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 **7 March 2019**

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

Membership:

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

Ian Evans, Kim James (Healthwatch Thurrock Representative) and Mandy Ansell (Accountable Officer, Clinical Commissioning Group)

Substitutes:

Councillors Alex Anderson, Sue Sammons and Sue Shinnick

Agenda

Open to Public and Press

Page

1. Apologies for Absence

2. Minutes **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 24 January 2019.

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: **27 February 2019**

Information for members of the public and councillors

Access to Information and Meetings

Members of the public can attend all meetings of the council and its committees and have the right to see the agenda, which will be published no later than 5 working days before the meeting, and minutes once they are published.

Recording of meetings

This meeting may be recorded for transmission and publication on the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is to be recorded.

Members of the public not wishing any speech or address to be recorded for publication to the Internet should contact Democratic Services to discuss any concerns.

If you have any queries regarding this, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

Guidelines on filming, photography, recording and use of social media at council and committee meetings

The council welcomes the filming, photography, recording and use of social media at council and committee meetings as a means of reporting on its proceedings because it helps to make the council more transparent and accountable to its local communities.

If you wish to film or photograph the proceedings of a meeting and have any special requirements or are intending to bring in large equipment please contact the Communications Team at CommunicationsTeam@thurrock.gov.uk before the meeting. The Chair of the meeting will then be consulted and their agreement sought to any specific request made.

Where members of the public use a laptop, tablet device, smart phone or similar devices to use social media, make recordings or take photographs these devices must be set to ‘silent’ mode to avoid interrupting proceedings of the council or committee.

The use of flash photography or additional lighting may be allowed provided it has been discussed prior to the meeting and agreement reached to ensure that it will not disrupt proceedings.

The Chair of the meeting may terminate or suspend filming, photography, recording and use of social media if any of these activities, in their opinion, are disrupting proceedings at the meeting.

Thurrock Council Wi-Fi

Wi-Fi is available throughout the Civic Offices. You can access Wi-Fi on your device by simply turning on the Wi-Fi on your laptop, Smartphone or tablet.

- You should connect to TBC-CIVIC
- Enter the password **Thurrock** to connect to/join the Wi-Fi network.
- A Terms & Conditions page should appear and you have to accept these before you can begin using Wi-Fi. Some devices require you to access your browser to bring up the Terms & Conditions page, which you must accept.

The ICT department can offer support for council owned devices only.

Evacuation Procedures

In the case of an emergency, you should evacuate the building using the nearest available exit and congregate at the assembly point at Kings Walk.

How to view this agenda on a tablet device

You can view the agenda on your iPad, Android Device or Blackberry Playbook with the free modern.gov app.

Members of the Council should ensure that their device is sufficiently charged, although a limited number of charging points will be available in Members Services.

To view any “exempt” information that may be included on the agenda for this meeting, Councillors should:

- Access the modern.gov app
- Enter your username and password

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

↓

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

Our Vision and Priorities for Thurrock

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

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 24 January 2019 at 7.00 pm

Present:	Councillors Victoria Holloway (Chair), John Allen (Vice-Chair), Tom Kelly, Cathy Kent, Elizabeth Rigby *(arrived 7.04pm)* and Joycelyn Redsell Ian Evans, Thurrock Coalition Kim James, Healthwatch Thurrock Representative
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Ian Wake, Director of Public Health Jeanette Hucey, Director of Transformation, Clinical Commissioning Group Malcolm McCann, EPUT, Executive Director of Community Services and Partnerships Mark Tebbs, Director of Commissioning, NHS Thurrock CCG Jenny Shade, Senior Democratic Services Officer

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

38. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 8 November 2018 were approved as a correct record.

The Minutes of the Extraordinary Health and Wellbeing Overview and Scrutiny Committee held on the 5 December 2018 were approved as a correct record.

39. Urgent Items

No urgent items were raised.

40. Declarations of Interests

No interests were declared.

41. HealthWatch

No items were raised by HealthWatch.

42. Verbal Update - SERICC

Councillor Holloway stated that Kim James from HealthWatch had helpfully and rightly brought to the committee's attention the matter of grant funding for

SERICC being stopped before an alternative provision had been put in place. Councillor Holloway had written to the Clinical Commissioning Group with the committee members concerns who in turn agreed to extend the funding to the 31 March 2019 whilst the pathway for sexual assault and abuse services could be developed through evidence base. Councillor Holloway stated that the Clinical Commissioning Group had been excellent in providing the information requested and discussing the plans going forward with the good intentions on getting the new pathway right. There was a considerable amount of work still to be done and a long way to go for those involved in developing the pathway to understand the needs of those who had experienced sexual violence and abuse and to understand the needs of their treatment and support. That both clinical and non-clinical options would need to be fully explored and developed so there was a true choice for both women and men that needed the support.

Councillor Holloway further added that due to the timing of the grant funding for SERICC an ambitious deadline had been set for the new pathway. That further evidence was still being collected through a Joint Strategic Needs Assessment and through discussions with service users which would not be completed by the proposed deadline. Therefore Councillor Holloway would write to the Clinical Commissioning Group to express her ongoing concerns and request that the evidence gathered should be considered properly and not rushed into by the 1 April 2019 deadline. So proposing that the existing system remain in place and resourced until all were assured the new system was fit for purpose.

Mark Tebbs confirmed the Clinical Commissioning Groups commitment for the outcome of the services to ensure the best practice was delivered.

Kim James stated that the concern was originally raised to ensure that an alternative provision would be in place before the grant money had stopped and thanked the Chair for her continued commitment.

The Chair requested that this item be added to the work programme for the 7 March 2019 committee.

43. Briefing Note - Referral to the Secretary of State : Orsett Hospital

Roger Harris, Director of Adults, Housing and Health provided a brief update on the referral made to the Secretary of State on the closure of Orsett Hospital.

A draft letter had been sent to the Sustainability and Transformation Partnership and the Clinical Commissioning Group Joint Committee for comment to which a response had been received. A letter had been sent to the Secretary of State on the 8 January 2019 to which a letter had been received back requesting further information. A further letter had been sent back to the Secretary of State on the 18 January 2019 with this requested information.

Councillor Redsell stated that she hoped the process would not put the proposed four Integrated Medical Centres in jeopardy. Roger Harris reassured Members that planning of the Integrated Medical Centres was well advanced and would continue. Although there may be some delay as no formal agreements, tenders or planning permissions would be adhered to. Roger Harris stated at this time there was no precise timetable and that the Secretary of State may decide to look at the referrals made by Thurrock and Southend on Sea at the same time.

The Chair stated that all Members were in agreement that the Integrated Medical Centres should happen.

44. Briefing Note - NHS Long Term Plan

Roger Harris, Director of Adults, Housing and Health, provided a brief update on the NHS Long Term Plan that had been published on the 7 January 2019 and referenced Members to the Executive Summary that had been published in the agenda.

Members agreed that a more detailed report be presented at the 7 March 2019 committee.

45. Adult Mental Health Service Transformation

Ian Wake, Director of Public Health, presented the report that set out the work undertaken to date to address problems in the local mental health and care system in Thurrock. It also set out plans with NHS Thurrock Clinical Commissioning Group, NHS and third sector provider partners to transform mental health services moving forward. The report also highlighted the issue of suicide prevention and how best to integrate commissioning of services between the Council and NHS. Ian Wake stated that the report sought HOSC support for the new programme of transformation and for proposals to reform the section 75 agreement between the Council and EPUT.

At the request of the Chair, Ian Wake presented a comprehensive and detailed PowerPoint presentation to members that covered:

- Epidemiological Overview of Mental Health
- Projected number of older people in Thurrock with depression – up to 2030
- Stakeholders
- Key Themes
- How to address under-diagnosis
- How to get into the system
- Emergency Response Pathway
- New treatment offer for Common Mental Health Disorders
- New enhanced treatment model
- Integrated Commissioning
- Next steps

This presentation can be found on-line at the following link.

https://democracy.thurrock.gov.uk/documents/b16658/Mental%20Health%20Transformation%20HOSC%20Presentation%2024th-Jan-2019%2019.00%20Health%20and%20Wellbeing%20Overview%20a.pdf?T=9

The Chair thanked Ian Wake for the very comprehensive presentation.

Councillor Redsell thanked Ian Wake for the presentation and stated that more should be done at an earlier age for those older children being diagnosed now with mental health issues.

Ian Wake stated there was no simple answer as there were multiple causes such as bullying at schools and plans were in place to address this. Councillor Redsell stated that bullying also needed to be addressed as this was a contributory factor with schools not picking this up early enough and schools would be expected to action this but in cases would not have sufficient time and resources to do this. Ian Wake continued by stating that excessive social media usage caused depression and anxiety in people. With neglect and sexual assault being key contributing factors for depression. That Mental Health school based teams were in schools addressing these issues and plans were in place to expand the mental health treatment provision.

The Council should encourage more physical activity. Ian Wake stated there was no simple answer to the physical activity question but there was a range of activities, sport provisions and infrastructures in place and this would be the opportunity to promote these.

Councillor Redsell continued to state that she did not know who the Local Area Coordinator was for her ward. Roger Harris agreed to organise an introductory meeting between Councillor Redsell and the Local Area Coordinator covering her ward.

Councillor Redsell questioned the 8628 residents being undiagnosed. Ian Wake stated these were primarily people who were unable to seek and ask for help. A high risk of depression was getting older and this may be stigma amongst elderly residents who may be too proud to ask for help. Councillor Redsell questioned whether the 8628 number was correct. Ian Wake stated that figures were produced by Public Health England following modelling undertaken by Imperial College in London based on demographics and was the best evidence base available.

Councillor Redsell stated that more could be done between the elderly and the young and referred Members to the popular TV programme that demonstrated the bond that brought the elderly and young together. Ian Wake agreed that the programme had some very valid points and demonstrated some opportunities.

Councillor Allen thanked Ian Wake for the presentation and questioned whether the waiting times for Thurrock Mind could get worse. Ian Wake stated

he did not have the figures for Thurrock Mind but the patients for IAPT NHS counselling service were being seen within 6 weeks. Ian Wake agreed that a long term solution would need to be addressed. Councillor Allen welcomed the change in waiting times and agreed that early intervention was vital.

Ian Evans had a concern on the individual placement scheme to which those people that received back-to-work support who had mental health conditions but did not fit in the parameters of IPS and questioned what plans were in place. Mark Tebbs stated there was evidence base around employment support with people with serious mental health illnesses. An employment specialist would be embedded in the mental health teams as part of active treatment programme and this had produced the best results. Ian Evans further questioned whether as part of the model would the third sector specialist employment be involved as well as having employment specialists embedded into the CMHT teams. Mark Tebbs stated that would go back to working holistically with local authority colleagues and working closely to ensure that those offers were joined up.

The Chair stated that this needed to be handled delicately when built into the model being designed.

Councillor Kent thanked Ian Wake for the presentation and questioned how the scheme would be monitored. Ian Wake stated there were plans to move to an outcome framework that would measure if people were getting better.

Councillor Kent stated that more awareness had to be undertaken inside and outside schools with schools having to take some responsibility. Councillor Kent questioned that with insufficient general practitioners in Thurrock how patients could be reassured that when they ring for appointments their calls would be answered. Ian Wake stated that it was a competitive market for general practitioners and that with the introduction of the Integrated Medical Centres would make Thurrock a more attractive place for new general practitioners to work. For those patients accessing mental health services would follow the crisis pathway which would enable people to access specialist crisis care via 111.

Councillor Kent asked whether there was sufficient staff to cope with the expected number of calls and how the 111 service would be publicised. Mark Tebbs stated that the business case had been finalised with the secured funding being built into the contract with a 6 to 9 month mobilisation plan. That it would take up to 9 months to recruit staff and was ambitious that the model would be up and running by next winter. That engagement would be made with members of the public and publicised.

The Chair questioned whether a similar service would be presented to young people and young children. Ian Wake stated the two plans would be undertaken under the Joint Strategic Need Assessment and through the School Mental Health Summit. Roger Harris stated that the Health and Wellbeing Board was the oversight group to ensure that the plans came together.

Malcolm McCann praised Ian Wake on the quality of the presentation and work undertaken into the analysis on the direction of travel. Malcolm McCann applauded the priority of addressing mental health in Thurrock and complimented the health and social care commissioners. That EPUT had been working hard to transform services and were on a better journey of recognising the need to work within localities such as Thurrock. With EPUT having a strong desire that mental health services should go into the Integrated Medical Centres and commitment to offering services locally.

Councillor Rigby questioned how schools were educating children on social media. Ian Wake stated that social media was a risk factor in schools and that there was mental health teams based in schools who would discuss and address such issues.

Councillor Kelly questioned whether Thurrock had a high rate of mental ill health compare to the national average. Ian Wake stated that he did not have the figures to hand and would provide this information for Members.

Councillor Kelly questioned the comparison of mental health cases in urban areas compared to the number of cases in rural areas. Ian Wake stated that this would depend on the type of urban and what type of rural areas and that age was a key drive into depression so was hard to separate. That there was strong evidence that living near green areas and trees the less likely people would suffer from depression. That there were dedicated members from the Public Health Team who worked alongside the Planning and Regeneration teams and conversations were taking place. This would be a key opportunity to get it right in the local plan. Mark Tebbs referred Members to the Mental Health Needs Index with the University of Manchester analysed all the numbers nationally where a score was given per area on their mental health needs. Further to Councillor Kelly's earlier question on the rate of mental health compared to the national average, Thurrock was broadly in the middle with significantly higher needs compared to Southend.

The Chair stated that it was evident that surrounding areas affected mental health and this should be addressed.

Councillor Kelly referred Members to Thurrock's population increase by 0.6% and that it was disappointing that new housing planning applications were being brought to committee but there appeared to be little prioritisation on health provisions. Roger Harris stated over the last 12 months there had been a housing and planning sub group alongside the Health and Wellbeing Board to try and shape and influence the local plan. That when planning applications were submitted it would be the intention to have early dialogue with developments to discuss the needs required.

The Chair stated that having recently sat on the Planning Committee it was evident of the constraints in the law in what the Council can do.

Members questioned where they should direct their constituents if asked about a referral for mental health. Roger Harris stated that the starting point would be either through their general practitioner or to ring 111. That the recommended route would be to contact Thurrock First who were open 7 days a week, 7am to 7pm and were able to make referrals to Grays Hall.

The Chair stated it was vital that local general practitioners received the appropriate training to ensure the right person was being seen and as quickly as possible.

The Chair stated it was good to hear that finally we were addressing the disparity in money with regards to mental and physical health and that once we start to treat mental health the same as we treat and cure cancer we had the system that would work for people.

The Chair also stated that the 8-12 week waiting times was still very concerning but recognised the work being put in to reduce these times. Ian Wake referred Members to the PowerPoint that displayed the work already done and that treatment times were down.

That Chair referenced that crisis care was a big issue and previously mentioned adjustments in beds and questioned at what point would we not need crisis care as money had been put into prevention. Mark Tebbs stated that more money was being invested into IAPT this financial year with more high intensity training being undertaken to keep up with the ongoing demand. Those specific pathways would be available for specialist services. Mark Tebbs stated that important point to make was the people can refer themselves and not have to wait for general practitioner appointments. The crisis care had been successfully implemented into Basildon Hospital and had been a good winter from a mental health prospective with some good response times. That regular winter plan meetings took place to look at all the indicators.

The Chair questioned when the plans would be put into place. Ian Wake stated he would like to manage expectations on timescales as this was a very complex system. With Thurrock at the start of formal transformation journey with a working case change document be ready by the end of the calendar year.

Councillor Allen requested the contact numbers for Thurrock First. Roger Harris agreed that the numbers would be forwarded to Members following the meeting.

RESOLVED

1. **That Health and Wellbeing Overview and Scrutiny Committee notes the contents of this report and comments on the direction of travel in terms of adult mental health system transformation**

2. **That Health and Wellbeing Overview and Scrutiny Committee comments on and supports the proposals as set out in section 7.14 to 7.15 of this report to develop a new Section 75 Agreement with EPUT from 1 April 2019 based on a longer term contract, with a revised performance and budget framework**

3. **That Health and Wellbeing Overview and Scrutiny Committee comments on and supports and approves the proposals set out in section 10 of this report in relation to suicide prevention.**

46. Work Programme

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

Members agreed that the NHS Long Term Plan report be added to the 7 March 2019 committee.

Members agreed that the SERICC (Sexual Abuse Counselling report) be replaced with a report titled Sexual Violence, Treatment and Recovery Pathway to the 7 March 2019 committee.

Members agreed that the Mental Health Update Care Package should be added to the work programme for the 2019/20 municipal year.

The meeting finished at 8.56 pm

Approved as a true and correct record

CHAIR

DATE

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

7 March 2019	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
Sexual Assault and Abuse Mental Health Pathway in Thurrock	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Mark Tebbs, Director of Commissioning NHS Thurrock Clinical Commissioning Group (CCG)	
Accountable Associate Director: Jane Itangata, Associate Director of Mental Health Commissioning, Mid and South Essex STP (Local Health and Care)	
Accountable Officer: Mandy Ansell, Accountable Officer, NHS Thurrock Clinical Commissioning Group	
This report is public	

Executive Summary

The purpose of this paper is to provide an overview regarding the work to improve the sexual assault and abuse mental health pathway in Thurrock. The review of the pathway has aimed to ensure that commissioners are fulfilling their respective commissioning responsibilities. This will help to ensure that we have the right balance of services in place to enable the system to achieve the best possible outcomes. In addition, we need to ensure that there are the right ongoing mechanisms in place to facilitate integrated working between providers.

Sexual assault and abuse are two of the most serious and damaging crimes in our society. Sexual violence survivors are at greater risk of a variety of mental health issues including anxiety, depression and post-traumatic stress disorder (PTSD). The clinical evidence is clear that trauma-focussed Cognitive Behavioural Therapy (CBT) sessions are the most effective treatment for PTSD in adult sexual violence victims and Child Sexual Abuse survivors.

The national strategy for sexual assault and violence states that commissioning arrangements nationally and locally are complex and fragmented. Local partners have therefore come together to develop a plan for improving the local outcomes. The pathway review found that there were opportunities to strengthen the clinical provision, improve integrated working and improve system wide education.

The CCG has invested in enhancing the NICE approved trauma-focussed pathway of the IAPT service. This is to ensure that Inclusion Thurrock, in partnership with Thurrock Mind, can continue to respond to the treatment needs of victims and survivors of sexual assault and abuse in a timely manner. The CCG has therefore

provided additional investment for 2 WTE trauma CBT therapists through the IAPT service to complement existing capacity. The additional therapists have been recruited and are due to start in April 2019. The CCG has also funded additional specialist trauma focussed training.

The CCG and Local authority colleagues have also agreed to utilise the Better Care Fund to extend the grant to SERICC to enable the completion of the Thurrock Joint Strategic Needs Assessment and for the development of an overarching Essex Wide Strategy. The Strategy work will be led by our colleagues from Police Fire Crime Commissioners (PFCC). These documents will aim to fully review the evidence base, clarify commissioning responsibilities between agencies and to ensure that we have a robust understanding of local need.

1. Recommendation(s)

1.1 The Health and Wellbeing Overview and Scrutiny Committee are asked to note the progress on the work to improve the Thurrock sexual assault and abuse pathway.

2. Introduction and Background

2.1 Sexual assault and abuse are two of the most serious and damaging crimes in our society. The impact of any sexual assault or abuse is largely hidden and often not fully understood, with no identified effects that are unique to these crimes. It is well known, however, that the damage and devastation caused are enormous, extremely varied and often lifelong. They present in different ways for different individuals from different genders and demographics; the commonality being serious trauma and often compound trauma. Feelings of profound fear, terror and anxiety have been described by victims and survivors, with safety and trust being significant factors in the recovery process. It can take many years for an individual to disclose sexual assault or abuse, particularly those people who have been abused or assaulted as a child, or those with a disability.

2.2 National Policy context

Over recent years, the profile of sexual offences has been raised significantly due to the Children's Commissioner's Inquiry into Child Sexual Exploitation in the family environment, the Independent Inquiry into Child Sexual Abuse (IICSA), the independent inquiry into child sexual exploitation in Rotherham, the various cases involving well-known individuals and, most recently, the emerging cases associated with football. This increases the likelihood of an impact on the uptake of mainstream services, and in particular, mental health services for non-recent victims and survivors of sexual assault and abuse.

In April 2018, 'The Strategic Direction for Sexual Assault and Abuse Services: Lifelong care for victims and survivors: 2018 – 2023' was published. It focuses on 6 priorities, namely:

- Strengthening the approach to prevention,

- Promoting safeguarding and the safety, protection and welfare of victims and survivors,
- Involving victims and survivors in the development and involvement of services,
- Introducing consistent quality standards,
- Driving collaboration and reducing fragmentation,
- Ensuring an appropriately trained workforce.

The document emphasises the complexity of the commissioning arrangement. It describes the fact that responsibilities 'spans a number of different systems and government organisations, including health, care and justice, and requires them to work together. The commissioners of services are varied, and there is a wide range of providers, including some specialist and third sector organisations. This creates a significant challenge, and all the different bodies can find it difficult to work together effectively to meet the lifelong needs of victims and survivors. This can result in fragmentation in service delivery, frustration and poor outcomes for victims and survivors of sexual assault and abuse over their lifetime'.

The national strategy helpfully outlines the commissioning responsibility (See Appendix 1 - Mental Health) for all parties.

2.3 Evidence Based Treatment

A summary review of effective support services for treating Mental Health needs of adult victims of sexual trauma is provided in appendix 2. The key points are:

- Sexual violence survivors are at greater risk of a variety of mental health issues including anxiety, depression and post-traumatic stress disorder (PTSD)
- Trauma-focussed CBT or EMDR sessions are most effective for treatment of PTSD in adult sexual violence victims / CSA survivors
- Trauma-informed care does not have an adequate evidence base and therefore is not supported as an effective treatment approach for PTSD.
- Individual sessions of at least one hour in length, and a treatment programme of at least 10 sessions were most effective
- A phase-based approach comprising of support to promote individual resilience **and** trauma-focussed therapy may be effective
- Training is needed within statutory services to recognise sexual abuse as a potential cause of mental health issues and to ask questions to facilitate disclosure in a more comfortable environment
- Specialist services are preferable to statutory services amongst survivors for facilitating disclosure and addressing other mental wellbeing needs

The evidence suggests that we require both strong evidence based treatment services and good specialist services which facilitate disclosure and support wellbeing. We need clear commissioning arrangements so that providers are clear about their role within the system. We need ongoing mechanisms to support integration between providers.

3. Improving the sexual assault and abuse mental health pathway in Thurrock

3.1 Inclusion Thurrock and Thurrock Mind have been providing treatment for trauma, including sexual violence/sexual abuse history, since April 2016 in line with NICE guidelines on the treatment of trauma. CBT and EMDR are the NICE recommended treatments for trauma.

3.2 Approximately one third of IAPT patients have experience of sexual assault or sexual abuse in their past. In some cases, patients presenting with depression or anxiety disorders also have histories of sexual trauma.

3.3 To meet demand the service has continued to invest in ongoing training and development of staff to provide effective, evidence-based treatment for trauma, for example, in February 2017 the service invited a trauma specialist working for the Traumatic Stress Service to deliver a one-day training course on enhanced CBT treatment for trauma.

3.4 In April 2017, the service invested in EMDR training for eight therapists who are now qualified and accredited EMDR therapists. Another therapist has initiated EMDR training and when qualified will bring the total to nine to ensure the service can deliver a trauma focussed pathway. All IAPT therapists are qualified to deliver CBT. 10 of the 18 CBT therapists have a professional background as qualified counsellors adding to the richness of expertise to enhance support to patients.

3.5 From the April 2019 there will be 2 WTE additional trauma CBT therapists in Thurrock. These therapists will provide continuity of care and named link workers with SERICC to enable the delivery of integrated care models.

3.6 A 2018 systematic review of the link between sexual abuse and borderline personality disorder (BPD) found sexual abuse was found to play a major role in BPD, particularly in women. Childhood sexual abuse is an important risk factor for BPD. Adult sexual abuse rates are significantly higher in BPD patients compared with other personality disorders. EPUT estimates that 70% of the patients on the current PD caseload (circa. 600) have a history of sexual assault and abuse. The development of the personality disorders service in primary care and enhancement of joint working between Inclusion Thurrock, EPUT's Psychology team and Thurrock Mind means that patients with personality disorder (and in all likelihood sexual abuse histories) will be supported with a seamless flow between and within services.

3.7 The KUF personality disorders training, and additional training on providing the STEPPS programme in primary care, will further aid therapists in treating patients with co-morbid personality disorder and sexual abuse trauma. This service is in the final phase of implementation with a view to complete roll out in Q1 of 2019 -20.

3.8 The Police Fire Crime Commissioners are bringing partners together from across Essex to develop a whole system strategy. This strategy will build consensus regarding the local interpretation of the national commissioning guidance. At the same time, our public health colleagues are completing the

work of the Thurrock Joint Strategic Need Assessment. These documents will aim to fully review the evidence base, clarify commissioning responsibilities between agencies and to ensure that we have a robust understanding of local need.

3.9 The CCG and Local authority colleagues have agreed to utilise the Better Care Fund to extend the grant to SERICC to enable the completion of the Thurrock Joint Strategic Needs Assessment and for the development of an overarching Essex Wide Strategy.

3.10 **Thurrock Whole System Review -** Over the last 3 months or so, commissioners have co-ordinated a number of workshops to develop a whole system development plan.

3.11 The issues identified are listed below:

- There are issues with the patient transition between services and the interfaces between the services.
- Some survivors still shy away from mental health services.
- Some survivors are not fully aware of the services available to them and what each services provides.
- The system requires better governance so there's a forum for shared learning and changes to services etc.
- The future state must include clear direction and guidance of how to refer / share information with secondary care services
- The local system requires further training to ensure that disclosure of victims of sexual assault and abuse is better managed
- The future state should support the joint management of victims' treatment where this is possible and required. The services that can be jointly managed need to be identified and agreed.
- The future state needs better 'branding' to ensure it is clear for both professionals and patients.
- There needs to be clearer guidance on referral protocols to ensure people end up in the right service at the right time. This will also help to ensure that organisations understand where they fit within the pathway. This needs to be underpinned by better information sharing when referring into the system.
- SERICC identified that there are numbers of referrals made into the service purely because the referring party has no resources to manage the patient. Similarly, they raised concerns that secondary care had closed cases, but that these were being retained needing support within SERICC.
- Shared care protocol needs to be consistently adhered to.

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

4.1 The action plan has been developed in consultation with PFCC, Thurrock Public Health Team, Inclusion, EPUT and SERICC.

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

N/A

6. Implications

6.1 Financial

Implications verified by: N/A

6.2 Legal

Implications verified by: N/A

6.3 Diversity and Equality

Implications verified by: N/A

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

N/A

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

N/A

8. Appendices to the report

Appendix 1 - Commissioning responsibilities
Appendix 2 - Summary Review of effective support services for treating Mental Health needs of adult victims of sexual trauma

Report Authors:

Mark Tebbs, Director of Commissioning, Thurrock CCG

Jane Itangata, Associate Director of Mental Health Commissioning, Mid and South Essex STP (Local Health and Care)

Maria Payne, Strategic Lead – Public Mental Health & Adult Mental Health Systems Transformation, Public Health Team

Commissioning Responsibilities

Commissioning responsibility	Service
NHS England	• Sexual Assault Referral Centres (SARCs) responsible for forensic medical examinations, medical care/support and follow up services in SARCs with Police and Crime Commissioners/Police • Child and adolescent mental health services Tier 4 (CAMHS Tier 4) • Contraception provided as an additional service under the GP contract • HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE)) • Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and patient-requested testing by GPs • Sexual health elements of prison and Immigration Removal Centre health services • Cervical screening • Specialist foetal medicine services
Clinical commissioning groups	• Mental health and Improving Access to Psychological Therapies (IAPT); services for depression and Post-Traumatic Stress Disorder (PTSD) that understand the specific needs of victims and survivors of sexual assault and abuse, including the third sector • Most abortion services • Sterilisation • Vasectomy • Non-sexual health elements of psychosexual health services • Gynaecology, including any use of contraception for non-contraceptive purposes • Secondary care services, including A&E • NHS 111 • Sexual health services for children and young people including paediatric care/support • Specialist voluntary sector services (in some areas) • Ambulance/blue light services
Police and Crime Commissioners	• Specific commissioning responsibilities for victims, including victims of sexual assault and abuse • Specialist voluntary sector services • Police 101 • In some forces, the police lead on the procurement of SARC services
Local authorities	• Comprehensive sexual health services, including most contraceptive services and all prescribing costs (excludes additional services commissioned from primary care) • STI testing and treatment, chlamydia screening and HIV testing • Specialist sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention, sexual health promotion and services in schools, colleges and pharmacies • Specialist voluntary sector services
Ministry of Justice	• National Male Survivor helpline • Rape support services with dedicated emotional and practical support services for victims of rape and other forms of sexual abuse aged 13 or over
Home Office	• National services for victims of child sexual abuse

This page is intentionally left blank

Summary Review of effective support services for treating Mental Health needs of adult victims of sexual trauma

Provided by Maria Payne and Jane Itangata

Current provider landscape

The current specialist service in Thurrock aimed at supporting victims of sexual violence is the South Essex Rape & Incest Crisis Centre (SERICC). The stated aim of SERICC is to "raise awareness, prevent and reduce sexual violence through the provision of high quality specialist support services". This service has been approved by Rape Crisis England & Wales and meets National Service Standards. The offer of SERICC includes:

- An information and support line
- Independent Sexual Violence Advisors (ISVA)
- Specialist Sexual Violence Counsellors (for mental wellbeing needs relating to their sexual abuse)
- Advocacy Service
- Brighter Futures
- Young People's Sexual Violence Counselling Service

It is worth noting that SERICC's counsellors are not CBT-trained and therefore do not treat mental health conditions such as depression and anxiety.

Inclusion Thurrock is commissioned as the IAPT (Improving Access to Psychological Therapies) provider in Thurrock to provide treatment of common mental health conditions – including those of sexual violence survivors; although they refer patients to SERICC for other specialist therapeutic support specifically related to their sexual violence trauma.

Thurrock's Recovery College (also delivered by Inclusion/MIND) provides peer recovery and self-management support to those with poorer mental health; however this does not have a specialist remit for sexual violence survivors.

This review aims to consider the evidence base for best practice in regards to mental health treatment provision for adult sexual violence (both recent and historical) survivors and will feed into discussions about service development.

Treatment of PTSD for sexual violence survivors and adult survivors of child sexual abuse

A 2009 meta-analysis (Taylor & Harvey, 2009) examined the results of 15 studies on the outcomes of different types of psychotherapeutic approaches for sexual assault victims experiencing PTSD or rape trauma symptoms. Included studies used a variety of treatments including cognitive processing therapy (CPT) , cognitive restructuring (CR) , eye movement desensitization reprocessing (EMDR) , imagery

rehearsal therapy (IRT) , and prolonged exposure (PE) . Results were highly consistent, producing effect sizes of .91 and .90 respectively. (Effect sizes larger than .8 are generally considered large, and these particular effects mean that the probability of the psychotherapy treatment being superior to the control is approximately 74%). The authors observed a pattern of larger effect sizes for studies involving some aspect of cognitive behavioural therapy (CBT) . This supports the guidance of NICE as well as the American Psychological Association which both recommend CBT strongly for the treatment of PTSD. Effects were maintained 6-12 months after treatment; indicating that psychotherapy is an effective treatment method for adults who have been sexually assaulted.

A separate 2014 meta-analysis (Ehring, 2014) examined psychological treatments for PTSD in adult survivors of childhood abuse. The 16 included RCTs evaluated a variety of treatments including trauma-focused CBT, non-trauma focused CBT and EMDR. Results showed trauma focused treatments were found to be more effective than non-trauma focused, with the best evidence overall specifically for trauma-focused CBT, though trauma-focused EMDR also appears to be effective. The key to both of these therapies seems to be that they focus mainly on processing the memory of the trauma and its meaning. However both trauma-focused and non-trauma focused treatments performed better than no treatment as those receiving either treatment showed significant improvement in depression, anxiety and dissociation compared to no-treatment groups.

This conclusion is supported by a 2011 review (Kendall, 2011) which also concluded that abuse focused therapy such as CBT, EMDR and emotion-focused therapy was generally beneficial and yielded symptom improvement amongst CSA survivors, regardless of the specific therapeutic technique used.

Cognitive behavioural therapy (CBT): a psychological intervention where the person works collaboratively with the therapist to identify the effects of thoughts, beliefs and interpretations on current symptoms, feelings states and problems areas. They learn the skills to identity, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms or problems, and appropriate coping skills. Duration of treatment varies depending on the disorder and its severity but for people with depression it should be in the range of 16 to 20 sessions over 3 to 4 months; for people with Generalised Anxiety Disorder (GAD) it should usually consist of 12 to 15 weekly sessions (fewer if the person recovers sooner, more if clinically required), each lasting 1 hour.

Trauma-focused CBT: a type of CBT specifically developed for people with PTSD that focuses on memories of trauma and negative thoughts and behaviours associated with such memories. The structure and content of the intervention are based on CBT principles with an explicit focus on the traumatic event that led to the disorder. The intervention normally consists of 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session,

longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

Eye movement desensitisation and reprocessing (EMDR): a psychological intervention for PTSD. During EMDR, the person is asked to concentrate on an image connected to the traumatic event and the related negative emotions, sensations and thoughts, while paying attention to something else, usually the therapist's fingers moving from side to side in front of the person's eyes. After each set of eye movements (about 20 seconds), the person is encouraged to discuss the images and emotions they felt during the eye movements. The process is repeated with a focus on any difficult, persisting memories. Once the person feels less distressed about the image, they are asked to concentrate on it while having a positive thought relating to it. The treatment should normally be 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

Phase-based approach

There is emerging evidence that a phase-based approach comprising skills training and trauma-focused interventions is more effective than trauma-focused treatment alone for this complex group. So in practice, a survivor could be receiving more than one type of intervention at once, potentially from different organisations. Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy is designed to foster the development and strengthening of emotion regulation and interpersonal skills and promote resilience before addressing the trauma directly. A 2010 study (Cloitre, 2010) compared STAIR therapy to Immediate Trauma Focused (ITF) therapy and found that after 6 months the STAIR group was more likely to achieve sustained and full PTSD remission relative to the ITF (27% versus 0%). STAIR produced greater improvements in emotion regulation than ITF and greater improvements in interpersonal problems. STAIR was associated with fewer cases of PTSD worsening relative to ITF. However this was a single small study, so more research is needed to fully understand the benefits of phase-based therapy over standard trauma focused methods.

Treatment modality

Both the Taylor & Harvey (2009) and Ehring (2014) studies looked at whether individual or group sessions were more effective for treating PTSD in sexual violence survivors and CSA survivors respectively. Both studies found individual sessions to produce greater improvements in outcomes than group sessions.

In terms of length of treatment, the authors observed that hour-long sessions, sessions delivered twice per week, and treatment programmes lasting 10 or more

sessions were considered to be most effective. Semi-structured approaches including 'homework' were also favoured by effect sizes.

Statutory vs. Specialist Services for addressing wider mental wellbeing needs

A 2018 piece of qualitative research from the University of Suffolk (Bond, 2018) explored adult CSA survivors' experience of support services overall – i.e. not just for their mental health needs. The research revealed that over 70% of survivors were more satisfied with the support offered by the specialist voluntary sector than statutory services both in regards to disclosure and treatment experience. The specialist services provided a more appropriate environment where survivors felt listened to, believed and respected for the first time.

Appropriate specialist support fostered trust and confidence in the service provided which facilitated greater treatment effects. The specialist provider differed from standard services in a number of important ways:

- Professionals had specialist training and many even had their own stories of trauma
- Shared experiences- true empathy rather than sympathy
- Addressing the cause, not just the symptoms
- Flexible, responsive, open-door provision tailored to individual needs
- No fixed time frames so survivors could take things at their own pace
- Service-user led instead of rigidly structured
- Long-term 'safety-net' support
- Access to other survivors

Summary

This review has found that most research around treatments and therapies for sexual violence victims revolves around the symptoms of PTSD. The evidence suggests that the most effective form of therapy for sexual violence-related PTSD is trauma-focused cognitive behavioural therapy or EMDR delivered on an individual basis for one hour sessions over at least ten sessions. Cognitive behavioural therapy and EMDR are the standard recommendations for survivors of sexual abuse by both NICE and the APA and are provided by Inclusion Thurrock.

However, while PTSD is a common and serious effect of sexual violence it is still only a symptom. Survivors who have experienced both statutory and specialist services expressed frustration with standard service focus on treating symptoms instead of addressing the trauma itself. Statutory services do not provide that same experience as specialist services to adequately support initial disclosure.

It is therefore concluded from the above research that whilst mental wellbeing needs relating to sexual violence trauma are best treated in a specialist sexual violence service setting, the treatment for sexual violence-related PTSD should be trauma-

focussed CBT or EMDR delivered on an individual basis (1 hour sessions) for at least ten sessions. There is some evidence that a phase/combined approach might be helpful, in that some sort of preparatory therapy (e.g. around interpersonal and assertiveness skills) before trauma-focused therapy begins.

References

Bond, E; Ellis, F; McCusker, J I'll be a survivor for the rest of my life: adult survivors of child sexual abuse and their experience of support services. 2018. University of Suffolk.

Cloitre, M; Stovall-McClough, KC; Nooner, K; Treatment for PTSD related to childhood abuse: a randomized controlled trial. 2010. American Journal of Psychiatry 167(8).

Ehring, T; Welboren, R; Morina, N Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. 2014. Clinical Psychology Review 34.

Kendall, L A Clinicians guide for treatment of adult survivors of childhood abuse: a literature review. 2011. Illinois State University.

Sneddon H; Wagner, N; Allnock, D Responding sensitively to survivors of child sexual abuse. 2016. University of Bedfordshire.

Taylor, JE; Harvey, ST Effects of psychotherapy with people who have been sexually assaulted: a meta-analysis. 2009. Centre for Reviews and Dissemination

This page is intentionally left blank

7 March 2019	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
NHS Long Term Plan: An Overview and Critique for Thurrock	
Wards and communities affected: All wards	**Key Decision** Non-Key
Report of: Ian Wake, Director of Public Health	
Accountable Assistant Director : n/a	
Accountable Director: Ian Wake, Director of Public Health Roger Harris, Corporate Director, Adults, Housing and Health	
This report is Public	

Executive Summary

In June 2018, the Prime Minister announced a new five-year funding settlement for the NHS; a 3.4% average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24, totalling a £20.5 billion increase over this period. To unlock this funding, the Department of Health and Social Care and NHS England were asked to develop a long-term plan. This document was published on 7 January 2019 and can be found here: www.longtermplan.nhs.uk

The NHS Long Term Plan contains a plethora of eye catching commitments. These can be summarised around five key themes:

- Finance and Resources
- Prevention and Health Inequalities
- New models of integrated care
- Action to improve care quality and outcomes in different clinical specialities
- Workforce

The digital agenda also features heavily throughout each of these themes.

The NHS Long Term Plan contains many positive proposals for Thurrock in terms of investment in prevention, improving clinical quality and outcomes, and integrated care. Many of the proposals set out within the plan are already being implemented locally, particularly in terms of new models of integrated care. However, the plan also raises concerns in terms of a potential centralising of some commissioning and delivery functions on an STP rather than Thurrock footprint, a greater role for the

NHS in commissioning Thurrock Public Health services and a lack of reference to both place based prevention and adult social care.

This paper sets out the proposals contained within the NHS Long Term Plan in detail and provides a critique of them in the context of Thurrock.

1. Recommendation(s)

1.1 That the Health and Wellbeing Overview and Scrutiny Committee consider and comment upon:

- **The report and the themes that it addresses.**
- **How the NHS Long Term Plan may be implemented in the context of the needs of the population of Thurrock and our existing system transformation agenda.**
- **The risks and opportunities associated with the wider proposed changes to the commissioning arrangements across Mid and South Essex STP.**

1.2 That the Health and Wellbeing Overview and Scrutiny Committee agree to receive further information about how the new funding will be invested in Thurrock.

2. Introduction and Background

2.1 In June 2018, the Prime Minister announced a new five-year funding settlement for the NHS; a 3.4% average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24, totalling a £20.5 billion increase over this period. To unlock this funding, the Department of Health and Social Care and NHS England were asked to develop a long-term plan. This document was published on 7 January 2019 and can be found here: www.longtermplan.nhs.uk

2.2 It is important to note that the funding settlement applies only to NHS England's budget. This means that some important areas of NHS spending including in the Department of Health and Social Care's budget; such as capital and education and training are not covered by it. Local authority public health spending and social care spending are also excluded. Consequently the plan is for the NHS only, and not the entire health and care system. It had been hoped that the Green Paper on long term funding options for Adult Social Care would also be published at the same time but the Green Paper publication has been put back.

2.3 The NHS Long Term Plan contains a plethora of eye catching commitments. These can be summarised around five key themes:

- Finance and Resources
- Prevention and Health Inequalities
- New models of integrated care
- Action to improve care quality and outcomes in different clinical specialities
- Workforce

The digital agenda also features heavily throughout each of these themes.

2.4 There is much to welcome within the new NHS Long Term Plan, together with a few proposals that raise potential concerns. This paper discusses each of these five themes in turn and critiques what they may mean for Thurrock in the context of the needs of our population and our existing strategic transformation plans. A full summary of every commitment within the plan can be found in Appendix A

3 Finance and Resources

3.1 The plan sets out considerable real terms cash increases to NHS budgets in England of £20.5Bn over the next five years (figure 1). This extra spending will need to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities.

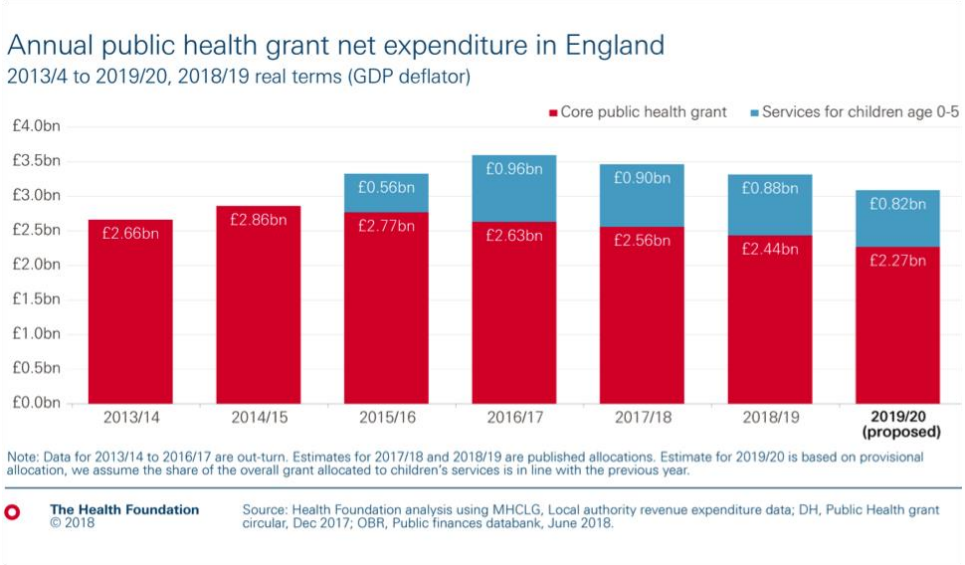
Figure 1 Real Terms Growth in NHS England Funding 2019/20 to 2023/24

3.2 However future funding for Adult Social Care is not included within the plan and will be subject to a delayed Green Paper now due later in 2019 and

possibly considered as part of the Government's Comprehensive Spending Review. Some commentators have labelled this decision a missed opportunity to tackle the issues faced by health and social care in a joined up way.

3.3 Despite being strong on prevention (see section 4), the plan also does not address Public Health Grant funding to local authorities, and the Government confirmed further reductions to the Public Health Grant in 2019/20 at the very end of 2018 (Figure 2), again drawing criticism from some for not thinking 'in a joined up way'.

Figure 2



3.4 When the Prime Minister announced the new funding settlement, she was clear that all NHS organisations must get back into financial balance by 2023/24. The plan gives further commitment to return the provider sector within the NHS to financial balance by 2020/21. To achieve this, NHS Improvement will deploy an accelerated turnaround process in the 30 worst financially performing trusts and a new financial recover fund of £1.05 billion will be created for trusts in deficit who sign up to their control totals

3.5 Part of the financial issues faced by NHS Providers centre around the flawed way in which the NHS financial regime operates. By rewarding activity in secondary care on a cost per case basis, whilst commissioning community providers on block contract the system both financially dis-incentivises community prevention activity that keeps patients out of hospital, and makes it difficult of secondary care providers to control costs when faced with difficult to predict and costly levels of unplanned activity. The measures in the plan seek to address this through changing the payment system from activity based payments to population based payments. There is also a further move away from individual to system control targets centred on new

Integrated Care Systems (ICSs) that will operate at STP level – in our case this is Mid and South Essex.

3.6 ICSs will become the level of the system where commissioners and providers (for both the NHS and local authorities) make shared decisions about financial planning, and prioritisation. The plan states that beyond 2019/20 Government will introduce further financial reforms that will support ICSs to deliver integrated care. Through a process of earned financial autonomy NHS England will give local health systems greater control over resources on the basis of a track record of strong financial and performance delivery, assessed in part through the new ICS accountability and performance framework.

3.7 The plan requires the NHS to deliver savings from administrative costs of more than £700 million, with £290 million to be delivered from savings in commissioning – CCG's have been told that they need to reduce their running costs by 20% by 1st April 2020. There is also focus on improved productivity through 10 priority areas which largely expand on existing schemes such as centralised procurement, e-rostering, e-prescribing, stopping procedures of limited clinical value and improving access to information.

What this means for Thurrock

3.8 Historically, the south and mid Essex health economy has been one of the most financially challenged in England, and so new resources are always welcome. It is however possible that Trusts within our own STP may be subject to further centralised 'Turn Around' processes referenced within the plan. The projected deficits for BTUH, Mid Essex Hospital Trust and Southend Hospital University Hospital Trust for 2018/19 are £27M, £60.7M and £10.9M respectively. Without system reform, there is a danger that 'more of the same' will result in growth monies being used to plug secondary care deficits.

3.9 The financial reforms in terms of a move away from activity based reward and towards population health outcomes are a welcome reform that seeks to address flaws in the current system that result in Trusts acting only in their own financial interest without regard to system wide impact. It also signals a move away from transactional commissioning towards population health that closely mirrors our own ambitions for a Thurrock Integrated Alliance Contract with system wide targets and financial risk and reward mechanisms. However, there is a clear direction of travel to set system level targets at STP and not CCG level which adds a potential level of complexity into local plans and moves system wide commissioning away from other Thurrock

local authority level place based initiatives. Setting population and system outcomes at STP rather than borough level also risks making them less meaningful and relevant to the needs of the Thurrock population.

3.10 Government announcement of further reductions in the Public Health Grant (PHG) for 2019/20 only days before the publication of an NHS Long Term Plan that places increasing prevention and addressing health inequalities at its heart, drew much criticism from sections of the public health profession on social media. Whilst public health should be seen as far more than commissioning of programmes from the PHG, obvious conclusions about a lack of joined up Government strategic thinking could be drawn. A combination of successful re-procurement of contracts funded from the PHG in Thurrock and three year financial planning by the DPH has mitigated the risk of substantial PHG decommissioning in 2019-20. However, it is clear that additional prevention ambitions set out in the Long Term NHS Plan will need to be funded through accessing a part of the additional £20.5Bn NHS growth monies rather than by relying on existing PHG resources. The commissioning mechanisms by which this is done, and how these new prevention services interface within those commissioned and delivered by Thurrock Council remains unclear in the plan and will perhaps need to be determined at a local level.

4 Prevention and Health Inequalities

4.1 The plan commits to a 'more concerted and systematic approach to reducing health inequalities', with a promise that action on inequalities will be central to everything that the NHS does. To support this ambition and to ensure that local plans are focused on reducing inequalities, specific, measurable goals will be set. Local areas will need to set out how they will achieve this in 2019, drawing on a menu of evidence based interventions developed by Public Health England. Changes to commissioning allocations for CCGs will ensure that a higher share of funding is targeted at areas with high inequalities and a review of inequalities adjustment to funding formulae will be undertaken.

4.2 The Plan specifically recognises that there are two major sets of work which need to progress in parallel:

- Population Health Management approaches – which requires action by everyone, including the NHS
- Place Based Approaches – including action on wider determinants such as planning, housing, education and employment outcomes and many other aspects the NHS is not set up to deliver on

4.3 We will not see improvements in health of the population without both. The NHS Plan itself explicitly acknowledges this where is says:

Action by the NHS is a complement to, but cannot be a substitute for, the important role for local government. In addition to its wider responsibilities for planning, education, housing, social care and economic development, in recent years it has also become responsible for funding and commissioning preventive health services, including smoking cessation, drug and alcohol services, sexual health, and early years support for children such as school nursing and health visitors. These services are funded by central government from the public health grant, and funding and availability of these services over the next five years which will be decided in the next Spending Review directly affects demand for NHS services.

4.4 The plan goes on to state that:

As many of these services are closely linked to NHS care, and in many case provided by NHS trusts, the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be.

4.5 The plan sets out a series of health improvement initiatives aimed at embedding prevention firmly within the 'day job' of NHS providers as opposed to being something commissioned from afar by local government. Trusts will gain increased responsibility for smoking cessation including implementation of 'The Ottawa model' which prescribes that all patients should have smoking status recorded and smokers offered specialist support to quit including Nicotine Replacement Therapy of other pharmacological interventions. The model will include a new smoke-free pathway for maternity services including focussed sessions and smoking cessation treatment for pregnant women who smoke. A new universal smoking cessation offer is also to be included as part of all specialist mental health services, including the option for patients admitted to in-patient mental health facilities to use e-cigarettes.

4.6 New weight management services are to become part of Primary Care for people with hypertension, a BMI of 30+ or type II diabetes.

4.7 The plan also talks about increased provision of Hospital Alcohol Care Teams to reduce significantly the number of A&E attendances, hospital bed-days and ambulance call outs that are alcohol related.

4.8 The NHS Diabetes Prevention Programme that seeks to identify those most at risk of developing diabetes and intervene with lifestyle modification programmes is set to receive double its current funding. The plan also sets out

ambition to address inequality in access to foot care teams for patients with diabetes, and trial a programme of diabetes referral through the prescription of very low calorie diets to those who are newly diagnosed.

4.9 Immunisation and screening programmes are given prominence in the plan with a new responsibility for CCGs to ensure that they are reducing health inequalities. At present responsibility for commissioning and monitoring immunisation and screening rests with NHS/Public Health England specialist teams.

4.10 By 2023/24 the plan sets out an ambition to increase the number of patients with serious mental ill-health receiving a health check by 110,000 a year to 390,000 a year.

What this means for Thurrock

4.11 The shift in focus for the NHS from an illness treatment service to (at least in part) one that focuses on preventing disease is hugely welcome. Every day in the NHS in England there are circa 1M contacts between patients and clinicians, and these present a tremendous opportunity for the health service to engage the population in a conversation about improving their health and wellbeing. Perhaps for too long, many clinicians have seen health improvement as someone else's responsibility and any move to change this is positive.

4.12 The plan sets out clear action on health inequality with a higher share of growth monies being targeted towards geographies with high levels of health inequity. What is less clear moving forward, is the geographical foot print on which this funding i.e. CCG vs STP will be rewarded or whether health inequality will be calculated as differences in health outcome *between* or *within* the geographical area. A funding formula based on the levels of health inequality within Thurrock is likely to be more generous than a funding formula that compared the level of health inequality within Mid and South Essex to England.

4.13 Smoking cessation services are currently commissioned and directly provided by the Thurrock Public Health Service. The focus this year has been on targeted support to smokers with other long term health conditions as the APHR 2016 identified that reducing smoking prevalence in this cohort will have the biggest impact on secondary care demand in the shortest possible time (however a universal offer is also available to any smoker who requests it). Performance against target has been significantly below the planned trajectory and the stop smoking core team have struggled to engage Primary and Secondary Care clinicians in activity to funnel smokers into cessation

services. Embedding and integrating stop smoking support within existing long term condition pathways in both primary, secondary and mental health trusts is highly desirable if as a system, we are going to act in a coordinate way to reduce smoking prevalence through cessation activity, and the strategic direction in the long term plan supports this approach. A paper with specific proposals as to the best mechanism to achieve this will be brought back to the Thurrock Integrated Care Alliance.

4.14 Public Health also already commission Alcohol Liaison Teams in hospital settings jointly with Essex and Southend Councils. Identifying and treating patients with underlying alcohol addiction is highly cost effective and returns system savings within year. Similarly weight management programmes including Sliming World, Weight Watchers and community weight management including exercise on referral are commissioned from the Thurrock PHG. The NHS Plan provides further scope and potential resources to expand these services.

4.15 Thurrock was one of the first wave adopters of the NHS Diabetes Prevention Programme. Additional resources through the NHS Long Term Plan to expand this programme are welcome.

4.16 National evidence suggests that people with serious mental ill-health experience some of the worst health inequalities of any group in England dying on average 15-20 years earlier than the general population. Action to address this has been set out in the recent papers to both Thurrock Health and Wellbeing Board and HOSC as part of a wider approach to transforming mental health services. A new Public Mental Health working group will bring forward new models of care over the next 12 months and expansion of new local approaches to embed cardio-vascular health checks in EPUT care pathways is welcome. However, although the NHS Plan has ambitions to increase the number of checks, population health gain will be limited unless this is undertaken in conjunction with lifestyle modification (and where appropriate) pharmacological interventions to reduce risk in those highlighted through this programme.

4.17 Focus on improving the coverage of immunisation and screening programmes set out in the plan is also welcome. These are currently the responsibility of the teams of dedicated Public Health England staff based in NHS England regional offices. They have generally felt remote and disconnected from both the wider Public Health Local Authority based system and CCG Primary Care transformation, despite GP practices being responsible for many of the programmes. Moving forward, if CCG's are given specific responsibilities for improving coverage rates there is an opportunity to integrate with our local Primary Care development work and team.

4.18 The proposals in the plan for the Government and NHS to consider a greater role in commissioning of Public Health services including sexual health, health visiting and school nursing came somewhat 'left-field' and has not to date been discussed with the public health professional body through usual channels such as the Association of Directors of Public Health or Faculty of Public Health. It is worth noting that currently the single public health commissioning function retained by the NHS – immunisation and screening programmes is the worst performing of all commissioned functions. Whilst there is perhaps some merit for re-integrating sexual health services into NHS commissioning functions (commissioning responsibilities are currently split with local authorities commissioning contraception and GU medicine services and the NHS commissioning HIV treatment), the case for the NHS commissioning school nursing and health visiting is less clear. These are clear public health functions that in Thurrock have been successfully integrated into our Brighter Futures Programme and align well with other local authority functions within children's services. A move to the NHS potentially adds an additional level of complexity and moves public health functions away from the Director of Public Health and specialist public health staff, for little obvious gain.

4.19 In conclusion, there is much to like within the NHS Long Term Plan in terms of a move to embed prevention within the work of the NHS and strengthen responsibilities of CCGs in reducing health inequalities. The Thurrock Public Health Team will need to work with senior officers in the CCG and NHS providers through the Thurrock Integrated Care Alliance to develop and agree plans to implement the proposals on prevention set out in plan locally.

5. New Models of Integrated Care

5.1 The plan confirms the shift towards integrated care and place-based systems which has been a defining feature of recent NHS policy. Integrated Care Systems (ICSs) will be the main mechanism for achieving this – the plan says that ICSs will cover all areas of England by April 2021 – and will increasingly focus on population health.

5.2 The plan outlines several core requirements for ICSs (such as the establishment of a partnership board comprising representatives from across the system) but stops short of setting out a detailed blueprint for their size or structure. Systems will be required to 'streamline' commissioning arrangements, which will 'typically involve' a single CCG across each ICS. It also recognises that NHS organisations will need to work in partnership with local authorities, the voluntary sector and other local partners to improve population health. A new NHS Integrated Provider Contract, Alliance

Agreement will be available in 2019 which will allow the contractual integration of Primary and Community Care, and support funding flows and collaboration between providers across the health and care system.

5.3 From 2019, population health management tools will be rolled out, enabling ICSs to identify groups at risk of adverse health outcomes and inequalities and to plan services accordingly. Existing approaches to bringing together health and social care budgets are also encouraged, with an expectation that the social care Green Paper will set out further proposals. Recent funding through the BCF and IBCF has been very important and extremely welcome – however these are only short term and what is required is a long term, publically acceptable way of funding the growing demand for Adult Social Care. There will also be a review of the Better Care Fund. It is dis-appointing that the LTP does not recognize the important role that the BCF has played in both drawing extra resources into the health and care system but also how it has facilitated better joint working – especially in Thurrock.

5.4 The move towards a more interconnected NHS will be supported by a 'duty to collaborate' on providers and commissioners, while NHS England and NHS Improvement will continue efforts to streamline their functions. The plan suggests that progress can continue to be made within the current legislative framework but also puts forward a list of potential legislative changes that would accelerate progress, in response to requests from the Health and Social Care Select Committee and the government. The proposed changes include allowing joint decision-making between providers and commissioners and reducing the role of competition in the NHS.

5.5 In line with the Forward View and the *General practice forward view*, improving care outside hospitals is one of the headline commitments in the plan. Encouragingly, the plan backs this goal with money: by 2023/24, funding for primary and community care will be at least £4.5 billion higher than in 2019/20 – ensuring that their share of NHS spending increases over the period.

5.6 The plan confirms that general practices will join together to form primary care networks – groups of neighbouring practices typically covering 30–50,000 people. Practices will enter network contracts, alongside their existing contracts, which will include a single fund through which network resources will flow. Primary care networks will be expected to take a proactive approach to managing population health and from 2020/21, will assess the needs of their local population to identify people who would benefit from targeted, proactive support. To incentivise this, a 'shared savings' scheme is proposed, under which networks will benefit financially from reductions in accident and emergency (A&E) attendances and hospital admissions. The existing

incentive scheme for GPs – the Quality and Outcomes Framework (QOF) – will also see 'significant changes' to encourage more personalised care.

5.7 Alongside primary care networks, the plan commits to developing 'fully integrated community-based health care', ending the current fragmentation of primary and community health care. This will involve developing multidisciplinary teams, including GPs, pharmacists, district nurses, community psychiatric nurses, reablement teams, community geriatricians, adult social care staff, allied health professionals and staff from the third sector working across primary care and hospital sites. Over the next five years, all parts of the country will be required to increase capacity in these teams so that crisis response services can meet response times set out in guidelines by the National Institute for Health and Care Excellence (NICE). Access to social prescribing will be extended, with more than 1,000 trained link workers in place by the end of 2020/21.

5.8 There is also a strong emphasis on developing digital services so that within five years, all patients will have the right to access GP consultations via telephone or online. Primary care networks will also roll out the successful approach pioneered by the enhanced health in care homes vanguards so that by 2023/24, all care homes are supported by teams of health care professionals (including named GPs) to provide care to residents and advice to staff.

What this means for Thurrock

5.9 The move to integrate primary and community health care around mixed skill workforce teams serving populations of 40-50K is welcome and replicates the model set out in the Tilbury and Chadwell Case for Change document already being rolled out locally including our mixed skill Primary Care workforce and Community Led Solutions teams, whilst building on it to encompass some new posts including Community Geriatricians. The LT Plan references the role of promoting self-care of these new teams and this is perhaps an area which is underdeveloped in Thurrock and which we need to focus on in 2019/20. The Public Health Team will bring forward proposals for self-care in our 2019/20 Service Plan.

5.10 The commitment to expand social prescribing with 1000 new social prescribers nationally by 2021 is also welcome and dove tails into the need to increase capacity locally. Perhaps one criticism that could be made is that 1000 new social prescribers nationally is under-ambitious given the scale of demand on Primary Care.

5.11 The focus on in-reach services to care homes also mirrors best practice already happening in part of Thurrock, where paramedics, GPs and pharmacists undertake weekly proactive review of residents and provides additional resources to ensure this occurs borough wide.

5.12 The move the population based health again links well with existing work locally, where Thurrock has plans that are significantly more developed than other localities in our STP area. The Better Care Together Thurrock programme forms the strong basis of a Population Health Management Programme, and the new Mede-analytics data lake will provide functionality to develop the risk stratification tools referenced in the plan, together with opportunities for identification and early proactive management of cohorts of patients at risk of serious adverse health events in 2019/20.

5.13 The proposals on Integrated Care Systems leave further questions, largely around geographical footprint. Better Care Together Thurrock forms the basis of a local ICS, triangulating population with place, community and integrated data, and delivering new models of integrated care. Although the plan stops short of specifying new geographical footprints for ICSs, it does talk about a single CCG for each ICS. There is a strong likelihood that locally, this will be at STP footprint. This geography makes little sense to Thurrock in terms of place base initiatives and builds an additional level of complexity in terms of boundaries crossing multiple local authorities. It presents a danger in terms of slowing down local transformation work if Thurrock is forced to operate in a wider system with other localities that have less developed integrated plans.

5.14 The LT Plan references new Alliance agreements and integrated provider contracts which may allow us to short cut proposals to develop something similar through the Thurrock Integrated Care Alliance. However, the LT Plan also raises questions relating to top down control from NHS England. It states that each ICS will need to agree system wide objectives with their relevant NHSE Locality Director and these will be a mixture of national and local priorities. More ominously it talks about ICSs needing to “earn” greater authority from NHSE to develop local initiatives, raising the Spector of centralised top down command and control. It is unclear how this will work in practice.

5.15 Finally, as referenced in section 3 there is little detail on Adult Social Care or integrated funding over and above some negative commentary on the Better Care Fund and talk that NHS funding being used to ‘prop up’ councils. If the plan is serious about integration of health and care, this separation of funding streams seems counter-intuitive.

6. Action to improve care quality and outcomes in different clinical specialities

6.1 Perhaps the most striking part of the plan is the sheer number of commitments relating to a group of clinical specialities where outcomes in the UK have sometimes lagged behind other similar western health systems. Priorities include cardio-vascular disease, cancer, mental health, maternity and neonatal health, diabetes and respiratory care.

6.2 **Cardio-vascular health.** The plan references an ambition to prevent up to 150,000 heart attacks, strokes and vascular dementia cases by 2029. Initiatives to achieve this will include improving the effectiveness of the NHS Health Check programme, hypertension case finding, expanding testing for Familial Hypercholesterolaemia, a national primary care audit on CVD prevention, rapid access to Heart Failure Nurses in hospital, improved access to echocardiography in Primary Care and scaled up cardio rehabilitation.

6.3 Specific ambitions for stroke care include implementation of more HASU units, implementation of high intensity stroke rehabilitation lasting six months or more, and a ten-fold increase in the proportion of patients who receive thrombectomy after stroke leading to 1600 more people being independent after their stroke by 2022.

What this means for Thurrock

6.4 Thurrock already has robust plans for Cardio-vascular disease prevention though the Long Term Conditions Working Group that match many of the ambitions set out above including hypertension case finding, improving the management of cardio-vascular disease in Primary Care through stretched QOF, improving the effectiveness of NHS Health Checks and upskilling of the Primary Care workforce in CVD management. The move to Integrated Medical Centres provides opportunities for increasing access to ECGs in Primary and Community Care, and the MSB hospital reconfiguration provides for creating a new HASU. There are however opportunities to use LT Plan investment to expand cardiac rehabilitation programmes for patients with Heart Failure.

6.5 **Cancer.** The LT Plan has a bold ambition to increase the proportion of cancers diagnosed at stage 1 and 2 from the current 50% to 75% by 2028. It aims to achieve this by increasing knowledge of GPs to recognise the early stages of cancer, accelerate diagnosis and treatment and maximising early diagnosis by identifying more cancers through screening.

6.6 A new Faecal Immunochemical screening test will be rolled out as part of the Bowel Cancer screening programme that has shown to increase uptake by 7% and the age at which screening starts will be lowered from 60 to 50. Similarly a new HPV Primary Screening test for cervical cancer will be implemented across England by 2020. Lung health checks to identify lung cancer earlier implemented together with mobile lung CT scanners in supermarket car parks.

6.7 A new 28 day maximum cancer definitive diagnosis standard will be implemented from 2020 together with a radical overhaul of the way diagnostic services are delivered for patients with suspected cancer including a roll out of Rapid Diagnostic Centres across the country equipped with the latest kit and expertise. There will be new capital investment in MRIs and CT scanners to address the fact that the NHS has the third lowest number of scanners per head of population in the OECD34 group of countries. Finally there will be investment in advanced radio-therapy and immunotherapy techniques including proton beam therapy and a routine offer of genomic testing to everyone with cancer who would benefit clinically, from 2023.

What this means for Thurrock

6.8 Cancer is the single biggest cause of death in Thurrock and historically our outcomes have been poorer than England's both in terms of cancer waiting time standards, fragmented diagnostic pathways, screening programme up take and early diagnosis. As such, the new investment set out in the plan is welcome. Perhaps the challenge will be implementation on the ground; we do not have a good track record on meeting existing cancer wait standards and have populations within the borough who have often not taken up the offer of cancer screening programmes. As a local health and care system we will need to bring forward plans to address these challenges.

6.9 **Mental Health.** The Plan references a huge range of ambitions to improve the treatment (and to some extent the prevention) of mental ill-health in both adults and children and young people. The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years. NHS England's renewed pledge means mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24. Children and Young People's Mental Health service funding will grown faster than over-all mental health funding with 70,000 more children and young people being able to access mental ill-health treatment services by 2020/21.

6.10 There will be new waiting time standards for children's eating disorder and crisis services. Plans already set out in an earlier government response

paper to a consultation on children's mental health are repeated including expanded CAMHS services and new Schools Based Mental Health Support Teams. There will also be a new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood based around the 'iThrive' model.

6.11 A new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood will extend current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults. The new model will deliver an integrated approach across health, social care, education and the voluntary sector, such as the evidenced-based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25 year olds.

6.12 For adults, the plan talks about an expansion of IAPT services for treatment of Common Mental Health Disorders with 380,000 additional adults being treated by 2023/24, together with an integration of provision with other physical long term condition treatment programmes. For those with Serious Mental Ill-Health, the plan references "New and Integrated models of Primary and Community Mental Health Care" with "access to psychological therapies, improved physical health care, employment support, personalised ad trauma-informed care, medicines management and support for self-harm and co-exiting substance misuse"

6.13 Expanding crisis care features strongly in the LT Plan including a commitment to 24/7 community based crisis care by 2020/21 including home treatment, integration with NHS 111, RAID services in A&E and alternative provision for those in crisis including Sanctuaries, Save Havens and Crisis Cafes.

What this means for Thurrock

6.14 New investment in mental health services should be broadly welcomed. The 2018 Children's and Adults Mental Health JSNAs together with LGA Peer Review and Thurrock Healthwatch research identified structural problems with children and adults local mental health systems. The proposals within the NHS LT plan fit well with transformation work already underway in Thurrock. There is a potential opportunity to main stream the three-year funding for our Schools Based Mental Health Wellbeing Service, and for the development of new models of care for Common Mental Health Disorders and SMI set out in the January 2019 HOSC Paper on Mental Health Transformation. A new 24-7 Crisis Care pathway has already been developed with plans for roll out in 2019/20 which will meet the commitments set out in NHS LT Plan ahead of schedule. However perhaps one criticism of the NHS LT Plan commitments is

that they remain largely clinical and perhaps do not match local ambitions to create a more holistic offer better integrated with community and place based initiatives.

6.15 Neo-natal, maternity and child health. The plan sets out a wide range of initiatives to improve clinical outcomes in this area, together with an ambition to reduce still birth, maternity mortality, neonatal mortality and serious brain injury by 50% by 2025.

6.16 There are commitments to implement the *Saving Babies Lives Care Bundle* by 2020 which has shown a 20% reduction in still births at maternity units where it has been piloted. Continuity of care for pregnant women and new mothers will also be improved with an ambition that 20% of all pregnant women will have the opportunity to have the same midwife caring for them throughout their pregnancy, birth and post-natally by March 2021. There will be increased access to evidence based care for women with post-natal depression and Personality Disorder diagnosis with an extension of help from 12 to 24 months after giving birth. This will include an expansion of access to psychological therapies with specialist perinatal mental health input and will include parent-infant, couple, co-parenting and family interventions including support for fathers.

6.17 A physio-therapy offer for women in the post-natal period who suffer faecal incontinence and pelvic organ prolapse will be expanded. There is a commitment to deliver an accredited infant feeding programme like the UNICEF Baby Friendly initiative in all maternity services. More broadly, there is a commitment to expansion of the neonatal workforce including allied health professionals supporting neonatal nurses.

6.18 The plan prioritises improvements in childhood immunisation coverage to the base level standards in the NHS PH function agreement. It also recognises that children and young people are most likely to attend A&E inappropriately and recommends developing new models of urgent care as part of a Community Multi-speciality Provider approach. Perhaps most significantly it recommends creation of a new 0 to 25 year old service model for young people that offers person-centred age appropriate care for children and young people and integrates physical and mental health.

What this means for Thurrock.

6.19 Again there is much to be welcomed in the plan although Maternity Service Planning in south Essex is notoriously complex, not least because of significant migration of expectant mothers from areas outside Essex into local units. As such, planning for delivery on the ground is likely to be challenging.

Strategic Partnership arrangements for children and young people in Thurrock need to be strengthened and new delivery plans will need to be developed as part of this process. It is unclear whether proposals to address inappropriate A&E attendances by children by creating new community provision will be successful. Evidence on creation of Minor Injuries Clinics in the community suggests that they had little to no impact on A&E use, and simply created additional supply-side demand.

6.20 **Acute and emergency Care.** The plan includes a significant package of measures aimed at reducing pressures on A&E departments. Many of the measures build on previous initiatives, including the introduction of clinical streaming at the front door to A&E and the roll-out of NHS 111 services across the country.

6.21 The plan commits to rolling out urgent treatment centres (UTCs) across the country by 2020 so that urgent care outside hospitals becomes more consistent for patients. UTCs will be GP-led facilities and will include access to some simple diagnostics and offer appointments bookable via NHS 111 for patients who do not need the expertise available at A&E departments. Alongside this, the plan aims to improve the advice available to patients over the phone and extend support for staff in the community by introducing a multidisciplinary clinical assessment service (CAS) as part of the NHS 111 service in 2019/20.

6.22 Over the same timeframe, all major A&E departments will introduce same day emergency care (also known as ambulatory emergency care). This will see some patients admitted from A&E undergo diagnosis and treatment in quick succession so that they can be discharged on the same day, rather than staying in hospital overnight. The plan estimates that up to one-third of all people admitted to hospital in an emergency could be discharged on the same day by rolling out this model. Despite ongoing concerns about operational performance in emergency care, the plan does not make any commitment on the four-hour A&E target, postponing any decision to restore performance standards until the Clinical Review of Standards reports in the spring.

6.23 Unlike some previous NHS strategies, the long-term plan does not assume that moves to strengthen primary and community care will reduce demand for inpatient hospital care. Instead, its plans for hospital bed numbers and staffing assume that acute care will grow broadly in line with the past three years (although the plan does not specify what figure it is using for this).

6.24 The plan includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert up to a third of face-to-face consultations in order to provide a more convenient service for

patients, free up staff time and save £1.1 billion a year if appointments were to continue growing at the current rate. It is not yet clear what this redesign will involve.

6.25 Although the plan notes that these changes will have implications for how waiting-times performance is calculated, there is no commitment to meet the 92 per cent target for 18-week waits. Instead, over five years, the volume of planned activity will increase year-on-year to reduce long waits and cut the number of people on the waiting list (currently more than 4 million). The commitment to reduce long waits is given teeth by the reintroduction of fines for providers and commissioners where patients wait 12 months or more.

What this means for Thurrock

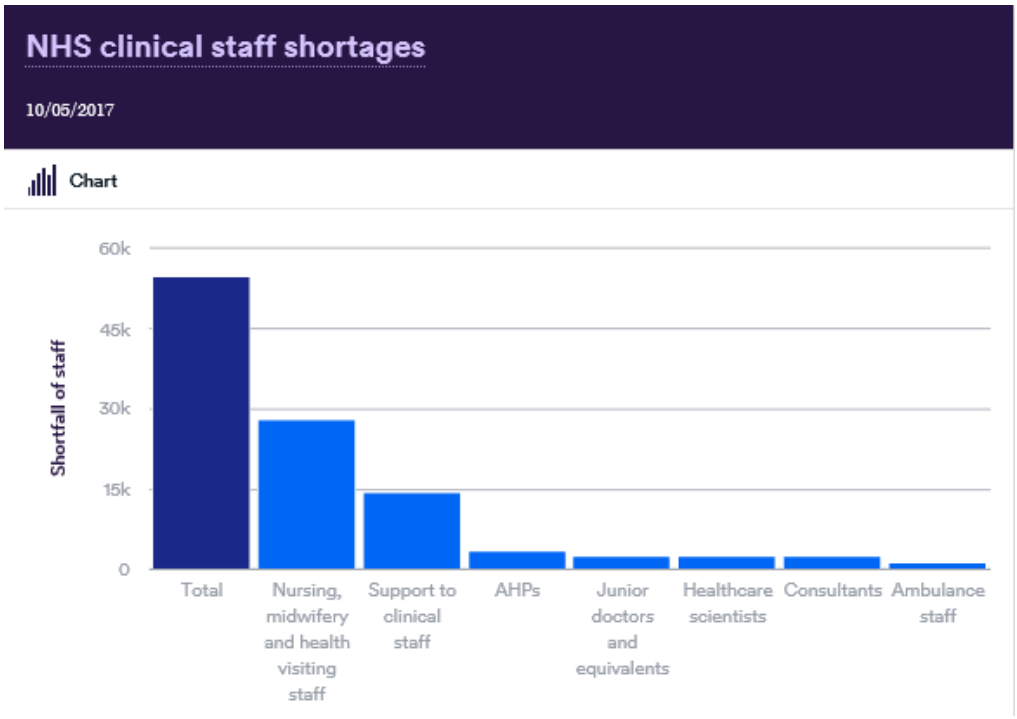
6.26 Some measures set out in the plan are already in place at Basildon Hospital including new approaches to ambulatory care and 'same day' wards. A lack of reform of the four-hour A&E waiting target is perhaps disappointing as it could be argued that treating patients who attend A&E with non-urgent or emergency conditions creates perverse clinical priorities and encourages misuse of the system. However, this was perhaps filed in the 'politically too difficult' box when the plan was developed.

6.27 Referencing DTOCs without considering Adult Social Care funding or transformation within the plan is perhaps short-sighted, although it is worth remembering that Thurrock benchmarks extremely well against CIPFA comparators on DTOC suggesting existing arrangements are largely effective. It remains to be seen whether the proposals that rely on deploying new technology can be delivered or whether or whether or not they will be effective in enabling providers to improve performance. We will need to wait for the publication of the clinical review of standards to better understand government expectations.

7. Workforce

7.1 Workforce shortages are currently one of the biggest challenges facing the health service. There were approximately 50,000 vacancies across all types of clinical staff in 2017 according to the National Audit Office. (Figure 3)

Figure 3



7.2 The plan recognises the scale of the challenge and sets out a range of specific measures to address it, although many will not be finalised until after the 2019 Spending Review which sets the budget for training, education and professional development. NHS Improvement, Health Education England and NHS England are tasked within the plan to form a cross sector National Workforce Group and publish a workforce implementation plan later in 2019.

7.3 The plan does set ambitions to reduce the nursing vacancy rate from 11.6% to 5% by 2028 by increasing the number of undergraduate nursing placements by 25% by 19/20 and offering new routes to nursing qualification including a new online nursing degrees and expansion of the nursing apprenticeship programme. It also reiterates the DH commitment to increase medical school places by 1,500 per year and suggests that this figure could increase further subject to the Spending Review. There is also ambition to increase numbers of paramedics and physio-therapists, podiatrists, speech and language therapists and radiographers working in Primary and Community Care, although again the plan is light on detail, stating that the Chief Allied Health Professions Officer will bring forward further proposals as part of a new national strategy on AHPs.

What this means for Thurrock

7.4 Workforce remains a major challenge in Thurrock. We are the second most under-GP'd area in England and have significant shortages of all clinical staff. Our proximity to both London and more affluent areas of Essex make attracting and retaining staff to the borough challenging. Our local transformation programmes including Integrated Medical Centres and New Models of Care aim to address this by making Thurrock an attractive place to operate as a clinician and our links to both the new Anglia Ruskin University Medical School and proposals for a new London Southbank School of Health and Social Care campus at Purfleet may also assist in the medium term.

7.5 The NHS LT Plan makes multiple commitments throughout that are dependent on successful increases in the clinical workforce, yet firm proposals to address the current shortfall are limited. Until these are brought forward following the forthcoming government spending review, this remains a major risk for us.

8. Final reflections and conclusions

8.1 There is much to feel optimistic about within the NHS Long Term Plan, and many proposals that mirror local transformation work already underway in Thurrock. New models of care for a mixed skill integrated community and primary care workforce match our own ambitions for Better Care Together Thurrock, and similarly new integrated alliance contracts, collaboration between NHS providers and commissioners and population health management approaches fit will with the local direction of travel set by the Thurrock Integrated Care Alliance. Similarly ambitions on mental health transformation, cardio-vascular disease management, diabetes, and integrated data.

8.2 What is less clear is the impact of organisational reform set out in plan. Whilst the plan stops short of specifying that the new ICSs will operate at STP level, this remains a strong possibility locally. Slimmed down CCGs (likely also to operate locally to operate at our STP level) risk slowing down transformation plans in Thurrock on Population Health and integrated care that are more advanced than some of our neighbours, and also risk moving focus away from Thurrock as a place, and resources away from local Primary Care transformation which has been so successful. There is an urgent need to agree with STP colleagues the different logical footprints for various aspects of NHS commissioning and transformation to take place over. We have benefited from being co-terminous with our local CCG and we don't want to lose that essential ingredient to good, close, local working.

8.3 The focus on shifting the NHS from a treatment to (at least in part) preventative service is hugely welcome, particularly at a time of reducing funding to other preventative services in the local health and care system, perhaps most obviously the Public Health Grant. Delivering this will however require significant organisational development activity if we are going to shift the attitudes of many in an NHS workforce that have historically not seen prevention as part of their job. It will also require leadership at a local level to move funding in CCG baselines from treatment to prevention initiatives if the ambitions in the NHS plan are to be realised. The NHS does not have a great history on funding prevention and public health budgets were often the first to be plundered in PCT days when acute services overspent.

8.4 Moves to consider a greater role for the NHS in commissioning of sexual health, health visiting and school nursing services came somewhat 'left field', with little further explanation. It is worth noting that the poorest performing Public Health services since the 2012 reforms have been those immunisation and screening services commissioned from the NHS. Further fragmentation in commissioning of particularly school nursing and health visiting locally risks adding additional complexity to our local Brighter Futures model.

8.5 Perhaps one of the greatest criticisms of the NHS LT Plan is that it is largely inward looking. The new funding will remain more or less entirely within the NHS itself and proposals for the long term funding of adult social care or wider prevention remain subject to future government strategy. Prevention is almost entirely focused on individuals without setting this in the context of wider determinants of health or community; settings that evidence suggests have much greater impact on over-all health outcome than individual care management or lifestyle modification approaches.

8.6 Finally, much of the plan is dependent on successful expansion of the NHS workforce. Again the strategic ambition is positive but the plan is light on detail and this is perhaps the biggest risk to successful implementation locally.

9. Implications

9.1 Financial

Implications verified by: **Mike Jones**

Senior Accountant, Adult Social Care

The NHS Plan sets out considerable new investment into the NHS locally, with year on year increases in CCG baseline budgets totalling £20.5Bn nationally over the next five years.

Funding will be drawn down into CCG baselines, and local plans will need to be developed to meet the ambitions accordingly.

The plan includes a new significant role in prevention for which there is insufficient funding within existing Public Health Grant allocations to address these aspirations.

Any implications that the plan has on the resources of the Local Authority will need to be discussed, in detail, through the Councils appropriate formal channel and decision making processes.

The future of public health funding for Local Authorities is current being considered as part of the governments reforms of fair funding needs, business rates retention consultations, and the 2019 spending review, for which the results and subsequent financial implications will not be known until later on in the year.

9.2 **Legal**

Implications verified by: **Sarah Okafor**

Barrister – Consultant

This paper is a critically constructive summary of the NHS Long Term Plan and the implications from it for Thurrock Council. On behalf of the Assistant Director for Law; I confirm I have read the report in full and there are no external legal implications identified, arising from the contents of it.

9.3 **Diversity and Equality**

Implications verified by: **Becky Price**

Team Manager - Community Development and Equalities

The initiatives outlined in this report will assist in future strategic planning to address health inequalities, placing a requirement on the local NHS to bring forward detailed plans to address variation in health outcome between different populations and linking future funding partly on success in reducing health inequalities. It is not clear at this stage between which geographical footprints reduction in health inequalities will be assessed.

9.4 **Other Implications (where significant) ie. Staff, Health, Sustainability, Crime and Disorder)**

None

10. Reasons for Recommendation

The NHS Long Term Plan will shape the major strategic direction of the NHS locally, and impact on local transformation programmes. It will be important that the council gives a strong voice in development of local NHS delivery plans and new organisational structures that will be responsible for its implementation at a local level.

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

The NHS Long Term Plan has been published. The Government may undertake further consultation on some of the proposals set out within in, for example an expanded role of the NHS in commissioning council Public Health functions.

12. Background papers used in preparing the report

None

13. Appendices to the report

Appendix 1 - The NHS Long Term Plan: Commitments

Report Author:

Ian Wake

Director of Public Health

Appendix 1

The NHS Long Term Plan: Commitments

This document itemises the commitments in the plan.

Chapter 1: A new service model for the 21st Century

Section	Commitment
1.8	Within 5 years expected to improve the responsiveness of community health crisis response services within two hours of the referral in line with National Institute for Health and Care excellence (NICE) guidelines where clinically judged appropriate
1.8	All parts of the country should be delivering reablement care within two days of referral
1.9	Practices enter into network contract
1.10	From 2019 NHS111 will start direct booking into GP practices across the country, as well as referring onto community pharmacists. Clinical Commissioning Groups (CCG) develop pharmacy connection schemes for patients who don‘t need primary medical services
1.15	We will upgrade NHS support to all care home residents who would benefit by 2023/24, with an Enhanced Health Care (EHCH) model rolled out across the whole country
1.17	From 2020/21 Primary Care Networks will assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed
1.25	From 2019/20 embed single multi-disciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP Out of Hours services
1.26	By Autumn 2020 fully implement Urgent Treatment Centre model
1.30	Every acute trust with a “Type 1 Accident and Emergency” department (ie fully staffed with Consultant Physicians) will: • move to a comprehensive model of Same Day Emergency Care (SDEC). The SDEC model should be embedded in every hospital, medical and surgical specialities during 2019/20 • provide an acute frailty service for a least 70 hours a week. Work towards clinical frailty assessment within 30 mins of arrival • test and begin implementing new emergency and urgent care standards
1.33	From 2020 embed Emergency Care Depts into UTCs and SDEC services

1.34	By 2023 Clinical Assessment Service will typically act as single point of access for patients
1.39	Rolle out NHS personalised Care Model reaching 2.5m people by 2023/2024 and aiming to double that within the decade
1.40	Over 1,000 trained social prescribing link workers will be in place by end of 2020/21 rising further by 2023/24 (no mention of how the actual interventions will be funded in plan, a major concern for local authorities and voluntary sector)
1.41	Accelerate roll out of Personal Health Budgets (PHB). By 2023/24 up to 200,000 people will benefit form PHB
1.44	Over next five years every patient in England will have the right to choose telephone or online consultations from their GP
1.47	Re-designing outpatient services over the next five ears
1.51	By April 2021 Integrated Care Systems (ICS) will cover the whole country

Chapter 2: More NHS action on prevention and health inequalities

Section	**Commitment**
2.9	By 2023/24 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services
2.10	Adapted model available for expectant mothers and their partners
2.11	New universal smoking cessation offer be available as part of the specialist mental health services for long-term users of specialist mental health, and learning disability services
2.14	Target support offer and access to weight management series in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+
2.20	Over next five years, hospital with highest rate of alcohol dependence-related admissions will be supported to fully establish specialist Alcohol Care Teams
2.21	By 2023/24 NHs will cut business mileage and fleet air pollution emissions by 20%
2.26	During 2019 all local systems expected to set out how they will specifically reduce health inequalities by 2020/24 and 2028/29
2.26	Expect all CCGs to ensure that all screening and vaccination programmes

	are designed to support a narrowing of health inequalities
2.28	By 2024 75% women from Black and Minority Ethnic communities and similar percentage of women from the most deprive groups will receive continuity of care from their midwife, throughout out their pregnancy, labour and post-natal period
2.30	By 2020/21 will ensure that at least 280,000 people living with Severe Mental Illness (SMI) have their physical health need met
2.30	By 2023/24 increase the number of people with SMI problems receiving physical health checks to an additional 110,000 people per year
2.31	Over five years we will invest to ensure that children with Learning Disabilities have their needs met by eyesight, hearing and dental services

Chapter 3: Further progress on care quality and outcomes

Section	Commitment
3.9	NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury
3.10	In 2019 aim to roll out the care bundle across every maternity unit in England
3.12	Spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative
3.13	By 2021 most women receive continuity of the person caring for them during pregnancy, during birth and postnatally
3.15	Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by the end of 2019/20
3.15	By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices
3.39	We will actively support children and young people to take part in clinical trials, so that participation among children remains high, and among teenagers and young adults rises to 50% by 2025
3.40	From September 2019, all boys aged 12 and 13 will be offered vaccination against Human Papilloma Virus-related diseases, such as oral, throat and anal cancer
3.45	From 2019/20 clinical networks will be rolled out to ensure we improve the quality of care for children with long-term conditions

	such as asthma, epilepsy and diabetes. (How these will differ from the Networks which the NHS rolled out between 2005 – 2010 remains to be seen)
Milestones for Cancer	• From 2019 NHS will start to roll out new Rapid Diagnostic Centres across the country. • In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days. • By 2020 HPV primary screening for cervical cancer will be in place across England. • By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. • By 2022 the lung health check model will be extended. • By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers. • By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.
Milestones for cardiovascular disease	• The NHS will help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years. • We will work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest. • By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.
Milestones for stroke care	• In 2019 we will, working with the Royal Colleges, pilot a new credentialing programme for hospital consultants to be trained to offer mechanical thrombectomy. • By 2020 we will begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of this Long-Term Plan. • By 2022 we will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke. • By 2025 we will have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit.
3.80	From April 2019 will ensure that, in line with clinical guidelines, patients with type 1 diabetes benefit from life changing flash glucose monitors
3.80	By 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes

3.89	Mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24
3.91	The Five Year Forward View for Mental Health set out plans for expanding IAPT services so at least 1.5 million people can access care each year by 2020/21. We will continue to expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long-term conditions. By 2023/24, an additional 380,000 adults and older adults will be able to access NICE-approved IAPT services
Milestones for mental health services for adults	• New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24. • By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post-crisis support. • By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis. • Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at ‘core 24’ standards in 2023/24, expanding to 100% thereafter.
3.108	The local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list
3.114	We will work to increase the number of people registering to participate in health research to one million by 2023/24
3.115	By 2023/24 the new NHS Genomic Medicine Service will sequence 500,000 whole genomes
3.117	From 2020/21 we will expand the current NHS England ‘Test Beds’ through regional Test Bed Clusters
3.119	**We will invest in spreading innovation between organisations. Funding for AHSNs, subject to their success in being able to spread proven innovations across England, will be guaranteed until April 2023**

Chapter 4: NHS staff will get the backing they need

Section	Commitment
4.12	Improve nursing vacancy rate to 5% by 2028
4.15	Extra 5,000 nursing undergraduate places funded from 2019/20
4.18	Continue investment in growth of nursing apprenticeships with 7,500 new nursing associates starting in 2019
4.19	Grow wider apprenticeships in clinical and non-clinical jobs in the NHS with the expectation that employers will offer all entry-level jobs as apprenticeships before considering other recruitment options
4.36	Improve staff retention by at least “% by 2025
4.42	Each NHS organisation will set is own target for BAME representation across its leadership team and broader workforce by 2021/22.
4.48	By 2021 NHSI will support NHS trust and FTs to deploy electronic rosters or e-job plans
4.54	Double the number of NHS volunteers over the next three years

Chapter 5: Digitally-enabled care will go mainstream across the NHS

Section	Commitment
5.12	In 2019/20, 100,000 women will be able to access their maternity record digitally with coverage extended to the whole country by 2023/24
5.13	We will work with the wider NHS, the voluntary sector, developers, and individuals in creating a range of apps to support particular conditions
5.13	By 2020, we aim to endorse a number of technologies that deliver digitally-enabled models of therapy for depression and anxiety disorders for use in IAPT services across the NHS
5.14	Support for people with long-term conditions will be improved by interoperability of data, mobile monitoring devices and the use of connected home technologies over the next few years
5.14	By 2023, the Summary Care Record functionality will be moved to the PHR held within the LHCR systems, which will be able to send reminders and alerts directly to the patient
5.17	Supporting moves towards prevention and support, we will go faster for community-based staff

5.21	Over the next five years, every patient will be able to access a GP digitally, and where appropriate, opt for a ‘virtual’ outpatient appointment
5.22	By 2024 all providers, across acute, community and mental health settings, will be expected to advance to a core level of digitisation
5.25	By 2022, technology will better support clinicians to improve the safety of and reduce the health risks faced by children and adults
5.26	During 2019, we will deploy population health management solutions to support ICSs to understand the areas of greatest health need and match NHS services to meet them
5.28	By 2021, pathology networks will mean quicker test turnaround times, improved access to more complex tests and better career opportunities for healthcare scientists at less overall cost
5.28	By 2023, diagnostic imaging networks will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret
Milestones for digital technology	• During 2019 we will introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in *The Future of Healthcare*. • By 2020, five geographies will deliver a longitudinal health and care record platform linking NHS and local authority organisations, three additional areas will follow in 2021. • In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual’s LHCR across the country over the next five years. • By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system. • In 2021/22, we will have systems that support population health management in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation. • By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices. • By 2023/24 every patient in England will be able to access a digital first primary care offer (see 1.44). • By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and LHCRs will cover the whole country.

This page is intentionally left blank

7 March 2019	ITEM: 9
Health & Wellbeing Overview and Scrutiny Committee	
Adult Social Care Local Account 2018-2020	
Wards and communities affected: All	**Key Decision:** No
Report of: Roger Harris – Corporate Director of Adults, Housing and Health	
Accountable Assistant Director: Les Billingham – Assistant Director of Adults and Community Development	
Accountable Director: Roger Harris – Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

The 2018-2020 Adult Social Care Local Account is our fifth such report. The report is aimed at the local community and describes how Adult Social Care has progressed against the 10 key priorities we set in the last Local Account, our key challenges, and describes the process of co-production used to identify our 10 priorities for the next two years.

A summary of Thurrock's performance on the key indicators in the national adult social care outcomes framework is also included in the report.

1. Recommendation(s)

1.1 That the Health & Wellbeing Overview and Scrutiny Committee consider and note the report.

2. Introduction and Background

2.1 Since 2011 and the abolition of the Care Quality Commission (CQC) Annual Performance Assessment, there have been a number of changes made to the performance framework for adult social care. The key elements of the approach to assessing and reporting on Adult Social Care performance are set out in the Department of Health publication: 'Transparency in Outcomes: A Framework for Quality in Adult Social Care' (March 2011).

2.2 At the heart of this change is a strong emphasis on the development of effective sector-led improvement. The sector-led approach is led by a national 'Towards Excellence in Adult Social Care Programme' (TEASC) that

includes the Department of Health, Care Quality Commission (CQC), Local Government Association (LGA) and the Association of Directors of Social Services (ADASS). Reports, known as local accounts, are seen as a central element of this model and this is a best practice requirement.

2.3 Local accounts are intended to be self-assessed and published by Councils. There is no National Government role in assurance and there is no specific guidance produced to cover the content of a local account.

2.4 Local accounts are expected to provide an account of the quality and outcome priorities which the council has agreed, and the progress it has made in achieving them. In short it aims to inform the public of what Adult Social Care does, who it is for, and what the progress and priorities are.

3. Issues, Options and Analysis of Options

3.1 The Local Account aims to tell people how we help adults who may require care and support in Thurrock. The report describes:

- How we spent our money
- Our achievements and the things we need to improve
- The method used to co-produce future priorities
- How the public can be involved and give their views

3.2 Following the production of the Local Account for 2016/17, Thurrock Diversity Network Limited forwarded a number of key questions and suggestions to the Co-Chairs of the Thurrock Disability Partnership Board, including the Assistant Director of Adults and Community Development.

3.3 A response to this feedback was presented to the Thurrock Disability Partnership Board in September 2017, with some formal recommendations and suggestions to improve future local accounts.

3.4 Three recommendations for future local accounts were then made by the Disability Partnership Board:

- To co-produce any future local account for Thurrock, in partnership with individuals, family members and carers with lived experience of local services, third sector and other interested parties
- To move from a 12-month cycle to 24 months to allow time for reflection, change and progress to be more effectively measured, built upon and celebrated
- For local account workshops to be facilitated by an external third party in collaboration with Thurrock Coalition

3.5 The Local Authority also agreed that future local accounts will:

- Be focussed on what service users and members of the public want to see in it
- Provide links to relevant websites where further information about projects can be sought
- Provide more examples of successes and outcomes achieved
- Be honest in what has gone wrong and what needs to be improved

3.6 A series of workshops were held by Thurrock Coalition and Community Catalysts CIC throughout August 2018 looking at what the Council is doing well and what it needs to improve, and agreeing what the priorities should be for the next two years. A full report from Thurrock Coalition on the outcomes of the workshops can be found at: http://www.thurrockcoalition.co.uk/wp-content/uploads/2018/10/Thurrock-Coalition-Informing-the-Local-Account-through-Coproduction-October-2018-FINAL.pdf

3.7 The Local Account 2018-2020 brings together the Council's assessment of achievements and challenges against the previous 10 priorities and the views of the participants from the workshops on what is working well and what needs to improve. The 10 key priorities for the next two years have been set by the participants of the workshops based on the things they felt were important.

4. Reasons for Recommendation

4.1 It is recognised as best practice to provide and publish a co-produced Local Account for Adult Social Care, and for this to be consulted and commented on by the Council, including by Overview and Scrutiny Committee.

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

5.1 This report has been co-produced by Thurrock Coalition, the Council's user-led organisation, in partnership with individuals, family members and carers with lived experience of local services, third sector and other interested parties through a series of workshops.

5.2 The report will be presented at various representative groups, including the Thurrock Coalition AGM. A steering group will be established to oversee the achievement of the priorities.

5.3 The Local Account will be published on the Council's corporate website and there will be an opportunity for the general public and/or service users to feedback comments and suggestions.

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

6.1 The Adult Social Care Local Account directly contributes to the delivery and achievement of the Council's vision and strategic priorities. In particular it

provides a means of reporting back to local people on how the Council is performing in delivering:

- People – a borough where people of all ages are proud to work and play, live and stay.
  This means:
  - 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 to together to improve health and wellbeing
  - Communities are empowered to make choices and be safer and stronger together

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant – Social Care & Commissioning

There are no specific financial implications arising from this report as this is just for members' information.

7.2 Legal

Implications verified by: **Sarah Okafor,**

Barrister (Consultant)

On behalf of the Director of Law. I have read the reports in full and confirm there are no specific legal issues or external implications appearing to arise from the report as this is just for the members' information.

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Strategic Lead Communities and Diversity

There are no specific diversity issues arising from this report that is prepared for members' information. As the Local Account demonstrates, decisions relating to adult social care are informed by considering the impact on groups and individuals with protected characteristics.

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 Local Account 2018-2020

Report Author:

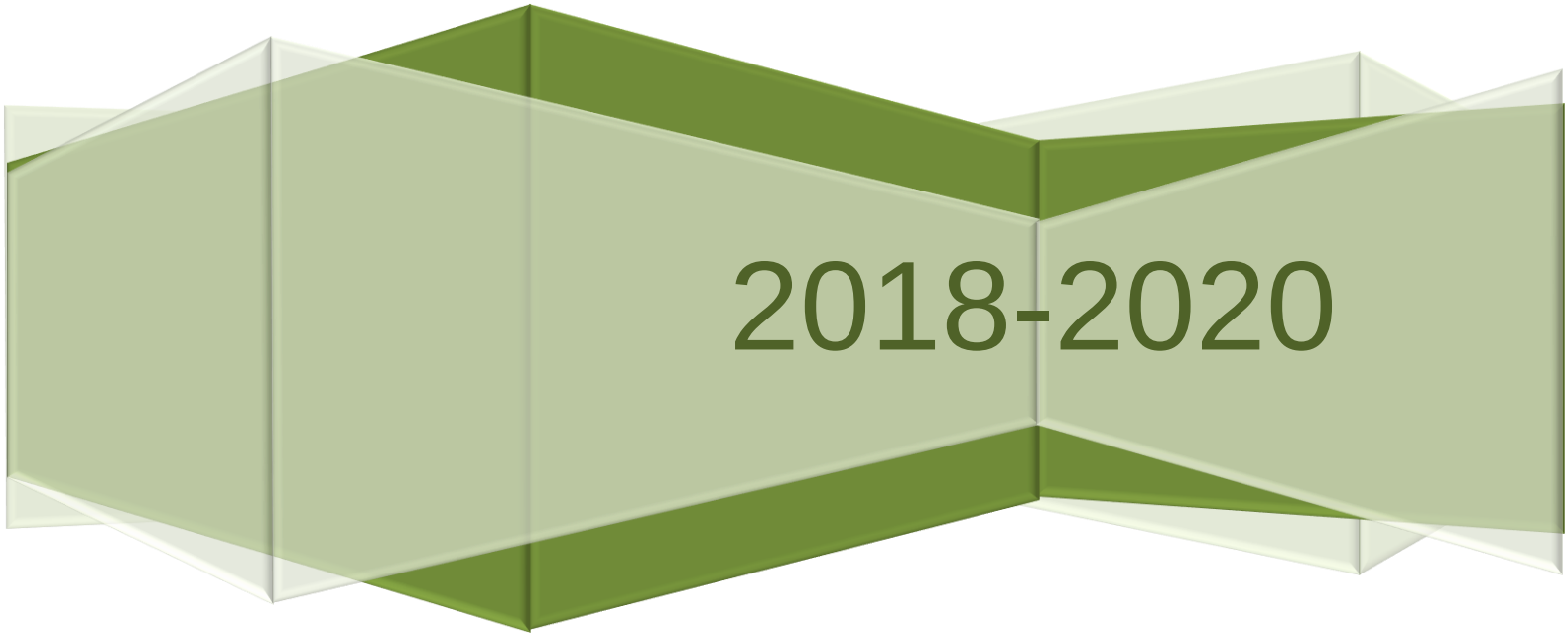
Les Billingham

Assistant Director of Adults and Community Development

This page is intentionally left blank

Adult Social Care in Thurrock

Making a positive difference – how well are we delivering Adult Social Care support and services in Thurrock



Introduction

Welcome to our Local Account covering the years 2018-2020. This Local Account describes the process of co-production used to identify our 10 priorities for the next two years. These priorities are, quite rightly, set by users of our service and will direct our activities over the period 2018-20.

In this account we will tell you about!

- How we spend our money.
- Our achievements against the previous Local Account.
- The method used to co-produce the priorities.
- How you can "Tell us what you think".

In previous reports we have talked about the financial and demographic challenge facing Adult Social Care and about our legal duties under the Care Act (2014). We have again talked about these areas and our ongoing responses to meet these challenges.

In the last report we also talked about the need to be radical in our approach. We believe we have been radical and creative in our transformation programme since the last Local Account; this is evident from the growing national profile this programme has attracted as being system fit for the 21st century.

Much has been done and there is still much to do. Achieving against the priorities co-produced in partnership with our "experts by experience" will be a major step toward our ongoing success.

Councillor Sue Little
Portfolio Holder Children's and Adults Social Care

Roger Harris
Corporate Director of Adults, Housing & Health

Ian Evans
Director,
Thurrock Coalition
(The User-Led Organisation for Thurrock)

Contents

Our Vision

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

The vision of Thurrock Council is '*An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future*'. In Adult Social Care we want people living in Thurrock to enjoy independent, rewarding and healthy lives in communities that are welcoming, inclusive, connected and safe. Unfortunately, we know that this is not the case for everyone, particularly for older adults and vulnerable people who require care and support.

There will always be a need for health and social care services. The problem at the moment is that those services are often only available at the point of crisis. The rising numbers of older and vulnerable adults needing services, together with the increasing budget pressures the Council faces, means that the current way of working is not sustainable or desirable.

We recognise that there is no single solution and that what is needed is a 'whole-system' approach. This means working in partnership with communities, services, partner organisations and the private sector to shift resources towards preventative well-being services and community solutions. It also means supporting individuals and communities to become stronger and draw on community resources to enable people to find their own personal solutions to meet needs and supporting individuals to remain independent.

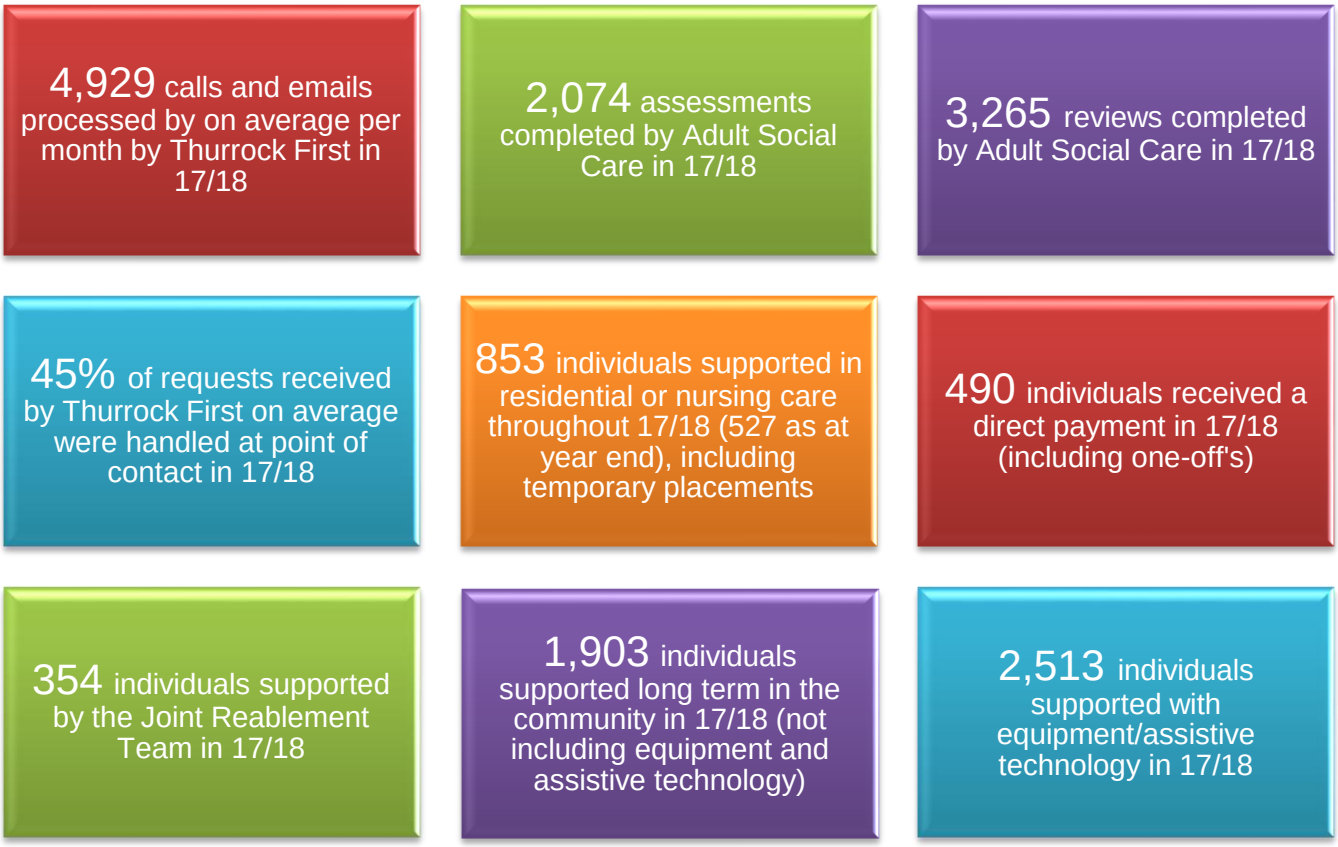
We have continued to develop this approach since the last local account was published in 2016. We have re-branded our transformation programme, moving from "Living Well in Thurrock" to "Better Care Together" as we feel this express the heart of our vision more accurately; a whole system that improves health and well-being for all that is achieved through genuine co-production with our partners, our communities and, most importantly with our citizens. Better Care Together is still based upon the three aspects of our transformation approach that informed our earlier approach:

Our Budget

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

* Gross expenditure. Please note – this expenditure does not include joint funding arrangements between the Local Authority and Clinical Commissioning Group. See Priority 1 for more details.

Key Facts and Figures



Our Key Challenges

Whilst growth in the demand for our services and the increasing complexity of the challenges facing some of those we support continues to put pressure on the whole health and well-being system, the financial pressures that we reported in the last local account have been addressed to some extent by central government in the last few budgets. However, there remains a critical need to be very efficient in the way we deliver services.

The challenges set out in the Care Act (2014) remain – these include the duty to “prevent, reduce or delay” the need for care and support, to integrate service delivery and to recognise the impact of housing on well-being and drive improvement.

In Thurrock we feel we have achieved a lot in terms of these duties, more needs to be done of course and the responses from our citizens set out in this account are evidence of this. However, we feel we have made a solid start and are confident that the next steps we are about to take will continue to improve our offer and meet these challenges effectively.

Co-production, in its fullest sense, sits at the core of everything we want to achieve, with this in mind the development of this local account has changed from the way we produced the version in 2016. The next section outlines the methodology employed in producing the Local Account for Thurrock for 2018/2020:

Local Accounts in Thurrock – A Way Forward

Local Accounts covering previous years in Thurrock, specifically 2016/17 identified 10 key areas of priority and achievement. The priorities were split in to two groups of five and discussed, and debated at two consecutive meetings (in April and May of 2017 respectively) of Thurrock Diversity Network (TDN) Limited. TDN is a member of Thurrock Coalition – the User-Led Organisation for Thurrock. TDN is a Community Benefit Society, consisting of over 60 individual and organisational members with an active, campaigning interest in Disability and Diversity issues, championing lived experience examples and supporting effective change and service improvement through constructive dialogue with the Local Authority.

Thurrock Diversity Network Limited forwarded a number of key questions and suggestions to the Co-Chairs of the Thurrock Disability Partnership Board, including the Assistant Director of Adults and Community Development.

Senior Council Officers analysed the feedback and compiled a response for presentation at the Thurrock Disability Partnership Board in September 2017 with some formal recommendations and suggestions to improve future Local Accounts.

Three recommendations for future Local Accounts were then made by the Disability Partnership Board, namely:

i) To co-produce any future Local Account for Thurrock, in partnership with individuals, family members and carers with lived experience of local services, third sector and other interested parties.

ii) To move from a 12-month cycle to 24 months to allow time for reflection, change and progress to be more effectively measured, built upon and celebrated.

iii) For Local Account workshops to be facilitated by an external third party in collaboration with Thurrock Coalition.

The Local Authority also agreed that Future Local Accounts will:

- **Be focussed on what service users and members of the public want to see in it.**
- **Provide links to relevant websites where further information about projects can be sought.**
- **Provide more examples of successes and outcomes achieved.**
- **Be honest in what has gone wrong and what needs to be improved.**

Review of Our Priorities for 2017-2018

Continue to joint up health and social care services through the Better Care Fund to support people better

Continue to strengthen communities and build community resilience by supporting small community based services

Increase the use of direct payments to allow people to manage their own care

Implement online self-assessments

Complete the re-modelling of home care services to improve choice and quality

Roll-out the delivery of Shared Lives in Thurrock

Put in place an independent system to ensure that our processes to financially assess individuals are fit for purpose

Re-tender the Healthwatch service to improve scope, ensuring quality of service

Develop a specialist autism service

Keep vulnerable people safe

Achievements 2017-2018 and Feedback from Workshops

A series of subsequent workshops were held by Thurrock Coalition and Community Catalysts CIC throughout August 2018 looking at informing the priorities for the Local Account going forward. The following is a summary of the achievements we have made against the priorities identified in the 2016 Local Account, and a summary of the feedback produced by the workshops.

Further details of the workshops appear in Appendix 2 (below). The Full Report is available at: http://www.thurrockcoalition.co.uk/wp-content/uploads/2018/10/Thurrock-Coalition-Informing-the-Local-Account-through-Coproduction-October-2018-FINAL.pdf

Priority 1 – Continue to join up health and social care services through the Better Care Fund to support people better

Achievements:

- Thurrock First – our single point of contact for Adult Social Care, Health and Mental Health became operational.
- "Better Care Together" a project to join up and improve Primary Care, the management of Long Term Conditions and Community Care, embedded in the community and focusing upon prevention, has been implemented in a pilot form in the Tilbury/Chadwell locality. Initiatives include:
    - Introducing Community Led Support (CLS)-bringing social work closer to where people live.
    - Implementing a new Primary Care workforce –Ensuring patients can be seen by the right professional in a timely manner.
    - Delivering a completely reformed service to people who need support to remain living at home through the introduction of Well-Being teams.
    - Improving the support, we provide to people living with Long Term Conditions to prevent them requiring crisis intervention through poor management of their symptoms.
    - Ensuring our other community based initiatives, such as Local Area Co-ordination, Micro Enterprise development; Social Prescribing and Time Banking are being fully integrated within a whole system approach to improving outcomes in Health and Well-Being for our citizens.
    - Reducing duplication of efforts and multiple-visits through greater co-ordination and sharing of data and responsibilities amongst professionals.
- Initial plans for the introduction of four Integrated Medical Centres across Thurrock have been agreed.
- A Design Team has been appointed to develop plans for a 21st Century care facility for older people on the Whiteacres site in South Ockendon.
- Expansion of the Better Care Fund to £43.1m. This pooled fund has enabled far more integrated commissioning of services between health and social care.

Summary of participant's views:

- Thurrock First is established, the triage system is good in principle but people have experienced long delays and difficulties in getting through.
- Work still to be done on prevention.

- Overall LACs are good, but some duplication in workload, individuals highlighted situations where there was a lack of specialism and a need to signpost to Third Sector organisations more effectively.
- Contact Information and referral options for LACs needs to be publicised to the general population. This feeds into a wider issue around publicising telephone and contact information on the Council's website as well as a wider Positive Marketing Strategy to celebrate the "visible" achievements of the Adult Social Care Directorate.
- In terms of integration, the various specific electronic systems need to be able to talk to one another and share information, including for example: LAS/LCS/SystmOne/NHS/Mobius as well as the specific teams on the ground: Hospital discharge/Community Team/Hospital Team – these all need streamlining.

Priority 2 – Continue to strengthen communities and build community resilience by supporting small community based services

Achievements:

- Expanding support for Micro-Enterprise development by the appointment of a dedicated post; there are now 75 enterprises with around 5 new start-ups each month.

Summary of participant's views:

- Individuals expressed the importance of having support to access the right activities in the community relevant to their age and respective peer group, so for example, not just bingo or crochet, but more active clubs such as dancing or computer training. Difficulties around mental health, isolation and loneliness were also highlighted, particularly in the evenings. Funding arrangements, complexities and longevity were also highlighted as a concern for participants.
- Community hubs and volunteers are good.
- A discussion followed around the production of digital community asset maps and Stronger Together, and Thurrock First (as both organisations are producing such maps. There was a degree of confusion over how many maps existed, how they can be accessed and how best to use them, and whether the LACs had ongoing input.
- More could be done to publicise the Social Prescribers project and the work they do, as a number of participants had not heard of them.
- Individuals also discussed Micro Enterprises, how to find out more and who has responsibility for ongoing quality assurance. Participants were of the view that Direct Payments and Micro Enterprises working well for Service Users who now get more choice and control.
- There is room for further improvement of communication between professionals and groups which in turn can build upon further insight into promotion and referrals.

Priority 3 – Increase the use of direct payments to allow people to manage their own care

Achievements:

- Increased the number of people using direct payments – from 242 in 2015/16 to 490 in 2017/18.
- Created a project management role to review the direct payment process.
- Implemented a Direct Payment Engagement Group (DPEG) which has provided awareness and training around common direct payment themes
- Introduction of a co-produced policy for Direct Payments (facilitated by Thurrock Coalition and the DPEG) designed to give service users more choice and control and to improve take up of Direct Payments by simplifying the process.
- Re-tendered the Direct Payment Advice & Support Service.
- Successfully piloted and implemented Individual Service Funds for day opportunities for people with learning and physical disabilities.
- Made the link between the use of direct payments and micro-enterprise providers to extend choice within the local market.
- Making strengths based social work the basis upon which all of our assessments and ongoing case management is delivered, thereby shifting power to the service user and increasing choice and control over the process.

Summary of participant's views:

- The new Direct Payments Project Manager Role is a really positive development. There is a need for people to be supported to be aware of all relevant Direct Payments information and responsibilities before signing up.
- There was a feeling that in terms of Mental Health there is a massive lack in uptake of Direct Payments.
- Micro enterprises are working well. Give(s) people choice and continuity.
- There needs to be an effective and meaningful and local Direct Payments brokerage service.
- There needs to be support available for individuals who lack capacity/understanding and have no family or friends? i.e. Discussion and awareness of the availability of legal protection for family/friends making decisions for people who lack capacity.

Priority 4 – Implement online self-assessments

Achievements:

- Introduction of OT self-assessment to improve turnaround times and reduce waiting lists. 483 completed self-assessments since 2016 from Thurrock residents. Of these, the resident's outcomes were met in full without the need for a face to face assessment for 238 individuals (49%).

  This has helped to avoid delays in waiting times for an assessment for the individual, reduced service demand and maintain waiting times within our corporate targets, and provided a financial saving of approx. £43k over the 2 years.

Of the remaining self-assessments received, 45% had progressed to a face to face assessment. However, it is worth noting that a good proportion of these have had their outcomes partially met through the self-assessment. This in turn has prevented delay for an element of an individual's support arrangements, and enabled the assessor's skills and time to be utilised in full when providing the appropriate support to achieve the remaining outcomes.

With waiting times dropping significantly, we're now finding that allocations are due before the self-assessment has been returned, and this also contributes to the remaining 45% stated above. Further work is now underway to continuously improve this service.

Summary of participant's views:

- The Local Authority should develop online carers assessments in co-production with the relevant third sector organisation(s).

Priority 5 – Complete the re-modelling of home care services to improve choice and quality

Achievements:

- In April 2018 a new home care contract was procured under the title "Living Well in Thurrock".
- Three successful organizations were awarded contracts under a new specification designed to improve choice, establish a sustainable service and to expand quality through working to produce outcomes keeping with those identified by the people we support.
- A further improvement to the delivery of support to people in their own homes will be trialed in Tilbury/Chadwell during 2019 through the introduction of "Well-being Teams". These small, self-managing teams will be deployed in communities covering small patches to ensure continuity of care (that is people see the same small group of workers and can establish a relationship with them). The onus will be on providing the majority of contact time possible through reducing bureaucracy and ensuring duplication (many people delivering different aspects of someone's care) is reduced, both aspects of which will improve quality and consistency whilst ensuring the service is efficient.

Summary of participant's views:

- For wellbeing / independent living – wellbeing is not promoted as a lack of accessibility through a lack of communication undermines the effectiveness of provision.
- Care providers in a particular area sometimes don't have capacity to take on a care package. If a client can't manage a DP, what happens? Need to ensure a choice of providers in an area.
- What happens when micro agencies aren't micro? (For example, when they get too big).

Priority 6 – Roll-out the delivery of Shared Lives in Thurrock

Achievements:

- Shared Lives Services was implemented from April 2017. Shared Lives Champions have been appointed in each team and a focussed Shared Lives Campaign took place to encourage take up. Unfortunately there has been a slow start in getting referrals and there are currently only four arrangements in place. However, referrals have been picking up and more Shared Lives Carers are being trained.

Summary of participant's views:

- Participants suggested that the initiative is really positive but the model and its potential needs to be publicized and communicated much better.
- Short Breaks v's Shared Lives?
- Participants discussed issues with transition from fostering into Shared Lives and potential implications on choice and control for individuals.

Priority 7 – Put in place an independent system to ensure that our processes to financially assess individuals are fit for purpose

Achievements:

- An internal review has been undertaken, the recommendations from which are now being implemented which will improve performance.
- We have visited a number of regional comparators to learn from best practice and we have had regular contact with the national body who oversee customer finance to ensure our processes and policies are in-keeping with changes in national guidelines.

Summary of participant's views:

- Give people feedback in accessible formats.
- Thurrock is good at asking people their views.
- There is a need to improve financial assessments so people fully understand the process, and their various technical aspects, including, for example: what is covered under Disability-related expenditure.
- There is a danger that financial assessments can be seen as intrusive so that care needs are not pursued. Reassurance and communication as to the reasoning and purpose of financial assessments need to be key considerations.

Priority 8 – Re-tender the Healthwatch service to improve scope, ensuring quality of service

Achievements:

- Healthwatch Thurrock has been re-tendered but continues to be provided by Thurrock CVS.
- The re-tendered service features the following improvements:
    - Increased community engagement to seek the views of local residents of Health and Social Care.
    - Facilitating the implementation of a People's Panel to oversee Orsett Hospital.
    - Seeking the views of residents on Mental Health Services in Thurrock.

Summary of participant's views:

- Good service for people struggling locally with under doctoring and concerns around hospital transport and the proposed changes to hospital services, including Orsett. What will the new contract say about advocating for patients and campaigning for positive service improvement in this specific context locally?
- People are still struggling to access timely healthcare appointments.
- Need more services for individuals with sensory impairments.

Priority 9 – Develop a specialist Autism service

Achievements:

- Work began in June 2018 on a new build of autism specialist housing provision in Thurrock. Thurrock Council is working jointly with Peabody Trust (formally 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 individuals outside of the borough.
- Medina Road is primarily aimed to meet the needs of those on the autistic spectrum and as a home for like. Ground works have already commenced on the site with an anticipated completion date of Autumn 2019.
- The Thurrock Autism Action Group has contributed to the design of the accommodation and will continue to help co-produce the service specification.

Summary of participant's views:

- The Autism Action Group urgently needs a Commissioning officer and permanent Local Authority Co-Chair.
- Is this Priority going to be wider than a housing project?
- Choice is key – 6 houses are commendable but is only the tip of the iceberg.
- Segregated housing is not great and the site is isolated.
- What about housing for people with Dementia?

Priority 10 – Keep vulnerable people safe

Achievements:

- Responded to over 1,400 concerns in the last two years, conducting over 340 section 42 enquiries.
- Responded to over 1,500 Deprivation of Liberty requests in the same period with 65% of these being granted.
- Set up a Safeguarding Practitioners Forum for learning and development and more informed responses to safeguarding concerns.
- 80 citizens with learning disabilities have attended Stay Safe events.
- Set up a multi-agency Self Neglect and Hoarding Panel to help support those who pose the highest risk to self.
- Funded the Lasting Power of Attorney project led by Thurrock Coalition supporting over 300 people to apply online.
- Commission a Safer Places Thurrock service with BATIAS.

Summary of participant's views:

- There used to be lots going on in my life – college, safety, cleaning, gardening. All stopped.
- Safeguarding working well with Advocacy Services.
- Needs a proper public campaign "Everyone's business!"

Setting the priorities for 2019-2020

The workshops went on to consider areas that the Council was doing well and areas for improvement and suggested priorities based upon a vote across all of the areas under consideration.

A report of the workshops activity is attached at Appendix 1 of this account; this provides the background and rationale for the priorities that follow:

Our 10 Key Priorities for 2019-2020

- Making the most of every contact counts -tell us once, ask us once.
- Join up Mental Health services and social care
- Public Health and Wellbeing - focus on prevention
- Direct Payments - Greater clarity for service users contemplating Direct Payments
- Training should be co-produced - a Community, Third Sector and Statutory offer
- Develop a Marketing Strategy for Adult Social Care
- Improve Home Care, Respite and Carers support
- Build upon community resillience
- Expand services for people on the Autistic spectrum
- Safeguarding and keeping vulnerable people safe

Next Steps

- Local Account to be taken to the various representative groups for agreement to continue the co-design cycle.
- Report to be taken to Thurrock Council's Health and Well-being Overview and Scrutiny Committee to ensure political oversight of the objectives.
- Establish a steering group from the council and members of the representative groups to oversee the achievement of the objectives.
- The steering group will have responsibility to produce regular reporting of performance against agreed objectives, to the Thurrock Disability Partnership Board and the Health & Wellbeing Overview & Scrutiny Committee from time to time, along with any recommendations the co-production of future Local Accounts.

Feedback – Tell Us What You Think

This is the end of our report. We hope you have found it interesting and informative.

We are very interested in your views about whether you have found this report helpful and your suggestions about how to improve it in the future. In addition, if you have any comments or suggestions about the activity being discussed in the report we would love to hear from you.

If you would like to give feedback on this report, you can do so through the following methods:

Email: ascfeedback@thurrock.gov.uk

Postal Address:
Performance, Quality & Business Intelligence
FREEPOST ANG1611
Thurrock Council
Civic Offices
New Road
Grays
Essex
RM17 6SL

Telephone Number: 01375 652643

Appendix One – Adult Social Care National Key Performance Indicators 2017/18

	Thurrock 2014/15	Thurrock 2015/16	Thurrock 2016/17	Thurrock 2017/18	Direction of Travel	England 2017/18	Thurrock Compared to England
1A - Social care-related quality of life	19.6	19.6	19.1	19.7	↑	19.1	↑
1B - % of people who use services who have control over their daily life	74.2	83.7	75.5	79.9	↑	77.7	↑
1C(1a) - % of people using social care who receive self-directed support	70.3	74.2	73.7	76.0	↑	89.7	↓
1C(1b) - % of carers who receive self-directed support	8.9	94.4	87.5	100.0	↑	83.4	↑
1C(2a) - % of people using social care who receive direct payments	31.6	28.6	28.4	28.0	↓	28.5	↓
1C(2b) - % of carers who receive direct payments	8.9	94.4	87.5	100.0	↑	74.1	↑
1D – Carer-reported quality of life score	7.9	-	7.5	-	-	-	-
1E - % of adults with learning disabilities in paid employment	7.3	7.4	6.3	6.8	↑	6.0	↑
1F - % of adults in contact with secondary mental health services in paid employment	8.9	9.9	8	9	-	7	↑
1G - % of adults with learning disabilities who live in their own home or with their family	83.1	85.2	69	75.6	↑	77.2	↓
1H - % of adults in contact with secondary mental health services who live independently, with or without support	75.4	72.2	67	64	↓	57	↑
1I(1) - % of people who use services who reported that they had as much social contact as they would like	49.2	47.9	50.0	47.2	↓	46.0	↑
1I(2) - % of carers who reported that they had as much social contact as they like	45.1	-	29.7	-	-	-	-
1J – Adjusted social care-related quality of life – impact of adult social care services	-	-	0.471	0.447	↓	0.405	↑
2A(1) - Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population	16.9	11.8	5.8	6.7	↑	14.0	↓
2A(2) - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	438.5	674.1	710	681.7	↓	628.2	↑

2B(1) - % of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)	86.0	90.8	88.4	88.7	↑	82.9	↑
2B(2) - % of older people (65 and over) who were offered reablement services following discharge from hospital	5.7	4.2	2.5	1.6	↓	2.9	↓
2C(1) - Delayed transfers of care from hospital per 100,000 population	7.4	5.0	10.5	7.4	↓	12.3	↓
2C(2) - Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	1.3	1.2	5.3	3.0	↓	4.3	↓
2C(3) – Delayed transfers of care from hospital that are jointly attributable to NHS and adult social care, per 100,000 population	-	-	-	0.4	-	0.9	↓
2D - % of new clients who received a short-term service during the year where the sequel to service was either no ongoing support or support of a lower level	49.4	86.9	27.6	46.6	↑	77.8	↓
3A - Overall satisfaction of people who use services with their care and support	64.5	69.2	67.9	47.3	↓	65.0	↓
3B – Overall satisfaction of carers with social services	42.9	-	40.2	-	-	-	-
3C - % of carers who report that they have been included or consulted in discussion about the person they care for	71.6	-	73.0	-	-	-	-
3D(1) - % of people who use services who find it easy to find information about support	75.5	85.8	75.7	71.6	↓	73.3	↓
3D(2) - % of carers who find it easy to find information about support	68.2	-	70.1	-	-	-	-
4A - % of people who use services who feel safe	71.7	72.8	66.7	75.4	↑	69.9	↑
4B - % of people who use services who say that those services have made them feel safe and secure	91.5	87.7	89.9	89.5	↓	86.3	↑

Appendix Two – Summary of Outcomes from Workshops

The Workshops – at a glance

The Workshops were facilitated by Community Catalysts CIC with operational and content support from Thurrock Coalition. There were three separate workshops, each lasting approximately three hours, each aimed at a specific audience, a mix of individuals, family members, carers, Adult Social Care and third sector professionals.

The full Report can be downloaded from: http://www.thurrockcoalition.co.uk/wp-content/uploads/2018/10/Thurrock-Coalition-Informing-the-Local-Account-through-Coproduction-October-2018-FINAL.pdf

The Workshops – the Process

Aimed at:

- Members of Thurrock Diversity Network who have lived or work experience of health and social care services and supports in Thurrock
- Members of the public who have experience of or an interest in health and social care services and supports in Thurrock
- Professionals and practitioners who deliver services or guide people through the health or care systems

Purpose:

- Inform people about the Local Account – its purpose and past progress
- Thank people who have been involved in the past for their contribution
- Demonstrate that contribution equals action and impact
- Engage people in contributing to a new Local Account

The Workshops – The Programme:

Adult Social Care in Thurrock

- What it is
- Current focus and challenges

What is the Local Account?

- What it is
- Why we do it
- What it covers

Looking back

- 2016/17 Local Account
- Gathering views on the 10 priority areas – Do participants recognise them? Are they the right priorities?
- Issues discussed, plans developed and action taken

Moving forward

- Things the Council is doing well
- Things the Council needs to improve
- Identifying and setting priorities for the future

Looking Back - The 2016/2017 Local Account Priorities

Participants were asked to consider the 10 Priorities from 2016/17 and discuss awareness of progress and achievements against each Priority, whether the Priorities are still relevant and to suggest some positive actions to consider. We have summarised the discussions below.

Priority 1: Continue to join up health and social care services though the Better Care Fund, to support people better

Summary of participant's views

- Thurrock First is established, the triage system is good in principle but people have experienced long delays and difficulties in getting through.
- Work still to be done on prevention
- Overall LACs are good, but some duplication in workload, individuals highlighted situations where there was a lack of specialism and a need to signpost to Third Sector organisations more effectively.
- Contact Information and referral options for LACs needs to be publicised to the general population. This feeds into a wider issue around publicising telephone and contact information on the Council's website as well as a wider Positive Marketing Strategy to celebrate the "visible" achievements of the Adult Social Care Directorate.
- In terms of integration, the various specific electronic systems need to be able to talk to one another and share information, including for example: LAS/LCS/SystmOne/NHS/Mobius as well as the specific teams on the ground: Hospital discharge/Community Team/Hospital Team – these all need streamlining.

Priority 2: Continue to strengthen communities and build community resilience by supporting small community based services

Summary of participant's views

- Individuals expressed the importance of having support to access the right activities in the community relevant to their age and respective peer group, so for example, not just bingo or crochet, but more active clubs such as dancing or computer training. Difficulties around mental health, isolation and loneliness were also highlighted, particularly in the evenings. Funding arrangements, complexities and longevity were also highlighted as a concern for participants.
- Community hubs and volunteers are good
- A discussion followed around the production of digital community asset maps and Stronger Together, and Thurrock First (as both organisations are producing such maps. There was a degree of confusion over how many maps existed, how they can be accessed and how best to use them, and whether the LACs had ongoing input
- More could be done to publicise the Social Prescribers project and the work they do, as a number of participants had not heard of them.
- Individuals also discussed Micro Enterprises, how to find out more and who has responsibility for ongoing quality assurance. Participants were of the view that Direct Payments and Micro Enterprises working well for Service Users who now get more choice and control
- There is room for further improvement of communication between professionals and groups which in turn can build upon further insight into promotion and referrals

Priority 3: Increase the use of direct payments to allow people to manage their own care

Summary of participant's views

- The new Direct Payments Project Manager Role is a really positive development. There is a need for people to be supported to be aware of all relevant Direct Payments information and responsibilities before signing up.
- There was a feeling that in terms of Mental Health there is a massive lack in uptake of Direct Payments.
- Micro enterprises are working well. Give(s) people choice and continuity
- There needs to be an effective and meaningful and local Direct Payments brokerage service
- There needs to be support available for individuals who lack capacity/understanding and have no family or friends? i.e. Discussion and awareness of the availability of legal protection for family/friends making decisions for people who lack capacity

Priority 4: Implement online self-assessments

Summary of participant's views

- The Local Authority should develop online carers assessments in co-production with the relevant third sector organisation(s)

Priority 5: Complete the re-modelling of home care services to improve choice and quality

Summary of participant's views

- For wellbeing / independent living – wellbeing is not promoted as a lack of accessibility through a lack of communication undermines the effectiveness of provision
- Care providers in a particular area sometimes don't have capacity to take on a care package. If a client can't manage a DP, what happens? Need to ensure a choice of providers in an area.
- What happens when micro agencies aren't micro? (For example, when they get too big).

Priority 6: Roll out the delivery of Shared Lives in Thurrock

Summary of participant's views

- Participants suggested that the initiative is really positive but the model and its potential needs to be publicised and communicated much better
- Short Breaks vs Shared Lives
- Participants discussed issues with transition from fostering into Shared Lives and potential implications on choice and control for individuals.

Priority 7 – Put in place an independent system to ensure that our processes to financially assess individuals are fit for purpose

Summary of participant's views

- Give people feedback in accessible formats
- Thurrock is good at asking people their views
- There is a need to improve financial assessments so people fully understand the process, and there various technical aspects, including, for example: what is covered under Disability-related expenditure
- There is a danger that financial assessments can be seen as intrusive so that care needs are

not pursued. Reassurance and communication as to the reasoning and purpose of financial assessments need to be key considerations in this regard.

Priority 8: Re-tender the Healthwatch service to improve scope, ensuring quality of service

Summary of participant's views

- Good service for people struggling locally with under doctoring and concerns around hospital transport and the proposed changes to hospital services, including Orsett. What will the new contract say about advocating for patients and campaigning for positive service improvement in this specific context locally?
- People are still struggling to access timely healthcare appointments
- Need more services for individuals with sensory impairments

Priority 9: Develop a specialist autism service

Summary of participant's views

- The Autism Action Group urgently needs a Commissioning officer and permanent Local Authority Co-Chair.
- Is this Priority going to be wider than a housing project?
- Choice is key – 6 houses are commendable but is only the tip of the iceberg.
- Segregated housing is not great and the site is isolated
- What about housing for people with Dementia?

Priority 10: Keep vulnerable people safe

Summary of participant's views

- There used to be lots going on in my life – college, safety, cleaning, gardening. All stopped
- Safeguarding working well with Advocacy Services
- Needs a proper public campaign "Everyone's business!"

Moving forward – Things the Council are doing well and things the Council need to improve

The workshop discussions then went on to discuss aspects of projects and initiatives that the Council are doing well, and secondly, elements that the Council needs to improve. We have collated some Key Positive Headlines and Aspects to improve, identified from across all 3 workshops. The full verbatim feedback appears in the Appendices to this Report.

Positive Headlines

- The wide range of Community Development Initiatives – Hubs, LACs and Micro Enterprises
- Supporting the Thurrock Coalition Lasting Power of Attorney Champions Project
- Work relating to Direct Payments
- Thurrock Carers Service
- Rapid Reablement and Assessment Service
- Health & Wellbeing pilot
- Building a vibrant care market
- Approach to Consultation and Co-production

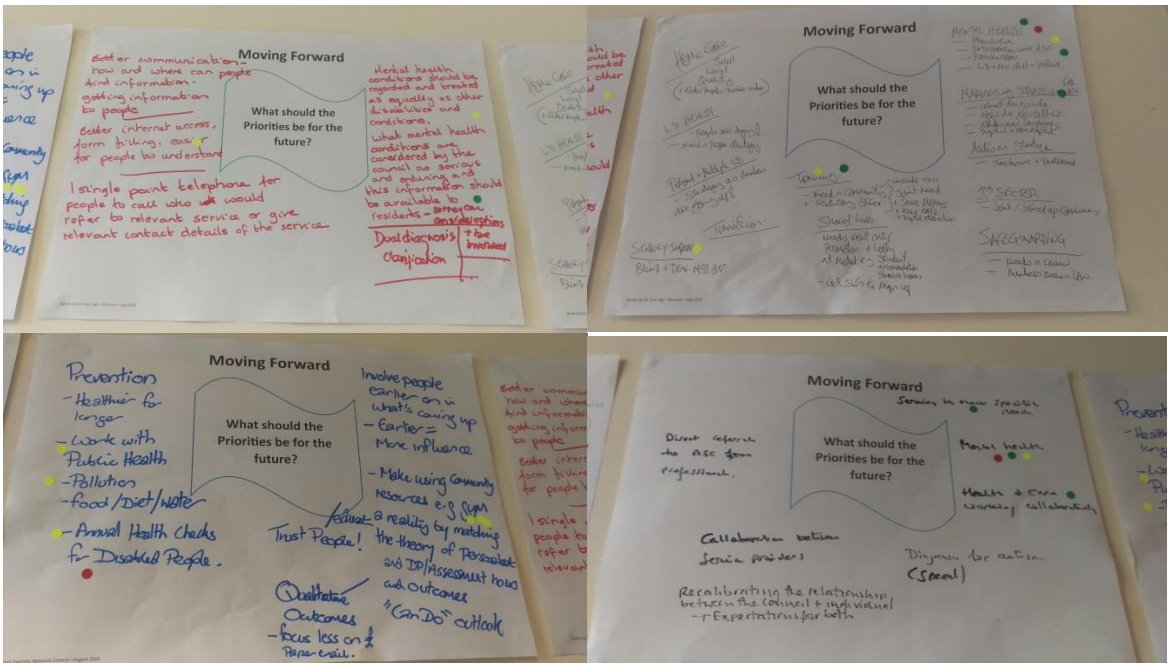
Key aspects to improve

- Marketing, publicity and advertising what Adult Social Care funds (and does not fund). Raise the profile of Adult Social Care/Charges/Partners/Groups etc. Good News!
- Moving towards and supporting people with online assessments
- Home Care
- Referrals from LACs to specialist Third Sector advice
- Communication and publicity around Thurrock First, including managing call volumes
- The Council website – Need to include telephone numbers and make the site easy to navigate – Should adopt and use the Three Click Navigation Rule.[1] Information needs to be in a range of accessible formats for different needs – not just digital only.
- GP/Primary health, relationships and mental health – early intervention and prevention.
- Continue to improve joint working including the integration of IT systems, more intuitive information sharing, and "looking outside the box" for creative solution focussed assessments of need, using the array of Community Development Initiatives and Third Sector organisations

Moving Forward - Identifying and setting priorities for the future

Participants were then asked to discuss and note down areas of Priority for the Council to consider and take forward. Based upon the range of discussions and experiences shared, a total of 72 priority topics/issues were subsequently identified.

Each individual was asked to vote for their top 3 Priorities that were of most importance to them.



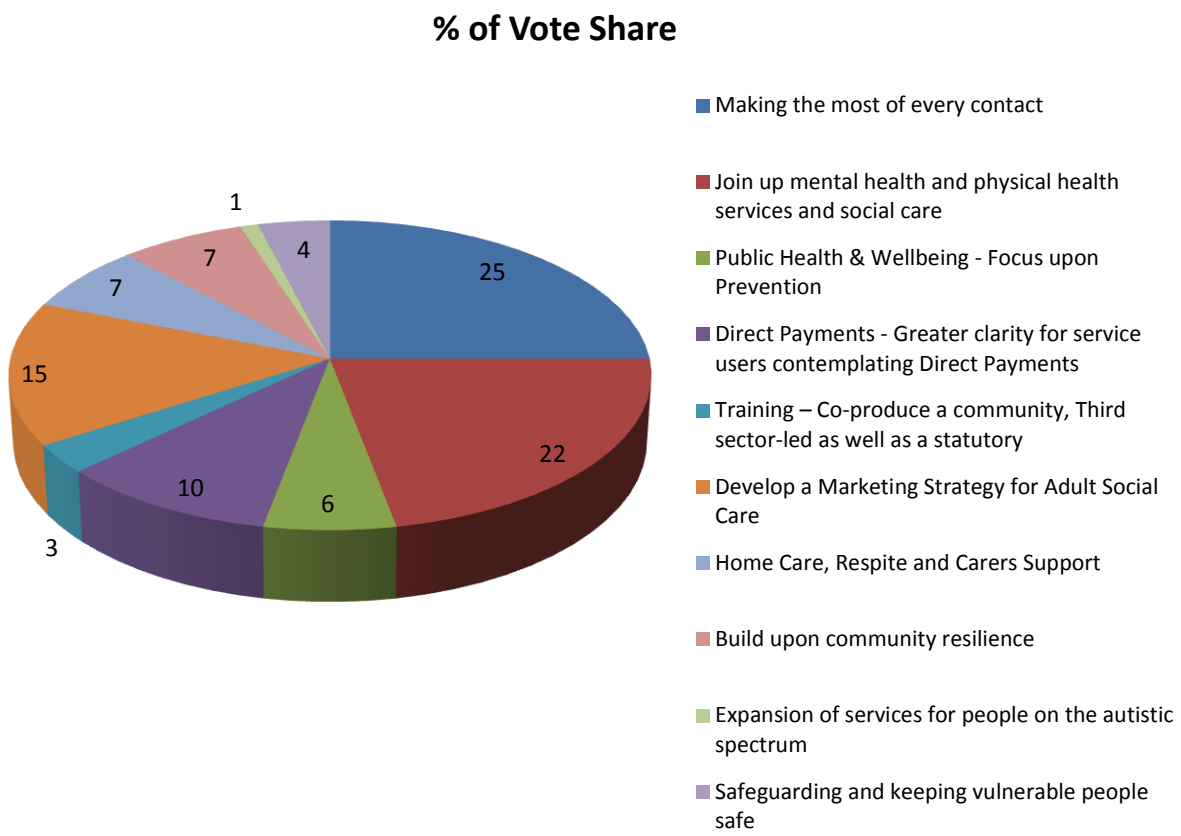
A sample of the Voting process for the new set of Priorities for the Thurrock Council Adult Social Care Local Account

[1] The *three-click rule* or *three click rule* is an unofficial *web* design *rule* concerning the design of *website navigation*. It suggests that a user of a *website* should be able to find any information with no more than *three* mouse *clicks*.

Voting for the Priorities

Following the voting, a degree of overlap became evident which then made it possible to group the priorities by topic and theme. The following 10 Priorities emerged from the discussions, views, suggestions and recommendations from all 3 workshops.

The overall percentage of vote share for each priority is displayed below:



This page is intentionally left blank

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
Adult Social Care - Fees & Charges Pricing Strategy 2019/20	Andrew Austin / appropriate finance officer	Officers
Thurrock Safeguarding Adults Board Annual Report 2017/18	Roger Harris	Officers
Improving Cancer Waiting Times	Andrew Pike	Officers
Communities First – A Strategy for developing Libraries as Community Hubs in Thurrock	Natalie Warren	Officers
Developing a new residential care facility and a new model of primary care in South Ockendon	Christopher Smith	Officers
Further Transformation to Continue Improving Standards in Primary Care	Ian Wake	Officers
Mental Health Urgent and Emergency Care	Mark Tebbs	Officers

24 January 2019		
HealthWatch	Kim James	Officers
Adult Mental Health Service Transformation	Roger Harris	Officers
Briefing Note - Referral to the Secretary of State – Orsett Hospital	Roger Harris	Officer
Verbal Update – SERICC	Mandy Ansell / Jane Itangata	Members
Briefing Note - NHS Long Term Plan	Roger Harris	Officers
7 March 2019		
HealthWatch	Kim James	Officers
Sexual Assault and Abuse Mental Health Pathway in Thurrock	Mark Tebbs, CCG	Members
NHS Long Term Plan: An overview and critique for Thurrock	Ian Wake	Officers
Verbal STP Update	Roger Harris	Officers
Adult Social Care Local Account 2018-2020	Les Billingham	Officers

Reports for 2019/20:

- Update on Cancer Waiting Times
- Flash Glucose Monitoring Report
- Update on Mental Health Urgent Care Package (Sept/Oct)
- Whole System's Obesity Strategy (June) – Faith Stow

Clerk: Jenny Shade
Last Updated: November 2018

This page is intentionally left blank