Campaigns delivered across Southend, Essex and Thurrock
- Pilot review and decisions for development in year 3 and beyond

**Communication plan**

We developed a communications and engagement plan in relation to the Children and Young People's Emotional Wellbeing and Mental Health Service across Southend, Essex and Thurrock to ensure consistent and aligned messages by the organisations within the collaborative.

**For further information about Reprezent and its activities, please visit**

**<http://essex.reprezent.org.uk>**



## Updated plan 2017-2020

Both commissioners and NELFT, our provider organisation will continue to implement a range of methods year on year for engaging children and young people, families, communities and professionals. This is embedded at all levels, as shown in some of the examples above, including service design, commissioning, quality improvement and decisions about individual care.

Commissioners are committed to continue to improve and build on our children, young people and family coproduction and plan to deliver further innovative engagement work with our children and young people by linking closely with our providers and voluntary / community organisations.

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# A clear role for schools

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

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

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

## Our plan

- ▶ From 1 November 2015, fast access to advice and guidance through a single point of access in each area of Southend, Essex and Thurrock.
- ▶ From year 1, a developing information portal for children's and young people's emotional wellbeing and mental health, giving information to schools and online techniques, such as self-help toolkits.
- ▶ Together with young people, schools and community leaders we will develop a peer mentoring scheme that equips young people themselves to be able to help others.
- ▶ We will co-design a pilot with schools to develop training and capacity within groups of schools. This will cover training, development of a common understanding about emotional wellbeing and mental health and testing stronger links between school staff and the new service.

## Year 2

The EWMHS and schools collaboration will also develop and promote clear referral pathways for school staff so that where more specialised support is needed, it can be accessed effectively and efficiently. Together, this enables schools to better support the children in their care while promoting good mental wellbeing and awareness of mental health issues more generally.

## Our progress

### Year 1

- The single point of access was established from 1 November 2015. Anecdotally, the feedback from schools is positive.
- NELFT is in partnership with *The Big White Wall*, which provides a comprehensive range of self-help tools for children, young people and those who support them. We are also promoting other existing online tools, such as *MindEd*, a free training site for school staff.
- As part of the schools support offer we will be launching an Information portal providing a range of information and advice on Emotional wellbeing and mental health including:
  - // Development of risk management toolkit/triage
  - // Support/service/training available
  - // Guidance on parental consent
- The new emotional wellbeing and mental health service has a schools support team which is planning to pilot schools support on four levels:
  - // Staff training covering self-harm, suicidality, anxiety, depression, bereavement
  - // Regular and specialist consultations on complex cases
  - // Regular supervision for pastoral staff and schools leaders
  - // Access to a range of courses for teachers and staff through links to independent sector partners, such as *Young Minds*, *Mental Health First Aid Youth* and *Mindfulness in Schools*

### Year 2

Throughout year 2, we will monitor referrals in detail, gather further information on how schools interact with the service and feed any outcomes into our schools support programme, both in real time and in planning for year 3.

During 2016/17 34 schools from across Southend Essex and Thurrock expressed an interest in being involved in Phase one of the EWMHS schools collaboration. All have been visited, and had their needs initially assessed and have agreed/started to collaborate with EWMHS in the first phase. Schools range across the geography and across primary, secondary and special provision.

The first phase is focussing on these schools/groups of schools and progress will be evaluated in April 2018. Wider roll-out of provision will follow as we learn, and will continue over the life time of our Plan.

## Updated plan 2017-20

The continuation of the schools support programme will be rolled-out during years 3, 4 and 5.

# Suicide prevention and support for children who harm themselves

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

## Our plan

During 2015/16, we will audit the existing Essex suicide prevention guidelines to identify next steps and improvements, which will include support for schools and other services.

## Our progress

Over the past few months we have reviewed the existing suicide guidance through; literature research, reviews into recent child deaths, interviews with stakeholders and focus groups with schools.

In general, we found that schools are only using the suicide guidance to manage incidents and would need some training to put more emphasis on prevention.

We also found increasing concerns about the rise in self-harm, for which there was no prevention guidance.

### Year 2

**We have worked together with the local safeguarding children boards, local authorities and local schools to:**

- Revise the existing suicide guidance
- Develop the self-harm guidance
- Develop an information portal for guidance tools for schools

## Updated plan 2017-20

We have a EWMHS Schools Conference day set for Schools, Commissioners, NELFT colleagues, VCS organisations and others to come together and ensure everyone understands the support and resources on offer to schools, the role Schools have in supporting children and young people and how they can support prevention and early intervention.

# CONCLUSION

As year 1 of our local transformation plan ended on 31 March 2016, our new single integrated service was five months into its first year.

In year 2 we were already seeing an impact on inequalities – children and young people have equal access to support and services across north and south Essex, the number of referrals accepted for treatment is over 80% across the patch. Vulnerable and disadvantaged children are considered high priority for assessment. We are learning from what children and young people say, including those who are seldom heard, and these issues are helping to shape new services in a way that works for them.

Some of the highlights of our achievements include:

- Creating the “one way in to services” that we promised
- Managing a significant increase in referrals and reaching many more children and young people
- Improving information and engagement with children and young people, including the launch of Rerezent, an innovative radio and online channel that reaches young people through music
- Setting in motion a major programme to connect with schools and other services to strengthen the resilience of children and young people
- Improving technology and information so that commissioners are able to see far more clearly the quality and impact of what is being provided; while staff have better access to information they need to provide the best possible evidence-based care.
- An increase in investments to tackle key priorities, including crisis care, eating disorders, ADHD, self-harm and care for vulnerable and disadvantaged children and young people.
- Establishing a new eating disorder service across Southend, Essex and Thurrock
- Establishing a new locality team structure and a completely transformed approach to providing care for children and families in the community and close to where they spend their lives.

## Managing the risks

Looking ahead to the next three years of our local transformation plan, we have identified the risks and ways to manage them, which are consistent with every scheme.

These are characterised in terms of:

- Workforce
- Information management and technology
- Culture
- Sustainability

Description of risk	Action to manage risks
<p><b>Workforce</b> As in other parts of the NHS nationally and locally, we face a challenge to recruit and retain the clinical workforce needed to deliver the new service model.</p> <p>The launch of this plan and the new service in Southend, Essex and Thurrock meant a wholesale change in skill mix and ways of working, with an associated change in staff.</p> <p>There remain a number of vacancies to be filled in year 3 and maintained in years 4, and 5.</p>	<p>NELFT recruited to 60 new posts in year 1 and further post were recruited to in year 2, we will continue to monitor and work with NELFT to manage workforce.</p> <p>In the short term, NELFT is able to share its own existing resources from outside Essex, and use of agency and bank staff where clinically appropriate and safe to do so.</p> <p>In the longer term, an ongoing assertive recruitment programme will work with national recruitment programmes and innovative opportunities, such as training schemes and apprenticeships.</p>
<p><b>IM&amp;T</b> The new service has a comprehensive new IT infrastructure and data quality to drive evidence-based, outcomes-driven services.</p> <p>The main challenge is to provide staff with the continuing support they need to adapt to new technology</p> <p>Previous services held limited electronic systems and many staff were accustomed to paper-based reporting.</p>	<p>Following our experience in year 1 of our plan, we have a transformation team and digital lead manager.</p> <p>Part of the transformation team's remit will be to coordinate support for technology training.</p> <p>Data quality is also a priority for the performance team, which completed a major data-cleansing project in year 2 and is implementing changes where required.</p>
<p><b>Culture</b> There are cultural challenges for both commissioners, who are collaborating across ten statutory organisations, and provider staff following a major transition from four previous organisations.</p>	<p>The commissioners have already reviewed and amended governance strategy and structure, to promote collaborative progress.</p> <p>NELFT is experienced in organisational development and cultural change and this has been brought to Essex by a new transformation support team.</p> <p>Commissioners and providers will continue to support each other through joint work on strategy and skills. A System Leadership event in year 2 supported by the Regional Clinical Network, has been a catalyst for this work and the learning from this event is being taken forward.</p>
<p><b>Sustainability</b> All health and care systems are working within a challenging environment with pressures on workforce, care quality and finance.</p>	<p>The introduction of sustainability and transformation plans (STPs) brings together all health and care partners and sets the roadmap for transformation that will bring the best of modern healthcare to local people.</p> <p>In Southend, Essex and Thurrock, the STPs will promote joined up working in localities, with new opportunities for fully integrated mental health care.</p>

## The way ahead

In years 1 and 2, we have steered a new service safely to full-scale operation, closing the gaps and treating more children and young people in the process. In year 3 we have focused on embedding the new service and working out mobilisation and culture changes, while beginning to review and plan additional improvements and priorities. We have a clear direction, confidence in delivery and signs of success after two years of implementation.

In years 3 and 4 we will begin to plan and draft the Local Transformation Sustainability Plan to support transformation beyond 2020.

From the basics of making information available, to training staff in schools and other public services, to specialists building relationships with families and communities, we will promote a collective responsibility for the emotional wellbeing and mental health of children and young people in Southend, Essex and Thurrock.

# Appendix 1

## Prevalence of mental health problems taken from ChiMat

Ref. National Child and Maternal Health Intelligence Network

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

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

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

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

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

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

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

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

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

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

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

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

## Estimated number of males aged 16 to 19 with neurotic disorders

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

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

## Estimated number of females aged 16 to 19 with neurotic disorders

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

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

## Estimated number of children with autistic spectrum disorders

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

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

## Suicide and self-harm

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

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

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

### **Self-harm is a related issue:**

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

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

# Appendix 2

## Further information on baseline activity in 2015/16

Following mobilisation of our new service model in November 2015 with a single service provider across Essex, there was a surge in demand and we are still seeing nearly double the number of cases, 6,354 as at March 2017 compared to the 3,200 cases which transferred to the new service provider on 1st November 2015.

This represents an increase to the caseload of 98% compared to that which transferred in November 2015, and although at the end of September 2016 we saw a drop in the caseload to 5308, by the end of March 2017 we had seen it rise again by 20% to 6354. The Table below refers.

CCG	as @ 01/11/2015	as @ 31/03/2016	as @ 30/09/2016	as @ 31/03/2017
Mid Essex	-	1,295	1,248	1,493
North East Essex	-	1,125	948	1,150
West Essex	-	1,035	820	929
Basildon and Brentwood	-	959	803	942
Southend	-	894	601	709
Thurrock	-	552	523	597
Castle Point and Rochford	-	572	365	534
<b>Essex</b>	<b>3,200</b>	<b>6,432</b>	<b>5,308</b>	<b>6,354</b>

The table below details the crisis team caseload at the point of transfer of the service in November 2015 compared to caseload as at the end of March 2016, and March 2017. At the end of March 2017 there has been a 26% decrease to the caseload compared to that which transferred at the end of November 2015. However, performance across the crisis teams exceeds that planned for 2016/17.

CCG	as @ 30/11/2015	as @ 31/03/2016	as @ 31/03/2017
Mid Essex	23	47	7
North East Essex	23	53	12
West Essex	11	30	6
Basildon & Brentwood	29	34	23
Southend	8	13	15
Thurrock	6	12	6
Castle Point & Rochford	9	21	11
<b>Essex</b>	<b>109</b>	<b>210</b>	<b>80</b>

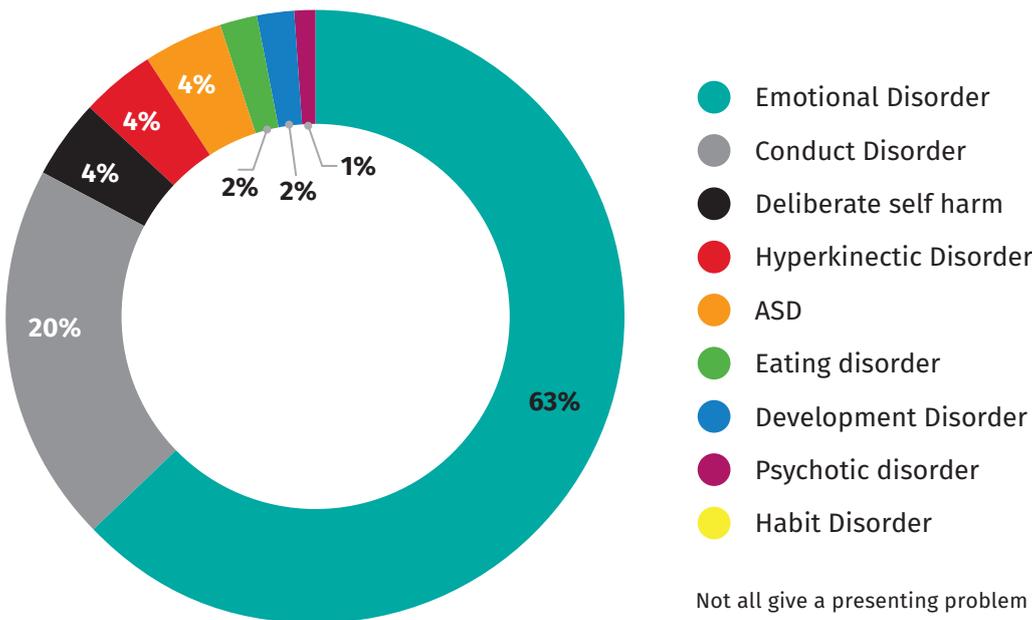
## Needs indicated by presenting problems in Southend, Essex and Thurrock

The chart below shows the presenting problems of those children and young people seen across Essex between April 2016 and March 2017. The top three presenting problems across Essex are Emotional Disorder, Conduct Disorder, and Deliberate Self Harm.

Across all seven CCGs the top two presentations are Emotional Disorder and Conduct Disorder demonstrating consistency across all CCG localities regards the most common presenting problems and equating to 83% of the presenting problems recorded.

Deliberate self-harm follows the same pattern as Essex being the 3rd most common presenting problem in Southend, and West Essex CCG localities, but it is notable that in Basildon and Brentwood, Castle Point and Rochford, and North East Essex CCG localities, ASD ranks as the 3rd most common presenting problem. Mid Essex is an outlier with a high number of eating disorder presentations ranking as 3rd most common presenting problem. Hyperkinetic disorder ranks as the 3rd most common presenting problem in Thurrock CCG.

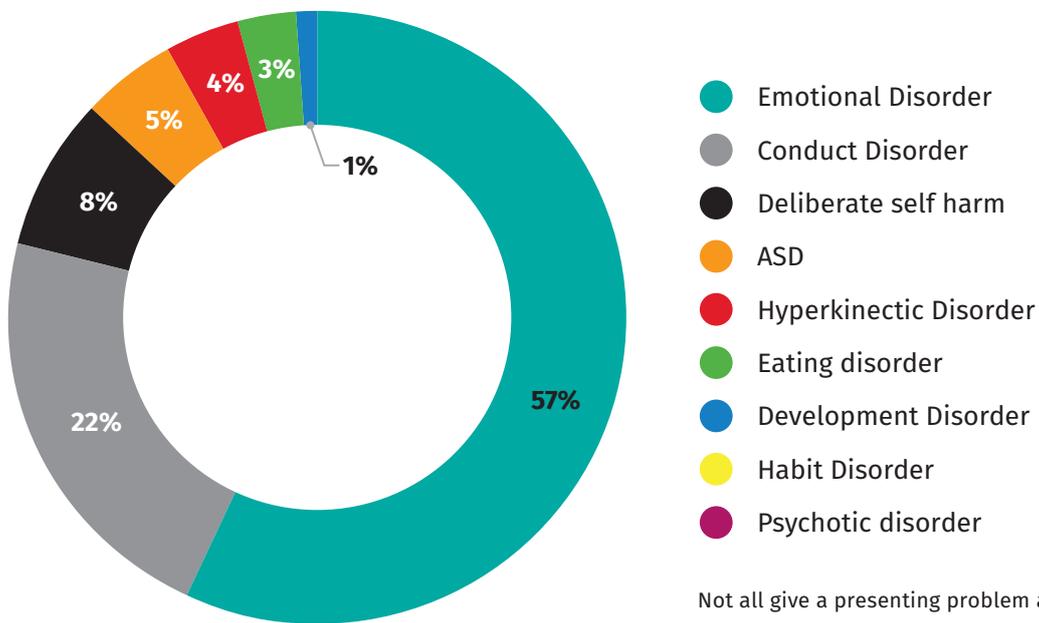
### Essex Top Presenting Problems of those Children and Young People seen between April 2016 and March 2017



Not all give a presenting problem and there can be more than one problem.

### Year 1 2015/16

### Snapshot of Top Presenting Problems across Essex of those Children and Young People seen between November 2015 and March 2016



Not all give a presenting problem and there can be more than one problem.

## Single Points of Access (SPA) across Southend Essex and Thurrock

It was a requirement of the newly designed service model to offer a Single Point of Access (SPA) in each of the three local authority areas across Essex, co-located and linking with existing Early Help and Advice services in that locality. Numbers of referrals across the three Essex SPAs remain consistent circa 800 – 1,000 referrals a month between April 2016 and March 2017. Capacity has been increased in the Essex SPA and an Essex SPA Manager appointed.

During 2016/17 there have been over 10,000 referrals across all three SPAs.

### Between April 2016 and March 2017 an average of:

- 680 referrals per month Essex SPA
- 90 referrals per month Southend SPA
- 80 referrals per month Thurrock SPA
- 80% of the total referrals are received by the Essex SPA
- North East Essex CCG has the highest referral rate as @ end of March 2017, followed by Mid and then West Essex CCG
- 56% referrals come from the North Essex CCGs
- Across Essex there has been a 20% increase in referrals during Q4 2016/17, compared to Q1 2016/17
- Southend CCG has seen the highest increase in referrals during Q4 2016/17, compared to Q1 2016/17

The figures in the table below reflect the number of referrals received by the SPAs during 2016/17.

It should be noted that there would be additional referrals from sources other than the SPAs.

SPA - total referrals received	Q1 2016	Q2 2016	Q3 2016	Q4 2016	2016/2017
CCG	as @ 30/06/2016	as @ 30/09/2016	as @ 31/12/2016	as @ 31/03/2017	Year to date
Basildon and Brentwood	319	297	351	451	1418
Castle Point and Rochford	235	202	226	284	947
Mid Essex	507	384	525	540	1956
North East Essex	541	441	543	669	2194
Southend	243	210	305	354	1112
Thurrock	249	213	222	271	955
West Essex	395	358	421	419	1593
<b>Essex</b>	<b>2,489</b>	<b>2,105</b>	<b>2,593</b>	<b>2,988</b>	<b>10,175</b>
<b>Plan</b>	<b>2824</b>	<b>2824</b>	<b>2824</b>	<b>2825</b>	<b>11297</b>
<b>% Variance (above/below plan)</b>	<b>-11.83</b>	<b>-25.46</b>	<b>-8.18</b>	<b>5.77</b>	<b>-9.93</b>

CCG	As @ 30/11/2016	As @ 31/03/2016
Mid Essex	210	950
North East Essex	183	940
West Essex	146	758
Basildon and Brentwood	99	695
Southend	70	504
Thurrock	96	470
Castlepoint and Rochford	73	390
<b>Essex</b>	<b>877</b>	<b>4,707</b>
<b>Plan</b>	<b>692</b>	<b>3,460</b>
<b>% Variance (above plan)</b>	<b>26.73</b>	<b>36.04</b>

## National CAMHS access targets

The national target for the NHS of reaching at least another 70,000 more children and young people annually from 2020/21 is expected to deliver increased access from meeting approx. 25% of those with a diagnosable condition locally, to at least 35%. These additional children and young people will be treated by NHS funded community services.

For Essex, this will mean that the NHS has a local target of reaching at least around 600 more children and young people annually from 2020/21.

The table below sets out an indicative trajectory for increased access.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-Funded Community MH service	28%	30%	32%	34%	35%
Number of additional CYP to be treated over 2014/15 baseline	179	298	417	537	596

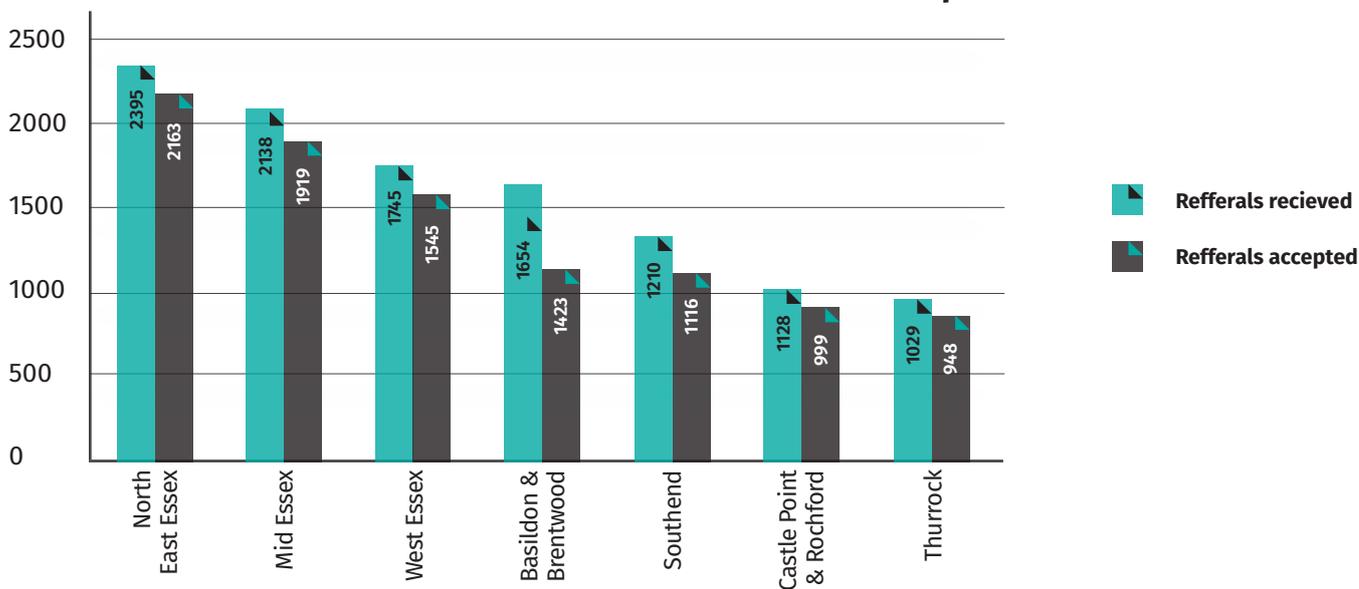
	2016/17	2017/18	2018/19	2019/20	2020/21
Number of additional CYP to be treated over 2014/15 baseline (Essex)	179	298	417	537	596
Southend	32	53	74	95	105
Basildon and Brentwood	20	33	46	60	66
Castle Point and Rochford	18	31	41	54	59
Thurrock	10	16	22	29	32
West Essex	26	43	60	77	86
Mid Essex	47	78	110	141	157
North East Essex	27	45	63	81	90
<b>Essex</b>	<b>179</b>	<b>299</b>	<b>417</b>	<b>537</b>	<b>596</b>

## Referrals from all sources across Essex, including the SPA

Since November 2015 and in year 1 of our LTP we launched a single integrated (Tier 2 and Tier 3) emotional wellbeing and mental health service (EWMHS).

The chart below shows the number of referrals received and the number accepted in 2016/17, by CCG locality.

**EWMHS referrals received v referrals accepted 2016/17**



The Table below details the number of referrals received compared to those accepted during 2016/17. The service model commissioned reflects a ‘catch and carry’ approach and the expectation is that 25% of referrals would be signposted to alternative provision. Commissioners would therefore expect an acceptance rate of 75% across Essex.

Community EWMHS CCG Activity April 2016 - March 2017			
CCG	Refferals Recieved	Refferals accepted	% acceptance rate
Basildon & Brentwood	1654	1423	86%
Castle Point & Rochford	1128	999	89%
Mid Essex	2138	1919	90%
North East Essex	2395	2163	90%
Southend	1210	1116	92%
Thurrock	1029	948	92%
West Essex	1745	1545	89%
<b>Essex</b>	<b>11299</b>	<b>10113</b>	<b>90%</b>

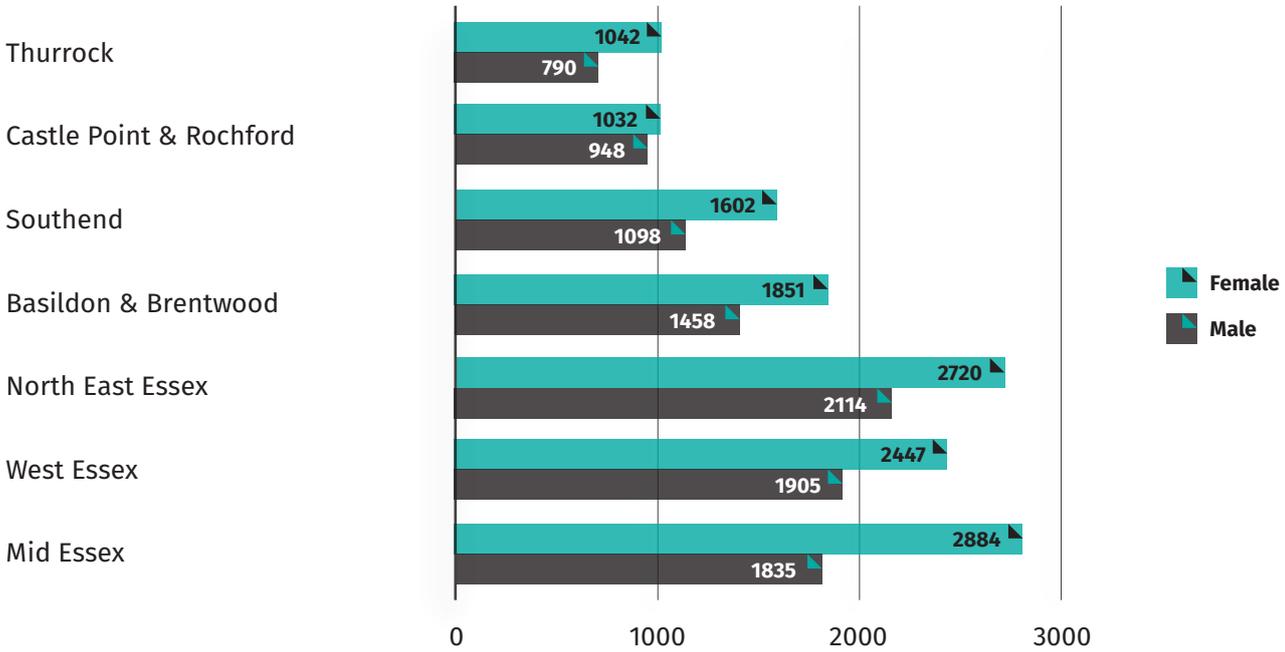
Community EWMHS CCG Activity Year 1: 2015-2016			
CCG	Refferals Recieved	Refferals accepted	% acceptance rate
Basildon & Brentwood	1455	1207	83%
Castle Point & Rochford	1021	857	84%
Mid Essex	1474	1240	84%
North East Essex	1572	1320	84%
Southend	1595	1427	89%
Thurrock	981	804	82%
West Essex	1357	1196	88%
<b>Essex</b>	<b>9455</b>	<b>8051</b>	<b>85%</b>

The NHS CAMHS Benchmarking Report for 2015/16 reported an average of 1,933 referrals accepted per 100,000 population. This equates to a 72% acceptance rate which is the lowest seen in recent years. An acceptance rate of 76%-79% has been reported for the last 3 years.

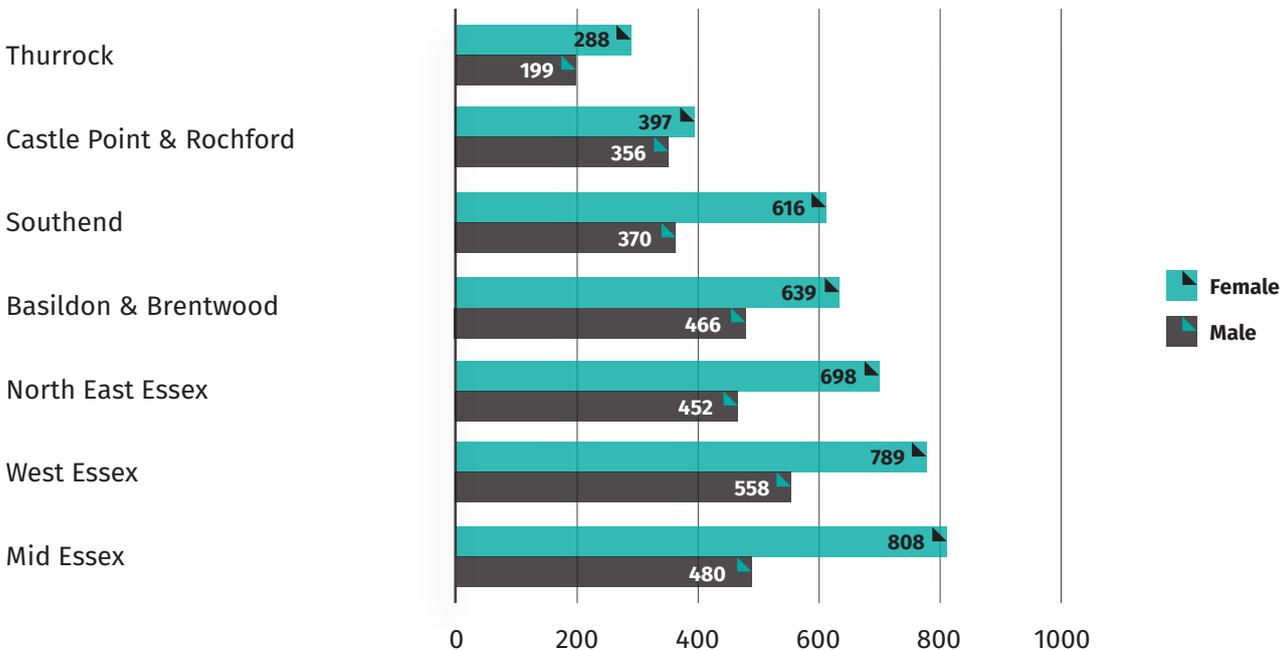
The acceptance rate across all Essex CCG localities is equitable and fairly consistent and is a significant improvement on the variances highlighted in our original LTP.

The chart below details the gender breakdown of referrals accepted into the service between April 2016 and March 2017.

### Gender Breakdown of referrals accepted 2016/2017



### Gender Breakdown of referrals accepted 2015/2016



The table below provides the breakdown of those young people seen by the service between April 2016 and March 2017, by age, across each of the CCG localities.

Age Band	Basildon & Brentwood	Castle Point & Rochford	Mid Essex	North East Essex	Southend	Thurrock	West Essex
0-4	27	9	33	53	24	17	45
5-9	413	240	550	825	451	238	712
10-15	2068	1263	2904	2671	1616	1060	2531
16-18	801	467	1230	1284	613	518	1063

Year 1: 2015-2016

Age Band	Basildon & Brentwood	Castle Point & Rochford	Mid Essex	North East Essex	Southend	Thurrock	West Essex
0-4	0	17	8	2	9	3	13
5-9	92	91	126	135	103	61	190
10-15	679	399	729	615	519	274	778
16-18	334	241	425	398	354	149	366

The next table shows actual referrals accepted into the service and compared with ChiMat estimates on indication of need, still suggests wide variation across Southend, Essex and Thurrock and considerable unmet need.

CCG	ChiMat estimated numbers needing a Tier 2 (2014) service	ChiMat estimated numbers needing a Tier 3 (2014) service	Total	Actual number of referrals accepted into the service	% of expected number
Southend	2685	710	3395	1116	33%
Thurrock	2850	755	3605	948	26%
Castle Point and Rochford	2430	645	3075	999	32%
Basildon & Brentwood	4115	1090	5205	1423	27%
Mid Essex	5515	1460	6975	1919	28%
North East Essex	4585	1215	5800	2163	37%
West Essex	4555	1205	5760	1545	27%

However, ChiMat prevalence data is sourced from the ONS midyear population estimates for 2014. We know there is going to be publication of a new prevalence study 2017/18 at which time this information will be refreshed.

### Generic EWMHS community contacts 2016/17

The table below shows assessments, initial and follow up appointments across the service.

Essex Activity Year April 2016 - March 2017									
CCG	Assessments	Plan	% Variance	1st Apps	Plan	% Variance	Follow ups	Plan	% Variance
Basildon & Brentwood	1389	823	68.77	1045	1284	-18.16	7626	5148	48.14
Castle Point and Rochford	718	665	7.97	629	970	-35.15	4394	3180	38.18
Mid Essex	1615	888	81.87	1238	1668	-25.78	10413	5563	87.18
North East Essex	1716	864	98.61	1518	1404	8.12	10737	5270	103.74
Southend	953	876	8.79	833	1291	-35.48	5688	3389	67.84
Thurrock	870	437	99.08	747	638	17.08	3772	2323	62.38
West Essex	1464	806	81.64	1078	1390	-22.45	11978	6934	72.74
Essex	<b>8725</b>	<b>5359</b>	<b>62.81</b>	<b>7088</b>	<b>8645</b>	<b>-18.01</b>	<b>54608</b>	<b>31807</b>	<b>71.69</b>

Year 1: 2015-2016								
Contacts	Basildon and Brentwood	Castle Point and Rochford	Mid Essex	North East Essex	Southend	Thurrock	West Essex	Total
1st Appointment	950	764	882	782	1,292	571	759	<b>6,000</b>
Follow up Appointment	4,405	3,206	5,411	4,479	5,632	2,966	5,636	<b>31,735</b>

## Crisis teams activity across Southend, Essex and Thurrock

The table below indicates the crisis activity across the five acute hospitals across Essex between April 2016 and March 2017

The national target for all age 24/7 crisis cover by 2020 could well mean that the future service model may look very different. An evaluation has been undertaken and the final report has been presented to commissioners who will need to discuss and consider future crisis service model.

### A&E crisis activity April 2016 – March 2017

A&E Crisis Activity - Essex		Target	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Year to date	
KPI5	Total number of crisis assessment undertaken in A&E for each locality, including out of hours No. and % of those presenting assessed within 4 hours of referral	100%	Vol (<4 hours)	53	59	72	71	43	97	99	120	90	94	111	1	1,044
			Vol (Total)	54	59	74	71	43	97	101	120	91	94	111	135	1,050
			Percentage	98.1%	100%	97.3%	100%	100%	100%	98%	100%	98.9%	100%	100%	100%	99.43%

### 2015/16

A&E Crisis Activity - Essex		Target	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Year to date	
KPI5	Total number of crisis assessment undertaken in A&E for each locality, including out of hours No. and % of those presenting assessed within 4 hours of referral	100%	Vol (<4 hours)	62	54	70	76	73	335
			Vol (Total)	65	55	70	78	73	341
			Percentage	95.4%	98.2%	100%	97.4%	100%	98.2%

#### Key points:

- Exception reports are received for all breaches
- Primary reason for breach is a number of presentations occurring simultaneously
- Number of breaches in one month is generally small, but a single breach will impact on percentage achievement
- During 2016/17, all CCGs other than Thurrock are showing a significant increase in A+ E crisis presentations in month 12 compared to month 1.
- During 2016/17 there have been over 1,000 referrals to the five A+ E departments across Essex, with 547 of these from across North Essex, equating to 53% of total activity.

## All community crisis activity 2016-2017

The Table below outlines the number of referrals to the crisis teams during the period April 2016 – March 2017, and shows positive improvement against plan for Basildon and Brentwood which has always been an outlier, and considerable over performance across Mid, North East Essex, West Essex CCGs

■ 923 referrals across North Essex

■ 738 referrals across South Essex

Of all the crisis referrals received, 65% present via A+E in South Essex, with 59% presenting via A+E across North Essex. Across each CCG locality virtually 2/3rds of crisis referrals are via A+E.

Crisis referrals	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	YTD	YTD Plan	% Variance
Basildon & Brentwood	23	26	17	16	9	20	28	17	16	18	25	38	253	278	-9
Castle Point and Rochford	7	8	16	17	9	16	15	19	10	10	8	24	159	154	3
Mid Essex	13	26	19	11	10	25	29	38	35	27	39	43	315	247	28
North East Essex	24	33	32	32	25	31	28	38	34	35	39	41	392	262	50
Southend	20	16	19	8	13	15	16	26	12	11	20	29	205	170	21
Thurrock	11	14	9	10	8	8	6	14	11	15	7	8	121	108	12
West Essex	17	9	18	15	8	16	13	27	21	30	17	25	216	158	37

Crisis Service Essex Activity Year April 2016 - March 2017									
CCG	Assessments	YTD Plan	% Variance	1st Appoints	YTD Plan	% Variance	Follow ups	YTD Plan	% Variance
Basildon & Brentwood	257	240	7.08	209	185	12.97	701	247	183.81
Castle Point and Rochford	160	125	28.00	141	110	28.18	330	168	96.43
Mid Essex	320	199	60.80	293	209	40.19	758	694	9.22
North East Essex	396	206	92.23	356	226	57.52	1046	619	68.98
Southend	209	151	38.41	171	130	31.54	431	218	97.71
Thurrock	139	96	44.79	102	77	32.47	296	101	193.07
West Essex	224	122	83.61	194	134	44.78	574	350	64.00
Essex	1750	1139	49.69	1466	1071	36.88	4136	2397	72.55

The Table above highlights all crisis activity during the period April 2016 to March 2017 by CCG. There is considerable over performance in North East Essex CCG, West Essex CCG, and Mid Essex CCG, with assessments equating to 55% of Essex overall performance.

## 2015/16

	Basildon and Brentwood	Castle Point and Rochford	Mid Essex	North East Essex	Southend	Thurrock	West Essex	Total
<b>Crisis referrals received</b>	186	94	230	247	142	70	154	<b>1123</b>

Crisis Activity	Basildon and Brentwood	Castle Point and Rochford	Mid Essex	North East Essex	Southend	Thurrock	West Essex	Total
<b>1st Appointment</b>	116	64	103	109	71	45	66	<b>574</b>
<b>1st Appointment</b>	77	46	87	94	54	32	56	<b>446</b>
<b>Follow up Appointment</b>	103	70	289	258	91	42	146	<b>999</b>

## Waiting times 2015/16

## Referral to assessment waiting times

## KPI 3a

## RTT waiting times

RTT KPI has significantly improved and across Essex we are now 2.83% above the RTT waiting time standard i.e. achieving 94.83% against the 92% waiting time standard as @ end of March 2017. Across Essex the RTT for April 2016 was 81.68% falling to 66.46% in July with month on month recovery thereafter until year end.

## KPI 3b

## RTT completed pathways

Significant improvement in achievement against 95% local standard rising from 87.45% in April 2016 to 92.99% as @ end of March 2017

## Referral to assessment waiting times

## KPI 4a

## RTA waiting to be seen

RAs @ end of March 2017, of those CYP waiting for assessment, 5% were waiting longer than 12 weeks compared to 38% waiting over 12 weeks as @ end of July 2016.

## KPI 4B

## RTA completed pathways

As @end of March 2017, 6,650 CYP completed treatment. Of those CYP, 58% completed treatment within 8 weeks and 76% in less than 12 weeks.

## Eating Disorders (ED) team activity across Southend Essex and Thurrock

During 2016/17 commissioners have supported NELFT with the development and mobilisation of the Eating Disorder service across all seven Essex CCGs and expansion to a county wide service.

The chart below shows the number of referrals received for Eating Disorders compared to those accepted, assessments, first and follow up appointments during 2016/17.

The Eating Disorder caseload for Southend and Thurrock CCGs has been held by the generic CAMHS teams with advice and support provided by the pan Essex ED team. When clinically safe to do so the caseload will gradually transferred to the new Eating Disorder team.

Community Eating Disorder Service - Essex Activity Year April 2016 - March 2017					
CCG	Referrals Rec'd	Referrals acpt'd	Assessments	1st Apps	Follow ups
Basildon & Brentwood	10	10	4	5	22
Castle Point and Rochford	5	5	2	2	7
Mid Essex	59	59	68	65	942
North East Essex	38	38	44	35	490
Southend	0	0	0	0	0
Thurrock	0	0	0	0	0
West Essex	29	28	38	31	334
<b>Essex</b>	<b>141</b>	<b>140</b>	<b>156</b>	<b>138</b>	<b>1795</b>

## Waiting times 2016/17

### Monitoring compliance with the new eating disorders waiting time standard

Monitoring of this standard has been on a monthly basis during 2016/17 in readiness for the tolerance levels to be set and the standard implemented from 2017/18.

### Q1 2016/17

08Q (Mid Essex CCG)	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	2	6	0	1	2	4	0	1	0	0	0	0	0	18	56.25%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	0	0	0	0	1	0	0	0	0	0	0	0	2	50.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	2	1	0	0	0	0	0	0	0	0	0	0	0	3		66.6%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

09Q (North East Essex CCG)	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	1	0	1	1	3	3	0	1	0	0	0	0	0	10	30.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	0	1	0	0	0	0	0	0	0	0	0	0	1	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	1	0	0	0	0	0	0	0	0	0	0	1		0.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

07H (West Essex CCG)	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	1	1	0	0	1	0	0	0	0	0	0	1	0	4	50.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	1	0	0	1	00.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	0	1	0	0	0	0	0	0	0	0	0	1		0.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

ALL EWMH 8	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	4	7	1	2	6	7	0	2	0	0	0	1	0	30	46.67%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	0	1	0	0	1	0	0	0	0	1	0	0	4	50.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	2	1	1	1	0	0	0	0	0	0	0	0	0	6		40.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

Q2 2016/17

06Q (Mid Essex x CCG)	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	2	1	3	2	1	1	0	0	0	0	0	0	0	10	80.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	2	0	0	0	0	0	0	0	0	0	0	0	3	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	2	0	0	0	0	0	0	0	0	0	0	0	0	2		100.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	1	0	0	0	0	0	0	0	0	0	0	0	1		0%

08Q (North East Essex x CCG)	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	0	1	2	3	1	0	0	0	0	0	0	0	0	7	30.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	1	0	0	0	0	0	0	0	0	0	0	0	1	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	1	0	0	0	0	0	0	0	0	0	0	0	1		0.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

08Q (West Essex x CCG)	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	0	1	0	1	0	1	0	0	0	0	0	0	0	3	66.67%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	1	1	1	0	0	0	0	0	0	0	0	0	3	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	1	1	0	0	0	0	0	0	0	0	0	0	0	2		50.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

99F (Castle point & Rochford CCG)	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0	n/a	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	1	0	0	0	0	0	0	0	0	0	0	0	1	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

ALL EWMH 8	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	2	3	6	8	1	2	1	0	0	0	0	0	0	20	80.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	5	1	1	0	0	0	0	0	0	0	0	0	8	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	3	2	0	0	0	0	0	0	0	0	0	0	0	6		60.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	1	0	0	0	0	0	0	0	0	0	0	0	1		0%

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Q3 2016/17

ALL EWMHS	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	2	7	9	3	0	0	0	0	0	0	0	0	0	21	100.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	4	1	1	0	1	0	0	0	0	0	0	0	8	87.50%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	1	1	0	0	0	0	0	0	0	0	0	0	0	2		50.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

06Q - Mid Essex x CCG	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	2	3	2	2	0	0	0	0	0	0	0	0	0	9	100.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	0	1	1	0	0	0	0	0	0	0	0	0	3	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

06T - North East Essex x CCG	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	0	4	2	0	0	0	0	0	0	0	0	0	0	6	100.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	1	0	0	1	0	0	0	0	0	0	0	0	2	50.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	1	0	0	0	0	0	0	0	0	0	0	0	1		0.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

07H - West Essex CCG	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	0	0	5	1	0	0	0	0	0	0	0	0	0	6	100.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	3	0	0	0	0	0	0	0	0	0	0	0	3	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	1	0	0	0	0	0	0	0	0	0	0	0	0	1		100.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

Q4 2016/17

2016/17 - QUATER 4	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
BASILDON & BRENTWOOD CCG (99E)	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	1	1	0	1	0	0	0	0	0	0	0	0	0	3	100.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	0	4	1	0	0	0	0	0	0	0	0	0	6	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

2016/17 - QUATER 4	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
CASTLE POINT AND ROCHFORD CCG (99F)	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	1	1	0	0	0	0	0	0	0	0	0	0	0	2	100.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	0	1	0	0	0	0	0	0	0	0	0	0	2	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

2016/17 - QUATER 4	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
SOUTH ESSEX CCG	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	1	6	2	1	0	1	0	0	0	0	0	0	1	12	83.33%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	1	0	0	0	0	0	0	0	0	0	0	0	1	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	1	0	0	0	0	0	0	0	0	0	0	0	0	1		100.00%
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

2016/17 - QUATER 4	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
NORTH ESSEX CCG	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	3	1	4	0	0	1	0	0	0	0	0	0	0	9	88.89%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

2016/17 - QUATER 4	Number of patients on CYP ED pathways, complete and incomplete pathways broken down by length of period from referral to treatment (weeks)														% Routine seen / waiting <4 weeks	% Urgent seen / waiting <1 week
WEST ESSEX CCG	G-t 0-1	Gt 1-2	Gt 2-3	Gt 3-4	Gt 4-5	Gt 5-6	Gt 6-7	Gt 7-8	Gt 8-9	Gt 9-10	Gt 10-11	Gt 11-12	Gt 12+	Total		
Length of completed CYP ED care pathways (routine cases) broken down by time band	2	0	1	0	0	0	0	0	0	0	0	0	0	3	100.00%	
Length of incomplete CYP ED care pathways (routine cases) broken down by time band	1	0	0	0	0	0	0	0	0	0	0	0	0	1	100.00%	
Length of completed CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a
Length of incomplete CYP ED care pathways (urgent cases) broken down by time band	0	0	0	0	0	0	0	0	0	0	0	0	0	0		n/a

#### **Tier 4 service provision – specialised services commissioned by NHS England**

These are Acute child and adolescent mental health (CAMHS) inpatient services, which are commissioned by NHS England and include; Eating Disorder inpatient units; Psychiatric Intensive Care Units, Low Secure Mental Illness; Low and Medium Secure Learning Disability inpatient hospitals.

#### **Collaborative Working**

Due to the capacity issues across the specialised commissioned services nationally, the inter relationship between commissioners within NHS England and the local CCGs is crucial. The Future in Mind Report (March 2015) provides a clear direction of travel for all commissioners.

There are a number of forums across the East of England where collaboration between commissioners takes place, which include the East of England Clinical Network CAMHS Forum, and the East of England Future in Mind Steering Group. In addition, there are regular meetings between local CCG commissioners and NHS England commissioners to ensure a whole systems approach to existing and developing community and in patient services.

Furthermore, local CCG commissioners are working closely with NHS England commissioners on the Transforming Care Programme of work, and the community pre-admission care and treatment review process for children and young people with learning disabilities and/or autistic spectrum disorders, behaviour that challenges, and mental health problems. The process is intended to challenge and check that there is no alternative to hospital admission.

*Implementing the Five Year Forward View for Mental Health* includes a requirement for all CCGs to develop collaborative commissioning plans with NHS England's specialised commissioning teams. These plans will include locally agreed trajectories for aligning in-patient beds to meet local need, and where there are reductions releasing resources to be redeployed in community-based services.

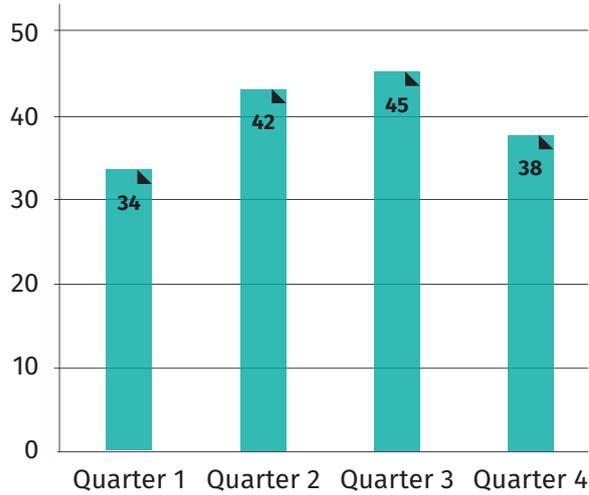
The new investment in development and implementation of clear evidence based pathways, including intensive home treatment where appropriate, for local community Crisis and Eating Disorder services across Essex is intended to reduce admissions to CAMHS Tier 4 in patient units, and where admission is required the length of stay is brief, with joint working and shared practice across services to promote continuity of care on transition back to the community.

**CAMHS Tier 4 inpatient activity**

Specialist Tier 4 in patient services in Essex are provided by North Essex Partnership University NHS Foundation Trust (NEP) based at the St Aubyn Centre in the north of the county, and by South Essex Partnership University NHS Foundation Trust, (SEPT), Poplar unit, in south Essex. These Trusts have since merged as Essex Partnership University Foundation Trust, (EPUT). There are 2 general acute wards and on PICU

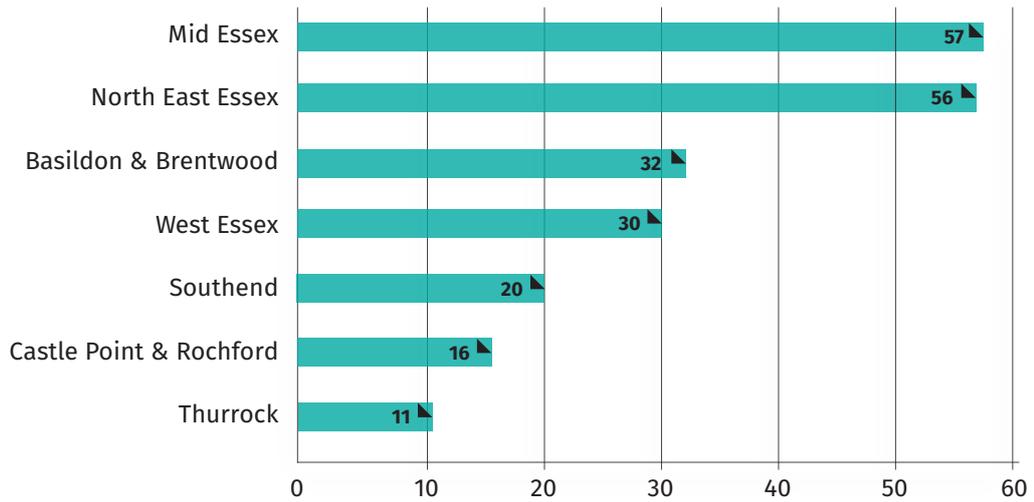
The Chart below shows new admissions in the quarter across the two trusts for 2016/17 based on information provided by commissioning colleagues at NHSE specialised commissioning.

**New Admissions - April 2016 - March 2017**  
St Aubyn Centre and Poplar Unit



The chart below shows admission rates by CCG to all facilities commissioned by specialised commissioning. The highest numbers of admissions to CAMHS Tier 4 across Essex CCGs originate from Mid Essex and North East Essex CCGs, which equate to over 50% of all Essex admissions.

**CAMHS admissions - Tier 4 inpatient services**  
April 2016 - March 2017



## Patient activity/length of stay reporting

The tables below summarise details of patient activity by CCG during April 2016 to March 2017 for all CAMHS inpatient service providers commissioned by specialised commissioning.

CCG	Primary Service Type	No. of Patients by ID	Total Length of stay	Average of LOS
<b>NHS Basildon and Brentwood CCG</b>	CAMHS Acute	26	5,602	215.45
	CAMHS Low Secure	2	278	139.00
	CAMHS PICU	2	361	180.50
	Eating Disorder	2	479	239.50
<b>NHS Southend CCG</b>	CAMHS Acute	12	2,223	185.25
	CAMHS LD	2	553	276.50
	CAMHS PICU	1	136	136.00
	Eating Disorder	5	935	187.00
<b>NHS North East Essex CCG</b>	Unknown (CAMHS) - Not Provide			
	CAMHS Acute	46	9,841	213.93
	CAMHS Low Secure	1	137	137.00
	CAMHS Medium secure			
	CAMHS PICU	5	1,225	245.00
<b>NHS Castle Point and Rochford CCG</b>	Eating Disorder	3	305	101.67
	Mental Illness	1	180	180.00
	CAMHS Acute	13	2,820	216.92
	CAMHS Low Secure	2	304	152.00
<b>NHS Mid Essex CCG</b>	CAMHS PICU	1	353	353.00
	CAMHS Acute	39	7,327	187.87
	CAMHS LD			
	CAMHS Low Secure	3	420	140.00
	CAMHS PICU	5	1,180	236.00
<b>NHS West Essex CCG</b>	Eating Disorder	10	2,130	213.00
	CAMHS Acute	25	5,128	205.12
	CAMHS Low Secure	1	286	286.00
	CAMHS Medium secure			
	CAMHS PICU	1	298	298.00
<b>NHS Thurrock CCG</b>	Eating Disorder	3	920	306.67
	CAMHS Acute	8	1,852	231.50
	CAMHS LD	1	40	40.00
	Eating Disorder	2	184	92.00

# Appendix 3

## Baseline assessment investment in 2016/17

The table below reflects the investment in CAMHS during 2015/16 across Tier 2, Tier 3 and Tier 4, Children's Learning Disability Services and Informal Advocacy.

2015/16 Baseline	Thurrock LA	Southend LA	Essex County Council	Southend CCG	Thurrock CCG	Castle Point & Rochford CCG	Basildon & Brentwood CCG	North East Essex CCG	Mid Essex CCG	West Essex CCG	Essex Total
<b>CAMHS Tier 2</b>	117,833	122,500	1,208,200	0	0	0	0	0	0	0	1,448,533
<b>CAMHS Tier 3 - NEP</b>	0	0	0	0	0	0	0	1,360,649	1,089,965	1,531,646	3,982,260
<b>CAMHS Tier 3 - SEPT</b>	0	0	0	533,400	582,800	511,400	969,400	0	0	0	2,597,000
<b>CAMHS Tier 2 &amp; 3 - NEFLT</b>	80,800	84,000	758,833	381,664	417,866	365,488	689,382	940,901	753,721	1,059,147	5,531,802
<b>CAMHS Tier 4</b>	0	0	0	735,641	424,846	69,689	490,513	1,531,925	1,658,855	1,291,872	6,203,341
<b>CAMHS/LD</b>	0	0	0	35,606	38,983	34,097	64,314	0	0	0	173,000
<b>Childrens Learning Disability Service</b>	0	0	0	0	0	0	0	123,447	98,888	138,959	361,294
<b>Informal Advocacy</b>	0	0	0	0	0	0	0	18,112	14,513	20,382	53,007
<b>Total</b>	198,633	206,500	1,967,033	1,686,311	1,464,495	980,674	2,213,609	3,975,034	3,615,942	4,042,006	20,350,237

## Additional investment 2015/16 through transformation funding – part year effect

CAMHS Actual spending15/16									
CCG share of Total Essex Allocation									
Workstreams		Basildon & Brentwood CCG 14.39%	Castle Point & Rochford CCG 10.21%	Mid Essex CCG 19.96%	North East Essex CCG 19.12%	Southend CCG 10.95%	Thurrock CCG 8.85%	West Essex CCG 16.52%	Total 100%
<b>Expansion of services for eating disorders</b>		24,463	17,357	33,932	32,504	18,615	15,045	28,084	<b>169,998</b>
<b>Deeper Dive needs analysis</b>	non-recurrent	21,585	15,315	29,940	28,680	16,425	13,275	24,780	<b>150,000</b>
<b>Publication of the LTP</b>	non-recurrent	2,655	1,884	3,683	3,528	2,020	1,633	3,048	<b>18,449</b>
<b>Engagement with Children &amp; Young People</b>		16,549	11,742	22,954	21,988	12,593	10,178	18,998	<b>115,002</b>
<b>Improved IM&amp;T infrastructure</b>	non-recurrent	33,241	23,585	46,108	44,167	25,295	20,444	38,161	<b>230,999</b>
<b>Project Management office for Transition</b>	non-recurrent	20,434	14,498	28,343	27,150	15,549	12,567	23,458	<b>141,998</b>
<b>Suicide and self-harm audit &amp; training</b>	non-recurrent	14,390	10,210	19,960	19,120	10,950	8,850	16,520	<b>100,000</b>
<b>Medicines Management review</b>	non-recurrent	7,195	5,105	9,980	9,560	5,475	4,425	8,260	<b>50,000</b>
<b>Enhanced crisis services to cover 9am-9pm 7 days a week</b>		22,017	15,621	30,539	29,254	16,754	13,541	25,276	<b>153,002</b>
<b>More staff in local teams to improve single point access</b>		4,317	3,063	5,988	5,736	3,285	2,655	4,956	<b>29,999</b>
<b>More senior clinicians in psychological services</b>		-	-	-	-	-	-	-	-
<b>More practitioners in psychological services</b>		-	-	-	-	-	-	-	-
<b>More staff in locality teams to respond to low to moderate needs</b>		-	-	-	-	-	-	-	-
<b>Extra management capacity</b>		-	-	-	-	-	-	-	-
<b>Training for therapy services (CYP IAPT)</b>		11,800	8,372	16,367	15,678	8,979	7,257	13,546	<b>81,997</b>
<b>Local partnership development sessions</b>		3,022	2,144	4,192	4,015	2,300	1,859	3,469	<b>21,001</b>
<b>Support and training for schools</b>		-	-	-	-	-	-	-	-
<b>Transformation support costs</b>		34,120	24,209	47,327	45,335	25,963	20,984	39,170	<b>237,108</b>
<b>Paediatric Liaison Pilot</b>	non-recurrent	-	20,500	-	-	20,500	-	-	<b>41,000</b>

## CAMHS investment in 2016/17

The table below reflects the investment in CAMHS during 2016/17.

Service	Thurrock LA	Southend LA	Essex County Council	Southend CCG	Thurrock CCG	Castle Point & Rochford CCG	Basildon & Brentwood CCG	North East Essex CCG	Mid Essex CCG	West Essex CCG	Essex Total
<b>CAMHS Tier 2 &amp; Tier 3</b>	196,000	204,000	1,841,000	926,000	1,014,000	887,000	1,673,000	2,283,000	1,829,000	2,570,000	<b>13,423,000</b>
<b>CAMHS Tier 4</b>				967,000	502,000	921,000	1,660,000	2,490,000	2,877,000	1,419,000	<b>10,836,000</b>
<b>CAMHS / LD</b>				36,000	39,000	34,000	65,000				<b>174,000</b>
<b>Childrens Learning Disability Service</b>								126,000	101,000	142,000	<b>369,000</b>
<b>Informal Advocacy</b>								18,000	15,000	21,000	<b>54,000</b>
<b>Total</b>	<b>196,000</b>	<b>204,000</b>	<b>1,841,000</b>	<b>1,929,000</b>	<b>1,555,000</b>	<b>1,842,000</b>	<b>3,398,000</b>	<b>4,917,000</b>	<b>4,822,000</b>	<b>4,152,000</b>	<b>24,856,000</b>

### Allocation of mental health Transformation funding to Essex CCGs

Funding for emotional wellbeing and mental health services for children and young people is managed as a single fund across Southend Essex and Thurrock. However, the table below shows an indicative division of funds between the CCGs and reflects the intended national investment.

CCG	2017/18	2018/19	2019/20
Basildon and Brentwood CCG	660,198	801,669	895,983
Castle Point and Rochford CCG	442,467	537,281	600,491
Mid Essex CCG	873,214	1,060,331	1,185,076
North East Essex CCG	873,884	1,061,144	1,185,985
Southend CCG	467,369	567,520	634,287
Thurrock CCG	397,768	483,004	539,828
West Essex CCG	745,314	905,024	1,011,498
<b>Essex</b>	<b>4,460,214</b>	<b>5,415,974</b>	<b>6,053,148</b>

In addition, £25m nationally has been made available to reduce waiting times. Half of the funding was released in October 2016 and the second half in January 2017 subject to assurance. The additional funding is shown below by CCG.

CCG	Value for Allocation £k
<b>NHS Basildon and Brentwood</b>	118
<b>NHS Castle Point, Rayleigh and Rochford</b>	79
<b>NHS Mid Essex</b>	156
<b>NHS North East Essex</b>	156
<b>NHS Southend</b>	83
<b>NHS Thurrock</b>	71
<b>NHS West Essex</b>	133
<b>Essex</b>	<b>796</b>

# CAMHS Financial Plan

Baseline Assessment Investment in 2016/17 Across All CAMHS Funding Streams	Thurrock LA £000	Southend LA £000	Essex County Council £000	Southend CCG £000	Thurrock CCG £000	Castle Point and Rochford CCG £000	Basildon and Brentwood CCG £000	North East Essex CCG £000	Mid Essex CCG £000	West Essex CCG £000	Total £000
New integrated Tier2/Tier 3 service	196	204	1,841	926	1,014	887	1,673	2,283	1,829	2,570	<b>13,422</b>
CAMHS Tier 4				967	502	921	1,660	2,490	2,887	1,419	<b>10,835</b>
CAMHS / LD				36	39	34	65				<b>175</b>
Children's Learning Disability Service								126	101	142	<b>368</b>
Informal Advocacy Services								18	15	21	<b>54</b>
<b>Total Baseline Investment in 2016/17</b>	<b>196</b>	<b>204</b>	<b>1,841</b>	<b>1,929</b>	<b>1,556</b>	<b>1,842</b>	<b>3,398</b>	<b>4,917</b>	<b>4,822</b>	<b>4,151</b>	<b>24,855</b>
<b>Investment from 2016/17 at Recurrent Values</b>											
Investment from Existing Budgets (Incl Parity of Esteem Investment)	196	204	1,841	1,929	1,556	1,842	3,398	4,917	4,822	4,151	<b>24,855</b>
Transformation Funding Investment				253	215	240	358	473	473	404	<b>2,416</b>
Eating Disorder Funding Investment				73	62	69	103	136	136	116	<b>693</b>
Children's and Young People's IAPT											<b>0</b>
<b>Total Recurrent Baseline Investment at the End of 2016/17</b>	<b>196</b>	<b>204</b>	<b>1,841</b>	<b>2,254</b>	<b>1,833</b>	<b>2,151</b>	<b>3,858</b>	<b>5,526</b>	<b>5,430</b>	<b>4,671</b>	<b>27,964</b>
Investment from 2016/17 at Non recurrent Values				4	3	4	5	7	7	6	<b>37</b>
<b>Total investment 2016/17</b>	<b>196</b>	<b>204</b>	<b>1,841</b>	<b>2,258</b>	<b>1,836</b>	<b>2,155</b>	<b>3,863</b>	<b>5,533</b>	<b>5,437</b>	<b>4,677</b>	<b>28,001</b>

New Investments Starting in 2015/16 Funded by National Allocations	2016/17 Spend											Planned investment 2017/18 funded by national allocations		Funding Source for 2017/18 Expenditure	
	Improving Access and Equality											Non Recurrent	Recurrent	CAMHS Transformation	Eating Disorders
	Non Recurrent	Recurrent	Total								Total	£000	£000	4,460,241	955,000
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Expansion in local services for specialist community Eating Disorders		693	<b>693</b>	100	85	95	141	187	187	159	<b>953</b>		953		953
Deep Dive needs assessment across each CCG locality			<b>0</b>								<b>0</b>				
Development and publication of the Essex wide Local Transformation Plan (LTP) with an accessible version for CYP and their families		4	4	1	1	1	2	2	2	2	<b>12</b>		12	12	
Medicines management review			0											0	
Enhanced crisis service cover across Southend Essex and Thurrock and building capacity in the teams to provide more intensive care at home		431	431	45	38	43	64	84	84	72	<b>431</b>		431	431	
Enhanced staffing capacity in the Single Points of Access teams to ensure better information, consultation and support, and signposting to local services		111	111	15	12	14	21	27	27	23	<b>140</b>		140	140	
Enhanced senior psychology posts across each locality to ensure high quality supervision		142	142	8	7	8	11	15	15	13	<b>76</b>		76	76	
Online Counselling Service				21	18	20	30	39	39	33	<b>200</b>		200	200	
Crisis re-modelling Match Funding				71	60	67	100	132	132	113	<b>674</b>		674	674	
<b>Building Capacity and Capability in the System</b>															
Development of Project Management Office (PMO) function to deliver on implementation of the new service model and transformation workstreams		75	<b>75</b>	11	10	11	16	21	21	18	<b>108</b>		108	108	
Increased junior psychology posts at a local level to enhance service delivery		376	<b>376</b>	44	38	42	62	82	82	70	<b>421</b>		421	421	
Additional staffing capacity in all locality teams with a specific focus on low to moderate needs		508	<b>508</b>	63	53	59	88	117	117	100	<b>598</b>		598	598	
Increase medical capacity (5 junior doctor posts) to increase our ability to respond CYP with more complex needs (SEND, LD, ADHD, ASD)		0	<b>0</b>	22	19	21	31	41	41	35	<b>208</b>		208	208	
Enhanced management capacity at a local level		290	<b>290</b>	30	26	29	43	57	57	48	<b>290</b>		290	290	
Additional local bespoke CYP IAPT training programmes over and above the national IAPT programme, with a specific focus on Primary Mental Health Workers		50	<b>50</b>	10	9	10	15	20	20	17	<b>100</b>		100	100	
<b>Building Resilience in the Community</b>															
Active engagement with children and young people across all CCG localities	37		<b>37</b>	0	0	0	0	0	0	0	<b>0</b>		0	0	
Building community resilience by providing additional support to schools and the voluntary sector		145	<b>145</b>	32	28	31	46	61	61	52	<b>310</b>	-	310	310	
Transformation support costs		263	<b>263</b>	0	0	0	0	0	0	0	<b>0</b>		0	0	
Publicity Communication and Engagement		23	<b>23</b>	10	9	10	15	20	20	17	<b>100</b>		100	100	
Transitions - support for young people leaving childrens services		0	<b>0</b>	42	36	40	59	78	78	67	<b>400</b>		400	400	
Childrens LD - additional capacity and equitable service offer		0	<b>0</b>	37	31	35	52	69	69	58	<b>350</b>		350	350	
			<b>0</b>										0	0	
<b>Total</b>	<b>37</b>	<b>3,109</b>	<b>3,146</b>	<b>563</b>	<b>479</b>	<b>533</b>	<b>795</b>	<b>1,052</b>	<b>1,052</b>	<b>898</b>	<b>5,371</b>	<b>0</b>	<b>5,371</b>	<b>4,418</b>	<b>953</b>

## Essex EWMHS Local Transformation Plan (LTP)

## Summary of Planned vs. Actual Spend 2016/17

	TOTAL	NHS Mid Essex CCG 19.58%	NHS North East Essex CCG 19.59%	NHS Thurrock CCG 8.92%	NHS West Essex CCG 16.71%	NHS Basildon and Brentwood CCG 14.80%	NHS Castle Point and Rochford CCG 9.92%	NHS Southend CCG 10.48%	Total Essex 100.00%
<b>Planned Spend</b>									
Eating disorders	991,336	194,082	194,231	88,409	165,655	146,737	98,344	103,878	991,336
Other transformation projects	3,057,684	598,629	599,088	272,689	510,947	452,596	303,332	320,403	3,057,684
<b>Total</b>	<b>4,049,020</b>	<b>792,711</b>	<b>793,711</b>	<b>361,097</b>	<b>676,602</b>	<b>599,333</b>	<b>401,675</b>	<b>424,282</b>	<b>4,049,020</b>
<b>Actual Spend</b>									
Eating disorders	693,288	135,731	135,835	61,828	115,850	102,620	68,776	72,647	693,288
Other transformation projects	2,453,083	480,261	480,629	218,769	409,917	363,104	243,353	257,050	2,453,083
<b>Total</b>	<b>3,146,371</b>	<b>615,992</b>	<b>616,464</b>	<b>280,598</b>	<b>525,767</b>	<b>465,724</b>	<b>312,130</b>	<b>329,697</b>	<b>3,146,371</b>
<b>Variance: under/over</b>									
Eating disorders	298,048	58,351	58,396	26,580	49,805	44,117	29,567	31,231	298,048
Other transformation projects	604,601	118,368	118,459	53,919	101,030	89,493	59,978	63,354	604,601
<b>Total</b>	<b>902,649</b>	<b>176,719</b>	<b>176,855</b>	<b>80,500</b>	<b>150,835</b>	<b>133,609</b>	<b>89,546</b>	<b>94,585</b>	<b>902,649</b>

## Explanation of underspend

### Eating disorder

LTP 1 - Slippage expected. In November 2015 Essex mobilised a new integrated Tier 2 and Tier 3 service model with a single new pan Essex provider. As a consequence, and following the need for consultation with staff from 4 incumbent providers there was a delay in recruitment to the new staffing structures afforded by the LTP monies. Recruitment of staff on a permanent basis commenced at the end of June 2016. It is acknowledged nationally that recruitment to specialist community ED services is challenging. The ED team was running with a 50% vacancy factor in January 2017, nearing full staffing compliment as @ end of March 2017 but still with 3 vacancies

### Other transformation projects

- LTP 4 - Majority of project support funded within existing CCG resource.
- LTP 14 - Slippage expected. In November 2015 Essex mobilised a new integrated Tier 2 and Tier 3 service model with a single new pan Essex provider. As a consequence, and following the need for consultation with staff from 4 incumbent providers there was a delay in recruitment to the new staffing structures afforded by the LTP monies. Recruitment of staff on a permanent basis commenced at the end of June 2016. Staff recruitment in specific CCG localities challenging. Some localities within Essex attract fringe supplements and therefore more attractive to staff
- LTP 15 - Scheme to be re-worked 2017/18 for increased support for CYP with SEN and complex needs as deanery confirmed no plans to release more junior doctors
- LTP 17 - Slippage incurred. NELFT working with ARU on development of a bespoke training package delay in delivery outside of their control. Monies used to address shortfall in backfill costs for release of CYP IAPT trainees instead
- LTP 22 - Non -recurrent. No costs incurred during Q4 2016/17. Still waiting for consensus across all CCGs for pan Essex approach to CTR process. From 2017/18 funded recurrently with in CCG allocations.
- LTP 23 - No costs incurred Q4 2016/17. Delay in CCG decision making process regards commitment to invest in identified LTP priorities and the requirement for new schemes to be supported by business cases that show return on investment
- LTP 24 - No costs incurred Q4 2016/17. Governance requirements of respective CCGs resulted in slippage and has delayed mobilisation of this service development
- LTP 21 - Existing CCG resource utilised for internal comms support. Therefore actuals spend was less than the planned estimate.
- LTP 25 - Service mobilised but costs reviewed and covered within enhanced crisis service provision. (LTP 10)
- LTP 20 - Actuals spend was less than the planned estimate due to delays with recruitment (Hub support function).

# Appendix 4

## Staffing of services in 2016/17

### Children’s and Young People’s Emotional Wellbeing and Mental Health Services

**Year 1 - 2015/16** – the priority was to support staff in transition to the new service model. This included formal induction training, and informal development through discussion and consultation with the new teams.

**Year 2 - 2016/17** – Following the staff TUPE transfer to the new service provider and post staff consultation, major local and national recruitment campaigns commenced. There was a high vacancy rate at this time and these numbers were inflated by the additional investment in staffing afforded through the LTP monies.

During year 2, there were also several review processes to assess needs and the case for change. These processes, focusing on a particular service area, listened to staff views and involved staff in developing new protocols.

The staff vacancy rate as @ end of March 2016, was 12.65% after five months of service delivery. The following table shows the staff vacancy rate gradually increasing between quarters one and quarters three of 2016 and a gradual decrease in the final quarter four of 2017.

Quality Requirement	Target / standard	Reporting Frequency	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017
<b>% Staff vacancy rate</b>	N/A	Q	14.8%	15.9%	64.9%	52.8%	56.6%	46.1%	57.9%	40.9%	38.8%	30.5%	28.6%	26.2%

As expected the staff vacancy rate is decreasing as newly appointed staff take up their posts.

The table below outlines the enhancement to the original staffing structure of our service provider funded through the LTP monies.

Description of work stream	Scheme Number	R/NR	Owner	Proposed Additional Staffing via LTP Funding	Comments
<b>Eating Disorders</b>	LTP 1	R	NEFLT	15.4 wte	Completed 2016/17 and in post
<b>Crisis Service</b>	LTP 10	R	NEFLT	4.73 wte	Complete 2016/17 and in post. Recruitment in certain localities across Essex continues to be challenging. Vacancies are filled with bank and agency staff
<b>Core CAMHS</b>	LTP 11	R	NEFLT	24.7 wte	Completed and in post
<b>Enhanced senior psychology posts across each locality to ensure high quality supervision</b>	LTP 12	R	NEFLT	Enhanced from Band 8a x 7 to Band 8b x 7	Completed and in post
<b>Enhanced management capacity at a local level, Southend and Thurrock</b>		R	NEFLT		Lift from 8c to 8d for service lead Associate Director
<b>Support Team for transformation</b>	LTP 6	R		2 wte	Completed and in post

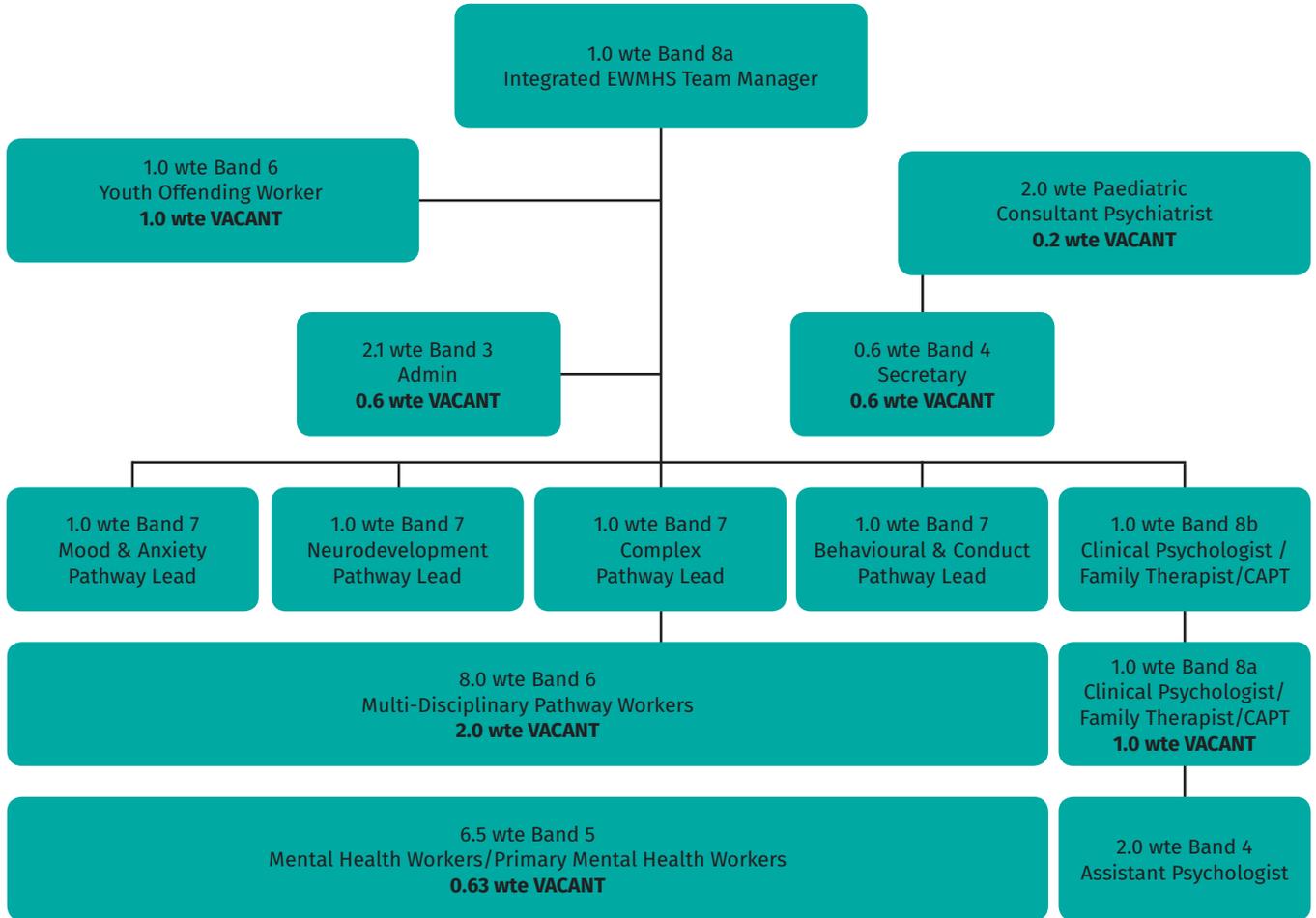
The table below details the staffing establishment for the EWMH service as at the end of March 2017.

**EWMHS Current staffing compliment as @ year end 2017**

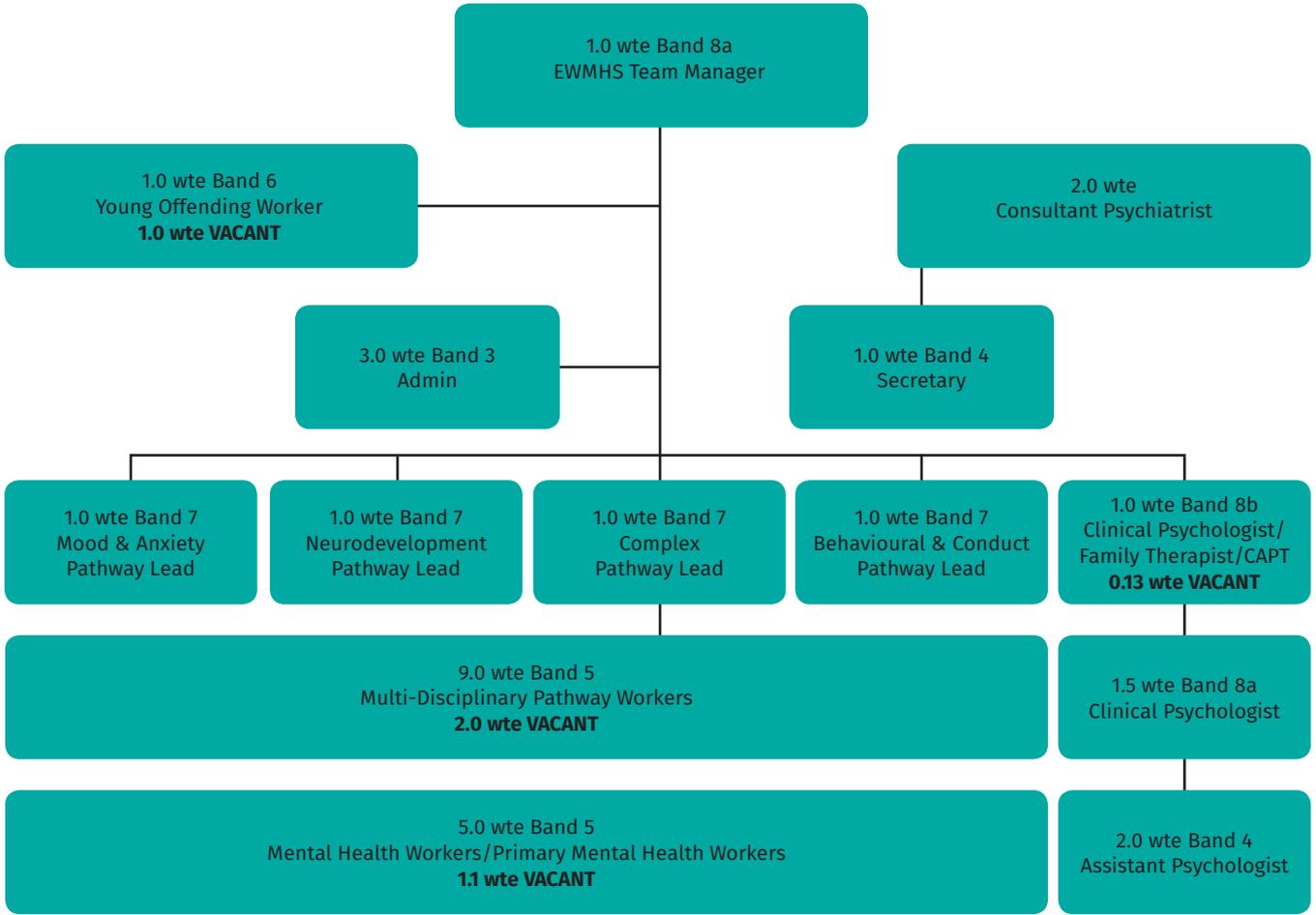
Quality Requirement	Target/Standard	Threshold	Reporting Frequency	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	YTD
WTE General Psychiatry	N/A	-	Q	-	-	-	-	-	4	-	-	3	-	-	2	2
WTE Child and Adolescent Psychiatry	N/A	-	Q	-	-	-	-	-	0	-	-	0	-	-	5.5	5.5
WTE Community Health Service Medical	N/A	-	Q	-	-	-	-	-	4	-	-	1	-	-	2	2
<b>WTE Medical and Dental Staff Total</b>	<b>N/A</b>	<b>-</b>	<b>Q</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>4</b>	<b>-</b>	<b>-</b>	<b>4</b>	<b>-</b>	<b>-</b>	<b>9.5</b>	<b>9.5</b>
WTE Senior Manager Clinical Support	N/A	-	Q	-	-	-	-	-	1	-	-	0	-	-	0	0
WTE Manager Clinical Support	N/A	-	Q	-	-	-	-	-	4	-	-	1	-	-	1	1
WTE Clerical and Administrative Central Functions	N/A	-	Q	-	-	-	-	-	11.69	-	-	10.41	-	-	11.91	11.91
WTE Clerical and Administrative Clinical Support	N/A	-	Q	-	-	-	-	-	4.91	-	-	8.41	-	-	14.83	14.83
<b>WTE Administration and Estates Staff Total</b>	<b>N/A</b>	<b>-</b>	<b>Q</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>21.6</b>	<b>-</b>	<b>-</b>	<b>19.82</b>	<b>-</b>	<b>-</b>	<b>27.73</b>	<b>27.73</b>
WTE HCA Community Services	N/A	-	Q	-	-	-	-	-	0.7	-	-	0	-	-	0	0
WTE Support Worker Community Services	N/A	-	Q	-	-	-	-	-	1	-	-	1	-	-	1	1
<b>WTE Health Care Assistants and Other Support Staff Total</b>	<b>N/A</b>	<b>-</b>	<b>Q</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1.7</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>1</b>
WTE Manager Community Services	N/A	-	Q	-	-	-	-	-	0	-	-	1	-	-	1	1
WTE Other 1st level (Level 1 Sub Part 1) Community Psychiatry	N/A	-	Q	-	-	-	-	-	0	-	-	0	-	-	0.8	0.8
WTE Other 1st level (Level 1 Sub Part 1) Community Services	N/A	-	Q	-	-	-	-	-	20.54	-	-	37.03	-	-	37.17	37.17
<b>WTE Nursing, Midwifery and Health Visiting Staff Total</b>	<b>N/A</b>	<b>-</b>	<b>Q</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>20.54</b>	<b>-</b>	<b>-</b>	<b>38.03</b>	<b>-</b>	<b>-</b>	<b>38.97</b>	<b>38.97</b>
WTE Manager Clinical Psychology	N/A	-	Q	-	-	-	-	-	2	-	-	1	-	-	1	1
WTE Manager Psychotherapy	N/A	-	Q	-	-	-	-	-	0.9	-	-	0	-	-	0	0
WTE Manager Social Services	N/A	-	Q	-	-	-	-	-	2	-	-	2.6	-	-	2.6	2.6
WTE Manager other Scientific, Therapeutic and Technical Staff	N/A	-	Q	-	-	-	-	-	0	-	-	2	-	-	3	3
WTE Therapist Occupational Therapy	N/A	-	Q	-	-	-	-	-	0.8	-	-	0.8	-	-	1.8	1.8
WTE Therapist Multi Therapies	N/A	-	Q	-	-	-	-	-	64.82	-	-	13.53	-	-	23.03	23.03
WTE Therapist Psychotherapy (IAPT)	N/A	-	Q	-	-	-	-	-	0	-	-	0.00	-	-	2.00	2.00
WTE Therapist Social Services	N/A	-	Q	-	-	-	-	-	1.5	-	-	5.59	-	-	10.69	10.69
WTE Therapist Other Scientific, Therapeutic and Technical Staff	N/A	-	Q	-	-	-	-	-	0	-	-	47.23	-	-	49.61	49.61
WTE Scientist Clinical Psychology	N/A	-	Q	-	-	-	-	-	15.24	-	-	14.03	-	-	13.07	13.07
WTE Scientist Psychotherapy	N/A	-	Q	-	-	-	-	-	3	-	-	1.867	-	-	1.9	1.9
WTE Assistant Practitioner Clinical Psychology	N/A	-	Q	-	-	-	-	-	1	-	-	5	-	-	15	15
WTE Helper/Assistant Other Scientific, Therapeutic and Technical Staff	N/A	-	Q	-	-	-	-	-	1	-	-	0	-	-	0	0
WTE Consultant Therapist / Scientist Other Scientific, Therapeutic & Technical Staff	N/A	-	Q	-	-	-	-	-	0	-	-	0	-	-	2.6	2.6
<b>WTE Scientific, Therapeutic and Technical Staff Total</b>	<b>N/A</b>	<b>-</b>	<b>Q</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>92.26</b>	<b>-</b>	<b>-</b>	<b>93.65</b>	<b>-</b>	<b>-</b>	<b>126.27</b>	<b>126.27</b>
WTE UNK	N/A	-	Q	-	-	-	-	-	8.75	-	-	0	-	-	7.5	7.5
<b>WTE UNK Total</b>	<b>N/A</b>	<b>-</b>	<b>Q</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>8.75</b>	<b>-</b>	<b>-</b>	<b>0</b>	<b>-</b>	<b>-</b>	<b>0</b>	<b>0</b>
<b>WTE Grand Total</b>	<b>N/A</b>	<b>-</b>	<b>Q</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>148.85</b>	<b>-</b>	<b>-</b>	<b>156.49</b>	<b>-</b>	<b>-</b>	<b>203.47</b>	<b>203.47</b>

# Staffing of current services as at end March 2017

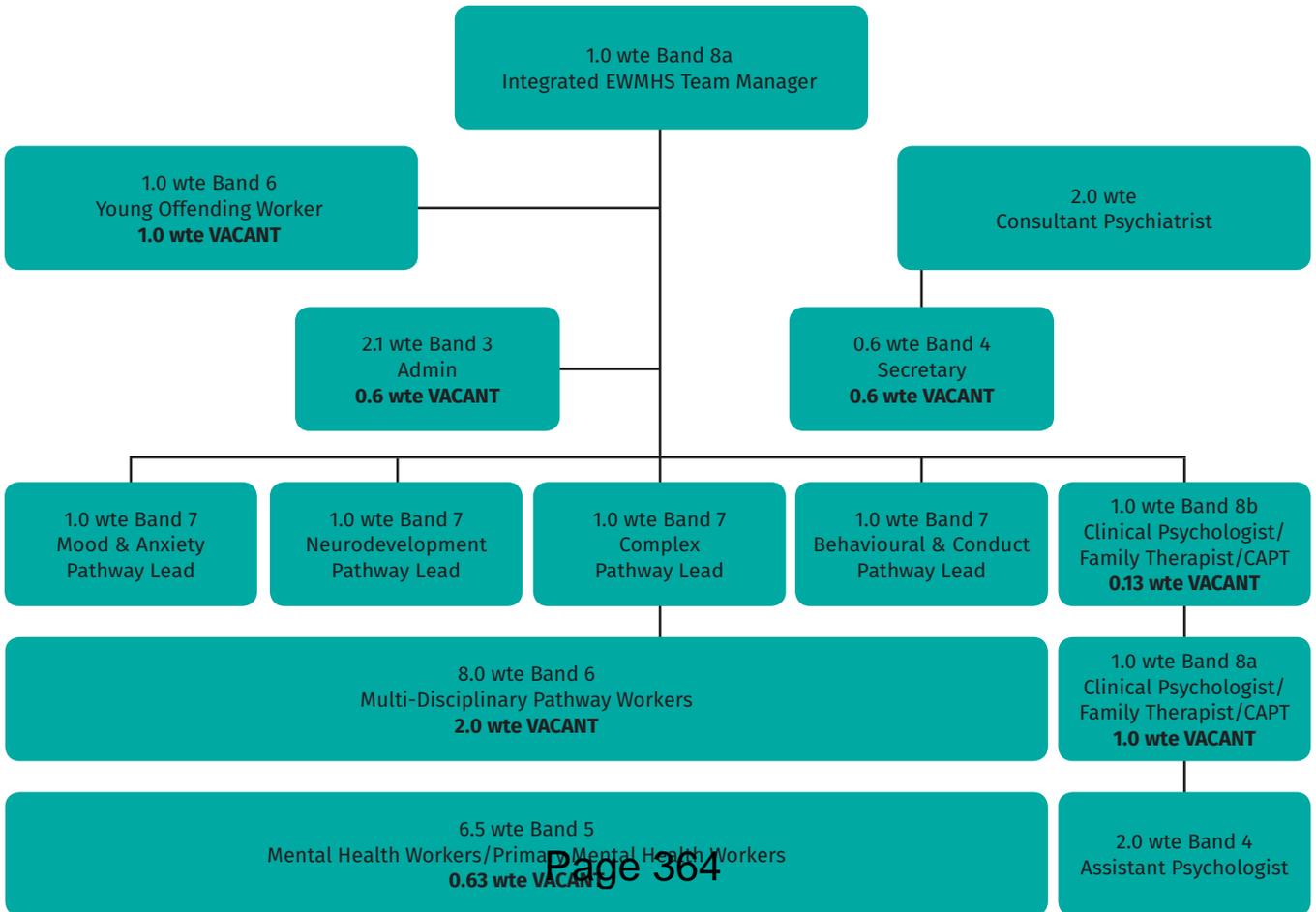
## EWMHS Southend



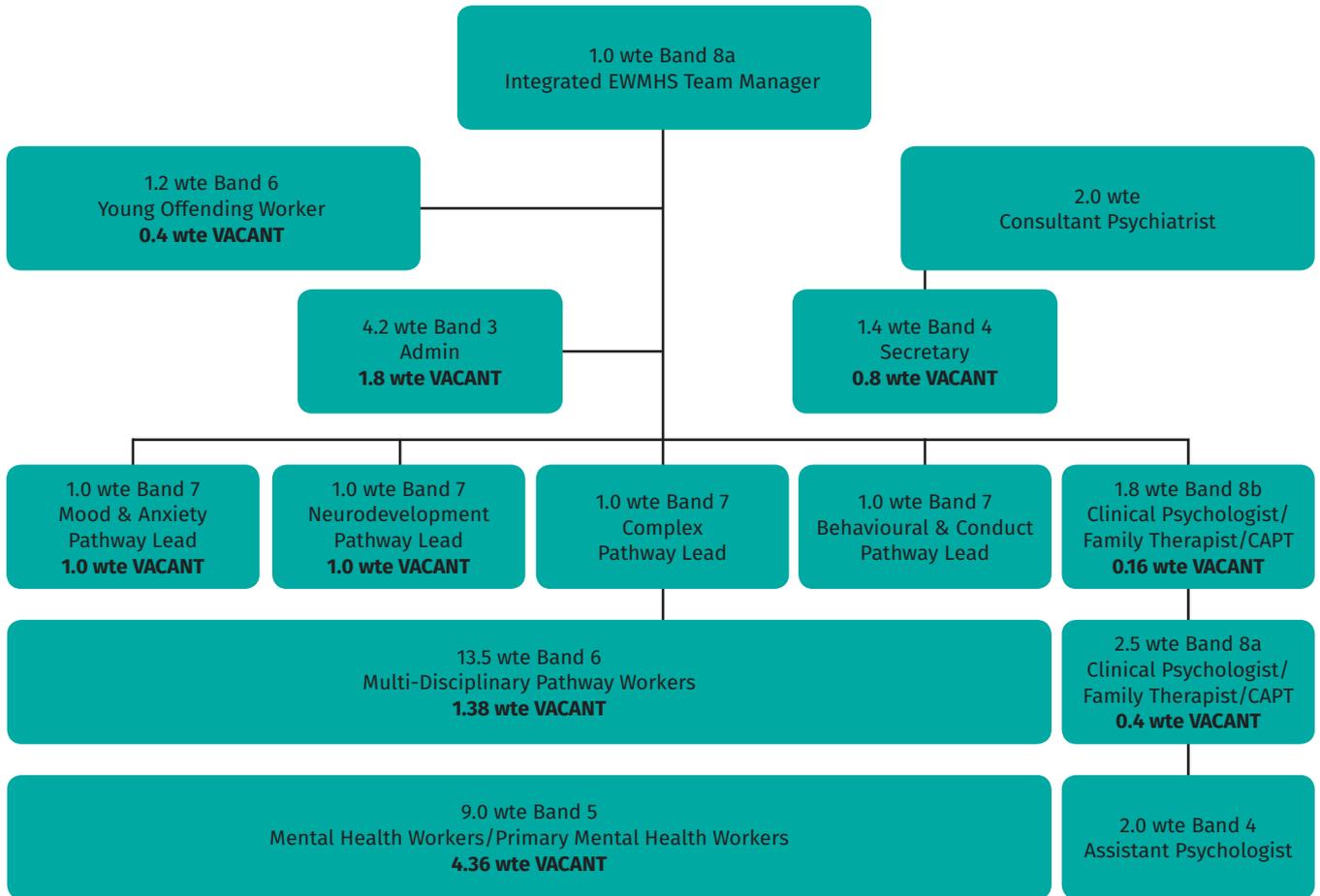
### EWMHS Basildon/Brentwood



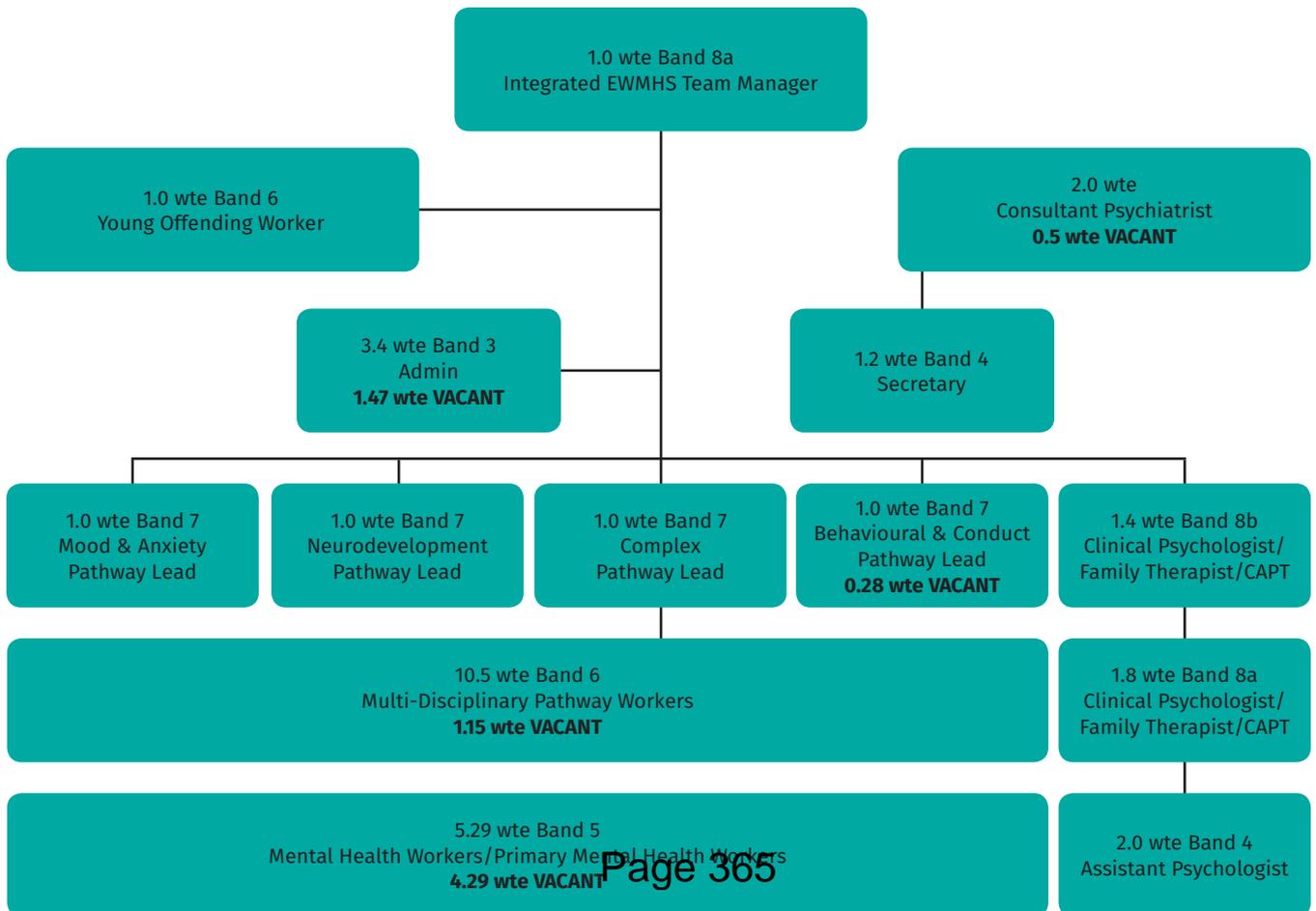
### EWMHS Southend



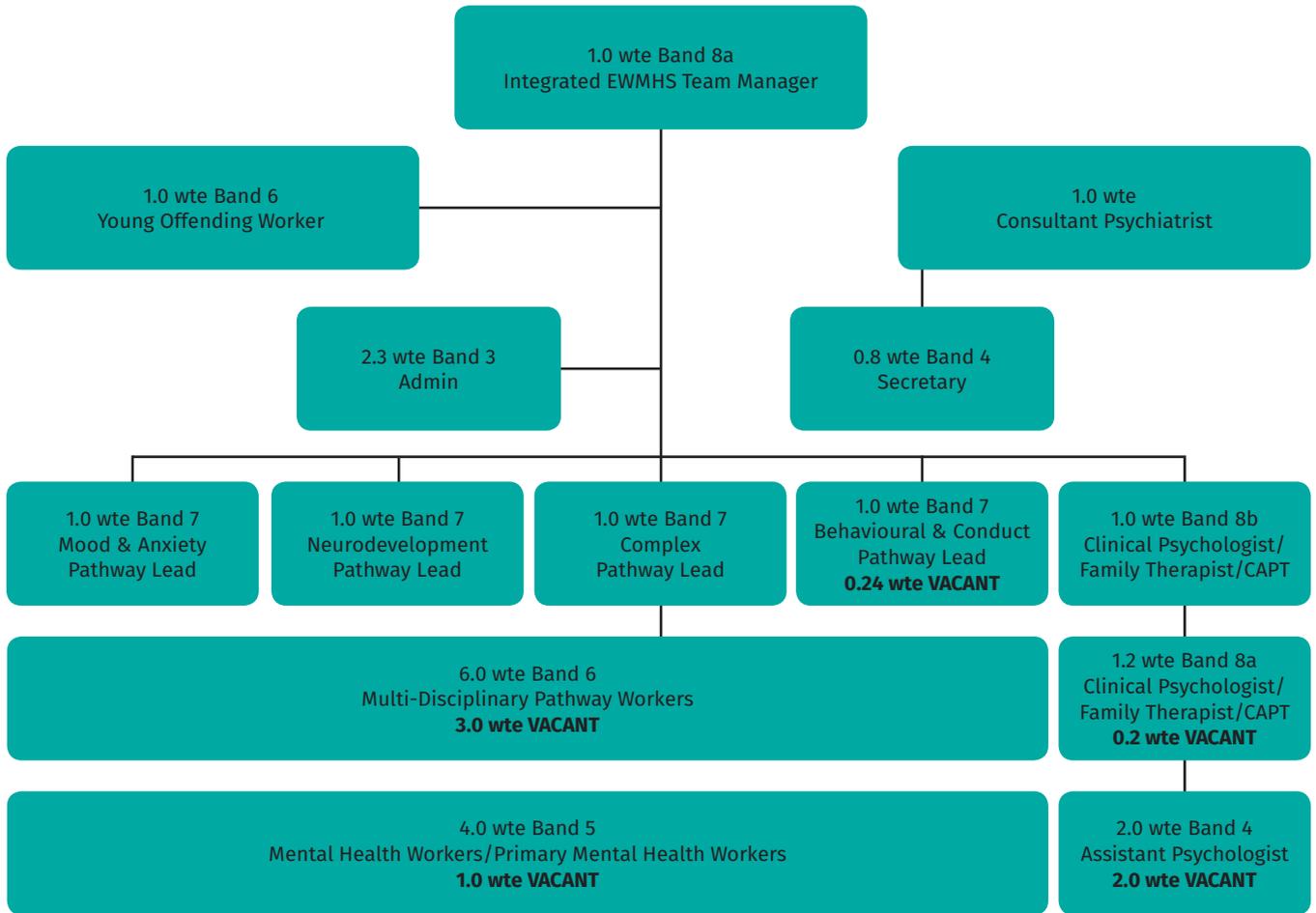
### EWMHS Mid Essex



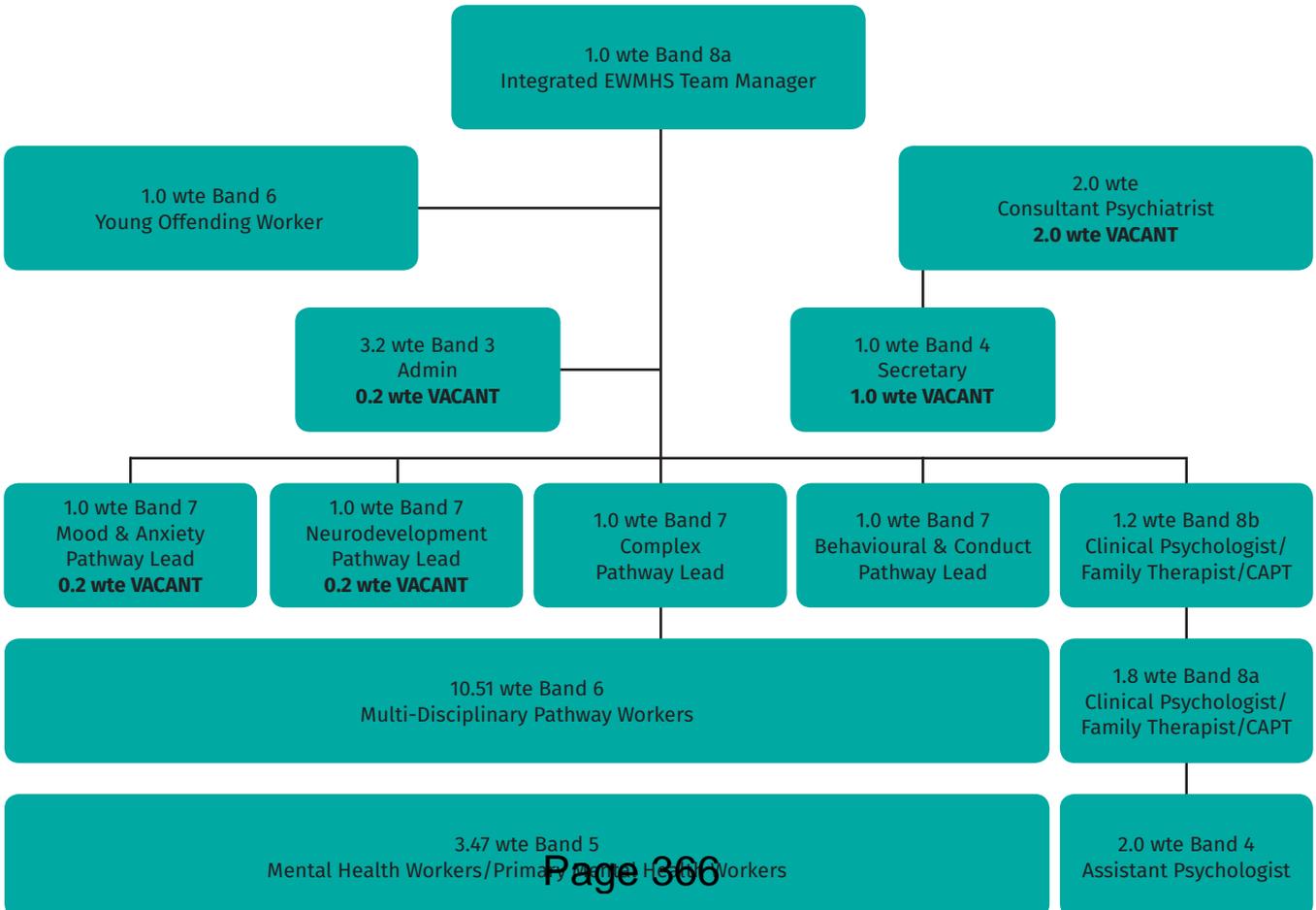
### EWMHS West Essex



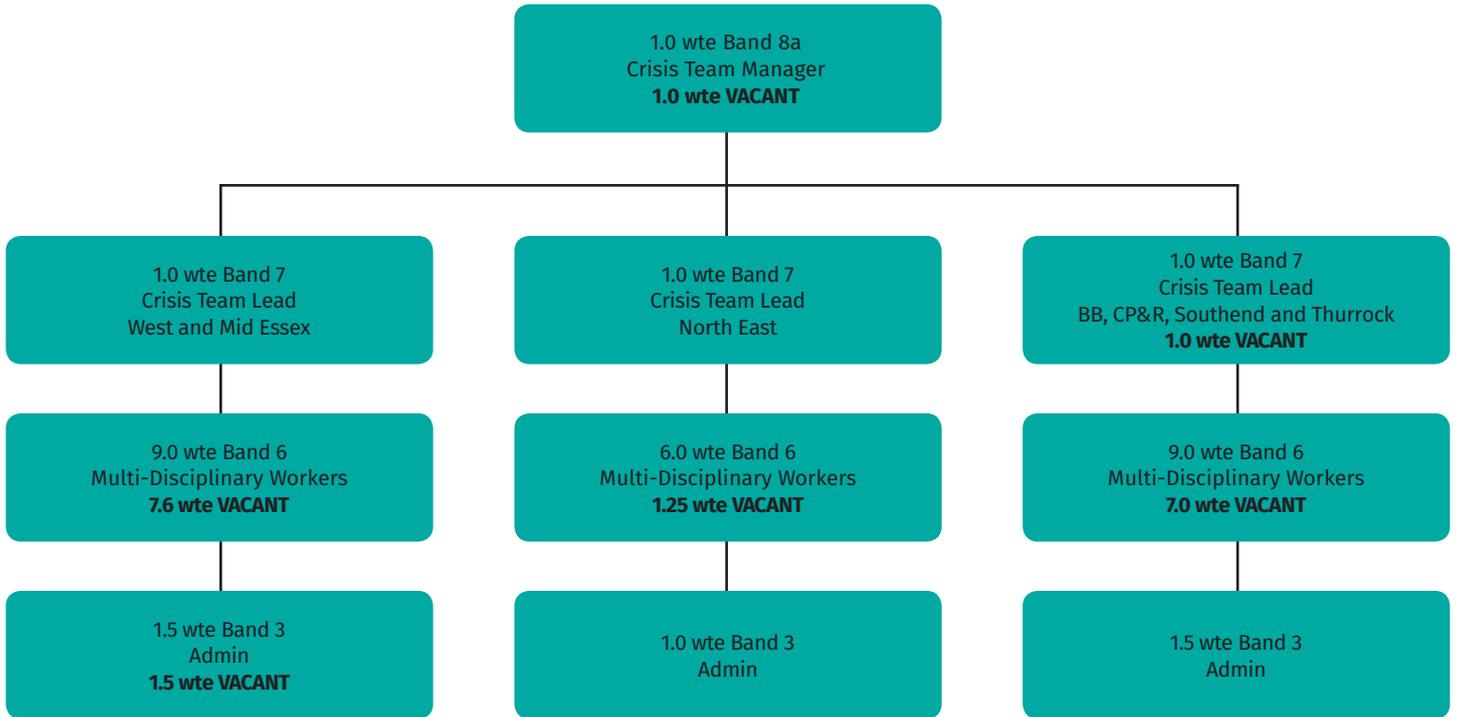
### EWMHS Thurrock



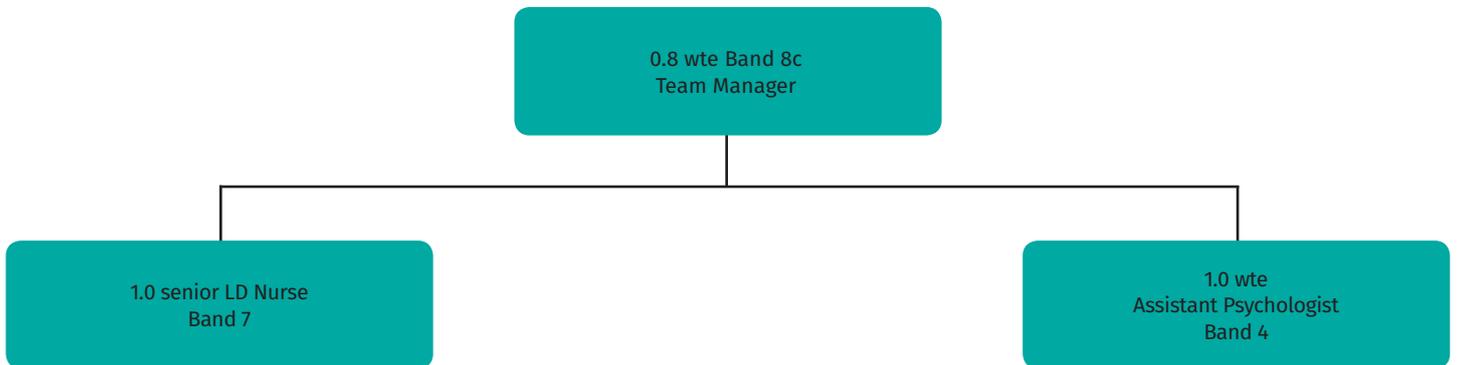
### EWMHS North Essex



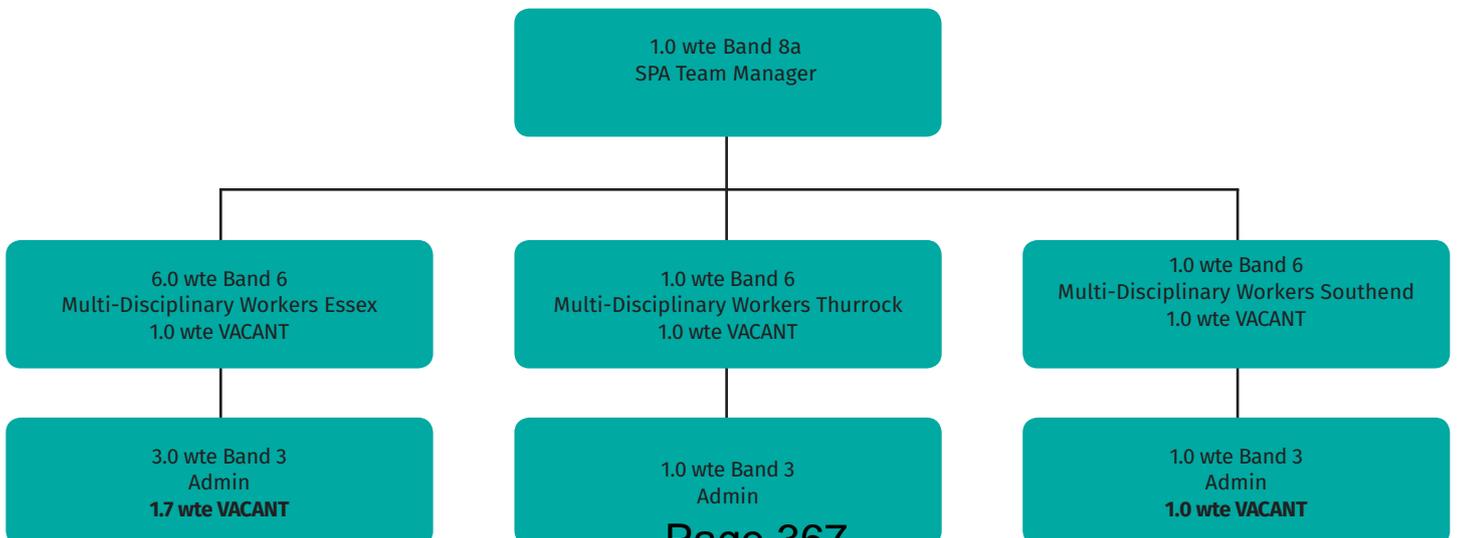
### EWMHS Crisis Team



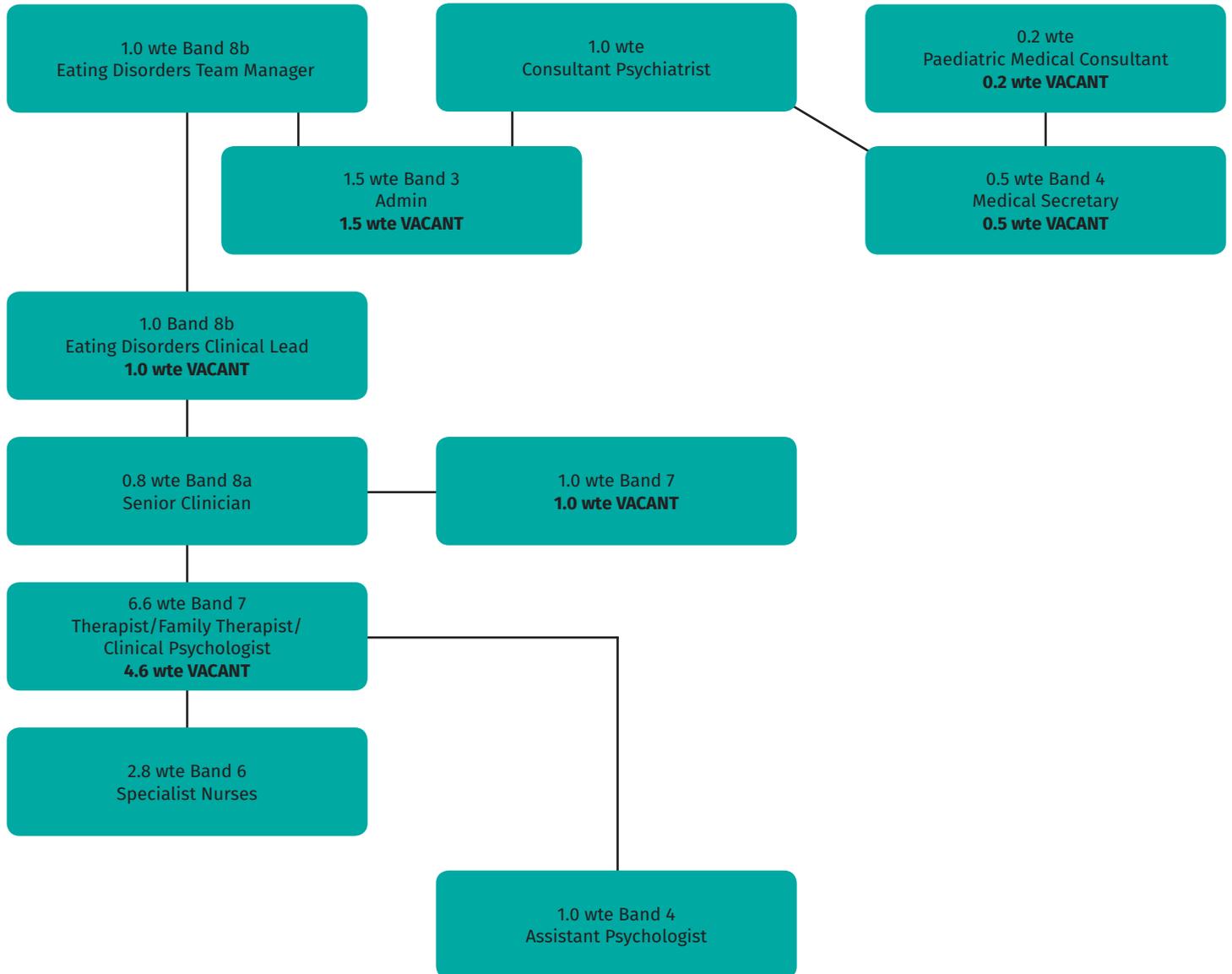
### EWMHS LD Team



### EWMHS SPA Team



### EWMHS Eating Disorders service



# CAMHS Tier 4 inpatient services

## Staffing of current services as at March 2017

### North Essex

Job Role	Band 2		Band 3		Band 4		Band 5		Band 6		Band 7		Band 8a		Band 8b		Total Tier 4	
	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE
Assistant	8	6.25															8	6.25
Assistant/Associate Practitioner																	0	0.40
Assistant/Associate Practitioner Nursing					4.4	9.34											4.4	9.34
Clinical Psychologist											1	0.00		1.00			2	2.00
Consultant																	2	2.00
Healthcare Assistant			14.4	13.54													14.4	13.54
Ward Matron													1	1.00			1	1.00
Nurse Manager											2	2.00					2	2.00
Occupational Therapist							0	1.00	1	1.00							1	2.00
Officer			3	2.25	2	2.00	1	1.00									6	5.25
Psychotherapist													2	2.93			3	3.93
Sister/Charge Nurse									6	6.86							6	5.86
Specialty Doctor																	2	1.00
Specialty Registrar																	1	2.00
Staff Nurse							10.4	12.33									10.4	12.33
Supervisor			1	1.00													1	1.00

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## South Essex

Job Role	Band 2		Band 3		Band 4		Band 5		Band 6		Band 7		Band 8a		Band 8b		Total Tier 4	
	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE
Nursing	8	7.89	6	6.00			6	8.24	2	2.00			1	1.00			23	22.00
Psychology													1	0.7	1	0.7	2	1.4
Occupational Therapist									1	1.00								
Family Therapy											1	1.00					1	1.00
Psychology Assistant					1	0.7											1	0.7
Medical Staff																		
Consultant																	1	1.00
SpR																	1	1.00
Staff Grade																	1	1.00
Admin																	2	2.00
Advocate Service																	1	0.2

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## Appendix 5

# Terms of Reference for the Child and Adolescent Mental Health Strategic Oversight Group, Collaborative Commissioning Forum, and Local Transformation Plan (LTP) Service Delivery Group

Southend Essex and Thurrock Child and Adolescent Mental Health Services (CAMHS) Strategic Oversight Group (SOG)

### Terms of Reference

#### Purpose

The purpose of this group is to have senior representation to ensure oversight of the complete CAMHS agenda. The meeting will be used as a Forum for discussion on all strategic matters relating to children's mental health including the STPs and as a means of sustaining the integrated commissioning arrangements across Southend Essex and Thurrock Local Authorities and Essex CCGs.

#### Governance

See Governance Chart below.

#### Functions

The group's key functions will be to:

- Act as the strategic forum for CAMHS transformation
- Oversee future iterations of the Local Transformation Plan (LTP)
- Monitor delivery of the LTP via assurance reports from the LTP Service Delivery Group
- Consider matters escalated from the Collaborative Commissioning Forum regarding the service contract and service delivery
- Ensure consistency and deliverability for matters to children's mental health across the three Sustainability and Transformation Plans (STP)
- Act as a Forum to explore all age approaches to mental health
- Ensure oversight of children's elements of the overarching mental health strategy

**Modus operandi**

Members of the group will:

- Act openly and transparently
- Respect the processes and business imperatives of partner organisations
- Be committed to resolving challenges through joint commissioning and partnership focused solutions
- Be creative
- Promote the interests of children and young people at all times

**Membership and Frequency of Meetings**

Membership is made up of one representative from each commissioning partner. For the CCGs the member should be either the AO or the DoN and for the local authorities an appropriate director. The strategic lead for CAMHS will be in attendance.

Meetings will be held monthly.

**Quoracy**

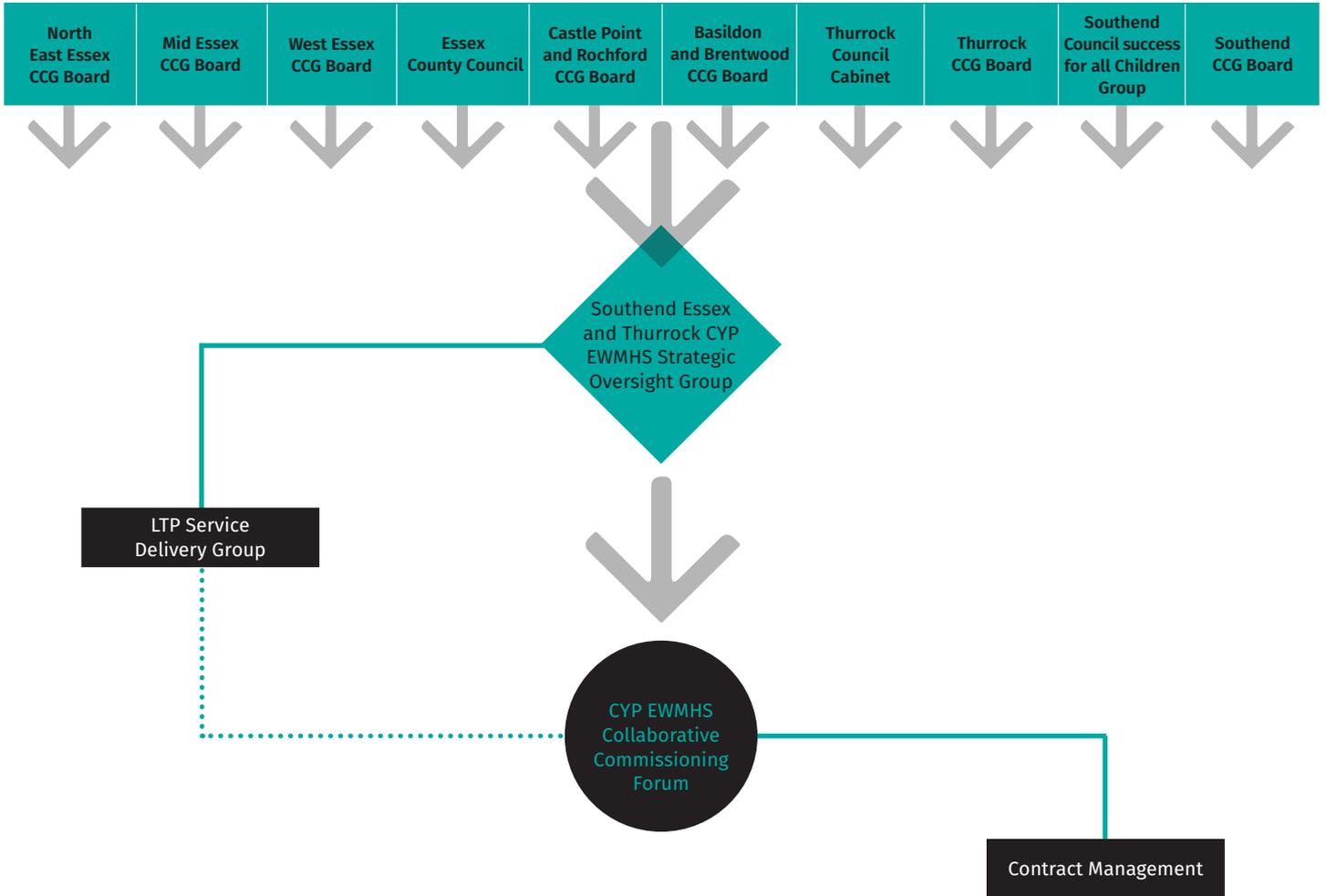
The group will be quorate with 4 CCG representatives and 2 LA representatives.

**Review**

These Terms of Reference will subject to regular review no later than 31st March 2017

Governance

### Children and Young People (CYP) Emotional Wellbeing and Mental Health Service (EWMHS) Partnership Governance



# Children and Young Peoples Emotional Wellbeing and Mental Health Service Collaborative Commissioning Forum (CCF)

## Terms of Reference

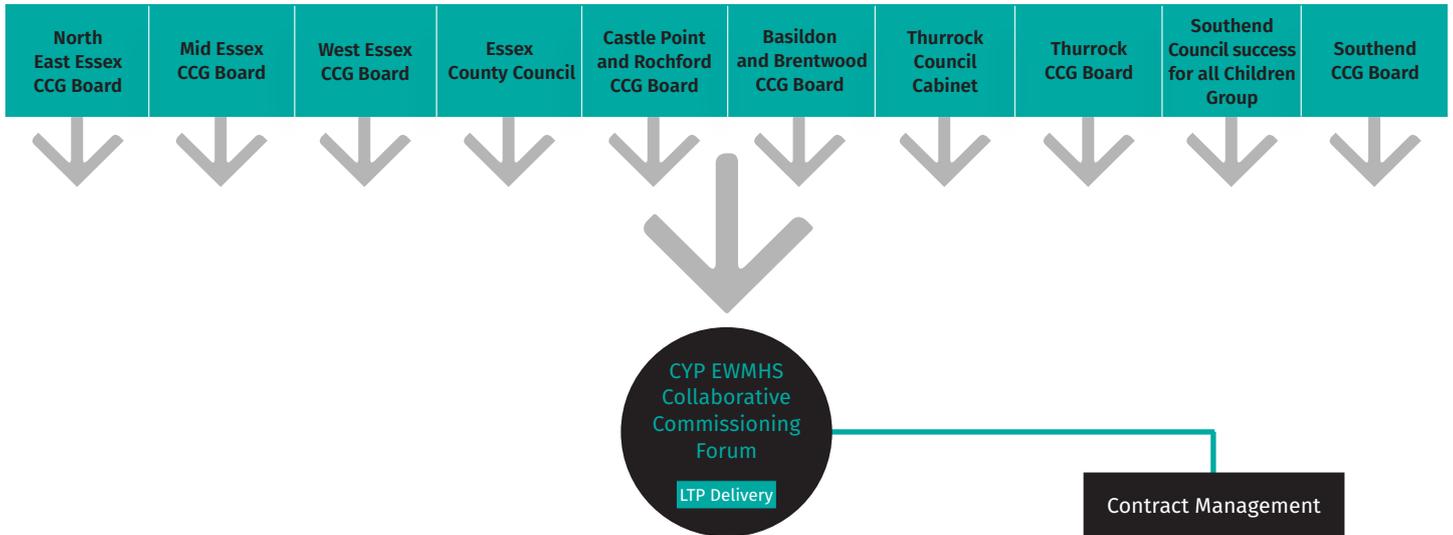
### Purpose

The Collaborative Forum has been established following award of the contract on the 1st June 2015, by agreement of the Commissioners. This forum will be used as the focus for discussion of all matters relating to Children and Young People’s Emotional Wellbeing and Mental Health (CYP EWMH) including strategic planning the commissioning contract, mobilising the LTP priorities/funding and the pursuit of the objectives and performance of the function of the Collaborative.

### Governance

Below is a map detailing the governance for the collaborative commissioning forum.

### Children and Young People (CYP) Emotional Wellbeing and Mental Health Service (EWMHS) Partnership Governance



## Functions

The Collaborative Forum's key functions are to:

- Act as the strategic forum for CYP EWMH transformation
- Act as the strategic forum to agree and mobilise LTP priorities and agree release of LTP funding
- Share information that enables collective understanding of any gaps in locally commissioned services that are impacting on children and young people.
- Use information to inform future commissioning intentions. This may include both the EWMHS services and also where there are gaps in local pathways at CCG/LA level.
- Oversee the production of a CYP EWMH strategy and transformation plan
- Monitor subsequent delivery of CYP EWMH strategy and transformation plan
- Discuss matters relating to the CYP EWMH commissioning contract and the pursuit of the objectives and performance of the function of the Collaborative.
- Monitor performance of the provider against contract and KPIs
- Monitor mobilisation plans of the new provider

## Modus operandi

Members of this group will undertake to:

- Act in an open, transparent and honest way
- Respect the processes and business imperatives of partner organisations both commissioners and providers
- Individual CCF members will be responsible for consistent cascade of information and communication of the work of the CCF back into partner organisations.
- Be creative in resolving the difficult issues raised through joint commissioning and partnership arrangements
- Conduct business on a consensual basis

## Membership and frequency of meetings

Membership is made up of one appointed senior representative from each commissioner with the delegated authority and responsibility to make decisions for their organisation. The group will be chaired by a local authority representative and the deputy chair will be appointed by the lead commissioner (West Essex CCG). The secretary for the forum will also be appointed by the lead commissioner.

The group will be chaired by: **Chris Martin**

The deputy chair is: **Jane Kinnibugh**

The group will be administered by: **Caroline Durell**

Meetings will be held monthly, with the agenda circulated 5 working days prior.

From time to time work will be carried out virtually by email or conference calls.

Organisation	Position	Name
Essex County Council – Chair	Commissioning Director – Children	Chris Martin
West Essex CCG – Deputy Chair	Director of Nursing	Jane Kinniburgh
Secretary	Joint CETR Co-ordinating Manager & EWMHS Administrator	Caroline Durell
<b>Children's commissioner</b>		
West Essex CCG	Head of Children's Commissioning	Jess Ford
North East Essex CCG	Senior Mental Health Commissioning Manager	Charlie Davies
Mid Essex CCG	Senior Commissioning Manager	Olabisi Williams
Castle Point and Rochford CCG	Strategy & Commissioning Manager – Children & Transition	Angela Ejoh
Basildon and Brentwood CCG	Senior Commissioning Manager	Alfred Bandakpara-Taylor
Thurrock CCG	Senior Commissioner for Children	Helen Farmer
Southend CCG	Strategy & Commissioning Manager – Children & Transition	Angela Ejoh
Thurrock Borough Council	Strategic Lead Children's Commissioning	Sue Green
Southend Borough Council	Strategy & Commissioning Manager – Children & Transition	Angela Ejoh
Essex County Council	Head of Commissioning – People	Clare Hardy
<b>Senior Director/Nurse</b>		
West Essex CCG	As above	As above
North East Essex CCG	TBC	TBC
Mid Essex CCG	Director of Finance	Dee Davey
Castle Point and Rochford CCG	Director of Strategy, Commissioning & Procurement	Jacqui Lansley
Basildon and Brentwood CCG	Director of Transformation	William Guy
Thurrock CCG	Director of Nursing	Jane Foster-Taylor
Southend CCG	Director of Strategy, Commissioning & Procurement	Jacqui Lansley
Thurrock Borough Council	Strategic Lead Children's Commissioning	Sue Green
Southend Borough Council	Director of Strategy, Commissioning & Procurement	Jacqui Lansley
Essex County Council	As above	As above
<b>Lead Commissioners</b>		
West Essex CCG	Assistant Director CAMHS Commissioning	Jessica Thom
West Essex CCG	CAMHS Commissioning Manager	Dawn Bolingbroke
West Essex CCG	Quality Lead	Theresa Smith
West Essex CCG	Contract Accountant	Chanuri Rodrigo

**Version Control**

Date	Version	Author	Summary of Changes
13/05/15	V.1	Alfie Ward	Produced initial Draft
19/08/2015	V.2	Sallie Mills Lewis	Review of functions
01/08/2017	V.3	Jessica Thom	Review of membership and functions
14/09/2017	V.4	Jessica Thom	Update on members

# Southend, Essex and Thurrock LTP Service Delivery Group

## Terms of Reference

### Purpose

- 1 The purpose of the Service Delivery Group is to provide a time limited task and finish group to oversee delivery and implementation of the priority work streams identified within the Essex Local Transformation Plan (LTP) for improving emotional wellbeing and mental health outcomes for children and young people.

### Objectives

- 2 To ensure that there are clear actions, targets and milestones for development and implementation of those priority work streams identified within the LTP, and set out below:
  - Development of an enhanced evidence based community eating disorder service.
  - Development of an Emotional Wellbeing and Mental Health Joint Strategic Needs Assessment
  - Refresh of the Southend Essex and Thurrock LTP
  - Active engagement and co-production with children and young people in the community across all CCG localities
  - Audit of effectiveness of teenage suicide prevention guidance and a review of the support required to prevent and manage self-harm
  - Medicines management review
  - Enhanced crisis service cover 24 hours a day seven days a week and building capacity to provide emergency care within the home
  - Enhanced staffing capacity in the Single Points of Access teams
  - Enhanced senior psychology staffing capacity
  - Enhanced junior psychology staffing capacity
  - Enhanced locality team capacity with a focus on low to moderate needs
  - Enhanced locality team management
  - Development and implementation of local bespoke children and young people IAPT training programs with a focus on Primary Mental Health Workers
  - Building community resilience by providing additional support to schools
  - Enhanced medical capacity (5 junior doctor posts) to respond to children and young people with more complex needs
- 3 To ensure the priority work streams are developed and implemented within agreed timescales.

## Membership

4 The Service Delivery Group will be chaired by the Essex CAMHS Strategic Lead, West Essex CCG.

5 The membership of the Service delivery Group will comprise of;

- Commissioning and Strategic Leads for Thurrock LA, Southend LA, ECC, CCGs
- Service Leads for NELFT
- Education commissioner representative
- Voluntary Sector representative
- Healthwatch Essex representative
- YOT representative
- NHSE Specialised Commissioning representative
- Adult Mental Health Commissioning representatives
- GP leads
- Public Health Commissioning representative

## Frequency of meetings

6 The Service Delivery Group will meet monthly

7 Lead commissioners will ensure that the work streams to be developed and implemented by NELFT are monitored through the monthly contract management meetings

## Governance

8 The Service Delivery Group will report to the CAMHS Collaborative Commissioning Forum.

# Appendix 6 Key Performance Indicators

LTP work stream	Description of local priority	Funding stream	Service user group that the priority is targeted at e.g. Under 18s with Eating Disorders, LAC, CYP who are sexually exploited	What is the evidence base for this intervention?	The expected outcome of the scheme	Main KPI	KPI baseline	KPI target	Date KPI to be achieved	Delivery of KPI
LTP 1	Create a specialist but community based eating disorder service. A multidisciplinary service covering all of Essex is proposed offering community based NICE (National Institute for Health and Care Excellence) concordant treatment. Intensive community support and specialist family based treatments are a core component. The specialist team will comprise medical and non-medical staff with significant eating disorder expertise and appropriate capacity and skills to meet the Access and Waiting Time Standard.	Eating Disorders	Under 18s with Eating Disorders inclusive of all vulnerable groups	NCCMH's England guidelines 2015	Improved waiting times and access, improved outcomes, reduced admissions to Tier 4	To record % of cases that received NICE concordant treatment within the standard's timeframes	10% of presenting cases	10% of presenting cases	March 2018 - 95% by 2020/21	KPI on track to deliver and reviewed in view of 95% target by 2020/21. Unify waiting time reporting demonstrates on target for compliance with standards
LTP 2	Deep dive needs analysis across each of the CCGs	15/16 Transformation Funds	All CYP but targeted at vulnerable groups	Part of evidence based development	Detailed knowledge of the CYP population needs across Essex	Delivery of quality assured needs assessment by March 2016	Not applicable	100% completion	Mar-16	100% completion delivered September 2016. Due for sign off by Essex Health and Wellbeing Board
LTP 3	Publication of the Southern Essex and Thurrock Local Transformation Plan	15/16 Transformation Funds	All CYP but targeted at vulnerable groups	Compliance with National guidance	Better informed CYP families and partners	Delivery of Plan with required timeframes	Not applicable	100% completion	Mar-16	100% completion and sign off by Lead commissioner, West Essex CCG on behalf of all 7 Essex CCGs, Thurrock and Southern Borough Councils and Essex County Council. Published on all ten partners websites and signed off by all three LA Health and Wellbeing Boards
LTP 4	Active engagement with CYP in partnership with Resprocent	15/16 Transformation Funds	All CYP	Best practice	Genuine engagement and co-production with CYP in the community	Number of accredited training places by locality	To be established during phase 1	10% of the total young people expressing an interest	Mar-17	Existing work is on track to deliver the following milestones: work has begun and is looking to roll out over the coming months. Launch of App October 2016. Campaigns in November, January and March. KPIs and Outcome measures for the Project will commence in November - including the anecdotes / qualitative outcomes
LTP 5	Improved RMT equipment, training and infrastructure	15/16 Transformation Funds	All CYP	Enabler for NICE compliance best practice	Agile working, real time outcome capture from CYP, better informed working practice	Number and % of service users with improving outcome scores	To be established	To be agreed from year 2 onwards	Mar-17	Original KPI not met. Revised KPI baseline to be established. KPI revised to March 2016.
LTP 6	PMO to deliver mobilisation and transformation work streams	15/16 Transformation Funds	All CYP	Delivery of national guidance	New service mobilised and new model of care being delivered implementation of new schemes on track	Not applicable as this is an enabler to ensure delivery of all KPIs	Not applicable	Not applicable	Mar-16	New service model mobilised but pace of change slower than anticipated
LTP 7	Suicide and self harm audits	15/16 Transformation Funds	All CYP	Best practice	Understanding of gaps and needs to identify next steps and improvements	Audit completed	Not applicable	Audit completed and action plan developed	Mar-16	100% completion delivered September 2016. Further investment to be considered in support of recommendations
LTP 8	Medicines management review	15/16 Transformation Funds	All CYP who are on prescribed medication	Best practice, NICE guidance, formulary compliance	Effective prescribing and monitoring of medication, improved collaborative working with other community service providers and improved access to medicines advice	Review completed	Not applicable	Review completed and forward plan developed	Mar-16	KPI not met. Delay in recruitment of Pharmacist - due to commence employment November 2016. Audit Plan completed. New date KPI to be achieved March 2017
LTP 9	Safe and effective mobilisation of the new integrated Essex wide EIMHS	15/16 Transformation Funds	All CYP and their families across Southern Essex and Thurrock	Best practice NICE guidance and national guidelines	Better access, earlier intervention, support to schools, improved crisis response, better outcome for CYP and their families	Improved access	To be established during 2015/16	95% within 18 weeks	Mar-16	KPI achieved as @ end of March 2016 but have not been able to agree a stretch target due to increased demand and deterioration in waiting times in year. Action plan with trajectory in place to achieve 95% before March 2017
LTP 10	Extending crisis services to 7 days per week 9am-5pm and building capacity for emergency care at home	15/16 Transformation Funds	All CYP who require crisis intervention	Crisis care concordant and response to identified local need	Fewer CAMHS presentations at A+E. Reduced demand on Tier 4. More home based packages of care available	4 hour response time	New service model	100%	Mar-16	KPI achieved. Monitored on a monthly basis
LTP 11	Enhanced staffing to improve single points of access	15/16 Transformation Funds	All CYP	Best practice and national guidance	Better access earlier intervention, quicker response	Response time within 48 hours	New service model	90%	Mar-16	KPI on track to deliver
LTP 12	Enhanced senior psychology services to assure high quality supervision	15/16 Transformation Funds	All CYP	CYP IAPT	Enhances patient safety improved outcomes	Improved individual clinical outcomes	Established 2015/16 as new service	To be agreed by end March 2016	Mar-17	KPI achieved. All new posts filled
LTP 13	Increased junior capacity within psychology at local level to enhance service delivery	15/16 Transformation Funds	All CYP	CYP IAPT	Improved skill mix leading to better individual clinical outcomes	Improved individual clinical outcomes	Established 2015/16 as new service	To be agreed by end of March 2016	Mar-17	KPI achieved. All new posts filled
LTP 14	Additional locality team capacity with a focus on low intensity support	15/16 Transformation Funds	All CYP with low to moderate mental health needs	CYP IAPT, early intervention national evidence regards intervening early	Improved capacity to ensure early access	Increased numbers of referrals	To be established as part of the new service	To be agreed by the end of March 2016	Mar-17	KPI achieved. Increased number of referrals absorbed into planned activity for 2016/17
LTP 15	Increase medical capacity (5 junior doctor posts) to increase our ability to respond CYP with more complex needs (SEMG, US, ADHD, ASD)	17/18 Transformation Funds	Vulnerable groups of CYP	Best practice, multi-agency working in partnership	Increased ability to respond to those CYP with more complex needs (SEMG, US, ASD, ADHD)	Improved individual clinical outcomes	Established as part of new service model	Appropriate KPIs to be set once the scheme has been finalised		
LTP 16	Enhanced locality team management	15/16 Transformation Funds	All CYP	Improved patient safety, national guidance	More capacity and capability within the system	Increased numbers of referrals	To be established as part of the new service	To be agreed by the end of March 2016	Mar-17	KPI on target
LTP 17	Additional local bespoke CYP IAPT courses focusing on Primary Mental Healthcare workers over and above the national IAPT training programme	15/16 Transformation Funds	All CYP	CYP IAPT	Enhanced evidence base practice delivered by junior workers achieving rapid cultural change	Number of staff trained	Establish baseline	20 who staff trained per annum	Mar-17	KPI on target.
LTP 18	Locality partnership development	15/16 Transformation Funds	Vulnerable groups of CYP	Partnership working	Qualitative input into deeper dive assessment of local need	1 development session per locality	Not applicable	7 sessions completed and local priorities identified	Mar-16	KPI achieved
LTP 19	Building community resilience by providing additional support to schools and the voluntary sector	15/16 Transformation Funds	All CYP	National guidance and best practice	Increased confidence in identifying mental health problems and more children supported in schools and in the community setting	Not applicable	Not applicable	Not applicable	Mar-16	KPI achieved. Rolling programme of training and development for schools based on the priorities identified by Essex schools. Pilots to be rolled out November 2016 in each of the three LA areas.
LTP 20	Transformation support costs	15/16 Transformation Funds	All CYP	Collaborative working across all agencies delivering services for CYP	Integrated service delivery and easier access and streamlined service delivery for CYP	Not applicable	Not applicable	Not applicable	Mar-16	KPI achieved
Work stream	Pediatric psychiatric liaison	15/16 Transformation Funds	Vulnerable groups of CYP	Collaborative working across service providers and targeting of vulnerable groups	Enhanced support for those children with highly complex healthcare needs	Improved individual clinical outcomes	To be established	To be established	Mar-16	KPI achieved. Pilots to be rolled out into mainstream services funded via CCGs community childrens services.
Work stream	Improved access	15/16 Transformation Funds	All CYP	Improving access and waiting times for CYP	More CYP are seen earlier	Shorter waiting times	Established 2015/16 as new service	To be established	Mar-16	KPI not met. Addressed through other work streams within the LTP
LTP-21	Publicity Communication and Engagement	16/17 Transformation Funds	All CYP	Best practice	Genuine engagement with voluntary sector and communities including proactive engagement with CYP	To be established once the scheme has been finalised				
LTP-22	Care and Treatment Review	16/17 Transformation Funds	CYP with LD and/or Autism, Challenging Behaviour and Mental Health problems	National guidance and best practice. Improving access. Collaborative working across service providers	Improved access and a better service offer for these CYP and their families. Reduction in admissions and LOS in Tier 4. Reduced presentations at A+E for this client group	To be established once the scheme has been finalised				
LTP-23	Transitions	16/17 Transformation Funds	All CYP	National guidance and best practice. Collaborative working	More facilitated support for CYP who do not meet the criteria for AMHS	Multi-agency transitions protocol to be developed	Not applicable	Transitions protocol developed and options for additional support services explored	Mar-18	Review completed and forward plan developed
LTP-24	Childrens LD	16/17 Transformation Funds	Vulnerable groups of CYP	National guidance and best practice. Improving access	Improved access and a better service offer across Essex	Review of current service provision across Essex	Not applicable	Review completed and forward plan developed	Nov-17	

## Would you like this information in another format?

If you would like this information in a different language or another format such as braille or large print, please contact us at the office below:

**Communications, West Essex CCG**

**Tel: 01992 566140**

**Email: [weccg.comms@nhs.net](mailto:weccg.comms@nhs.net)**

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**MINUTES**  
**Integrated Commissioning Executive**  
 30 November 2017

<b>Attendees</b>
Roger Harris (RH) – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Mark Tebbs (MT) – Director of Commissioning, NHS Thurrock CCG
Jane Foster-Taylor (JFT) – Chief Nurse, NHS Thurrock CCG
Jeanette Hucey (JH) – Director of Transformation, NHS Thurrock CCG
Tendai Mngangwa (TM) - Head of Finance, NHS Thurrock CCG
David Mountford, (DM) Interim Chief Finance Officer, NHS Thurrock CCG
Jo Freeman (JF) – Management Accountant, Thurrock Council
Catherine Wilson (CW) – Strategic Lead for Commissioning and Procurement, Thurrock Council
Emma Sanford (ES) - Strategic Lead-Health & Social Care, Thurrock Council
Iqbal Vaza (IV) – Strategic Lead for Performance, Quality and Information, Thurrock Council
Maria Payne(AL) – Senior Public Health Manager, Thurrock Council
Allison Hall (AH) – Commissioning Officer, Thurrock Council
Ceri Armstrong (CA) – Senior Health and Social Care Development Manager , Thurrock Council
Christopher Smith (CS) – Programme Manager Health and Social Care Transformation, Thurrock Council

<b>Apologies</b>
Mandy Ansell (MA) – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Ian Wake (IW) – Director of Public Health, Thurrock Council
Les Billingham (LB) – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Mike Jones (MJ) – Strategic Resources Accountant, Thurrock Council

<b>Item No.</b>	<b>Subject</b>	<b>Action Owner and Deadlines</b>
<b>1.</b>	<b>Welcome and Introductions</b>	
	RH agreed to Chair the meeting and introductions were made.  No conflicts of interest were declared.	
<b>2.</b>	<b>Minutes of the last meeting</b>	
	The minutes were agreed.  Matters arising: <ul style="list-style-type: none"> <li>It was noted that the letter of approval from NHS England for the Thurrock Better Care Fund Plan 2017-19 had been received on 30 October 2017.</li> </ul>	

	<ul style="list-style-type: none"> <li>•With regard to the action additional Public Health spending to be included in the BCF Pooled Fund, Jo and Tendai and Emma will meet to agree the necessary accounting treatment.</li> <li>•With regard to the action for Ian, Catherine, Jane, Irene Lewsey, and Philip Clark to meet to get a better understanding of the blockages, and to draft a plan to improve flows involving assessments, the matter will be discussed further in the DTOC item below.</li> <li>•In relation to the action for Iqbal and Catherine to review the Key Lines of Enquiry for Care Quality Commission Reviews, Jane offered to advise on the CCG practice for CQC visits.</li> <li>• With regard to sharing the performance report with the CCG Finance and Performance Committee, Ann and Iqbal to note there is a virtual meeting to be held on 15/12/2017, and the report will be sent by email.</li> <li>•It was noted that the Social Prescribing Business Case was on the agenda for the next meeting on 28 December. However, this meeting may need to be brought forward – depending on the volume of other business requiring discussion. Christopher to advise.</li> </ul>	<p>JF; TM; ES</p> <p>IV; CW; JFT</p> <p>AL; IV</p> <p>CS</p>
<b>3.</b>	<b>MedeAnalytics – Proof of Concept</b>	
	<p>Emma introduced the presentation by explaining that the objective was to demonstrate that the terms of Phase 1 proof of concept have been met. Specifically:</p> <ul style="list-style-type: none"> <li>• Data can be pseudo-anonymised at source in such a way that it can still be linked to other data sets</li> <li>• This data can be transferred using a secure FTP transfer process</li> <li>• The data can be linked with another data set that has been through the same process</li> <li>• The data can then be used to analyse patients common to the two data sets</li> </ul> <p>She said she hoped the Executive would sign off the proof of concept in order for the work to progress to further phases.</p> <p>The current dataset includes all BTUH inpatient data for the last 2 years 2015-17 (but not A&amp;E or outpatients data), and ASC data for the 4 years 2014-18.</p> <p>Iqbal noted that the limiting factor at this stage is the power of the data matching engine.</p> <p>Emma explained in one example that analysis has shown that those with ASC packages had fewer attendances at BTUH, with the exception of MSK episodes.</p> <p>Jane noted that at this stage community services data was</p>	<p>ES</p>

	<p>also not included, and that these were likely to include the most frail.</p> <p>Emma praised the capability of the dashboard facility, but noted that in terms of outputs this was work in progress.</p> <p>By way of a further example, she said she hoped to be able to identify changes in ASC packages following strokes or TIAs, and thus show the potential cost of strokes to ASC.</p> <p>David said in his experience the key to getting value from these types of systems was to ensure those using it have the necessary training.</p> <p>The system currently has issues related to defining cohorts, setting date ranges and identifying sequences of events for individuals.</p> <p>Regarding the inclusion of SUS data, Maria explained that issues have arisen with the Council's application to NHS Digital. A telephone call to resolve matters is booked for later today but it is not clear how long it will be before approval for the inclusion of SUS data will be received.</p> <p>Jane said a Privacy Impact Assessment for pseudonomised data from BTUH needs to be in place.</p> <p>Roger asked when the MDTs would be able to see identifiable patient data?</p> <p>Emma clarified that this data would only be accessible to those involved in direct patient care but will come after the Proof of Concept is signed off.</p> <p>Emma confirmed that as the data transfer and linking capability has been demonstrated, the recommendation was to sign off the Proof of Concept. Primary Care and Community Services data can then be added.</p> <p>She also confirmed that the agreement was that the contractor would be paid once the dataset were added, and so if IG issues which preclude data transfer were encountered there would be no cost.</p> <p>The plan was to start in Tilbury with a meeting scheduled for 4<sup>th</sup> December with GP practices and community providers including IAPT to determine IG processes and information sharing agreements.</p> <p>The meeting approved the recommendation on the Proof of Concept. Roger asked that the Executive be given a further update in 3 months (the meeting to be held on 22 February 2018).</p>	
4.	<p><b>Better Care Fund 2017-19</b></p> <ul style="list-style-type: none"> <li>• Update on the mobilisation of services in BCF schemes</li> </ul>	

	<p>Catherine confirmed the additional staff funded by the BCF were now in place.</p> <p>A proposal has been received from Ngage for the Home from Hospital service, and this could be in place in a few weeks as there was no requirement to tender.</p> <p>The Bridging service is to be extended (both the hours covered and the period of time the service will be offered). She agreed to bring further details to the next meeting.</p> <p>Roger asked for this to include mobilisation dates and costs.</p> <p>Mark suggested it should also include an indication of performance in relation to delayed transfers of care.</p> <p>•Mid Year Finance Review</p> <p>It was noted that the papers tabled do not currently show the slippage on the spend on individual projects. More time is needed to prepare this analysis and so discussion of the item was deferred to the next meeting.</p> <p>•Quarter 2 Return</p> <p>Allison introduced the Q2 Return. This was approved for submission. It was noted that performance in Q3 (due 19 January 2018) and Q4 may be more challenging. As the Q3 return will not be available for the next meeting it was agreed it would be signed off electronically.</p> <p>It was noted that the IBCF Return was also due on 19 January. This only requires being sign off by the Council but will be shared with the CCG.</p>	CW
5.	<p><b>BCF Performance report</b></p> <p>It has been understood that the November data, to be reported in January, will be used as the baseline for future performance. However, the letter from NHS England suggested the September data would be used.</p> <p>The weekly analysis provided by Ann is reckoned to capture 95% of the data (it is not possible to collect data from hospitals outside the area). This currently shows that while the target is 299 delayed days 348 days is projected to the end of the Month. However, it was agreed that the case needs to be made that the IBCF has in fact helped to prevent further delayed transfers of care.</p> <p>It was noted that the current month's delays were primarily attributed to ASC and Health delays were on target although the data has not yet been validated.</p> <p>Jane noted the impact of winter is reflected in the figures. Mark suggested that differentiating delays in this way was not helpful especially as we were attempting to address issues across the whole system.</p>	

	<p>It was agreed that Catherine would convene a meeting to look at the operational issues behind the delays and Public Health would be asked to provide some analysis.</p> <p>It was noted that the Council's procurement of Domiciliary Care was delayed because of the impact of the National Living Wage and the move to zoned rather than whole Borough lots. The successful tenders are now expected to be announced in early January 2018.</p>	CW/IL
<b>6</b>	<b>Update on Digital 2020</b>	
	<p>Iqbal explained that the Mid and South Essex STP bid for funding for digital integration had not been successful. However, the STP may now fund work to develop a plan for digital integration. This would include the capability for a shared care record. He agreed to draft a short report on the E Digital 2020 proposal for the Executive meeting in January 2018.</p>	IV
<b>8</b>	<b>Sustainability and Transformation Plan consultation</b>	
	<p>.It was noted that the Joint Committee has agreed to publish and consult on the Pre Consultation Business Case, although the proposal for Orsett Hospital is not yet available.</p>	
<b>9.</b>	<b>Any Other Business</b>	
	<p>Mark explained that the Accountable Care Partnership has been tasked with scoping new commissioning arrangements to include commissioning, contracting, gain share and an outcomes framework.</p> <p>Jeanette suggested this would need to be linked to the Sustainability and Transformation Plan but it was not clear how to do so. Common principles could be agreed but not pooling across the STP footprint.</p> <p>Roger suggested this should be taken forward by the a Steering Group including Mark, Catherine, Jeanette and himself</p>	RH/MT/JH/CW

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**MINUTES**  
**Integrated Commissioning Executive (ICE)**  
 25 January 2018

Attendees
Roger Harris – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Mandy Ansell – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Jane Foster-Taylor – Chief Nurse, NHS Thurrock CCG
Jeanette Hucey – Director of Transformation, NHS Thurrock CCG
Tendai Mngangwa - Head of Finance, NHS Thurrock CCG
David Mountford, Interim Chief Finance Officer, NHS Thurrock CCG
Mark Tebbs – Director of Commissioning, NHS Thurrock CCG
Ian Wake – Director of Public Health, Thurrock Council
Catherine Wilson – Strategic Lead for Commissioning and Procurement, Thurrock Council
Iqbal Vaza – Strategic Lead for Performance, Quality and Information, Thurrock Council
Les Billingham – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Allison Hall – Commissioning Officer, Thurrock Council
Christopher Smith – Programme Manager Health and Social Care Transformation, Thurrock Council
Darren Kristiansen – Business Manager Health and Wellbeing Board, Thurrock Council

Apologies
Mike Jones – Strategic Resources Accountant, Thurrock Council
Jo Freeman – Management Accountant, Thurrock Council
Ceri Armstrong - Senior Health and Social Care Development Manager , Thurrock Council

**1. Welcome and Introductions**

No conflicts of interest were declared.

**2. Minutes of the last meeting**

The minutes were agreed. Members considered action points arising at the 30 November 2017 ICE meeting. During discussions the following points were made:

- Emma Sanford (Public Health) is continuing discussions with Jo Freeman about the accounting treatment necessary to incorporate additional Public Health spending in the BCF Pooled Fund.

**Action Emma Sanford / Jo Freeman**

- The performance report has been provided electronically for consideration by the CCG Finance and Performance Committee. It was agreed that Dave Mountford will advise Council colleagues when the next meeting is being scheduled.

**Action Dave Mountford**

- The Social Prescribing Business Case has now been completed and is subject to evaluation. It was agreed that this would be considered at the next ICE meeting.  
**Action Jeanette Hucey.**

- The MedeAnalytics application to IGuard has now been approved by NHS Digital who is responsible for considering proposals to develop new processes. A meeting has now been scheduled with 8 GP practices across Tilbury and Chadwell. A meeting has also been arranged with NELFT to consider how to incorporate its data into the MedeAnalytics system. It was agreed that a further update will be provided at the next ICE meeting  
**Action Emma Sanford**

- CCG and Council officers have agreed through meetings outside of ICE that the Bridging Service contract should be extended for one year and will continue to support the efficient discharge of patients from hospital. The annual contract is £253,939.20 (1 February 2018 – 31 January 2019). It was agreed that funding would be considered and ratified by ICE members at the next meeting.  
**Action Catherine Wilson**

### 3. BCF Plan 2017 - 2019

#### Update on the mobilisation of services in BCF schemes

Catherine Wilson provided members with an update. Key points included:

- The following services are now operational:
  - By Your Side delivered by Ngage is providing a home from hospital service
  - The domiciliary care night service is an extended service.
- The community team has now recruited an additional staff member, providing additional resource and support.
- The Alzheimer's Society contract had been bolstered with additional financial support of £15,500 for the 2017/18 FY. The additional funding provides resources to manage additional demand for their memory and community service. It was agreed that consideration will be provided on whether the additional funding can be sustained for FY2018/19 at the next meeting.  
**Action Catherine Wilson**

- The Red Bag Initiative is now in place. Members learned that challenges had been experienced by other areas. It was agreed that Jane Foster-Taylor would discuss with Irene Lewsey further and update members at the next meeting.  
**Action Jane Foster-Taylor**

- The planned work focussed on older people's wellbeing has been deferred due to winter pressures. It was agreed that funding provided to NELFT can be extended for a period of three months.  
**Action Catherine Wilson**

- Catherine Wilson agreed to provide members with a summary note, to be circulated with these minutes. Members agreed that future update on the mobilisation of services in BCF schemes will include a verbal update and written paper.  
**Action Catherine Wilson**

#### Mid-Year Finance Review

Tendai Mngangwa introduced the agenda. The following points were made:

- The total value of underspend is £358,362 for FY 2017/18, some of which has been committed to provide the following:
  - Bridging Service (£42,000). It is anticipated that funding will be spent this FY.
  - Home from Hospital 'by your side' (£35,130). It is anticipated that funding may be spent this FY.
  - Stretched QOF in Tilbury and Chadwell (£34,000). It is anticipated that funding will not be used this FY.
  - Night Service John Stanley (£29,167). It is anticipated that this funding will be spent this FY.
  - Thurrock First system integration (£130,000). Members agreed that this funding should be clarified.

**Action Jo Freeman**

- The initial estimated underspend of £87,020 will be clarified at the next meeting to facilitate reallocation of finances and to determine the anticipated carry forward requirements for 2018/19 FY.

**Action Tendai Mhangagwa and Jo Freeman**

- Financial support has been committed to specific projects that include:
  - A falls prevention service (£311,500), which currently is estimated to underspend by £87,020. It was agreed that this would be confirmed and reported at the next ICE meeting.
  - The Hypertension Detection Project has now been rolled out to pharmacies and is also going to be rolled out to GP practices and community hubs. Members acknowledged that the scheme remains largely the same and only the partners involved in HDP are expanding. It was agreed that a paper would be provided at the February ICE meeting.

**Action Monica Scrobotovici**

#### Process for agreeing 18 – 19 budget

It was agreed that an initial meeting would be set up to discuss the process for agreeing the 2018/19 budget. The meeting would include Roger Harris, Mike Jones, Mark Tebbs, David Mountford and Tendai Mhangagwa. Roger Harris agreed to ensure the meeting is arranged.

**Action Roger Harris**

#### **4. The Delayed Transfers of Care (DToC report), including update on deep dive and delays in mental health services and BCF Scorecard.**

Iqbal Vaza introduced the DToC report. The following points were made:

- On the whole performance has been good with targets being met in most months. Members noted that Adult Social Care had experienced an increase from 77 to 177 delayed days between October and November 2017, highlighting particular challenges being experienced during that time.
- There were 308 delayed transfers of care (delayed days) in November 2017, not achieving the monthly target by 11 days. However, the estimate for December is expected to achieve the target of 310 delayed transfers of care.
- The current year-end projection will be 223 days under target and an improvement in performance when compared with last year.

- It was agreed that in addition to the number of delayed transfer days the DToC report should include data on patient numbers and where practicable a summary setting out reasons for those delays.

**Action Iqbal**

- The deep dive exercise that had been planned has been deferred. Board members acknowledged that performance data demonstrates effective controls are in place and DToC are subject to high levels of scrutiny. It was agreed that the scope and requirements of the deep dive will be further defined and reported back to a future meeting.

**Action Ian Wake**

Iqbal Vaza reported progress against the BCF Scorecard. The following points were made:

- The way in which data is collected has changed which has had an impact on the RAG rating for the BCF scorecard indicator 5.1, the total non-elective admissions to hospital (general and acute), all age. Thurrock is not forecast to achieve the target for 2017/18. It was agreed that consideration should be given to how performance can be reported using the new and previous data collection methods. This will enable performance to be compared against previous outcomes while meeting current reporting requirements.

**Action Iqbal and Abdul**

- Performance against indicator 5.3, the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation is measured by identifying a cohort of patients remain at home on the 91<sup>st</sup> day following being discharged from hospital and have not been readmitted to the hospital. The target of 91% has not been achieved with best performance being recorded at 83% in quarter 4 (December 2017). Members noted that the Joint Reablement Team had been experiencing additional unforeseen pressure and prioritising the provision of a substantial number of hours of domiciliary care that had previously been available through an external provider.
- Members agreed that action plans should be developed for red rated targets and that a summary report should be provided that sets out challenges experienced with achieving those targets and remedial action being taken. It was agreed that consideration to how best to incorporate key information on action being taken into the scorecard.

**Action Iqbal (incorporating action summary into scorecard)**

**Action Catherine Wilson / Mark Tebbs (developing action plans for red rated targets)**

- Members requested that the quality of the work of Ann Laing, responsible for producing reports was acknowledged and welcomed in the meeting's minutes.

## **5. iBCF and BCF Quarter 3 returns**

Allison Hall advised members that iBCF and BCF Quarter 3 returns had been circulated to ICE members electronically and are approved by the Group.

## **6. The implications of using the BCF for the Transforming Care Partnership**

Catherine Wilson advised members about initial proposals currently being explored by Essex and Southend Councils and 6 CCGs to pool LD budgets to support people being discharged from hospital.

It was proposed that the BCF is used in future to pool budgets within Thurrock for placement costs only. Members agreed the proposal in principle subject to a further detailed paper being provided for consideration at the next meeting.

**Action Catherine Wilson**

#### **7. GP Provision in Collins House**

Catherine Wilson advised members that the local authority commissioned College Health to provide GP support at Collins House in December 2016. The GP provides support to individuals occupying re-ablement beds. Members were asked to consider how the GP should be funded in future. It was agreed that this would be considered at the next meeting.

**Action Mark Tebbs**

#### **8. Integrated approach to commissioning**

Catherine Wilson and Mark Tebbs introduced the item by asking members to consider how the remit of ICE may be changed to support the joined up integrated approach to commissioning specific services, which might involve future meetings comprising two parts.

It was agreed that a paper will be provided at the next meeting which includes a new TOR for the Group and proposals on how ICE may operate in future to facilitate an integrated approach to commissioning.

**Action Catherine Wilson**

Members were asked to consider and approve proposals for Thurrock Council and Thurrock CCG to jointly commission the community stroke project, provided by the Stroke Association for 2018/19. Proposals to pool funding within the BCF were agreed. Members noted that this approach has enabled the funding to be reduced to £54,949 for FY18/19, providing a saving of £3,000.

#### **9. CQC Review – CQC Thurrock data profile**

Members considered the CQC local systems review data for 2017/18. It is envisaged that all local authorities will be inspected over the next 18 months /2 years.

#### **10. Any other business**

Members were advised that applications for Digital Discharging to Social Care had been submitted by the Council on behalf of Thurrock and Southend Councils and BTUH (referred to as the Digital Integration Project).

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**PUBLIC Minutes of the meeting of the Health and Wellbeing Board held  
Tuesday 30 January 2018, 3:00 - 5:30pm**

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**Present:** Councillors James Halden (Chair), Sue Little, Robert Gledhill, Steve Liddiard and Leslie Gamester

Tom Abell, Deputy Chief Executive and Chief Transformation Officer Basildon and Thurrock University Hospitals Foundation Trust  
Mandy Ansell Accountable Officer, Thurrock CCG  
David Archibald, Independent Chair of Local Safeguarding Children's Board  
Roger Harris, Corporate Director of Adults, Housing and Health  
Kristina Jackson, Chief Executive, Thurrock CVS  
Kim James, Chief Operating Officer, Thurrock Healthwatch  
Rory Patterson, Corporate Director of Children's Services  
Julie Rogers, Director of Environment and Highways  
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust  
Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust  
Ian Wake, Director of Public Health

**Apologies:** Dr Anjan Bose, Clinical Representative, Thurrock CCG  
Graham Carey, Chair of Thurrock Adults Safeguarding Board  
Steve Cox, Corporate Director of Environment and Place  
Jane Foster-Taylor, Executive Nurse, Thurrock CCG  
Malcolm McCann Executive Director of Community Services and Partnerships, South Essex Partnership Foundation Trust  
Clare Panniker, Chief Executive of Basildon and Thurrock University Hospitals Foundation Trust  
Andrew Pike, Director of Commissioning Operations, NHS England Essex and East Anglia

**Did not attend:** Dr Anand Deshpande, Chair of Thurrock CCG

**In attendance:** Ceri Armstrong, Senior Health and Social Care Development Manager  
Nick Boulter, Sport England  
Grant Greatrex, Sports and Leisure Policy & Development Manager  
Tim Elwell-Sutton, Assistant Director and Consultant in Public Health  
David McHendry, KKP  
Linda Smart, Deputy Chief Nurse, Thurrock CCG  
Andrew Vowles, Programme Director, Mid & South Essex Sustainability & Transformation Partnership

## **1. Welcome and Introductions**

Apologies were noted.

## **2. Minutes**

The minutes of the Health and Wellbeing Board held on 14 November 2017 were approved as a correct record.

## **3. Urgent Items**

There were no urgent items provided in advance of the meeting.

## **4. Declaration of Interests**

There were no declarations of interest.

## **5. Active Places Strategy**

A presentation was given to the Board on the Council's Active Place Strategy by Grant Greatrex (Sports and Leisure Policy and Development Manager), Nick Boulter (Sport England), and David McHendry (KPP).

The Board were made aware that the Active Place Strategy was in fact a suite of strategies consisting of Open Space; Active Travel; Playing Pitch; and Indoor Build Facilities. The Strategy would contribute in the main to the delivery of the Health and Wellbeing Strategy goal 'Healthier Environments' and the objective 'Create places that make it easy to exercise and be active' – although there were also links to many more goals and objectives.

Nick Boulter clarified the role of Sport England. It was the government agency responsible for setting and delivering the community sport strategy. The latest strategy had been launched in 2016 and shifted from being purely 'sports-driven' to focusing on improving health and wellbeing. For example investment principles included 'tackling inactivity'.

A key element of Thurrock's approach was the provision of sport and physical activity facilities. There was a discussion about what this might look like although there were no firm plans in place at this point in time.

Board members raised concerns about the breadth of community engagement – this included information and input from people with disabilities to ensure that the 'Active Place' was accessible to all. Engagement needed to include a wide range of community groups and needed to focus on what people wanted to do rather than what facilities they might want.

There was some discussion about linkages with Health and possible opportunities to integrate or co-locate.

It was important that plans took in to consideration the population increase that would be brought about by plans for 32,000 new homes. It was possible that section 106 monies could be used innovatively to contribute to the outcomes the Strategy wanted to achieve.

Resolved:

That the Board note the Active Place Strategy.

## **6. Annual Public Health Report**

Tim Elwell-Sutton, Assistant Director and Consultant in Public Health presented the 2017 Annual Report of the Director of Public Health. The focus of the report for 2017 was 'A Sustainable Children's Social Care System for the Future'.

Tim stated that the reason for the focus on children's social care was that the early years of a child's life was critical to their longer term health and wellbeing.

A key observation was that over the years, there had been a significant reduction in the amount spent on prevention, with a greater proportion of the budget being spent on placements. This was a scenario replicated nationally.

Tim commented that Thurrock's level of Looked After Children was high – but that it was difficult to explain why that was. The ability to invest in prevention, particularly if the focus was on working with families, might help to prevent children becoming 'looked after'.

Board members raised the benefits of the Edge of Care/Pause programmes. These intervened across multiple of areas of a family's life and could contribute towards reduce the risk of children becoming looked after.

The Corporate Director of Children's Services stated that there had been a slight reduction in Looked After Children as a result of changes made. The Pause programme was seen to be successful in reducing the number of court proceedings as it worked with mothers who had previously had children removed so that if they went on to have more children there was less risk of subsequent children being taken in to care.

Resolved:

That the contents and recommendations of the report be supported by the Board; and

That the Board note plans to hold a Mental Health summit to address emotional and mental health issues which contribute to the wider health and wellbeing issues amongst young people.

## **7. Mid & South Essex Sustainability and Transformation Programme Consultation**

Andy Vowles, Programme Director for the Mid and South Essex Sustainability and Transformation Programme (STP) provided the Board with an update on the current consultation which was seeking views on:

- The overall plan for health and care;
- Proposals for hospital services in Southend, Chelmsford and Basildon; and
- Proposals to transfer services from Orsett Hospital to new centres closer to where people live.

The Board were asked to comment on proposals.

Concerns were raised by Board members about the accessibility of the consultation, and the Chair stated that Healthwatch had worked to bridge any gaps.

The Board were also concerned that the consultation about the future of Orsett Hospital had not been consulted on separately. In response, the Deputy Chief Executive of Basildon and Thurrock University Hospitals Foundation Trust (BTUH) stated that three further meetings were being organised specifically focused on Orsett Hospital. These would take place prior to the end of the consultation period.

The Chair stated that the process needed to be far more responsive to concerns being raised. For example the consultation on Orsett Hospital being part of the consultation on the proposals for hospital services in Southend, Chelmsford and Basildon despite a request for this not to happen.

Councillor Little wished to know how the Orsett site would be used, and the Deputy Chief Executive of BTUH responded that no decision had been made on the future of the site.

Resolved:

That the Board note the update and consider the proposals published for consultation.

## **8. Integrated Commissioning Executive and Health and Wellbeing Executive minutes**

Resolved:

That the minutes of the Integrated Commissioning Executive 28 September 2017 and 26 October 2017 and the minutes of the Health and Wellbeing Executive Committee 23 November 2017 be agreed.

**9. Work Programme**

Resolved:

That the Board's future work programme be agreed.

**The meeting finished at 5pm.** Approved as a true and correct record

**CHAIR.....**

**DATE.....**

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**Health and Wellbeing Board and Health and  
Meeting Planner**

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
<p>Health and Wellbeing Board – March 18</p>	<p>Friday 16 March 11-1.30</p> <p>Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September</p> <p>Invitations sent to members</p> <p>Have ordered room for Friday 23 March from 12.30-4.00pm should a room change and date change be needed</p>	<ol style="list-style-type: none"> <li>1. <b>STP update</b></li> <li>2. <b>Pharmaceutical Needs Assessment</b> (Maria Payne)</li> <li>3. <b>Adults Mental Health JSNA</b> (Deferred from Sept meeting)</li> <li>4. <b>Local Transformation Plan ‘open up reach out’ children’s mental health</b> (Sue Green / Paula McCullough) (20 minutes)</li> <li>5. <b>ICE and HWB Executive Committee minutes</b> January ICE / 8 Feb Exec</li> </ol>	<p>Implications and papers ready to brief Cllr Halden: Wed Mon 26 Feb</p> <p>Publishing date Thurs 8 March</p>	

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
<p>Health and Wellbeing Board meeting</p>	<p>Amended to Friday 8 June 2018. 10:30-1:00pm on advice from Matt Boulter following his attendance at DMT on 12/12/17</p> <p>Committee Room 1</p> <p>Fri 18 May 2018 10.30 – 1.00</p> <p>Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September</p> <p>Invitations sent to members</p>	<ol style="list-style-type: none"> <li>1. <b>STP update</b></li> <li>2. <b>Update on LD targeted health checks and preliminary results.</b> Suggested time slot – 10-15mins (Thurrock CCG)</li> <li>3. <b>New Models of Care – Case for Change update</b> <ul style="list-style-type: none"> <li>o Wellbeing Teams</li> <li>o LTC programme</li> <li>o Alliance agreement</li> </ul> </li> <li>4. <b>Health of looked after children</b></li> <li>5. <b>Update (Malcolm Taylor / Sue Green)</b> <ol style="list-style-type: none"> <li>a. Suicide prevention toolkit</li> <li>b. Self-harm toolkit</li> <li>c. Online portal</li> </ol> </li> <li>6. <b>Mental Health Summit</b></li> <li>7. <b>Essex Southend and Thurrock Mental Health Strategy – Local Plan</b> (Catherine Wilson)</li> <li>8. <b>Essex, Southend and Thurrock Dementia Strategy Local Plan</b> (Catherine Wilson)</li> <li>9. <b>HWB Exec Committee and ICE minutes</b> Feb ICE</li> <li>10. <b>Forward planner</b></li> </ol>	<p>Implications and papers ready to brief Cllr Halden: Friday 18 May</p> <p>Publishing date Thurs 31 May</p>	

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	<p>Friday 13 July 2018 10.30 – 1.00</p> <p>Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September</p> <p>Invitations sent to members</p>	<ol style="list-style-type: none"> <li>1. Health and Wellbeing Strategy Annual Report – Year 2 (to include update on Outcomes Framework)</li> <li>2. HWB Terms of Reference</li> <li>3. HPAG Annual Report and HPAG TOR</li> </ol>	<p>Implications and papers ready to brief Cllr Halden: Thurs 21 June</p> <p>Publishing date: Thurs 5 July</p>	

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	<p data-bbox="371 384 584 440">Fri 21 September 2018</p> <p data-bbox="371 507 607 713">Room reserved from 10.00-1.30 – Reservation sent to room hire 21 September Invitations sent to members</p>		<p data-bbox="1301 355 1464 507">Implications and papers ready to brief Cllr Halden: Mon 3 Sept</p> <p data-bbox="1301 571 1464 659">Publishing date Thurs 13 Sept</p>	

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	Friday 23 November 2018 10.30 – 1.00pm	<p>Plan on a page and Education attainment results (Michele Lucas)  <b>Reflects agenda item being included on Nov 17 HWB</b></p> <p>Open Up Reach Out Year Four Sign Off emotional wellbeing and mental health services for young people. Paula McCullough</p>	<p>Implications and papers ready to brief Cllr Halden:  <b>Wed 7 Nov</b></p> <p>Publishing date <b>Thurs 15 Nov</b></p>	
Health and Wellbeing Board meeting	January 2019		<p>Implications and papers ready to brief Cllr Halden:</p> <p>Publishing date</p>	