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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **6 September 2018**

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

Membership:

Councillors Victoria Holloway (Chair), John Allen (Vice-Chair), Cathy Kent, Elizabeth Rigby and Joycelyn Redsell

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

Substitutes:

Councillors Alex Anderson, Sue Sammons and Sue Shinnick

Agenda

Open to Public and Press

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1. Apologies for Absence

2. Minutes **5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 14 June 2018.

3. Urgent Items

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

4. Declarations of Interests

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **29 August 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?**

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

Pecuniary

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:

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

Non- pecuniary

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

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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 Overview and Scrutiny Committee held on 14 June 2018 at 7.00 pm

Present:	Councillors Victoria Holloway (Chair), John Allen (Vice-Chair), Abbie Akinbohun and Elizabeth Rigby
Apologies:	Ian Evans, Thurrock Coalition Kim James, HealthWatch
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group Tania Sitch, Integrated Care Director for Thurrock, Thurrock Council and North East London Foundation Trust Jenny Shade, Senior Democratic Services Officer Kallum Davies, Democratic Services Officer

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

1. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 12 March 2018 were approved as a correct record.

2. Urgent Items

There were no items of urgent business.

3. Declarations of Interests

No interests were declared.

4. HealthWatch

No HealthWatch items were raised.

5. For Thurrock in Thurrock - New Models of Care across health and social care

Roger Harris, Corporate Director of Adults Housing and Health, presented the report that updated Members on the New Models of Care innovation that had been launched in Tilbury and Chadwell as part of Phase 2 of the Thurrock transformation programme in collaboration with local health partners, the voluntary and community sector. Roger Harris referred Members to the four principles:

1. The development of a new Primary Care Workforce – to address the shortages of GP's and improve the Primary Care offer.
2. Improved identification and early treatment of people with Long Term Conditions.
3. The redesign of the health and social care workforce and all community based solutions.
4. The development of four Integrated Medical Centres to ensure that we have 21st Century local facilities.

Tania Sitch, Integrated Care for Thurrock Council and North East London Foundation Trust, explained the development of this new exciting project to Members and how the new 12 new workers would support the 8 practices in Tilbury and Chadwell to ensure that GPs are used where most needed and to reduce waiting times. That the implementation of the integrated workforce will bring together health, mental health, social care and the voluntary sector to ensure more coordinated care and a more personal response. Those 13 programmes devised to improve the identification of treatment with evaluation being undertaken by Public Health England and the University of Birmingham to ensure that it was robust and that outcomes were focused.

Mandy Ansell stated that this project would involve and be joined up with Health, Social Care and the Health and Wellbeing Board Strategies.

Roger Harris stated the Integrated Medical Centres were being designed to support the Council and Clinical Commissioning Group for primary care services. The design of the Tilbury and Chadwell site had now been commissioned and that this would probably be the first of the 4 sites being developed with health partners. The second site being Stanford and Corringham based on a similar model as the Tilbury and Chadwell site, the third at Purfleet as part of the Purfleet Regeneration Programme which would soon be commissioning an architect and design team. The fourth site would be at Grays Thurrock Hospital which would concentrate on services covering the whole of Thurrock e.g. the Minor Injuries Unit (MIU). The development plan would be 3 years with lots of work including planning applications, business cases and signing of leases. That huge commitment had been made by Thurrock Council and Health providers.

The Chair thanked Officers for their very interesting presentation.

Councillor Rigby questioned would the Integrated Medical Centres reduce GP appointment times and had this model been undertaken elsewhere. Tania Sitch stated that similar trials had been undertaken but not to the extent that Thurrock are proposing with this being one of the first ever model of shared services.

Mandy Ansell stated that Thurrock had been identified as one of the worst under doctored areas in the country with the recruitment of doctors being one of the biggest challenges. Thurrock had relied on doctors and nurses from overseas as not enough GP graduates were coming through the process.

Councillor Allen stated with the shortage of GPs in Tilbury he welcomed the Integrated Medical Centres and questioned what services would they provide. Tania Sitch stated that more services would come out of Basildon Hospital, space had been committed at these Integrated Medical Centres to accommodate outpatients with those services from Orsett Hospital going into all 4 Integrated Medical centres with one off services going to just one specific centre. This would prevent residents having to go to 2 or more different places for appointments.

Councillor Allen stated that it was great that all services would be available closer together but had concerns how the Integrated Medical Centres would cope with the increase in population with the proposed 32,000 new homes to be built in Thurrock and would this not call for Thurrock to have its own hospital.

Roger Harris stated that the Integrated Medical Centre planning process had included some form of future proofing to ensure that the centres were used in the most effective way and had taken into account the proposed growth in population. Roger Harris stated that it was very unlikely that an acute hospital would be built in Thurrock but that this decision would fall to the National Health Service.

Councillor Holloway reiterated comments made previously that the Integrated Medical Centres should be up and running before any consideration to close Orsett Hospital was made. Councillor Holloway commented that in regards to a new hospital, Thurrock had an existing hospital and when proposals are made as to what happens there we need to look at the existing hospital before looking at a new one.

Councillor Akinbohun questioned how convinced were Officers that this model would work in the long run. Tania Sitch stated that there were community representatives on the group that would hopefully spread the good news on the work being undertaken. With a new employed full time Engagement Officer to work with Communications on promoting the services and proving the roles of the workforce. That the new workforce were trained staff to a level in how best a patient should be seen, undertaking tests and knowing when to refer patients for further appointment. Tania Sitch also stated that tougher measures would be put in place for appointment making.

Mandy Ansell briefed Members of a pilot of extended physiotherapist services where patient numbers were higher seeing the physiotherapist directly rather than waiting to see a doctor and then having to wait for an appointment to come through. That a PhD Pharmacist working on the medical review rather than GPs. Mandy Ansell stated that it was about patient experience and that the positivity out of this should be built on. It was ensuring that the patient was at the right place at the right time.

The Chair stated how excellent to see how primary care was improving and that Thurrock had received national recognition and was glad that Thurrock was leading the way.

The Chair questioned when changes to the timelines re referrals would be shown. Tania Sitch stated that recruitment to this skills mix was underway and that the role of the care navigators would be to navigate patients to the right service. That the model for Tilbury and Chadwell would be rolled out to the 3 other localities with funding from the Clinical Commissioning Group.

The Chair requested that a further report be added to the 2019/20 municipal calendar work programme for further updates.

Mandy Ansell stated that the Director of Public Health monitored progress closely and that the Quality and Outcome Framework focused on identifying each patient and that treatment was provided when needed.

Councillor Allen asked Officers to confirm that it was the ambition to have the Tilbury and Chadwell Hub opened by 2020. Roger Harris stated that this was the aim.

Councillor Allen questioned whether the new workforce had been recruited, when they would start and would the proposed model enable them to visit all practices. Tania Sitch stated that the recruitment process had begun with the intention that new workforce would support and spend time at all 8 practices based on the need.

The Chair thanked Officers for the report.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee commented on the progress made with delivering the New Models of Care.**

2. **That the item be added to the 2019/20 municipal year work programme.**

6. Verbal Update on Learning Disability Health Checks

Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group, updated Members on the current position of the Learning Disability Health Checks following the Clinical Commissioning Group taking over the commissioning arrangements in April 2016. At this time there had been a poor uptake of only 34%. In 2017 following the hard work of the Clinical Commissioning Group an established list of 64% had been achieved. Mandy Ansell was pleased to announce to Members that this year a 77% established list had been achieved. This was helped with more flexibility as to when the health checks could be undertaken and where they take place. HealthWatch had also worked hard on care plans. Mandy Ansell stated that not all practices had taken up this service and that those patients requiring learning disability health checks would be seen at other practices. That Jackie Doyle-Price, Member of Parliament for Thurrock, had recognised these achievements as a

future model to be used nationally and that goals had been set for next year to push this figure even higher.

Councillor Rigby questioned whether this service could be offered to all residents. Mandy Ansell stated that any resident on a GPs list can request a health check. Those residents over 40 years of age should have a routine health check. The National Health Service had lines of health delivery that had to be undertaken such as Elderly Health Checks and checks for Looked After Children. The Quality and Outcome Framework was to help fund GPs to improve the quality of health care being delivered with life time questions being asked of residents at early appointments.

The Chair stated that the importance of disabled people being identified and provided with services was crucial.

Councillor Rigby questioned why residents undertaking a disability health check were invited in for a health check but not all other residents. Mandy Ansell stated that the disability health checks were being undertaken from a particular funded stream which offered this facility. There were other schemes where primary care could be obtained and it was vital that residents took responsibility for their own health and looked after each other.

The Chair stated that the importance of the proposed Integrated Medical Centre would encourage all residents to undertake these health checks.

Councillor Akinbohun questioned why some practices had not taken up the service. Mandy Ansell explained that the National Health Service commissioned GP practices with core services and then practices can chose to add services to their portfolio, known as Directed Enhanced Services. These services are offered as an income but not all practices chose to participate. Those practices that do participate would be paid per health check.

Councillor Allen stated that all Thurrock residents should be entitled to a body MOT every 18 months that could identify early indications of poor health. Mandy Ansell stated that all residents are entitled to have health checks at practices which would normally be undertaken by a practice nurse. If following this health check, referral was required an appointment would be made with the GP.

Councillor Rigby asked whether the Learning Disability Checks were undertaken by the GP or nurse. Mandy Ansell stated these could be undertaken by either.

The Chair requested that this item be added to the 2019/20 municipal calendar work programme for further updates.

7. Verbal Update Sustainability and Transformation Partnership (STP) Consultation

Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group, presented to Members an update of Sustainability and Transformation Partnership with new arrangements for larger planning footprints for the future of health and care services with the main focus for hospitals was the reconfiguration. The Sustainability and Transformation Partnership configured of Clinical Commissioning Groups, Acute Trusts and Community Partners. That it was the statutory responsibility of the Clinical Commissioning Group to work together with partners, be accountable and ensure the services are in the right place. That the consultation recognised that the 3 hospitals were not sustainable as they currently stand. That last year's bad winter had a detrimental effect on accident and emergency service with elective surgeries being cancelled due to the pressures put on Basildon Hospital. Part of the Sustainability and Transformation Partnership focused on the future of Orsett Hospital.

That the Clinical Commissioning Group worked closely with Basildon Hospital with a decision being made on the 6 July 2018 on what services would be transferred out of the hospital.

Mandy Ansell offered Members the opportunity of an induction and an understanding of the roles undertaken by the Clinical Commissioning Group.

Councillor Allen questioned the bad weather crisis and asked whether this was just at Basildon Hospital or nationally. Mandy Ansell stated that this nationally with most elective surgeries being cancelled. That this had been a very stressful period for the National Health Service.

Councillor Allen stated that Basildon Hospital covered a huge area and had failures in the past been related to too many people attending. Mandy Ansell stated that there were a considerable amount of patient flows out of Southend, Dartford and Queens into Basildon Hospital but the hospital was coping well to meet the needs. That Basildon Hospital relied on agency staff and that staff targets had to be met but was performing well with the current workforce situation. That the 62 day cancer target was slightly below for Thurrock and that the Clinical Commissioning Group had commissioned a deep dive.

The Chair questioned where the new models of care that covered all the hospitals would be situated geographically. Mandy Ansell stated that the model of care would be segmented by service, by age, be measured by an 18 weeks pathway, diagnosis would be sent by GP and decision made on the need for surgery or other intervention.

That one proposal would be to put controlled COLD work in place where they would not be interrupted by emergencies. One area of concern was Cancer that required specialist surgery with the Burns Unit currently at the Mid Essex hospital. Each hospital would have an accident and emergency at each location.

Councillor Akinbohun questioned whether the public consultation was effective in the decision making. Mandy Ansell stated that it was a statutory obligation to consult with members of the public and patients. By law consultations were undertaken with the Health and Wellbeing Overview and Scrutiny Committee, HealthWatch, disability groups and specific care groups to understand what was important about services and what specific needs were required. That a quality assessment was undertaken of every proposal and that the final document was online for Members to view.

The Chair notified Members that the consultation had now closed and notification of the outcomes were being anticipated shortly.

Councillor Allen thanked Mandy Ansell for her knowledgeable report. Councillor Allen questioned whether there were boundaries as to where blue light ambulance decided on where to take patients in regards to where they lived in the borough. Mandy Ansell stated that Thurrock was served by the South England Ambulance Service and would automatically take patients to Basildon Hospital wherever that resident lived.

8. Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership (STP) for Mid and South Essex

Roger Harris, Corporate Director of Adults Housing and Health, presented the report which outlined Thurrock's agreement to join with Essex and Southend to participate in the Joint Health and Wellbeing Overview and Scrutiny Committee that covered the Sustainability and Transformation Programme. The report provided Members with an update, purpose of the work and Thurrock representation of the Joint Health and Wellbeing Overview and Scrutiny Committee. That all 3 authorities had decided to keep their power to refer matters to the Secretary of State locally rather than delegate this power to the Joint Health and Wellbeing Overview and Scrutiny Committee. Roger Harris referred Members to the Terms of Reference in Appendix 1. That Councillor Holloway had been elected vice chair of the Joint Health and Wellbeing Overview and Scrutiny Committee at the last meeting. That the next informal meeting was scheduled for the 19 June to be held in Chelmsford with a formal meeting scheduled for the 30 August which would be held in Thurrock. The Joint Health and Wellbeing Overview and Scrutiny had 2 of the 4 Thurrock seats filled by Councillor Holloway and Councillor Fish but had 2 vacancies to fill.

The Chair asked Members whether there were any nominations. Councillor Rigby volunteered to sit on the committee but stated that she would not be able to attend on the 19 June due to undertaking some mandatory licensing training.

The Chair questioned whether political proportionality should apply to the Joint Health and Wellbeing Overview and Scrutiny Committee and should a Thurrock Independent member be nominated. Councillor Allen, as Thurrock

Independent Vice Chair to the Health and Wellbeing Overview and Scrutiny Committee was unable to commit at this time.

The Chair requested that the democratic services contact the Leader of the Thurrock Independent to ask whether he would like to nominate a member.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee noted the terms of reference for the Joint Health and Wellbeing Overview and Scrutiny Committee with Essex and Southend.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee appointed a further Member, Councillor Elizabeth Rigby, to represent Thurrock Health and Wellbeing Overview and Scrutiny Committee at the Joint Health and Wellbeing Overview and Scrutiny Committee.**

3. **That the remaining seat would be offered for nomination to Members of the Thurrock Independent party.**

4. **That the Health and Wellbeing Overview and Scrutiny Committee agreed the approach to the Joint Health and Wellbeing Overview and Scrutiny Committee outlined in the report.**

9. Work Programme

The Chair asked Members if there were any items to be added or discussed for the work programme for the 2018-19 municipal year.

Members agreed that the Mental Health Peer Challenge be added to the work programme for the 8 September 2018 committee.

Members agreed that the Thurrock Integrated Care Alliance be removed from the 8 September 2018 committee and placed on the 8 November 2018 committee.

Members agreed that the Cancer Wait Times be removed from the 8 September 2018 committee and placed on the 8 November 2018 committee.

Members agreed that the Verbal Update on Learning Disability Health Checks be added to the work programme for the municipal year 2019/20.

Members agreed that the Sustainability and Transformation Partnership be added to the work programme for the municipal year 2019/20.

RESOLVED

1. **That the item Mental Health Peer Challenge be added to the 8 September 2018 committee.**

2. **That the item Thurrock Integrated Care Alliance be added to the 8 November 2018 committee.**

3. **That the item Cancer Wait Times be added to the 8 November 2018 committee.**

4. **That the item Verbal Update on Learning Disability Health Checks be added to the 2019/20 work programme.**

5. **That the item Sustainability and Transformation Partnership be added to the 2019/20 work programme.**

The meeting finished at 8.40 pm

Approved as a true and correct record

CHAIR

DATE

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6 September 2018	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Young Person's Substance Misuse Treatment Service Re-Procurement	
Wards and communities affected: All	**Key Decision:** Key
Report of: Kev Malone – Public Health Programme Manager	
Accountable Assistant Director: Andrea Clement – Assistant Director and Consultant in Public Health	
Accountable Director: Roger Harris – Corporate Director of Adults, Housing and Health / Ian Wake – Director of Public Health	
This report is Public	

Executive Summary

Thurrock Council has a duty to use a proportion of its Public Health grant to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services. The contract for the Young Person's Substance Misuse Treatment Service expires on 31 March 2019 and a new contract and service is therefore required from 1 April 2019.

The Thurrock Public Health team has conducted a full needs assessment, incorporating a literature review, of young people's substance misuse in the borough. This document sets out a series of recommendations for the new service specification and is appended to this report.

A variety of stakeholders were consulted and the responses were factored into the service redesign.

Thurrock's 10-17 year old population is set to increase by 30% over the next ten years and the service needs to be responsive to this increase and any impact this might have on service demand.

The new service will see a greater emphasis on coordinating family therapy and developing peer-led programmes, since these were recommendations from the needs assessment and literature review. The latter will enhance and diversify the offer and overcome the risk of adults designing interventions based on their perception of the risks rather than the actual experiences of young people.

1. Recommendation(s)

1.1 For the Health and Wellbeing Overview and Scrutiny Committee to be appraised of and comment on the re-procurement of the Young Person's Substance Misuse Treatment Service prior to Cabinet.

1.2 To invite comments on the recommendations within the needs assessment.

2. Introduction and Background

2.1 The Public Health Grant is provided to local authorities to give them the funding needed to discharge their public health responsibilities. Broadly these responsibilities include:

- Improve significantly the health and wellbeing of local populations;
- Carry out health protection and health improvement functions delegated from the Secretary of State;
- Reduce health inequalities for all ages, including within hard to reach groups;
- Ensure the provision of population-wide healthcare advice.

2.2 The grant is made under Section 31 of the Local Government Act 2003 and the Secretary of State has set down conditions to govern its use. The primary purpose of the conditions is to ensure that the grant is used to assist the local authority to comply with its Public Health duties and mandatory functions, that it is spent appropriately and accounted for properly.

2.3 A local authority must, in using the grant, have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services.

2.4 The contract for the Young Person's Substance Misuse Treatment Service expires on 31 March 2019 and a new contract and service is required from 1 April 2019.

2.5 Thurrock has a small but cost-effective and high performing Young Person's Substance Misuse Treatment Service. It integrates well with other services and enjoys a strong reputation across the borough, particularly with schools/academies and across children's services.

2.6 The existing contract (3 years plus 2 year option to extend) is coming to the end of its full 5-years and notwithstanding that set out in 2.5 commissioners have conducted a full needs assessment to ensure the new service offer remains up to date, incorporates the latest best practice, guidance and recommendations and is responsive to the needs of our local children and young person's population.

2.7 **Costs**: The current contract value was £135,000pa and a similar annual contract value is forecast for the new contract, subject to any fluctuations in service demand as set out in section 3 below.

2.8 The service works with those young people aged under 18 years old who live in Thurrock or who attend a Thurrock education provision. The service delivers structured interventions to help young people address their substance misuse. This can take the form of abstinence-based recovery whereby clients cease their misuse, or harm reduction interventions.

2.9 The service delivers prevention and education interventions across our schools and colleges and at community events throughout the year. It also works with children who may not have a substance misuse need, but whose parents/carers may have a substance misuse need and be a client with the adult treatment service; these clients are broadly referred to as 'hidden harm'. The hidden harm and prevention and education work of the service accounts for roughly half of the services activity.

3. Issues, Options and Analysis of Options

3.1 Thurrock's population for those aged under 18 is set to steadily increase over the next 10 years by 13%, to 47,476. Moreover, for those aged 10-17 the projected increase is 30% over 10 years. This is a significant amount of growth and it is not yet possible to determine what the demand on the service will be due to a rapidly changing drug market. However, the new service needs the flexibility to respond to these changes.

3.2 The literature review and consultation with service users identified a theme for providing more family therapy interventions. These have a strong impact on improved outcomes, so the new service will feature more of this type of intervention.

3.3 The service will continue to offer interventions that help address the wider determinants of health, such as sexual health screenings, smoking cessation, mental health support and engagement/re-engagement with employment, education or training. It will also continue to work in close partnership with the Youth Offending Service.

3.4 The new service will be available for those vulnerable young people up to the age of 25 if they have a special educational need or disability and the service is more appropriate to their need than the adult service. It will continue to work in partnership with the adult service if a prescribing treatment modality is deemed appropriate e.g. substitute opiate medication, since there is no prescribing element to the young person's contract.

3.5 The literature review recommended that the new service is open to developing peer-led programmes to enhance and diversify the offer and overcome the risk of adults designing interventions based on their perception of the risks rather than the actual experiences of young people.

3.6 Drug and alcohol treatment services typically suffer an impact on performance when they are retendered; this is both a local and national phenomenon. This is mostly attributable to clients being sensitive to change and it can take time for them to re-engage in treatment. For this reason commissioners have sought assurance from Procurement for a 4+1+1 year contract.

4. Reasons for Recommendation

4.1 To update the Health and Wellbeing Overview and Scrutiny Committee and ensure its input prior to seeking approval from Cabinet to re-procure the service.

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

5.1 A number of stakeholders have been consulted with in preparing this re-procurement. Partner agencies across children's services, youth justice and mental health services in both the public and voluntary sector were invited to comment on the process and provide recommendations.

5.2 Thurrock's Youth Cabinet was appraised of the above and asked for any comments or recommendations.

5.3 The Adult and Young Person's drug and alcohol treatment services were also consulted for any comments or recommendations.

5.4 A small number of young people in treatment for substance misuse or who were receiving support to better understand their parent's/carer's substance misuse were also consulted.

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

6.1 The Young Person's Substance Misuse Treatment Service will contribute to the delivery of the Council's vision and priorities for **People**, in particular:

- High quality, consistent and accessible public services which are right first time
- Reducing the associated costs to local communities and socio-economic/health costs to the individual caused by substance misuse
- Breaking the intergenerational cycle of substance misuse
- De-normalising and reducing the prevalence of young person's substance misuse

6.2 Moreover, the service that will result from this work will support Goals 1, 3, 4 and 5 of the Health and Wellbeing Strategy, together with the associated objectives. In the below table, those sections highlighted in green (1a&b, 3b, 4b&c) are directly affected, with those in yellow (1c&d, 3a&d, 5a,b&d) indirectly affected:

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 mental ill-health, particularly in high risk	4D. Provide high quality GP and hospital care to Thurrock	5D. Prevent and treat cancer better

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care & Commissioning

The funding for this contract will continue to be provided through the Public Health Grant allocations until such time the ring fence is removed from the grant conditions, this contract will then become an ongoing General Fund commitment and necessary provision will be made for this.

7.2 Legal

Implications verified by: **Sarah Okafor**

Barrister (Consultant)

Under section 11 of the Children Act 2004, Thurrock Council has a duty to make such arrangements to ensure it is in a position to discharge its functions having regard for the need to safeguard and promote the welfare of children and young people. There are duties and powers to support children and young people in need and to safeguard children and young people from significant harm under the Children Act 1989. Some of these duties and powers extend to young people up to the age of 25 years of age when certain criteria may be satisfied.

Under section 12 of the Health and Social Care Act 2012 a duty is imposed upon Thurrock Council to take the steps as it considers appropriate for improving the health of all people within its area, and also to address behaviour that may be detrimental to public health. The provisions of services proposed within the report meets the requirements as set out towards promoting the welfare and health of vulnerable children and young people. The recommended services are to fund appropriately through the Public Health Grant. The procurement processes will be undertaken in accordance with the Public Contract EU Regulations as well as in compliance with the Contract Procurement Rules of Thurrock Council.

Accordingly, on behalf of the Director of Law, I have read the report, and there appears to be no external legal implications arising from the report recommendations, which are intended to exercise powers and meet the duties towards children and young people as set out, through the planning and procurement of young people's substance misuse services.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The service is open to all residents across the borough who meets the age threshold set out in 2.8. The Needs Assessment tells us that our rate of engaging minority groups into treatment is better than our comparators and the service will continue to work to ensure that all groups and communities have awareness of and ability to engage where appropriate. Consultation included Thurrock Youth Cabinet, partner agencies and service users.

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

None

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

- Thurrock Young Person's Substance Misuse Needs Assessment 2018

9. Appendices to the report

Appendix 1 - Thurrock Young Person's Substance Misuse Needs Assessment 2018.

Report Author:

Kev Malone
Public Health Programme Manager
Adults, Housing and Health

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Brighter Futures

Thurrock Young Person's Substance Misuse

Needs Assessment 2018

Author

Kev Malone	DAAT Lead, Public Health Programme Manager

Acknowledgements

Karen Balthasar	Public Health Graduate Trainee
Beth Capps	Senior Public Health Programme Manager
Maria Payne	Senior Public Health Programme Manager
Nicola Smith	Public Health Intelligence Analyst
Jason Read	Operations Manager, Youth Offending Service

Thanks must also go to the Aubrey Keep Library Service who supported with the literature review that informed this report.

Contents

1. Executive Summary

This assessment examines the needs of young people aged less than 18 years residing in Thurrock and who access or may need to access the specialist substance misuse service. This report incorporates a literature review, an analysis of the local epidemiology and the National Drug Treatment Monitoring System (NDTMS) data, service user engagement and a review of previous benchmarking to determine cost-effectiveness.

This work will help to inform a refresh of the service specification for the young person's substance misuse service which is being retendered in 2018/19 ready for a new contract to commence on 1st April 2019.

The literature review examines the current evidence base and new interventions including best practice. The service offer can be enhanced through the recommendations in this report, informing the new service specification. This report includes a brief evaluation of the current service with key areas highlighted for continuation in the new service specification.

Additionally, the views of service users and their families are incorporated into this document and will serve to co-produce the revised service specification. Other relevant stakeholders such as the current adult and young person's substance misuse treatment providers and the Children's Services team at Thurrock Council have been contacted as part of the service specification refresh and their views and advice will help in shaping the new specification as it undergoes redesign.

This document is also used to inform and make recommendations to commissioners of children's services and to update Brighter Futures partners as to the current evidence base and data explaining drug and alcohol use in children and young people with some guidance about approaches that can be employed to tackle this.

The epidemiology section in this document tells us that we can expect to see a significant increase in the young person's population in Thurrock over the next decade, and by 30% in those aged 10-17 years old. With young person's substance misuse prevalence estimates being unreliable, it is hard to determine what the demand might be on the treatment service from this population increase. Moreover, coordinated preventative interventions under the Brighter Futures umbrella of services should see many young people diverted from becoming problematic substance misusers. This will be an area of close monitoring over the coming years.

The evidence base tells us we should continue to offer coordinated packages of care that address the wider determinants of heath, such as referrals to sexual health and stop smoking support services and partnership working with mental health and youth offending services (YOS) to safeguard our young people. We must remain vigilant of the local dugs market and associated gang activity.

The benefits of preventative and educational interventions outweigh the risks of increasing awareness leading to increased usage of substances and that such programmes should continue. Where practicable, peer mentors should support these initiatives since it has a greater impact on young people than when delivered by school staff alone.

Effective multi-agency working is a strong theme in the literature review and current practice of the existing service, resulting in a high performing, safe service. The new service should therefore continue to integrate as part of Brighter Futures to strengthen multi-agency working and further improve outcomes for children, young people and their families. The size and structure of the current service is meeting the current needs of the local treatment population. The ethnicity of those in treatment is reflective of the local population, whereas the gender split sees more girls aged under 13 accessing support for Hidden Harm (support where their parents have a substance misuse need) whereas boys dominate the 13-17 age categories where we find them in treatment for their own substance misuse needs, irrespective of whether their parents have a substance misuse need too.

Referrals to the service come from a wide variety of partner agencies, which demonstrates effective multi-agency working, although referrals from health and mental health services could be improved as the figure is 4% locally against 11% nationally and we will work to better understand the reason for this.

The vast majority of young people in treatment are in mainstream education, 73% against a national average of 57%. This demonstrates that the local service is better at engaging and accessing young people in our schools and colleges and preventing the escalation of risk that often leads to persistent absenteeism and exclusion. The service does still work with those pupils in alternative education provision such as the pupil referral unit (PRU).

Most young people in treatment, 88%, live at home with their parents or relatives and this figure is in line with the national average of 84%. The remainder are either in the care system or in supported or independent accommodation. With a third of young people in treatment having several wider vulnerabilities such as offending behaviour, Hidden Harm, safeguarding concerns or mental health problems this tells us that many young people in treatment have complex needs; these young people will generally spend longer in treatment and require more regular interventions.

Cannabis and alcohol remain by far the drugs of choice in Thurrock, at 86% and 57% respectively, with ecstasy and cocaine making up just 15% and 10% of cited substances respectively. Poly drug use is common across the treatment population; using more than one substance problematically. An anomaly in the Thurrock data is nicotine, which is actually the second most prevalent substance recorded at 67%; however, this is because the local service is adept at screening for tobacco use and referring to stop smoking services.

The waiting times are now generally good, with planned exit rates being higher than the national average and unplanned exit rates being lower than the national average. Last year the re-presentation rate was unblemished with nobody re-presenting for treatment within 6-months of treatment exit. This reflects the quality of interventions administered and/or the client's positive engagement in treatment. Furthermore, exit questionnaires have shown that clients are happy with the service, meaning they are more likely to re-present if they relapse. Young people tend to spend less time in treatment compared to the national average, meaning the service can identify and effectively treat its clients, then identify new clients, thus having a positive impact on the prevalence of substance misuse across our young person's population.

Psychosocial and motivational interventions are the most popular ones used in Thurrock, with much stronger multi-agency working compared to the national average. Interestingly, our use of harm reduction interventions is far lower than the national average and we need to understand why. We also need to increase the take-up of sexual health screening by those clients that are eligible. We work well with criminal justice clients from the Youth Offending Service (YOS) and we should continue to co-locate a member of staff there at least once a week. This will ensure that we continue to meet the needs of the one in five substance misuse clients that report offending behaviour as a wider vulnerability. According to the YOS, substance misuse was the 4th lowest risk factor out of 12, yet it should be noted that the YOS caseload is higher than the substance misuse service and many of these young people will be clients in both services.

With regards to clients that require a prescribed treatment modality such as opiate substitute therapy (OST), more commonly known as methadone, there is a contractual agreement in place between the adults and young person's service and this should continue in future. This exceptional clause has not been required for the duration of the expiring 5-year contract.

This document asks two key questions of commissioners, firstly whether the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high risk groups. We are confident that the answer is yes. Secondly, has the current provider targeted and 'found' the highest risk groups of children and young people? Based on the evidence of those children and young people in treatment with multiple specific and/or wider vulnerabilities the answer also has to be yes.

Key Lines of Enquiry

- Does the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high-risk groups?
- Has the current provider targeted and 'found' the highest risk groups of children and young people (CYP)?

2. Introduction

2.1 Background/Context

Substance misuse is often a symptom rather than a cause of vulnerability among young people. Many have broader difficulties in their lives that are compounded by drugs and alcohol and which need addressing at the same time. Viewing young people holistically as whole beings and tackling the root causes of substance misuse is more likely to reduce the number of young people who

experience long term negative impacts on their physical and mental health and go on to misuse substances into adulthood potentially as a form of 'self-medication'[1].

Young person's substance misuse treatment services engage vulnerable young people and intervene early to avoid or limit escalating risk and harm from substance misuse. The objective of such services is to support sustained recovery by supporting young people through the entire treatment process; from entrance into treatment to the point of re-integration back into the wider community[2].

Evidence shows that young people's lives can improve when they have access to substance misuse services alongside support to address their wider health and wellbeing needs. This means that the commissioning and delivery of specialist drug and alcohol interventions should take place within wider service structures that meet a range of needs. There is growing recognition that drug and alcohol services should be designed to address the wider determinants of health and that more effective joined up support should be available to tackle the complex needs experienced by many service users. For example, Inclusion (Thurrock's adult drug and alcohol treatment provider) offers support around issues such as intimate partner violence[3].

A Department for Education cost-benefit analysis found that every £1 invested in specialist substance misuse interventions delivered up to £8 in long-term savings and around £2.50 within two years, meaning that this can be a cost-effective way of reducing future demand on health and social care services[4]. A life course approach to drug prevention that covers early years, family support, universal drug education, and targeted and specialist support for young people is one of the key aims of the Government's 2017 Drug Strategy.

Parental drug use can compromise children's health and development, as well as impact on parenting capacity. Research cited in the Government's Hidden Harm report 2011[5] estimated that there were between 200,000 and 300,000 children in England and Wales where one or both parents had serious drug problems – representing 2-3% of children under 16. Children of parental drinkers are also at risk of Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder (FASD[6]) – which is a series of preventable birth defects caused entirely by a woman drinking alcohol at any

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[1] Public Health England. (2015). The International Evidence on the Prevention of Drug and Alcohol use: Summary and examples of implementation in England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669654/Preventing_drug_and_alcohol_misuse__international_evidence_and_implementation_examples.pdf (Accessed June 2018).

[2] Drugscope. (2013). Issues in Recovery: A Changing Landscape for Commissioning. http://www.drugwise.org.uk/wp-content/uploads/Regional-briefing-Changing-landscape-for-commissioning.pdf (Accessed June 2018)

[3] Drugscope. (2013). Issues in Recovery: A Changing Landscape for Commissioning. http://www.drugwise.org.uk/wp-content/uploads/Regional-briefing-Changing-landscape-for-commissioning.pdf (Accessed June 2018).

[4] Gov.UK, Public Health Matters. https://publichealthmatters.blog.gov.uk/2016/07/25/tools-for-assessing-value-for-money-for-alcohol-and-drug-treatment/ (Accessed July 2018).

[5] Gov.UK. (2018). https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users (Accessed July 2018).

[6] The Parliamentary Office of Science and Technology. Post Note number 570. (February 2018). http://researchbriefings.files.parliament.uk/documents/POST-PN-0570/POST-PN-0570.pdf (Accessed July 2018).

time during her pregnancy, often even before she knows that she is pregnant. Estimates by Alcohol Concern suggest that there were 7,317 children born in England in 2012 with FASD. The lifetime cost to the economy for a child born with FAS was estimated at £1,500,000, and the adverse consequences experienced by children can include: weakened immune systems; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; as well as poor educational attainment.

Caveats and limitations of the data

First there can be limited interrogation of the data extracts provided as it was not possible to develop an enhanced analytical approach (e.g. using multivariate statistical techniques) that could determine whether any correlations or associations between factors are statistically significant. The National Drug Treatment Monitoring System (NDTMS) datasets used in this report refer to small numbers of people in treatment and, unlike adult treatment data, do not come with prevalence estimates and penetration rates to compare against.

Current Service Provision

Thurrock's young person's substance misuse treatment service is currently provided by CGL (Change, Grow, Live) Wize Up. Over the life of the contract the service has been developed by recruiting an apprentice, a student social worker, a harm-reduction worker and peer mentors. This service development led to the team recently moving to slightly larger premises, still within a few minutes' walk of the adult treatment service that is now delivered by Inclusion Visions Thurrock (Midland Partnership Foundation Trust (MPFT)). Wize Up works with individual young people as well as families, if appropriate. This supports much of the research that illustrates the strength of working with the entire family unit to reduce risk of harm relating to substance misuse or to support recovery. It is important to note that substance misuse can and often does affect the family and community more widely and not just the person who is misusing substances or alcohol[7].

The local context is of a service which has a strong reputation across schools and partner agencies. The vast majority of interventions are provided via outreach, either in schools or other settings around the borough and occasionally even in the client's home. Only on rare exceptions would a client need to be seen at the provider's office.

Schools are very welcoming of the service and the support it provides to young people. Arrangements are made to ensure the keyworkers and students can meet at mutually agreeable times and venues which have the least impact upon learning e.g. at school and where possible during free periods.

Besides casework, the service also delivers prevention and awareness raising sessions across assemblies and suitable lessons, e.g. Physical, Social, Health, Economic (PSHE) lessons, to ensure a wider audience are aware of the risks associated with substance misuse, how to reduce the harm if they are to take the risks, and where to go for help should that be required.

[7] Drugscope. (2013). Issues in Recovery: A Changing Landscape for Commissioning. http://www.drugwise.org.uk/wp-content/uploads/Regional-briefing-Changing-landscape-for-commissioning.pdf (Accessed June 2018).

Drug use observed in Children and Young People in Thurrock

The drugs of choice used by young people in Thurrock have for a long time been cannabis and alcohol, which is reflected in the treatment population as the two main substances cited by young people in treatment. The main concern with cannabis is the increasing strength caused by hybridising the plants, upping the tetrahydrocannabinol (THC) levels and reducing the cannabidiol (CBD) levels. THC is the principal psychoactive constituent of cannabis and CBD, which has no psychoactive effect, is used in pharmaceutical medications[8]. Anecdotal evidence set out in the following three paragraphs has come by way of either the adult or young person's substance misuse services or from partner organisations and agencies that attend the Community Safety Partnership.

Novel Psychoactive substances (NPS), also known as legal highs or club drugs have seen an emergence in Thurrock in recent years, although not across the treatment population. For example, we know from street littler and local intelligence that the use of nitrous oxide (laughing gas) is a growing trend not in children and young people but in young adults who regularly discard their metal canisters in public car parks of an evening, but who are not presenting to treatment for support. This group of young adults are treatment naïve; they do not recognise the risks to themselves or the impact on others and do not regard themselves as requiring support with their risky behaviour. The misuse of nitrous oxide is not an entirely new phenomenon – the Victorians used to have laughing gas parties!

Synthetic cannabinoids, commonly referred to as Spice, are not an NPS that we see in the young person's treatment population. Anecdotal evidence from the adult treatment service suggests usage even amongst adults is rare and tends to be found in the criminal justice client group when serving custodial sentences.

Further anecdotal evidence suggests some young people in Thurrock are misusing Xanax, although they are not presenting for treatment. Xanax is a benzodiazepine, also known as Alprazolam, which has an immediate onset of action. It was introduced as a treatment for anxiety and panic attacks in the US in 1981 and became a popular recreational drug[9]. In the UK the recreational use of benzodiazepines has typically involved those prescribed by the NHS, in particular diazepam diverted from regulated supplies. A number of benzodiazepines have emerged on the NPS market in the last decade although the emergence of Alprazolam appears to be far more recent[10] and the size and scale of the market is still largely unknown.

Children and Young people in treatment

Thurrock had 94 clients in treatment (rolling 12 months April-March 2017/18), split across structured treatment for substance misuse and early intervention and prevention at a ratio of approximately 1:2 clients. Of those clients, 67 were new presentations to treatment[11]. The proportionately large

[8] Medical Marijuana Inc. News. (2017). https://news.medicalmarijuanainc.com/differences-cbd-thc/ (Accessed July 2018).
[9] National Survey on Drug Use and Health. (NSDUH-2016). https://www.datafiles.samhsa.gov/study/national-survey-drug-use-and-health-nsduh-2016-nid17184 (Accessed June 2018).
[10] DrugWatch Information Sheet: Alprazolam (Xanax). (2018). http://michaellinnell.org.uk/resources/downloads/Alprazolam%20(Xanax)%20briefing%201.0%209_2_18.pdf (Accessed June 2018).
[11] 2017-18 NDTMS CYP DAAT data

number of new clients was due to both an expansion of the Thurrock service and because the time spent in treatment in Thurrock is lower than the national average.

The majority of referrals to the service come from schools and social care, followed by youth criminal justice agencies (such as the Youth Offending Service - YOS). Most clients are in full time education, with a smaller percentage not in employment, education or training (NEET) and the smallest groups are those in apprenticeships or employment.

Many clients reported starting to misuse substances before the age of 16. In accordance with findings from Young Addaction[12] the majority of young people first use drugs when they are 13-14 years old. However, the age at which young people begin to use specific drugs seems to vary; a minority of young people begin their drug use with cannabis and alcohol prior to starting secondary school with the use of cocaine often beginning at a later age. This research suggests that the early teen years offer a key opportunity for early intervention and prevention. Additionally, substance misuse is often coupled with vulnerabilities including being involved in offending behaviour, being excluded from school, care leavers and looked after children. Young people who misuse substance are also more likely to engage in other risk taking behaviours – such as unsafe sexual behaviours, criminal activity and domestic abuse[13].

The numbers accessing the service are relatively small but nevertheless illustrate effective partnership working across Thurrock and demonstrate the young person's substance misuse service's ability to engage and work with some of the most complex cases that involve support from a range of agencies.

In the context of substance misuse, and as noted above, Hidden Harm refers to those young people who have parents or carers that misuse substances. Some of these young people are primary school pupils aged 11-years or younger. Others are older and may have a substance misuse need of their own alongside their hidden harm vulnerabilities.

Nationally, best practice standards apply to service providers to ensure they identify, assess, treat and exit or transfer clients consistently across the sector[14]. Public Health England, which subsumed the National Treatment Agency in 2013, also lays out a set of commissioning standards for specialist substance misuse services for young people, which was published in January 2017[15]. This was a rapid mixed methods evidence review of current provision and highlighted the main principles for commissioning. It ostensibly provides a framework of 4 key principles to ensure that: young people and their needs are at the centre of service provision; quality governance is in place for all services;

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[12] Young Addaction. (2015). Young People and Substance Abuse. http://www.youngpeopleshealth.org.uk/wp-content/uploads/2016/06/Young-People-and-Substance-Misuse-Report.pdf (Accessed June 2018).
[13] Young Addaction. (2015). Young People and Substance Abuse. http://www.youngpeopleshealth.org.uk/wp-contents/uploads/216/06/Young People and Substance-Misuse-Report.pdf. (Accessed June 2018).
[14] College Centre for Quality Improvement. (2012). Practice Standards for young people with substance misuse problems.
https://www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems.pdf (Accesses June 2018).
[15] Public Health England. (2017). Specialist substance misuse services for young people: Main principles for commissioning.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/583218/Specialist_substance_misuse_services_for_young_people.pdf (Accessed June 2018).

multiple vulnerabilities and complex needs are addressed and that appropriate transitional arrangements exist for young people becoming young adults.

2.2 Objectives

The aim of this needs assessment is to examine the needs of young people aged less than 18 years residing in Thurrock and who access or may need to access the specialist substance misuse service. It also reviews the existing service offer and seeks to provide recommendations on where and how to enhance this offer. The report looks to identify gaps or barriers in service provision and provides recommendations to overcome these. Fundamentally, it seeks to discover whether the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high-risk groups set out in this document. It also seeks to determine whether the current provider has targeted and 'found' the highest risk groups of children and young people and Thurrock and supported them through treatment.

3. Epidemiology

Key Points

Population

- Thurrock's population for those aged under 18 is set to steadily increase over the next 10 years by 13%, to 47,476
- For those aged 10-17 the projected increase is 30% over 10 years
- Prevalence estimates for young person's substance misuse are currently notoriously difficult to estimate
- Numbers in treatment have increased to a level three times that of 2014

Treatment Population

- It is not yet possible to determine whether the increase in treatment numbers is due to an increase in local prevalence of substance misuse or whether the increased capacity of the existing service has enabled more young people to access treatment
- We are better than the national average at engaging with young people who require substance misuse interventions that are in mainstream education, thus preventing the escalation of wider vulnerabilities
- Over half of young people in treatment are engaged in poly-drug misuse
- Almost 1 in 5 clients have been assessed as being involved in offending behaviour

Criminal Justice

- Young offenders (or those at risk of offending) are a highly marginalised group and often have greater health needs than the non-offending population, experiencing exposure to inequalities in health that persist into adult life, including a higher incidence of physical and mental ill health, sexually-transmitted disease, injuries, and early pregnancy in females
- Drugs offences were uncommon and substance misuse was the 4th lowest risk factor at assessment, out of 12 risk factors

3.1 Population

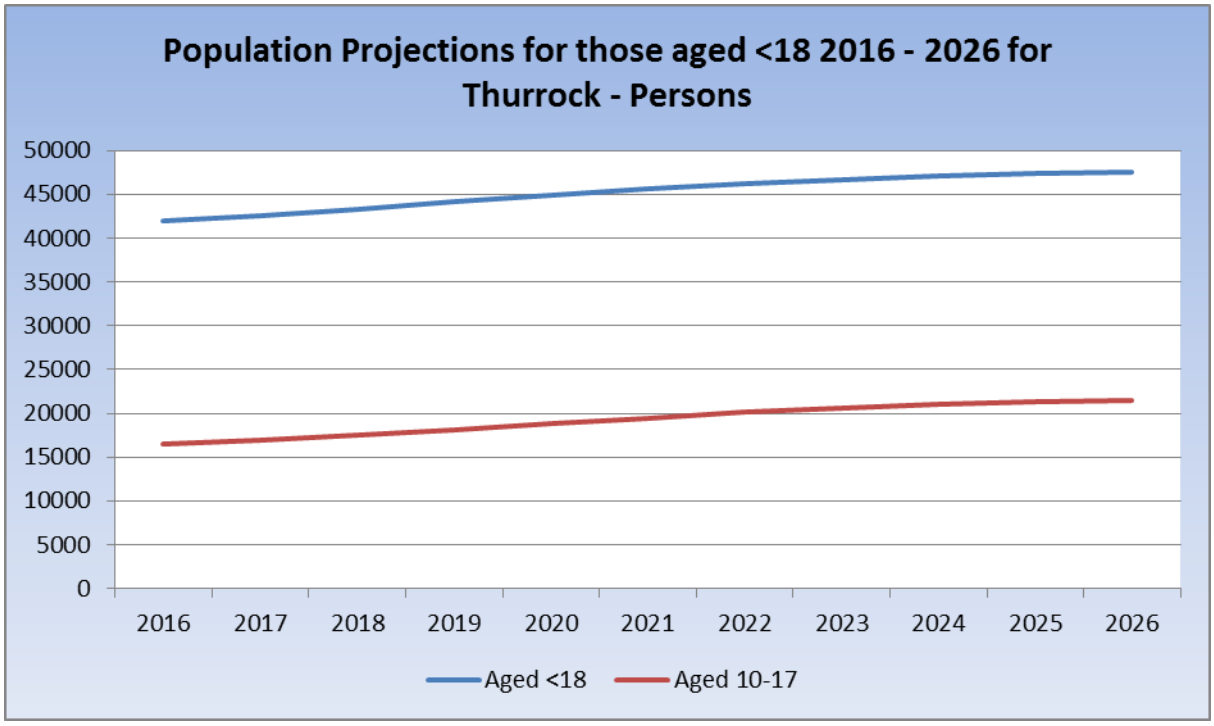
What do we know?

The numbers of young people in treatment misusing substances are generally small, which means using Chartered Institute of Public Finance and Accountancy (CIPFA) comparators is unreliable. The Local Outcome Comparators (LOC) is used for adult services, so for young people it is the norm to compare against national averages.

As of mid-2016 Thurrock had a population estimate of 168,428. Of this, Thurrock's young person's population of under 18's is 42,030 and those aged 10-17 is 16,532. The 10-17 age group is deliberately used since 10 is the age that a child becomes criminally responsible in the eyes of the law and 18 is when young people are deemed to be adults. It is also the age that a client will access the adult treatment service as opposed to the service at the focus of this document.

Thurrock's population for those aged under 18 is set to steadily increase over the next 10 years from 42,030 to 47,476 (from the 2016 baseline), which is an increase of 13%. For those aged 10-17 the projected increase is 30% over 10 years.

Figure 1: Population Projections for those aged < 18 years in Thurrock, 2016-2026



Source: ONS

Against this population increase, the prevalence estimates for young people's substance misuse are notoriously difficult to determine, meaning we cannot say with certainty what the actual level of treatment need is across our young person's population. However, in 2014/15 the What About Youth (WAY) Survey was launched as part of a government pledge to make improvements to the health of young people. The purpose was to collect robust local level data on a range of topics relating to young people, to help drive an improvement in outcomes. Unfortunately the survey has

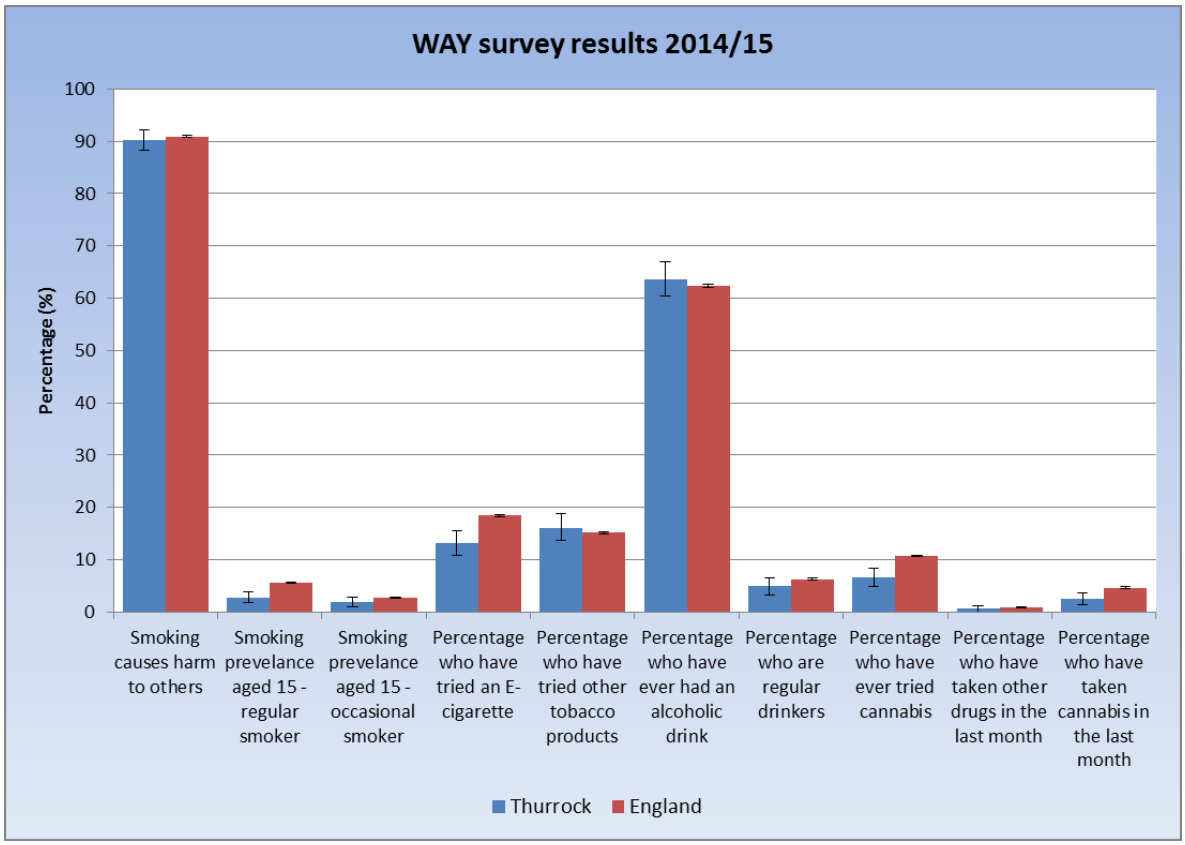
not since been repeated so we cannot compare years or make a trend analysis, although it does provide some useful data on risky behaviours such as tobacco, alcohol and cannabis use.

Around 300,000 15 year olds were randomly selected by the Department of Education and were invited to complete the questionnaire, with around 120,000 completed questionnaires being returned. For Thurrock this equated to 608 questionnaires. Some of the questions asked were regarding substance use and asked for their opinions about this topic.

90% of those who answered the survey in Thurrock felt that smoking caused harm to others, which was a similar percentage to England overall. From the survey 2.3% classed themselves as regular smokers and 1.9% as occasional smokers. Interestingly, the proportion of regular smokers in Thurrock is significantly below the England average. Regarding e-cigarettes, 13.2% of respondents in Thurrock said they had tried one (also significantly below the England average) and 16.1% had tried 'other tobacco products'.

Regarding substance misuse, 63.6% of young people in Thurrock said they had tried an alcoholic drink. Nationally the figure was 62.4%. Almost 5% in Thurrock classed themselves as regular drinkers. Regarding cannabis, 6.6% of young people living in Thurrock said they had tried cannabis with 2.5% having taken it within the last month. This data is summarised in the following figure.

Figure 2: WAY Survey results, Thurrock, 2014/15



Source: Fingertips

The findings from the WAY survey broadly match those from the Smoking, Drinking and Drugs (SDD) surveys. In addition the Brighter Futures survey was commissioned by Thurrock Council to improve local data related to the emotional health and well-being of children and young people. The

intention of this supplementary data source is to improve local knowledge, contribute to local priorities and strategies and improve the provision of needs-led services to children, young people and families. Questions covered a range of risky behaviours and asked approximately 1,000 young people about their level of engagement in them.

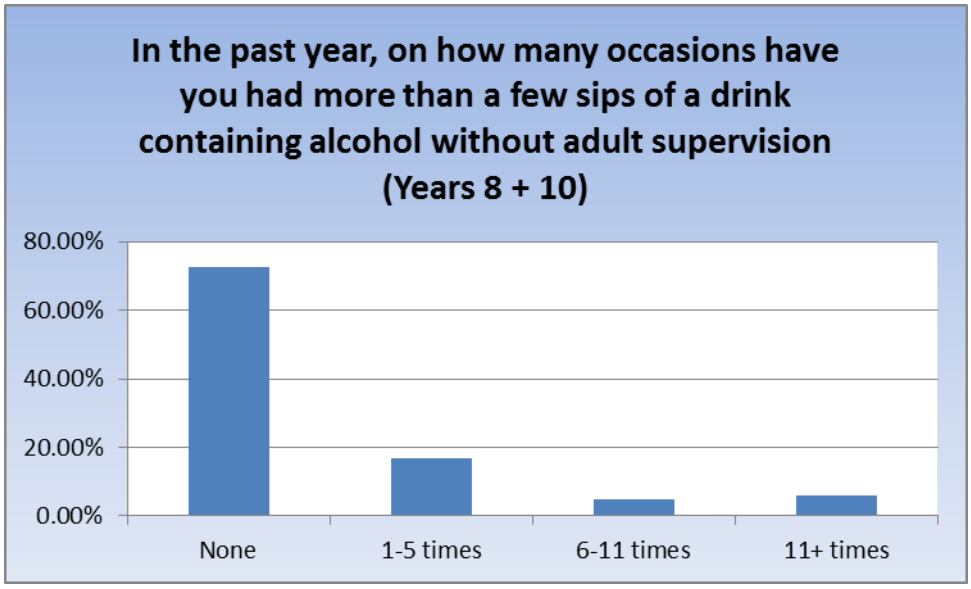
There are limitations to this data. Firstly, the sample size is relatively small and it is based on a single survey, so we recognise that it provides just a snapshot of young people's experiences. The reliability of the responses remains to be proven. Some respondents will have exaggerated their substance misuse, whereas others who were cautious as to the confidentiality of the survey may have minimised or denied any substance misuse. In a sample size of approximately 1,000 pupils we expect this 'noise' within the data to have cancelled itself out. The survey will be repeated annually so the pool of data and our confidence in its accuracy will increase in future years. Until then, the key areas of interest from the inaugural survey are set out below.

Figure 3: Brighter Futures Survey - How many times have you tried alcohol without an adult being around (year 6 in Thurrock)

Source: Brighter Futures survey 2016/17

The figure above illustrates that just over 10% of Year 6 pupils surveyed said they had tried alcohol without an adult being around.

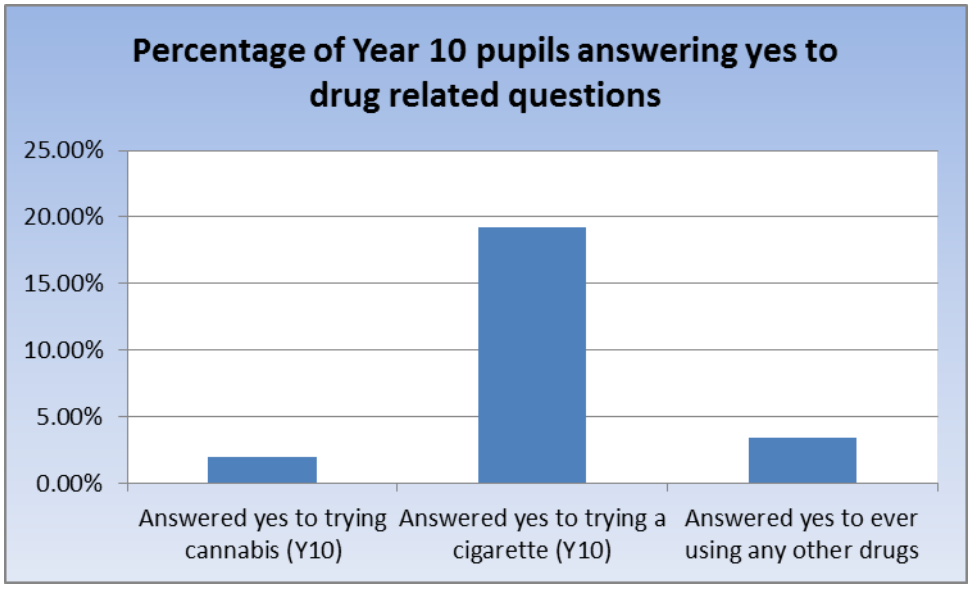
Figure 4: Brighter Futures Survey - In the past year, on how many occasions have you had more than a few sips of a drink containing alcohol without adult supervision (Years 8+10 in Thurrock)



Source: Brighter Futures survey 2016/17

Just over 16% of year 8 and 10 pupils surveyed said they have had 'more than a few sips' of a drink containing alcohol without adult supervision on at least one occasion in the past year, although over 70% had not.

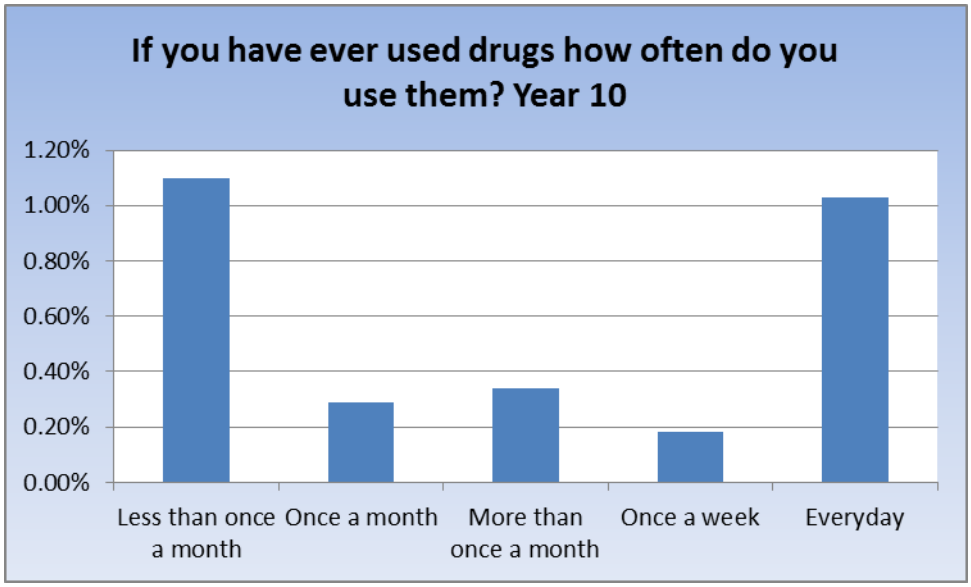
Figure 5: Brighter Futures Survey - percentage of year 10 pupils in Thurrock answering yes to drug related questions - have you tried, cannabis, tobacco or using any other drugs?



Source: Brighter Futures survey 2016/17

Almost 2% of year 10 pupils surveyed answered 'yes' to having tried cannabis, 19.2% had tried a cigarette and 3.38% had tried other types of drugs.

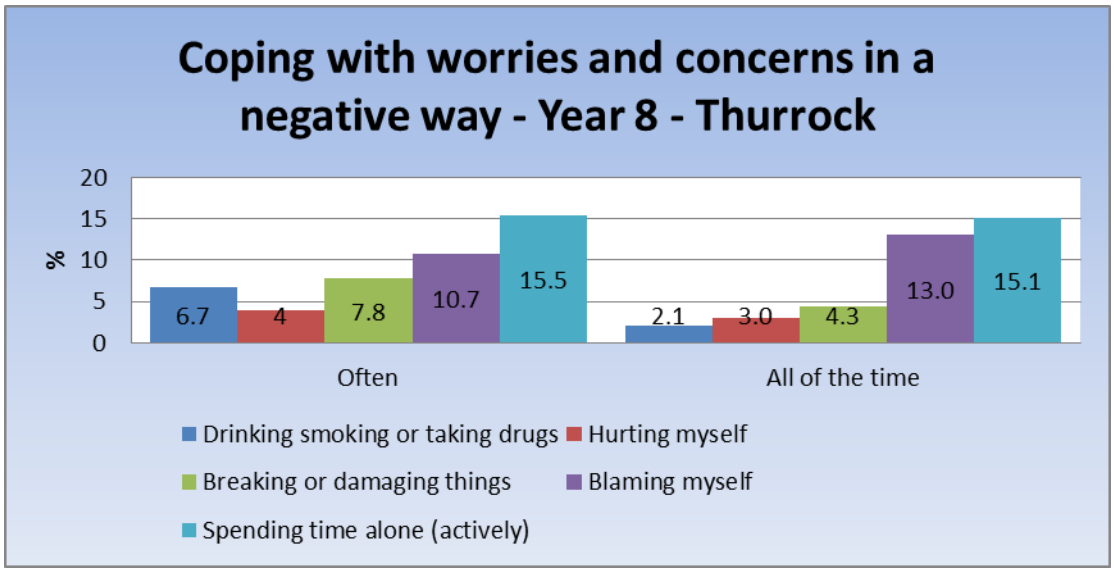
Figure 6: Brighter Futures Survey - If you have ever used drugs, how often do you use them (Year 10), Thurrock



Source: Brighter Futures survey 2016/17

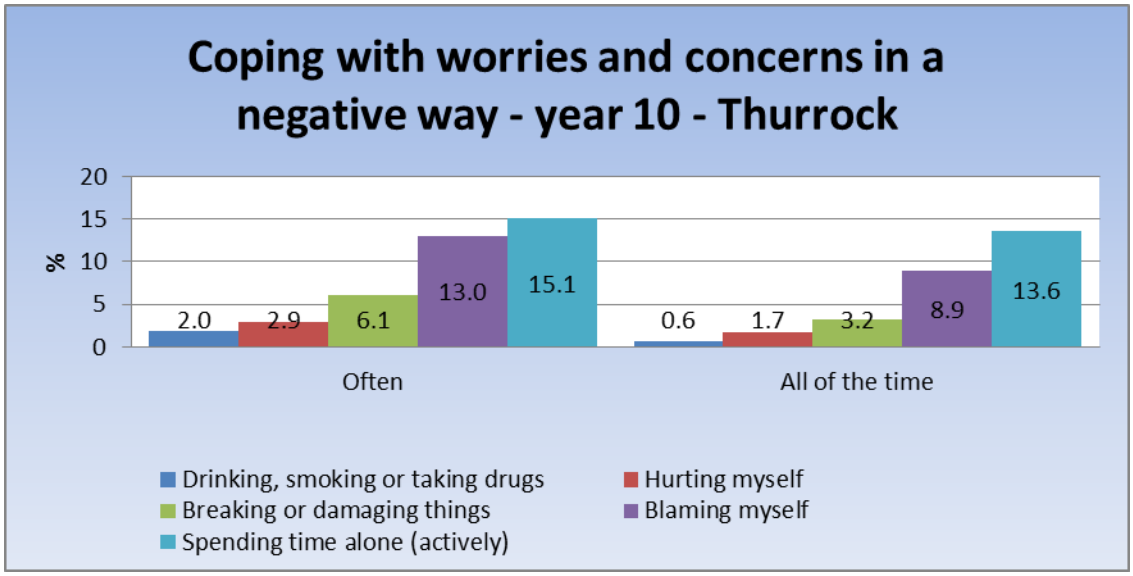
As highlighted in the figure above, just over 1% of year 10 pupils surveyed answered that they used drugs every day.

Figure 7: Brighter Futures Survey - Coping with worries and concerns in a negative way (Year 8), Thurrock



Source: Brighter Futures survey 2016/17

Figure 8: Brighter Futures Survey - Coping with worries and concerns in a negative way (Year 10), Thurrock

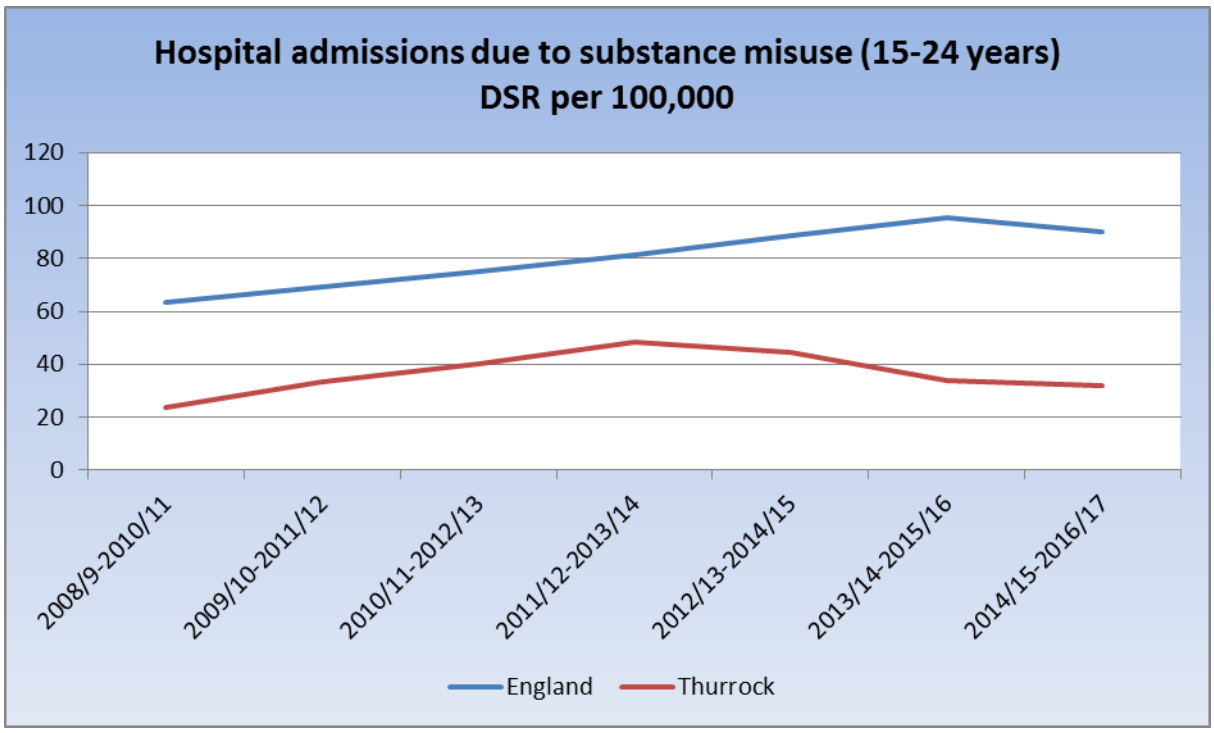


Source: Brighter Futures survey 2016/17

The survey recorded that 6.7% of Year 8 pupils surveyed coped with worries and concerns by drinking, smoking or taking drugs often and that 2.1% did it all the time. For year 10 this was 2.0% and 0.6% respectively, which is a downward trend but could be confounded by the lower rate of survey completion in year 10 compared with year 8 pupils. Moreover, a slightly higher percentage of year 10's said they drank, smoked or took drugs none of the time (89%), rarely (5%) or some of the time (4%) compared to year 8's that were 88%, 3% and 3% across the same questions. This shows that more year 10's never drink, smoke or take drugs, or if they do they are more likely to do it rarely or some of the time.

With regards to A&E/hospital attendances due to substance misuse, overall Thurrock has lower levels of admissions than England. The rate was increasing between 2008/9-2010/11 and 2011/12-2013/14 but has been reducing over the more recent few years. However, the level in 2014/15-2016/17 is still higher than that of 2008/09-2010/11. A recording issue at the nearest A&E department was attributed to the drop in the Thurrock rate from 2011/12-2013/14. Once rectified we saw the rate of decline reduce. Quite why the Thurrock rate is so far below the national average remains to be fully understood. The data largely refers to alcohol misuse and the nearest A&E departments are out of borough. There is a possibility that due to accessibility Thurrock young people simply do not present to A&E for alcohol related illness or injury compared to their national counterparts, that the local ambulance service and nearest A&E departments provide effective treatment that prevents hospital admissions in this group or that it is simply not accurately recognised that alcohol/drugs is the main cause for the hospital admission.

Figure 9: Hospital Admissions due to Substance Misuse (15-24 years), DSR per 100,000 Thurrock 2008-2017

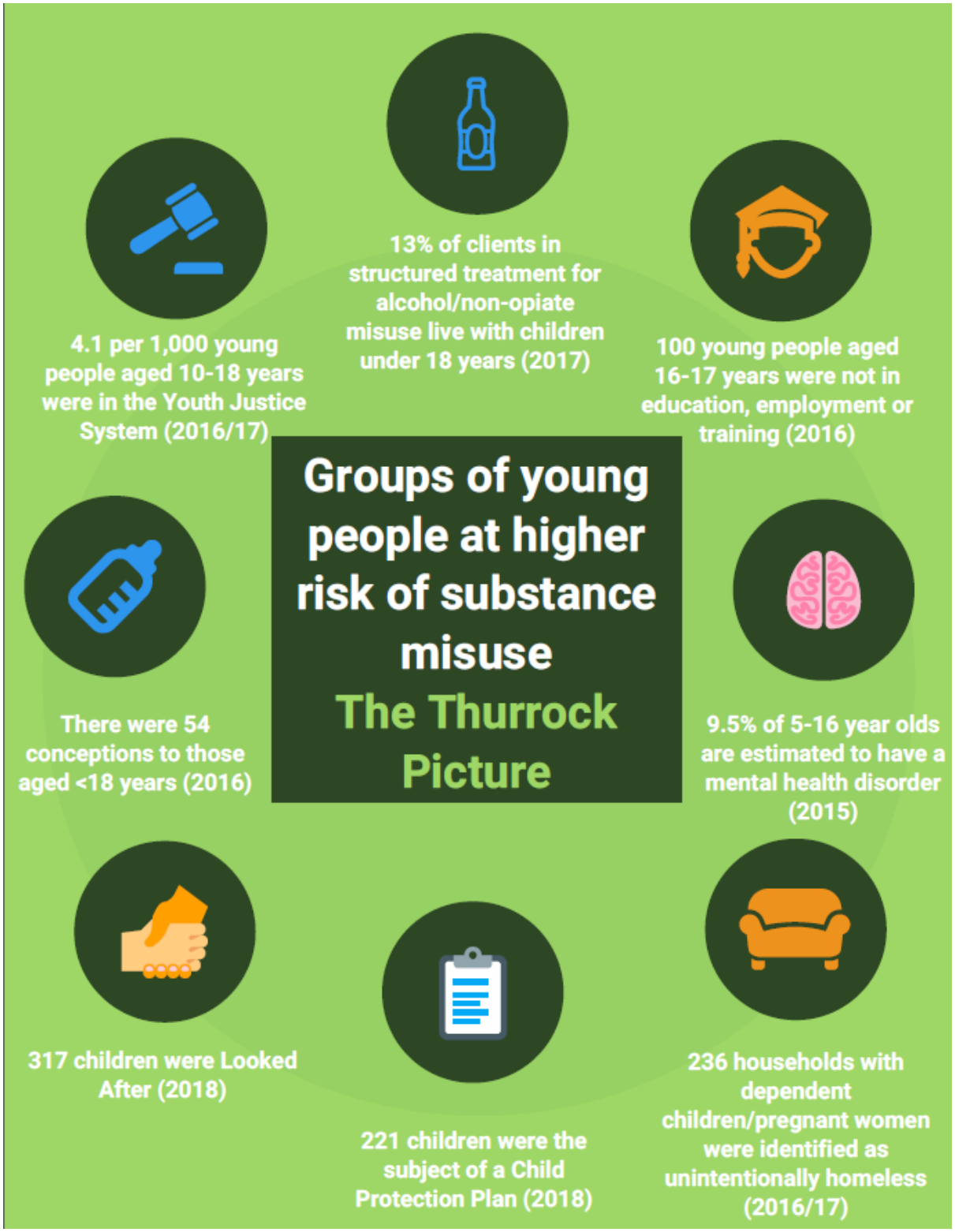


Source: Fingertips

3.2 Description of the treatment population

The following infographic provides a picture of the groups of Thurrock young people at higher risk of substance misuse.

Figure 10: Groups of Young People at Higher Risk of Substance Abuse: The Thurrock Picture



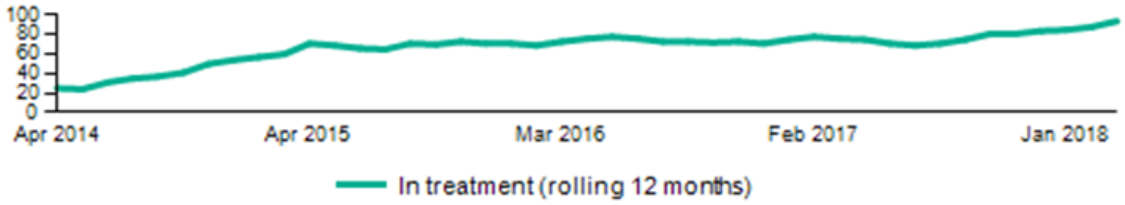
Source: NDTMS 2017/18, PHE Fingertips

What do we know?

Entering Treatment

As of March 2018 the young person's substance misuse service had 94 people in treatment. This is rolling data and the below graph illustrates the steady rise in treatment numbers across the last 5 years, which matches the lifetime of the expiring contract.

Figure 11: Number of young people accessing treatment in Thurrock, 2014-2018



Source: NDTMS

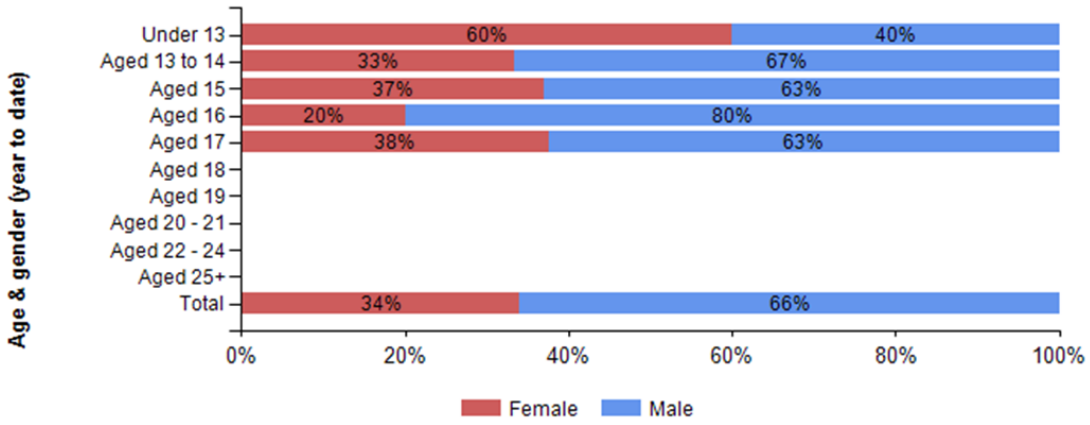
The numbers in treatment were unusually low in April 2014 due to the transfer of cases from the outgoing provider, particularly as the client group are naturally sensitive to change. Added to this is the requirement for clients to be closed to the outgoing provider and opened as new clients to the incoming provider and we find some clients disengaged from treatment for a while until reassurance spread across the treatment community.

The service works with those young people aged up to 18 years of age. Some similar services elsewhere also work with vulnerable adults up to the age of 25. For Thurrock, the adult and young person contracts have agreements built in to allow for transfer of such clients by exception.

In Thurrock, there were 94 new entrants to treatment services in 2017/18 and the below graph illustrates the gender split of those in treatment. The very young clients tend to be majority female, accessing hidden harm support. As age increases we see a sudden shift towards males being the majority group in treatment. Age of initiation is often the strongest predictor of the length and severity of substance misuse problems – the younger the age that young people start to use, the greater the likelihood of them becoming adult problematic drug users. (It is noted that this does not necessarily indicate the age of initiation). This underpins the findings from Young Addaction[16], as noted in the Introduction in this report.

[16] Young Addaction. (2015). Young People and Substance Abuse. http://www.youngpeopleshealth.org.uk/wp-content/uploads/2016/06/Young-People-and-Substance-Misuse-Report.pdf (Accessed June 2018).

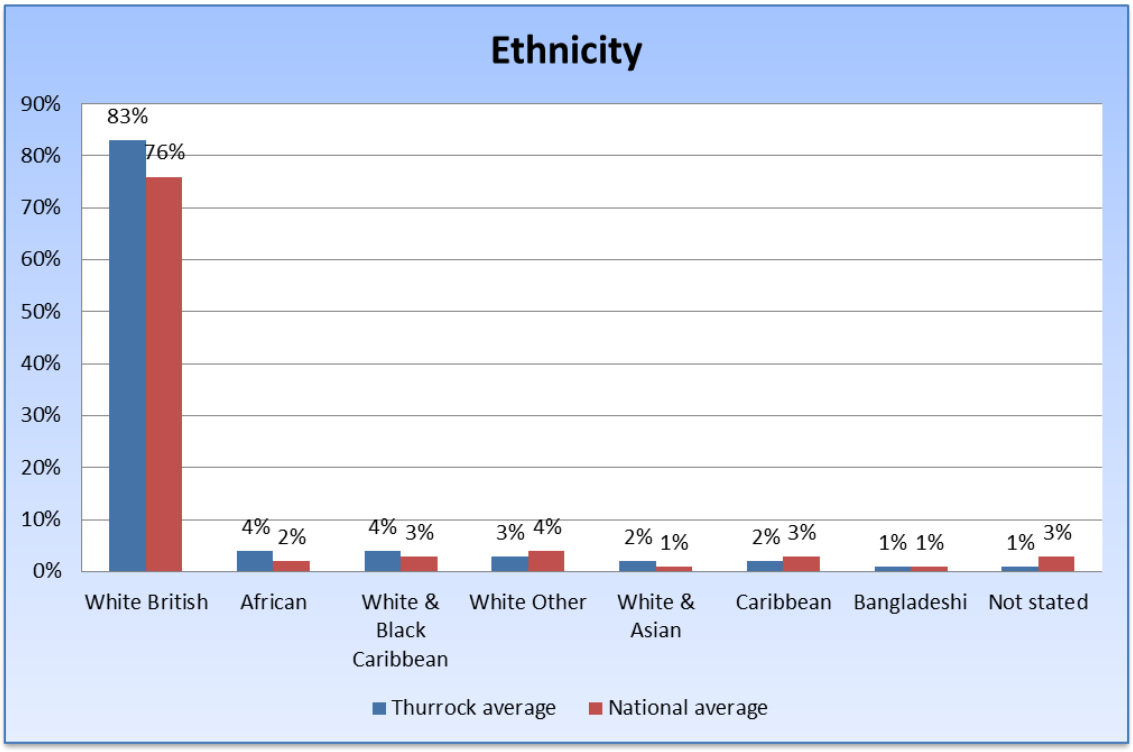
Figure 12: The age of young people entering treatment services in Thurrock in 2017/18



Source: NDTMS

In terms of ethnicity, those in treatment were predominantly White British, with six ethnic minority groups making up the remaining client groups. This was not dissimilar to the national average, where the unaccounted 7% was split equally across 7 other ethnic minority groups. The service receives referrals from numerous agencies and partners, including self-referral. The percentages here are unlikely to be a reflection of the true substance misuse levels within these ethnic groups and accurately determining the prevalence estimates across these groups is not currently possible. What we can see is that the service works with twice as many African and 25% more White & Black Caribbean young people than the national average.

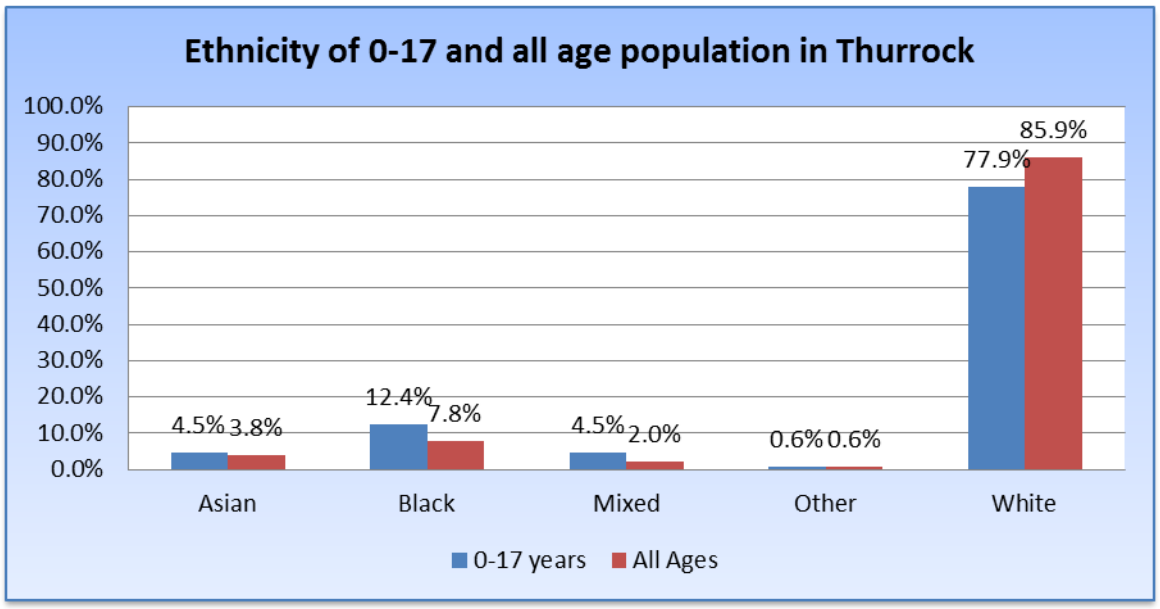
Figure 13: Ethnicity of young people accessing treatment in Thurrock, 2017/18



Source: NDTMS

Our child population in Thurrock is more ethnically diverse than the all age population. The figure below compares the ethnicity of the local population aged 0-17 years with the ethnicity of the total Thurrock population. From this, it can be seen that there is a lower proportion of White residents in the 0-17 population and a higher proportion of Asian, Black and Mixed ethnic groups, which tells us that the local service is identifying and working proportionately across these ethnic groups.

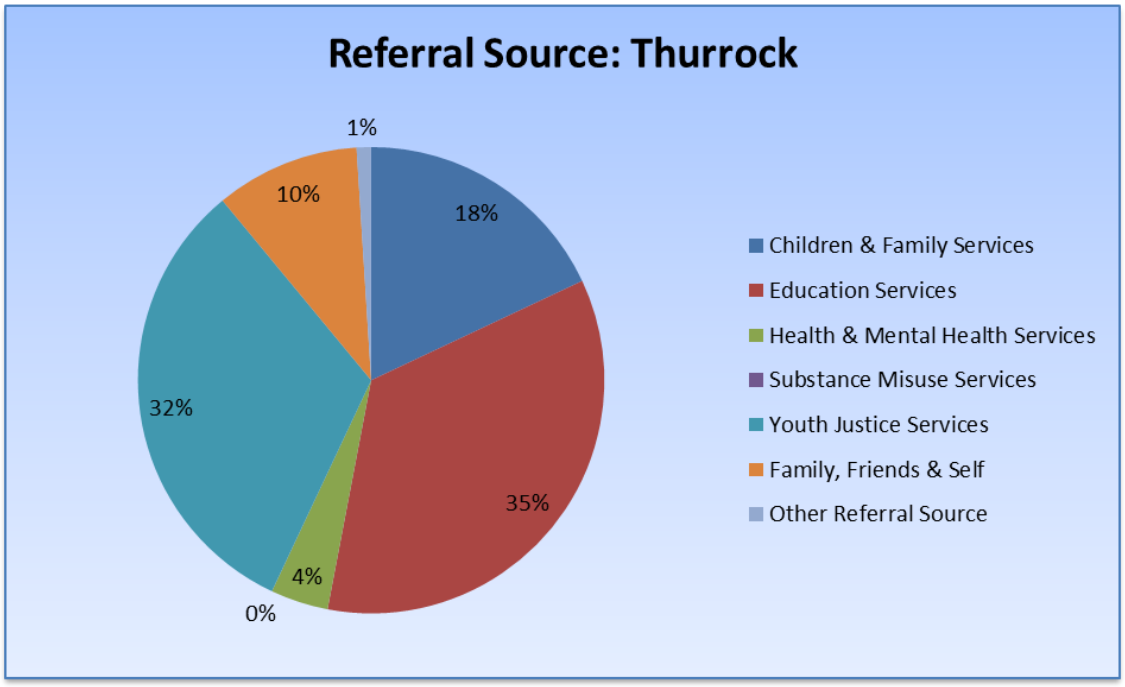
Figure 14: Ethnicity of 0-17 year and all age population in Thurrock



Source: Child and Maternal Health Intelligence Network

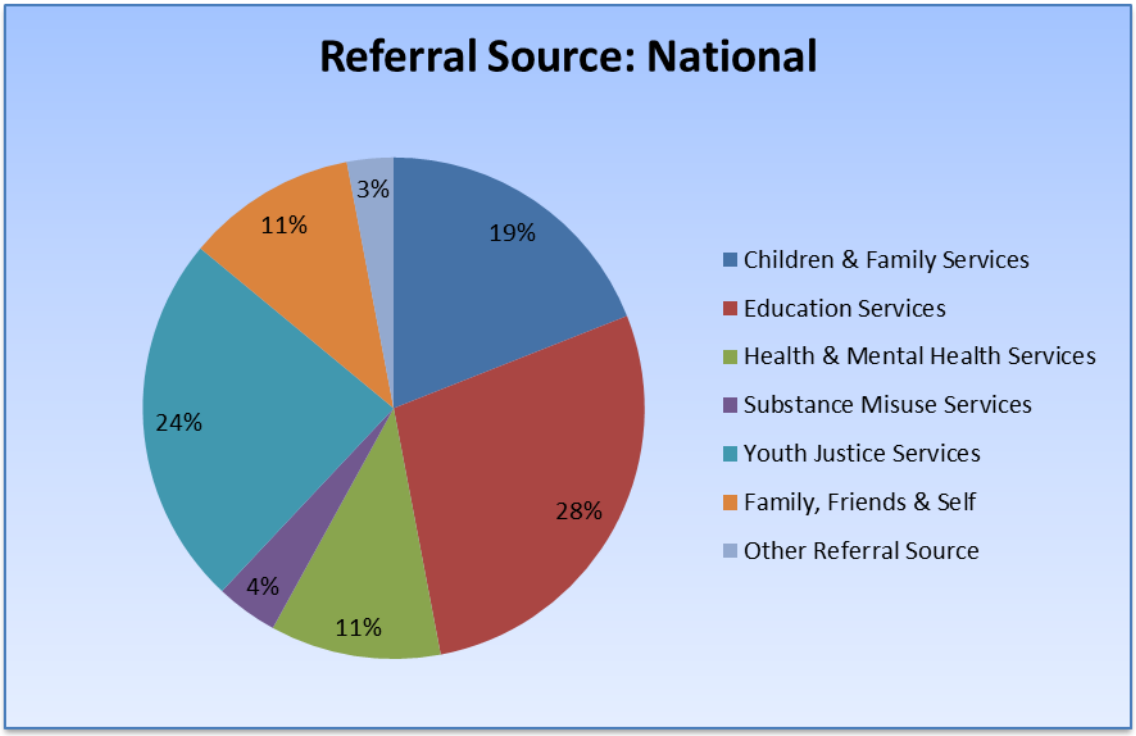
Referrals to the service come from a range of sources, illustrated by the below pie chart. The vast majority have come from Education and Youth Justice Services, demonstrating effective referral pathways and partnership working. Thurrock is above the national average against these two referral sources, considerably so with regards to Youth Justice Services. Children's Services is also a popular referral source, followed by Friends, Family or Self-referral, both of which are in line with the national averages. Just 4% of Thurrock referrals came from Health & Mental Health Services compared to 11% nationally and should be an area of future focus.

Figure 15: Referral Source for young people accessing treatment in Thurrock, 2017/18



Source: NDTMS

Figure 16: Referral Source for young people accessing services, nationally, 2017/18

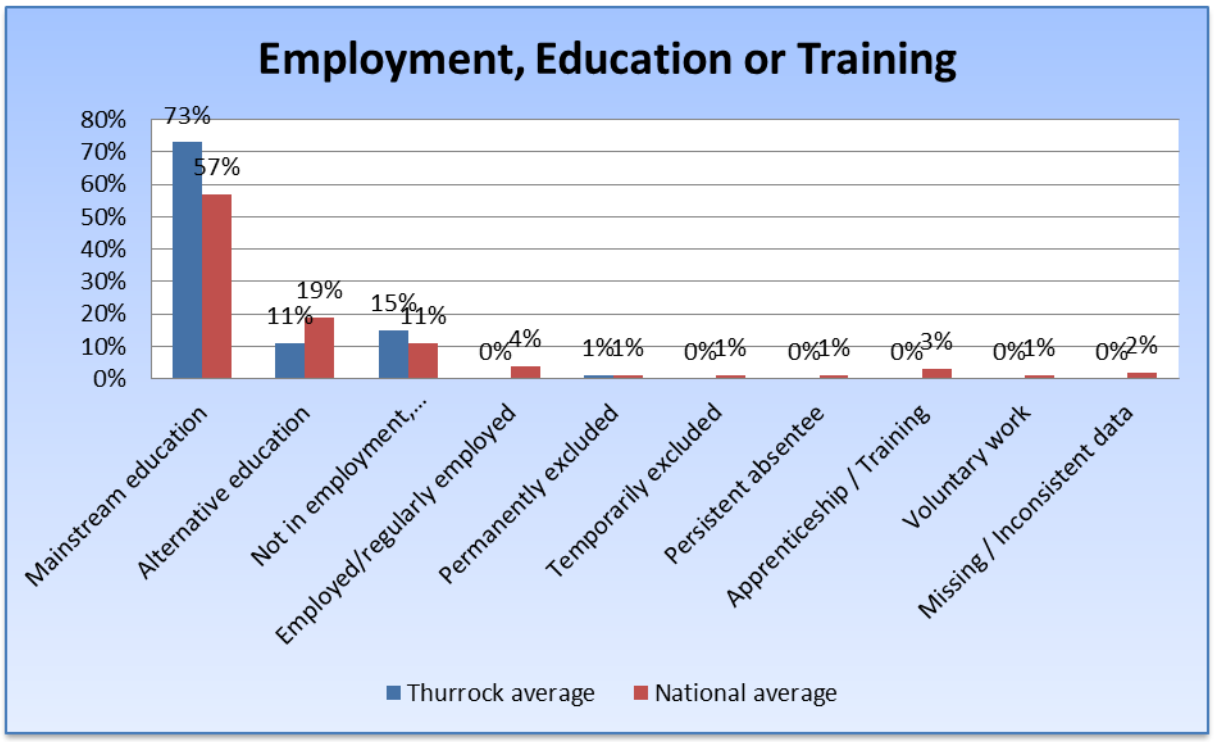


Source: NDTMS

In terms of education, employment or training, the majority of young people in treatment were in mainstream education, a figure that was above the national average. The next largest group for Thurrock were those not in employment, education or training (NEET), closely followed by those in

an alternative education programme such as the Pupil Referral Unit (PRU). These figures were similar to the national average. The remaining group was formed of individuals who were permanently excluded. No young people were recorded as being in full time or regular employment; the national average being 4%. Nationally, the unaccounted 8% was shared across the bottom 5 groups in the below graph.

Figure 17: Young People who are in treatment who remain in employment, education or training in Thurrock, 2017/18

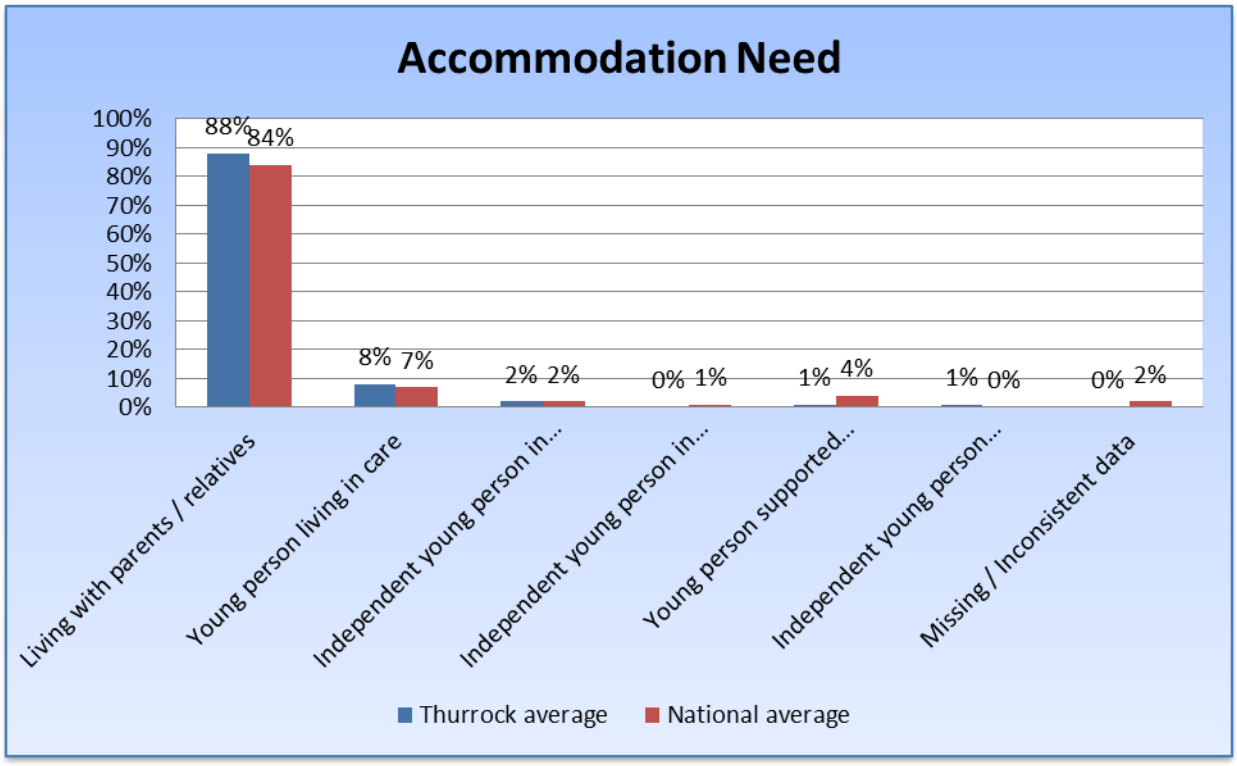


Source: NDTMS

We can see from the above graph that in Thurrock we are better than the national average at engaging with young people who require substance misuse interventions that are in mainstream education, thus preventing the escalation of wider vulnerabilities that are set out below.

The vast majority of young people in treatment in Thurrock live with their parents or relatives, with the remainder split across living in care, independent accommodation or supported housing. This broadly matches the national averages for such a client group. The no fixed abode category refers to those clients who 'sofa surf' and rotate usually between a core group of friends' addresses as opposed to being street homeless.

Figure 18: Accommodation need of young people accessing treatment in Thurrock 2017/18



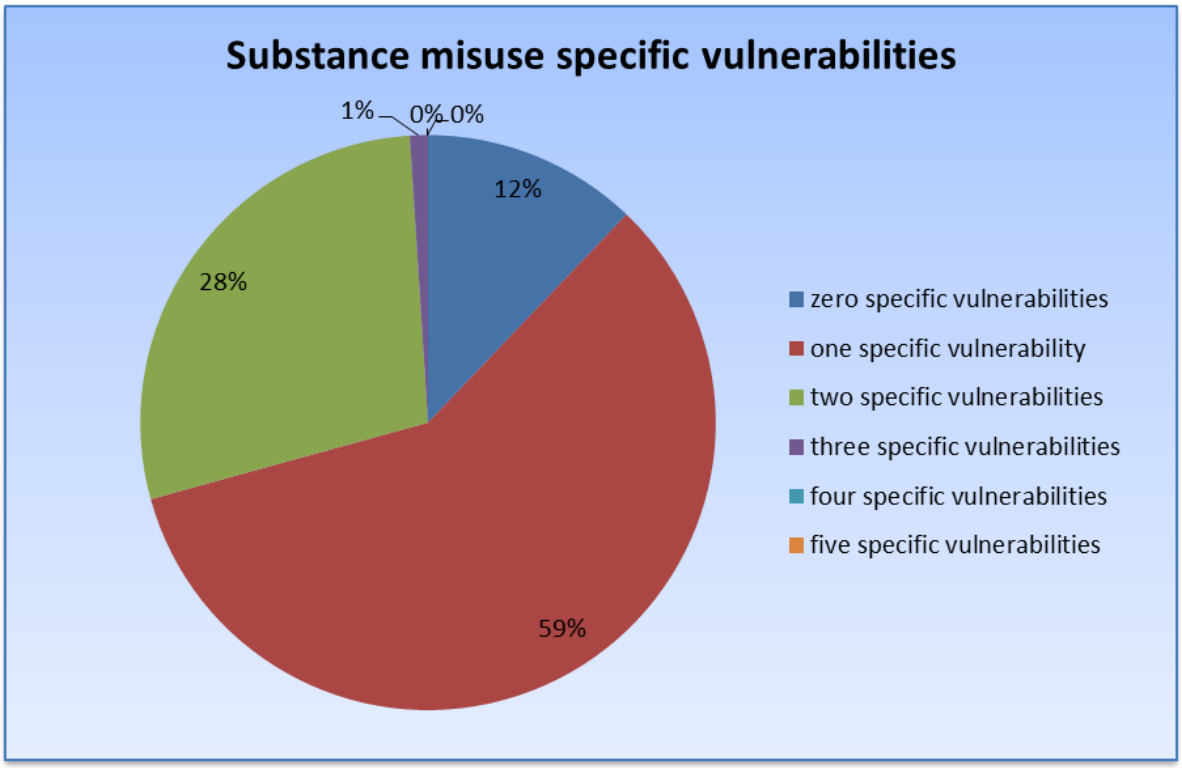
Source: NDTMS

Substance misuse specific vulnerabilities are categorised in 5 groups:

1. Early onset of usage (young age when misuse begins)
2. Poly-drug user (more than one problematic substance misused)
3. High risk alcohol user
4. Opiate or crack user
5. Injecting

The following pie chart illustrates these groups; it should be noted that Thurrock has no opiate or crack users or injecting young people in treatment (groups 4 and 5). Therefore the segments in the following pie chart refer to clients who have either no specific vulnerabilities or have up to three specific vulnerabilities from groups 1-3 above.

Figure 19: Number of substance misuse specific vulnerabilities experienced by young people in Thurrock, 2017/18



Source: NDTMS

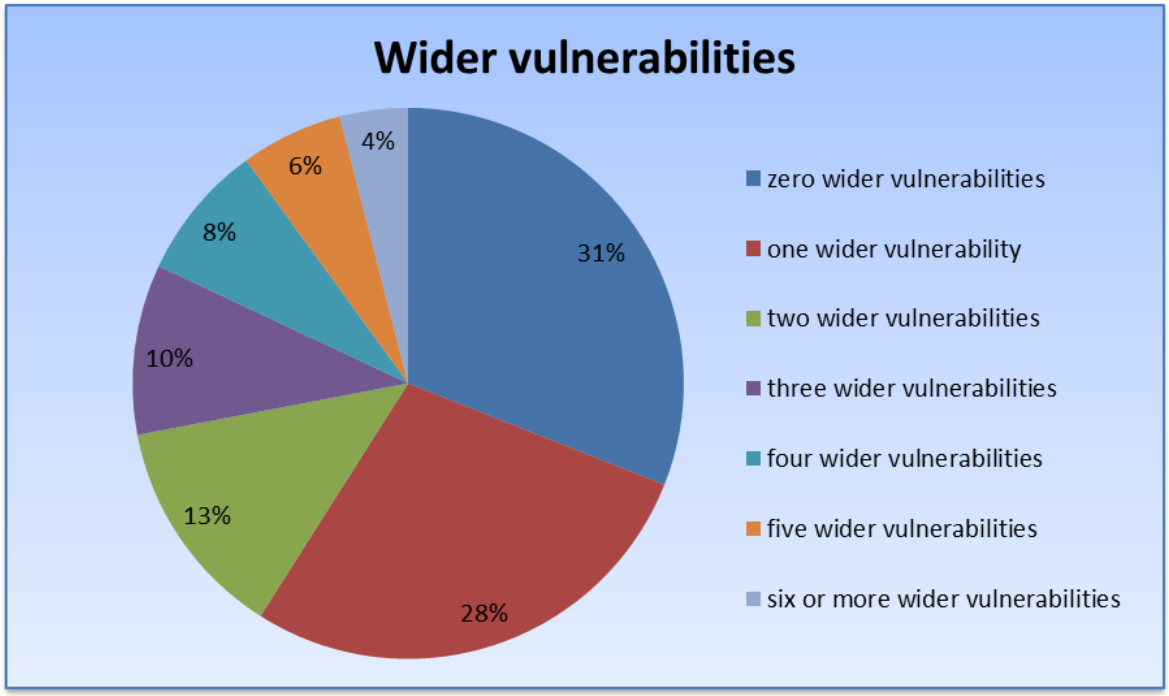
Wider vulnerabilities form a larger list of twelve categories:

1. Looked After Child
2. Child In Need
3. Domestic Abuse
4. Mental Health problem
5. Sexual exploitation
6. Self-harm
7. Not in Employment, Education or Training (NEET)
8. Housing problems
9. Parental status / pregnant
10. Child Protection Plan
11. Anti-social behaviour / criminal act
12. Affected by others' substance misuse.

The following pie chart illustrates the complexities of the client group in Thurrock, with roughly a third of clients having no wider vulnerabilities from the above list, a third having one or two wider vulnerabilities and the remaining third of clients having three to six or more vulnerabilities. By definition, those clients scoring three or more wider vulnerabilities will be very complex cases with multi-agency action plans; high users of services. These clients are more likely to demonstrate offending behaviour, poor school attendance or attainment and suffer socio-economic disadvantages, which might include living in a deprived part of the borough or have parents/carers who are unemployed and who may have a substance misuse need of their own. They are likely to

utilise more keyworker time and spend longer in treatment compared to clients with fewer wider vulnerabilities.

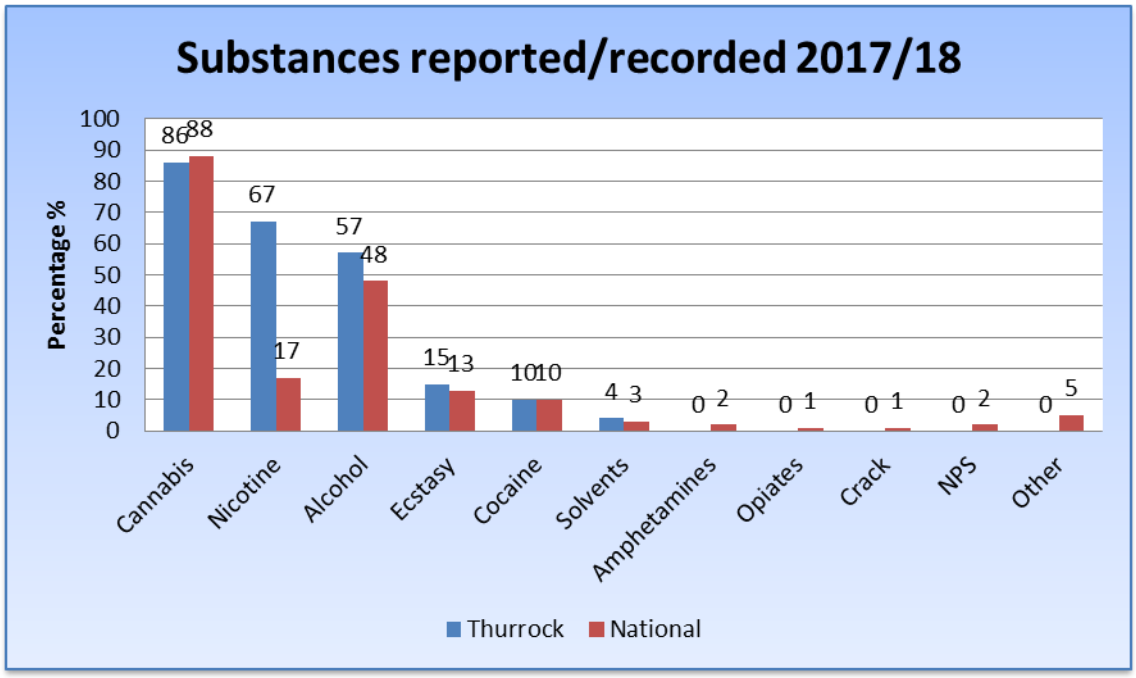
Figure 20: Number of wider vulnerabilities experienced by young people accessing treatment in Thurrock, 2017/18



Source: NDTMS

The main type of substance misuse service offered in Thurrock in 2017/18 was for cannabis, followed by alcohol. When compared to the national average, Thurrock was broadly in line with the national data, although it can be noted that no young people were in treatment for opiate or crack misuse. The main anomaly is the data for nicotine. Thurrock's data has stood out in the national figures for the last 5 years when we implemented stop smoking referrals into the treatment offer; by definition cannabis misuse will almost always involve some level of tobacco smoking. Cocaine and ecstasy are not common drugs cited by young people in treatment, and the level of misuse in Thurrock is in line with the national picture.

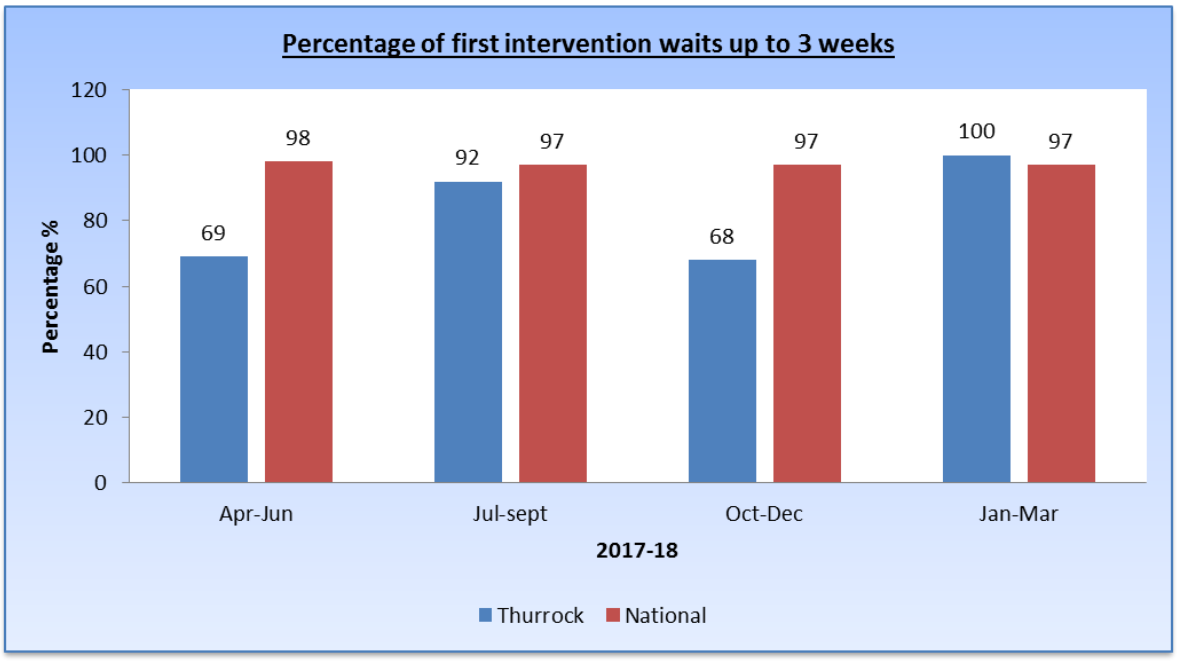
Figure 21: Young people entering treatment services in 2017/18 in Thurrock and England by substance type



Source: NDTMS. Technical Notes: Figures are of YP in specialist substance misuse community services 2017/18. Substances cited are from any episode for the young person in the year (any citation in drug 1, 2 or 3). Individuals may have cited more than one problematic substance so percentages may sum to more than 100%

Waiting times

Figure 22: Percentage of first intervention waits of up to 3 weeks, 2017/18 (Thurrock and nationally)



Source: NDTMS

The graph above shows that the waiting time for Children and Young people in Thurrock to be seen by the service is worse than the national average for the first 9 months of 2017-18 but slightly better

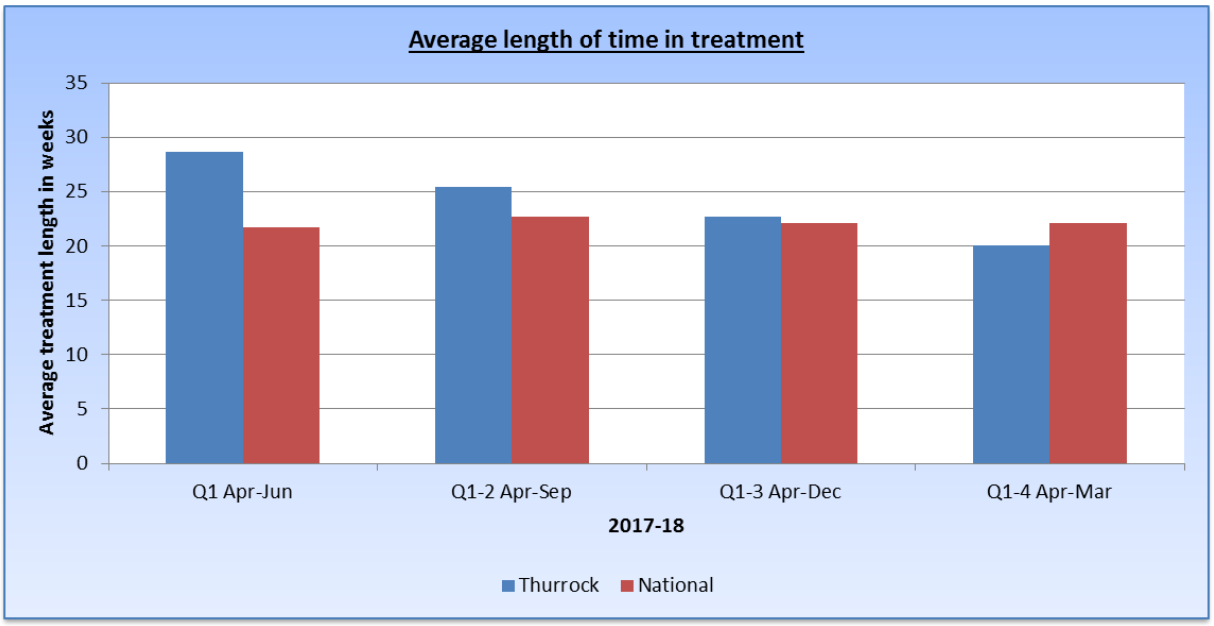
for quarter 4, with 100% being seen within 3 weeks; demonstrating that young people no longer have to wait lengthy periods between assessment and the start of their treatment. It also signifies that the longer waiting times observed at the start of 2017/18 has been reduced. Consequently it is proposed that this should continue to be monitored by the new for Thurrock.

In Treatment

The graph below outlines the average length of time that young people were in treatment services in Thurrock in 2017/18. Young people generally spend less time in specialist interventions than adults because their substance misuse is not entrenched; however those with complex care needs often require support for longer.

The data below shows that the average length of time in treatment for Thurrock young people is slightly less than the national average when looking at the Q1-4 Apr-Mar columns. This tells us that more clients are in treatment for shorter periods of time, and fewer clients are in treatment for lengthy periods, suggesting good engagement by young people or effective treatment delivery by the provider.

Figure 23: Average length of time in treatment, 2017/18 (Thurrock and nationally)

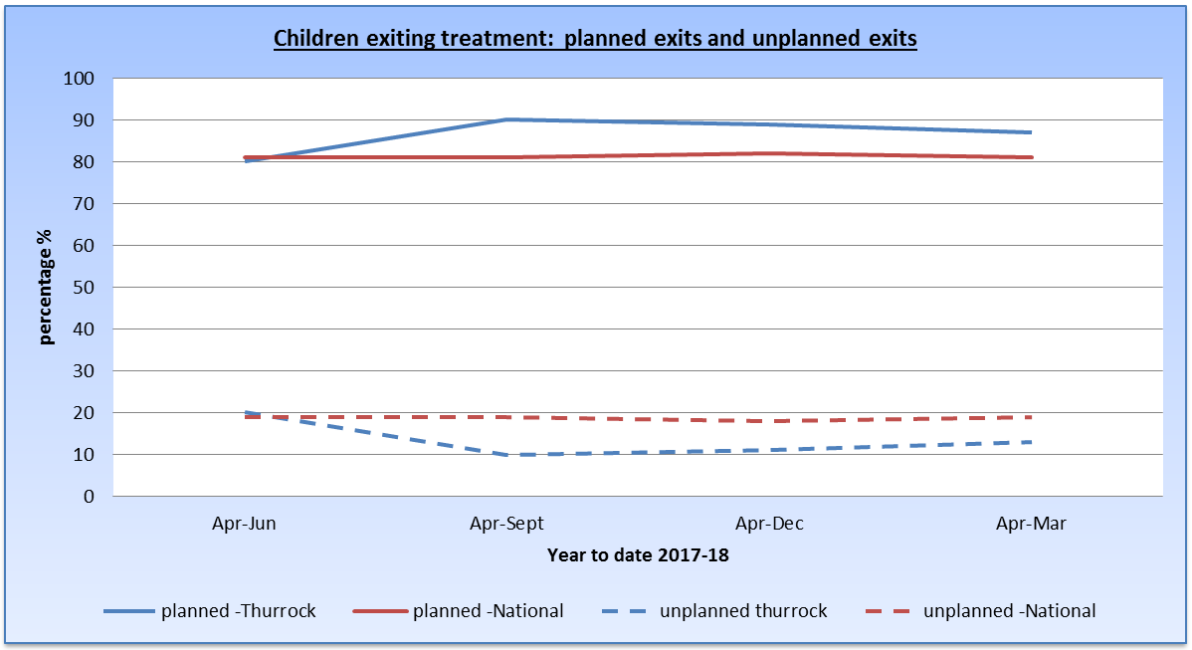


Source: NDTMS

The graph below shows that there are a higher percentage of planned exits in Thurrock young people comparing with nationally and less unplanned exits than national data shows. This suggests that although children are staying in treatment on average slightly longer, they are doing so appropriately and in a planned way. The fact that there have been no re-presentations to the service from last year (at the time of writing this document) supports this interpretation and reflects the quality of interventions delivered. Re-presentations are clients who re-present for treatment within 6-monthsd of treatment exit. Given the high satisfaction with the service based on both the annual service reviews which include analysis of feedback questionnaires and the service user engagement for this report, we can expect clients to want to re-present if the need were to arise,

whereas poor service user satisfaction would logically cause clients to not re-present, thus artificially inflating the re-presentation rate performance.

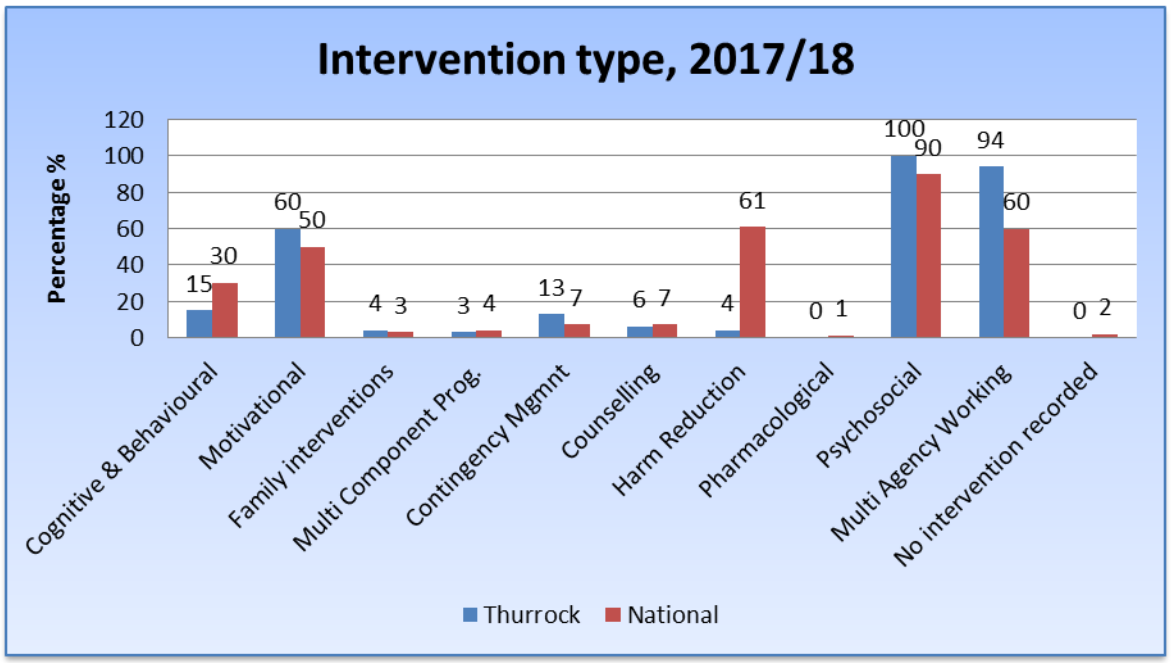
Figure 24: Children exiting treatment, planned exits and unplanned exits, 2017/18 (Thurrock and nationally)



Source: NDTMS

Young people have better outcomes when they receive a range of interventions as part of their personalised package of care. The figure below outlines the percentage of young people accessing different types of interventions in Thurrock and England. The majority of young people in Thurrock access psychosocial interventions followed by motivational interventions, whereas nationally more young people accessed harm reduction interventions as the second most common intervention. For Thurrock, cognitive and behavioural interventions were half the national level. However, almost all intervention types for Thurrock included multi-agency working, a level far higher than the national average and which demonstrates both the complexities of the local caseload and our excellent partnership working – something we expect the new service to incorporate and continue.

Figure 25: Types of substance misuse interventions accessed by young people in Thurrock and England, 2017/18



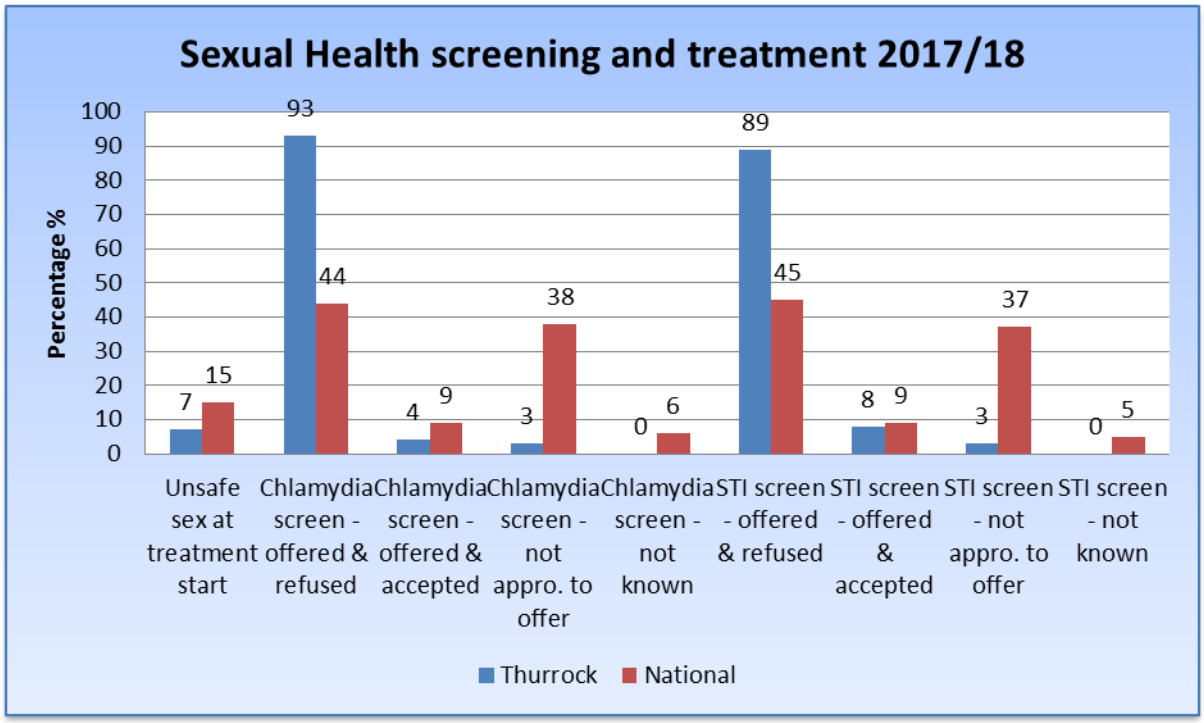
Source: NDTMS. Technical Notes: Overview of intervention figures are out of YP accessing specialist substance misuse services in the year to date period. Each individual is only reported once against each intervention type. † An individual may have received more than one intervention type so percentages may sum to more than 100%. Multi Agency Working figures are out of all young people receiving structured specialist treatment only.

The vast majority of interventions are delivered in the community (99%) which typically refers to schools or colleges. The remaining 1% of interventions are delivered in the home. This broadly reflects the national picture, which is 97% and 3% respectively.

Young people in treatment are, where appropriate, screened and referred for treatment for chlamydia and sexually transmitted infections (STIs). Thurrock young people report half the level of unsafe sex at treatment start compared to the national average. What we can see from the below figure is that the offered and refused percentage for chlamydia and STIs is twice that of the national average and we should better understand why the level of acceptance of sexual health treatment is so low. Against this, we can see that in over a third of cases it is not appropriate to offer chlamydia or STI treatment, which is significantly higher than the national average of just 3%. We know that in Thurrock much of the hidden harm casework is with children under the age of 13, hence why it is recorded in this way; unless a disclosure is made by the young person it would not be appropriate to offer such a young client a sexual health screening.

Offering free and open access to sexual health advice and treatment will help young people make healthy choices regarding their own sexual health. Thurrock's Integrated Sexual Health Service currently offers young people sexual health advice and treatment when needed, which in turn can help to prevent unplanned teenage conceptions.

Figure 26: Sexual Health screening and treatment in 2017/18 (Thurrock and nationally)



Source: NDTMS

3.3 Criminal Justice

The 2016 Children and Young People's Joint Strategic Needs Assessment (JSNA) tells us that young offenders (or those at risk of offending) are a highly marginalised group and often have greater health needs than the non-offending population, experiencing exposure to inequalities in health that persist into adult life, including a higher incidence of physical and mental ill health, sexually-transmitted disease, injuries, and early pregnancy in females.

Youth Offending Teams (YOT)/Services (YOS) consist of professionals from Social Care, Probation, the police as well as Health & Education. They work with young people aged 10-17 who have been either convicted in the Courts or have been made subject to a pre-Court outcome. Interventions can take place in the community or in the secure estate and are designed and implemented to address the risk factors that each young person presents. They also work with the victims of Youth Crime and manage restorative justice processes.

YOS prevention work focuses upon young people aged 8 to 17 years before they enter the criminal justice system but at a time where they are presenting offending or anti-social behaviour.

What do we know?

There were 207 offences committed in Thurrock in 2013/14 that were known to the Youth Offending Team – 174 were committed by males and 33 by females. This is in line with national and adult data. The most common type of offence committed was Violence against a person, with 53 of the 207

offences falling into this category. Drugs Offence accounted for 18 offences. Again, this is in line with national and adult data.

The assessed generic risk factors for young people offending and re-offending in Thurrock indicate that the most common risk factor is thinking & behaviour, followed by family and personal relationships, emotional and mental health, education, training and employment and attitudes to offending. The least common is physical health. An increase has been observed in young people presenting Emotional & Mental Health issues linked to their offending. However, this may be due to the increase of increasingly robust services within the YOS which is ensuring that issues are identified and managed. There also may be a link to the increase of young people being supervised who have been involved in serious youth violence and the emotional issues it can instigate. Perhaps surprisingly, substance misuse was the 4th lowest risk factor at assessment, out of 12 risk factors.

Due to high migration from the London Boroughs, the Thurrock YOS is supervising a number of young people who have links to serious youth violence and gangs. We remain vigilant to the strong association between this gang activity and its links to emerging drugs markets, particularly regarding county lines and cuckooing[17]. County lines refers to city-based gangs operating phone lines and transactions for drug dealing that permeate into surrounding areas such as from London and into Thurrock and the Home Counties. Cuckooing refers to gang members taking over the properties of vulnerable people in order to use the premises as a base to operate their drug dealing.

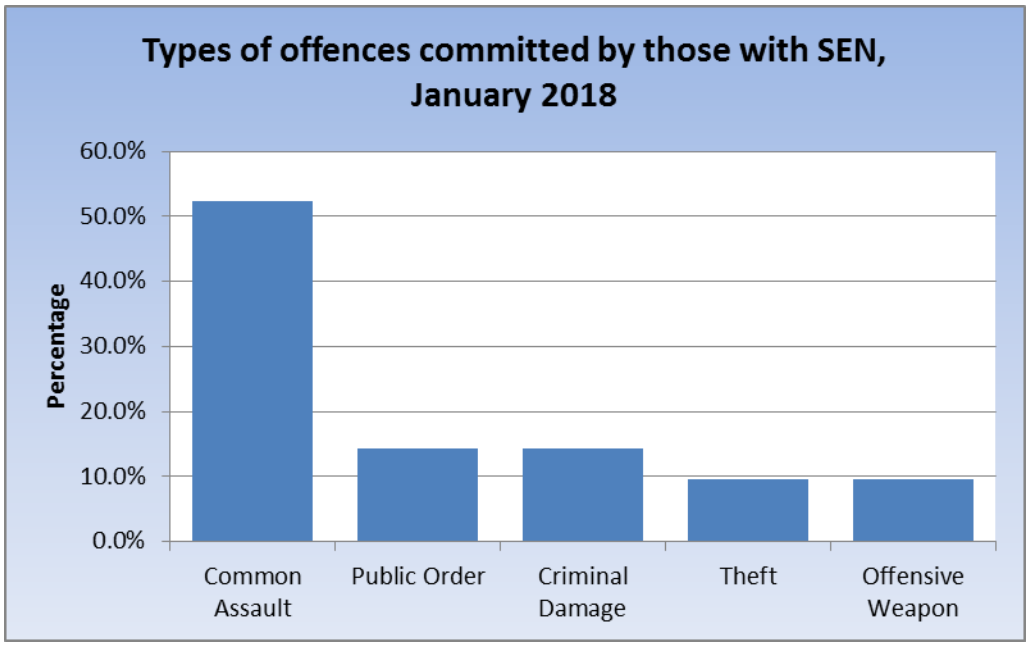
At the point of analysis (July 2018), 11 of the 54 cases on the YOS caseload (not including young people subject to prevention interventions or out of court disposals) had Special Educational Needs (SEN) recorded in their initial ASSET plus assessment (20%). Of these 11 cases, seven had Education, Care and Health plans (ECHP), two had Statements of special Educational Needs (SEN) and two had special needs identified but where not currently subject to an ECHP or SEN statement.

One key outcome measured by the YOS is the rate of reoffending 1 year post-conviction. Looking at all young people who offended in a six month period who are then tracked for a year, it was ascertained that 33% of them were identified as having special educational needs, which is proportionally higher than would be expected.

When considering the types of crimes committed by this cohort, it can be seen that the most prolific offence committed by young people with Special Educational Needs is common assault, followed by criminal damage and Public Order offences. The rate of common assaults committed by young people with special educational needs is higher than that of the general population, (52% as opposed to 39%) and the comparison is similar in respect of criminal damage and public offender order offences. It should be noted that these offences are often reactionary and directly linked to behaviour management, perhaps related to anxiety, frustration and communication problems.

[17] Vice. How Drug Dealing Gangs Are Taking Over the Countryside. (2018) https://www.vice.com/en_uk/article/zm84bx/how-londons-drug-dealing-gangs-are-taking-over-the-countryside (Accessed July 2018).

Figure 27 Types of offences committed by children with SEN, January 2018



Source: Thurrock Council Youth Offending Service, January 2018

What are we doing in Thurrock?

The YOS historically employed a full time substance misuse worker, but in recent years they referred clients to treatment and interventions facilitated by Thurrock's young person's substance misuse service. In 2013-14 over 8% of convictions were in relation to possession or possession with intent to supply of illegal substances but the use amongst our client base is far bigger. However, whilst this can increase other risk factors it is rarely the sole reason for their offending. The use of class A drugs is rare in young people in Thurrock, but there were a number of convictions of young people dealing crack & heroin in 13-14.

2017/18 NDTMS data tells us that 18% of young people in treatment had offending recorded as a sub-intervention for their multi-agency support package, meaning that almost 1 in 5 clients have been assessed as being involved in offending behaviour. In 2017/18 the young person's substance misuse service co-located a member of staff in the YOS one-day a week. It should be noted that many of these clients will also be those noted in the YOS data.

Recommendations

Population

- The expected 30% increase in the 10-17 year old population over the next ten years and the uncertainty of what impact this will have on treatment numbers means we need to continually assess and be responsive to potential increases in service demand
- The major issues and future risk factors for Thurrock are the continued increase in migration from the London boroughs, especially in relation to the management of young people who have been involved in serious youth violence

Recommendations - continued

Population

- The increasingly diverse population and consequent increase in the BME population will result in changing risk factors and a change in interventions and supervision will be needed to meet these
- The increase of young people involved in gangs brings with it the increased risk of sexual exploitation and increases in vulnerability and safeguarding which has been evident over the preceding years. The strategy to manage this risk is more partnership working both locally and with the London boroughs which are the sources of the migration
- Additionally, although it is not yet presenting itself, there may be an increase in substance misuse issues specifically related to Class A addiction in young people and the provider must be responsive to this
- Provider to continue to be accommodating of complex cases with multiple wider vulnerabilities
- Commissioners to deepen their understanding of the A&E hospital admissions data
- Brighter futures partners to recognise that some young people state they are using drink or drugs to cope with worries/anxiety and to be responsive to this via targeted support or universal prevention and education interventions

Treatment population

- Provider to increase the acceptance of sexual health screening, where deemed appropriate/eligible and to explore why our referrals are lower and how to strengthen links to sexual health services
- Regularly review the use of Novel Psychoactive Substances ((NPS), also referred to as Legal Highs or Club Drugs) and adapt the treatment offer accordingly
- Reaching treatment naive parents who require treatment for substance misuse, due to children experiencing hidden harm, is a challenge for treatment services and something they must maintain a focus on
- Continue to ensure that appropriate links are being made locally between Brighter Futures partners and particularly between services for domestic and sexual violence, young people and substance misuse to address and support the specific and wider vulnerabilities set out in Figures 10, 19 & 20 and ensure strong multi-agency working remains a priority of the new service
- Commissioners to review the referral pathways from children and young person's health and mental health services to better understand the low referral rate compared to the national average
- Our use of harm reduction interventions is far lower than the national average and commissioners need to understand why this is the case and what the implications are
- Provider to continue to offer referrals for stop smoking support
- Commissioner to match the new service specification to the existing age eligibility of up to 18 years old, with exception for up to 25 years old if SEND/disabled and appropriate
- Provider to explore why fewer referrals come from those young people in apprenticeships or employment, compared to national average

Recommendations – continued

Criminal Justice

- Provider and commissioner to remain vigilant to the strong association between gang activity and its links to emerging drugs markets, particularly regarding county lines and cuckooing
- Continue to co-locate a young person's substance misuse service worker in the YOS at least once a week and recommend this in the updated service specification
- Brighter Futures partners to be vigilant of SEND children being disproportionately represented in YOS data and cater for their additional needs

4. Literature review summary

A comprehensive literature view has been conducted by commissioners, largely based on a review of articles and publications that resulted from a literature search conducted by the Aubrey Keep Library.

Key Points

Prevention & Education

- Prevention and education programmes carry a risk of increasing use of substances, but overall, the benefits outweigh these risks if even from a harm reduction perspective.
- Prevention and education work in schools is a key focus of the current young person's substance misuse service

Treatment

- The trends and high risk groups set out in the infographic in Figure 10 are explored in the below summary
- Family therapy is emerging as an area of best practice
- Multi-agency working is key to ensuring that the whole child is supported holistically
- Hidden Harm work with children of substance misusing parents/carers continues to have a strong evidence base
- Our Stop Smoking Service has long since forged effective partnership working with our substance misuse service and the latest evidence shows that this can be a mutually beneficial investment
- Coproduction should feature in programme development to prevent the focus being on what adults perceive the issues to be

Mental Health

- Rates of Common Mental Health Disorders (CMHDs) such as depression and anxiety have recently increased in the children and young people population
- Substance misuse can be linked to suicidal ideation
- Review partnership working with Mental Health services to ensure service delivery is not fragmented

Kev Malone – DAAT Lead, Public Health Programme Manager, Public Health

4.1 Prevention & Education

How far we can go to prevent substance misuse is a topic of contention, since it is a fact that drug and alcohol problems persist in our society and generations of young people continue to use drugs and alcohol, whether that be experimentally, recreationally or to hazardous and harmful levels despite increasing awareness of the potential for harm.

Programmes designed to prevent substance misuse in young people have almost invariably been designed by adults, based on their concerns regarding drug and alcohol use rather than young people's experiences. It is important to note that there are intrinsic difference between adults and children of different ages. Furthermore, the experiences of this generation of young people likely differs greatly from the childhood experiences of the current generation of adults, particularly with the more recent boom in technology and the development of numerous social media platforms[18]. Evaluations of these programmes have also tended to be undertaken over a relatively short time frame and more longitudinal studies are needed to determine whether prevention and education is truly effective. According to Phil Harris', *Youthoria*[19], this has led to the implementation of poor prevention programmes, which have resulted in poor outcomes and thus provide justification for disinvestment, with such strategies being branded as education rather than prevention.

However, there is a benefit to these overarching education-style programmes. Getting universal prevention messages across to large groups of young people can ensure that they take informed risks. The counter argument is that this heightens young people's awareness of the opportunities that exist, some of whom might seek out these opportunities. Education programmes, therefore, tend to focus on harm reduction messages, rather than the zero tolerance scare mongering messages that were favoured in the 1980s and 1990s; evidence shows us that young people take risks, it's their nature to do so, and as such minimising the risk should be the focus.

However, there is a case to argue for targeted or selective prevention. For example, we know that young people with key vulnerabilities as outlined above are much more likely to participate in such risk taking behaviour. We know that these young people tend to have poor school attendance or attainment, might live in a 'troubled family' unit, could be known to mental health services, be an open case with children's social care or even be in the care system. They are more likely to be engaged in offending behaviour and could already be in the criminal justice system, perhaps already on the caseload of the youth offending service (YOS). A limitation of this approach is that it's a generalisation and not all young people in these cohorts will be engaged in substance misuse. Moreover, there is a risk of stigmatisation and the feeling of being 'singled out' on top of other vulnerabilities young people may be facing. Indicated prevention is a method that targets those young people known to be engaged in risky behaviours and substance misuse. Interventions can help prevent normalisation or escalation of the behaviours and begins to cross over into the realms of treatment, often referred to as early intervention or early help.

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[18] Public Health England. (2015). The International Evidence on the Prevention of Drug and Alcohol use: Summary and examples of implementation in England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669654/Preventing_drug_and_alcohol_misuse__international_evidence_and_implementation_examples.pdf (Accessed June 2017).

[19] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 128-131.

The success of any targeted prevention intervention will be reliant on the skill of the facilitator/keyworker and honesty of the young person. Since a number of agencies might be working with that child or family a multi-agency approach with effective information sharing will be important to enable building up a more accurate picture of the true situation, particularly where young people attempt to play agencies off against one another. Reasons for doing so might include wanting to resist change, particularly where the behaviour or activity is seen by the young person as enjoyable and interventions are being enforced by statutory agencies, or where the young person fears dramatic intervention such as removal from a family unit.

The outcomes of specific prevention and education programmes across alcohol, tobacco and cannabis suggest that the initial short-term impact was similar for tobacco and alcohol. However, the longer-term impact on smoking reduction was three times higher than the reductions in alcohol use and that alcohol programmes were more likely to have no effect or a harmful effect in that they could increase drinking post-intervention. A larger scale study also found similar results; most effective in reducing tobacco consumption, then 'all drugs' then alcohol and finally 'soft drugs'[20].

The question of who delivers these programmes is important. Young people tend to respond poorly to teachers delivering drug and alcohol prevention messages in PSHE lessons; teachers are not supposed to be viewed as fallible but instead as pillars of the community with reputations to uphold. Having core subject matter teachers suddenly delivering messages about reducing the risks of substance misuse, or even delivering zero-tolerance messages can blur the lines between the teacher-pupil relationship. Measuring the learning is difficult, since many young people are likely to consider teachers as not coming from a position of experience. Those teachers that might share experiential messages further risk the teacher-pupil relationship, with the exception being those pupils that admire the risks their teacher may have taken, which then risks normalising the substance misuse.

However, having guest speakers from local substance misuse services overcomes this issue. The evidence suggests that if the messages come from one's peers the impact is even greater than teacher-led programmes, and that health professionals appear to be more effective delivery agents than peers[21].

It is likely that a suite of coordinated and well-presented universal and targeted interventions will have the largest impact on reducing substance misuse, or risk of harm for young people living in the borough[22].

As outlined above Hidden Harm is a term used in drug and alcohol treatment to refer specifically to young people whose parents/carers misuse substances. These parents/carers may be in treatment themselves and the young people might also have a substance misuse need of their own. It is a complex area of work, much of which sits within the realms of prevention and education since there

[20] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 154-155.
[21] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 161.
[22] Public Health England. (2017). Young People's Statistics from the National Drugs Treatment Monitoring System (NDTMS) 1st April 2016 to 31st March 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664945/Young-people-statistics-report-from-the-national-drug-treatment-monitoring-system-2016-2017.pdf (Accessed June 2017).

is a need to help young people understand their situation and divert them from falling into the intergenerational cycle of substance misuse. Furthermore, great care is required when working with this cohort because once the gravity of their situation has been unpacked before them they are almost always unable to change their circumstances by themselves. This topic will be explored further under 'Treatment'.

4.2 Treatment

Measuring the efficacy of treatment modalities for young people is a challenge. A young person's age is deemed to be a poor measure of maturity so it is not easy to determine which interventions suit a certain age group, particularly if the young people in question have experienced some degree of developmental delay.

With the exception of young children receiving support under the Hidden Harm agenda, young people in treatment are generally at a transitional phase whereby the safety of parental influences (however limited these may or may not be) fall into decline and give way to peer influences. Add to this an increase in emotionality and life stresses, particularly via relationships and exam or employment pressures and hormonal changes during puberty, and one can see how some young people might turn to substance misuse as a form of distraction, 'self-medication' or, a source of enjoyment. For this reason, the notion of abstinence-based recovery can seem a paradox. Instead, the focus is often to ensure that repeated exposure to substances does not lead to physical dependence in adulthood and that young people can be provided with the tools to avoid addiction and instead develop their resilience, increase will power and be directed towards meaningful activities such as hobbies, recreational activities or voluntary work that are all strong attributes to attaining life skills and achieving recovery[23]. This is somewhat of a challenge considering that as children move into adulthood their opportunities to earn a wage and have disposable income both increase dramatically, therefore, enabling them to afford a lifestyle that might have negative connotations, could involve committing criminal offences if misusing banned substances and ultimately be harmful to their physical and mental health. On the other hand, employment is one of the most protective factors for health and well-being and as such may begin to reduce some of the fears or vulnerabilities that young people were facing during adolescence[24].

Treatment methods to address these risks and issues lie along a continuum with harm reduction at one end and abstinence-based recovery at the other. In between are a myriad of psychosocial interventions that include cognitive behavioural therapy (CBT), motivational interviewing (MI), counselling, 12-step programmes, multi-agency input, peer support, group work and 1:1 sessions all designed to lead the young person towards aftercare and recovery. For some young people enforcement (especially if known to criminal justice agencies) will come into play and treatment providers will be obliged to inform youth justice agencies whether or not a young person at the centre of a multi-agency action plan is complying with the terms of their court order. This in itself can have an effect on the client-keyworker relationship and thus impact on the success of the interventions.

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[23] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 169 & 175.

[24] Waddell, G. & Burton, A.K for Department of Work and Pensions (2006). Is Work Good for your Health and Wellbeing? https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf (Accessed June 2018).

MI has been found to be effective with adolescent substance misusers in a number of studies. The brief intervention recognises that motivation for change occurs in stages and reflective listening is important in guiding the young person towards change. Reflective listening is an advanced technique that reflects back the deeper messages in the young person's statement.

The Thurrock service does not provide counselling in-house, but by working with existing Services such as the Emotional Wellbeing and Mental Health Service (EWMHS) it enables service providers to ensure continuity of care for children and young people and that the 'whole person' is being treated. Brighter Futures provides a structure for working in partnership with other services to improve this for CYP in Thurrock.

CBT is the most common treatment delivered in community settings for young people with substance misuse problems and is a generic name given that covers a wide range of cognitive and behavioural approaches. It assumes that human behaviours are governed by an individuals' self-efficacy belief; our expectation that we can perform a task to a given standard. It is based less on ability than ones' perception of their ability, something referred to as reciprocal determinism. Therefore, belief, performance and response are inter-linked. Where clients lack self-efficacy belief and turn to substance misuse as a coping strategy, CBT can be effective in assessing a young person's triggers in high-risk situations and then teaching them a range of coping skills to overcome the triggers without resorting to use.

The Twelve Step approach was developed in the 1930's for adults and has been adapted for young people. It is faith-based and a well-known version is Alcoholics Anonymous. These programmes are prevalent across the globe and have developed into Narcotics Anonymous and Cocaine Anonymous. Ostensibly a set of twelve therapeutic exercises, the programmes have become difficult to evaluate such is the extreme diversity of the organisation and its members.

Randomised Control Trials in young person's substance misuse treatment have shown that when comparing structured treatment approaches head-to-head at gold standard, there is no one treatment model that demonstrates superiority over another. This is referred to as the 'dodo-bird effect'[25]. It is taken from *Alice in Wonderland* where the Queen announces that everyone is a winner and that there are prizes for all. Numerous studies including those of meta-analysis have shown that treatment outcomes are driven more by the relationship between the client and the therapist or keyworker than by the quality of the intervention delivered. Lambert's (1992) studies support this theory, where 15% of outcomes were based on therapeutic approach, 15% were a placebo response, 40% were attributed to extra-therapeutic responses such as gaining employment, entering a new relationship, etc., and 30% were driven by the client-practitioner relationship[26]. This suggests that some focus in designing specialist substance misuse services relies on recruiting the 'right' people who will be able to develop rapport with young people and build that ever important client-practitioner relationship. This does not come without its challenges. However, evaluation and research of effective services could focus on characteristics and skill-sets of practitioners as a means of beginning to un-pick this complex issue.

[25] Luborsky, l., Rosenthal, R. and Diguer, L. (2002) The Dodo Bird Verdict is Alive and Well – Mostly. *Clinical Psychology Science and Practice.* 9, 3-12.
[26] Lambert, M.J. (1992) Implications of Outcome Research for Psychotherapy Integration. In Norcross, J.C. and Goldfrieds, M.R. (Eds.) *Handbook of Psychotherapy Integration*. Basic Books.

Many young people enter treatment independent of their parents or carers knowledge. There is sometimes good reason for this, especially where the young person might experience an increase in risk or safeguarding issues. Having said this, there is a growing body of evidence that tells us that where parents/carers can be engaged in the young person's treatment the outcomes can be improved[27]. Currently this is not commonplace in the existing service. Systemic and behavioural family therapies and family case conferencing are examples of interventions that can be used to good effect. The impact could be far greater if completed in conjunction with family members who are in treatment with the adult drug and alcohol treatment service, since it would deepen the understanding of both the parents and the children and help them identify ways to further build on the progress they are making and to work together as an effective a family unit. This could also aid in supporting young people to overcome some of their vulnerabilities by building closer relationships with their family.

Effective multi-agency working and information sharing is key to success with this client group, whether the staff are co-located in one multi-agency service or operate as a virtual team but remain based in their parent organisation. The Thurrock service operates a blend of the two models, with one staff member being co-located at YOS one day a week. This increases the opportunity to facilitate casework with criminal justice clients, particularly where transport is a barrier due to the two services currently being based in separate towns within the borough. The current service is exploring further integration with the Brighter Futures work as this develops and this should continue in order to further increase effective partnership working.

Aftercare in young people is critical since their self-efficacy belief in change is generally lower than in adults, meaning a focus on abstinence-based recovery that is popular with adults is often an unrealistic proposition for many young people. The reasons for this include the fact that their exposure to the negative socio-economic aspects of substance misuse and the health impact, particularly regarding developing or accelerating long-term conditions do not begin to crystallise in the teenage years. Young people go through puberty at a stage where their brain is still developing, they often do not fully comprehend the consequences of their behaviour, Moreover, young people in treatment tend to have little or no prior experience to call upon, and as such the temptations and opportunities thrust upon them during the developmental stages of adolescence into adult may mean that they adapt rather than sustain change. This can particularly be the case if they continue to spend time with friends who engage in substance misuse, who may encourage them to resume their past behaviours. Furthermore, because trends in substance misuse develop so quickly, e.g. the rapidly changing NPS market, treatment methods are often lagging behind the realities of what young people are experiencing. Broadly, adults tend to relapse due to unpleasant mood states and conflict, whereas young people tend to relapse due to positive emotional states and social pressure, with alcohol being a common factor even if wasn't when they first presented to treatment[28]. Harm reduction interventions help to reduce these risks when abstinence is not seen as achievable by the client.

Therefore, keeping young people on track with their treatment and ensuring they do not relapse and represent to treatment is a significant challenge with different drivers compared to the more

[27] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 209-2016.
[28] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 217.

established treatment methods seen with the adult population. Young people need to create or strengthen pro-social networks to assist with recovery back into mainstream society. Unlike the challenges of helping adults find meaningful employment, a big advantage with young people is that they will almost always be in some form of education that they can develop their engagement with to strengthen their recovery capital.

Where young people demonstrate a desire to give something back to the service for the treatment they have received, every opportunity should be taken to engage them onto a peer mentor programme, as is common in adult treatment settings. This is largely an emerging area within young people's substance misuse services and something that will underpin the evidence base mentioned earlier that young people are more likely to listen to their peers than their teachers, as in the case of prevention and education programmes. Moreover, those still in treatment can see that recovery is both tangible and achievable.

4.3 Mental Health

The rates of mental health conditions such as depression and anxiety has increased across adolescence, with anxiety disorders being the most common mental health problem in those young people presenting for substance misuse treatment. Children with anxiety disorders often delay the initiation of drug and alcohol use, however, once initiated consumption tends to increase dramatically[29]. There is some evidence to suggest that even after cessation from substance misuse that anxiety disorders can persist.

Numerous studies have identified a prevalence of suicidal ideation in young people, the peak of which tends to occur in early adolescents through overdose or self-harming behaviours for example cutting, but few attempts result in death. The rates are higher in young people who misuse substances and poly-drug using and opiate misuse are the substances most associated with suicide. In Thurrock we currently don't have any opiate or crack using clients in treatment in the young person's service; however, poly-drug misuse is very common, with 52% of those in treatment in 2017/18 reporting using multiple substances. In spite of this, the service has not had a client death in the duration of its expiring 5-year contract.

As noted under 'treatment' above, effective multi-agency working with EWMHS and the Brighter Futures agenda is important to ensure that the whole-child is supported and that treatment is not fragmented between agencies working in silos.

[29] Harris, P (2013) Can Substance Misuse Be Prevented in Young People? *Youthoria*. 202-203.

Recommendations

Prevention & Education

- Preventative interventions should continue to feature in future service delivery
- Service design should involve further development of peer-led programmes to enhance and diversify the offer and overcome the risk of adults designing interventions based on their perception of the risks rather than the actual experiences of young people

Treatment

- Specialist services to deliver DAAT are necessary for CYP although a partnership approach to delivering services to CYP in Thurrock is important. Services should integrate as part of the Brighter Futures group of services to maximise benefits to children and their families whilst giving appropriate support to other professionals involved in their care
- Where practicable, programmes should be co-produced with young people to prevent the focus being based on adults' perceptions of the issues
- Evidence supports family therapy being available, this should be considered as an offer as part of the new service specification but needs to be child led and clearly will not be appropriate in every therapeutic relationship. There is particular benefit if any adults in the family unit who have a substance misuse need are also in treatment
- Future treatment options should include Motivational Interviewing, CBT and Twelve Step programmes at the discretion of the client
- Motivational interventions are utilised more in Thurrock when compared to national trends where Harm Reduction interventions are considerably more prominent. A deeper analysis of this intervention should be conducted by commissioners to understand whether our new service provider should offer more harm reduction interventions to our residents
- Continue to offer Hidden Harm support to children affected by parental substance misuse
- Provider to continue to refer to stop smoking support services
- Continue to work closely with the mental health services (EWMHS) to ensure that if young people complete treatment for substance misuse that they can receive any necessary help for enduring mental health problems such as depression or anxiety disorder

Mental Health

- Continued and further integration as part of Brighter Futures and partnership working with Mental Health services will be beneficial for improving outcomes for children, young people and their families
- Ensure that the service remains vigilant to the heightened risk of suicide across its client base; such is the link between suicidal ideation and substance misuse.

5. Tier 4 treatment provision and prescribed treatment modalities

Key Points

- Tier 4 treatment and prescribing modalities for Thurrock children and young people are incredibly rare
- These treatment modalities have not been activated during the five years of the expiring contract

Tier 4 treatment refers to those clients who require an inpatient or community detoxification or rehabilitation programme. This is a highly specialised area of drug and alcohol treatment more typically seen in the adult treatment population, since such clients have experienced chronic substance misuse and this is not something we tend to see in the under 18 population.

Where clients are in need of a prescribed treatment modality, on the rare exception that it's required, the service is able to provide this in partnership with the adult drug and alcohol treatment service who are commissioned to provide prescribed treatment modalities e.g. opiate substitute therapy (OST) (more commonly known as methadone) or medication to help with medical withdrawal from alcohol. In the lifetime of the expiring 5-year contract the incumbent service provider has never needed to utilise this partnership agreement.

The future needs of Thurrock young people do not indicate a risk of a sudden high demand in Tier 4 or prescribed treatment modalities, but we will remain vigilant to local drug market trends and treatment activity.

Transition into adult service

Currently, if a young person in treatment is approaching the age of 18, a decision is reached between the adult and young person's service as to whether it is appropriate to keep them in the young person's service or transfer them into the adult service for a continuation of their treatment episode. This is decided on a case by case basis, is good practice and should continue in the future.

Recommendations

- The future service specification should retain the current clause regarding partnership working with the adult service to cater for such exceptional cases

6. Return on Investment

Key Points

- The existing service model represents good value for money, with high quality interventions and strong performance
- Waiting times have been an area of focus for improvement, and service growth helped address this

6.1 Benchmarking and cost impact of service

A Department for Education cost-benefit analysis found that every £1 invested in specialist substance misuse interventions delivered up to £8 in long-term savings and almost £2 within two years, meaning that this can be a cost-effective way of reducing future demand on health and social care services. A life course approach to drug prevention that covers early years, family support, universal drug education, and targeted and specialist support for young people is one of the key aims of the Government's 2017 Drug Strategy.

How does our current service compare?

The Thurrock Drug and Alcohol Action Team (DAAT), (part of Public Health) conducted a comprehensive benchmarking exercise back in 2015/16, see appendix 1. This incorporated 3 other CIPFA comparator upper tier local authorities and measured the Thurrock services against performance and cost. In summary, the Thurrock service was seen to have strong performance, with an excellent representation rate demonstrating interventions were of high quality, thus ensuring clients exit treatment and remain in recovery.

The only noted improvements to the service offer were length of waiting times which could have been better. At the time this was attributable to the small staff team that has since seen growth by 50%, plus additional roles for student social workers and an apprentice. A peer mentoring scheme was also launched, which evolved into an accredited offer in 2017/18.

In 2016 the service was the lowest cost across those compared in the benchmarking exercise at almost 5 times cheaper. The budget for the Thurrock young person's service has since increased from £75,000 to £135,000, yet this would still place it at over 2.5 times cheaper than the comparable services. Anecdotally, Thurrock DAAT has spoken with other local commissioners regarding their young person's services and this latest figure still seems to be the case.

Recommendations

- The current service model should be retained in the new service specification

7. Co-production

Key Points

- Service users are happy with the existing treatment offer
- Parents/carers also value the existing treatment offer
- Staffs' friendliness, knowledge and expertise is highly valued
- (A caveat of this section is that the sample size was small)

7.1 Service user and stakeholder engagement

Service users and stakeholders have been invited to engage in the retender of this service. Service users were contacted by the incumbent provider and stakeholders were written to by commissioners asking for any comments or recommendations on the existing service. Commissioners also attended Thurrock's Youth Cabinet and will be devising an electronic survey to send out to its members for cascading across the secondary schools in the borough.

Meantime, commissioners met with a two client groups accessing treatment at the incumbent provider, to seek their views on the current service offer. The questions for the Youth Cabinet and clients are in appendix 2 and the transcript from these sessions with the clients is in appendix 3.

The first session was with a 17 year old female cannabis user who had been in treatment for just over a month. They gave a very positive account of the support they had received and, whilst stating that their parent felt she shouldn't require structured treatment to address her cannabis misuse, the client herself felt this would not have been possible alone. In terms of accessing family sessions, they felt their parent might be awkward if attending a session with them, but could see the value in it. They could not identify any areas to strengthen the service offer, felt the service was accessible and would recommend it to peers.

The second session was with a family unit comprising a mother, grandmother and three of five children, albeit the 3-year-old did not actively participate. The children were accessing the service to receive support for Hidden Harm; the now estranged father/step father had been the misusing adult in a complex multi-agency case. Their involvement with the service was due to end in the coming weeks. All participants heavily valued the support they had received and felt it had enabled them to become closer as a family. The children felt the support they had received had helped them to understand their emotions and they valued their independent time talking with the keyworker. All family members felt the service was accessible and the parent and grandparent valued both the independent and family sessions. Of particular note were the 'unsent letters' that the children wrote and gave to their mum, which deepened mum's understanding of what her children were experiencing and brought them closer together. The family could not identify any areas where the service could be improved and had already recommended the service.

It is important to note that the service provider was the gatekeeper to organising these primary sources of research and an element of bias should be factored into this. Nevertheless, clients were sought based on their availability and willingness to participate, for which commissioners are grateful.

Other relevant stakeholders such as the current adult and young person's substance misuse treatment providers and the Children's Services team at Thurrock Council have been contacted as part of the service specification refresh and ultimately will support in shaping the design of the service as it goes through the re-tendering process.

Recommendations

- To offer more family sessions where assessed as appropriate
- No further areas to strengthen the existing treatment offer were identified by the service users and the parent or grandparent

8. Conclusion

The above document makes a series of recommendations under each section, of which will be cross referenced with the existing service specification and updated where necessary.

The epidemiology section in this document tells us that we can expect to see a significant increase in the young person's population in Thurrock over the next decade, and particularly so in those aged 10-17 years old. Quite how many of these young people will require treatment for substance misuse is hard to determine since the prevalence estimates for substance misuse are virtually impossible to determine, and due to the revised approach to delivering coordinated preventative interventions under the Brighter Futures umbrella of services, many young people may be diverted from becoming problematic substance misusers. This will be an area of close monitoring over the coming years.

It is right that we continue to offer coordinated packages of care that address the wider determinants of heath, such as referrals to sexual health and stop smoking support services and partnership working with mental health and youth offending services (YOS) to safeguard our young people. We must remain vigilant of the local dugs market and associated gang activity.

The literature review confirms that with regards to prevention and education programmes, the benefits of preventing harm outweigh the risks of increasing awareness and usage of substances and that such programmes should continue. Where practicable, peer mentors should support these initiatives since it has a greater impact on young people than when delivered by school staff alone.

The service should continue to integrate as part of Brighter Futures to strengthen multi-agency working and further improve outcomes for children, young people and their families. The current service demonstrates strong performance and balanced caseloads, suggesting the size and structure of the service is meeting the needs of the local treatment population.

So in response to the question of whether the population in treatment demonstrate the expected characteristics based on the national literature review evidence and the data on high risk groups, we are confident that the answer is yes. Has the current provider targeted and 'found' the highest risk groups of children and young people? Based on the above evidence of those children and young people in treatment with multiple specific and/or wider vulnerabilities the answer also has to be yes.

9. Appendices

Appendix 1: DAAT Benchmarking, 2015

Appendix 2: Service User/Parental/Youth Cabinet questions

Appendix 3: Service User & Parental feedback

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6 September 2018	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
Primary Care Strategy - Thurrock Clinical Commissioning Group	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Rahul Chaudhari - Director of Primary Care	
Accountable Director: Mandy Ansell - Accountable Officer (Thurrock CCG)	
This report is public	

Executive Summary

Current high level modelling across the STP shows that there is an existing, and growing, demand and capacity gap for Primary Care services. This is more prominent in Thurrock as we are one of the most under-doctored boroughs nationally.

Thurrock CCG has been working with the CCG's, practices and the LMCs across our STP. The system has collectively developed a primary care strategy. We believe our plan has the potential to regenerate and revitalise primary care locally, reducing workload, especially for GPs, improving the service we offer to patients and making mid and south Essex a place where staff want to come and work.

This paper aims to appraise the committee on the:

- STP Primary Care Strategy

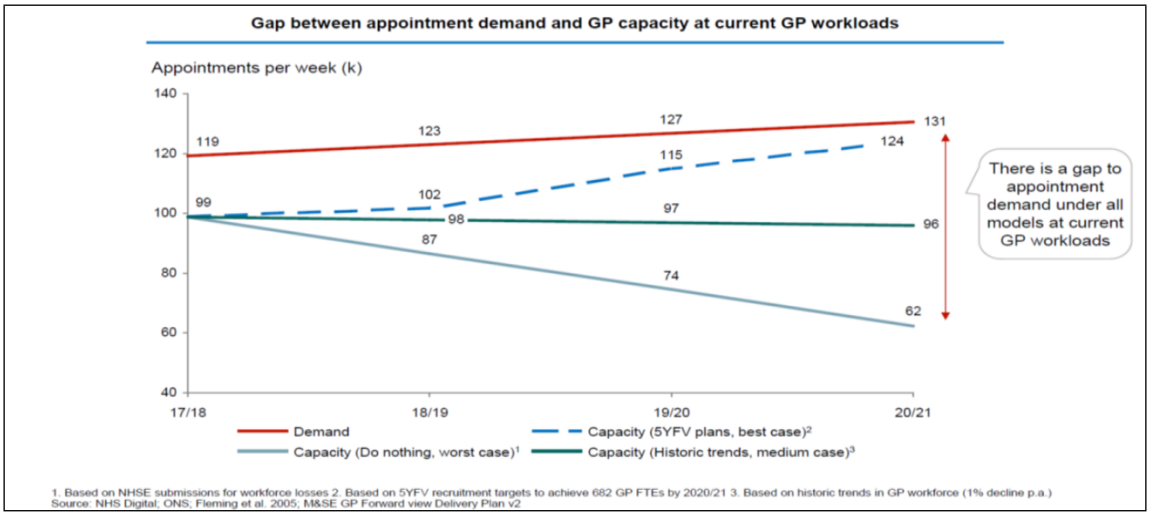
Introduction and Background

Overview

General Practice in Mid and South Essex is at a crossroads. We know that if we carry on as we are, with some of the lowest staffing levels in England, poor morale, excessive workload and difficulty recruiting the staff we need, practices - and individual GPs - will collapse and the quality and safety of the service we provide to local people will deteriorate.

Current high level modelling across the STP shows that there is an existing, and growing, demand and capacity gap for Primary Care Services. Getting an accurate picture of the local situation will be a key first step of the implementation plan, but early analysis shows this Mid and South Essex scenario is reflected across

Thurrock.



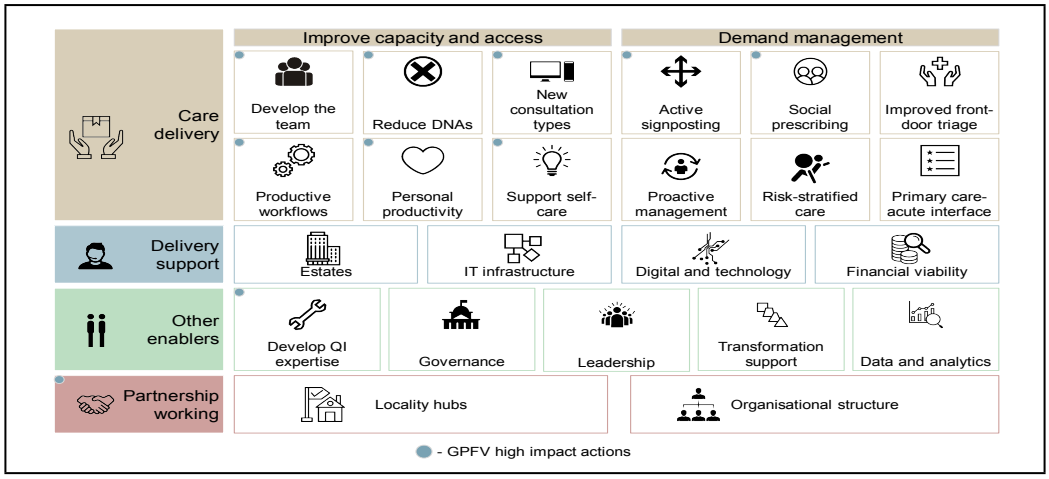
This is not a future anyone wants. That is why, Thurrock CCG has been working with the CCG's, practices and the LMCs across our STP, and the system has collectively developed this strategy and the supporting *narrative*. We believe our plan has the potential to regenerate and revitalise primary care locally, reducing workload, especially for GPs, improving the service we offer to patients and making Mid and South Essex a place where staff want to come and work.

Three key themes lie at the heart of our strategy. Firstly, to expand and change the primary care workforce so that we move from a service that is GP delivered to one that is GP led. We want to recruit more GPs and nurses, but also a wide range of other professionals so that we have vibrant, multi-disciplinary teams in general practice.

Secondly, we want practices to accelerate progress in coming together to form localities covering populations of roughly 30-50,000 people. As seen through local examples by working together in localities that they own and control, practices are able to support one another, benefit from economies of scale, improve access for patients and provide a strong foundation for locally integrating a wide range of services.

Thirdly, we plan to do all we can to quickly support practices to manage demand and reduce workload. Our plans include more systematic deployment of proven methods of triage and care navigation, as well as widespread use of digital technology to promote and enable new models of care delivery and reduce bureaucracy.

At its heart it focuses on increasing capacity, improving access and managing demand through the implementation of a range of solutions.



The strategy will help us to build that the solid local foundations that are essential for the further expansion of, and integration with, a wide range of out of hospital services, including community nursing, social care and voluntary organisations.

This work has been overseen by the Joint Committee of the five CCGs - and a work programme specific steering group and working group, consisting of local CCG staff and with local GP input and the Committee have now endorsed the Strategy and the approach to delivery. Whilst the strategy has been developed collectively, the document should be a locally owned strategy, and requires a local implementation and investment plan.

Associated Paper

The “Umbrella” STP Strategy.

Report Author:

Rahul Chaudhari

Director of Primary Care

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NHS Basildon and Brentwood Clinical Commissioning Group

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Mid Essex Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

NHS Thurrock Clinical Commissioning Group

INVESTING IN OUR FUTURE

MID & SOUTH ESSEX STP PRIMARY CARE STRATEGY

GENERAL PRACTICE

JUNE 2018

FINAL

CONTENTS

EXECUTIVE SUMMARY

General practice in mid and south Essex is at a crossroads. We know that if we carry on as we are, with some of the lowest staffing levels in England, poor morale, excessive workload and difficulty recruiting the staff we need, practices – and individual GPs - will collapse and the quality and safety of the service we provide to local people will deteriorate.

This is not a future anyone wants. That is why, working with practices and the LMCs across our STP, we have developed this strategy and our supporting *narrative*. We believe our plan has the potential to regenerate and revitalise primary care locally, reducing workload, especially for GPs, improving the service we offer to patients and making mid and south Essex a place where staff want to come and work.

Three key themes lie at the heart of our strategy. Firstly, to expand and change the primary care workforce so that we move from a service that is GP delivered to one that is GP led. We want to recruit more GPs and nurses, but also a wide range of other professionals so that we have vibrant, multi-disciplinary teams in general practice.

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Our strategy will help us to build that the solid local foundations that are essential for the further expansion of, and integration with, a wide range of out of hospital services, including community nursing, social care and voluntary organisations.

We know that we need to increase investment in general practice to deliver our future model of care. We estimate that fully implementing this strategy will require additional recurrent investment of £35m a year by 2020/21, as a result of significantly increased investment in workforce, estate and digital solutions. We also know that we need to invest in estate; this plan sets out the 'pipeline' that each CCG has developed.

We have already made progress in many areas. What we set out in this plan is not new or unique. What we have lacked until now, however, is a unified strategy that sets a clear direction for all parts of our STP.

This plan has been developed by the five CCGs in our STP working in partnership, as well as with local practices and the LMCs. We will build on this partnership and the momentum we have generated as we implement this plan; doing some things once across the STP where it makes sense to do so, and co-ordinating and sharing our local delivery plans.

1. INTRODUCTION

This strategy has been developed by the five CCGs within the mid and south Essex, working alongside practices and the LMCs. It was initiated by the Joint Committee of the CCGs, who recognised that while our STP now has a clear plan for the future of hospital services, we do not have plans of equivalent depth and rigour for primary care.

Its purpose is not to recreate or supersede work already underway in CCGs; rather it is intended to provide a single unifying vision and strategy that can be shared and owned by practices, LMCs, CCG Boards and external partners.

Although the strategy is set at STP level, the drive and energy required to implement it must come locally, from CCGs working together with practices, patients, councils and local organisations.

It is important to clarify terminology at the outset. Although in this document we regularly refer to 'primary care', our scope is limited to general practice; we do not consider in any detail other primary care services such as dentistry or optometry.

We also recognise that general practice is only part of a much wider local care system; providing effective, patient-centred care involves close integration with a wide range of other services, including social care, housing, mental health, community nursing and colleagues in hospital. We have not attempted to address this wider out of hospital picture here: our approach is to focus on re-establishing strong general practice first, as we believe this is a prerequisite for effective local integration.

We have also endeavoured to keep this document reasonably short so it is as accessible as possible. Further detail on the work that supports our strategy is available in both the *narrative* that has been developed in partnership with practices, and the *detailed technical appendix* that supports this paper.

The document is organised in eight main sections:

- Case for change
- Future model of care
- Workforce
- Digital
- Estates
- Finance
- Communications and engagement
- Implementation

This strategy will be finalised by early May 2018. It is then our intention to ask the Boards of each of the five CCGs to formally agree it, together with their local implementation and investment plan.

2. CASE FOR CHANGE

About this section

In this section we set out why we believe we need to take a new approach if we are to create a secure and stable future for general practice. We show how our STP has exceptionally low staffing levels, how this is likely to worsen in the future, and the impact this has on workload, morale, recruitment and our ability to provide consistently high quality services for patients.

There is a powerful case for change for general practice across our STP:

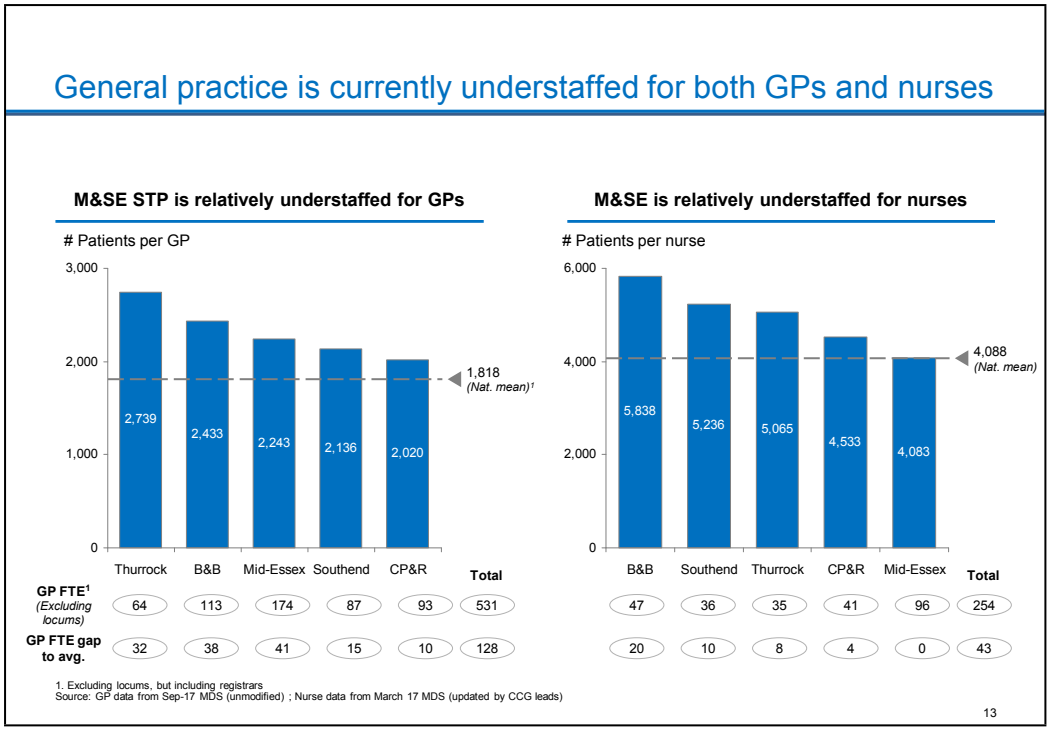
- General practice is understaffed, resulting in high workload
- Retirements will further reduce staffing levels
- Morale is low and we face long running recruitment challenges
- There is insufficient capacity to meet current demand
- The gap between demand and capacity will widen in future
- The service experienced by our patients is variable

General practice is understaffed, resulting in high workload

We know that against most of the key measures, primary care in mid and south Essex has significantly fewer clinical staff than the national average. This is the biggest challenge we face, and risks creating a downward spiral that is difficult to escape from:

- Low staffing levels increase workload, making staff in general practice vulnerable to burnout and, in extreme cases, possibly jeopardising safety
- High workload in turn negatively affects morale and makes mid and south Essex a relatively unattractive place for people to come and work in
- The resulting turnover and difficulties in recruitment lead to overall staffing levels reducing further – adding to the workload of those that remain.

On two of the key measures, the number of GPs per head of population and the number of practice nurses, our STP had significantly fewer staff per head of population than average. In the case of GPs, all five CCGs are below average, with Thurrock and Basildon & Brentwood having particularly low staff numbers. The overall pattern for practices nurses is similar, four of the five CCGs having significantly fewer staff than average.

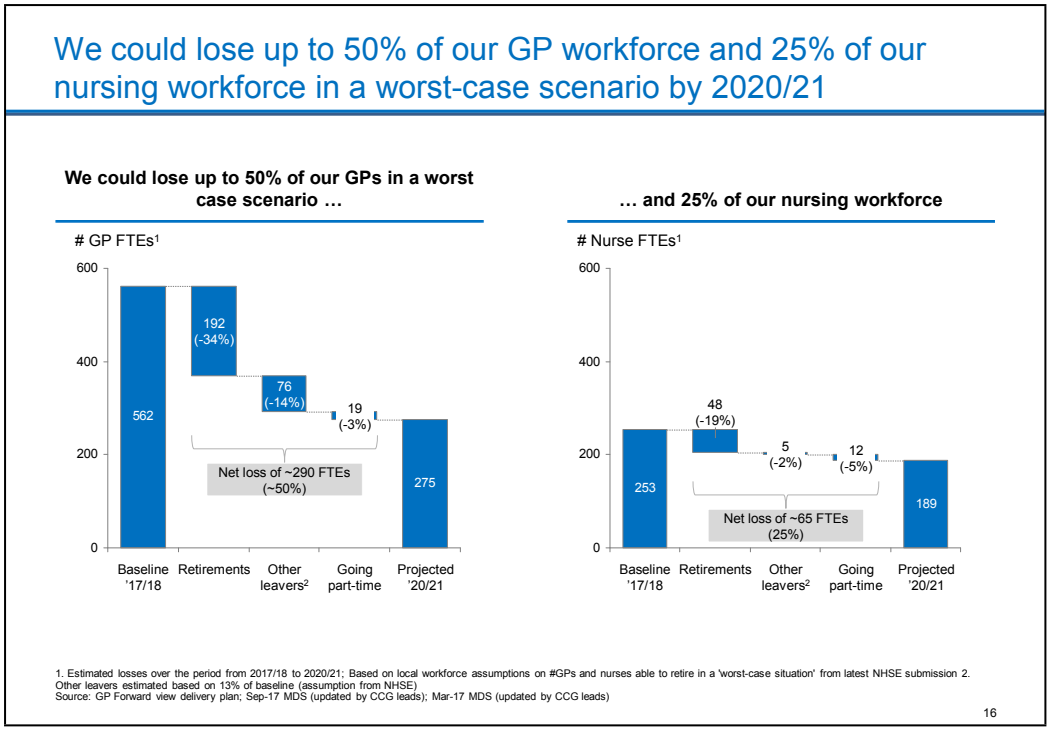


One consequence of the low level of 'core' staffing in general practice is that our STP relies much more heavily on locums and temporary staff than other areas. As well as being expensive, this can negatively impact on some patients by reducing continuity of care. This issue is considered further in the section on Workforce.

Workforce shortages in primary care are further compounded by staffing shortfalls in other local community services. Although we do not yet have STP level data, we do know that in many parts of our area there are significant vacancy rates in key services, such as community nursing.

Retirements will further reduce staffing levels

A further challenge for our STP is that the profile of our primary care workforce is relatively old, meaning that there is the potential for significant levels of retirement in the years to come. Health Education England has concluded that that this challenge is more significant in our STP than in any other part of England. Without mitigating action, this will further reduce staffing levels in general practice, exacerbating the problems outlined above.



Morale is low and we face long-running recruitment challenges

One consequence of the low staffing levels and high workload is a negative impact on morale. There is no uniform measure of morale or wider staff satisfaction in general practice (an anomaly that we are keen to address, as set out in the following section of this document), but we know from anecdotal evidence, as well as from high levels of turnover and early retirements, that morale in general practice in our STP is at a very low level.

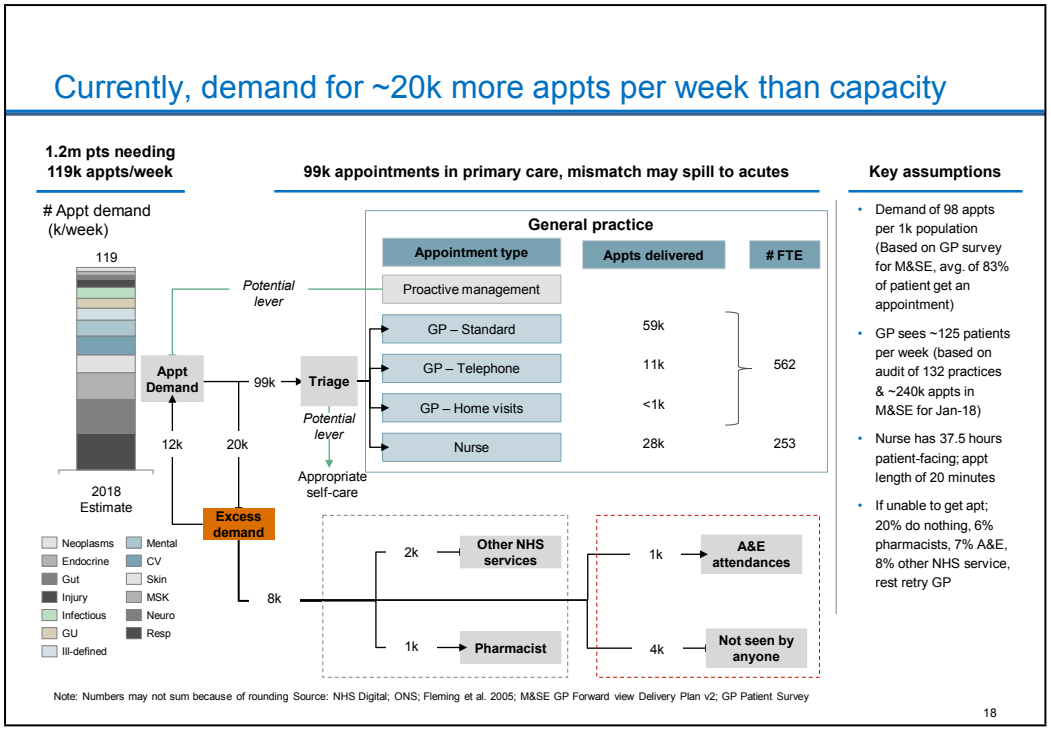
This challenge is compounded by the difficulty we experience in recruiting new, permanent staff. This affects all staff groups, but is more pronounced for GPs – a number of practices across our STP have vacancies that they have been unable to recruit to for a long period of time.

There is insufficient capacity to meet current levels of demand

As a result of the low level of staffing in our STP, we know that demand for care in our STP exceeds capacity. However, until now we have not been able to quantify this gap.

We have for the first time calculated the balance between demand (as expressed by patients seeking an appointment in primary care) and capacity (measured as appointment slots available). We carried out this exercise across the whole STP in early 2018.

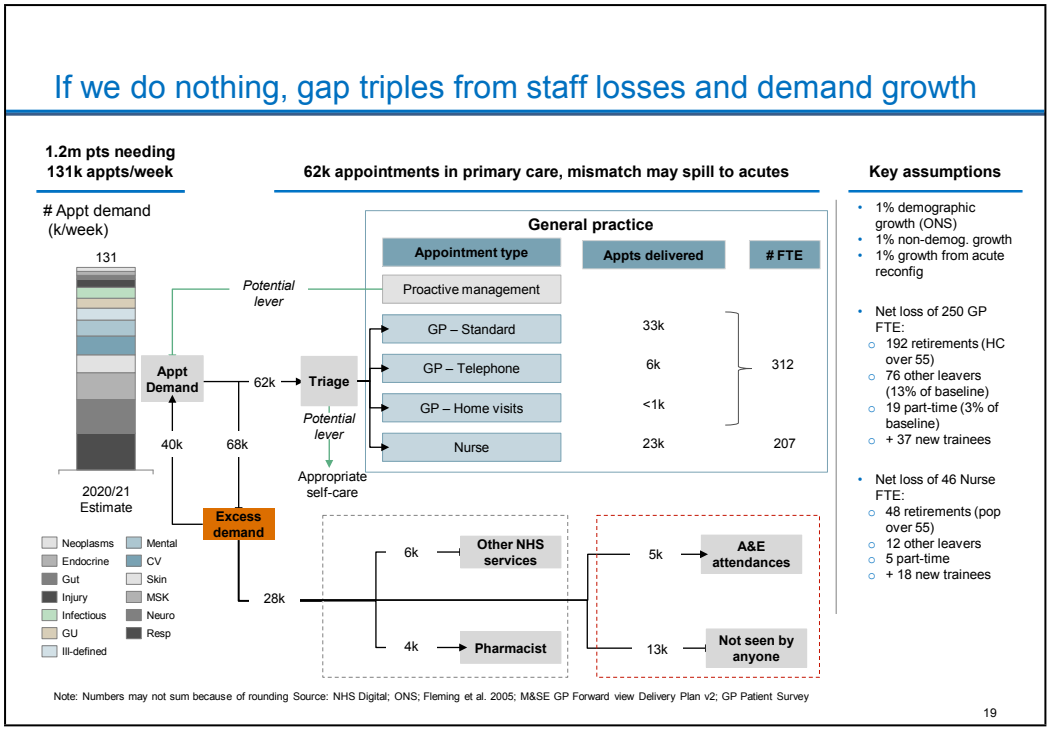
The results show that we have a very significant imbalance at present, with demand for appointments outstripping the available capacity by 20,000 a week. Taking data from the national patient survey, we estimate that in an average week there is demand for approximately 119,000 appointments in general practice. By reviewing data held by each practice, we know that on average there are 99,000 appointment slots available, largely split between GPs and practice nurses.



We do not know what the 20,000 patients per week who are unable to get an appointment do next. However, it is reasonable to assume that a significant proportion will attend A&E, increasing pressure on that service. This hypothesis is supported by survey evidence, which frequently highlights 'could not get an appointment with my GP' as a reason given by patients for attending A&E. In addition, it is also plausible that there are some people who do not get an appointment who really need medical attention – and in those cases their condition may deteriorate markedly before they are able to access treatment.

The gap between demand and capacity will widen in future

It is also clear that, without action, this gap will widen in future years. This is driven by two main factors. Firstly, demand will grow, as a result of population growth, demographic change and the impact of some services shifting from a hospital setting into primary and community care. Secondly, capacity will reduce, as the impact of losing clinical staff (partially to retirements) feeds through. We estimate that if we carry on as we are by 2020/21 in a 'worse case' scenario the gap between the demand for appointments and the capacity available could have widened from 20,000 to over 60,000.



Prior to the development of this strategy, we agreed plans to address the capacity shortfall in general practice, with a particular focus on increasing staffing levels. This includes a detailed plan to recruit more GPs, as part of our local response to the national *GP Forward View* strategy.

However, we know that there are significant risks associated with this element of the plan, not least the fact that we are relying heavily on overseas recruitment to find the additional GPs we need, and that we are in effect in competition with other areas to attract staff whose skills are in short supply. For this reason, out new model of care (set out in the following section) emphasises the importance of creating a much broader workforce in primary care.

The service experienced by patients is variable

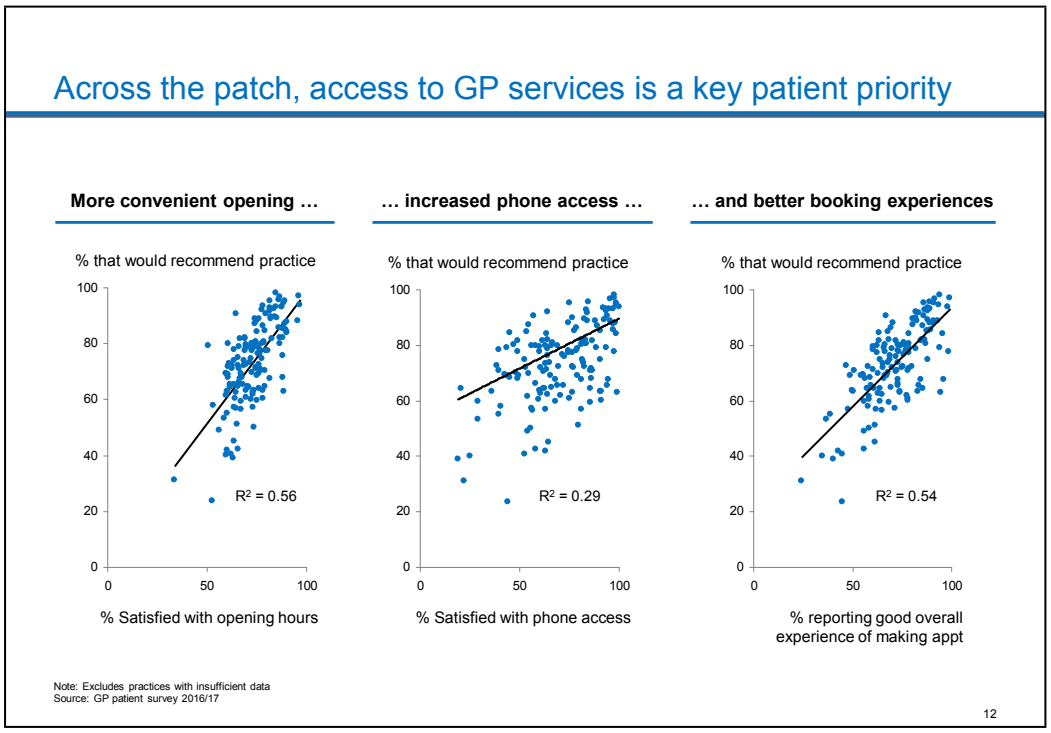
As a result of the challenges set out above – low staffing levels, high levels of retirement, low morale and problems recruiting – we know that the service currently experienced by patients is highly variable.

For example, patient surveys show that all five CCGs are below the national average in the percentage of patients who would recommend their practice; only one CCG is higher than the average for the percentage of patients who are happy with opening hours; and one CCG – Basildon – is below the national average on all of the key measures.

Metric	Mid Essex	Basildon	Thurrock	Southend	CP&R	STP Avg.	National Avg.
% Who would recommend the practice	76	71	67	72	76	72	77
% Satisfied with phone access	65	70	72	72	70	70	71
% Satisfied with opening hours	72	71	71	73	77	73	76
% Who saw/spoke to nurse or GP same or next day	52	46	48	48	54	50	50
% Reporting good overall experience of making appointment	71	68	69	72	76	71	73

We know that one of the key drivers of patient satisfaction is access to services. As set out in the following exhibit, there is a clear correlation between three of the key measures of patient access – satisfaction with opening hours, with phone access and with experience of making an appointment – and how likely a patient is to recommend their practice to others.

This is a particular challenge in our STP, where there is a significant – and widening – gap between demand for services and capacity.



Although many factors affect overall health outcomes - and at an aggregate level our STP has better than average outcomes - there is considerable variation at CCG level. For example, Southend has significantly worse mortality rates for liver disease than average, and Thurrock and Basildon both have higher mortality rates for cancer.

Metric	Mid Essex	Basildon	Thurrock	Southend	CP&R	STP Avg.	National Avg.
Potential years of life lost from amenable causes per 100k pop - Female	1,567	2,009	2,186	1,782	1,801	1,825	1,869
Potential years of life lost from healthcare amenable causes per 100k pop - Male	1,780	2,265	2,207	2,307	2,204	2,099	2,266
Under 75 mortality rates from cancer per 100k pop	107	127	130	116	112	117	120
Under 75 mortality rates from CV disease per 100k pop	50	59	76	65	62	60	64
Under 75 mortality rates from liver disease per 100k pop	11	11	15	21	9	13	16
Health related QOL for people with long term conditions	0.77	0.74	0.75	0.74	0.76	0.76	0.74

This variability, together with other the factors set out above, led us to conclude that we needed to go further and develop a different model of care for general practice. Our conclusions are set out in the following section.

3. FUTURE MODEL OF CARE

About this section

This section sets out the key elements of our future model of care; the detail behind this overview is contained in the *strategic narrative* which complements this document.

We describe how we plan to move to a GP led, rather than GP delivered, service, and to encourage practices to increasingly work 'at scale' by coming together in localities. We detail and quantify our plans to reduce workload and close the demand-capacity gap by expanding the workforce on primary care, managing demand and eliminating bureaucracy.

Overall approach

We have developed our future model of care in discussion with practices from across mid and south Essex, and have also tested our thinking with a wide range of partners including the LMCs. We have captured the detailed thinking **in our strategic narrative for general practice** which accompanies this document.

Our approach to transforming primary care seeks to protect and build on the strengths of general practice that are greatly valued by patients, whilst also ensuring that practices are resilient, flourishing and an integral part of a wider network of health and care services.

There are two key proposals at the heart of our future model:

- Moving away from a system in which services are principally GP delivered to one where services are GP led
- Encouraging and enabling practices to come together to form and lead localities serving populations of approximately 30 - 50,000 people

From GP delivered to GP led services

Although many practices have for some time employed a range of clinical staff (such as practice nurses and health care assistants), in many instances the norm remains for almost all care to be delivered by a GP, often in quite traditional ways – for example, with almost all consultations being face to face and in undifferentiated appointment slots.

Given the imbalance between demand and capacity and the recruitment challenges outlined in the previous section, it is clear that this model will be difficult, if not impossible, to sustain. There are also other reasons to think it could and should change:

- A model where the default is for patients to directly access a GP (and usually for a standard amount of time) is not tailored to an individual patient's need or circumstances
- When GP capacity is outstripped by demand, as it has been locally for some time, then it is important that highly skilled GPs are able to focus their time on the patients with the most complex needs, such as those with long term conditions
- A range of studies have demonstrated that having improved or direct access to a wider range of clinical skills such as nurses, physiotherapists and mental health workers can improve patient care and reduce pressure on GPs
- Most practices are, on their own, too small to be able to integrate effectively with other statutory services, such as social care

Our new model would see practices employing, or having direct access to, a much wider range of disciplines than is presently the case, including nurses, support workers, physiotherapists, clinical pharmacists and mental health specialists. While GPs would remain accountable for the care delivered to the patients on their list, only patients who really need the 'specialist generalist' skills of a GP would be directly seen by them; many other patients would be triaged and directed to another member of the team.

We recognise that changing the care model in this way may require other developments to make it as effective as possible; for example, building in opportunities for trust to be built within new teams, and enabling members of the extended team to refer patients where appropriate.

Under this model, we envisage that a range of new ways of seeing patients would develop, including telephone consultations, increased use of e-consult systems and remote monitoring.

Over time, we also envisage that GPs could play a wider leadership role in integrating local services, for example bringing together council led services like social care, as well as those provided by the voluntary sector.

Developing hubs/localities

The second key aspect of the future model we have developed is to encourage practices to come together and form hubs or localities serving a population of roughly 30,000 to 50,000 people. This is already happening in many areas across the STP, but progress is variable and lacks a common framework.

In our discussions with practices, we have emphasised that a key aspect of a successful locality will be to serve the practices that are within it; we believe this will be key if our new model is to be successful. Equally, we have been clear that joining or forming a locality is voluntary for practices – we think it is essential that practices *want* to join.

We anticipate that practices will in general lead and make the key decisions about their locality. One core function will be to ensure that the locality supports individual practices, for example by reducing workload or taking on some work on its behalf where this is appropriate.

Localities will have a key role in:

- Managing and reducing demand, for example through common triage processes and the deployment of Care Navigators
- Providing a common 'building block' for integration of other services, such as community, mental health and social care
- Ensuring that at a locality level there is consistent modelling of demand and capacity
- Providing tools to help practices manage workload
- Supporting practices with the recruitment of staff, potentially building on the existing expertise built up through the EPIC programme
- Creating the critical mass that will enable some services that have traditionally been provided in a hospital setting to be redesigned and re-provided in the community
- Supporting practices to reduce bureaucracy by, for example, sharing back office functions and implementing digital solutions
- Leading patient education on accessing services and self care

Localities could take many forms, however to be effective they will need to have some core features, including:

- Coherent geographical coverage
- Clear governance and decision making processes, such as a memorandum of understanding
- Strong and credible leadership and an enthusiasm for working with partners
- Demonstrable practice sign up

We anticipate that localities will operate differently in different localities, and we will encourage them to innovate, develop new models and evolve. We believe that having thriving will localities help us to unlock the potential offered by integrating health, care and voluntary services locally.

Over time, some localities could, in discussion with their CCGs and local partners, take on a range of additional budgets and functions. More detail on how localities might over time progress through several 'levels' is set out in our overall STP plan.

Reducing practices' workload

In discussions with practices, we have emphasised the need to move quickly to reduce workload. Over the medium term, this will largely be achieved by increased recruitment, the development of the wider workforce and working together in localities, as set out above.

We know we cannot wait until new staff are in place, however, particularly given the skills shortages that currently exist and that slow recruitment to vacant or new posts. Therefore, we want to move quickly to help practices reduce pressure in the coming months, for example by:

- More consistent triage
- Clearer navigation of patients to alternative services
- Reductions in bureaucracy
- Quicker access to the wider support team, such as district nurses
- Enabling emerging localities to share resources
- Seeking opportunities for improving integration with and access to key services, such as social care.

We anticipate that addressing this issue will be a key element of CCG's Implementation and Investment Plans (see Section 9).

Closing the demand – capacity gap

The Case for Change identified that at present there is a gap of almost 20,000 appointments a week between demand for care in general practice and its current capacity, and that this is likely to widen considerably in the future. Closing this gap is one of the key drivers for developing this strategy.

In developing our future model, we have identified four main ways in which we can close this gap:

- Manage the demand for primary care more effectively
- Recruitment of additional GPs and a range of other clinicians to significantly create capacity
- Work together in localities to enable the benefits of operating at scale to be realised
- Harness the opportunities that digital solutions could offer

The following exhibit sets out, at a high level, both the key elements of each of the four main 'solutions' and where relevant the possible impact on closing the capacity gap that we face. More detail on each of these areas, and the supporting evidence we have drawn on, is available in the appendix.

'Solution'		What solutions could we offer to practices in a locality?	Potential impact
Manage demand	Improved front-door triage	• Training for reception care navigators and social prescribers • Training for nurse/GP-led telephone triage systems • Access to free/subsidised e-consult and AI triage systems • Opportunity for shared triage in community hubs/via NHS 111	• 3–15% reduction in appointment demand 0 — 50
	Proactive management and risk-stratified care	• Enhanced care home services, with support from acutes • Improved EOL care in the community, with support from acutes • Self-care tools and Apps proven to drive behavioural change • Targeted outreach calls reduce primary & secondary care activity	• Up to 4% reduction in appointment demand • Future benefit from improved LTC case finding 0 — 50 (0, 4)
Create capacity	Improved use of the wider workforce	• Pump-priming to hire wider workforce roles, with minimum effective uptake req. per role (e.g., no less than 0.5 FTE/practice) • Tailored needs analysis and skills audit per locality • Training to up-skill existing staff	• Up to 24–40% reduction in GP clinical appointments based on model used 0 — 50 (24, 40)
	Reduced GP admin burden	• Pump-priming to hire GP admin assistants • Access to free/subsidised personal productivity tools and training • Opportunity for shared back-office functions in locality hub	• Up to 3–16% reduction in GP workload 0 — 50 (3, 16)
Operate at scale	Locality hub model of working	• Infrastructure to support working in virtual or physical hubs • Community hub estates and co-location of services to support MDT working	• Demand redistribution and reduced locum use • Increased staff satisfaction and retention
Digital opportunities	Harness new technology to improve efficiency	• Use of technology to enable and promote self care • Automated systems to extract key data enabling reduced bureaucracy	• Reduced demand for appointments • Reduced bureaucracy

We think that practices, by working together in the locality model and with appropriate support, could reduce the pressure by managing demand for care more effectively. This has two main components: improving the 'front door' triage so that patients access services (and the professional) that is right for them and their needs; and by making more systematic use of existing tools such as predictive modelling and care planning to improve care for people with complex needs such as long term conditions. There is good evidence from elsewhere in the country that a systematic approach to this area is effective in managing demand in general practice.

The second and by far the most significant 'solution' is to expand capacity, principally by increasing the workforce – both of GPs and other clinical staff. As set out below, to close the capacity gap we need to recruit another 120 GPs (in line with our STP's *Forward View* target), as well as more clinical practitioners, physiotherapists, mental health and social care professionals and a range of other support staff.

The staffing mix outlined below has been built up by modelling the additional staff required to close the gap, and testing this model against the projections made previously as part of our response to the *GP Forward View*, as well as with localities that have already begun to implement this model.

			Essex draft strategy (2020/21)[1]	
Skill mix	**Baseline** *(2017/18)*	**Est. cost per FTE (£K)**	**FTE Δ to baseline**	**Additional cost (£M)**
GP	562	101	120	12.2
Clinical practitioner	256	48	69	3.4
Physical	0	48	42	2.0
Mental	0	48	20	1.0
Social	0	48	12	0.6
HCA	77	27	29	0.8
Other DPC	63	27	13	0.3
Admin	990	23	87[2]	2.0
Total	1.9k		0.4k	22

Mapping of roles to skill mix

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Physical — Physio
- Mental —MH Therapist; CPN

A further strand in creating capacity is to support practices to reduce bureaucracy in order free up clinical capacity. This includes streamlining back office processes by operating at scale across localities; working with other partner such as hospitals to reduce demands on practices; and increased use of administrative assistants to release clinical time.

The third broad 'solution' we have identified are a range of benefits that we believe will flow as a result of practices operating at scale in localities. Although we have not at this point attempted to quantify the benefit of these measures, we think it is likely to be considerable; key aspects include:

- Sharing capacity at time of peak demand
- Rolling our common technologies and approaches to risk stratification
- Developing physical hubs to accommodate wider professional teams

Finally, we consider there to be considerable opportunity to improve efficiency by taking a more systematic approach to the adoption and spread of digital technology. Once again, in order to be prudent we have not counted on a direct benefit of these changes, but key aspects include:

- Care navigation tools
- Self-care and community support
- Shared care records
- Process and productively improvement tools

Taken together, we believe the four 'solutions' outlined above – managing demand, creating capacity, operating at scale and digital opportunities - could close the capacity gap identified in the previous chapter.

However, we recognise that whilst we need to expand capacity now, we also need to support practices to manage and where possible reduce the existing workload. We set out in Section 3 some of the steps we believe we can take quickly in order to help practices, including more consistent triage, better care navigation and reducing bureaucracy.

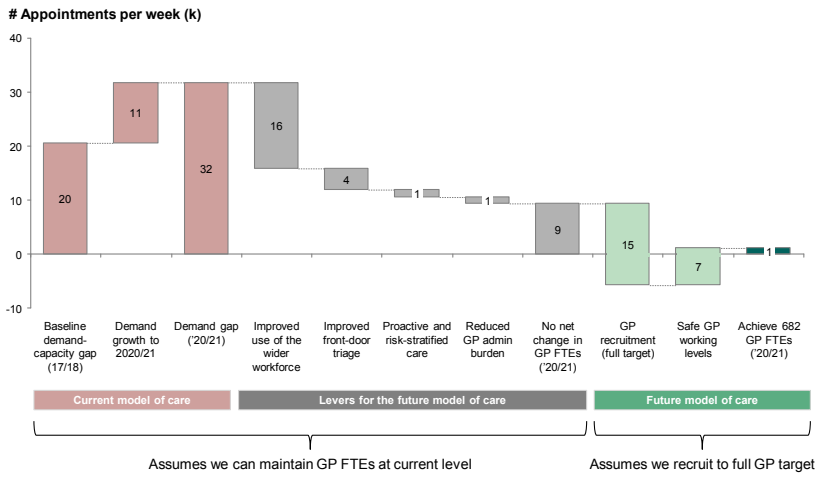
The following exhibit shows our predicted demand-capacity gap of 32,000 appointments a week by 2020/21, made up of our current estimated gap (20,000 appointments) and the projected increase in demand (11,000 appointments). We then factor in the positive impact of key aspects of the four solutions outlined above by 2020/21:

- Increases to the non-GP workforce and the development of a wider mix of staff – resulting in 16,000 more appointments available
- Better demand management though more effective front-door triage – results in a predicted gain of 4,000 appointments
- Consistent use of risk stratification and proactive care - results in a capacity gain of 1,000 appointment
- Reductions in bureaucracy - result in freeing up capacity of about 1,000 appointments.

Taken together, these measures result in a remaining gap of about 9,000 appointments. This residual gap is addressed recruiting the additional GPs that we need to implement our future model of care. If we then hit our *Forward View* target for GP recruitment, we will have an excess of capacity over demand, which would then enable us to reduce GP workload to BMA safe working standards (see below).

Closing the gap between demand and appointments

We can close the est. 32k appointment gap, and achieve safer GP working levels by 2020/21



Key assumptions

- Demand of 98 appts per 1k population in '17/18; growth of 3% p.a. to '20/21
- Safe working GP levels of 115 appts per week
- Uptake of 50% of the wider workforce model across M&SE
- Front-door triage reduces apt demand by 3%
- Proactive care reduces apt demand by 1%
- Reduced GP admin burden increases apt capacity by 2%

Source: NHS Digital; ONS; Fleming et al. 2005; M&SE GP Forward view Delivery Plan v2

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Safe working in general practice

One of our main objectives in rebalancing demand for care and capacity in primary care is to enable us to move towards safe working levels for GPs. At present, due to our historically low levels of staffing, we believe many GPs are working above the levels recommended by the BMA with most GPs seeing well over 30 patients per working day. By fully implementing our new model, we think this will enable a full time GP to see approximately 23 patients per day, in line with BMA guidance.

Measuring outcomes

At present, we do not systematically track outcomes in primary care at either an individual practice or locality level. This means that the priorities and targets we are aiming for are not always clear, and it is difficult to track and understand levels of progress.

However, we are clear that it would not make sense to try and set a single 'binding' set of outcome measures on all localities. To do so would risk alienating some areas and would also fail to capture the legitimate differing priorities across the footprint. Therefore, our emerging approach is to develop a menu of outcomes that localities can choose from (and that can be added to if necessary), together with a small set of core indicators that we will agree across our STP.

Types of outcome measure

In developing this work, we have identifying three main categories of outcomes that we think each locality should use: patient impact; practice level impact; and system impact. There is a wide range of indicators that it may be appropriate to use in each of these categories; some examples are set out below:

In measuring patient impact, we anticipate drawing primarily on the data that is available from the national survey, as this is a robust data set on how patients view their local practice. Over time, as we expand capacity in general practice and introduce the new model of care set out in this section, we would anticipate improvements in most or all of these measures. We are also keen to work with localities to develop further metrics that 'build out' from measures of access and capture other aspects of the patient experience.

We are also very keen to measure practice level impact, with a particular focus on staff satisfaction and morale. General practice is an anomaly in the NHS, in that there are at present no routine staff surveys in place. We are keen to correct this anomaly, and have identified one tool – the Maslach Inventory – that we are keen to pilot using across our STP. The Local Medical Committees are supportive of this approach and we plan to work with them to run a baseline assessment in the summer of 2018.

Our third category – system impact – seeks to determine how effective practices and localities are in supporting the overall effectiveness of the wider health and care system. There are several measures that could be used here, but we are particularly keen to focus on those that consider rates of hospital utilisation. In general, we would expect that increased investment in, and the improving capacity of, primary care will lead to a narrowing in the present variation in acute utilisation.

Clinical outcomes

As localities develop, we are keen that they obtain the expert advice of their local Director of Public Health to take advice on and set appropriate clinical outcome indicators. We anticipate that by focusing on a small number of clinical outcome indicators, rooted in a thorough needs assessment, localities will be able to focus their services and interventions on meeting specific local needs. Discussions to date suggest that the most fruitful measures are likely to be those that focus on the effective management of long term conditions such as diabetes or heart disease.

Developing our approach to outcomes

As we work with existing and emerging localities to complete a self-assessment and then subsequently agree a development plan (see section on implementation), one of the areas for discussion will be outcomes measurement. In any final agreement between a locality and its CCG, we would expect to see clear statement on the outcomes that have been selected as local priorities, together with target level of achievement and how they will be reviewed.

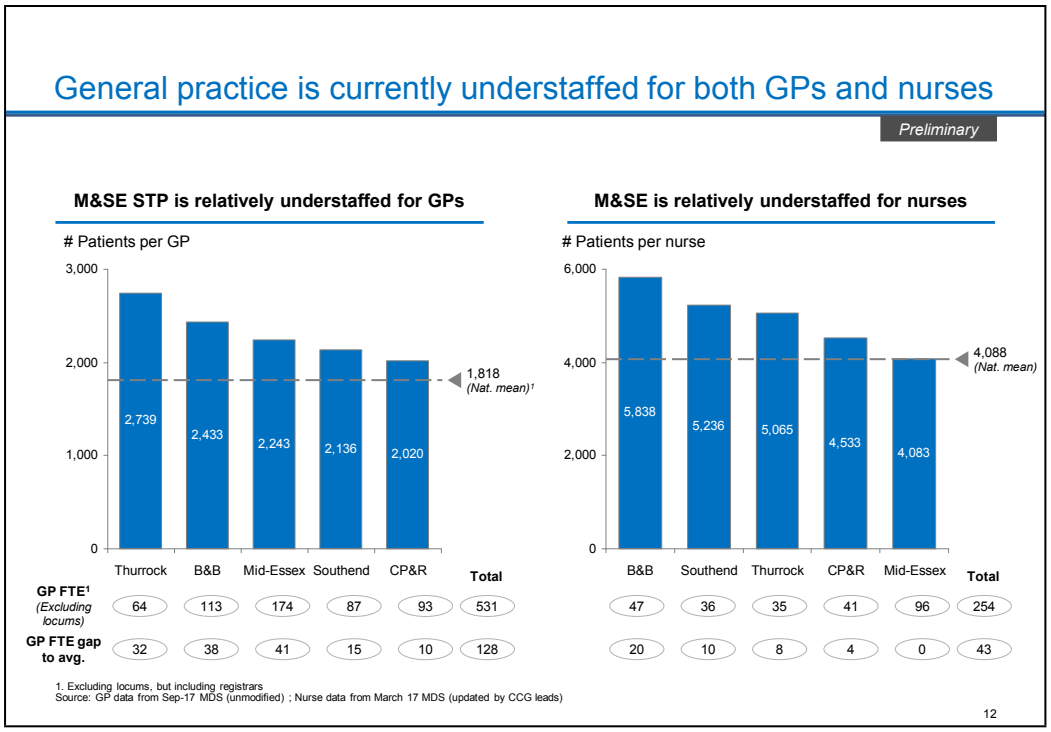
4. WORKFORCE

About this section

This section sets out our plans to expand and change the workforce in primary care. It outlines the challenge posed by our starting point, together with the importance of developing and implementing our new approach to workforce in order to differentiate our STP from others and make mid and south Essex an attractive place for staff to come and work in.

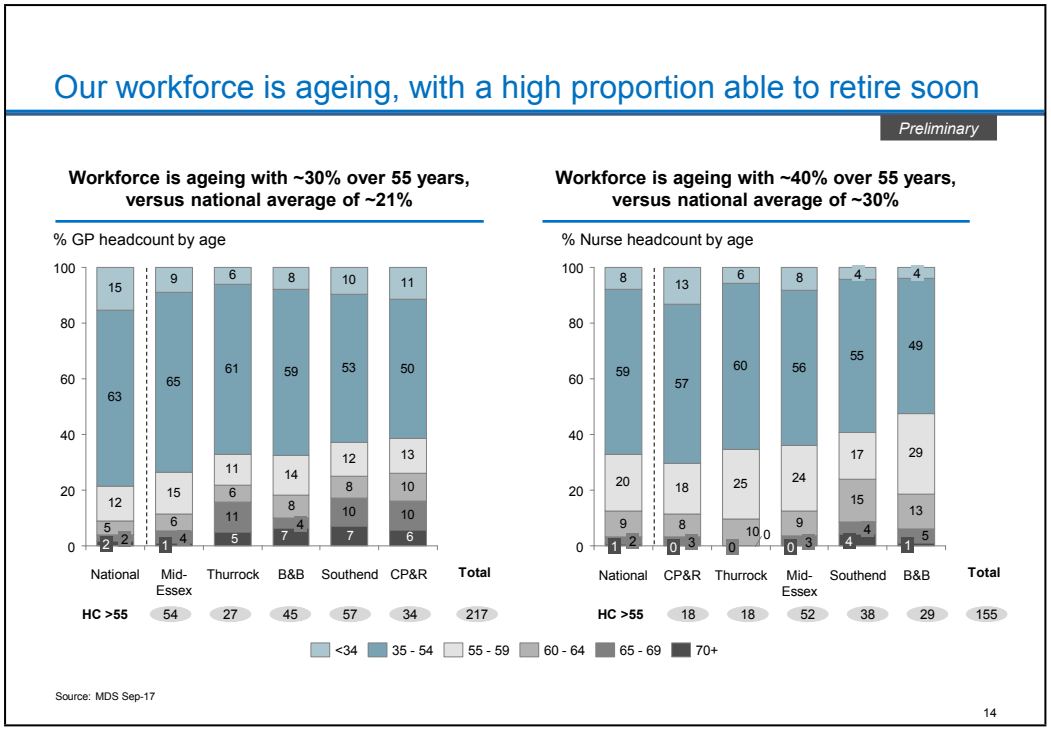
The Challenge

One of the main reasons we have developed this strategy is because we face a workforce crisis in primary care. One of the underlying – and longstanding – factors is that we have significantly fewer doctors and nurses per head than the national average:

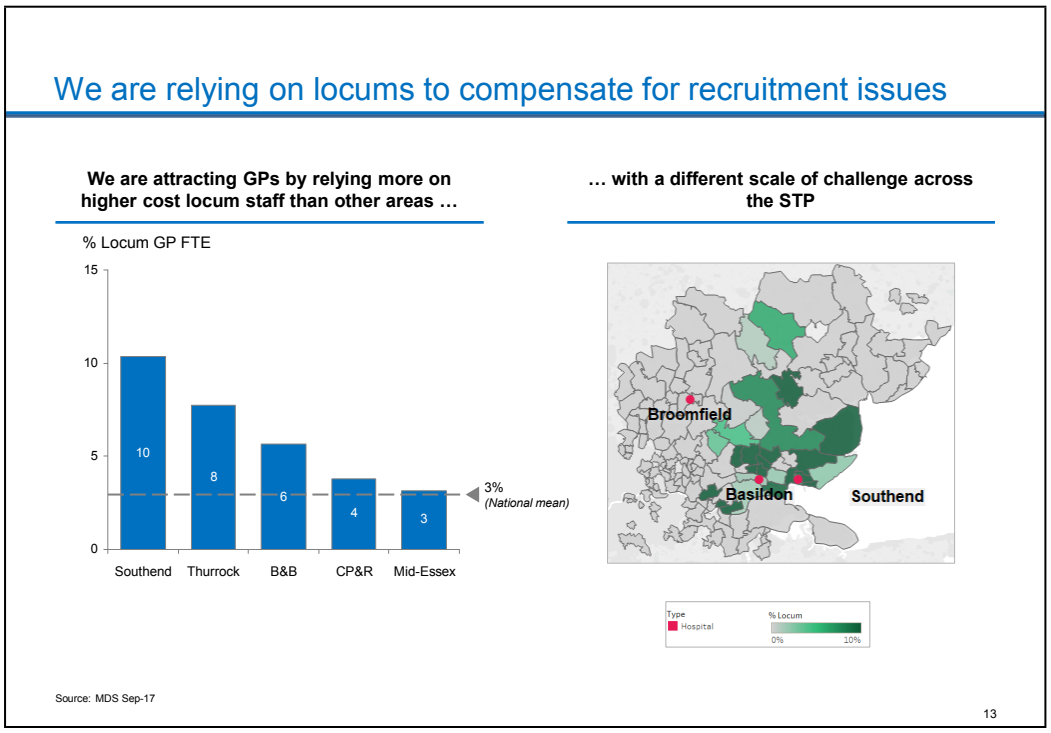


This clearly exacerbates the demand-capacity gap that we outlined in the case for change, as well as increasing the workload of and pressure on existing staff.

In addition, this position is likely to get worse in the coming years due to the age profile of our primary care workforce, which results in exceptionally high levels of predicted retirement. In fact, Health Education England recently identified that the retirement challenge in mid and south Essex as the greatest in England.



As a result of these pressures, as an STP we are heavily reliant on locums, with the challenge most pronounced in the south of the patch. As well as being expensive, this affects continuity of care for patients and potentially impacts on the quality of consultations.



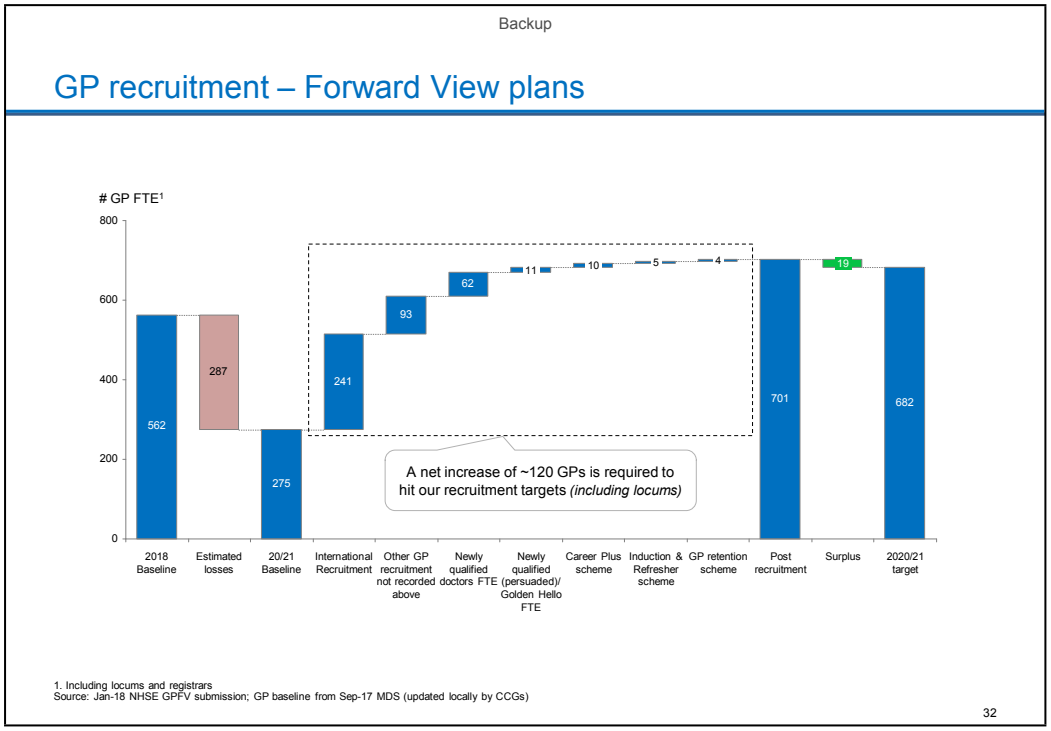
New model of care – workforce implications

As set out in the previous chapter, our new model of care has three key implications for our future workforce:

- Firstly, we need to recruit and retain significantly more GPs and practice nurses, building on our *GP Forward View* plans
- Secondly, we need to develop new roles and recruit a wider set of skills and disciplines into primary care, including pharmacists, GP assistants and mental health specialists, as well as think more creatively about possible new roles, particularly at the boundary of health and social care
- Thirdly, we need to reduce workload and make current roles more attractive, so that we have a competitive advantage in recruitment.

GP Forward View

As part of our pre-existing plans, we are aiming to recruit significantly more GPs across mid and south Essex. If successful, these plans will enable us to hit our national target of having 682 Full Time Equivalent (FTE) GPs in post by 2020.



However, it can be seen that we are heavily reliant on international recruitment in order to achieve our target and, although we have experience of running successful local programmes in the past, we recognise that this is a considerable risk. This is one of the reasons why, in this strategy, we advocate moving away from a service that is predominantly GP delivered to one that is GP led, building up a primary care workforce that includes a much wider range of professional disciplines.

Wider primary care workforce

At an STP level, in addition to recruiting additional GPs, to fully implement the new model of care we know we need to recruit or redeploy almost 200 additional staff, drawn from a wide range of professional disciplines:

Skill mix	Baseline *(2017/18)*	Essex draft strategy (2020/21)[1] FTE Δ to baseline
GP	562	120
Clinical practitioner	256	69
Physical	0	42
Mental	0	20
Social	0	12
HCA	77	29
Other DPC	63	13
Admin	990	87

Mapping of roles to skill mix

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Physical — Physio
- Mental —MH Therapist; CPN

At this point, this is a top down estimate at STP level, albeit based on previous work as part of implementing the *GP Forward View* and tested with localities that are already developing a similar model. We plan to refine this model over the coming months as CCGs work in detail with their practices and emerging localities to determine the skill mix that is best able to meet local needs. We also anticipate that many localities will want to work with local partners, such as councils, to design new, flexible and innovate roles that are best able to meet individual's needs, rather than be designed around traditional organisational silos.

STP general practice workforce strategy

It is clear that expanding and changing the workforce in our STP is the biggest challenge we face. We believe that implementing our future model of care will be crucial in differentiating mid and south Essex from other areas, and make it easier to recruit the staff we need.

We have also identified a number of areas where, working together across the STP, we need to do more. We have recently agreed to establish a single resource (a workforce 'hub' or PMO) to co-ordinate our work across the STP.

Recruitment

We know that in some cases, such as the recent international recruitment of GPs, there is a benefit to recruiting on a larger footprint such as an STP. As we get a clearer 'bottom up' picture of the additional staff that practices and localites are looking to recruit, we will develop STP wide recruitment campaigns, including holding information evenings and running regular assessment centres for cohorts of staff. In this way, we think we will achieve a higher profile for our STP, encourage more applicants for local roles and be able to establish and 'at scale' approach to recruitment.

The recent establishment of the new Medical School at Anglia Ruskin University will be of huge benefit to our STP, and will greatly support recruitment. The new School has a specific focus on training general practitioners, which should help establish a local source of new recruits. In addition, the establishment of the Medical School will support a range of other workforce initiatives, including improving research opportunities and strengthening continuing professional development.

Retention

We will explore the further steps we can take to encourage and enable existing staff to continue to work and contribute locally. This will include looking at further financial incentives for key groups, better meeting development needs and identifying clearer opportunities for career progression.

Workforce intelligence

We recognise that having clear, timely and accurate local workforce data is key if we are to plan effectively at CCG and STP level. We will work more closely with HEE, the Local Workforce Action Board and practices to develop our workforce intelligence function, and see this as a vital role for the hub/PMO that we are establishing.

New roles and job design

Our new model of care relies on recruiting a wider range of staff, but also on developing new roles, such as physician assistants, generic care workers and support staff. In order to minimise duplication, we plan to work with practices and stakeholders to develop a common approach to these roles, such standardised job descriptions, person specifications and competency frameworks.

Role rotation

We are keen to expore how we can make all primary care roles in our STP more attractive and rewarding. One aspect we will look at is designing roles that enable staff to move across localaities and care settings, building on previous work to develop staff 'passports'. We think that such a development will lead to higher job satisfaction, improved professional development and better recruitment and retention.

Training and development

Our new model of care places considerable emphasis on all primary care staff working to the top of their skill set; for example, over time we envisage that the majority of direct pateint contact for many GPs will be with patients with the most complex needs. As a result, having comprehensive, ongoing training and development programmes for all staff groups will be vital.

As practices are in general relatively small orgnisations, training and development programmes can be fragmented. Working with practices and emerging localities, we plan to address this by building STP wide training and development programmes, and will seek to identify how we can support practices and localities to release staff, for example by helping with backfill.

5. DIGITAL

About this section

This section sets out our plans to accelerate the deployment of digital solutions. We view digital as a key enabler that will support practices to reduce workload, manage demand and provide a better service for patients. We outline the main areas in which we think digital can make a contribution, and summarise our approach to prioritisation.

We know that the use of digital and other technologies will be a key enabler for our future model of care. Digital and other technologies have the potential to help with the better management of demand, create capacity in general practice, reduce bureaucracy and support localities to operate at scale. We also know that to date we have made limited progress in this key area; work has been somewhat fragmented and we lack a unifying vision and architecture.

Digital as an enabler

In section 3 of this document – future model of care – we identified a number of potential solutions which, taken together, could help practices reduce their workload and close the gap between demand and capacity. Several of these solutions are dependent upon, or would be significantly enhanced by, the systematic deployment of digital solutions. Examples include:

<u>Managing demand</u>

- *Self-care and community support*. These tools are well developed and have a range of applications, including apps and software that support behaviour change (for example people with diabetes) as well as providing online support for people with a wide range of conditions including anxiety and depression
- *Care navigation and triage*. These technologies support self-care, such as by navigating patients to appropriate sources of information and support, as well as by providing opportunities for rapid access to consultations, often via computers or smartphones
- *Prediction and risk stratification*. There are a number of established tools that can support practices to risk stratify patients on their list and identify those patients that have 'rising risk'. This enables comprehensive care plans to be put in place for these individuals, enabling them to stay well for longer

<u>Creating capacity</u>

- *Patient pathways and treatment*. These tools can support patients and professionals to provide improved on-going care and reduce the need for regular consultations, for example through remote patient monitoring where the patient's readings are constantly logged and reported automatically, with anomalies or concerning patterns flagged to the patient and their GP

- *Processes and productivity*. There is considerable scope to better harness technology to reduce bureaucracy in primary care. Solutions that are already available include digital dictation that is integrated with clinical systems, and tools that enable automated data extraction from primary care platforms such as SystemOne.

Operating at scale

- *Communication across settings*. Having access to patient level information across a range of care settings is vital, especially as patients are frequently in contact with multiple services. As well as a core shared core record, further digital solutions now enable summary records to be held on smartphones, and for automatic communication with patients (such as appointment reminders, medication alerts etc.)

More detail on some of the digital solutions that we have reviewed in developing this strategy are included in the appendix.

Implementing Digital Solutions

There are many reasons why our uptake of digital solutions has been relatively slow. One key aspect is that there are now so many technologies and solutions available, and this makes it difficult to prioritise and sequence any roll out. A second factor is that in general decisions to purchase or roll out any particular solution rest with individual practices, which inevitably results in a somewhat disjointed approach and makes 'at scale' decisions problematic. Thirdly, there is a recognised lack of skills and capacity in this area: we do not yet invest in roles whose prime purpose is to support practices and partners to implement digital solutions.

To help address the first issue, in developing this strategy we have found it helpful to segment digital solutions into three main areas:

- Core to implementation of our strategy and system wide – such as shared care records
- Well-developed technologies that are low cost, easy to implement and with a clear impact – such as those that reduce bureaucracy for practices
- 'Big bet' opportunities that are not yet proven but have the potential to have a significant impact – such as AI based triage systems

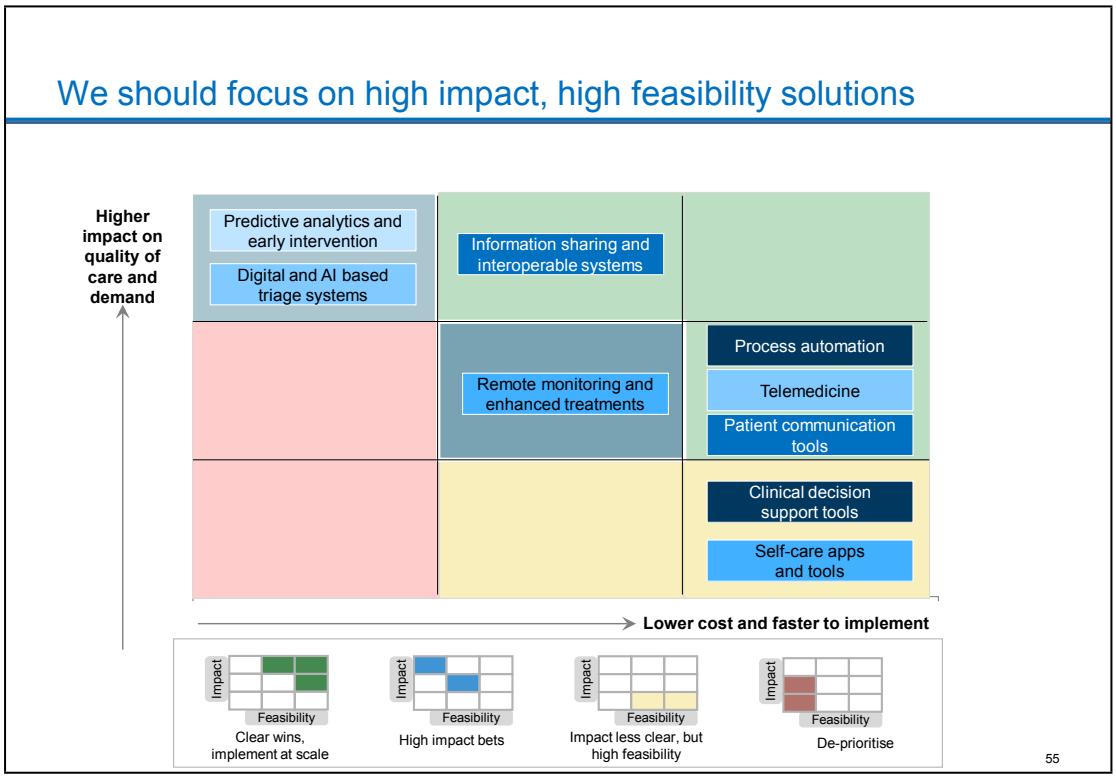
Segmenting in this way helps to break the solutions down into more manageable categories, and should also help our STP to prioritise.

We think that our approach of encouraging practices to come together to work in localities will help address the issue of fragmentation. We are developing a diagnostic tool for localities so they can assess where their strengths and weaknesses lie, with the intention that this then results in a development plan. One aspect of this tool is considering digital solutions, so that in future we hope to see whole localities agreeing a clear approach to rolling out the digital solutions that will best meet their needs.

The final issue – capacity and capability – has been recognised across the STP. As the five CCGs within our footprint increasingly share management capacity, addressing this deficiency will be a priority.

Approach to decision making and implementation

In order to help prioritise possible digital solutions that could support practices, localities and our STP, we have developed an approach to determining which areas to focus on. This considers both the potential impact of the technology on quality of care and demand, and the cost and likely speed of implementation:



We know we need to think 'digital first' as we implement this strategy. Our priorities to help ensure this happens are:

- Build appropriate capacity and capability within the STP to support localities and practices
- Work with existing and emerging localities to develop and agree a digital roll out plan
- Complete a prioritisation exercise to identify solutions which, in agreement with localities, could be developed STP wide
- Set aside investment to support the roll out of digital technologies (set out in the Finance Chapter).

6. ESTATES

About this section

This section highlights the importance of improving and developing the quality of the estate in primary care. It sets out the current position, details the proposed capital 'pipelines' that have been developed by each CCG to support delivery of this strategy and highlights the areas in which our STP will need support if we are to accelerate progress.

Our existing primary care estate

Having modern, fit for purpose buildings is a central part of our vision for the future of primary care. As a starting point, all practices need to be able to provide services in premises that are accessible, attractive and of high quality. But to fully deliver our new model of care we need to go further, by developing physical or virtual hubs that support locality working, provide accommodation for the additional staff we plan to recruit and enabling services to be integrated and - where possible - co-located.

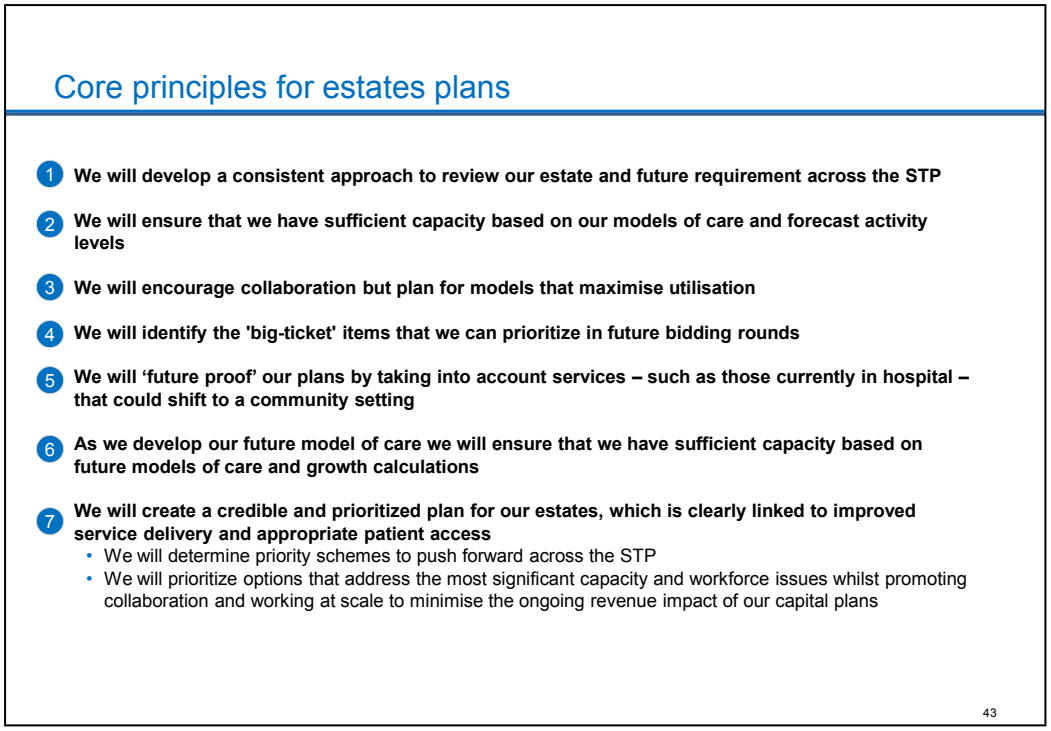
Our starting point is some way from this vision. Our existing primary care estate is below current benchmarks for our region:

- Although at present services are currently provided from 220 premises across the STP with a total internal area of almost approximately 62,000 square metres, we estimate that we have a current space deficit of over 21,000 square metres
- We estimate that population growth, shifting demography and the development of new models of care may require up to an additional 14,000 square metres
- A number of premises are well below the standards expected of a health care facility
- Current utilisation of buildings is poorly understood, but is highly variable across the STP

Although CCGs already have plans in place to address many of these issues, in developing this strategy we have refined our approach and developed more detail on the developments that are being planned in each CCG.

Principles for estates development

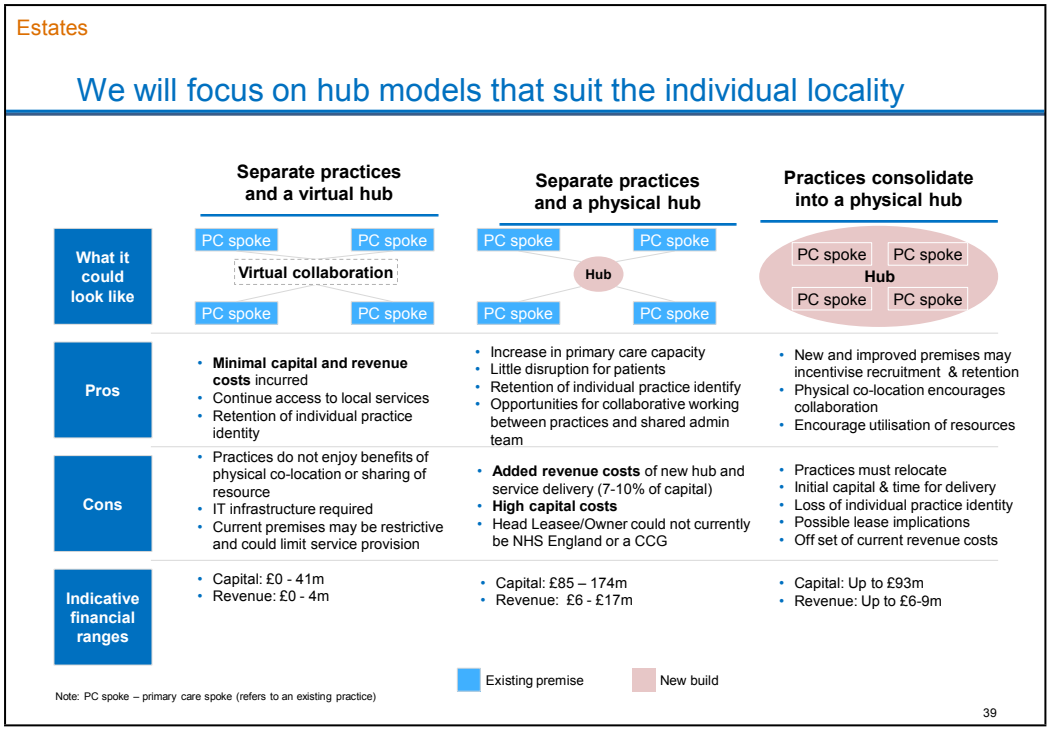
In developing our work on estates, we discussed and agreed a set of high level principles that we have used to guide our work:



Our approach to developing hubs

As set out in our new model of care, in future we want practices to work together and from localities. Over time, we anticipate that a wide range of services will 'wrap around' or integrate with these localities, including community nursing, social care and voluntary organisations. We have agreed that we will prioritise estates solutions that directly support delivery of this vision.

However, at the same time we recognise that building a physical hub potentially housing several practices and a wide range of other services is not practical in all areas, particularly in the more rural parts of our footprint. As a result, we have developed a broad model that is flexible, and is able to support the development of hubs at three different levels:



In some instances, geography will determine that we will need to establish a virtual hub, with distinct practice premises remaining but with significantly improved facilities and an upgraded IT infrastructure to enable joint working. In other cases, the best solution may be to retain separate practice premises but supplement these with a single hub (which could be an existing building that is repurposed or a new build) to form the base for the wider team and for the delivery of a broader range of services. Finally, in some areas it will be possible to establish a physical hub, bringing together two or more practices and a wider range of services into either a new or existing building. A number of our CCGs have plans to develop this type of hub.

Our development 'pipeline'

As part of our work on estates, each of the five CCGs in our footprint has been reviewing its approach to potential future capital development, and has established a draft development pipeline. At an aggregate level, the total capital cost of the entire programme (spread over the next 12 years) is £242m, with the peak years profiled to be 2019/20 – 2022/23:

CCG	Scheme	Value £m Total Capital	Profile Dates - Capital Spend 2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Future
Scheme Summary:														
Mid Essex	CCG led primary care and LHC developments	68.24	1.80	20.74	11.34	3.99	6.00	0.00	0.00	0.00	1.17	2.33	9.17	1.83
B&B	CCG led primary care and LHC developments	28.65	0.45	9.34	9.52	2.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Thurrock	CCG led primary care and LHC developments	48.54	7.31	16.59	11.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Southend	CCG led primary care and LHC developments	48.40	1.60	3.05	12.93	14.52	5.70	5.40	3.20	0.00	0.00	0.00	0.00	0.00
CPR	CCG led primary care and LHC developments	49.13	1.60	2.00	19.03	15.82	3.80	4.38	1.87	0.00	0.00	0.00	0.00	0.00
		242.95	**12.76**	**51.73**	**64.02**	**36.33**	**15.50**	**9.78**	**5.07**	**0.00**	**1.17**	**2.33**	**9.17**	**1.83**

The tables that follow set out the latest position in each CCG, including the estimated capital cost and which year it is likely to fall in, the estimated on-going revenue consequences and an assessment of progress to date in identifying the source of capital, developing a business case and identifying the development (note the practice names have ben removed).

Mid Essex CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Community Hospital	10.60	0.74	0.00	0.00	8.48	2.12	0.00	0.00	R	A	G
Health Hub	7.90	0.55	0.00	0.00	0.99	5.93	0.99	0.00	A	A	G
GP Practice	5.50	0.55	0.00	0.00	0.00	0.00	1.83	3.67	R	R	R
GP Practice	5.50	0.39	0.00	0.00	0.00	0.00	0.00	5.50	R	R	R
GP Practice	5.50	0.39	0.00	0.00	0.00	0.00	0.00	5.50	R	R	R
GP Practice Hub	5.00	0.50	5.00	0.00	0.00	0.00	0.00	0.00	R	R	R
GP Practice	5.00	0.50	0.00	0.00	4.00	1.00	0.00	0.00	R	R	R
GP Practice	3.50	0.35	0.00	0.00	2.57	0.93	0.00	0.00	R	A	R
GP Practice	3.50	0.25	0.00	0.00	0.00	0.00	1.17	2.33	R	R	R
GP Practice	3.50	0.25	0.00	0.00	0.00	0.00	0.00	3.50	R	R	R
GP Practice	3.00	0.11	3.00	0.00	0.00	0.00	0.00	0.00	R	R	R
GP Practice	2.10	0.21	0.00	1.40	0.70	0.00	0.00	0.00	A	R	R
GP Practice	2.00	0.07	0.00	0.40	1.60	0.00	0.00	0.00	A	R	R
GP Practice	2.00	0.20	0.00	0.00	1.33	0.67	0.00	0.00	A	R	R
GP Practice	1.00	0.04	1.00	0.00	0.00	0.00	0.00	0.00	A	R	R
Other schemes (Capital <£1m)	2.64	0.14	0.86	0.00	1.08	0.70	0.00	0.00			
Total	**68.24**	**5.21**	**9.86**	**1.80**	**20.74**	**11.34**	**3.99**	**20.50**			

Basildon & Brentwood CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
GP Practice	5.00	0.18	5.00	0.00	0.00	0.00	0.00	0.00	R	R	R
Health Centre	5.00	0.50	0.00	0.00	0.00	3.89	1.11	0.00	R	R	R
GP Practice	4.75	0.48	0.00	0.32	3.80	0.63	0.00	0.00	A	A	G
GP Practice	4.50	0.45	0.00	0.00	3.60	0.90	0.00	0.00	A	R	G
Health Centre	4.50	0.32	0.00	0.00	0.00	3.60	0.90	0.00	A	R	R
Community Hospital	2.00	0.20	2.00	0.00	0.00	0.00	0.00	0.00	R	R	R
GP Practice	2.00	0.20	0.00	0.13	1.60	0.27	0.00	0.00	R	A	G
Other schemes (Capital <£1m)	0.90	0.01	0.32	0.00	0.34	0.24	0.00	0.00			
Total	**28.65**	**2.32**	**7.32**	**0.45**	**9.34**	**9.52**	**2.01**	**0.00**			

Thurrock CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Healthy Living Centre	12.00	0.42	0.00	6.40	5.60	0.00	0.00	0.00	G	G	G
Healthy Living Centre	15.00	1.05	0.00	0.00	6.00	9.00	0.00	0.00	A	A	G
Healthy Living Centre	15.00	1.50	0.00	0.00	7.00	8.00	0.00	0.00	A	A	G
Community Hospital	5.00	0.50	5.00	0.00	0.00	0.00	0.00	0.00	A	R	R
Health Centre	4.80	0.34	4.80	0.00	0.00	0.00	0.00	0.00	R	R	R
Health Centre	3.66	0.13	3.66	0.00	0.00	0.00	0.00	0.00	R	R	R
Community Hospital	2.00	0.07	0.00	0.13	1.60	0.27	0.00	0.00	A	A	G
Other schemes (Capital <£1m)	2.28	0.05	0.00	0.77	1.34	0.17	0.00	0.00			
Total	**59.74**	**4.05**	**13.46**	**7.31**	**21.54**	**17.44**	**0.00**	**0.00**			

Southend CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Integrated Care Hub	10.00	1.00	0.00	0.00	0.00	4.00	6.00	0.00	R	R	R
Primary Care Spoke	4.00	0.40	0.00	0.00	0.00	0.00	0.00	4.00	R	R	R
Primary Care Spoke	4.00	0.28	0.00	0.00	0.00	0.50	3.00	0.50	R	R	R
Primary Care Spoke	4.00	0.40	0.00	0.00	0.00	0.00	0.00	4.00	R	R	R
Primary Care Spoke	3.00	0.21	0.00	0.00	1.40	1.60	0.00	0.00	R	R	R
Primary Care Spoke	3.00	0.30	0.00	0.00	0.00	0.00	1.80	1.20	R	R	R
Integrated Care Hub	3.00	0.30	0.00	0.00	0.00	0.00	0.00	3.00	R	R	R
Integrated Care Hub	3.00	0.30	0.00	0.00	0.20	2.40	0.40	0.00	R	R	R
New Integrated administrative Hub	2.50	0.09	0.00	0.00	1.00	1.50	0.00	0.00	R	R	R
Primary Care Spoke	2.00	0.07	0.00	0.00	0.25	1.50	0.25	0.00	R	R	R
Primary Care Spoke	2.00	0.00	0.00	0.00	0.00	0.00	1.20	0.80	R	R	R
Integrated Care Hub	2.00	0.20	0.00	0.00	0.00	1.33	0.67	0.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	1.20	0.80	R	R	R
Primary Care Spoke	1.50	0.00	0.00	1.50	0.00	0.00	0.00	0.00	G	A	R
Other schemes (Capital <£1m)	2.40	0.07	2.00	0.10	0.20	0.10	0.00	0.00			
Total	**48.40**	**3.82**	**2.00**	**1.60**	**3.05**	**12.93**	**14.52**	**14.30**			

Castle Point & Rochford CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Integrated Care Hub	8.00	0.80	0.00	0.00	0.00	3.20	4.80	0.00	R	R	R
Integrated Care Hub	8.00	0.80	0.00	0.00	0.00	3.20	4.80	0.00	R	A	G
Integrated Care Hub	6.00	0.60	0.00	0.00	0.00	4.80	1.20	0.00	R	R	R
Primary Care Spoke	5.00	0.50	0.00	0.00	0.00	3.00	2.00	0.00	R	R	R
Primary Care Spoke	4.00	0.40	0.00	0.00	0.00	0.00	0.75	3.25	R	R	R
Health Centre	3.00	0.30	0.00	0.00	0.60	2.40	0.00	0.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	0.00	2.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.93	1.07	0.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	1.20	0.80	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	0.00	2.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	0.00	2.00	R	R	R
Health Centre	2.00	0.00	0.00	1.60	0.40	0.00	0.00	0.00	A	A	R
New Integrated administrative Hub	1.50	0.05	0.00	0.00	0.60	0.90	0.00	0.00	R	R	R
New Integrated administrative Hub	1.00	0.04	0.00	0.00	0.40	0.60	0.00	0.00	R	R	R
Other schemes (Capital <£1m)	0.63	0.00	0.63	0.00	0.00	0.00	0.00	0.00			
Total	**49.13**	**4.49**	**0.63**	**1.60**	**2.00**	**19.03**	**15.82**	**10.05**			

Accelerating progress - support required

We know that the pipeline outlined above is ambitious, and recognise that our STP will require support from NHSE, as well as system partners, to deliver it.

Capital

The majority of the schemes that are well developed do not rely on accessing additional public sector capital over and above existing ITTF funds, as there are a range of other sources of funding available for these developments, including:

- Councils (for example Thurrock Council investing in Integrated Medical Centres)
- Third Party Developments
- Section 106 funding
- Development grants

However, it is possible that there may be an increased demand for public sector capital in the outer years of the programme, as a number of the these proposals included in the CCG schedules do not yet have a confirmed source of capital.

Capacity and cost of development

A significant barrier to accelerating progress with the delivery of our capital programme is a lack of expertise in the local footprint to develop the business cases to the required level of detail, and the limited access to non-recurrent funding to commission expert support, such as the completion of feasibility studies. We are however making progress in this area, with the establishment of a senior post to focus on estates across our STP.

These twin issues are clearly challenges for most STPs; we plan to discuss possible solutions – such as devolving capacity currently held in NHSE or a more innovative approach to the use of ETTF funding – with partners in the system.

Meeting recurrent costs

Perhaps the biggest single barrier to implementing the estates solutions outlined above is a lack of revenue to support each scheme's on-going costs. Although the exact cost varies scheme by scheme – and in some cases can be offset by other savings – we estimate that the average revenue cost of is circa 8% of the capital cost. Although the revenue consequences do not feed through to CCGs for some time, meeting these costs is clearly a concern and acts as a brake on the delivery of the capital programme.

In the following section (finance) we have included an estimate that up to £8m of additional revenue will be required to support the costs of the major schemes identified by the CCGs. However, if the *entire* capital pipeline were to be delivered, the revenue consequences would likely exceed this sum.

STP estate strategy and workbook – next steps

All STPs are required to prepare and submit to NHSE a comprehensive estate strategy (covering the entire estate, not just primary care) by July 2018. We will be building on the work completed as part of preparing this strategy to review the overall capital pipeline for primary care and complete further prioritisation of proposals, drawing on the principles set out above. We anticipate that this work will be co-ordinated by the primary care estates group that we plan to establish (see Implementation section, below), and in liaison with local partners such as councils.

7. FINANCE

About this section

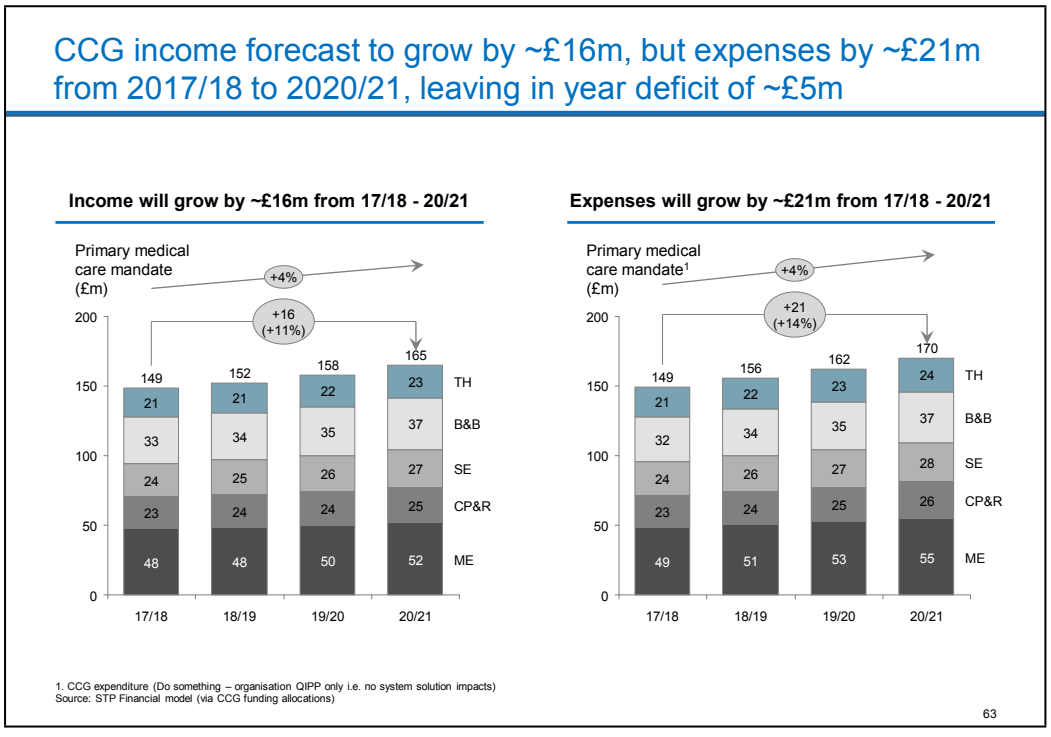
In this section, we set out how much we estimate implementing our new model of care is likely to cost, and identify how we might be able fund the increased expenditure on workforce, estates and other enablers. Although we can see a path to a balanced financial position, there are a range of risks; mitigating these will need CCG Boards to take some difficult decisions about priorities as well as the support of NHS England.

Current and planned levels of expenditure

At present across the STP we invest approximately £149m in core general practice services. As we have a mixed commissioning landscape, these budgets are split across the five CCGs and NHS England. Based on likely increases to funding that have been announced nationally, we anticipate that this total budget will increase by approximately £16m to £165m in 2020/21.

In developing this strategy, we have used national growth assumptions to estimate how much the cost of our existing model is likely to increase during this same period (2017/18 to 2020/21); our modelling suggests that costs will go up by approximately £21m to £170m.

Taking the anticipated increases in funding and expenditure together, it can be seen that by 2020/21 there is likely to be a 'do nothing' deficit of approximately £5m in these core services.



Costs of new model of care

However, as set out in the case for change, we know that we cannot continue with the same model of care, and we have worked with a wide range of practices and other stakeholders to design a new approach. Once the broad outline of the model had been developed, we were then able to estimate its likely cost.

We believe that the additional costs associated with the new model fall into three main areas:

- Workforce – the cost of the additional staff that the system is likely to require in order to close the capacity gap set out in the case for change
- Estates – the additional *recurrent* costs associated with building new or refurbishing existing premises, with a focus on those developments that will make the most significant contribution to delivering this strategy (set out in detail in the previous section)
- Other key enablers – focusing in particular on the likely cost of digital solutions and the change management capacity that may be required

Workforce

In our new model of care, we move from a principally GP delivered service to one that is GP led, supported by a much wider range of clinical and other disciplines than is presently the case. Based on a range of discussions, we have estimated how many additional staff we would require (over the 2017/18 baseline) across the key staff groups. We have then been able to estimate the additional cost of these staff.

At this point this is a 'top down' analysis and will change as CCGs and localities develop detailed plans. It can be seen from the below that if half of our practices have introduced the new model by 2020/21, then this will cost an additional £22m over the current baseline.

Based on the model chosen, the future model workforce could have recurring costs of between £16–£22M

Preliminary

Skill mix	Baseline *(2017/18)*	Est. cost per FTE (£K)	Flat GPs and mixed skilled workforce (2020/21) FTE Δ to baseline	Flat GPs and mixed skilled workforce (2020/21) Additional cost (£M)	Current GPFV targets (2020/21) FTE Δ to baseline	Current GPFV targets (2020/21) Additional cost (£M)	Essex draft strategy (2020/21)[1] FTE Δ to baseline	Essex draft strategy (2020/21)[1] Additional cost (£M)
GP	562	101	-	-	120	12.2	120	12.2
Clinical practitioner	256	48	142	6.9	84	4.1	69	3.4
Physical	0	48	84	4.1	17	0.8	42	2.0
Mental	0	48	40	1.9	0	0.0	20	1.0
Social	0	48	24	1.2	0	0.0	12	0.6
HCA	77	27	29	0.8	29	0.8	29	0.8
Other DPC	63	27	13	0.3	13	0.3	13	0.3
Admin	990	23	26	0.6	26	0.6	87[2]	2.0
Total	**1.9k**		**0.4k**	**16**	**0.3k**	**19**	**0.4k**	**22**

Suggested mapping of roles to skill mix

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Mental —MH Therapist; CPN
- Physical — Physio

1. Based on 50% of practices moving to the proposed locality workforce model 2. Assume uptake of 0.5 GP Assistant FTE per practice; GP cost—2015/16 GPMS income; £48k for AFC 7 and 24% uplift to FLC; HCA and other DPC—AFC4 and 24% uplift; Admin—AFC3 and 24% uplift
Source: M&SE NHSE submission; Agenda for Change Pay Scales; Sep-17 MDS and Mar-17 MDS (corrected by CCG leads – based on individual practice submissions)

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Estates

As set out in the previous section, to implement the new model of care we have assumed we will need to invest in premises, in particular to enable the working at scale which is at the heart of our strategy.

As part of our work we have developed a detailed general practice capital 'pipeline' at CCG level. We have estimated that if every scheme in this multi-year pipeline were to be delivered, the total capital cost would be in excess of £240m, although we anticipate this will fall markedly as we prioritise developments. There are a number of options open to CCGs in order to raise the capital required, including third party developments, collaboration with partners – especially local authorities - and public sector capital.

In order to create a sustainable recurrent financial strategy, we have focused on the ongoing costs of increased capital investment. At this point it is difficult to be certain about the exact costs (as this depends on the a range of factors, including how much of each CCGs pipeline in progressed, who owns and runs any new buildings, the cost of facilities that are being replaced etc.), but we have assumed that we will want to develop a number of hubs and other improvements over the coming years, and estimate that the direct additional recurrent estates costs will be between £3m and £9m.

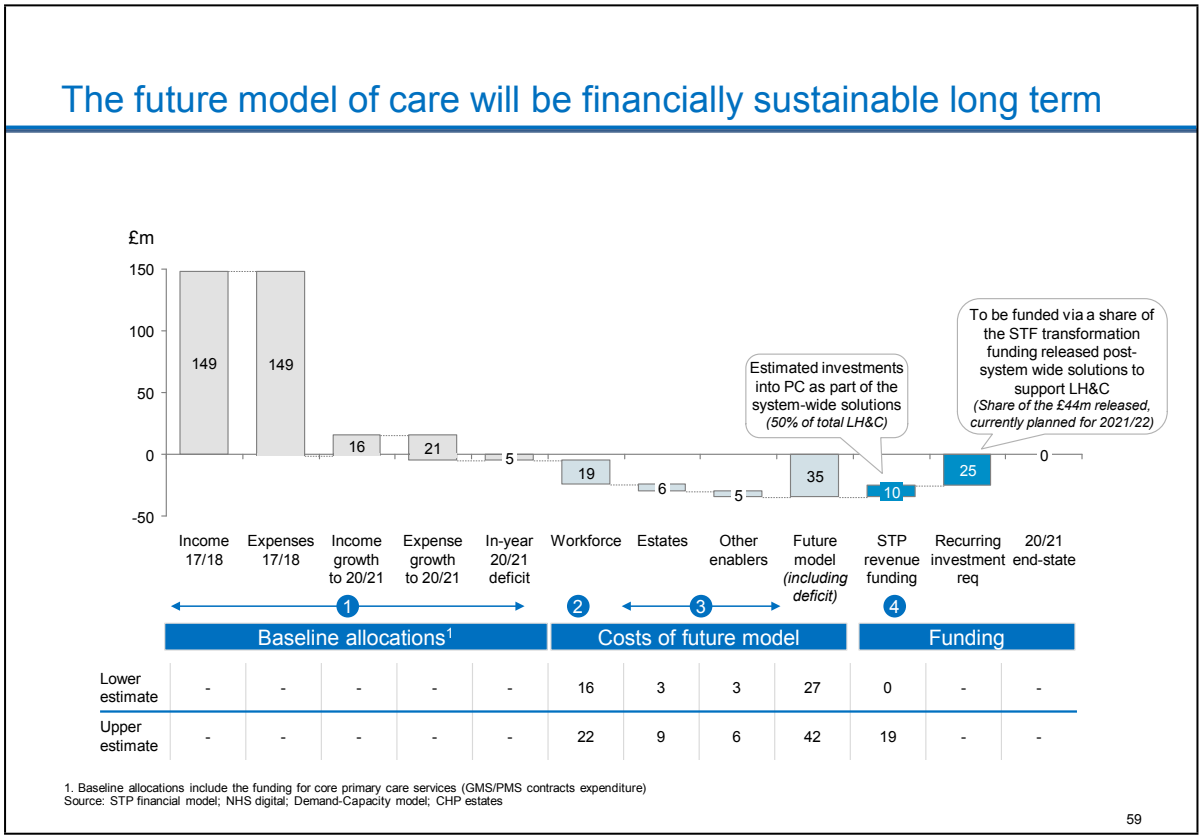
Other enablers

To fully implement this strategy, we think we will need to invest in a small number of other enablers, in particular digital solutions and change management capacity. At this point we do not have detailed plans across each of the five CCGs, but a 'top down' assessment suggest that we will need to invest between approximately £3m and £6m to support the introduction of these key enablers.

Category	Potential schemes	Recurring costs (£m)	Comments
Other enablers	Population health and data analytics support	£0.3 - £0.6m	• Lower – Assume 1 FTE per CCG at £50k FLC • Upper – Assume 2 FTE per CCG at £50k
	Technology enablers	£2 – 4m	• Lower – Assume ongoing cost of ~£2m (as planned for 2018/19 GPIT spend) • Upper – Assume twice '18/19 spend for provision of additional digital services
	Management resource to engage GPs	£0.6 – 1.6m	• Lower – assume 0.5 FTE per locality at £50k FLC • Upper – assume 1 FTE per locality at £65k FLC
	Total	**£2.9 – £6.2m**	

Overall financial position

We have combined our estimates of current and planned increases in expenditure and the anticipated cost of introducing our new model of care so that there is a clear overview:



Section 1 (the first five bars) shows that after taking into account anticipated growth in income and expenditure over the period 2020/21, there is a likely deficit of approximately £5m if we continue to provide these services with no major changes to the delivery model. Sections two and three (the next four bars) show the anticipated additional cost of introducing the new model, which is approximately £30m by 2020/21. Taken together, this suggests an overall deficit position after

moving to our new model of care of £35m by 2020/21. The final section (4 – the three bars on the right) set out how this financial gap could be closed; this is outlined below.

We have broken down the STP financial bridge into each CCG in order to understand the local position. These are included in the detailed annex to this strategy.

Funding our new model of care

There are three main elements to our plan to close the financial gap identified above and ensure we have a financially sustainable system. However, it is important to emphasise that there are risks associated with each element; addressing these will require CCG Boards to make some difficult decisions about priorities, and will also require the support of NHSE (see below).

Firstly, all CCGs have in 2017/18 and 2018/19 invested additional resources in primary care over and above core GMS and PMS, in particular to support extended access. Although some of these funds are non-recurrent, we anticipate similar levels of funding to be future years so should be available for investment in primary care. We have estimated this will be £9m a year across the STP. We believe the risk of these funds not being available for investment is relatively low, and CCGs laregely control where they are invested.

Secondly, we know from national planning guidance that our STP is scheduled to receive an additional £78m in Sustainability and Transformation Funds (STF) in 2020/21. These are funds that are currently top sliced nationally by NHS England to pay for a range of programmes such as the Vanguard initiative.

These funds are not earmarked specifically for primary care and there will be competing demands for investment. Therefore, in order to be prudent we have assumed that approximately £16m is available to support this strategy, which is consistent with national estimates on the likely cost of implementing the *GP Forward View*. We believe that this level of funding is likely to be made available and within the control of CCGs, but recognise that there is a significant risk that they will be required to address other pressures (e.g. overspends in hospitals or funding new national imperatives).

Taken together, we have assumed that these two elements (other CCG funds of £9m and STF funding of £16m) provide an additional £25m to support the implementation of this strategy.

Thirdly, we have identified that an additional £10m may be available by 2020/21 as a result of wider changes to the way in which services are delivered. In our STP's overall plan, we agreed a model that would see some services (principally outpatients) that are traditionally provided in hospital move into a community setting, allowing our acute providers to concentrate on services which can only be delivered in a hospital setting. The funding released from providing these services in a community setting enables us to both pay for those new services and also invest a proportion into our core community and primary care services. We have estimated the element for investment into primary care services will be circa £10m.

However, we know that this element of funding is the riskiest: experience tells us that releasing real savings from the hospital sector for investment in the community is far from straightforward.

Support required from NHSE to deliver this strategy

Although we have developed a financial strategy that indicates our new model of care is affordable, we know there are significant risks to this plan. These risks, together with the support that we think we need from NHSE to mitigate them, are set out below:

Funding source	**Approx. amount (20/21)**	**Level of risk**	**Support required**
CCG baseline funding (in addition to core PMS/GMS)	£9m	**Low** – funds are largely either included in CCG baselines or available via bidding process	CCGs supported to 'ring fence' current expenditure on primary care CCGs encouraged to increase primary care spending from within allocations (e.g. an element of 0.5% investment fund) Allocations that are currently made following bidding processes moved to CCG baselines, to maximise local flexibility
Additional STF allocation	£16m	**Medium** – the amounts to be allocated to our STP in 2020/21 are clear, but there is a risk that these are either ring fenced or tied to delivering additional requirements	Full STF allocation made without any ring fencing of funds or tied to the delivery of new or additional commitments
Funding released from re-provision of acute services	£10m	**High** – if acute demand exceeds our wider STP plan, or if services are not successfully re-provided in an out of hospital setting, these funds will not be available	Explore other funding options with CCGs, such as repayment of historic debt, prioritising primary care for investment of any additional growth received, development of STP investment pool

8. COMMUNICATIONS AND ENGAGEMENT

About this section

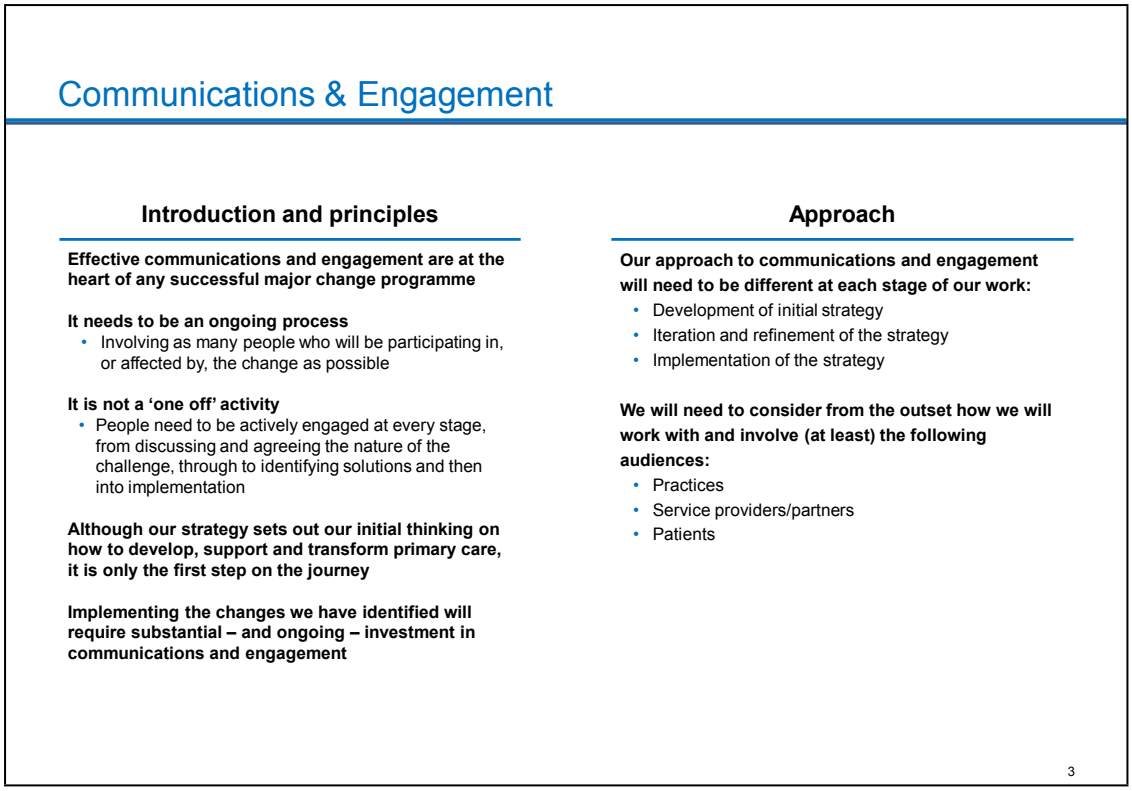
This section sets out the work we have already done to engage local practices and other partners in agreeing the case for change and developing the solutions proposed in this strategy. It then outlines how we plan to build on this by continuing to work closely with patients, practices and partners as we finalise our strategy and, crucially, move into implementation.

Context

Effective communications and engagement are at the heart of any successful major change programme. It is not a 'one off' activity – people need to be actively engaged at every stage, from discussing and agreeing the nature of the challenge, through to identifying solutions and into implementation.

Although this document sets out our initial thinking on how to develop, support and transform primary care, it is only the first step on our journey. Designing the detail of and then implementing the changes we have identified will require substantial – and ongoing – investment in communications and engagement.

The principles and broad approach we agreed in developing this strategy are set out below:



Phases

Our broad approach has been to divide our communication and engagement work into three main phases, and our approach is necessarily different at each stage as more and more people are affected by implementing our new model of care. The main phases are:

- *Development* of initial strategy
- Iteration and *refinement* of the strategy
- *Implementation* of the strategy

Audiences

General practice sits at the centre of our health and care system. As a result, because we are seeking to work with practice to make changes to the way it operates, we need to engage not just with practices and their patients but also with the very wide range of other services and partners that they interact with. In fact, many of the opportunities or solutions we have identified in this strategy are entirely dependent on other organisations changing what they do, so their ongoing involvement is vital.

In applying our three phase approach, we have identified three main audiences to focus on in our communications and engagement:

- Practices
- Service providers and system partners
- Patients

Engaging with Practices

Effective engagement with practices has been our top priority during the first phase of our work; without practice level buy in, little will change and this strategy will not be delivered. We have worked hard to engage practices in the first phase of developing this strategy, and want to build on this as we move into refinement and implementation:

Phase	Objective	Activity	Status
1 - Strategy development	Raise awareness of programme and its objectives	Updates on progress and emerging thinking to CCG Joint Committee	Complete
	Raise awareness of programme and its objectives	Presentations to and discussions with practice 'Time to Learn' events at each CCG	Complete
	Discuss and agree main solutions to be developed	Discussion at each CCG Clinical Executive (or equivalent)	Complete
	Discuss and agree main solutions to be developed	Presentation to and discussion with CCG senior management team	Complete
	Discuss and agree main solutions to be developed	Meetings with CCG Chairs	Complete
2 - Refinement of strategy	Discussion of draft strategy	Meeting with Joint Committee of the CCGs	April
	To share draft strategy, gather feedback and update/finalise plan	Discussion at each CCG Clinical Executive Presentations to and discussions with practice Time to Learn events	Apr/May
3 - Implementation	To finalise approach to implementation	Discussions at each CCG Governing body, including final sign off of the strategy and local implementation plan	May/June
	To share/review progress with implementing agreed priorities and spread learning across the system	CCG executives/Governing Bodies Updates to Practice Time to Learn events in each CCG	Ongoing feedback

Providers and system partners

Successful implementation of this strategy will necessitate some changes to the way our partners organise and deliver services. For example, developing localities as a way of integrating services may require some staff – such as those employed by community providers – to be realigned. This will need the agreement of many organisations, making their involvement in each of the three phases vital.

Phase	Partner	Objective	Activity	When
1 - Strategy development	**Acute Trust Group**	Ensure awareness of primary care strategy at strategic level	Discussion with senior staff	Complete

	Community and MH providers	Ensure awareness of primary care strategy at strategic level	Meeting with CEOs/lead directors	Complete
	Health and Wellbeing Boards	Ensure awareness of primary care strategy at strategic level	Briefings for HWBs	Complete
	Healthwatch	Ensure awareness of primary care strategy at strategic level	Discussion with senior staff	Complete
2 – refinement of strategy	**Acute Trust Group**	Identity potential joint solutions (e.g. access to consultant expertise to practices, OP clinics in community)	Discussion with trust Medical Directors Share draft papers for comment with key staff	Apr/May
	Community and MH providers	Opportunity to gather/contribute ideas on solutions and implementation	Involvement of senior provider staff in solution design workshops/new models Share draft papers for comment with key staff	May
	Health and Wellbeing Boards	Identify implications of emerging strategy on social care/create opportunities to contribute to solution design	Involvement of senior provider staff in solution design workshops/new models Share draft papers for comment with key staff	Apr/May
	Healthwatch	Involvement in co-ordination of patient awareness	Discussions with senior officers from each of the three Healthwatch organisations	Apr/May

As we move into implementation, which will be led by the five CCGs across the STP, we anticipate that detailed local arrangements will be put in place (such as implementation or delivery boards) to ensure that all local partners are fully involved in local discussions at all stages. There are already good engagement mechanisms in place in many parts of our STP, but we envisage that delivering this STP-wide strategy will provide renewed focus an impetus.

Patients

Involving patients in the development of this strategy and, in particular, in identifying potential solutions in each locality will be important. If we fully implement our new model of care, the service patients receive from general practice will increasingly look and feel different, for example:

- There is likely to be routine triage in place when a patient contacts the practice, rather than 'automatic' access to a GP

- Patients will increasingly see a wider range of professionals at their practice rather than being directed to a GP or a nurse
- Patients may sometimes be asked to travel to a locality hub or a neighbouring practice in order to be seen

These changes will, over time, require some shifts in patient behaviour if our new model of care is to be successful. This is much more likely to happen if patients are involved in discussing solutions at every stage.

Although we will seek to co-ordinate patient engagement in the development and implementation of this strategy at an STP level, including working with partners that represent and advocate for patients such as the three Healthwatch organisations and the STP Service User Advisory Group, we think that in order to be effective most patient engagement work needs to be led locally.

This is because the broad model of care that we have set out in this strategy will look different in each place – no two CCGs or localities are the same. It is therefore vital that the conversation with patients and carers about exactly what the service model should be in a given areas is a local one.

We have strong foundations in place to progress this work. For example, all CCGs have lay members that have a particular role in advocating for patients, and many have well established patient advisory panels. Another key route for involving patients at every stage will be at practice level, through practice patient participation groups (PPGs), which are ideally positioned to discuss very local challenges and proposed solutions.

9. IMPLEMENTATION

About this section

This section sets out our thinking on how to make this strategy a reality, moving at scale and at pace. It describes an approach where each CCG leads local implementation, but in a co-ordinated way, doing things once across the STP where that makes sense. It sets out our 'offer' to practices, as well as plans to identify a first wave of localities and the support that they can expect to receive.

Overview of approach to implementation

This document is an 'umbrella' primary care strategy for our STP, building on and complementing pre-existing plans in each of the five CCGs.

In determining our approach to implementation this strategy, we have considered the best way of balancing several factors, including:

- We are not all starting from the same place – in some of our CCGs, plans to develop general practice and localities are better developed than others
- Implementation will not be at the same pace everywhere – we have been explicit with practices that implementing the new model of care is voluntary; as a consequence, it is natural that some areas will progress faster than others
- The local context is critical – we know that the challenges in each part of our patch are different and, as a result, the approach to implementation will differ also.

As a result of these factors, we have concluded that the right approach is for each CCG to lead implementation in partnership with their local practices and localities, but within a consistent STP wide framework.

Establishing a 'leading edge' of localities

We are keen to work with a small number of localities that have the capability and drive to make rapid progress. We believe that this will be the best way of generating momentum, capturing learning and acting as a wider catalyst for change in general practice.

As a first step in implementing this strategy, each of the five CCGs plans to identify practices/localities that could become a 'wave 1' locality. In order to enter the first wave, practices and localities must be able to demonstrate that they meet some essential criteria, including:

- Appropriate population coverage (size and geographically coherent)
- Credible leadership
- Commitment to ongoing development of locality
- Demonstrable practice sign up

The 'offer' to practices

We anticipate that there will be a clear incentive or 'offer' for practices to enter wave one. Although the details of the offer will vary CCG by CCG, the core elements are likely to be:

- *Reducing workload* – by accessing additional support including workforce, as well as rolling out support to more effectively triage and manage patient flow
- *Access to recurrent funding* - in order to build the locality model and the extended workforce that is required to increase capacity, as set out in our future model of care
- *Support with estate* – where required, a clear 'route map' for a locality to secure the capital required for new or redeveloped premises, including the non-recurrent revenue needed to develop the case, as well as the on-going revenue costs
- *Access to CCG management support* – depending on the locality's needs the CCG will commit to making relevant management expertise, such as change management, HR, governance or data skills, directly available to support the locality
- *Access to learning networks* – localities in wave one would have prioritised access to both local and national packages of development
- *Support to pilot innovation* – localities in wave one would be encouraged to innovate and actively supported to trail new initiatives, especially digital solutions

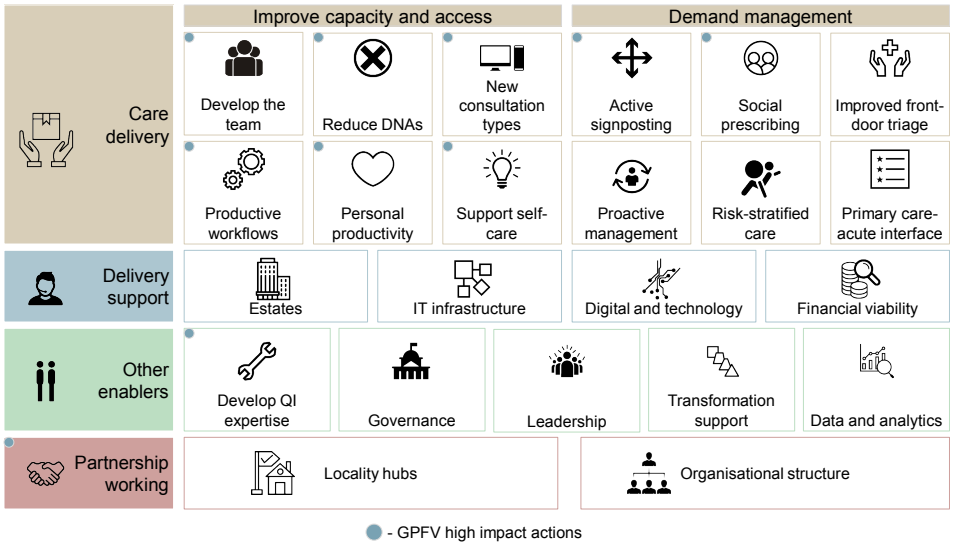
We are also exploring the potential NHSE national funding that may be available to support leading edge localities.

Locality self-assessment/diagnostic

Because the starting point and needs of each locality will be different, the first step in supporting localities will be for them to complete, in partnership with their CCG, a simple self-assessment or diagnostic tool that we have developed. This is flexible tool that is designed to structure a series of conversations to determine where a particular locality's development priorities lie. It is *not* intended to be a checklist or an assurance tool.

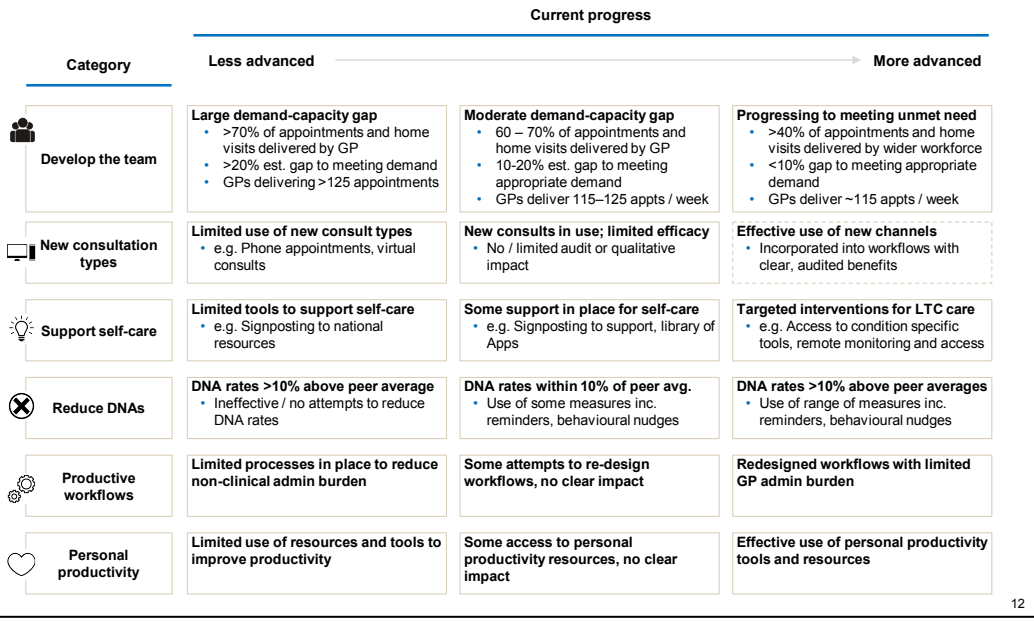
The development tool will consider a range of domains that are relevant to becoming a high performing locality, and also help localities to consider where they are now as well as where they might need to be in future:

Locality development guide: Key areas



The tool we have developed will also enable localities to assess where they lie on a spectrum of development in each of the domains, against a description of best practice:

Locality development guide: progress to date



More detail on the tool we have developed is available in the appendix to this document.

Locality development plans

The self-assessment will result in an agreed locality development plan. This plan will set out who will do what by when in order to move the locality on to the next stage of their development, and is likely to cover:

- The demand-capacity gap
- The numbers and skill mix of any additional staff required to close this gap
- Any estate or capital implications
- Approach to innovation and digital

Where appropriate, this plan would take the form of a specific commitment between the locality and the CCG, covering, for example:

- Approach to meeting costs of any expansion in the wider workforce
- Prioritisation of any capital development that is required
- Access to and funding for specific tools, such as enabling new types of consultations
- Working with local partner such as councils
- Outcome metrics that will be put in place

STP wide work streams

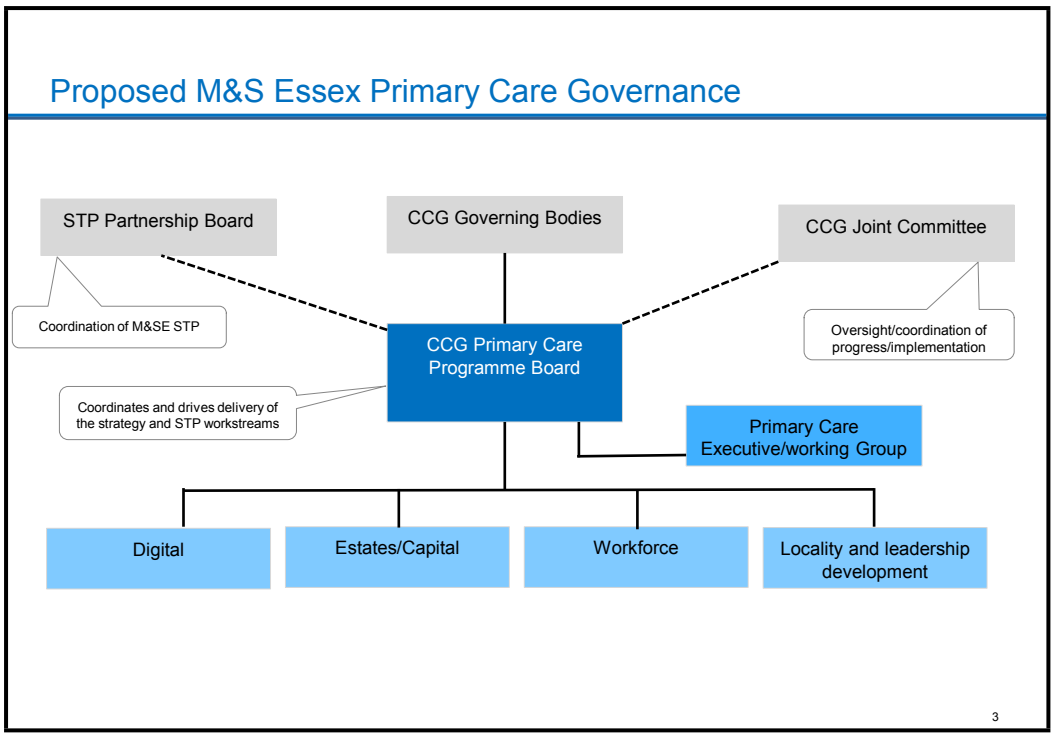
Although implementing this strategy will principally be the responsibility of the five CCGs in our footprint, we know that in some areas is will make sense to coordinate and do things once, adopting an STP wide approach. The key areas we have identified to date, and in which we will develop co-ordinated implementation plans, are:

- Digital
- Development of estates/capital
- Some aspects of workforce, such as work on defining consistent new roles and STP wide recruitment activities
- Practice/locality development offer, which could span legal advice, organisational development expertise and HR support

Governance

Work to develop our STP primary care strategy was initiated by the Joint Committee of the five CCGs. Although this Committee does not have delegated authority to take decisions on primary care, it is an invaluable co-ordinating mechanism, and will continue to act in this capacity as we move into the implementation phase.

To support implementation, we are recommending establishing an STP Primary Care Programme Board so that there is appropriate co-ordination and to ensure that pace is maintained. This Programme Board will be supported by workstreams in each of the four areas of STP wide work outlined above, and will report joint to the five CCGs and the Joint Committee:



Timetable and immediate next steps

We anticipate the key next steps to implement this strategy are:

Date	Activity
6 April 2018	Joint Committee of CCG to discuss this draft strategy and identify areas for further development
4 May 2018	Joint Committee of CCGs invited to endorse this strategy and recommend that it is considered by each CCG Governing Body
June 2018	CCG Governing Bodies invited to formally approve this strategy and its local implementation and investment plan
Late May to August	'Leading edge' localities identified by CCGs Successful localities selected and diagnostic tool completed First locality development plans agreed and signed off
6 July 2018	Joint Committee of CCGs notes that the STP Primary care strategy and local implementation/delivery plans have been agreed by all five CCGs

APPENDIX

See separate supporting document

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6 September 2018	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
Integrated Medical Centres: Delivering High Quality Health Provision for Thurrock	
Wards and communities affected: All	**Key Decision:** Key
Report of: Roger Harris – Corporate Director Adults, Housing and Health / Steve Cox Corporate Director Place	
Accountable Assistant Director: Detlev Munster, Assistant Director Property, Regeneration and Development / Les Billingham Assistant Director Adult Social Care and Communities	
Accountable Director: Steve Cox, Corporate Director, Place. Roger Harris, Corporate Director Adults, Housing and Health	
This report is Public	

Executive Summary

It is well evidenced that some areas of Thurrock have poor access to quality health care provision. The Council and partners in the health sector have been working together to develop a new model of care that will see services delivered via an integrated model and delivered from modern, high quality premises able to attract the best staff. Four brand new Integrated Medical Centres (IMCs) are proposed with the intention of locating services in the heart of the communities that they serve and bringing more health care services under one roof to improve and simplify pathways for patients.

The decision taken by the July meeting of the Joint Clinical Commissioning Group (CCG) Committee to close Orsett Hospital and re-locate services into the community further supports the need to develop IMCs in a timely manner. This report updates Members on progress of all four IMCs and gives particular detail on the delivery of the Tilbury and Chadwell IMC which the Council is leading on.

1. Recommendation(s)

The Health and Wellbeing Overview and Scrutiny Committee are asked to:

1.1. Comment on the current development with the delivery of the 4 Integrated Medical Centres across Thurrock.

2. Introduction and Background

2.1. Members will be aware that the quality of health provision in several areas of the Borough falls below the standards that the Council and NHS partners would like to see delivered. The Council, with its NHS partners, have an exciting opportunity to address this and improve the health and well-being of the population of Thurrock by moving from outdated facilities and fragmented services, improving the capacity and capability of primary, community and mental health care and delivering an integrated health, social care and community/third sector care model with Thurrock's residents at its heart.

2.2. To this end the Council has entered into a Memorandum of Understanding (May 2017) with Basildon and Thurrock Hospitals NHS Foundation Trust (BTUH), Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT), and Thurrock Clinical Commissioning Group (the CCG) for the creation of four new Integrated Medical Centres (IMCs) in Thurrock.

2.3. The IMCs will serve local populations and will be located in:

- Tilbury - to primarily serve Tilbury and Chadwell;
- Corringham – to primarily serve Stanford and Corringham;
- Grays – to primarily serve Grays but also to act as a Central Hub for the whole of Thurrock; and
- Purfleet – to primarily serve Purfleet, Aveley and South Ockendon.

2.4. The Council has been working with the CCG and service providers to develop the concept of Integrated Medical Centres (IMCs) which will provide an integrated model of care, in high quality premises located in the communities that they serve. The IMCs, will be crucial to the introduction of the New Model of Care as presented by the Director of Public Health, including the new Primary Care offer, Well-Being Teams and Technology Enabled Care.

2.5. In July 2018, following the public consultation, the Joint Committee of the 5 Clinical Commissioning Groups in mid and south Essex gave approval to implement proposals for moving services currently provided at Orsett Hospital, including out-patients, tests and scans, to the four new IMCs in Thurrock. The work to develop the IMC concept undertaken to date is capable of being adapted to ensure that capacity is available to support this additional requirement at the four IMCs already proposed. It is however clear that the successful delivery of the IMCs is now even more critical.

2.6. The IMC programme is being developed through a Collaborative Programme Board meeting monthly and attended by the NHS colleagues, service providers and Council representatives including the Corporate Director Adults, Housing and Health, Regeneration and Legal and Finance as required.

2.7. In July 2017 Cabinet gave approval for the Council to lead on the delivery of the Tilbury and Chadwell IMC, to procure a design team and to receive a

future report on the Purfleet IMC. This report provides an update on the Tilbury and Chadwell IMC and requests approvals that will enable the project to continue to progress. It also highlights the current status of the three other IMCs.

2.8. Further discussions have been taking place with health partners over the future provision of community mental health services to improve their accessibility. The recent Mental Health Peer Review was clear that, where possible, mental health provision should be integrated into the proposed IMCs and officers are now planning to see how this can be implemented.

3. Issues, Options and Analysis of Options

3.1 IMC Decision Making Timeline:

Due to the number of partners included in the IMC programme there is a number of decision making gateways to be navigated. The CCG Joint Committee at its meeting on 6 July agreed a range of proposals in relation to acute hospital re-configuration including the closure of Orsett Hospital. The table below shows the proposed timetable for decision making and when the IMCs can then progress to construction.

Gateway	Reason	Date
CCG Joint Committee	Approved closure of Orsett hospital but only when IMCs are open and no clinical services will move outside of Thurrock that currently service Thurrock residents.	6th July 2018
Thurrock Council Cabinet	To approve the ongoing role of the Council in delivering the Tilbury and Chadwell IMC	Sept 2018
Outline Business Case to BTUH Boards	To secure approval for the location of services, BTUH's role and financial business plan	Oct 2018
OBC to CCG	To secure approval for location of services commissioned by the CCG and the role of the CCG in ongoing risk share	Oct 2018
Primary Care OBC to NHS England Capital Investment Oversight Group	To secure NHS approval of the change to service provision required to locate primary care services in the IMCs	Oct 2018
FBC to all above Boards/Groups	To secure final approval for the location of services and any cost implications associated with the change	Spring 2019

OBC = Outline Business Case
FBC = Full Business Case

Delivery of the IMC Programme

3.2 **Introduction and proposed People's Panel**

There has been extensive planning and consultation over the delivery and the content of the proposed Integrated Medical Centres and we are now very much in delivery mode and the individual descriptions below reflect that. A People's Panel is being established to oversee the detailed delivery programme and this is being established with the help of Thurrock Healthwatch. This will also look at what services are best delivered from which IMC.

Tilbury and Chadwell IMC

3.3 The aspiration to deliver four IMCs in 2020/21 remains challenging, however, since the Council took the decision to lead on the delivery of the Tilbury and Chadwell IMC on the site of the Community Resource Centre in Tilbury (site plan attached at Appendix 1) work has progressed significantly.

3.4 The Council, CCG and service providers have worked collaboratively to develop a schedule of accommodation that can be provided at Tilbury and Chadwell IMC. This accommodation schedule fully subscribes to the integrated vision and includes provision for:

3.4.1 Multi-functional consult exam rooms;
3.4.2 therapy rooms;
3.4.3 treatment rooms;
3.4.4 interview rooms;
3.4.5 group rooms;
3.4.6 phlebotomy bay;
3.4.7 mobile imaging docking bay;
3.4.8 shared workspace;
3.4.9 library;
3.4.10 community hub; and
3.4.11 public access meeting rooms.

3.5 The suite of flexible clinical rooms enables multiple services to make use of the space meaning patients can access multiple services in a single Centre. The community elements such as the library and community hub have a key role to play in addressing the wider determinants of health. This is supported by shared workspace which will allow staff from council departments and other services to be based at the centre on a flexible basis bringing the delivery of public services into the community and creating better opportunities for joined up working across professions.

3.6 Following a competitive tender process Pick Everard were appointed as designers in October 2017. Design work has reached RIBA Stage 2 with the designers having produced an outline design and cost plan. More detailed design work has recently commenced with a view to developing and consulting on a full planning application in autumn of this year.

3.7 A CABE design workshop to review the outline plans was held in May 2018. The report from this session has provided some useful feedback, in particular how the ethos of the building can be translated into the external space around it to continue the theme of healthy living. The panel recognised the clear potential for the building to have a positive impact on the urban fabric of Tilbury and the vitality of the Town Centre with the report suggesting that the scheme had the potential to be award winning and encouraging the Council and design team to set high aspirations to create a lasting benefit to the area.

3.8 Whilst the design team is currently directly appointed by the Council it is envisaged that the contract for the capital development will be procured on a design and build basis and the design team will ultimately be novated to the contractor. This will keep consistency within the professional team whilst providing price certainty on the capital works and ensuring that risk is transferred to the contractor wherever possible.

3.9 The design and build contract will be procured via the NHS Procure22 framework and let on a phased basis with contractors initially being asked to do a discrete package of work to develop cost certainty (culminating in a guaranteed maximum price for the scheme). This information is a prerequisite to the Outline Business Case for the NHS. Phasing the contractor commission ensures that this information can be provided in a timely manner whilst limiting the financial exposure to the Council should the required approval not ultimately be secured.

3.10 Alongside the design work a number of surveys have taken place on site to assess the ground conditions, ecology, acoustics etc and inform the development of the initial cost plan. Early survey work has established the particular ground conditions on the site and allowed early pricing of abnormals which are a key risk to development in Tilbury.

3.11 The next stage of work will further refine the design of the IMC and cost plan and prepare the planning application.

3.12 The previous Cabinet report highlighted the intention for the Council to use prudential borrowing to fund the capital cost of the Tilbury IMC and to secure the borrowing against the income stream generated from the building's lease to a third party. The Council is committed to supporting the IMCs and the principles of the borrowing would therefore be set to provide the maximum level of affordability for the Centre. It is proposed that no interest would be levied against the capital amount beyond that which the Council itself would be charged to access the borrowing and that the borrowing would be repaid over a period of 30 years. The IMC is not intended to provide a financial return to the Council but that lease and rental income should cover the borrowing costs.

3.13 The new model of service provision intended to be delivered from the IMCs is focussed on integration of services across provider boundaries. With the

exception of the primary care area (which has a distinct funding mechanism), providers will not have dedicated rooms that may stand empty outside of set clinic hours, rather rooms will be multifunctional and therefore interchangeable across services. Maximising the use of the space and limiting void time will support the affordability of the Centre for providers and reinforce the integration of services but it will also require a move away from a typical head lease/sub lease arrangement as services taking the sub leases will not have defined square metre areas on which to base sub lease valuations. Whilst the Council in its role as landlord will have the protection of a standard head lease the Council will also be an occupier of the centre and so has an interest in how the sub lease arrangements will also work.

3.14 Providers are currently working together to establish a set of finance principles which seek to share the risk and rewards created as a result of actual occupancy levels when the IMCs are operational and reflecting this principle of shared space. The shared approach to risk incentivises all partners to maintain utilisation of the Centres and provides reassurance to the Council (as landlord and the organisation contributing the full capital funding to the Tilbury and Chadwell IMC) that the risk of non-repayment of the borrowing is mitigated as far as possible.

3.15 These broad principles are accepted by all partners in the emerging Thurrock Integrated Care Alliance (TICA). TICA is the overall umbrella group established by all NHS partners and the Council locally to take forward our integrated health and care agenda. An agreement to define these principles is currently being drafted and once agreed in final form will be the basis of the financial structure across all four IMC's.

3.16 Basildon and Thurrock University Hospital (BTUH) have stated that they would like to become the head leaseholder for his facility. Now that the cost plan has been produced and a proposed head leaseholder has been identified the Council and BTUH can assess affordability and start to develop Heads of Terms on an Agreement to Lease. An Agreement to Lease will be required before the main building contract is awarded to minimise the financial risk to the Council.

3.17 As highlighted in the previous report to Cabinet and supported by the CABE design review there is a clear regeneration benefit to bringing increased footfall to the centre of Tilbury, revitalising the Civic Square and acting as a benchmark for design quality. To this end the brief to the design team has been to ensure the building works in terms of the functionality of the centre but also makes a positive contribution to the urban fabric of the area. This high quality design ambition will come at a cost premium which is over and above what service providers need to operate a functional centre. The current cost plan includes for this premium but it is noted that pursuing this strategy of quality design could make the IMC unaffordable to providers taking on the head or sub leases if the requirement is for the rental stream to pay off the full capital cost. The Council will be asked to consider making a financial investment into the scheme (rather than looking to value engineer the building

or extend the loan term) to ensure that the regeneration objectives are delivered as well as the health objectives. The level of this potential investment will be determined via the detailed discussions with BTUH in their role as proposed head leaseholder and will be confirmed before the main building contract is awarded.

Stanford and Corringham IMC

3.18 The delivery of the Stanford and Corringham IMC, on the site of 105 The Sorrells, Stanford Le Hope, is being led and funded by NELFT. Planning consent for the IMC was secured in 2016 and amended in 2018 to extend the proposed opening hours.

3.19 A decision on the Business Case for the development is expected to be taken by the NELFT Board in autumn 2018. With an estimated build period of 15 months, it is anticipated that the IMC could be operational from late 2020.

Purfleet and South Ockendon IMC

3.20 It is intended that the Purfleet and South Ockendon IMC will be delivered as part of the wider Purfleet Centre regeneration scheme. An outline planning application which includes medical facilities was submitted in December 2017 and is expected to go to planning committee in the autumn of this year. The Purfleet IMC is part of the wider Phase 1development proposal submitted by PCRL and reflects how key this is to the whole project.

3.21 Purfleet Centre Regeneration Ltd (PCRL), the appointed developer for the scheme is committed to assisting with the delivery of the IMC as part of the development. The schedule of accommodation is being finalised with partners and detailed design work will then commence (commissioned by PCRL). The funding strategy for this IMC is still to be finalised. Delivery of this IMC is expected to be in 2021.

Grays IMC

3.22 Thurrock Community Hospital has been designated as the new IMC for Grays and is the only IMC which will be predominantly a refurbishment of an existing healthcare facility rather than a new-build development. The site is owned by EPUT which leases part of the site to NELFT and third sector providers. The site has 19 separate buildings with over half of the buildings vacant or underutilised which means the estate is inefficient in use and offers an opportunity to reconfigure and redesign to improve delivery.

3.23 The Council is committed to support EPUT with some Master Planning for the site, and has recently agreed a specification with EPUT and partners for this Master Planning exercise. Quotes are being obtained from suitable agencies to undertake this work As the only site already built, Thurrock Community Hospital offers the opportunity to renovate and redesign facilities to

accommodate services, with the potential to bring services on line in a shorter time frame.

3.24 The CCG is also in consultation with relevant primary care providers to try and ensure that there is a significant primary care service on site because until recently it was going to be the only IMC without GP services at its core. These discussions are ongoing but health colleagues are confident of a positive outcome.

Integrated Medical Centres (Phase 2)

3.25 The Council is currently procuring the Design Team for the 21st Century Residential Facility on the White Acre/Dilkes Wood site on Daiglen Drive in South Ockendon. This is not an IMC but is a related project which will improve the health provision in Thurrock.

3.26 As reported to Cabinet in December 2017, the South Ockendon Health Centre on an adjacent site on Darenth Lane is currently occupied by a single handed GP Practice, a branch surgery of an Aveley Practice, and a range of other clinical services including Health Visitors and Dentists. Health partners have confirmed the building is no longer fit for purpose, and they see potential benefits in redeveloping the site to create a new health centre which could bring together other surgeries from the local area, and to equip it with a fuller range of primary care facilities. A further report, with detailed funding and development proposals for the construction of the new Residential Facility, together with the initial proposals for a new health centre, will be brought to Cabinet for approval in December 2018.

3.27 Officers and the Chair of the HWB Board have been in discussions with officers from BTUH and the CCG to agree the next stages of this programme and ensure that we see this as a long term development leading to stronger primary and community services and more services moving out of an acute hospital setting where appropriate. Collins House will continue to be part of this – we already have step down beds and interim beds at Collins House to support hospital discharge and we see Collins House and the new residential development at Whiteacres as being key alternatives to un-necessary stays in a hospital bed.

3.28 As stated above we are reviewing current mental health services with our main provider EPUT and CCG commissioners. We are very keen that mental health services are also part of the IMC programme and this will be assessed as part of the ongoing discussions about the exact content and core delivery from each IMC.

4. Reasons for Recommendations

4.1 Delivery of the IMC programme is essential to securing high quality health outcomes for Thurrock residents. The Council has agreed to take the lead on the delivery of the Tilbury and Chadwell IMC and has already committed

funding to the initial design phase. Further approvals are now required to allow this project to progress to the next stage.

4.2 The tender for the capital works will be in excess of the £750,000 threshold that can be approved by Directors and therefore requires a Cabinet decision. This tender is expected to be issued later this year.

4.3 Approval to delegate the award of the construction contract is requested to ensure that the delivery programme of the IMC is maintained and new premises delivered as soon as possible.

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

5.1 This report will be presented to Planning Transport and Regeneration Overview and Scrutiny Committee on the 11 September and Health Overview and Scrutiny on the 6 September and a verbal update on comments will be provided to Cabinet at the meeting.

5.2 The Tilbury IMC has undergone a pre-application consultation with the Local Planning Authority and a CABE design workshop.

5.3 Further public consultation on the specifics of the IMCs will be undertaken as part of the planning process. For Tilbury and Chadwell IMC this is programmed for autumn 2018.

5.4 It is understood that Health Watch will be organising a People's Panel to gain public input into the development of all four IMCs.

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

6.1 The IMC programme supports all three subsections of the 'People' element of the Council's corporate vision and priorities.

6.2 The programme also supports the four principles stated in the Thurrock Health and Wellbeing Strategy 2016-2021 and has a specific reference under 'Goal 4 Quality care, centred around the person' of the same strategy.

6.3 The Council is committed to an MoU with partners to secure the delivery of four IMCs in Thurrock. The approvals recommended in this report will assist the Council in meeting its obligations under this MoU.

7. Implications

7.1 Financial

Implications verified by: **Sean Clark**

Director of Finance and IT

There are clear financial implications to the content of this report with the intention to use prudential borrowing to fund the capital cost of the Tilbury and Chadwell IMC. Income from leases and rentals should cover the council's cost of capital making the scheme cost neutral. The risk sharing approach to the operation of the centre reduces the risk to the Council and the necessary due diligence would be undertaken on the financial standing of the proposed head leaseholder prior to entering into the lease. Should the leaseholder default on the loan repayments the Council would retain the freehold of the asset which could be used for another purpose.

It is noted that an element of financial support may be required to ensure that a high quality building is developed. Should this be required provision will need to be made in the Capital Programme.

7.2 **Legal**

Implications verified by: **Benita Edwards**

Interim Deputy Head of Law

It is proposed that the contractor be procured using the NHS Procure 22 framework. That procedure shall ensure that the tender process is carried out in a fair and transparent way and that it complies with the Public Contract Regulations 2015 as well as with the Council's Contract Procedure Rules. Accordingly, in approving this report, the Council shall be acting lawfully.

The report notes that an agreement to lease and head lease will be required to deliver the Tilbury and Chadwell IMC. A report or reports seeking approval for entry into an agreement for lease and authority to grant one or more leases shall be tabled in due course. The Council's internal legal and assets teams will provide support on ensuring that the required agreements adequately protect the Council's position.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community and Equalities Manager

The IMC programme is crucial in addressing the health inequalities currently experienced in some areas of the Borough. All buildings developed as part of the programme will need to comply with equalities legislation and pay attention to the particular needs of the visitors to the centre a high proportion of whom are likely to be vulnerable.

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

The development of the Tilbury IMC will allow staff from several Council departments to work in the community that they serve improving public access to vital services.

There is a clear health benefit to pursuing this programme of work.

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):

- Cabinet Report: 12 July 2017, Integrated Medical Centre Delivery Plan - Phase 1. https://democracy.thurrock.gov.uk/documents/s12467/Integrated%20Medical%20Centre%20Delivery%20Plan%20Phase%201%20Decision%2001104436.pdf

9. Appendices to the report

Appendix 1 - Tilbury IMC Site Plan

Report Author:

Rebecca Ellsmore

Programmes and Projects Manager

Place

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APPENDIX 1

SITE PLAN

With the preferred option agreed amongst the Client Team, the east half of the Civic Square was chosen to be our proposed site. This will result in the existing health and fitness centre being demolished to allow the new IMC to be constructed within a single phase.

The majority of the massing on the east side of the site is 2 storey with 2 single storey. Out-buildingand a 3-4 storey framed tower formally used for fire and rescue excercises.

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6 September 2018	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Market Development Strategy – Commissioning a Diverse Market	
Wards and communities affected: All	**Key Decision:** Key
Report of: Catherine Wilson – Strategic Lead Commissioning and Procurement	
Accountable Assistant Director: N/A	
Accountable Director: Roger Harris – Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

It is a requirement that Adult Social Care publishes a Market Development Statement (MDS). The document sets out how we see the social care market developing over the coming years.

The document sets out current and predicted need; the strategic context we are operating in; what we spend, changing trends and implications for providers.

We use this document as a basis of discussion with current and potential providers to ensure that the market changes to meet our vision of where we want to be.

1. Recommendation(s)

1.1 That the Health and Wellbeing Overview and Scrutiny Committee comments on the Market Development Strategy.

2. Introduction and Background

2.1 The MDS describes the current and potential future demand and supply for adult social care services and outlines the model of care the Council wishes to secure for the population in the future.

2.2 It also details what in the market needs to be encouraged and what does not. This includes size and shape of the market, funding and resources and what needs to change and how the Council will purchase in the future.

2.3 Equally, the MDS makes current and potential providers think about their future plans and investment e.g. what service they may want to set up, whether they should they disinvest in a certain model etc.

2.4 The MDS also ensures that providers are aware of major changes such as the piloting of Wellbeing Teams and the introduction of place based social work teams.

2.5 The MDS aims to be a 'living document' and work is already underway to commence delivering against the commissioning intentions contained within. Thurrock Council will be developing a range of smaller subject specific products (Market Position Statements – MPS) that aim to address some of the current shortfall of service provision locally but also changes the way that the council plans to commission services in order that they are more cost effective and sustainable.

Thurrock Council will be developing MPS's which will detail the commissioning and procurement approach to be taken to change the market. There will be a suite of these products that sit under the Market Development Strategy (in effect they will be the delivery plans of the MDS).

The four plans will be:

- Mental Health MPS – To be published 2019
- Supported Housing and Accommodation Based MPS - 2019
- Carers – To be published 2019
- Home Care and Community Based Services – 2020

The timing of these documents reflect other work currently being undertaken e.g. the Carers MPS will be developed after the Carers Strategy is finalised. In addition to these documents we will also be publishing an Adult Social Care Workforce Strategy.

3. Issues, Options and Analysis of Options

3.1 The Care Market Development Strategy reflects the changing role of a local authority from that of a provider of services to the shaper of care markets. The statutory guidance regarding the Care Act advised that one of the ways to meet the responsibilities of this new role was to publish a Market Position Strategy containing both Market Intelligence data (supply and demand) and the approach to Market Intervention (Commissioners actions).

4. Reasons for Recommendation

4.1 It is a requirement that we develop a Market Development Strategy.

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

5.1 Prior to the development of the Market Development Strategy we engaged with the following groups:

- Thurrock Older People's Parliament
- Thurrock Emotional Wellbeing Forum for Individuals, Family Members and Carers
- Thurrock Disability Partnership Board
- Thurrock Autism Action Group
- Direct Payment Engagement Group

and sought answers to the following questions:

1. What care and support services do you want in the future?
2. What do you think works well?
3. What care and support service should be improved and how?
4. What should we stop doing?
5. What should we start doing (are there any gaps in service)?

We also consulted with existing providers via email to ask 'what information you would like the document to include and/or what issues you would like the document to address'.

The responses from people who use services and providers of services are key components in the development of this strategy.

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

6.1 This should have a positive impact on the corporate priority 'People' – specifically 'high quality, consistent and accessible public services which are right first time' by creating a diverse market offer and ensuring choice and control for service users.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care & Commissioning

The MDS is intended to ensure that the market changes to meet Adult Social Care's vision for the future. There are potential financial implications which will not be known until the various work streams begin and progress through their respective pilot periods and their success can be meaningfully measured. This will be monitored through ongoing close working between Corporate Finance and the Directorate. There is a degree of uncertainty regarding future funding levels for Adult Social Care, therefore any financial pressures or

potential for savings we identify as a result of this will be built into the Medium Term Financial Forecast. Further reports focused in individual projects will need to be presented to the Health & Wellbeing Overview & Scrutiny Committee in due course.

7.2 **Legal**

Implications verified by: **Sarah Okafor**

Barrister (Consultant)

The Care Act 2014 underpins and makes provisions for the development of the care services market in adult social care. Under the legislation, local authorities, the Department of Health and the Care Quality Commission have market related responsibilities. Section 5 sets out the duties upon Thurrock Council to facilitate a diverse, sustainable and high quality market for their whole local population. This includes for people who pay for their own care and support. Therefore, a strategy that promotes an efficient and effective operation of care and support services as a whole market is required.

Further, sections 48 to 56 of the Act, places duties upon the key regulator and local authorities to ensure no one goes without care if their providers business fails. The CQC is required to maintain oversight and local authorities are under a duty to ensure continuity of care when business failure leads to service cessation. Accordingly, the proposed Market Development Strategy is consistent with the above legal obligations and responsibilities to the local population.

On behalf of the Director of Law for Thurrock Council, I have read the full report and the accompanying attachment, and there appears to be no external legal implications arising from the proposed strategy, which is consistent with the legal framework and the associated Guidance.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

There are no adverse diversity and equality implications contained in this report, however any future actions taken could potentially impact on the local community/providers including the voluntary and community sector. Any significant change in provision requires a separate Communities and Equality Impact Assessment prior to implementation to assess the impact of decisions on protected characteristics and the local community.

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

None

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

- N/A

9. Appendices to the report

Appendix 1 - Market Development Strategy 2018 - 2023

Report Author:

Sarah Turner
Commissioning Officer
Adult Social Care

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APPENDIX 1

Care Market Development Strategy:

Commissioning a Diverse Market

2018 – 2023

Executive Summary

In 2015 we wrote Thurrock Council's first Market Position Statement detailing the challenges that faced adult social care and the health economy, we set out our thinking to support the development of a diverse, responsive and creative market set against the unprecedented demand for services and the reductions in public sector budgets both centrally and locally. We set out a vision of growth and partnership working supporting individuals to have more choice and control of any support they required with an acknowledgement that as a Council we needed to commission differently.

In 2018 we are now consolidating our initial Market Position Statement into a Care Market Development Strategy that builds on and further develops a new vision for Commissioning and provision. The whole health and social care economy still faces considerable challenges, increasing demands, fragility within the market and decreasing budgets, however we are clear that this can only be solved by an integrated approach across every aspect of what we do.

We currently commission nearly 2000 more hours of home care per week since the last Market Position Statement yet the number of people supported has not significantly increased. This challenge shows the increasing size, intensity and complexity of care packages. We expect this trend to continue and as such must work across the whole system to meet the needs of people who require support.

With that premise the whole system in Thurrock is starting to work together to develop an Alliance approach which will mean commitment from the Council, Health, Providers and the voluntary sector to find solutions together, to focus on individual and population outcomes and most importantly to ensure that people who require support and services influence how that support is delivered and have more control. Solutions are not just service driven but a much wider range of community and personal resource.

The integrated approach across health and social care has been consolidated with a vibrant and effective Better Care Fund, supporting joint initiatives. To further develop our integrated way of working at a community level we are working in partnership to deliver our Better Care Together approach, this is a new model of care based on having services closer to the individual, more responsive with and a clear focus on outcomes.

We are piloting well-being teams which are a new way of delivering domiciliary care, far more focused on the person having choice and control funded by individual budgets. Alongside this we are piloting a refocus of Social Work Teams to be community based with localised budgets and being more easily accessible to the community itself. Health services within primary care are also being redesigned again to be more community based, reduce duplication and offer far more early intervention preventing the need for attendance at A&E or admission to hospital. These new approaches once evaluated will be rolled out across Thurrock under

an overarching Alliance Agreement. In addition, we are also developing more responsive technology to support independence and rethinking our approach to residential support with our 21st Century living project a multi-facetted response to living and support solutions for older age adults.

Our vision is one of partnership with people who deliver and have lived experiences of services, within the place and community where they live, which in turn will brings prosperity to the health and care market together with the wider commercial prosperity of Thurrock. This vision encompasses the Council priorities:

People – a borough where people of all ages are proud to work and play, live and stay.
Place – a heritage-rich borough which is ambitious for its future.
Prosperity – a borough which enables everyone to achieve their aspirations.

Finally, it is helpful to highlight some of the really positive progress that has been made since the publication of the last Market Position Statement in 2015. The detail of this progress is given at Appendix One however some key achievements are:

- The development of a Shared Lives Scheme which was delivered in collaboration with Social Finance an entrepreneurial group of businesses wanting to invest in social support. This 5 year contract aims to deliver 75 matches to offer positive alternatives to more traditional service responses.
- The implementation of Individual Service Funds which support people to have more control of their service provision without having the full responsibility of a direct payment.
- The development of over 50 micro enterprises. We recognised the need to diversify the market in the last Market Position Statement. As such we undertook a two year project to develop this segment of the market.
- Accommodation and support is key and a great deal has been achieved through the development of a refurbished complex of flats for people with learning disabilities, the agreement between the Council and Peabody Housing Association to develop 6 specialist units of accommodation for people with autism in Medina Road and the expansion of capacity for people requiring support who have dementia.
- Our Director of Public Health has produced a detailed report discussing the sustainability of the health and social care system and this has been an influential tool in our move towards an alliance approach, integrated commissioning and our Better Care Together agenda for locally base social work, health care, and living well at home teams.

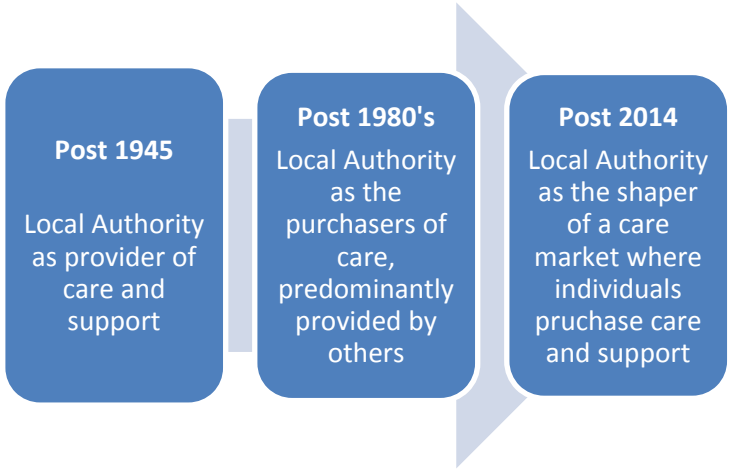
Our Market Development Strategy 2018 to 2023 supports a diversity of approach which is not just service based but solution focussed encompassing the whole community of Thurrock and valuing partnership and collaborative working.

1. Introduction and Policy Context

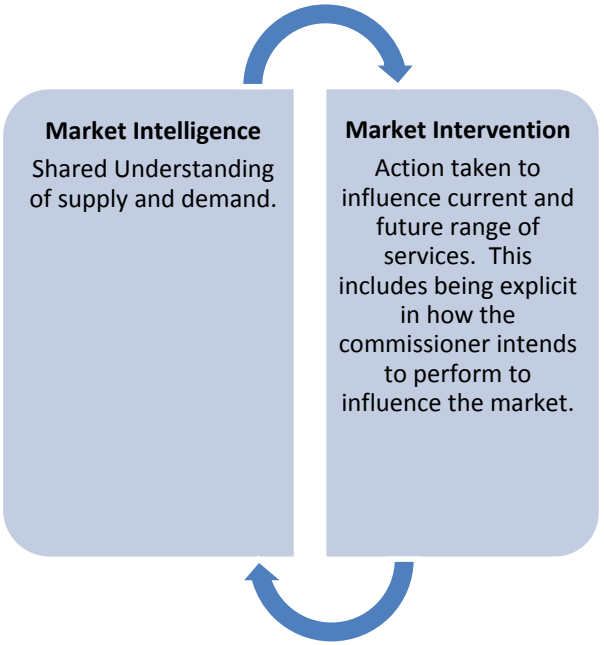
The Care Market Development Strategy is aimed at both existing and potential providers of Adult Social Care services in Thurrock to ensure that we develop a diverse market that can meet the needs of local people. This strategy will help us to deliver the Council's Corporate Vision (specifically the priorities contained in the plan under 'People'). This strategy also meets the Health and Wellbeing Strategy (Goal 4 – Quality Care, centred around the person).

More information about the Corporate Plan and the Health and Wellbeing Strategy can be found at;
https://www.thurrock.gov.uk/priorities-strategies-and-plans

The Care Market Development Strategy reflects the changing role of a local authority from that of a provider of services to the shaper of care markets



Although the local authority may still purchase care, the introduction of the Care Act in 2014 cemented the change of role by explicitly giving Local Authorities *'overarching responsibility to ensure there is a diverse, sustainable and quality care and support market operating in its area. There needs to be sufficient care and support to available to enable choice for all those who need care and support, including carers'.*



The statutory guidance regarding the Care Act advised that one of the ways to meet the responsibilities of this new role was to publish a Market Position Strategy containing both Market Intelligence data and the approach to Market Intervention.

2. Background

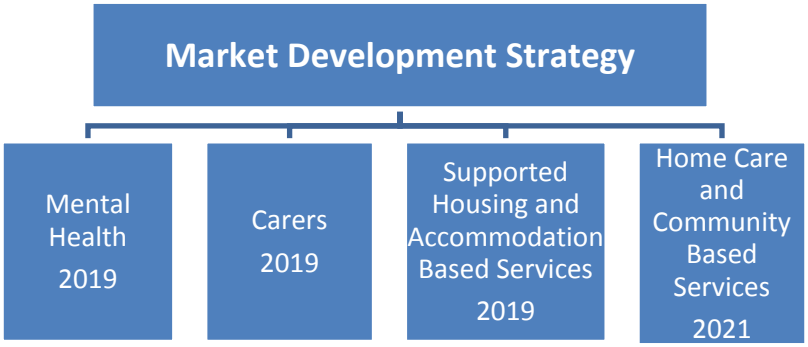
In 2014 Thurrock Council published its first Market Position Statement (MPS). The purpose of the document was to:

- Indicate the changes to Adult Social Care services the local authority wishes to encourage;
- Present data and direction to providers to enable them to plan and invest as appropriate for the future (based on need and user preference);
- Detail how the local authority will intervene and shape the market

There was a significant number of actions contained in that document which have been achieved, such as the start of a Shared Lives Scheme, development of a large number of micro enterprises and a number of specialist housing schemes for Older People, Learning Disabilities and people with Autism built to Happi standards (a full update is contained in appendix 1).

This document plans to build upon the success of the MPS but with a focus on increasing the diversity of the market thereby expanding real choice for service users. The Care Market Development Strategy is a concise document that clearly articulates the vision for the future and what Commissioners intend to do to make that vision a reality.

Due to a number of initiatives there will also be smaller, more subject focussed products published over the next two years. The Supported Housing and Accommodation Based Services MPS will be published in March 2019. It is a key component of a new commissioning role in Adult Social Care to define the model/s of supported housing and other accommodation based services. In 2019 we will also be publishing a Housing Strategy for Older People based on the findings of the Annual Public Health Report regarding the housing needs of Older People in Thurrock. This will result in a clear message to providers or potential providers of these services.



A separate Mental Health MPS will also be published as a new joint appointment has been created across Adult Social Care and Public Health.

A Carers strategy is being developed during 2018 and although we know of some areas of development where gaps in provision have already been identified, we want to ensure that this strategy and the voice of Carers shape the market. Lastly, we are piloting Wellbeing Teams in Thurrock (detailed in section 4) and do not want to present a position on the future of home care until we have the outcome of the pilot (which ends late Autumn 2020).

3. Transforming health and Adult Social Care in Thurrock

The health and care system is in the midst of a number of significant and sustained challenges. Transformation of the existing system is a must so that residents are able to achieve the outcomes that matter most to them. A robust and flexible market place that supports our vision for health and care underpins our ability to succeed. It is key therefore that market providers current and future understand what they need to do to be able to respond to our direction of travel as set out by this document.

Our transformation journey began in 2012 with a programme called **Building Positive Futures**. There were a number of achievements under the Programme including Local Area Coordination, HAPPI (Housing our Ageing Population Panel for Innovation) housing schemes, growth in supported accommodation, and the development of community hubs (please see appendix 1). We started to have conversations with people requiring support that focused on 'what a good life' was to them.

Following the success achieved under Building Positive Futures, phase 2 of Thurrock's transformation programme was launched – '**For Thurrock in Thurrock**' (FTIT) in partnership with local Health partners and the Voluntary and Community Sector (VCS) and built on the work started under Building Positive Futures. The work programme introduced Thurrock First (our single point of access to health and care services), Social Prescribing in some of Thurrock's GP surgeries, the development of independent living accommodation, and scoping the development of a 21st century residential care facility. Phase 2 of transformation sought to influence the health and care system so that it focused on achieving and sustaining 'wellbeing'.

We have now entered phase 3 of our transformation journey **Better Care Together Thurrock** which consolidates and expands the approach further still – with a focus on place and on whole system redesign. The success of phase 3 is dependent on collaboration across all partners with a commitment to sign up to and deliver a shared goal.

Key Principles

We have worked with communities and partners to develop a set of principles that underpin the Health and care system we want to achieve. These are as follows:

We will all work together to ensure that:

- We are focused on supporting individuals to achieve the outcomes that are most important to them;
- The amount of resource we spend on bureaucracy is kept to a minimum – ensuring that the maximum amount is available to provide individuals with the solution they require;
- We will all work in partnership to identify and provide the best solution;
- Our solutions look to utilise the assets available within the local area and not just focus on the services we provide;
- We are flexible enough to respond and adapt to individuals and their neighbourhood's changing circumstances;
- Responsibility for maintaining and improving health and wellbeing is shared by everyone within their neighbourhood;
- Our starting point will always be to prevent, reduce and delay the requirement for a social care and health service; but….

- If a service is the best solution, we will ensure it is appropriate, easy to access, of high quality and provided in a timely manner.

The Future – what 'system transformation' will achieve

The current health and care system has predominantly focused on responding to need and waiting until individuals reach crisis point. To successfully overcome the current challenges that face us and our population, we must redesign the foundations upon which the health and care system is based, ensuring that they help people to 'live well'. For example:

- A focus on strengths not on need – reducing dependency;
- Empowering individuals to take control
- Targeting interventions so that they prevent crisis;
- The importance of outcomes as opposed to process;
- The need to reduce duplication, bureaucracy and process to ensure that the majority of resource is focused on providing support;
- The importance of technology to enable improved outcomes; and
- The importance of a solution and outcome focus and not of a service and prescription model.

We have collaborated with Health and community partners to begin to put into practice our future model as part of Better Care Together Thurrock. We are not starting from the beginning; the current phase of transformation builds on and consolidates phases 1 and 2 of our programme.

Better Care Together Thurrock aims to deliver system redesign around a population in a place. Based on a report by the Director of Public Health, Better Care Together Thurrock aims 'to provide better outcomes for individuals that are closer to home, holistic and that create efficiencies within the Health and Care system'. The report demonstrated that in one area of Thurrock, 9 out of 10 people attending Accident and Emergency could have received the support they required within the community. Further analysis also identified that 50% of hospital spend accounted for only 1.8% of the population. The report acted as a 'case for change' to support phase 3, and identified a number of solutions:

- Increasing the capacity of primary care;
- Improving case finding and the management of Long Term Conditions; and
- Proactive, Integrated Community Health and Wellbeing.

Phase 3 of our transformation programme responds to the findings and recommendations contained within the report through:

- Organisational change
- Developing how we commission
- Engaging with and involving staff, individuals and communities
- Becoming outcome focused and evidence based

Achieving this creativity and innovation will be at the heart of what we do. For example, we are currently in the process of developing two self-managed Wellbeing Teams as an alternative model to domiciliary care; and are also developing a Community-based Social Work Team who will be tasked with developing and creating innovative solutions for social work responses. We are also piloting new approaches to technology enabled care so that we use technology where it will help improve the outcomes for people.

It is important that as we transform, we do not lose sight of the three themes that helped to define our transformation journey at the start, as these are as important now as they were then:

- Stronger Communities;
- The Built Environment; and
- The Health and Care Infrastructure.

Most importantly, our overriding approach must be to develop a system that results in a different outcome for the people that use it – and not recreate a system that's based on the same thinking that created it.

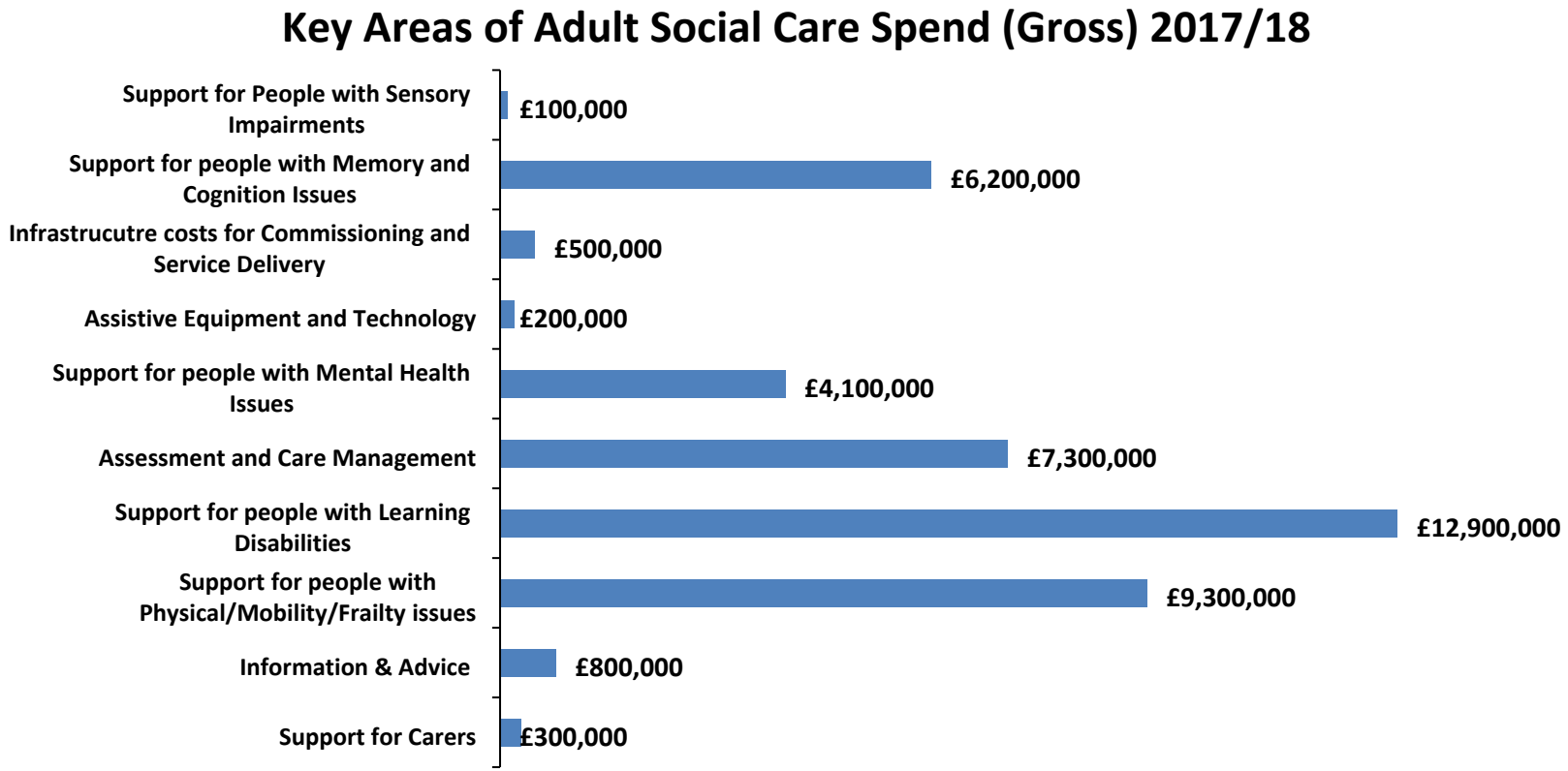
What this means for providers of services.

We want to work with providers of care homes, home care and a range of other community services to ensure they are able to play their full part in Better Care Together. We will be working with providers to ensure that their services are:

- **personalised and reflect the outcomes that are most important for each service user;**
- **deeply rooted in the local community, and able to make use of community assets (facilities, organisations and networks) which will deliver the solutions service users require;**
- **increasingly geared up to respond to the integrated commissioning of social care and health in Thurrock, and better able to provide holistic services**
- **able to make the most of Technology Enabled Care Services (including telehealth, telecare, and telemedicine) in the support they offer service users;**
- **equipping service users to take more control over their lives, including via direct payments, Individual Service Funds (ISF's) and working to reduce dependence of services.**

4. Spend and Key Statistics

We spent £41.7 million (Gross) on Adult Social Care services in 2017/18. The chart below shows how our spending is split across key areas:



Market Position Statement 2014	Current Position
1 in 5 service users were in receipt of a direct payment at the last MPS	1 in 4 service users now have a direct payment.
In 2014 we commissioned 5000 hours of homecare per week	We currently commission 7000 hours of homecare per week, an increase of 2000 hours per week since 2014.
Aged 18+ Net spend per head of pop. Aged 18+ was £272 in 2012/13 - lower than the average of £359	Net spend per head of population aged 18+ was £264 in 2016/17 – lower than the England average of £344
In 2014 we had 13 care homes/593 beds (residential and nursing) for older people and people dementia in borough.	We still have 13 residential care homes however there has been a slight increase in the number of beds for people with dementia making the total 611.
In 2014 we had 23 care homes/147 beds for working age adults in the borough.	We now have 19 care homes/139 beds for working age adults in the borough

5. What service users want

Over the past 6 months Thurrock Council has worked with the following groups to gain a greater understanding of user needs and aspirations;

- The Thurrock Autism Action Groups
- The Thurrock Disability Partnership Board
- The Thurrock Emotional Wellbeing Forum for Individuals, Family Members and Carers
- The Thurrock Older People's Parliament (OPP)
- Direct Payment Engagement Group

These groups have highlighted what outcomes people feel are important, how these are being achieved at the moment and what services and support need changing or are missing.

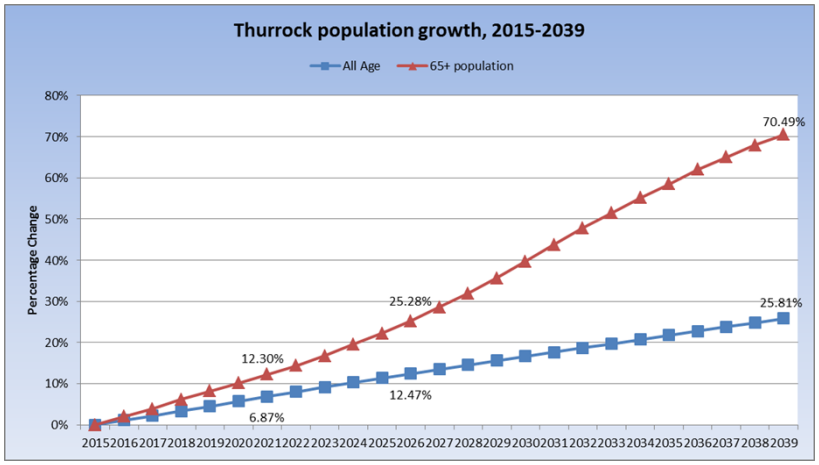
There were some consistent messages across all groups;

1. The difficulty in accessing services and the lack of coordination between them.
2. The importance of continuity of carer/support worker. Concerns about reliability of carers having to travel throughout the borough and lack off flexibility and contingency in how we commission home care
3. Information needs to be accessible to all (needs to be in a variety of formats – not just digitally available). More training needs to be available to skill people to match the digital approach but people also need a 'person' to talk to.
4. Direct payments are important. Including timely information about what a direct payment can be used for and what options are available for care and support. Users identified the need for a PA agency as they felt new users may have difficulty finding a PA. Specific need for highly trained PA's for people with Autism and specialist/high needs.
5. Increase in care and support options for people with dementia
6. Requires more flexibility in services – specifically respite services and home care
7. Value micro providers but felt they could benefit from being able to access more training
8. Wanted commissioners to understand that social interaction is as valuable as physical interaction.
9. Specialist service for people with complex/profound Autism
10. Felt there needs to be a service between residential care and independent living and that independent living needed a clearer definition.

Most groups also reported that they need an improved accessible transport system (especially to attend medical appointments). There was also a general desire to be independent – for example the OPP group emphasised the importance to them of aids and adaptations to stop them requiring more intensive services.

6. Needs of service users

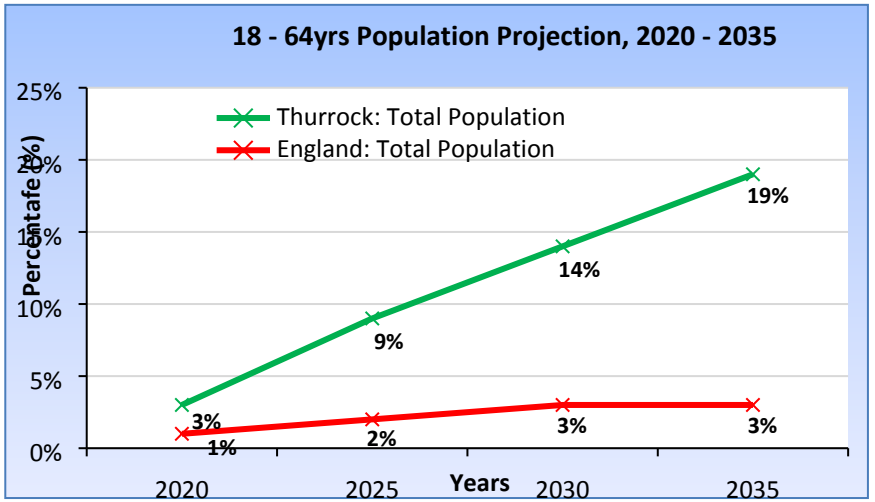
The latest population estimates 165,184 of which 83,835 (50.7%) were female and 81,349 (49.3%) male. This is estimated to rise to 201,000 by 2035. It is known that nationally the population is living longer, albeit not necessarily healthier, lives. Whilst it is expected that in Thurrock, the population might grow by 6.87% by 2021, this is almost doubled in those aged 65+ (12.3%), and this age group is expected to increase at a much higher rate for all years after this date.



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. *T*hose aged 65+ are the highest users of Adult Social Care services and are also more likely to develop multiple long term conditions, which results in increased demand for health and social care services[1].

[1] Maria Payne, *Likely contributors towards future social care needs*, Thurrock Council

However, it is not just the number of Older People that will experience a significant increase. There is a marked increase in those aged 18 – 64 in Thurrock compared to the projections for England.

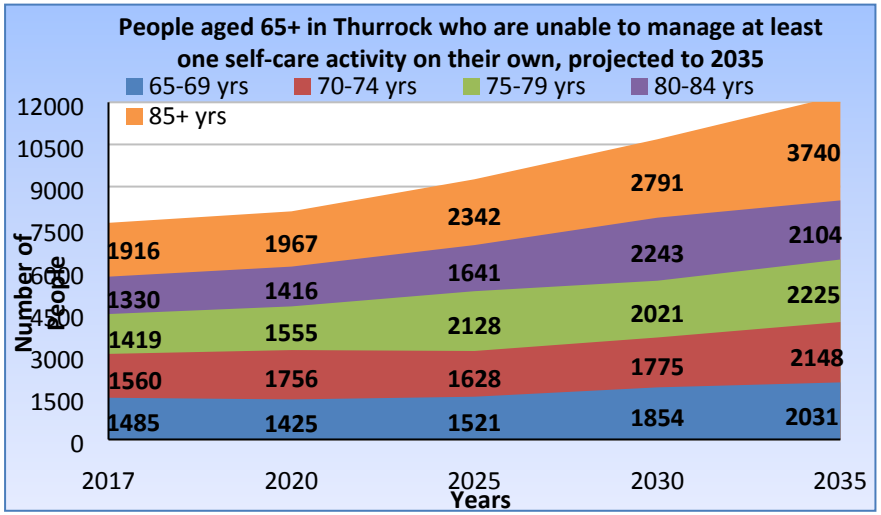


Other indicators of the demand of health and social care are lifestyle behaviours. Thurrock has particularly high numbers of people undertaking behaviours relating to smoking (Thurrock already has more hospital admissions attributable to smoking than both regional and national averages) and obesity (70.3% of adults in Thurrock are either overweight or obese).

Key Points - Without a successful transformation of the health and social care system and public health initiatives, the growth in population coupled with risky behaviours and high levels of deprivation is likely to lead to a significant increase in health and social care usage.

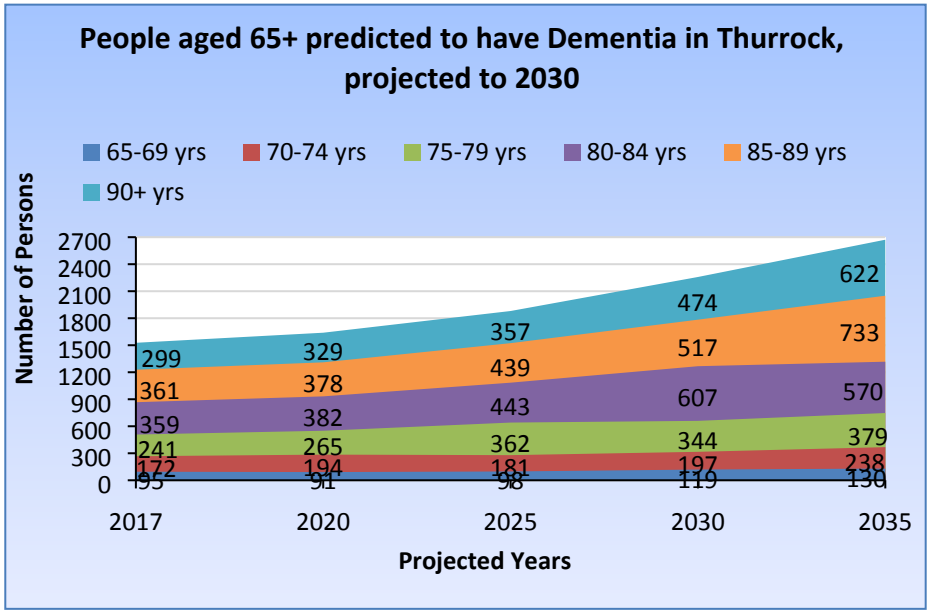
6.1 Needs of Older People (65+)

As can be seen from the figure below there is a predicted increase of 59% by 2035 in the number of people aged 65+ in Thurrock who cannot undertake even one self-care activity (basic personal care activities e.g. dressing, feeding, washing and toileting) independently and therefore will be requiring support from Adult Social Care.



In 2017 the total number of people was 7,710 and is projected to increase to 12,248 by 2035 with the largest increase in 85+ year age group, which sees an increase of 95.20% during this period.

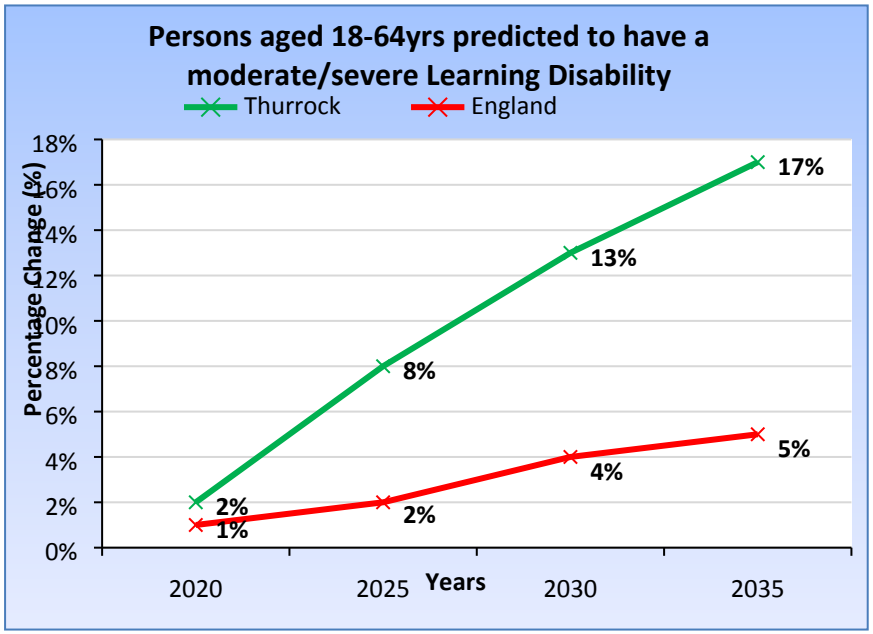
It is estimated that the number of people aged 65+ with dementia could increase by 75% between 2017 and 2030. The 85+ age group have the greatest prevalence in dementia. People in this age group with dementia more than doubles during this period from 660 to 1355.



Key Points - Although there is a projected increase in need for all people aged 65+, there is significant growth in those 85+ with physical ill health and dementia.

This pressure should be considered alongside the high levels of obesity in Thurrock which will require both an increase in the number of carers and the purchase of expensive bariatric equipment to deliver care and meet need safely.

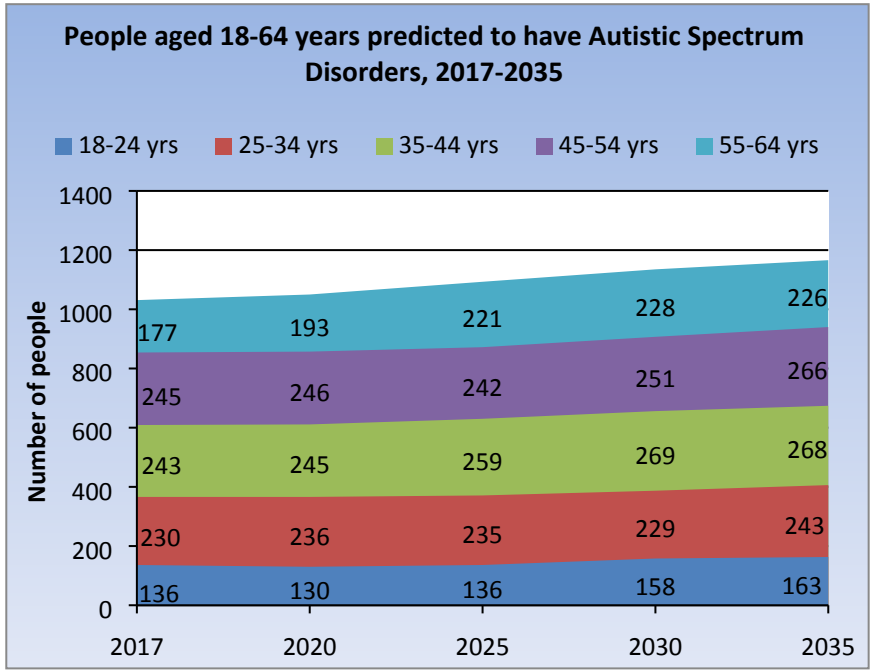
6.2 Needs of working age adults (18 – 64)



Thurrock is expected to have a significant increase in people aged 18 to 64 years with a moderate/severe Learning Disability compared with the national average (Thurrock has a disproportionate number of people with a Learning Disability compared to the national average as a result of a historical closure of Learning Disability long stay hospital in the area). This increase is largely due to people with a Learning Disability already known to Adult Social Care living longer – a large growth area for Thurrock is those aged 45 to 64.

The other area of growth is those 18 to 24. This is due to the location of two specialist schools in the borough meeting the needs of children with disabilities.

One of these schools also has a specialist unit for children with Autism. Although the table below shows a 13% increase in the number of people aged 18 to 64 with Autism, this does not fully reflect the reality and we expect it to be much more. This data is based on national averages and does not reflect that Thurrock has specialist provision which attracts families with autistic children to the borough.



In the last MPS we identified this potential increase in young people who would require Adult Social Care provision and the need for more specialist accommodation solutions. This assumption has been supported by the increase in young people with Autism coming through the transitions process requiring support. In the last MPS, Adult Social Care identified the need for purpose built accommodation for people with Autism. Thurrock Council is working jointly with Peabody Trust (formerly Family Mosaic) to develop their site in Medina Road, Grays to build 6 self-contained properties to support people to live independently as an alternative to placing outside of the borough. Medina Road is primarily aimed to meet the needs of those on the autistic spectrum and as a home for life. Ground works have already commenced on the site with an anticipated completion date of autumn 2019.

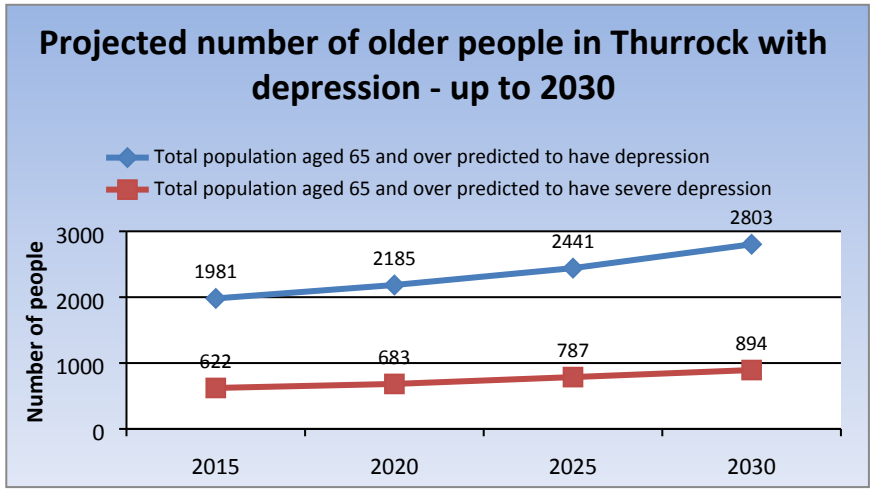
Key Points - We expect a significant rise in working age adults with a moderate/severe Learning Disability (largely people already known to Adult Social Care aged 45 to 64) and younger people with Autism.

6.3 Mental ill Health

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.

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

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%[2].



One particular area of Mental ill Health which is expected to have disproportionate growth in Thurrock is the projected number of Older People with depression. Thurrock's mental health JSNA identifies 1981 Older People with depression – this is expected to increase to 2803 by 2030, which is an increase of 41.5%. 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%.

The same document also identifies how mental health interacts with

[2] Thurrock Council, *Joint Strategic Needs Assessment – Mental Health*, 2018

physical health and risky behaviours such as smoking, substance misuse and obesity.

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	**There is a strong link between social isolation and mental ill health.**	**A high proportion of people misusing drugs and alcohol also suffer from mental illness**
40% of Older People living in nursing/care services suffer depression. Older People in residential care are two to three times more likely to experience depression than Older People in the community[3].	**Those with serious mental illness have extremely high rates of smoking**	**There is a strong association between obesity and poor mental health.**

Key Points - Mental Health will be an increasing focus for the Council and Health colleagues over the next year.

There are strong links between obesity, smoking and poor mental health. As can be seen from section 6, Thurrock has higher than average prevalence of these lifestyle behaviours.

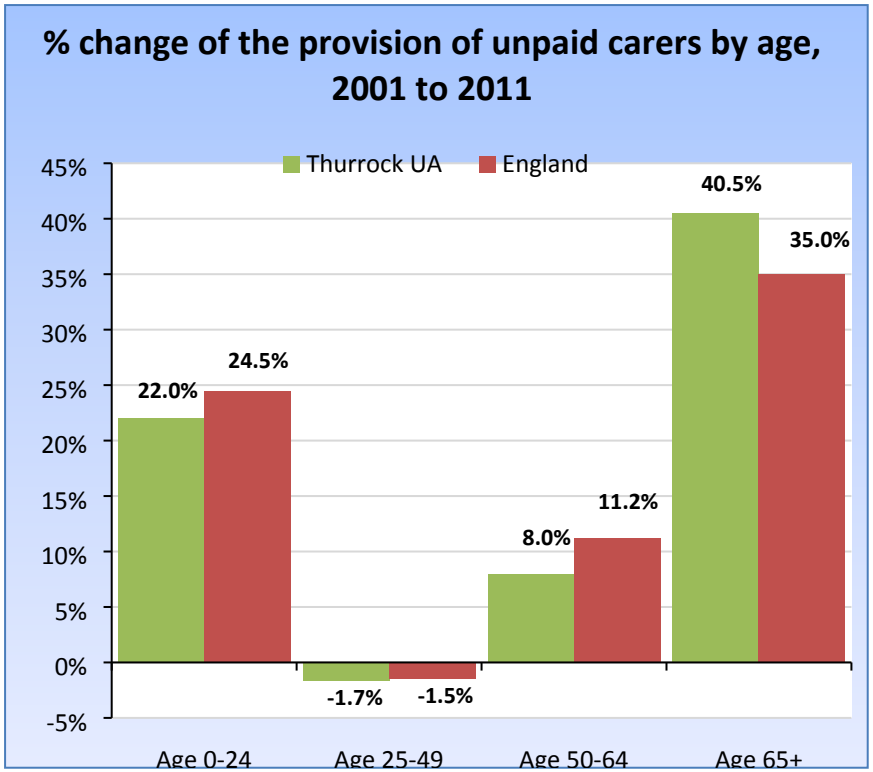
If we consider the link between mental health and physical health, section 6.1 shows an expected increase of 59% by 2035 in the number of people aged 65+ in Thurrock who cannot undertake even one self-care activity. This will impact significantly on mental health services but also suggests a much greater degree of integration is required between mental and physical health services if we are to adequately meet the needs of the population.

Thurrock has higher than average permanent residential admissions for Older People. If 40% of Older People living in nursing/care services suffer depression – then the impetus must be on the Council to explore preventative service and/or greater links to the community for those people where residential care is the most appropriate service to meet their needs.

6.4 Needs of Carers

Carers are people who spend a significant proportion of their life providing unpaid support to a relative, partner, friend or neighbour who is ill, frail, elderly, disabled or has mental health or substance misuse issues. They are a diverse and significant group of people – over 3 in 5 people in the UK will become Carers at some point in their lives. Nationally 1 in 8 adults (6 million people) are Carers and of these, 1.2million Carers provide more than 50 hours of care per week. The 2011 census shows that 26% of those identifying as caring in Thurrock provided this high level of care. This is higher that regional (23%) and national averages (22%).

[3] *Assessing the mental health needs of older people*. SCIE Guide 3, 2006



In Thurrock it is estimated that some 20,000[4] people are Carers. However, of these under 5% are actually known to public services and formally recognised and receiving caring support. In 2016/17 Carers in Thurrock were primarily providing support for Older People or people with a long term illness. The majority of Carers were aged 51-64.

[4] Census data suggests 1 in 8 people are carers. This has been applied to current population projection data.

Caring can be a rewarding experience but many face isolation, poverty, discrimination, ill health, frustration and resentment as a result of their caring role. For example, a Carers survey carried out in Thurrock in 2016 found that 84% of respondents said that caring meant that they either had no control or some but not enough control over their daily life; in addition 78% said that they had encountered financial difficulties in the previous 12 months and most worryingly, there is a significant increase on previous surveys in the number of Carers reporting social isolation.

However, 70% of respondents did report that they found it easy to obtain and access information they needed for their caring role, compared with a national average of 64%. Thurrock Carers also reported a higher than national average satisfaction with social services (40% and 39% respectively).

With Thurrock facing a growing and ageing population, there is likely to be an increase in the demands on Carers who are themselves becoming older and are already providing the bulk of care and support.

Key Points – The projected rise in Older People and people with long term conditions means there will be more people caring. Without adequate support for Carers there will be an increased strain on the health and social care system.

The large amount of care provided by Carers in Thurrock, coupled with the increase in Carers self-reporting as being socially isolated will result in an increase in the use of mental health services if appropriate support and interventions are not put in place.

6.4 Workforce

Most of the health and social care budget gets spent on staff and it is therefore essential that we address the national and local shortage in the care workforce.

Social care has to compete with both the NHS and other sectors such as retail in order to attract staff. Thurrock faces particularly difficulties in attracting staff into the care sector as a wide variety of other employment opportunities such as retail (Intu lakeside is based in the borough and planning expansion) and a large and growing logistics sector (e.g. Amazon has recently opened a large distribution centre in Tilbury) trying to attract the same pool of people. Some of the initiatives we are developing in Thurrock are attempting to address this issue. The Wellbeing teams should lead to better care delivery but part of this should be greater job satisfaction and increased pay for care workers.

In addition, we are aware that as we look towards greater integration with health, that the workforce of the future may need different skills that it does today. As such, we are starting to develop a Care Workforce Strategy for Thurrock that will be published in 2019.

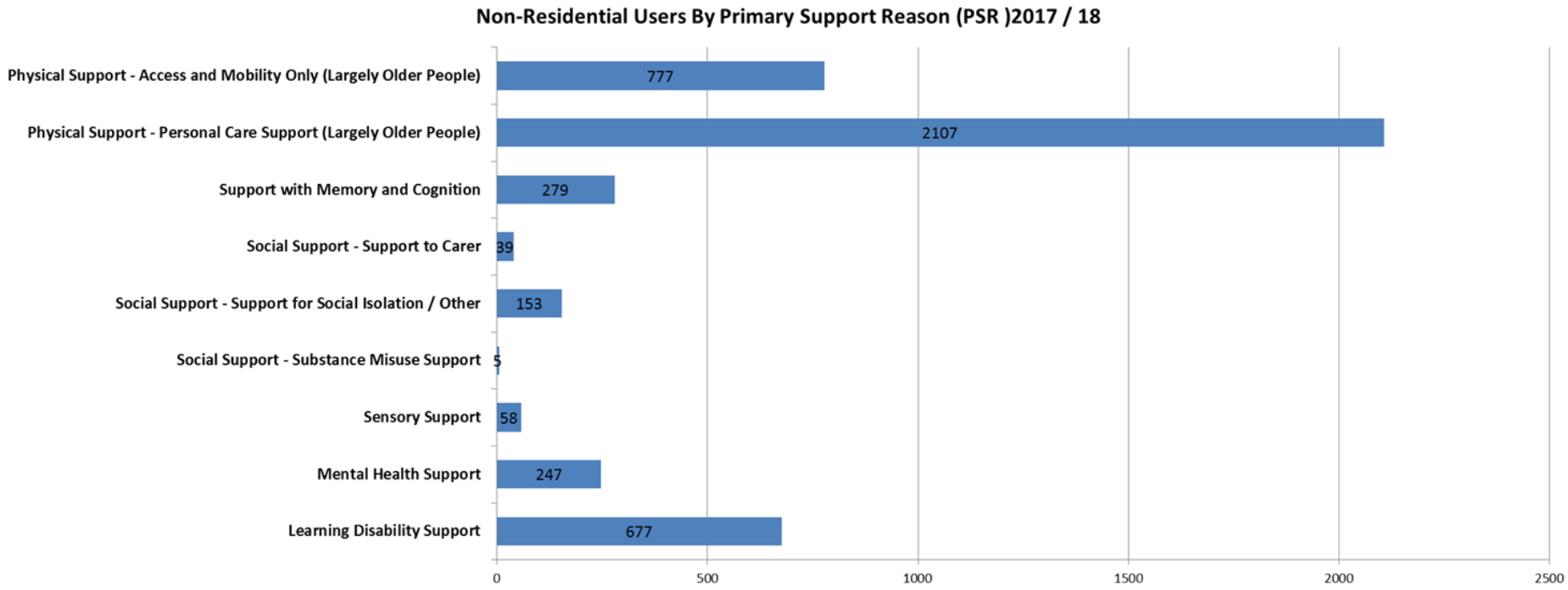
Key Points – Health and Social Care is about people. Without attracting adequate numbers of well trained staff into the sector we cannot meet the increasingly complex needs of service users.

7. Diversity of the Market

7.1 Community Based Provision

In 2017/18 the primary users of community based services were people needing:

- Physical Support – Personal Care Support and accessing the community (largely Older People)
- Learning Disability Support.
- Support with Memory and Cognition (largely Older People with Dementia)
- Mental Health Support (Working Age Adults).



This reflects the previous MPS' areas of concern regarding the increasing requirement for physical support for Older People. This has indeed placed strain on the traditional homecare market within Thurrock as we have seen an increase of nearly 2000 hour of home care commissioned each week since 2014.

Within the last MPS there was a clear intention to diversify the non-residential care market and encourage the use of other forms of service provision whilst simultaneously reducing residential care dependence. While growth of the Shared Lives market has been initially slower than anticipated, usage of other non-residential care options has increased.

The increased focus on maintaining individuals in the community has resulted in the proliferation of non-residential support options for increasingly complex cases. Thus, options such as Supported Living and combined Direct Payments / Homecare packages have increased which has shifted spending patterns to new key areas of growth; Learning Disability; Mental Health; and Older People (physical support).

This shift of £4.3m investment from residential to community based services has enabled a greater flexibility in meeting eligible needs for Thurrock residents in an increasingly challenging non-residential market place and provided a platform for the growth of micro-enterprises in Thurrock.

One of the main challenges moving forward in commissioning and maintaining a diverse market will be adapting and working with providers to meet the service users changing requirements.

As stated previously a great proportion of our current spend is attributable to services for people with a Learning Disability or Mental Health needs. As these groups have some of the lowest average ages for Direct Payment and Supported Living (see appendix 2) it is likely other needs will manifest as these individuals age e.g. there will be an increasing requirement to meet the needs of Learning Disability service users who develop dementia.

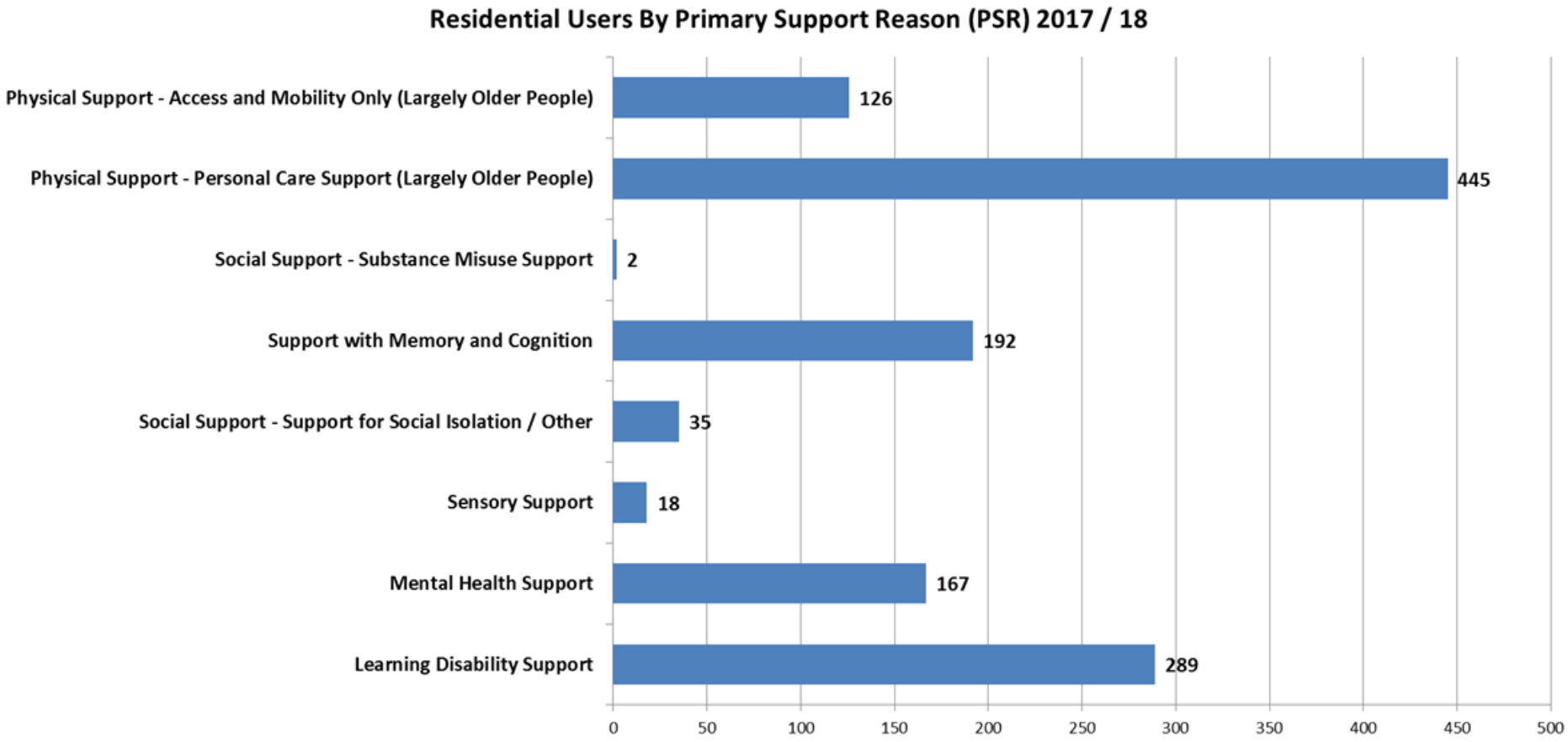
If we aim to support these individuals within the community longer term more bespoke services or specialist services may need to be sourced.

Under 1% of users of community based services are Carers. In 2017/18 only 11 Carers received a direct payment with the needs of most Carers of Older People being met by Council run services. The lack of choice and diversity of provision for Carers is a priority now that a comprehensive information, support and advice service has been procured.

Key Points – There has been a greater use of community based services since 2014. This has led to a greater diversity of provision including the development of micro providers. We expect this trend to continue and will work with providers to define and develop services to meet;

- **The need for supported housing**
- **The needs of Carers**
- **The need for more specialist/bespoke services for people with complex needs e.g. Autism, People with both learning disabilities and dementia etc.**

7.2 Residential Market



Externally provided residential provision (the Council retains one in-house residential care home for Older People) totalled over £20m in 2017 / 18, of which the vast majority was spent with private businesses. We have significantly more people in residential care with physical support /personal care needs (primarily Older People). However, spend does not reflect the number of placements, as although a much lower number of individuals are in residential care than previously, spend on Learning Disability residential care is significantly higher (nearly double).

This is (to a degree) to be expected with the two specialist schools within the borough and the forecast above national demographic trend increases in Learning Disability.

The spending pattern for residential service, in combination with community based spend for Mental Health and high average ages in homecare and day care would point to a potential short comings in our present range of options that address the mental wellbeing of people 65+. This will present a more significant future challenge given the forecasted pressures outlined in the 'needs of Older People' (section 6.1) earlier in this document.

Thurrock's Brokerage team do not report a need for more in-borough residential care placements for people with mental ill health but do require a greater diversity of mental health supported accommodation. This is exacerbated by the increase in demand, both current and predicted of this service type for clients with Mental ill-health.

At present internal brokerage services are reporting a consistent 5% void rate for traditional Older People residential care across the borough. This is in keeping with overarching trends which has seen a continual reduction in traditional Older People placements since 2010 via externally sourced places (329 individuals in April 2010 compared to 257 in April 2018).

Although actual placements are showing a reduction, our forecast due to demographic pressures (even factoring in community based service solutions) is showing at best a stabilisation or small increase in the number of residential placements for Older People with physical support needs. As we currently have a 5% void rate in Older People residential care we will not support the development of further traditional residential care provision. The proposed development of the White Acres site into a care home for the 21st Century may create extra capacity in the system and will provide a new model of residential based care that we may wish to replicate.

While growth in residential placements for people with a Learning Disability have only grown slightly since April 2010 the forecast growth in this user group shows this as a potential issue for the Authority. A proportion of this demand has been absored via non-residential service provision which is evidenced by the increasing spending for people with a Learning Disability across all service types.

When looking at forecasted growth and the increase in average weekly cost per placement (please see appendix 2) you can conclude that the Authority will be faced with increased demand and increased levels of client complexity.

Although we are forecasting an increase in service users with Learning Disability with complex needs, Thurrock continues with the commitment from our last MPS to not support the development of traditional Learning Disability residential care homes. Due to our successful development of housing based solutions (please see key facts – section 4) we have enough traditional residential care provision and have voids in some existing schemes.

Looking at the average age of the service user groups in combination with the spend data, Learning Disability Support has by far the lowest average age and the highest proportion of spend. When looking at this in combination with the non-residential data detailed above or the demographic information outlined in the 'needs for working age adults' (section 6.2) would suggest the need for clearer step up/down pathways throughout the journey through the Adult Social Care system for this service user group.

It has been highlighted that we will need to continue to work with providers to develop innovative solutions for young people with Learning Disabilities and Autism (including purpose built schemes like Medina Road) in order to address this trend.

Thurrock's Brokerage team report an under provision of certain types of supported living for both LD and MH (including dual diagnosis) – the supported housing and accommodation MPS will clearly define the required model/s.

Key Points – The main user of residential care is Older People yet the largest area of spend on residential care is for people with a Learning Disability.

We will not support the development of traditional residential care for Older People, People with Mental ill Health or Learning Disabilities.

There is an under provision in accommodation based services for working age adults (Learning Disabilities, Mental ill Health and Autism), especially for people with complex needs. The supported housing and accommodation MPS will clearly define the required models and number of units required over the next 5 years.

8. Future shape of the market and Key Actions

The main areas of growth for Providers are;

- Services that address both physical and mental wellbeing.
- Integrated services that can meet health and social care needs.
- Services for people with mental ill health – gaps in service will be defined as part of the MPS (to be published in 2019).
- Service that can respond to people utilising a direct payment/Individual Service Funds/own funding.
- Services for Carers.
- Supported Housing - Exact models to be defined in the Supported Housing and Accommodation Based Services (to be published in 2019).
- Young people with Autism.
- The development of alternative no/low cost community based solutions is a key objective. Providers may want to consider their approach to Social Value initiatives as part of their future service development in Thurrock.

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
1.	Integrated Commissioning and Holistic Care	• Without a successful transformation of the health and social care system and public health initiatives, the growth in population coupled with risky behaviours and high levels of deprivation is likely to lead to a significant increase in health and social care usage. • 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 problem. • If we consider the link between mental health and physical health, there is an expected increase of 59% by 2035 in the number of people aged 65 and over in Thurrock who cannot undertake even one self-care activity. This will impact significantly on mental health services but also suggests a much greater degree of integration is required between mental and physical health services if we are to	• Integrated Commissioning enhanced through the Better Care Fund will be more fully developed through the creation of an Alliance partnership across all commissioners and providers to become more outcome and locally focused. • Commissioners will be looking for every opportunity over the next 5 years to commission services with health and housing colleagues where it benefits the community do so. • Commissioners will also be looking to develop services that can meet both the physical and mental wellbeing of service

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
		adequately meet the needs of the population. • Service users reported the difficult in accessing services and the lack of coordination between them. • Service users wanted commissioners to understand that social interaction is a valuable as physical interaction.	users. This will be an area of growth for those Providers who can respond to this need. Part of mental wellbeing is addressing social isolation – as such commissioners will be more explicit in future specifications about the value of social interaction.
2.	Diversity of Provision	• Thurrock Council gave £179.5k[5] to the Voluntary and Community Section in 2018/19 through the Adult Social Care grant bidding process. • 37% of the total gross non-residential spend in 2017/18 was made to organisations that were 'not for profit'. • Development of Micro Providers. • There is little diversity of provision (type of service or provider type) for Carers. • There is little diversity of provision for young people with Autism.	• We view the voluntary and community sector as an essential partner in meeting our prevention responsibilities under the Care Act. Now we have developed our grant bidding process and due to the added value provided by these organisations we hope to commit to 3 year grant funding agreements to enable stability to the sector to enable a greater degree of planning beyond the yearly cycle currently in place. • We recognised the need to diversify the market in our 2014 MPS. As part of this we undertook a 2 year project to develop this segment of the market. This has resulted in over 50 local services being supported to set up in Thurrock. All services focus on improving the lives of local residents by providing support in the

[5] 30K of this is funded by Thurrock Clinical Commissioning Group

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
			fields of health, care and/or support in home and community and have increased the choice of services available locally. Due to its success, from 2018, the continued support and development of new micro-enterprises will form part of our mainstream service offer. • We recognise there is little diversity of provision for Carers and young people with Autism and will seek to address this through engagement with existing and new providers to enable people to utilise direct payments/own funds in the short term and formal market intervention such as the publication of new opportunities through framework type agreements medium to longer term.
3.	Direct Payments	• 1 in 4 service users now have a direct payment. This is compared with 1 in 5 service users at the last MPS. • Service users felt that direct payments are important, including timely information about what a direct payment can be used for and what option are available for care and support. Users identified the need for a PA agency as they felt new users may have difficulty finding a PA without one.	• This growth in direct payments occurred during a period where because of provider failure, some service users who were utilising a direct payment to purchase home care had to return to commissioned services. • We expect this trend of increased take up of direct payments to continue. The Authority will continue to promote direct payments as a viable option and will introduce a PA register that is easily

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
			accessible to the public. • The Direct Payment Engagement Group (DPEG) was developed in February 2018 to ensure the council has a greater understanding of service user's experience of direct payments. The Direct Payment policy is currently being reviewed by service users and practitioners so that people have greater understanding of what direct payments can be used for and any associated processes.
4.	Residential Care	• Our permanent admissions of younger adults aged 18 to 64 to residential and nursing care is approximately 50% lower than the national and regional average. • Although we have greatly reduced our dependence on residential care for Older People through the development of alternatives such as Extra Care Housing, Thurrock still has higher than average permanent residential admissions for Older People compared to regional and national averages[6]. If 40% of Older People living in nursing/care services suffer depression – then the impetus must be on the Council to explore preventative service and/or greater links to the community for those people where residential care is the most appropriate service to meet their needs. • Consistently 5% voids of Older People residential care.	• We do not support the development of any traditional residential care services for Older People or working age adults within the borough. • Thurrock has committed to achieving dementia care home standards by 2020 and will be working with existing services over the next two years to achieve this. • We need to create greater links between residential care homes and the wider community to tackle social isolation and depression.

[6] Adult Social Care Key Performance Indicators 2016/17. 710 per 100,000 compared to 610 and 524

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
		• Some voids in Learning Disability residential care – even though three homes have closed since the last MPS.	
5.	Supported Living	• There has been a significant increase in the use of supported accommodation for adults of working age since the publication of the last MPS. The Council has utilised its own housing stock to develop some of these schemes for people with a Learning Disability. • Service users felt there needed to be a service between residential care and independent living and that independent living requires a clearer definition. • The development of extra care housing has led to greater choice for Older People. Current void levels and waiting lists suggest we do not require further development at this time.	• The council is experiencing an increase in demand for supported accommodation for working age adults. We will define the model/s of supported accommodation we wish to purchase in the Supported Housing and Accommodation Based MPS – this document will be published in 2019. • The Council will not support the development of further extra care housing schemes at this time.
6.	Home Care	• We commission 7000 hours of homecare per week to over 700 users. This is an increase of nearly 2000 hours per week since the last MPS. • Service users reported that they wanted greater flexibility of service. They also emphasised the importance of continuity of carer/support worker. Concerns were also raised about the reliability of carers having to travel throughout the borough. • Service users wanted commissioners to understand that social interaction is a valuable as physical interaction. • Services should be deeply rooted in the local community. • We will be piloting Wellbeing teams. Outcomes from this pilot will	• We have seen a significant increase in the number of home care hours provided but not necessarily the number of people supported. • In 2017 we commissioned a Living Well @ Home Service and are currently in the implementation phase. When fully operation, 4 providers will operate within contained areas of the borough. This is to ensure that the providers and their carers get to know an area and can draw upon other services and assets in the local community (including those provided by

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
		inform future service developments and ultimately the commissioning approach.	the voluntary and community sector) to meet service users outcomes. This approach will also greatly reduce travel time and should result in greater consistency of carers. • By January 2019 we will start our Wellbeing Team pilot which will facilitate two Wellbeing Teams within the Tilbury and Chadwell location. Wellbeing Teams are self-managed, values led neighbourhood based teams. They focus on three key elements; o Making sure service users are safe and well o Ensuring people are in control of their live o All service users are connected to family, friends and the community.
7.	Older People and People with Dementia	• There is a project increase in need for all people aged 65and over. There is significant growth in those 85+ with physical ill health and dementia. • Service users felt there should be an increase in care and support options for people with dementia.	• There is very little diversity of provision for Older People and people with dementia. • Health and social care are currently reviewing the pathway for people with dementia and any gaps in service will be identified as part of this process and communicated to providers in the Mental Health MPS in 2019. • Although Dementia will form part of the

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
			Mental Health MPS, the Council is committed to increasing the range of services available to meet service user and their Carers needs. This will likely be through a framework type agreement.
8.	Learning Disabilities and Autism	• We expect a significant rise in working age adult with a moderate to severe Learning Disability and younger people with Autism. • Service users felt there should be more specialist services for people with complex/profound Autism.	• Advances in care and support have meant that a lot of our service users with Learning Disabilities are living longer. Although this is something to celebrate we do realise that this also brings some additional issues. In particular, we know we need to plan to meet the needs of people with Learning Disabilities who also have dementia. Although there will not be a large number of service users requiring this support – it is an area of development. • We will continue to develop housing related solutions for people with Learning Disabilities and Autism. The Medina Road site is our first purpose built development for people with Autism. However, current demographic data and trends in service users transitioning from Children's to Adult Social Care suggests that we may need more of this type of service going forward. Full details will be published separately in our Supported Housing and

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
			Accommodation Based MPS in 2019. • Following a tender exercise, Thurrock opened an Accredited List in January 2018. This allows for a variety of providers who pass the accreditation process to advertise their services. We now have three providers offering a range of day opportunities; the process will be re-opened to allow more providers to join but will also be replicated for other areas of support for people with a Learning Disability and/or Autism.
9.	Mental Health	• 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. • 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.	• This will be an area of increased focus over the next year for health and social care – the joint appointment of a Public Health and Adult Social Care commissioner during 2018 for Mental Health evidences our commitment to improving the lives of people with Mental ill health in Thurrock. • The Mental Health and Autism MPS will be a deep dive into the existing health and social care system. It will also identify any gaps in services. This is a potential area of growth for providers.
10.	Informal/Family Carers	• The projected increase in Older People and people with long term conditions means there will be more people caring.	• We need to improve the support available for Carers in Thurrock to help them continue with their caring role. Without

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
		• The large amount of care provided by Carers in Thurrock, couple with the increase in Carers self-reporting as being socially isolated will result in increased use of mental health services if appropriate support and interventions are not in place. • Service users reported they wanted greater flexibility of respite services. • There is limited choice in provision. • Thurrock has a low spend and low take-up of direct payments for Carers.	this, there will be increased strain on a health and social care system already under pressure. • We have already commissioned an Information, Advice and Support Service for Carers which started in June 2018. • We will publish a Carers Strategy in 2019, in which we will detail what services Carers want. We will then hold an engagement event to encourage providers to operate in Thurrock and meet the needs of Carers.
11.	Workforce	• Health and social care is about people. Without attracting adequate numbers of well trained staff into the sector we cannot meet the increasingly complex needs of service users. • Service users felt there was a need for highly trained PA's for people with Autism and specialist/high needs. • We need to encourage people into a career in care - the complexity of support has increased the number of hours of home care by 2000 since the last MPS and the sector is finding it increasingly difficult to attract enough people to meet need.	• A separate workforce strategy for Thurrock will be developed which will localise the National Health and Social Care Workforce Strategy due for publication in July 2018. • The availability of training for PA's and micro providers will be considered as part of the Direct Payment agenda. • The introduction of Wellbeing Teams will support a chosen career in care by financially rewarding and empowering staff and preventing social care from being seen as a 'Cinderella Service'.
12.	Technology enabled care	• Technology Enabled Care has a place in preventing, reducing and delaying the need for social care.	• By December 2018 we will pilot Technology Enabled Care within the

No.	Market Segment / Initiative	Supply and Demand (Market Intelligence) and service users Views	How the Authority will shape the market (Market Intervention)
		• Thurrock Councils digital transformation strategy, Connect Thurrock is transforming the way residents of Thurrock live their lives and communicate. https://www.thurrock.gov.uk/digital-and-information-technology-strategy/connected-thurrock-2017-2020	Tilbury and Chadwell location building on strength based approach to enhance quality of life for service users. This will increase dignity and opportunities to stay more connected with family, friends and the community by the use of technology such as video conferencing, apps and sensors.

Appendix One – Review of the Market Position Statement 2014/18

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
1	Communities become more resilient and self-supporting, and improvements to the homes and built environment enable more people to stay well.	• Commissioned services will no longer be our first response but our last. We will work with people to find the solution in their own community. • As the LAC and ABCD initiative gain momentum there will be an impact on the amount of commissioned services. Traditional service solutions will only be used when all other avenues have been explored. • We will support voluntary and community groups with initiatives that strengthen the community.	• We have developed the 'stronger communities' agenda through the Stronger Together Partnership. This has included: the development of six community hubs across the Borough, the development of a number of micro enterprises, the development of social prescribing in a number of GP practices, and the implementation of a Shared Lives scheme. The continued growth of resilient and self-supporting communities is an underpinning theme of our health and social care transformation programme – Better Care Together Thurrock. • The Director of Public Health published a report on developing a sustainable health and care system. In this, he concluded that the development of preventative initiatives such as Local Area Coordination had contributed to the reduction of the number of people requiring a social care service. Whilst the number of people requiring a social care service had reduced, the complexity of cases being dealt with had increased – this was further

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
			evidence that a preventative approach was leading to people requiring a service at a later stage. • Social Care has increasingly adopted a strength based approach – focusing on 'what's strong' rather than 'what's wrong'. This includes an assessment process that focuses on identifying and meeting the outcomes most important to the person being assessed. The approach focuses on looking at solutions rather than services – which can include support provided from within the community. • Through the Stronger Together Partnership, an initiative known as Small Sparks exists. This provides small grants for community initiatives. We provide support to develop micro-enterprises as well as supporting community-based groups and initiatives to develop via our Local Area Coordinators.
2	The Council and the CCG are committed to integrated commissioning. The Council and CCG commissioning functions will be integrated removing duplication and improving outcomes for people. In addition, the Council will be hosting the Better Care	• Single commissioning arrangements across the Council and CCG. • Single set of commissioning intentions and commissioning strategy.	• As the host organisation for the Better Care Fund since 2015, the Council works closely with NHS Commissioners and Providers to ensure the delivery of integrated care in line with the objectives of the Better Care Fund Plan

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
	Fund (BCF).	• As the host organisation, the Council will be responsible for contract managing the elements of NHS contracts that sit as part of the Better Care Pooled Fund.	for Thurrock. This has been very successful and forms the basis of further work to expand the principles of the better care fund to other service areas.
3	The new Care Act 2014 introduces the requirement for all service users to have a personal budget. This will mean that all service users will have a clear understanding about the financial resources available to them.	• Thurrock Council expects most people in the future (or an authorised person on their behalf) will take this personal budget as a direct payment. • In the future the Council may not be the main commissioner of services. Both the money and power will shift from the Local Authority to individuals needing support and their Carers. • Individual purchasers may be looking for something different to services available via a Local Authority. • As more people utilise a direct payment to purchase P.A. support, an agency able to offer this service may become a need.	• Direct Payment take up has increased to its highest level within Thurrock increasing from £3.9m in 14/15 to £4.3m in 17/18. • Uptake has also mirrored spend increasing from 744 instances in 14/15 to 816 in 17/18 despite provider failures and general difficulties in the market place. • Service user engagement and Provider engagement has aided market diversity and increases in Micro Enterprise usage. • Joint working with the ULO to increase service user understanding on how Direct Payments can be used.
4	The new Care Act 2014 places a duty on the local authority to Promote Diversity and Quality in Provision of Service.	• This means that Thurrock Council needs to ensure that service users have a variety of providers and a range of high quality services to choose from.	• The initial 2 year project has seen 50 local services supported to set up in Thurrock All services focus on improving the lives of local residents by providing support in the fields of

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
		• We will actively work with potential providers including micro and small / medium enterprises to ensure that service users (and Carers) are offered real choice and foster innovation locally. • We will actively support the development of micro and social enterprises.	health, care and/or support in home and community and have increased the choice of services available locally. Due to its success, from 2018, the continued support and development of new micro-enterprises will form part of our mainstream service offer.
5	The new Care Act 2014 places a duty on the local authority to assess whether a Carer has support needs and to provide or arrange for the provision of services, facilities or resources which contribute towards preventing or delaying the development by Carers of needs for support.	• The provision of information and advice is a core component of the Act. We see this provision as not only the responsibility of the Council but of every provider. • If eligible, Carers will also be given a personal budget. • We expect that in the future most Carers will utilise a direct payment to arrange support. • This could be a growth area for existing and prospective providers. • A review of the market has little diversity of provider in the Carers support service sector. Thurrock Council is encouraging increased diversity in the provider profile. As the number of people taking a direct payment and choice of providers grows, we expect our internally run services may adapt to reflect this. • We will actively support the development of a	• Following a tender exercise, in 2018 a consortium of local voluntary sector providers were successful in delivering an information, support and advice service for Carers. This contract is for a period of 5 years and following feedback from Carers allows the provider to carry out assessments on behalf of the council. It will also introduce a Carers emergency scheme. • Spend on Carers services and the diversity of provision for Carers is low. As such, following the implementation of the accredited list for day opportunities – a similar approach will be taken for Carers to ensure a greater diversity of provision in Thurrock. • The council successfully commissioned a Shared Lives scheme in February 2017. This is a 5 year contract to develop and grow the scheme to meet

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
		Shared Lives scheme locally as an alternative to residential respite.	our Care Act requirements of increasing our offer of services and as an alternative to residential care placements made outside of the borough.
6	There is an increase in Thurrock's population, especially those aged over 70 and people with dementia.	• Innovative and high quality community based provision aimed at Older People and people with dementia is an area of potential growth. • We are working closely with housing developers and our own housing, planning and regeneration departments to support the building of homes to HAPPI standards for older and vulnerable people. This is part of our strategy to enable older and vulnerable people to live independently in their community.	• This is still an area of potential growth. • Adult Social Care, under the auspices of the Health and Wellbeing Board, established the Housing and Planning Advisory Group (HPAG) to ensure that they could influence planning and development to better meet future demand.
7	The number of service users in residential care is decreasing and as a result so is spend.	• We may support the development of a high quality small dementia with challenging behaviour nursing home or unit. • We will not support the development of additional Learning Disability residential care schemes in Thurrock. • However, we will actively support the development of a shared lives scheme locally as an alternative to residential care. • Although we anticipate a growth in people with Autism and as such may require additional	• Since the last MPS an existing residential scheme that accommodated our dementia service users with behaviour that challenges expanded during the last few years. At this point, this expansion in service is meeting the need. • There has been a reduction in 3 Learning Disability care homes since the last MPS. Due to the use of other forms of accommodation based services there is still no requirement to expand on existing provision.

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
		specialist services in borough, this detail will be contained with the Autism Strategy – the final version will be published oh the Council's website in April 2015. Current and potential providers should reference to this document to understand our desired service profile before investing in local Autism services. • We will not support the development of additional mental health or Learning Disability residential care schemes in Thurrock. • We will be developing a step up/step down service provision for mental health.	• There has been no increase in borough of mental health residential care. However, we have increased the availability of mental health supported accommodation in borough. • Step up step down mental health provision has not been developed as yet but is still planned. The main obstacle has been locating appropriate accommodation for this use.
8	The number of service users being supported in the community is increasing and as a result so is spend.	• As the development of extra care is relatively recent, the Council is still evaluating the impact of this service and as to whether we wish to roll this out on a wider scale. We will report in 2015. • Due to the success of Elizabeth Gardens we will consider (as part of the evaluation) supporting a small extra care housing development for Older People and people with dementia in the west of the borough (as we currently have no provision here). • Also, subject to this evaluation we will consider the development of a small extra care scheme for people with Learning Disabilities. • Unlike many areas we have the opportunity to	• The addition of extra care schemes in Thurrock has added to the diversity of provision available to Older People. At this point, we do not have sufficient demand (as evidenced by waiting lists and voids) to consider the development of additional schemes in the area. • We are increasingly meeting the needs of people with Learning Disabilities through the development of supported accommodation utilising council housing stock e.g. Chichester close and LD Project (which utilises empty sheltered housing officer accommodation).

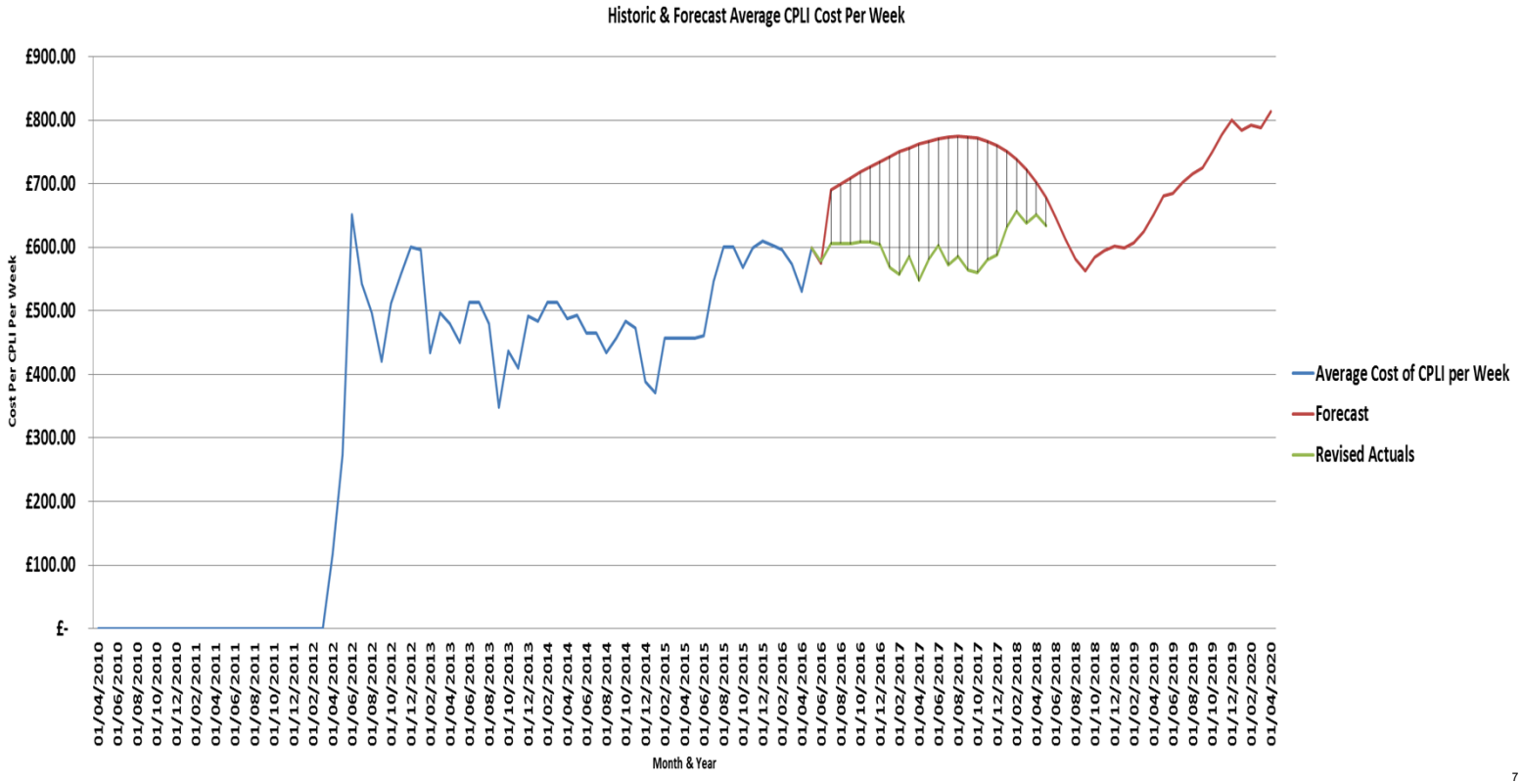
No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
		utilise RSL and Council owned accommodation for supported living. As such, we will wherever possible utilise this resource and encourage the separation of landlord and support functions for long term provision. We will commission any support separately or service users can utilise a direct payment to arrange their own. • We will actively work towards a 100% of our long term supported living provision meeting REACH standards. • A recent review of the market has shown little diversity of provider in Learning Disability day services. Thurrock Council will be encouraging increased diversity in the provider profile. This will most likely be by the use of a framework type agreement. • We are anticipating a growth in service users with autism. This will form part of the framework type agreement (detailed above). This information will be contained within the Autism Strategy to be published in April 2015. Current and potential providers should refer to this document to understand our desired service profile before investing in local autism services.	• Although we have continued to develop supported housing schemes which separate support and landlord e.g. Chichester close. We still need to review and formally define future supported living provision. This will be developed during 2018 and published in 2019. • Following a tender exercise, Thurrock opened an Accredited List in January 2018. This allows for a variety of providers who pass the accreditation process to advertise their services. We now have three providers offering a range of day opportunities; the process will be re- opened to allow more providers to join. • Autism is still an area of growing need in Thurrock. To meet this need ground works have already commenced on the development of a 6 unit specialist housing scheme for people with autism – this has an anticipated completion date of autumn 2019.
9	The number of direct payments is increasing.	• We expect direct payments to become the primary way care and support is purchased.	• The Council has introduced Individual Service Funds (initially) for all eligible Working Age individuals. This has

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
		• In the future providers will have a relationship directly with service users – not the Council. • Although the Council current commissions home care under existing contracts with three providers, direct payments are increasing. This offers a real opportunity for the increase of organisations (large and small) who want to provide care to people either receiving a direct payment or self-funding.	introduced a more inclusive approach to support planning, commissioning and provider relationships. Support planning is now carried out in conjunction with the chosen provider and individual and flexibility given so the individual can use the service as flexibly. • PA take up from167 instances in 14/15 to 276 instance in 17/18.
10	Our assessment and Care Management Services are becoming much more closely embedded into the communities they service and ensuring that strengths and outcomes are more important as needs and outputs in their practice.	• Programme of culture transformation is underway that will require providers to engage with fieldwork to find creative solutions based on strength and choice. • Locality will become a crucial factor in solution finding. The challenge for providers will be to add value to the communities in which they provide. • A genuine partnership with the citizen will be a feature of the relationship between them, their support planner and provider; paternalistic models of support will be a thing of the past.	• We have carried out a number of separate pieces of work to develop cultural transformation. This includes a series of staff workshops and reviewing the process for carrying out assessments so that they focus on strengths and outcomes – looking at a range of solutions to meet those outcomes rather than a sole service response. • We have developed a community asset map so that practitioners can see what is available within a person's locality. This means that solutions local to where the person lives can be identified. • The assessment process firmly puts the person at the centre of that process –

No.	Driver for Change identified in 2014 MPS	Implications for Providers in 2014 MPS	Update – Did we achieve what we set out to do?
			ensuring that the person can identify what's important to them and the outcomes they most want to achieve. We work closely with Thurrock Coalition (our User Led Organisation) to ensure that new initiatives continue to be coproduced and enable rather than disable.
11	Our transition service is committed to providing flexible and appropriate support for young people with disabilities moving through transition to adult hood that maximises their independence and promotes community inclusion.	• Residential models of accommodation will become the service solutions of last resort for disabled young people. • Community based solutions to lifestyle and respite support will be an area of potential growth. • Shared Lives approaches will also be encouraged for this group.	• We have focused on developing solutions that enable disabled young people to have greater choice over how their outcomes are met. This includes developing supported housing schemes (e.g. Medina Road), the conversion of ex-Sheltered Housing Warden Houses, and the development of a Shared Lives Scheme that enables individuals to live within a family home.

Appendix Two – Technical/Data Appendix

Chart 1 – Average Cost of Service for Mental Health Service Users



[7]

[7] CPLI – Care Package Line Items (the services provided to a specific individual/service users)

Chart 2 – Numbers of Older People in Residential Care per month

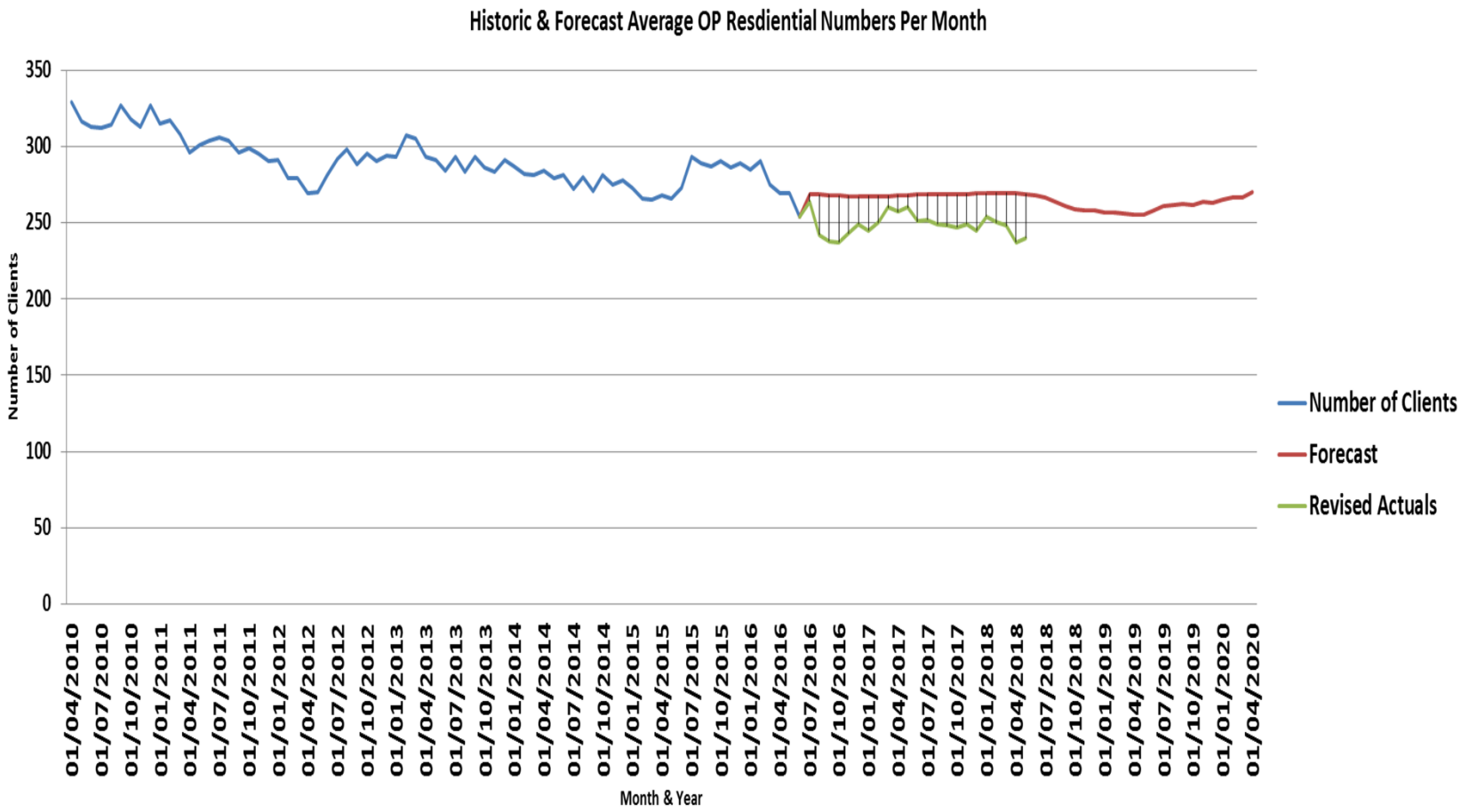


Chart 3 – Average Cost of Service for Service Users with a Learning Disability

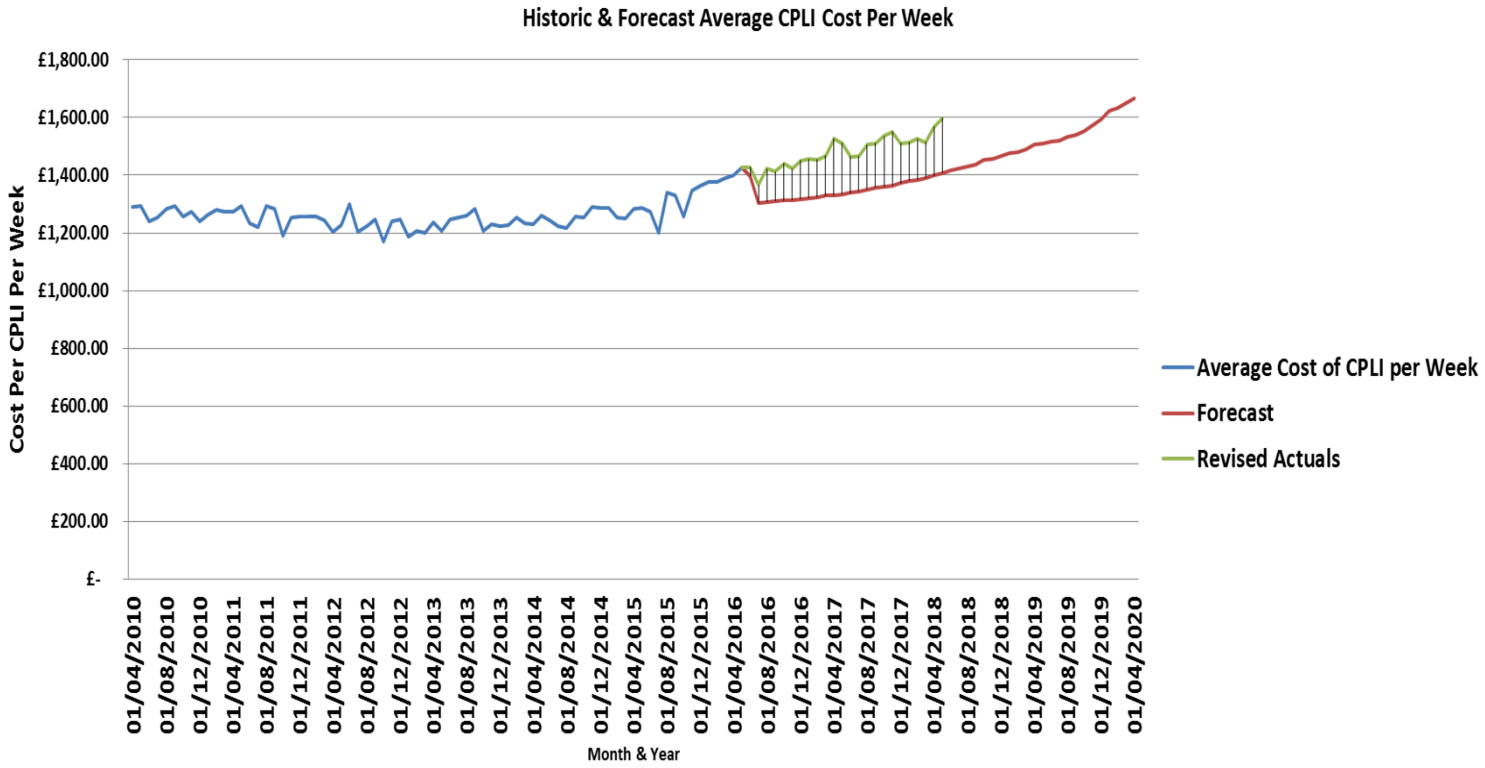


Chart 4 – Number of People with a Learning Disability in Residential Care

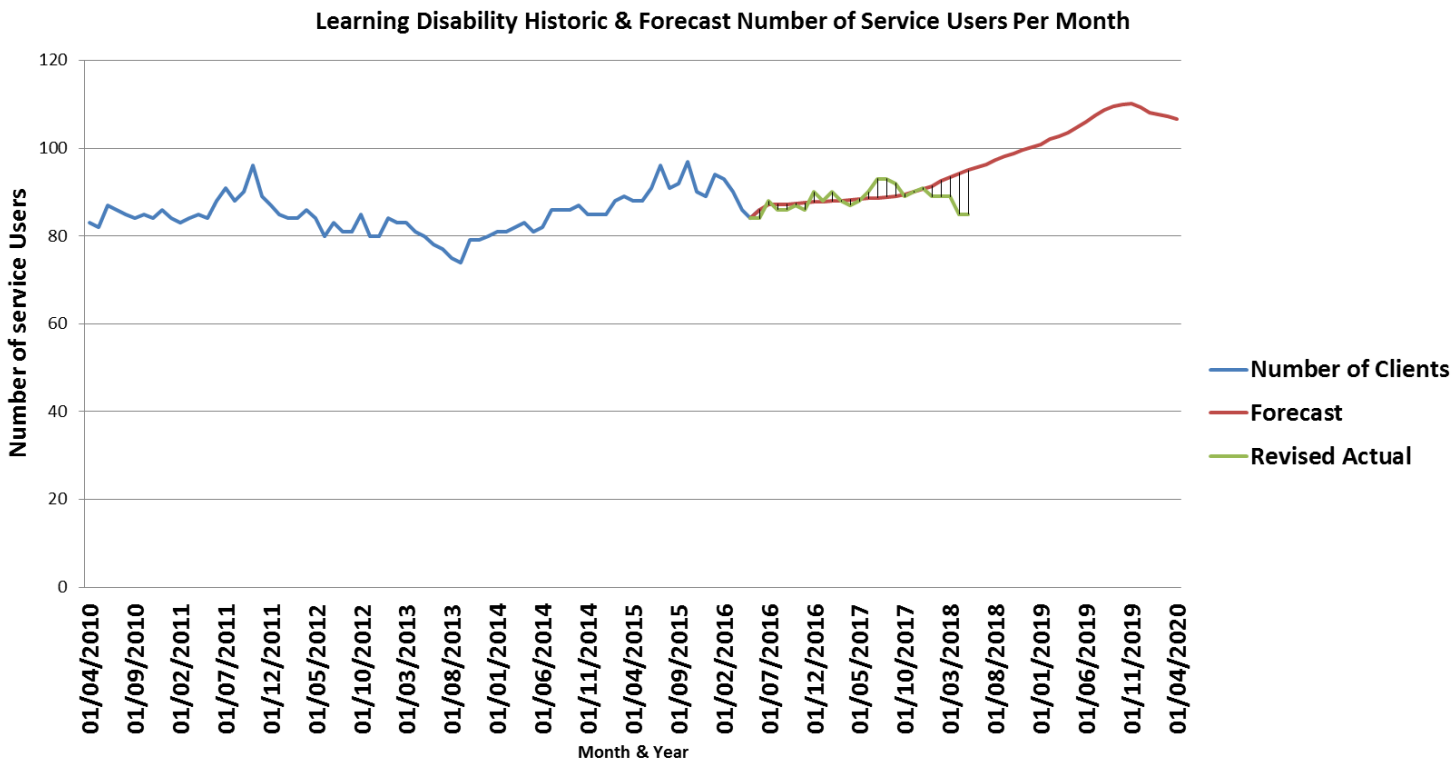


Chart 5 – Gross spend on Residential Care Provision by Provider Type

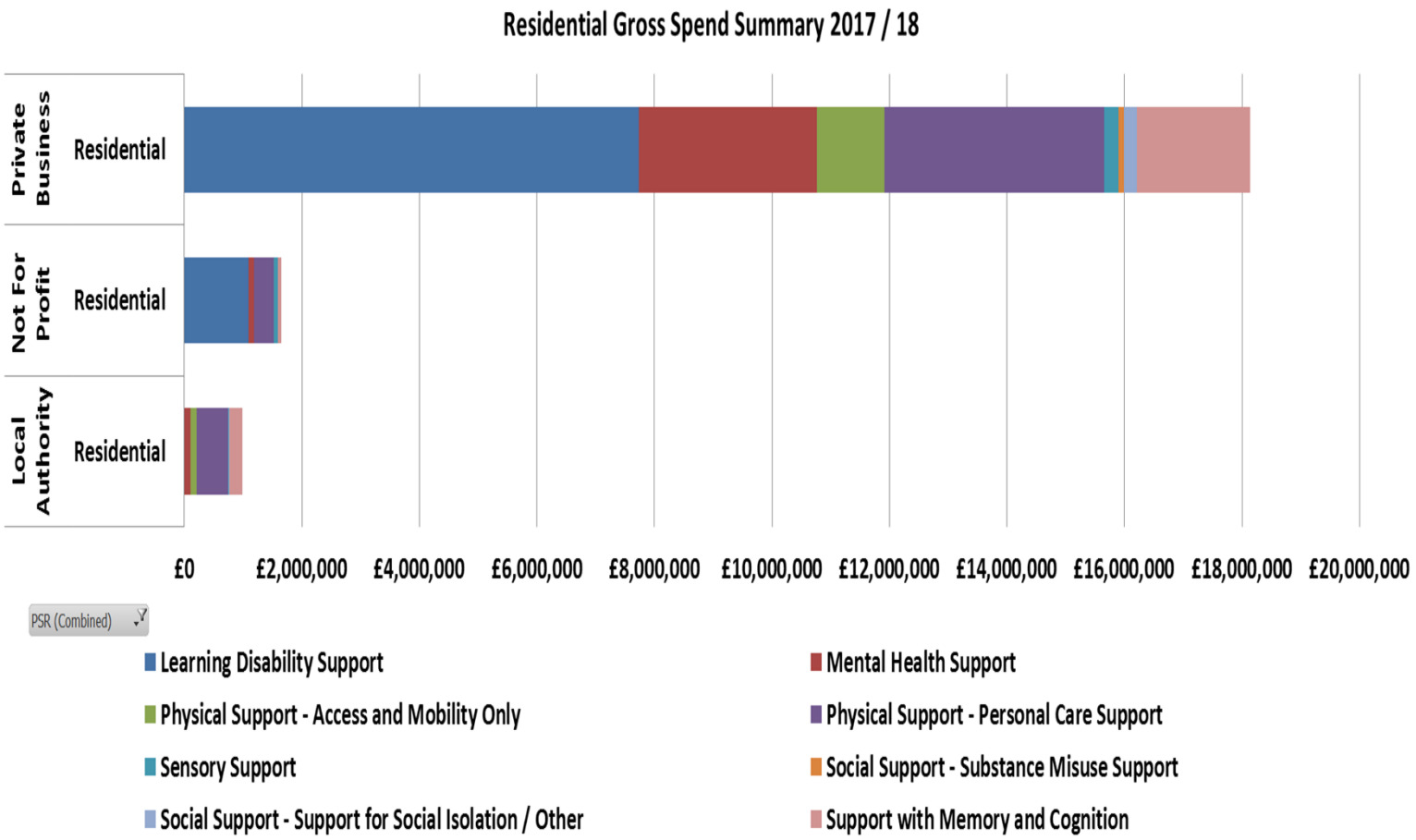


Chart 6 – Average Age of Users of Community Based Services

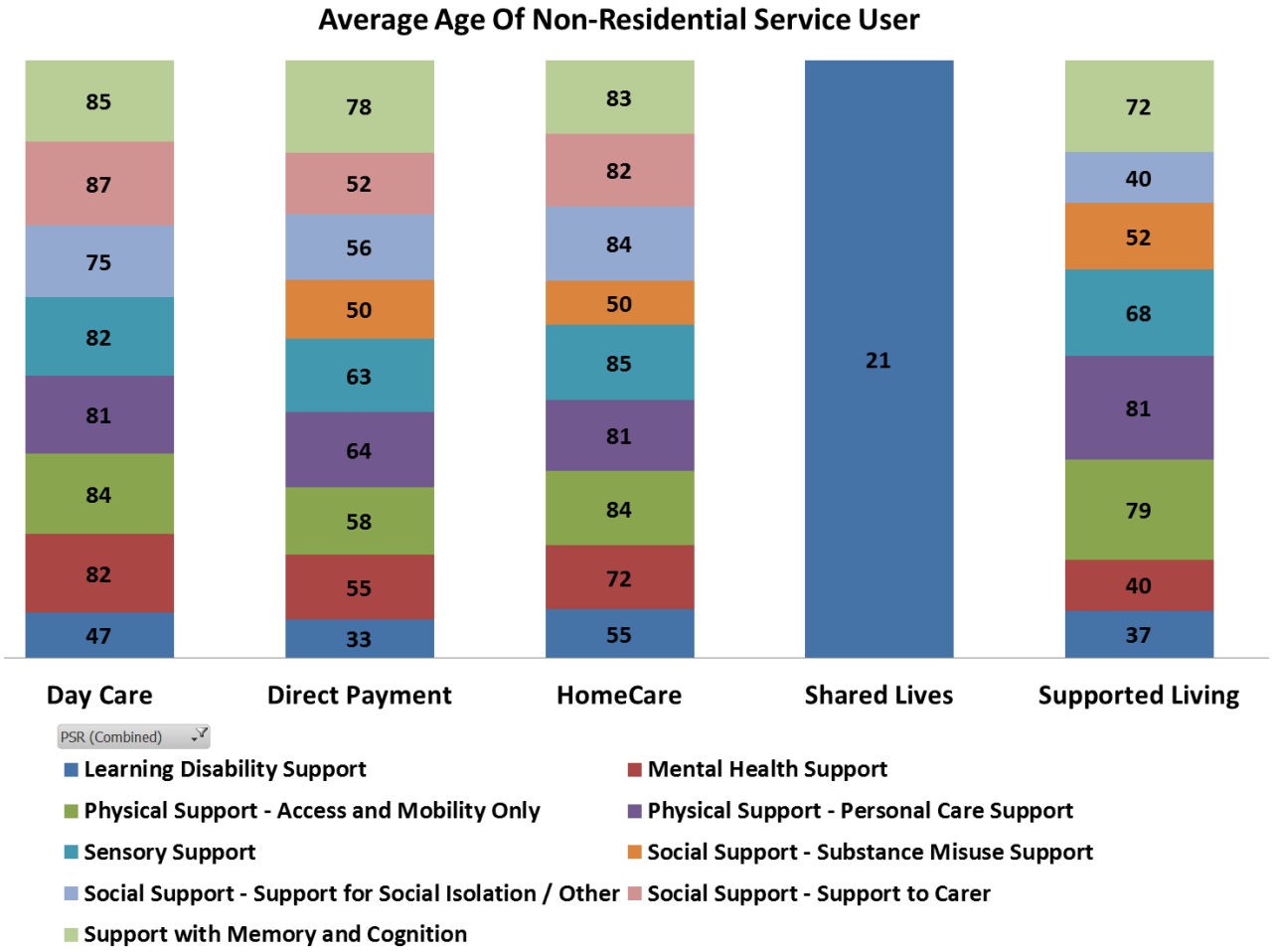


Chart 7 – Average of Service Users in Residential Care by Primary Reason for Support

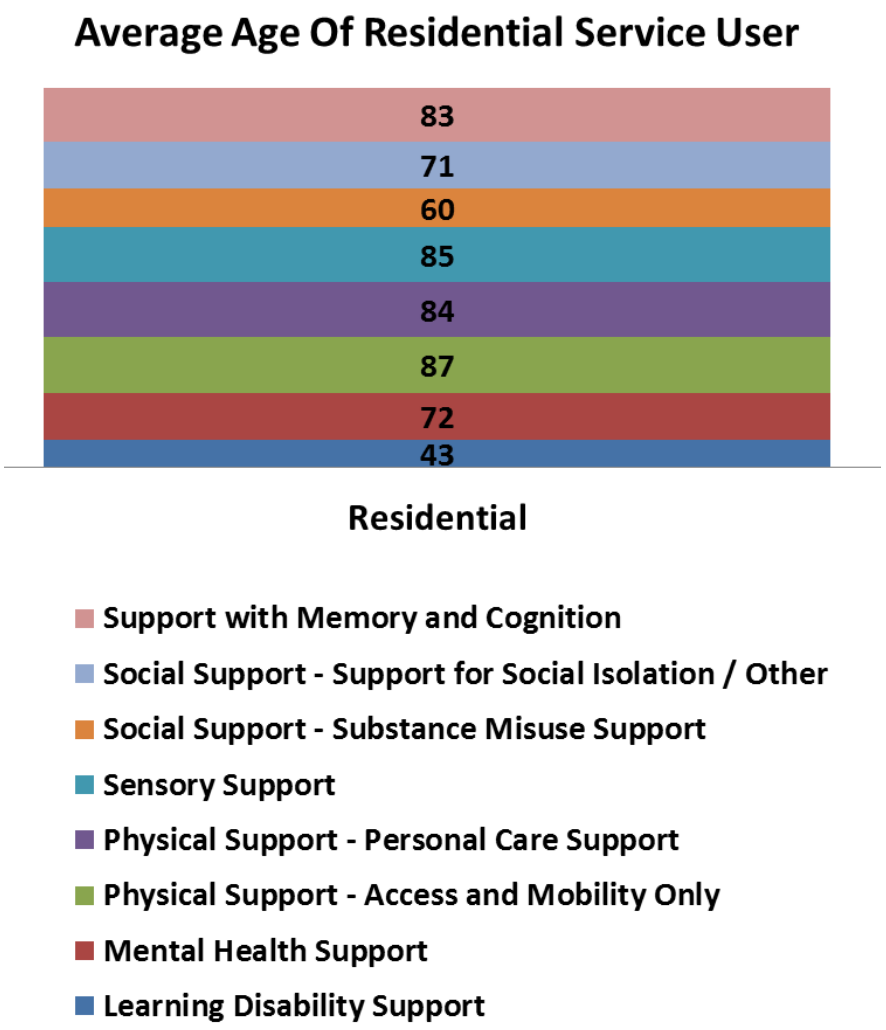
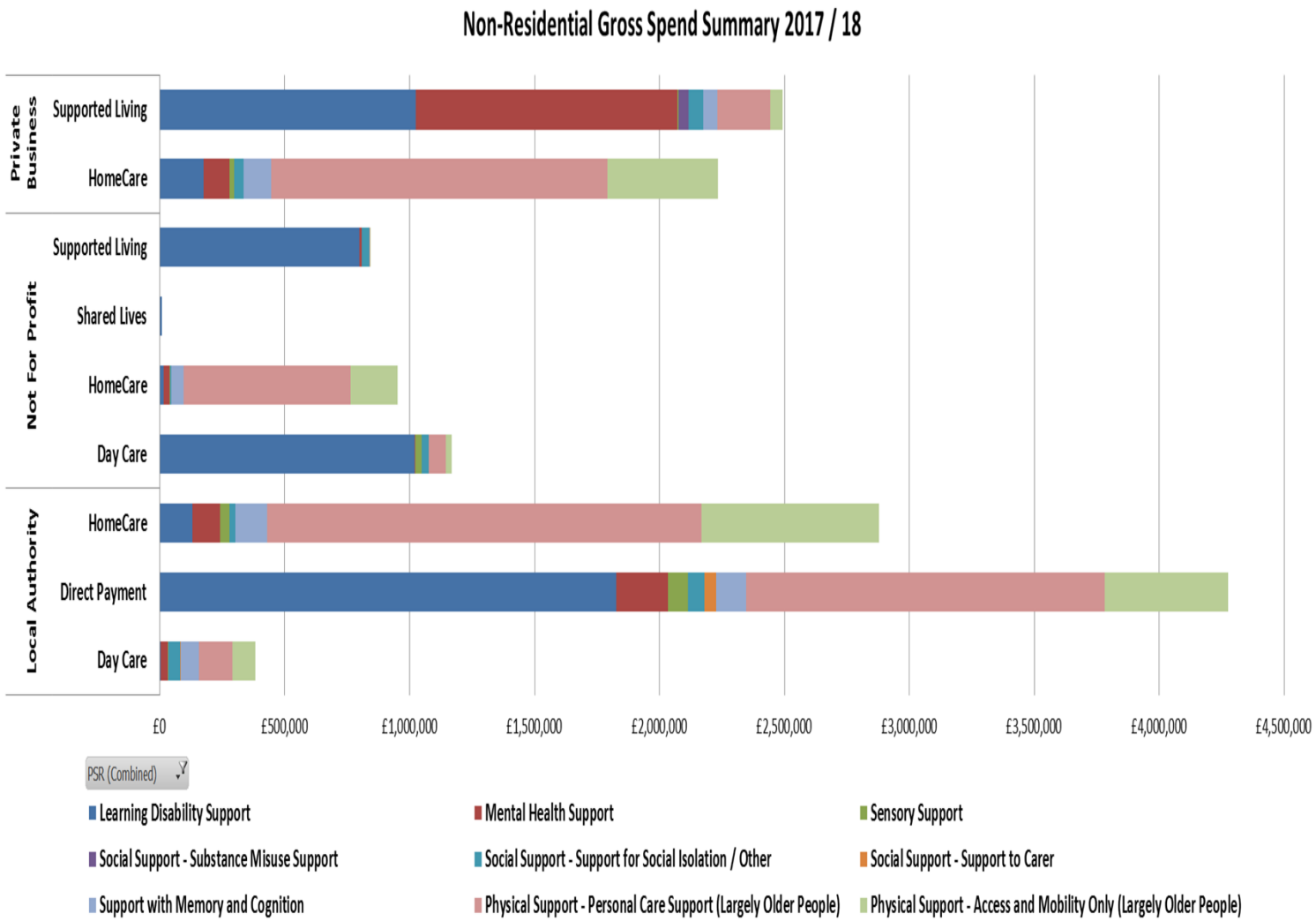


Chart 8 – Gross Spend Summary for Community Based Services



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6 September 2018	ITEM: 11
Health and Wellbeing Overview and Scrutiny Committee	
2017/18 Annual Complaints and Representations Report	
Wards and communities affected: All	**Key Decision:** Non Key
Report of: Tina Martin, Statutory & Corporate Complaints Manager	
Accountable Assistant Director: Les Billingham, Assistant Director, Adult Social Care	
Accountable Director: Roger Harris, Corporate Director of Adults, Housing & Health	
This report is public	

Executive Summary

The annual report for Thurrock Council on the operation of the Adult Social Care Complaints Procedure covering the period 1 April 2017 – 31 March 2018 is attached as Appendix 1. It is a statutory requirement to produce an annual complaints report on adult social care complaints.

The report sets out the number of representations received in the year including the number of complaints, key issues arising from complaints and the learning and improvement activity for the department.

A total of 404 representations were received during 2017-2018 as detailed below:

- 185 compliments
- 46 Initial Feedback
- 37 complaints received
- 5 MP enquiries
- 74 Member enquiries
- 9 MEP enquiries
- 3 Local Government Ombudsman enquiries

1. Recommendation(s)

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

2. Introduction and Background

2.1 This is the annual report for Thurrock Council on the operation of the Adult Social Care Complaints Procedure covering the period 1st April 2017 – 31st March 2018. It is a statutory requirement to produce an annual complaints report on Adult Social Care complaints.

3. Issues, Options and Analysis of Options

3.1 This is a monitoring report for noting, therefore there is no options analysis. The annual report attached as Appendix 1 includes consideration of reasons for complaints, issues arising from complaints and service learning and improvement activity in response.

3.2 **The headline messages for this report are:**

3.3 **Summary of representations received 2016/17**

- 185 compliments
- 46 Initial Feedback
- 37 complaints received
- 5 MP enquiries
- 74 Member enquiries
- 9 MEP enquiries
- 3 Local Government Ombudsman enquiries

Further detail on compliments, complaints and enquiries is outlined in Appendix 1.

3.4 **Local Government Ombudsman**

There were 3 cases received from the Ombudsman's office for this reporting year.

Further detail on both cases is outlined in Appendix 1.

3.5 **Learning from Complaints**

Complaints and feedback provide the service with an opportunity to identify things that can be improved; they provide a vital source of insight about people's experience of social care services.

Upheld complaints are routinely analysed to determine themes and trends and services are responsible for implementing learning swiftly. Robust monitoring and evidencing of corrective actions is a key theme for the next reporting year.

3.6 **Looking Forward**

The Corporate Complaints Team continues to facilitate the customer feedback process for Adult Statutory Services.

The team will be looking to provide further guidance and support to all services and the focus will be on improving the handling of complaints, the quality of responses and to increase learning from complaints and compliments, to ensure that a robust mechanism is in place for sharing lessons learnt, best practice and potential development.

Further detail on work priorities is outlined in Appendix 1.

4. Reasons for Recommendation

4.1 It is a statutory requirement to produce an annual complaints report on adult social care complaints. It is best practice for this to be considered by Overview and Scrutiny. This report is for monitoring and noting.

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

5.1 This report has been agreed with the Adult Social Care senior management team. Consideration of complaints issues and learning and improvement arising from them are identified as an ongoing priority in the report.

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

6.1 All learning and key trends identified in the complaints and compliments reporting has a direct impact on the quality of service delivery and performance. The reporting ensures that valuable feedback received from service users and carers is captured effectively and regularly monitored with the primary focus on putting things right or highlighting and promoting where services are working well.

7. Implications

7.1 **Financial**

Implications verified by: **Laura Last**
Management Accountant

There are no specific issues arising from this report.

7.2 **Legal**

Implications verified by: **David Lawson**
Assistant Director of Law & Governance

There are no legal implications as the report is being compiled in accordance with regulation 18 of the Complaint Regulations.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development & Equalities Manager

There are no specific diversity issues arising from this report.

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

- None

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

- None

9. Appendices to the report

Appendix 1 – Adult Social Care Complaints and Representations Annual Report 2017/18.

Report Author:

Tina Martin

Statutory & Corporate Complaints Manager

HR, OD & Transformation

Appendix 1

Adult Social Care
Annual Complaints & Representations Report

April 2017 – March 2018

Tina Martin
Statutory & Corporate Complaints Manager
HR, OD &Transformation

April 2018

1. Introduction

Every local authority with responsibilities for social care services is required to produce an annual report which outlines the working of adult complaints and representations. This report covers the period April 2017 to March 2018.

The procedure for dealing with adult social care complaints and representations is determined by the following legislation:

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- The accompanying guidance 'Listening, Responding and Improving: a guide to better customer care (DoH 2009).

The Regulations state that:

- Every organisation must have a Complaints Manager
- Every organisation has a single stage system to deal with complaints
- Complaints should be dealt with within a maximum of 6 months and that this can only be extended with the complainant's agreement
- Following investigation of the complaint by the Council, if the complainant remains dissatisfied, the next stage is the Local Government & Social Care Ombudsman
- Every organisation must make the complainant aware of the response period they work to and the way the response will be handled
- Where complaints involve several organisations, these organisations should discuss and agree who will take the lead
- The Local Government & Social Care Ombudsman will consider complaints from those people who fund their own social care and will liaise directly with the relevant organisation
- Complainants must approach the council to highlight their complaint within 12 months of the incident happening, or within 12 months of discovering the problem. Complaints outside of this timeframe are individually considered by the Complaints Manager and an assessment made regarding whether a fair and transparent investigation can still be carried out.

Thurrock adult social care arranges and supports provision of a wide range of commissioned and in-house care, to support people to live independently in their homes and to increase levels of choice and control over the support they receive. It also supports residential or nursing care when this becomes necessary. The department also has lead responsibility for safeguarding adults and provides some services jointly with Health.

The complaints process provides the council with an additional means of monitoring performance and improving service quality and provides an important opportunity to learn from complaints made by service users and advocates.

2. Key facts

2.1 We believe that dealing effectively with complaints is essential to providing good services and we use feedback from complaints to improve our services.

2.2 In 2017/2018 we received 37 Stage 1 complaints about Adult Social Care services. This is compared to 98 received in 2016/2017.

2.3 In 2017/2018, the timeliness of complaints was 95% compared to the previous year of 46% of complaints responded to within time. This is a significant improvement in performance. The time frame for most complaints is 20 working days however this can increase to 3 months for complex cases.

2.4 Of the 37 complaints received during the year, 1 case was determined by the Local Government & Social Care Ombudsman and the decision was not to continue the investigation.

2.5 There is a marked improvement for responding to MP, MEP and Member enquiries within timeframe compared to previous years.

2.6 There has been an increase in the number of compliments received compared to previous years.

2.7 Service dashboards are issued to the senior management team which provide high level summaries on types of feedback received.

3. Statutory and Corporate Complaints

The council may receive legitimate complaints that do not fall within the boundaries of the Statutory Social Care Complaints Procedure. These will usually fall within the remit of the Council's Corporate Complaints Process which is a three stage process with different timelines.

4. The Complaints Procedure

The council also receives feedback which does not constitute a formal complaint; these are classified as 'initial feedback'. These are forwarded to the service with a request that swift action takes place to resolve the issue thereby negating the need for a formal complaint taking place. Therefore the two entry points into the complaints system are outlined below and the Statutory Complaints & Information Governance Officer monitors the progress of all cases at either entry point.

Our aim is to resolve complaints within 20 working days for most complaints, and within 3 months for complex complaints.

Once the single stage process has been concluded and if dissatisfaction still remains, the complainant has the right to refer their complaint to the Local Government & Social Care Ombudsman (LGSCO) for further consideration. The LGSCO is the independent organisation authorised to investigate complaints where the council's own investigation and response has not resolved the issues to the complainant's satisfaction.

Complainants do have the right to approach the LGSCO at any time; however the Ombudsman's policy is that the local authority should be given the opportunity to consider the complaint first. It will normally refer complaints back to the council to investigation unless exceptional circumstances apply.

5. Alternative Dispute Resolution (ADR)

Should a complainant remain dissatisfied with the outcome of their complaint the case is initially referred to the Complaints Manager for review. It is at this stage that ADR is considered and implemented if it is appropriate to do so.

This can include the Complaints Manager providing conciliation and mediation, in agreement with the complainant and the service, in order to resolve any further issues without the need for referral to the Local Government & Social Care Ombudsman.

In the reporting period there was one ADR undertaken:

	Service Provision	**No of hours**
Case 1	Early Intervention & Prevention Team	4
		4

6. Advocacy for vulnerable people

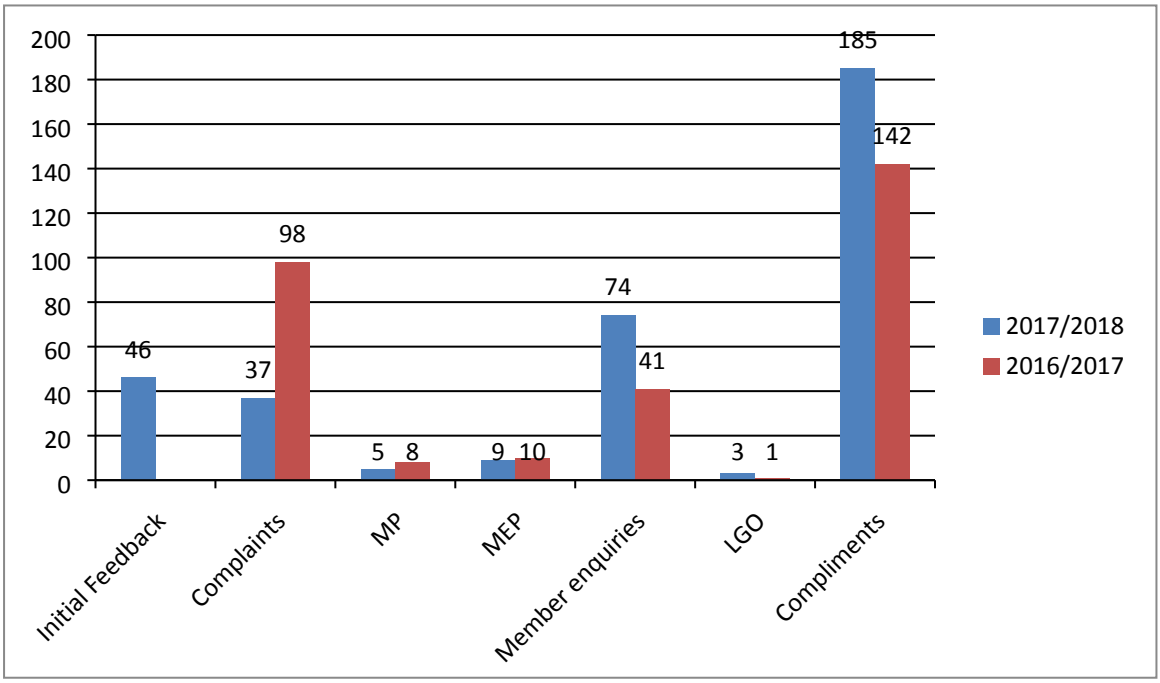
The council commissions advocacy services including Mental Capacity advocacy encompassing Deprivation of Liberty Safeguards. It is available for people who have substantial difficulty in understanding decisions that need to be made or in expressing their views, when there is no one else who can assist or speak on the person's behalf.

The scope of our contract covers older people with mental health aged 65 and over, adults of working age with mental ill health and adults who have a learning disability or sensory impaired aged over 18 years.

The service is independent of statutory organisations and service provider agencies. POhWER is the main commissioned provider for advocacy within Thurrock and support service users with various concerns and queries across a range of services including housing, social care and debt management.

7. Summary of Representations

7.1 A total of 404 representations were received in the reporting period. This is attributed as follows:



7.2 During the 2017/18 financial year, Thurrock's Adult Social Care Services received 37 new complaints. This is a decrease of 61 compared to the previous year. Data regarding Grays Hall has not been included within this figure, please see 7.4.

7.3 Of these 37 complaints, 25 were related to the council's adult social care in-house service and 12 were concerning commissioned providers. The dashboard titled 'Commissioning & Procurement' illustrates a total of 14 complaints received, 2 of these related to the council's own Contract Team and the remaining 12 were commissioned providers.

7.4 <u>Adult Social Care In-House Service</u>

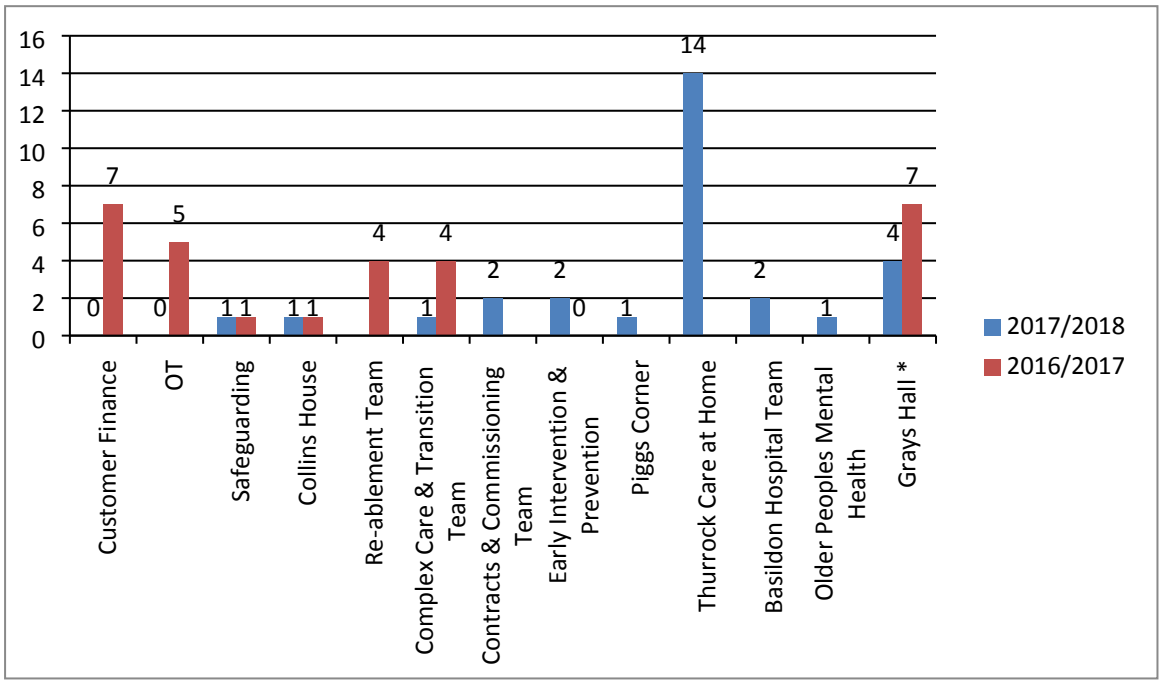
Analysis on adult social care in-house services as shown that root causes relate to:

- Quality of service/care
- Staff conduct

- Decision making
- Missed appointments.

- The dashboard titled 'Day Care, Extra Care, Thurrock Care at Home & Joint Reablement Team' depicts that 16 complaints were received, 14 complaints (56%) were received for Thurrock Care at Home with the remaining 2 for the other services. Thurrock Care at Home's complaints related to the following:
    - 8 related to missed appointments,
    - 3 communication breakdown,
    - 2 staff conduct
    - 1 service delays.

In all instances for complaints regarding adult social care, the complaints procedure may be superseded by the safeguarding procedure if a referral is made which identifies safeguarding alerts. The complaint will be placed on hold awaiting the outcome of the safeguarding investigation.



(*Complaints regarding this service are not managed by the council and follow a different process.)

7.5 <u>Commissioned Providers</u>

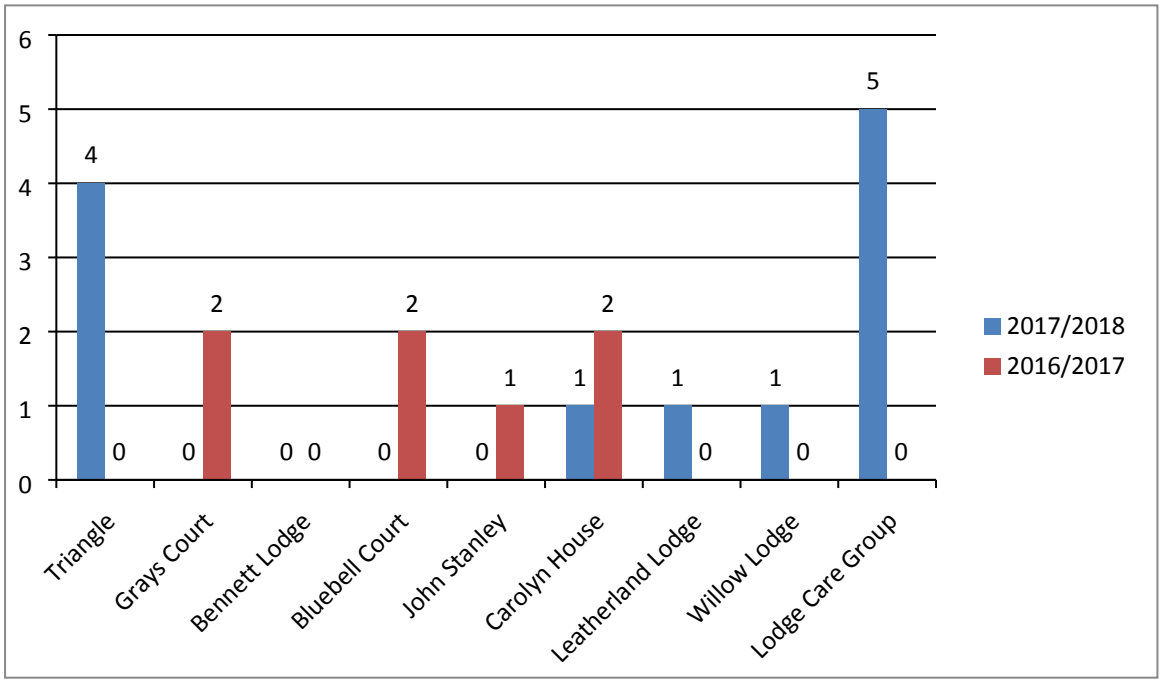
Analysis on commissioned providers has shown that root causes relate to:

- Late appointments
- Quality of care
- Staff conduct
- Missed appointments
- Communication

- 5 complaints (42%) were received for Lodge Care Group:
  - 3 related to quality of care,
  - 1 missed appointment
  - 1 staff conduct

- 4 complaints (33%) were received for Triangle:
  - 3 related to quality of care,
  - 1 late appointment

In terms of monitoring and oversight of these complaints, the Contracts Team check providers' complaint policies to ensure they have procedures in place. A sample is then cross checked to ascertain whether they have been investigated appropriately and that this outcome has been communicated to the complainant. Initial feedback is also captured.



7.6 The Care Quality Commission requires all care providers to have in place clear and robust complaint procedures. Anyone who receives a service from an external provider will usually complain to the provider and these will be responded to in accordance with the provider's own complaints procedure. The Contract & Compliance Team closely monitor these services in accordance with the statutory contractors monitoring framework.

7.7 The council commissions independent care home providers for service users requiring residential care, based on an assessment of their individual needs. The Home Provider investigates any complaints in line with their own complaints procedure.

7.8 There is a high demand for home care within Thurrock and the commissioned provider agencies work closely with Thurrock's Commissioning and Contract Team to ensure that service users receive care packages that directly meet their

needs. The Contract, Compliance Monitoring Team are key to ensuring that any complaints received are thoroughly investigated.

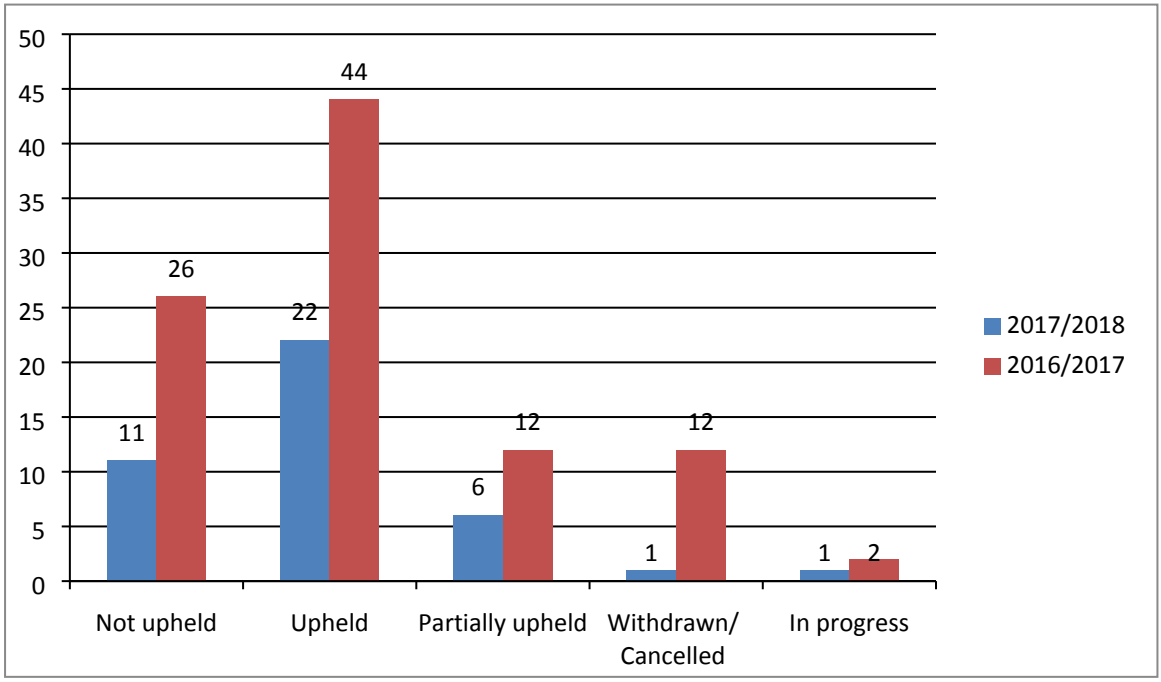
8. Risk assessment of complaints

8.1 The Complaints Team undertake a risk assessment of each complaint in order to ascertain the seriousness of the issues raised and to ensure the appropriate course of action is taken.

8.2 Any complaint that raises significant issues regarding the quality of care, safeguarding issues, denial of rights, or has clear quality assurance or risk management issues that may cause lasting problems for the organisation, or highlights the possibility of litigation/adverse local publicity, is highlighted immediately to senior management. Where appropriate, it follows the council's safeguarding procedures.

8.3 If a Safeguarding investigation is already underway, or deemed necessary in relation to the same concerns being raised by the complainant, then the Safeguarding investigation will take precedence. The complainant is then advised to refer the matter back to the Complaints Team if the investigation outcome has not resolved their concerns.

9. Complaint outcomes



9.1 There were a total of 39 complaints that were investigated and resolved during 2017/2018. There is 1 complaint in progress at the time of this report.

9.2 A total of 11 complaints were not upheld.

9.3 A total of 28 complaints were either upheld or partially upheld. Learning is required form the relevant service for all cases that fall into these categories.

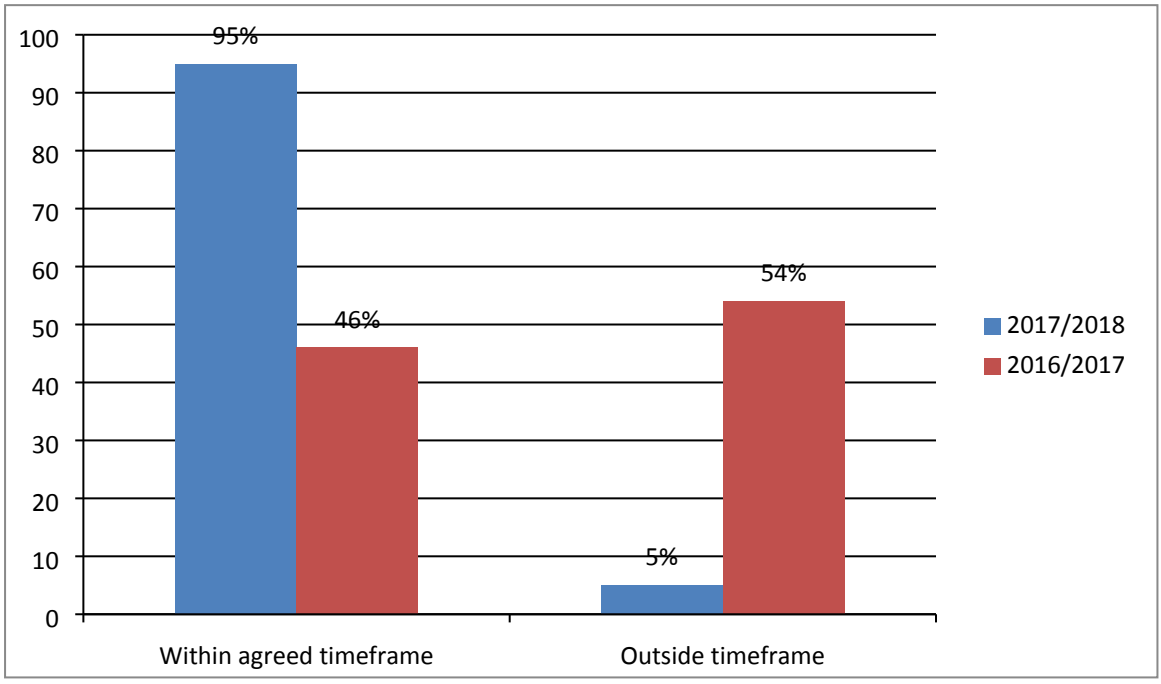
9.4 Of the 22 cases that were upheld, these related to:

7 for missed appointments
4 for communication
3 quality of care
3 for assessments
2 related to quality of service
2 staff conduct
1 service delays

9.5 Of the 6 cases that were partially upheld, these related to:

2 for quality of care
1 for communication
1 for late appointments
1 quality of service
1 staff conduct

10. Complaint timescales



10.1 The council remains committed to ensuring that adult care services address complaints as soon as possible and that investigation deadlines do not compromise the quality of any investigation. The Complaints Team continue to track progress of all active complaints and will provide advice, guidance and support as and when required.

10.2 The Complaints Team continue to provide a quality checking service for all investigating officers to ensure that all of the issues have been answered, that corporate standards are followed and that the complainant is aware of the next steps available to them should they remain dissatisfied.

11. Learning from complaints

11.1 Complaints provide a vital source of insight about people's experience of social care services, and how those services can improve.

11.2 Services are required to outline learning from all upheld or partially upheld complaints; these are submitted to the Complaints Team who will track and monitor learning outputs. This helps improve staff learning and professional development and identifies any service improvements

11.3 Case studies are shaped and some are publicly available on the council's webpage for review. Some case studies are attached for information.

12. MP, MEP & Members Enquiries

	2017/2018	% on time	2016/2017	% on time
MP	5	5 (100%)	8	5 (63%)
MEP	9	8 (89%)	10	5 (56%)
Members	74	71 (97%)	41	31 (76%)

12.1 MP, MEP & Members enquiries are received on behalf of services users and as of 1 September 2017, services have 7 working days to issue a response rather than 10 working days.

The complexity of a complaint may mean that targets may not be able to be reached however the data above evidences strong commitment from services to respond within timeframes and this is a significant improvement from previous years.

13. Compliments

	2017/2018	2016/2017
No of compliments	185	142

Service areas	Number of compliments 2017/2018
Blue Badge Team	1
Disabled Facilities Grant Team	6
Early Intervention & Prevention Teams	12
Local Area Coordination	4
Public Health	1
Rapid Response Assessment Service	3
Collins House	23

Reablement Team	34
Thurrock Care at Home	71
Basildon Hospital Team	9
Thurrock First	5
Occupational Therapy Team	2
Social Work Intervention and Transition Team	3
Grays Court Care	1
Willows Lodge	1
Safeguarding Team	2
TLC	1
Older People's Meath Health Team	6

13.1 Compliments help to highlight good quality service and give staff encouragement to continue delivering services of the highest standard particularly at challenging times and when faced with competing demands.

14. Local Government & Social Care Ombudsman

	2017/2018	2016/2017
LGO enquiries received	3	1

14.1 The Local Government & Social Care Ombudsman cannot question whether a Council's decision is right or wrong simply because the complainant disagrees with it. The LGSCO must consider whether there has been fault in the way the decision was reached. If there has been fault, the LGSCO considers whether this has resulted in injustice and will recommend a remedy, this can be monetary and/or otherwise.

14.2 The reporting period has seen an increase in the number of formal enquiries considered compared to the previous year.

Case 1: Complaint about a commissioned care home regarding managers and staff not communicating with the family, unprofessionalism, incomplete and inaccurate records about Mr B's care and not enough skilled or trained staff. The Ombudsman advised they would not investigate Mrs A's complaint as it was unlikely they could add to the care provider's response. *Outcome – discontinued investigation*

The remaining two cases are ongoing at the time of this report.

15. Work Priorities for 2018/2019

During the year 2018/2019 the Complaints Team will continue to focus on:

- Supporting services by undertaking the initial assessment and subsequent complaint plan agreement with complainants to instil confidence and evidence transparency of the complaints procedure

- Improved monitoring of active complaints and initial concerns to ensure swift resolution and supporting service areas wherever possible

- Robust monitoring of corrective actions that have arisen from complaints to ensue continuous service improvements can be made and uploaded onto the council webpage

- Working with service areas and in consultation with staff to ensure timely responses to MP, MEP & Members enquiries

- Provide advice, guidance and support though training and/or workshops as appropriate

- Ensuring that learning from upheld complaints is evidenced and made publicly available on the council's You Said We Did section of our webpage.

- Continuous review of data quality for all types of adult social care feedback.

Complaint case studies

Mr A, a service user wished to have earlier morning care calls. Mr A requested that the care agency contact him to discuss this further however no contact was made.

The investigation concluded that one of carers was unable to facilitate an earlier appointment, due to the residential locality of another member of the team and a time specific medication call prior to Mr A's. Due to human error, the agency had overlooked contacting Mr A to inform him of this.

The service advised that moving forward Mr A's calls would be as close to his requested time as possible, however this might need to be provided by another team. An apology was extended for the breakdown in communicating this to him.

The service stated that all contact staff have been reminded of the importance of effective communication with Service Users and a new system has been implemented to track incoming correspondence/telephone calls to ensure appropriate call backs are made

Mrs O, a service user expressed her concerns that her care calls were being completed for the allotted time of 30 minutes

The investigating officer reviewed Mrs O's call log records and advised that she was receiving her allocated call time. However, there was some evidence to suggest that some calls were less than 30 minutes.

The carers have been reminded that they need to deliver the full 30 minutes of care. An apology was provided for any inconvenience caused.

The above actions should ensure there are no further incidents of this nature.

A relative of Mrs R, a service user, complained that her medication was not administered correctly

The investigation concluded that when the carer attended Mrs R, she refused to take her medication and informed the carer that she would take them later; the medication was left with Mrs R by the carer. The carer advised a relative of Mrs R's was present and she believed they would help her to take the medication at a later time.

The service acknowledged that the medication should not have been left with Mrs R as this does not follow the correct process.

As a result of this complaint, the carer was reminded of the important of adhering to the medication policy and this incident should not occur again.

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6 September 2018	ITEM: 12
Health and Wellbeing Overview and Scrutiny Committee	
Mental Health Peer Review	
Wards and communities affected: All	**Key Decision:** Yes
Report of: Roger Harris : Corporate Director - Adults, Housing and Health	
Accountable Assistant Director: Les Billingham – Assistant Director Adult Social Care and Community Development	
Accountable Director: Roger Harris : Corporate Director - Adults, Housing and Health	
This report is Public	

Executive Summary

Thurrock Council, in conjunction with Thurrock Clinical Commissioning Group (CCG), invited the Local Government Association (LGA) to undertake a Peer Review of the wider mental health provision in Thurrock to see whether it was meeting the needs of Thurrock residents.

The review was undertaken between 12 and the 14 June 2018 and attached at Appendix 1 is a copy of the slide presentation received at the end of review feedback session which summarises the findings and recommendations of the review team.

1. Recommendations :

1.1 Health and Wellbeing Overview and Scrutiny Committee are asked to comment on the findings of the Mental Health Peer review.

2. Introduction and Background

2.1 Officers for some time have felt that the wider mental health provision in Thurrock needed reviewing. We have had our existing arrangements with the mental health trust – Essex Partnership University NHS Foundation Trust (EPUT) for over 10 years and seconded our social care staff (approx. 20 staff) to EPUT as part of a Section 75 agreement.

2.2 Adult social care has been on a significant transformation journey and recently this has been joined with the CCG transformation plans to become a single programme - under the banner of “For Thurrock in Thurrock”. There

was a view that the service model for mental health had lagged behind the progress being made by FTIT in other parts of health and social care delivery.

2.3 Equally, we were very aware from the discussions with services users, third sector organisations and Thurrock Healthwatch that the demand for mental health support was growing but that people were finding it hard to access services when they wanted them.

2.4 Recent initiatives such as Inclusion Thurrock, the Recovery College and Local Area Co-ordination (although not specifically a mental health focussed offer) were getting very good feedback from service users but it was felt that the whole pathway need an external check and challenge to ensure that it was fit for purpose and was sufficiently community focussed.

2.5 Adult Social Care locally and nationally has been under considerable pressure for many years as demand has grown and resources have been stretched. Recent financial support in terms of the adult social care precept and the Better Care Fund have been very welcome but little of this had gone into mental health support as the urgent need was to support the growth in demand for services in domiciliary and residential care. This will be reviewed as part of the Directorate's response to the Peer Review findings.

3. Issues, Options and Analysis of Options

3.1 Thurrock invited the LGA to undertake the Peer Review and an expert team was assembled. The Review Team were :

- Ian Winter CBE – Independent consultant.
- Cllr Philip Corthorne – Cabinet member for Social Services, Housing, Health and Wellbeing, London Borough of Hillingdon.
- Carline Taylor – Director of Adult Services and Housing (Torbay Council).
- Helen Maneuf – Assistant Director, Planning and Resources (Adult Care Services) Hertfordshire County Council.
- Bryan Mitchell – Charity Co-ordinator, My Life My Choice – Oxfordshire.
- Katherine Foreman – Independent Nurse, Medway CCG.
- Jonathan Trubshaw – Peer Review Manager, LGA.

3.2 A significant amount of work was undertaken prior to the visit to ensure that the team met as wide a range of people as possible and the views of as many people and organisations as possible could be assembled. The timetable and the list of people seen is listed in the Appendix. It was also extremely helpful that the Public Health team had just completed the JSNA mental health which provided an excellent overview of the current demands, pressures and service gaps locally – this has been to HOSC previously.

3.3 We are very grateful to the Thurrock Coalition and to Thurrock Healthwatch who arranged for a series of questionnaires to be completed prior to the visit to give some depth to the interview sessions and get people thinking in

advance of the issues they wanted to raise. This meant the interview sessions, especially with users and carers where especially valuable.

3.4 The finding of the review were summarised into 9 “Areas for consideration” :

- Commissioners to develop an improvement plan for EPUT as a provider in Thurrock;
- Develop joint commissioning arrangements between the Council and the CCG;
- Commission for the “middle” of mental health needs;
- Create a Mental Health Programme Group, including children and transition, to ensure the elements of an improvement plan are coordinated to overcome current fragmentation of initiatives, including the JSNA recommendations;
- Develop service user involvement further e.g. in training, remunerated participation in project groups, reviews and inspections;
- Thurrock Council and CCG to agree new operating model which develops referral routes and new pathways whilst managing demand in the system;
- Drive innovation for Thurrock Mental health, which matches Adult Social Care Transformation;
- Capitalise on the “place at the table” to push models of integration in the STP. Recognise risk of NHS changing footprints and requirements in the next 10 years;
- The current model of social work needs urgent revision; social workers need support to practice with support in crisis incidents and bed finding.

3.5 Broadly officers support these set of recommendations and work has already started on most areas :

- Senior meetings are taking place between the Council and EPUT to look at reviewing the current operating model and the wider mental health pathway;
- In consultation with EPUT we are looking to include mental health staff in the proposed Integrated Medical Centres;
- A finance and performance sub-group has been set up to look at reviewing the current KPIs and how the existing system is performing and developing a more outcome based set of indicators;
- A stated above the mental health JSNA has recently been agreed which gives a great deal of useful information about current provision and future demand. The Director of Public Health is bringing together the Peer Review and JSNA into a single Action Plan;
- The Director has asked that a more detailed financial summary is produced to see how much money we are spending on mental health and how this compares with other areas. We have not, as a Council, prioritised this area for growth recently due to other pressures;
- We are urgently seeking to fill the vacant commissioning post.

As stated a more detailed Action Plan will come back to the October Cabinet which will also include consideration as to whether we should extend the current Section 75 with EPUT or not.

4. Reasons for Recommendation

4.1 The recommendations at this stage are only to comment on and note the recommendations of the Peer Review. Generally the view of officers is to support the findings of the review and a detailed action plan is being produced which will come back to the October Cabinet.

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

5.1 The Peer Review team undertook extensive consultations with staff, members, users, carers and third sector groups as part of their on-site investigations.

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

6.1 Mental health and wider support for vulnerable people has been identified as a key corporate priority for the year ahead.

7. Implications

7.1 Financial

Implications verified by: **Roger Harris**

Corporate Director : Adults Housing and Health

The report is for noting at this stage.

7.2 Legal

Implications verified by: **Roger Harris**

Corporate Director : Adults Housing and Health

The report is for noting at this stage.

7.3 Diversity and Equality

Implications verified by: **Roger Harris**

Corporate Director : Adults Housing and Health

The report is for noting at this stage.

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

N/A

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

N/A

9. Appendices to the report

Appendix 1 - Slide pack summary of review findings and recommendation

Report Author:

Roger Harris

Corporate Director

Adults, Housing and Health

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Local Government Association

Thurrock Council Adults Social Care – Mental Health **Peer Review Report**

June 2018

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Executive Summary

1. Thurrock Council requested that the Local Government Association undertake an Adults Social Care Peer Review at the Council and with partners that specifically focussed on the work to support adults with mental health issues. The work was commissioned by Roger Harris, Director of Adults, Housing and Health and he was the client for this work. He was seeking an external view on how the Council and its partners primarily in the NHS identify and make changes to both the adults mental health offer and the way the service is delivered and managed.

2. One of the areas Thurrock wished to test through the peer review was whether the current mental health 'offer' was fit for purpose and the extent to which it prevents as well as reacts and deals with the whole person, taking account of key areas such as housing, employment, social isolation and physical health, all of which contribute significantly to identifying a sustainable, long term solution for the individual.

3. The Public Health team published a Joint Strategic Needs Assessment on Mental Health in February 2018. The key findings of the JSNA are:

    - The mental health offer is fragmented;
    - There is under-diagnosis and variation in diagnosing mental health – there is a wide range of diagnoses between GP practices;
    - Quality of care is not always in line with the highest standards; and
    - A better understanding of the link between long-term conditions and mental health in particular is required.

4. The peer team was impressed with the commitment of the elected members that they met and the passion of the Chief Executive and Director of Resources for addressing the mental health needs of the people of Thurrock. There was a clear vision expressed by all the leadership team with the challenging aim to ensure that, "no one is left behind".

5. There was a cross-party commitment to health and social care and this was evident in the support for initiatives to address mental health needs. It was reported by some of the people whom the team met that the scrutiny function could be somewhat adversarial in nature. There may be opportunities for elected members to adopt a more outward looking and enquiring style in its work which could enhance their approach to scrutinising the Mental Health offer.

6. The team saw significant evidence of the council's Transformation work, building on a "strengths based approach" through initiatives such as the introduction of the Local Area Coordinators and through close working relationships with local community organisations. However, this has yet to be transferred into Mental Health services and more needs to be done to support those in the community who are at risk of escalating into crisis. The maintenance of high NHS thresholds is seen by service users as an obstacle in accessing more general, prevention services. There is a need for a clear action plan to drive forward the required improvements in the MH offer, so that it achieves the articulated vision. The big challenge here is to modernise and

personalise the seconded and commissioned services in the partnership (Section75) between the Council and the current NHS provider.

7. The team was impressed with the council's ability and skill to agree a four year balanced budget and recognised this achievement, particularly given the wider context of the challenges to public sector finance. Nonetheless, savings are being applied to Adult Social Care (ASC) and these will have implications for the wider service offer.

8. It was evident from all the people that the team met there was a strong pride in their community. Although people identified with their own 'urban village' within the overall area of Thurrock there was a commitment to the people around them. The workforce is relatively stable with many people who had come to work for the council remaining for a number of years; building knowledge of their local communities and developing strong inter-agency relationships.

9. The team considered that the council had the right people participating in the Health and Wellbeing Board (HWB). Though it was also recognised that it was not functioning to its maximum capacity. The HWB could benefit by refocussing on Thurrock's response to immediate and longer term mental health issues and supporting strong and consistent leadership based on transforming the care right across all adult services, including in seconded and commissioned Mental Health services.

10. Healthwatch involvement in the Mental Health agenda was strong and they have a standing item on the scrutiny committee's agenda. This could be further built on so that the scrutiny process and the work of the HWB could become more proactive.

11. The team recognised the commitment of the council's leadership on the Mental Health agenda, bringing in the components of Adult Social Care (ASC), Health, Housing and the influences of the economic environment. This is supported by skilled analysis and information from Public Health. This provides a basis for developing challenging and more robust relationships with partners in the development of services.

12. The team recognised the tension of a stretched leadership team wishing to focus on the transformation of Thurrock and the call to participate in a complex set of Sustainability and Transformation Partnership (STP) and other arrangements of a wider geography. Thurrock may not be able to sustain its local innovations unless they are perceived as part of a set of solutions within a wider geography with the NHS and are urged to play a full leadership role within the wider NHS/Social care environment.

13. An important start to achieve more rapid change would be to strengthen the commissioning/programme management support to Mental Health services. This is best done in partnership with the CCG. While there is a need to re-establish some of the "harder" elements of a transactional contract relationship with the NHS Trust provider, there is also a need to rapidly challenge and then develop a firm commissioning framework based on outcomes for people.

14. Thurrock's current arrangements for statutory adults' mental health services are not unusual. The concerns and frustrations expressed and experiences of individuals would be common to many local authority areas across England. Mental health provision is combined as part of a large provider (EPUT) within an NHS governance provision. Social care is provided by the local authority in-house, with a number of commissioning contracts in the independent sector. There is no straightforward structural solution to ensure that the resources and processes at Thurrock's disposal achieve the right outcomes for the people of Thurrock and their mental health. The report outlines a number of areas to be strengthened and partner collaborations which can be re-thought to achieve better outcomes for communities of Thurrock.

Report
Background

15. Thurrock's Mental Health offer for adults of working age is delivered through a section 75 agreement between the Council and Essex Partnership University Foundation Trust (EPUT). The Council's mental health social work staff (ASW) are seconded to EPUT and based at Grays Hall, EPUT's Thurrock base. Older People's Mental Health services are delivered from and by the Council with EPUT employees as part of the team.

16. An initial Mental Health strategy was developed in 2012 across South Essex. This was a partnership strategy and included South Essex PCTs, Essex County Council, Southend Borough Council, and Thurrock Council. The Strategy was overseen by a mental health steering group with the lead partner being Southend Council. The Strategy recognised that a significant amount of work was required to improve service provision and it was agreed to work in partnership with the South Essex Partnership NHS Foundation Trust (SEPT) to re-model provision. This had limited success which then led to a wider review of services.

17. Following the NHS restructure and establishment of Clinical Commissioning Groups (CCGs), the seven CCGs across greater Essex, three local authorities and two mental health providers (South Essex Partnership NHS Foundation Trust – SEPT, and North Essex NHS Foundation Trust – NEPT) commissioned a formal review of mental health services in 2015 in order to assess the current state of those services and make recommendations for a way forward. The review found that commissioning and service provision was fragmented across Essex, with no clear focus regarding integration together with significant financial challenges.

18. A number of recommendations were identified as a result of the 2015 review. These included simplifying commissioning arrangements and working better across commissioning organisations. Following the review, a decision was made to develop a joint Strategy to deliver mental health services across all ten partner organisations. This resulted in a Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021, which reflected the direction of travel contained within the Five Year Forward View for Mental Health. It was agreed that whilst the Strategy itself spanned greater Essex (e.g. the totality of Southend Council, Thurrock Council and Essex County Council boundaries), each area would have its own implementation plan.

19. Following a decision not to retender for a provider to deliver the mental health offer, the two Mental Health Trusts announced their intention to pursue a merger – which would offer the opportunity for service redesign. The merger was completed in 2017. Whilst there has been change over the years through strategy redevelopment and organisational restructure, the 'offer' and model used to deliver it is seen by Thurrock in their position statement as very traditional and lacking in flexibility and creativity. In reality the newly formed Trust has been mainly consumed by its internal issues of merger and financial stability. There is an emerging acceptance that a new focus on service development in Mental Health is needed.

Scope:

20. The Council's delegated Statutory Duties relating to Adult Social Care under the Care Act 2014 are delivered by Essex Partnership University Foundation Trust through a Section 75 Partnership Agreement.

21. The Council asked the peer review team to comment on the following areas within the current model of metal health service delivery:

    - The extent to which the current service 'gate keeps' with thresholds set so high as to prevent a significant group of people from accessing required support;
    - The extent that current arrangements and organisational culture delivers a person-centred, strength-based approach – including a focus on delivering outcomes and a move away from 'one size fits all';
    - To what extent the current 'offer' needs to expand – both to respond to the recent Mental Health Joint Strategic Needs Assessment and the extent to which the market is robust enough to deliver against this;
    - The extent to which the current offer is holistic – e.g. deals with both the MH condition and with the underlying conditions which we know exacerbate or contribute towards the needs.
    - The extent to which the service is preventative, not just reactive, in its approach;
    - The interface between other key partners – e.g. housing and primary care;
    - The extent that the Section 75 (including robustness of governance, decision making arrangements and the delivery of delegated statutory duties) is fit for purpose and possible areas of change; and
    - To what extent current partnership arrangements are working effectively – both in terms of provider (Essex Partnership University Foundation Trust – EPUT, and commissioning (Thurrock CCG/Thurrock Council).

22. A peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.

23. The members of the peer review team were:

- **Ian Winter CBE** – Independent Consultant (formerly Director of Social Services and Senior Civil Servant)
- **Cllr Philip Corthorne** – Cabinet Member for Social Services, Housing, Health and Wellbeing London Borough of Hillingdon
- **Caroline Taylor** – Director of Adult Services and Housing, Torbay Council
- **Helen Maneuf** – Assistant Director – Planning and Resources (Adult Care Services) Hertfordshire County Council

- **Bryan Michell** – Charity Coordinator, My Life My Choice, Oxfordshire
- **Katherine Foreman** – Independent Nurse, Medway CCG
- **Jonathan Trubshaw** – Peer Review Manager, Local Government Association

24. The team were on-site for three days from Tuesday 12th June to Thursday 14th June 2018. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

- interviews and discussions with councillors, officers and partners
- focus groups and interviews with managers, practitioners, frontline staff and people using services and their carers
- reading documents provided by the Council, including position statements developed by the council and by the Thurrock Coalition.

25. The peer review team would like to thank staff, people using services, carers, partners, commissioned providers and councillors for their open and constructive responses during the review process. The team was made very welcome and would in particular like to thank Ceri Armstrong, Senior Health and Social Care Development Manager and Deirdre Whyte for their invaluable assistance in planning and undertaking this review.

26. Our feedback to the Council on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the review in response to the eight points set out in the Scope that Thurrock asked the peer team to consider.

Thresholds

27. The team recognised that thresholds for accessing various levels of support for Mental Health (MH) issues had been set and applied. However, there was some disagreement as to how the thresholds were met and this has resulted in a lack of consistency in how they were applied.

28. The team heard differences in perception of what was considered to be a "crisis", how this was determined by the individuals working with the service user and also in the understanding of how the threshold criteria were then applied. This was the case at both individual and service level understanding. Further clarity about the threshold definitions would be a priority activity, but needs to be done with the direct involvement of service users/3rd Sector colleagues.

29. There appeared to be an open referral system from Local Area Coordinators (LAC), which is an Adult Social Care (ASC)-led approach now embedded within Thurrock for people with lower level care and support needs. The LACs aim to connect people into their local communities and to access opportunities aimed at supporting them to sustain their independence. However, it was unclear to the team what the threshold levels were for this service, although it was understood to have been designed to support 'vulnerable people', typically those with: feelings of isolation, depression, physical disability, sensory impairment, learning difficulties and more complex mental health problems. The impression was that the service was for anyone who felt they needed some help and that the support on offer did not appear to be time limited. A clearer and more widely communicated understanding of the LAC offer may benefit those delivering, referring into and receiving the service.

30. The team heard evidence from service users that when high level need was identified; they perceived that the service they received from Grays Hall (the acute MH provision) was good. This was evidenced from a number of sources.

31. However, the team heard from service users, carers and some frontline staff that the Crisis Team was seen as the 'gatekeepers' of access to MH services and that they maintained high thresholds, which denied those in lower levels of need access to services that might prevent their condition escalating. Some service users described Grays Hall as being "impenetrable", which caused them and those caring for them increased distress and increased effort in putting their case forward. Service users stated that if they did not meet the threshold for being allocated a bed then getting access to other services was very difficult.

32. The Essex Partnership University Trust (EPUT) made the team aware that Grays Hall does not operate a crisis line. This was not the perception of the service users whom the team met and it was heard that people in crisis may be directed to attend Grays Hall by other partners in the system, for example Housing staff. More needs to be done urgently to ensure that those wishing to access services or may potentially wish to do so in the future have clear

information about what is available to them and who enables them to access it.

33. The GP referral system was described by both front line staff and service users as building in delays and uncertainty into the process. The view expressed to the team was that the model adopted was medically driven and did not fully align to ASC or the aspirations of individuals. Whilst it was recognised that managing demand and shaping demand to meet the resource available was necessary, the team heard a number of times that the GP gateway was not easy to get through. There is now a need to open up other referral routes; although this would need to be done as part of an holistic review and change of the system supporting MH provision.

34. The performance information that the team saw was not clearly based on outcomes for people. This needs to be addressed so that individual workers can demonstrate how service users are benefiting from specific interventions and managers can clearly see how the service is delivering for the people of Thurrock in line with the stated aims and aspirations. There needs to be a clear, robust and defendable performance management system that will drive and determine future action.

Person-centred, Outcome Focussed

36. The introduction of the LACs was widely considered a strength and that they contribute significantly to a person-centred service. The team heard examples of where the LACs work with individuals was perceived to have prevented a deterioration of the person's circumstances into crisis and other examples of outcome focussed support. Examples included; a homeless individual with a complex MH illness who was helped to access benefit payments and housing. Another example was of a man who was released from prison with a supply of medication without being linked to either a GP surgery of community mental health team and the LACs were able to arranged this However, some service users reported LACs were not always easy to get hold of or able to respond to requests quickly enough. There may need to be further communication on how the LAC resource is used, so as to manage expectations both internally with other frontline staff and with service users. There were also reports of some inconsistency in approach and skill level between different LACs. The team also acknowledge that the LAC programme is designed to respond to individual and locality need and that therefore some variation is inevitable. More could be done to ensure the overall programme is managed so there is a more consistent standard of offer.

37. The team heard evidence of individual social workers putting in significant effort to ensure the people they work with were cared for in a personalised and appropriate way. However, needs to be more challenging discussions with managers to ensure that social workers focus on the complex issues and cases. Those with less complex needs should be signposted to other MH support arrangements and interventions.

38. In the team's view there needs to be greater clarity about what is required of social workers in the MH service to both ensure statutory requirements are met and the priorities and transformation programme is fulfilled. Social work practice and values as a profession need to be more robustly asserted and owned within the EPUT arrangements, including support to staff working within the Grays Hall team. The team was told that "the nursing and social work roles at Grays Hall are indistinguishable, other than that the nurses give injections" and that social workers at Grays Hall seem to have "lost their compassion" because of process driven top-down mechanisms of the NHS Trust. The team received evidence that staff seconded to EPUT were seen as separate from the council. Seconded staff were working to a medical model of care rather than the ASC transformation model that has been undertaken elsewhere in the council and which promotes a strengths-based approach. The work already undertaken in Thurrock, including the Chief Social Worker initiative, is strong and should be used as a catalyst to change the dynamic that currently exists within the present arrangements. The team acknowledged that significant change has occurred in EPUT but more pace is needed.

39. The fact that the Thurrock based services for Mental Health is but a small part of EPUT should not detract from the urgent need for person centred outcome

focused changes in practice and process. This should not wait for any complex/revised S75 arrangements.

40. The team received evidence from both frontline staff and service users that Mind, Inclusion Thurrock (IAPT) and the Recovery College services are well regarded. The work with and by partners was generally regarded as good and that once an individual had been given a diagnosis they were positive about the service that they received. However, getting a diagnosis was seen as not being a straightforward process. Without a diagnosis the services received were reported as being very variable in terms of quality, level of provision and geographic availability, depending on what was available within the community.

41. Cross-party elected member support for the MH agenda and for service improvement was evident. Future potential changes in the requirement for MH services are considered sensitively at the top levels of the organisation and work to develop political relationships is on-going.

42. Housing services reported that they worked well with Grays Hall on individual cases. By the nature of the Grays Hall cases, these were individuals with high levels of need. However, more needs to be done to develop a more preventative approach, particularly for those individuals who do not quite meet the threshold criteria. The team was not aware of a specialist housing plan for individuals with MH issues that builds on the existing positive work in Housing.

43. The team noted that Thurrock has low numbers of rough sleepers. Whilst this is commendable there could be more done to understand the reasons for this and how people access services once coming to the council's attention.

44. The team considered that there was some effective preventative provision for vulnerable people who may have a heightened risk of homeless. There is an outreach worker who is responsible for identifying rough sleepers and working with them to find housing solutions. This is a shared resource with Basildon, which is building intelligence on hidden homelessness in the borough. However, this was stretched and given the rising demand from the movement of people from inner-London to Thurrock and some evidence of deliberate movement of people by inner London authorities may be of concern for the future.

Market Capacity and Development

45. In the team's view the Joint Strategic Needs Analysis (JSNA) for MH was a strong and robust document that was clearly evidenced based and provides the basis for some clear decision making. There was also a Market Position Statement (MPS) and this too could form the basis of sound decisions; although this may require some updating. However, more could be done to ensure that frontline staff are aware of the JSNA and how this can be used to inform their practice and to take forward the recommendations contained therein. In short, this very useful document needs some straightforward practice based applications and priority suggestions for next steps. There should also be a more detailed analysis of the MH market needs to inform an updated MPS and the specialist accommodation required to support this. There is an appetite and now is the right time to pursue this though a more robust joint commissioning approach.

46. The team noted that the Housing Investment and Regeneration Group recognised vulnerable people and the impact that their living circumstances can have on their MH. There is a proactive in-house housing team dealing with difficult supply issues for those with MH concerns. The team heard that Housing was interested in how the asset based community development work that ACS has taken forward could be applied to MH.

47. The team heard from frontline housing staff that they would appreciate if the personalisation approach and values in that are practiced in ASC could be built on and taken into Housing. More could be gained by considering the individual's needs at the outset and arranging accommodation to meet these.

48. Thurrock has shown innovation in terms of supporting the fragile social care market particularly in Domiciliary Care. Lessons learnt from this could be applied to approaches in addressing capacity within the MH market.

49. The team was impressed with the examples of good practice that were seen during the review, including Community Hubs and strength based conversations that were witnessed in ASC and voluntary sector settings. These need to be aligned and more coherently planned into the overall service model, which includes the nascent, four integrated medical centres. Transformed services must be the driver at the heart of these developments whatever their final configuration.

50. Building on the council's experience in other areas of work there is an opportunity to Invest to Save to deliver accommodation to meet the needs of those with MH issues in Thurrock. The peers considered that a business case could be developed for investment in housing in-borough to avoid potentially more expensive out-of-area placements. This should be an opportunity to explore jointly with colleagues in the Clinical Commissioning Group (CCG), focus could be given to addressing out of area placements. The positive and pragmatic support of the CCG was very evident in this Review and should be capitalised on.

Holistic Offer

52. The team heard that the new combined access point 'Thurrock First' is experienced as responsive and innovative in streamlining pathways into care and support. Thurrock First is a telephone service which acts as a single point of contact for social care, mental health and community services. Feedback regarding the service has been positive and demonstrates a commitment to integrated working. There has been difficulty recruiting to the mental health positions and an opportunity exists to strengthen the offer to local people by incorporating housing.

53. The joint commitment to the development of (four) Integrated Medical Centres was seen as creating a clear vision for how a whole service/system approach, to meet the needs of service users, could be delivered. Although the difficulties in realising this vision were understood the programme provided real opportunities for working more closely together and supporting transformation.

54. The joint funding of the Integrated Care Director was seen as positive and as a commitment to working together.

55. Housing officers reported that there are good opportunities for resolve operational housing issues through the existing forum of the Mental Health Operational Group.

56. There is 70% coverage of social prescribing across GP surgeries and the voluntary sector reported this is having a positive impact and links in with other community resources including practical support in dealing with debt, housing difficulties, weight management, and sexual abuse. An example of strong community leadership is the re-generation of Hardie Park that offers a 'Men in Sheds' initiative, gardening groups and a café with a children's play area.

57. The team was impressed with the work being undertaken with the North East London NHS Foundation Trust (NELFT) and piloted in Tilbury and Chadwell. Opportunities now exist to develop these further with EPUT and this may also help enhance the relationship between Thurrock and EPUT.

58. Secondary Mental Health care needs to benefit from a wider multi-disciplinary approach, where currently the focus is too narrow on specific disciplines. The team also heard from some services users that they perceived there to be a high level of staff turn-over at Grays Hall. The council may wish to consider how changes affecting service users are communicated and what additional support may be required in any hand-over processes.

59. It was clearly recognised that there were incompatibilities between the EPUT and ASC IT and information systems. Staff reported having to put information in twice and of losing information off the system even when it was correctly entered. Duplication of effort causes frustration and there is concern that some records are incomplete. Over the past 6 months EPUT has experienced internal IT issues and has been unable to generate management

reports. In the team's view this has contributed to a disconnect between ASC and EPUT. Steps are now being taken to address communication issues between the two organisations; however the data cleanse is still in process. The team appreciate that the issue is not unique to Thurrock nor is reconciling the two systems necessarily achievable in the short-term. However, ways of working around some of the priority requirements need to be devised quickly.

Prevention

60. The work of the Recovery College and Inclusion Thurrock in supporting people to develop the capacity to cope with their MH issues was seen as positive. The work of Mind was recognised as a significant asset, both within the council and in the wider community. There were requests from service users for Mind to reinstate their offer of a 'safe place' for those with MH issues to meet and discuss their concerns without necessarily needing further interventions. Service users recognised the importance of the services provided by a range of organisations and asked for wider promotion and accessibility for all those in the community.

61. The team heard from frontline staff and providers that there is a cohort of people, who although not presently in crisis may well escalate and require high-level support. These people were not currently receiving services, either through their GP or elsewhere but were struggling and not accessing any preventative support. The team was also told that the Older People's Mental Health service workload does not allow for a focus on prevention. The council, together with the CCG may wish to consider the funding of prevention activities in MH as an invest to save approach. This could include the wider promotion and signposting of existing community support as well as directly facilitating initiatives.

62. The team was made aware that Thurrock First currently had a gap in expertise around MH housing. It may be worthwhile putting in place interim measures to ensure this is filled as soon as possible, whilst a permanent solution is arranged.

63. In the team's view there are opportunities with partners to agree a housing strategy and policy for people with MH issues. It was widely recognised that a person's immediate environment could contribute, both positively and negatively, towards their mental wellbeing. It was reported that; "*The same people float around the system*", whose circumstances are known and if systemic interventions could be made their recovery could be improved.

64. The team recognised that Thurrock has put considerable effort into developing good links with providers and service user groups. These provide useful mechanisms for communicating and gaining views, not least in shaping the preparations and scope for the peer review. However, more could be done to ensure there is greater understanding of the Care Act 2014 and the requirements this places on partners and the impacts this has on those wishing to access services.

65. A number of participants reported to the team that there was improving out-reach in Purfleet and South Ockendon and that Healthwatch was providing useful feedback to prevent direct interventions.

Working with Other Community Partners

66. There was recent evidence of EPUT and local authority actively acknowledging that they urgently need to improve their relationship. The team heard that some forthright communications from ASC had been a key prompt in promoting a more positive attitude towards working together. It was recognised that EPUT had undergone significant change and that as this process evolved there was an increasing ability to focus on external relationships. However, the joint relationship is not yet sufficiently robust to ensure the challenges of meeting the MH needs of the community are adequately addressed and the opportunities that combined effort brings are realised. The relationship between EPUT and the local authority needs recalibrating so that both organisations move on from legacy issues and past working differences. This work is now urgent and must be driven by practical, real and measurable outcomes. Process measures will not suffice. Evidence of this was abundant in this Review. The local authority and the CCG should work hand in hand to set out specific practice based requirements and development plan with EPUT. While emphasising this is a commissioning relationship (i.e. mainly transactional), it is in the interest of all partners to work co-operatively on a practice basis to achieve change, while recognising that where necessary the rigour of contracting may need to be invoked

67. The team received robust evidence of good practice taking place in the community. Some of the examples included: Community Hubs, Social Prescribing, Micro-enterprises, Housing First and Shared Lives. Service users recognised that Community Hubs were places to get information, to connect with others and to use resources, including access to computers.

68. From the meetings with partners the team concluded that there were positive relationships across partners and those involved came with a ‘can-do’ attitude. There was an ability and openness to talk about problems and difficulties that partners were experiencing and that others were willing to support or help where appropriate. However, some of the work appeared to be disjointed and isolated, which is understandable in an environment of innovation. More work could be done to share ideas and link with existing interventions and projects in a consolidating framework. This could build on existing networks and focus what is required, as identified in the JSNA.

69. The Thurrock Coalition was considered to be strong by a range of contributors. The council appreciated that the Coalition provided robust and valuable challenge that effectively contributed to service and care improvements. It was recognised that some of the feedback may be difficult to act upon, including the view expressed from the independent sector about uncertainty regarding future funding and the risk this places on further integration. By engaging earlier so that solutions can be fully co-produced difficult decisions can be jointly owned.

Section 75

70. In the team's view the Section 75 arrangements are the means by which agreed outcomes are achieved. In this respect while there may be merit in re-writing the agreement, the time and effort taken to do this should not outweigh the benefits that may result from the reworking. In short, it may be better to continue with the current agreement but underpin and extrapolate these with more specific outcome based and transformational measures that help to change the actual practice in services.

71. There are already some more beneficial relationships with EPUT, as noted earlier. The Operations Group has been given new impetus and is ready to take on a more engaged role; including provider and service user representation. This gives more opportunity for co-production and jointly developing innovative ideas, building on the work already undertaken to make use of the Better Care Fund.

72. The team could find no evidence of a single reporting and outcomes framework. This is a significant shortfall. There did not appear a clear way of linking performance and outcomes for individuals and for the wider impact of interventions. There are opportunities to work with Southend-on-Sea Borough Council and Essex County Council to create a mechanism that can be used to compare data. There are also opportunities to build on the similarities between Thurrock and Southend-on-Sea (both unitary authorities on the southern edge of Essex and both working with EPUT) to create a single point of contact to help focus and consistently target commissioning issues.

73. In the team's view the current operating model for social work practice appeared to be under some strain in the current working arrangements. There needs to be greater levels of assurance that social care values and approaches are part of EPUT ways of working, including executive board level representation of social work issues. A higher level awareness of social work practice may help address practical issues, including the ensuring that the crisis team is available to support Approved Mental Health Professionals (AMHPs) when they are working with someone in crisis and to minimise the need for AMHPs to be responsible for bed-finding. The Principle Social Worker may also have a role in championing social care values within the wider Health and Social Care partnership.

74. The Team heard that social care staff seconded into EPUT seemed to adopt the health led culture of their host organisation. This health-based influence shapes practice, which can lead to professional tensions. More needs to be done to ensure that social care values and personalised practices are recognised and given equal priority.

Commissioning Arrangements

75. Public Health was considered to be a very significant asset in Thurrock's commissioning work. There is a clear understanding of what needs to be done and has driven the "Case for Change" which has been identified through the JSNA. This was evidenced through the setting of Stretched Quality and Outcomes Frameworks (QOF) for GPs.

76. There are now open opportunities to work together with other commissioners, particularly with those in similar authorities, such as Southend-on-Sea. There are also opportunities to work more closely with EPUT to realise the benefits of a more developed commissioning culture. A clear plan of priority action is required that consolidates the new approach (see para 46) with the management of EPUT, that sets out and monitors what is required from the relationship.

77. There are opportunities to build on the joint commissioning approach with the CCG and to capitalise on the strong relationship. The team heard that due to staffing issues there has been a gap in the Council's commissioning capacity and this needs to be addressed quickly and in partnership with the CCG. The team also saw some evidence that at present the CCG appears to be specifically focussed on commissioning primary and secondary care. Although this may be understandable a more collaborative approach would also more effectively take social care considerations into account.

78. Thurrock has developed a reputation for innovation and the ability to deliver transformation. The council is well regarded by partners and there are opportunities to build on existing relationships developing a co-production approach within the commissioned environment. Now is the time to take the learning and experience of ASC transformation and apply it directly to Mental Health activity. This will get the service in the right shape for innovation and support the fulfilment of the Council's vision.

79. In the team's view there is a need for a clear plan on how the partners will address those people who were described as the "*Missing Middle*"; those with MH issues that are not severe enough for in-patient treatment nor who can function well without support. Subjects that the plan could cover include; access to 24/7 crisis support (for frontline professionals supporting those escalating to crisis in the community), clearly signposted and resourced step-down support, specific support for those with a dual diagnosis. The absence of support for this latter point was seen as a significant gap by stake-holders that the team met.

80. The development of four Integrated Medical Centres was seen as a great aspiration for providing a focus for support to people in their communities. The council may wish to consider, within context of NHS/STP, how realistic is the delivery timetable and how flexible is the service model. There may be options for a different number of centres, whilst still achieving the necessary outcomes for those wishing to access services. Expectations will then need to be managed at the political, organisational and community levels if there is variance to the original concept. There does need to be a realistic and

pragmatic approach that acknowledges further major changes in NHS formulations/organisational shape which may impact on local arrangements and priorities.

Recommendations

- Commissioners to develop an agreed improvement plan with and for EPUT as a provider in Thurrock that clearly sets out expectations and direction through the contractual arrangements using the existing operational group to drive this.

- Develop joint commissioning arrangements between council and CCG specifically to 'beef up' the broad requirements of the existing S75 and set out outcome based performance driven measures.

- Commission for 'the Middle' of Mental Health needs, i.e. emphasise prevention.

- Create a Mental Health programme group, including Children and Transition, to ensure the elements of an improvement plan are coordinated to overcome current fragmentation of initiatives, including the JSNA recommendations.

- Develop service user involvement further e.g. in training, remunerated participation in project groups, reviews and inspections.

- Thurrock Council and CCG to agree new operating model which develops referral routes and new pathways whilst managing demand in the system.

- Drive innovation for Thurrock Mental Health, which matches Adult Social Care transformation. Capitalise on the 'place at the table' to push models of integration in STP. Recognise the risk of NHS changing footprints and requirements in the next ten years.

- The current model of social work needs urgent revision; social workers need support to practice with assistance provided in crisis incidents and bed finding.

Contact details

For more information about the Adult Social Care – Mental Health Peer Review at Thurrock Council please contact:

Marcus Coulson
Programme Manager – Adults Peer Challenges
Local Government Association
Email: marcus.coulson@local.gov.uk
Tel: 07766 252 853

For more information on adults peer challenges and peer reviews and the work of the Local Government Association please see our website https://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care

6 September 2018	ITEM: 13
Health and Wellbeing Overview and Scrutiny Committee	
Establishment of a Task and Finish Group in relation to Orsett Hospital	
Wards and communities affected: All	**Key Decision:** Non-key decision
Report of: Jenny Shade, Senior Democratic Services Officer	
Accountable Assistant Director: David Lawson, Assistant Director of Law & Governance	
Accountable Director: Sean Clark, Corporate Director of Finance and IT	
This report is public	

Executive Summary

Following the announcement that Orsett Hospital will close, Councillor Holloway, Chair of the Health and Wellbeing Overview and Scrutiny Committee expressed that Terms of Reference for a Task and Finish Group to be brought to the Committee for consideration.

1. Recommendation(s)

1.1 That the Health and Wellbeing Overview and Scrutiny Committee establish a Task and Finish Group under the title of review of the future options for Orsett Hospital.

1.2 That the terms of reference (attached as Appendix 1) be adopted.

2. Introduction and Background

2.1 Following the Joint Committee of the five Clinical Commissioning Groups in Mid and South Essex held on the 6 July 2018 it was agreed that Orsett Hospital would close. It was also agreed that Orsett Hospital would not close until the four Integrated Medical Centres are up and running and that no clinical services for Thurrock patients would move outside of Thurrock. This agreement had been consistent with the Memorandum of Understanding agreed between the Council and Health partners in 2017.

2.2 The closure of the hospital will see all healthcare services transferred to new medical centres which will be located across Thurrock, Basildon and Brentwood.

2.3 Thurrock Council currently works alongside Essex and Southend Councils on a Joint Health Scrutiny Committee to review the Sustainability and Transformation Partnership for Mid and South Essex to which Thurrock Health and Wellbeing Overview and Scrutiny Committee Members attend.

2.4 The proposed review of the future of Orsett Hospital will be a Task and Finish Group as defined by the Constitution, and membership will be appointed through nominations by political leaders.

2.5 The Health and Wellbeing Overview and Scrutiny Committee will act as the parent committee to any task and finish group it establishes.

3. Options and Analysis of Options

3.1 The Terms of Reference are not exhaustive and there are options to explore other methods of research and information gathering.

3.2 A Task and Finish Group is the most appropriate body for the review of the future of Orsett Hospital. This option preserves the Overview and Scrutiny Committee's autonomy to undertake its own workload whilst minimising formality and bureaucracy by allowing public meetings to be convened as and when required.

4. Reasons for Recommendation

4.1 This recommendation would represent an effective way for the Council to discharge any formal Member related activity in relation to the review of Orsett Hospital.

4.2 It would also allow the Committee to add an objective viewpoint to the current processes in relation to moving services from Orsett Hospital.

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

5.1 None

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

6.1 The recommendation is seeking to establish a Task and Finish Group that will allow elected members, as well as members of the public representing relevant interest groups, to engage and shape the Council response to the review of Orsett Hospital. This promotes and increases democracy.

7. Implications

7.1 **Financial**

Implications verified by **Jo Freeman**

Management Account Social Care & Commissioning

There are no financial implications in the establishment of the Task and Finish Group as no Member will receive a special responsibility allowance for the duties. Officer time will be required to attend and carry out the work of the Task and Finish Group. Any financial implications arising from recommendations of the Task and Finish Group would need to be assessed when appropriate.

7.2 **Legal**

Implications verified by **David Lawson**

Assistant Director of Law & Governance

The establishment of a Task and Finish Group complies with Chapter 4 Rule 8 of the constitution.

7.3 **Diversity and Equality**

Implications verified by **Becky Price**

Community Development and Equalities

There are no diversity or equality implications related to the establishment of this Task and Finish Group. Appointments will be made through political Group Leaders and any lay co-opted member will be appointed through a fair and equitable process.

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

None

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

None

9. Appendices to the report

Appendix 1: Terms of Reference

Report Author:

Jenny Shade

Senior Democratic Services Officer

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Orsett Hospital Task and Finish Group

Terms of Reference

Aim:
To scrutinise the current proposed closure process of Orsett Hospital to include:

- the proposed transfer of services;
- the timings and the operational position of the integrated medical centres;
- to have a clear focus on the future of Orsett Hospital and to address alternative proposals.

Membership:
6 elected Members (to be decided on politically proportion)

Chair:
The Chair and Vice-Chair shall be elected by the membership of the Task and Finish Group at its first meeting. The appointment will last until the work of the Task and Finish Group is complete.

Duration:
The Task and Finish Group shall continue until such time as all business of the Task and Finish Group is complete. The proposed end date of the Review will be February 2019.

Activities:
The Task and Finish Group will undertake all but not exclusively the following activities:

September 2018	Seek membership nominations from Group Leaders
September/early October 2018	Convene first meeting to: • Meet with Officers and receive general information pack on the Orsett Hospital Issue • Agree any public consultation process (for example focus group) • Invite any witnesses who will be needed to provide background information on the Topic • Identify patient groups affected by closure and seek information from them • Undertake any research on the topic for Task and Finish Group
November 2018	Undertake a site visit to Orsett Hospital
December 2018	Hold witness session with CCG, NHS and Chair of Health and Wellbeing Board
January 2019	Consult with HealthWatch and Thurrock Coalition

Early February 2019	Site visit to proposed locations of the Integrated Medical Centres
February 2019	Meet to formulate recommendations Write report Bring back report to Task and Finish Group/Health and Wellbeing Overview and Scrutiny Committee and Cabinet

Health Overview & Scrutiny Committee
Work Programme
2018/19

Dates of Meetings: 14 June 2018, 6 September 2018, 8 November 2018, 24 January 2019 and 7 March 2019
Dates of Joint HOSC Meetings: 6 June 2018, 19 June 2018, 30 August 2018

Topic	Lead Officer	Requested by Officer/Member
6 June 2018		
Joint HOSC - Mid and South Essex STP @ Southend	Thurrock/Southend and Essex	Officers
14 June 2018		
HealthWatch	Kim James	Officers
For Thurrock in Thurrock - New Models of Care across health and social care	Roger Harris / Tania Sitch	Officers
Verbal Update on Learning Disability Health Checks	Mandy Ansell / CCG	Officers
STP Consultation Verbal Update	Mandy Ansell / CCG	Officers
Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership (STP) for Mid and South Essex	Roger Harris	Officers
19 June 2018		
Joint HOSC - Mid and South Essex STP @ TBC	Thurrock/Southend and Essex	Officers
30 August 2018		
Joint HOSC - Mid and South Essex STP @ TBC	Thurrock/Southend and Essex	Officers
6 September 2018		

HealthWatch	Kim James	Officers
STP Consultation Outcome	Roger Harris	Officers
Young Person's Misuse Treatment Service Re-Procurement	Kevin Malone	Officers
Primary Care Strategy - Thurrock Clinical Commissioning Group	Andy Vowles / Rahul Chaudhari	Officers
Integrated Medical Centres : Delivering high quality health provision for Thurrock	Christopher Smith	Officers
Market Development Strategy - Commissioning a Diverse Market	Sarah Turner	Officers
2017/18 Annual Complaints and Representations Report	Tina Martin	Officers
Adult Social Care : Mental Health Peer Review	Roger Harris	Officers
Establishment of a Task and Finish Group in relation to Orsett Hospital	Roger Harris	Cllr Holloway
8 November 2018		
HealthWatch	Kim James	Officers
Thurrock Safeguarding Adults Board Strategic Plan 2017/20	Levi Sinden / Jim Nicholson	Officers
Adult Social Care Funding : Green Paper Proposals	Roger Harris	Officers
Fees & Charges Report	Andrew Austin / appropriate finance officer	Officers
Safeguarding Annual Report 2017/18	Roger Harris	Officers
Meals on Wheels Provision	Alison Hall	Officers
Thurrock Integrated Care Alliance	Catherine Wilson / Jeanette Hucey	Officers
Cancer Wait Times	CCG / Ian Wake	Officers
Community Hubs and Libraries Strategy	Natalie Warren	Officers

24 January 2019		
HealthWatch	Kim James	Officers
Public Health's Primary Care Transformation Programme	Emma Sanford	Officers
7 March 2019		
HealthWatch	Kim James	Officers

Clerk: Jenny Shade
Last Updated: July 2018

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